1979-1980

HOUSE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

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STATE HEALTH INSURANCE (FILE NO. 5)

FISCAL NOTES - HB 977 / SB 277

CHILDREN'S CODES (SB 106 / HB 204, 1977-78)

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HB 4

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SCR 40

DEPT.
OF
ED

READ

AN OVERVIEW OF

THE

DEPARTMENT OF HEALTH AND SOCIAL SERVICES

February 19'

DIVISION OF ADMINISTRATIVE SERVICES

The Division of Administrative Services provides needed services to the department's program divisions, offices and agencies, plus the commissioner's office. Included services are personnel, supply, fiscal, accounting, federal financial reporting, budget preparation and execution, expenditure monitoring and control, contract administration, employee payroll, mail/messenger and graphic arts. The civil rights and equal employment opportunity programs are also coordinated through this division.

DIVISION OF CORRECTIONS

The state-operated adult institutional programs provided custody and treatment programs for an average of 711 prisoners each day during FY 78. The division continued to obtain services by contract from the Federal Bureau of Prisons at a level averaging 45 prisoners during the year, and also continued to contract with local jails for temporary services at Kodiak, Kenai, Bethel, and Sitka. The following operational changes were made with respect to adult correctional centers:

The opening of the Ridgeview Correctional Center in December 1977 heralded the first exclusively women's program correctional center in the State. Although available funds in FY 78 fell considerably short of renovation needs, the facility is operational and secure, and further renovations are planned for FY 79. The facility appears to have satisfied the Human Rights Commission's formal complaint, by providing more suitable housing and programs. Adult basic education, drug and alcohol counseling, cooking, needlework, and recreational activities are now available. The facility has a limited capacity of 28 and has maintained a population

near that level since December.

The 3rd Avenue Correctional Center has been changed to house maximum security prisoners as well as medium and minimum security prisoners for the purpose of classification, transferring persons to institutions throughout the state in order to place the prisoner in the institution which most nearly fits his needs. A prisoner's average length of stay at 3rd Avenue is six (6) weeks.

The 6th Avenue Correctional Center houses only pre-trial and unsentenced prisoners. It is no longer a program facility. Its primary purpose is to serve the Anchorage area as an intake facility for all arrested offenders in the Anchorage area.

The Nome State Correctional Facility came on line as a State facility on October 1, 1977. Formerly the facility was managed by the City of Nome, Alaska. The Nome Facility is rated at 30 beds and is staffed by 11 correctional employees. The Nome Facility is now handling nearly twice as many offenders as it did when it was a city jail.

The Division of Corrections provided services to a daily average of 130 youths in the state-operated McLaughlin Youth Center. Additionally, through contracts for specialized care, an average of 40 youths received services outside the state. The majority of youths for whom the division is responsible received care under community placement through probation services. During FY 78 the probation/parole information system provided services for 62 average workload units per month per probation.

AJIS terminals have been installed and are operational in all Alaska Correctional Institutions and in the Regional Probation and Parole Office, except Nome, and all stations are connected to the central records room in Juneau. There are 13 terminals presently operating. The system frequently handles more than 300 messages per day. The messages provide a flow of management information to and from the central office and between the institutions. The system is used to facilitate the transfer of prisoners, to provide statistical information (morning counts, etc.) and to issue requests and directives. It also provides (daily) personnel information and data on juvenile incidents as well as facilitating file searches and number assignments and is used to issue NLETS information to a nation-wide justice reporting system.

The need to develop and implement a statewide medical care program became more evident in FY 78 Statewide medical costs approached $0.75 million, and the continued upward trend in prisoner population dictated the move toward medical care standardization. A federal grant--a medical care demonstration project for jails--was secured, and a medical administrator has been employed. It is expected that medical care for prisoners will not only be improved, but cost reductions and avoidance of costly lawsuits will be realized.

A Corrections Career Ladder Program has been developed with a balanced emphasis on the need for the public safety through improved security staffing patterns, and the establishment of a formal structure for treatment staff trained for specializing in the development, operation, and evaluation of reformative programs for prisoners. The Career Ladder is designed for maximum flexibility in staffing through the use of a

component structure that may be tailored to meet specific or unique staffing needs. A major problem has been, and continues to be, the lack of sufficient state funds to meet training needs, rather than relying on the use of grant funds for 50% of the training programs.

DIVISION OF MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES

The Division of Mental Health and Developmental Disabilities is responsible for the development, implementation, and administration of programs for the prevention and treatment of mental illness and for the habilitation of developmentally disabled persons. The division also seeks to further public awareness of mental health and developmental disabilities.

The division provides in-patient psychiatric services at the Alaska Psychiatric Institute, a 200-bed JCAH accredited acute-care facility for the mentally ill. Harborview Developmental Center in Valdez, a 120-bed certified Intermediate Care Facility for the Mentally Retarded (ICF/MR), provides care, training, education and habilitation for the developmentally disabled. In addition, the division operates regional mental health offices in Anchorage, Fairbanks, and Juneau to provide statewide coordination, development, and technical assistance for community mental health services.

The division is currently providing grants-in-aid to 19 locally controlled and operated community mental health centers located throughout Alaska. In addition, services for the developmentally disabled are provided at the local level under contractual agreements administered by the division. These community based developmental disabilities services are located in

Anchorage, Fairbanks, Juneau, and Ketchikan.

Services to the courts and the Division of Corrections are provided, for the most part, at the recently opened Psychiatric Security Unit at the Alaska Psychiatric Institute. This 14-bed unit is a medium security unit providing evaluations and observations for the court and short-term treatment for the mentally ill offender.

The Governor's Mental Health Advisory Council and the Governor's Council on the Handicapped and Gifted provide advice and recommendations to the division concerning the delivery of services to the mentally ill and the developmentally disabled.

DIVISION OF PUBLIC ASSISTANCE

The Division of Public Assistance administers the following programs: Adult Public Assistance, Aid to Families with Dependent Children, Food Stamps, General Relief, Medicaid, and General Relief Medical.

Regional offices are maintained in Juneau, Anchorage, Fairbanks, Bethel, and Kotzebue to supervise 20 district offices. There are 149 full-time and 11 part-time positions within the division. The division has a fiscal 1979 budget appropriation of approximately $75 million, of which 47 per cent is federally funded.

During FY 1978, medical care was provided to approximately 12,500 Medicaid recipients at a cost of $25.8 million (50 per cent federally funded). Services covered by Medicaid include in-patient and out-patient hospital,

laboratory and x-ray, skilled nursing and intermediate facility care, physician's services, early and periodic screening, diagnosis and treatment, home health, transportation, optometrist's services, eyeglasses, treatment for speech, hearing and language disorders and in-patient psychiatric care.

Individuals not eligible for Medicaid may be eligible to receive help from General Relief-Medical. In FY 1978, $6.2 million (100 per cent state funded) were spent on services similar to those provided under the Medicaid program with the exception of home health and screening programs.

Benefits totalling $5.25 million were paid to recipients of Adult Public Assistance during FY 1978. Payments by program during the year were: Old Age Assistance, average payment of $112.78 was made to 1,849 recipients each month for total of $2.5 million; Aid to the Disabled, average payment of $135.48 to 1,633 recipients each month with total payments of $2.15 million; Aid to the Blind, average payment of $131.51 to 66 recipients each month with total payments of $104,200.

Persons not eligible for financial assistance under any of the categorical programs may be eligible for General Relief. Through this program emergency help such as one-time payment to vendor for rent or fuel is available. The total paid during FY 1976 under the General Relief program was $500,900.

Financial aid totalling $16 million was paid to 11,821 recipients eligible for Aid to Families with Dependent Children with an average payment of $113.09 per month.

The new Catastrohpic Illness Program provides medical assistance to eligible applicants who have experienced a single illness or injury during a 12-month period which, after all other sources of payment have been exhausted, leaves medical expenses of more than $1,000. The total amount expended during FY 78 was $450,000.

Approximately $2.49 million was spent on determination of eligibility for all programs administered by the division. Determination of eligibility is done by 78 eligibility workers located throughout the state.

DIVISION OF PUBLIC HEALTH

During FY 78, the Division of Public Health continued to provide preventive medical and environmental health services to the citizens of the state. Significant accomplishments included:

-A statewide immunization program aimed particularly at infants and preschool children. A survey of children entering school showed that 98.3% had received all required immunizations. This figure exceeds the national goal set by HEW.

-Provision of some 335,000 public health nursing services to people in all parts of the state. The types of services included maternal and child health, communicable disease control, screening for diseases, acute care and preventive services in mental health, substance abuse and accident prevention.

-Provision of new leased space for health centers in Nome and Wasilla and modification of health centers in Kake, Hoonah, Kenai,

Dillingham, and McGrath to permit more effective services and better coordination of state programs with those of regional native health corporations.

-Development of standards and regulations for Metabolic Screening of Newborn Infants. The implementation of these standards and regulations places Alaska among the top five states with screening programs for early detection of metabolic disorders leading to mental retardation.

-Granting of interim approval to four (4) local laboratories in the state for microbiological examination of water samples from public drinking water supplies. This marks the first time in Alaska that non-state laboratories have been approved for this service.

-Isolation and identification of the three influenza virus strains involved in the past winter's flu season. Screening of over 900 specimens submitted on suspected influenza cases, confirmed that the so-called Russian (USSR) strain cases were restricted to military personnel and not present in the civilian population.

-Strengthening of the otitis media program in the Bethel area.

-Issuance of educational materials on management of commerical food service activities and on prevention of botulism in home prepared foods.

-Production of 37 programs on public health issues which were shown as part of the Alaska Television Satellite Demonstration Project.

-Production of new educational materials which included two coloring

books for the otitis media project; pamphlets describing the services and special clinics for four (4) different health centers, grocery bag stuffers for "Week of the Young Child," Wrangell TB Clinic, "No Shots - No Day Care," Hearing Screening and Noise-Induced Hearing Loss. Pamphlets were designed for Handicapped Children's Program, Botulism, Ear Aches and Draining Ears, and After a Tympanoplasty Operation.

-Completion of data entry of Southeastern Regional facilities health data in the Patient Care Information System. This system which will be used by state-operated health centers and Alaska Native Health Service facilities will make a significant contribution towards improved patient care by providing current surveillance lists for needed follow-up on patients and eliminating duplication of services.

DIVISION OF SOCIAL SERVICES

The Division of Social Services, through its six (6) regional offices and 37 field offices, provided statewide child and adult protective services in response to problems of neglect, abuse or exploitation. The division served more than 4,800 children and over 350 adults through these services. Of the more than 4,800 children served, 70% received supportive services while residing in their own home. Another 1,256 children received services while residing in foster care arrangements.

In addition, the staff of the division provided information and referral services for more than 5,000 individuals to help them to identify and utilize appropriate services provided by other public and private agencies. Individual and family counseling was provided for over 2,700

individuals by the social work staff.

Services made available for clients for the Division through purchase arrangements with private contractors included protective services, day care for over 200 children, and homemaker services for over 500 individuals and families.

OFFICE OF ALCOHOLISM AND DRUG ABUSE

The Office of Alcoholism and Drug Abuse was administratively combined in FY 78. There are still separate statutes and two (2) separate Advisory Boards for Alcoholism and Drug Abuse.

The Office funds 26 alcoholism prevention, treatment or rehabilitation programs in Anchorage, Fairbanks, Kotzebue, Nome, McGrath, Bethel, Napaskiak, Unalaska, Dillingham, Copper River, Tok, Kodiak, Kenai, Yakutat, Juneau, Sitka, Hoonah, Kake, Petersburg, Wrangell, and Ketchikan. Many of those programs are co-funded by the Division of Mental Health and Developmental Disabilities, the Criminal Justice Planning Agency, C.E.T.A., the Indian Health Service and the Veterans Administration. Major efforts this year are being made to solidify working relationships between these programs and other interested agencies, including the criminal justice system, mental health and social services programs, and the schools. It is estimated that more than 5,000 clients will utilize these programs during FY 79.

The Office funds 11 drug abuse prevention, treatment and rehabilitation programs in Anchorage, Fairbanks, Nome, Dillingham, Sitka, Petersburg,

and Ketchikan. Services range from youth recreation and counseling programs in Fairbanks, Petersburg, Sitka, and Ketchikan, to methadone maintenance programs for hard drug addicts in Anchorage and Fairbanks. The projection is for more than 1,000 clients to utilize these services during FY 79.

In both Alcoholism and Drug Abuse, there is a heavy demand for increased prevention programming, training for program staff and boards, and better evaluation technology for programs, including outcomes of treatment.

There is on file in the State Office a total of $6 million in requests for alcoholism programs, as well as a total of $2 million of requests for Drug Abuse programming, for a combined total of $8 million. Total available FY 79 funds for the Alcoholism program amount to $2.6 million, while for Drug Abuse, the total is $9 hundred thousand. The State Office of Alcoholism and Drug Abuse estimates that approximately 40% of the need expressed by local communities is currently being met.

OFFICE OF STATE HEALTH PLANNING AND DEVELOPMENT

Increased responsibilities led to the reorganization of the Office of Planning and Research into two (2) separate units, the Office of State Health Planning and Development (OSHPD) and the Office of Information Systems (OIS). These new offices will concentrate on the areas of health planning and data collection and analysis in order to provide the department with necessary information for the delivery of human service programs.

More specifically, the Office of State Health Planning and Development (OSHPD) is responsible for implementing the National Health Planning and Resource Development Act (P.L. 93-641) and licensing and certifying all state medical facilities.

P.L. 93-641 provides for the coordination of health planning efforts at the local, regional, and state levels. In Alaska, this planning effort is coordinated through the OSHPD in conjunction with the three (3) regional health system agencies and the Statewide Health Coordinating Council, who have just completed a proposed State Health Plan. The planning scheme attempts to prevent a duplication of effort and to allow efficient and optimum use of valuable resources. By lending technical assistance and expertise to local and regional planning, a more uniform approach to solving Alaskan health problems will be realized.

The Office of State Health Planning and Development is also responsible for licensing and certifying all state medical facilities. This includes those facilities that are providing part or all levels of care under Medicaid and Medicare.

OFFICE OF INFORMATION SYSTEMS

The new Office of Information Systems (OIS) has retained all of the responsibilities of the data services unit that was located within the former Office of Planning and Research. The main focus of OIS remains progamming and systems analysis for all department divisions and offices. Support is also provided for new department projects that require immediate analysis for decision-making at the division level. OIS also

provides statistical reporting and research for all divisions and offices, so that the ever increasing population will continue to be served effectively by the department and its human services programs.

Under the new organization, the Bureau of Vital Statistics and the State Center for Health and Social Statistics report directly to the Coordinator of OIS. This management scheme provides for the assimilation and distribution of data information within the department on a uniform basis and without duplication of effort. Office of Information Systems is currently developing a common data base for use by the department to provide a more effective long range delivery of services.

OFFICE ON AGING

The Office on Aging increased the numbers of hot meals served to senior Alaskans by more than 20%, and increased the amount of transportation provided to the elderly by the same percentage. New meal sites were developed, or the number of meal sites was increased, in Haines, Hydaburg, Pelican, Petersburg, Sitka, Palmer, the Cook Inlet Native Association in Anchorage, and Nenana. Cordova, Dillingham, and Bethel have new general senior centers, which were provided under Title III.

For the first time, the Department, through the Office on Aging, placed approximately 125 persons age 55 or over in part-time employment under Title IX of the Older Americans Act. These senior citizens work for a maximum of 1,300 hours per year, largely in community service activities, including the provision of in-home services for other elderly citizens.

In those areas where the federal government has built housing for the elderly, the Office on Aging has attempted to provide a network of services based in the home community to help senior citizens remain at home. Programs were started in Juneau, Anchorage, Fairbanks, and Ketchikan.

The Governor's Task Force on Aging met several times during FY 78 under the leadership of the Governor's Division of Policy Development and Planning. The Task Force held public hearings and established specialized sub-groups to examine the needs of the elderly. The effort initiated by the Task Force is being continued by the Department of Health and Social Services in its focus on Alternative Care for Senior Alaskans. As a part of the latter project, the Department made a presentation to the Governor, to public groups, and the House Health, Education and Social Services Committee of the Legislature.

OFFICE OF INTERNAL REVIEW

The Office of Internal Review has the responsibility for: (1) audit of contracts, grants, hospitals and nursing homes funded by the Department; (2) collections of monies owing to the Department where recovery has proven to be difficult; and (3) investigation where fraud is suspected in any of the department programs, but primarily in the Public Assistance programs including Food Stamps and Mediciaid. It is the goal of this unit to reduce unauthorized expenditure of federal and state tax dollars by identifying overpayments made to contractors, grantees, and medical providers; to recover funds identified as owing to the department; and to reduce fraud through vigorous prosecution of persons found claiming

benefits as a result of willful mispresentation. A system to identify and recover funds where third party liability exists for medical services is being developed.

BOARD OF PAROLE

The Parole Board staff during FY 78 continued to provide professional support and training for the members of the Board of Parole and the staff of the Division of Corrections. Staff maintained files, conducted hearings, and administered the operation of the parole system in Alaska.

Staff also continued to provide expertise for policies and procedures development as well as administrative, research and clerical support.

EMPLOYMENT

Total number of employees authorized on July 1, 1978	1,741
Total number of permanent employees on July 1, 1978	1,686

BUDGET
FY 78 (Including continuations, supplementals, revisions)

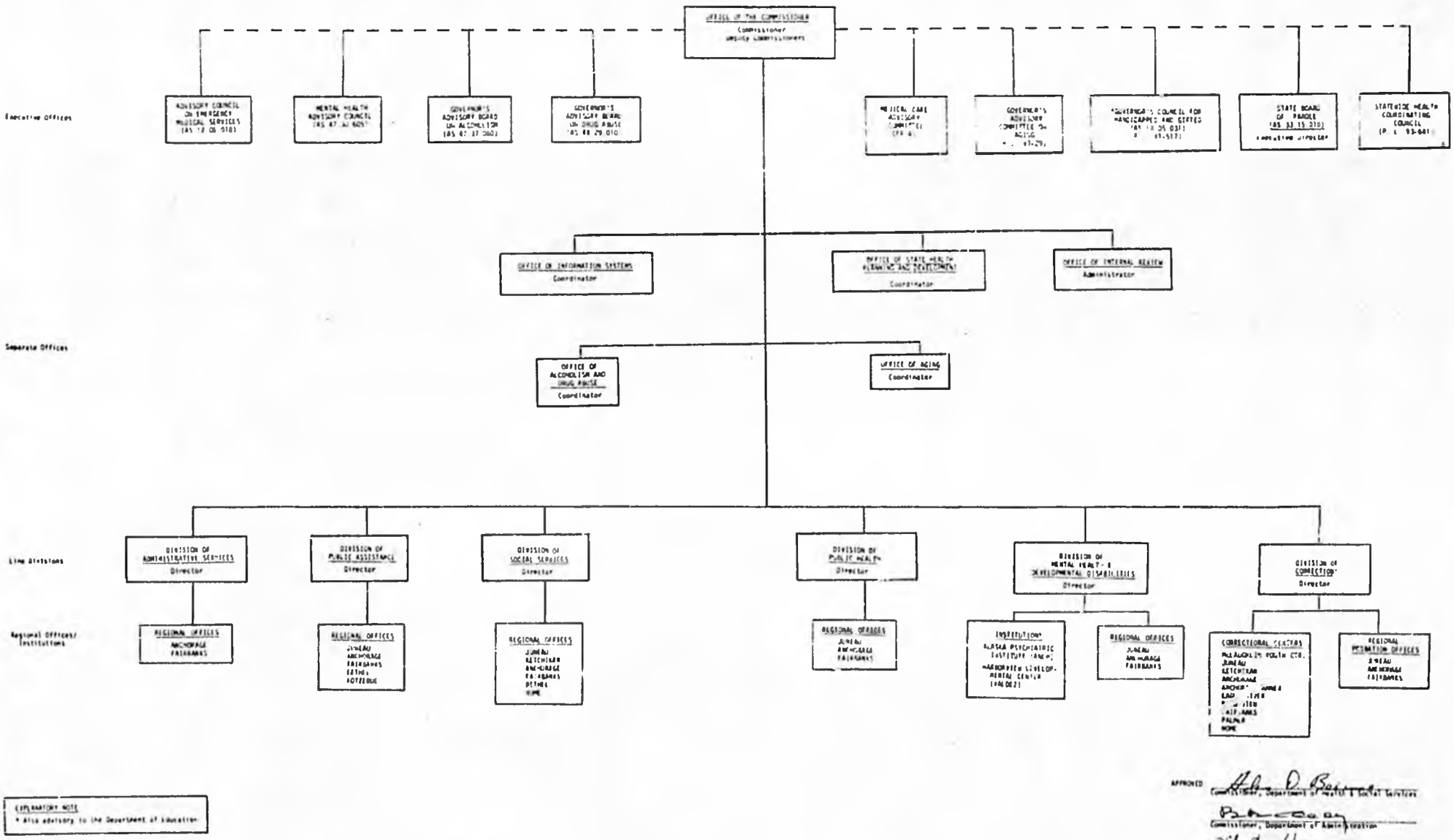
Total budget - State funds	106,045,636
Total budget - Federal funds	49,050,875
TOTAL	155,096,511
Expenditures - State funds	93,145,638
Expenditures - Federal funds	43,602,156
TOTAL	136,747,794

COSTS
FY 78 (Average Monthly Payment)

Programs	Per Person
Division of Social Services	
Foster homes	285.00
Division of Public Assistance	
Old age assistance	112.78
Aid to the disabled	135.48
Aid to the blind	120.60
Aid to families with dependent children	113.09
Division of Mental Health	
Alaska Psychiatric Institute: Average cost per patient/day	185.00
Harborview Developmental Center: Average cost per patient/day	116.05
Division of Corrections	
Average cost statewide for keeping an adult in a state facility	53.67
Average cost statewide for keeping a juvenile in a state facility	74.95

DEPARTMENT OF HEALTH AND SOCIAL SERVICES

Unit Organization Chart



APPROVED

Commissioner, Department of Health & Social Services

Commissioner, Department of Administration

Governor of Alaska

EFFECTIVE DATE September 10, 1976

DEPARTMENT OF HEALTH AND SOCIAL SERVICES
Administration and Support BRU

OFFICE OF THE COMMISSIONER

Commissioner (PX)	R/31	0001
Secretary III (PX)	R/12	0002

DEPUTY COMMISSIONER FOR PROGRAM MANAGEMENT

Deputy Commissioner (PX)	R/28	0269
Secretary II	R/11	0271

DEPUTY COMMISSIONER FOR ADMINISTRATIVE MANAGEMENT

Deputy Commissioner (PX)	R/28	0268
Secretary II	R/11	0006

OFFICE OF SPECIAL ASSISTANT

Special Assistant (PX)	R/23	0289
Information Officer II	R/17	0296
Secretary I	R/10	0044

Janis Stiles

DEPUTY COMMISSIONER FOR FIELD OPERATIONS (ANCHORAGE)

Deputy Commissioner (PX)	R/28	0005
Secretary II	R/11	0270

DIVISION OF ADMINISTRATIVE SERVICES

DIRECTOR/REGIONAL OFFICES

Office of the Director

Director, Admin Services	R/26	0022
Administrative Officer II	R/19	0041
Administrative Assistant II	R/14	0013
Secretary I	R/10	0097
Clerk Typist III	R/8	0073

Southcentral Regional Office

Adm Officer III (Reg Adm)	R/21	0054
Clerk Typist III	R/8	0071

Northern Regional Office

Adm Officer I (Reg Adm)	R/17	0061
Clerk Typist III	R/8	0062

PERSONNEL OPERATIONS SECTION

SERO

	Personnel Officer IV	R/22	0037
1)	Accountant V	R/20	0010
	Asst Personnel Officer II	R/18	0067
	Personnel Assistant II	R/14	0107
	Administrative Assistant II	R/14	0015
	Accounting Clerk II	R/9	0092
	Accounting Clerk II	R/9	0016
2)	Accounting Clerk II	R/9	0063
	Clerk IV	R/9	0095
	Clerk Typist III	R/8	0009
	Clerk Typist III	R/8	0108
	Clerk Typist II	R/7	0003

SCRO

	Asst Personnel Officer III	R/20	0064
	Asst Personnel Officer I	R/16	0056
	Personnel Assistant I	R/12	0008
	Accounting Clerk II	R/9	0065
	Clerk Typist III	R/8	0072
	Clerk I	R/6	0046

NRO

	Personnel Assistant I	R/12	0050

GENERAL SERVICES/SUPPLY

General Services

SERO

Supply Officer IV	R/19	0023
Mail Clerk Carrier III	R/9	0029
Supply Clerk II	R/9	0025
Teletype Operator I	R/8	0081
Supply Clerk I	R/8	0090

SCRO

Supply Officer II	R/16	0066
Supply Assistant I	R/12	0059
Clerk Typist III	R/8	0056
Messenger	R/6	0094

NRO

Supply Clerk I	R/6	0063

GRAPHIC ARTS

Graphic Artist II	R/15	0093
Graphic Artist I	R/13	0041

Ben Ellison

FINANCIAL MANAGEMENT

Management and Budget Section

Program Budget Analyst V	R/22	0037
Program Budget Analyst IV	R/20	0093
Program Budget Analyst III	R/18	0004
Program Budget Analyst III	R/18	0095
Program Budget Technician	R/12	0085

Financial Operations Section

Finance Officer IV	R/22	0057
Finance Officer III	R/20	0028
Clerk Typist III	R/8	0048
Clerk Typist III	R/8	0092

Revenue Unit

Accountant IV	R/18	0088
Accountant III	R/16	0012
Accounting Clerk II	R/9	0096

Contracts/Leasing Unit

Contracts Officer I	R/14	0052

Expenditure Unit

Accountant V	R/18	0011
Accountant IV	R/16	0245
Accountant I	R/14	0164
Accountant II	R/14	0098
Accountant I	R/12	0106
Accounting Clerk III	R/10	0103
Accounting Clerk III	R/10	0105
Accounting Clerk III	R/10	0020
Accounting Clerk III	R/10	0014
Accounting Clerk II	R/9	0087
Accounting Clerk II	R/9	0049
Accounting Clerk II	R/9	0021
Accounting Clerk II	R/9	0018
Accounting Clerk II	R/9	0017
Clerk Typist II	R/7	0102

EXPLANATORY NOTE:

1) A reclassification is pending for this position.
2) This position to be transferred to Revenue Unit.

August 1, 1978

RECAP - AUTHORIZED POSITIONS

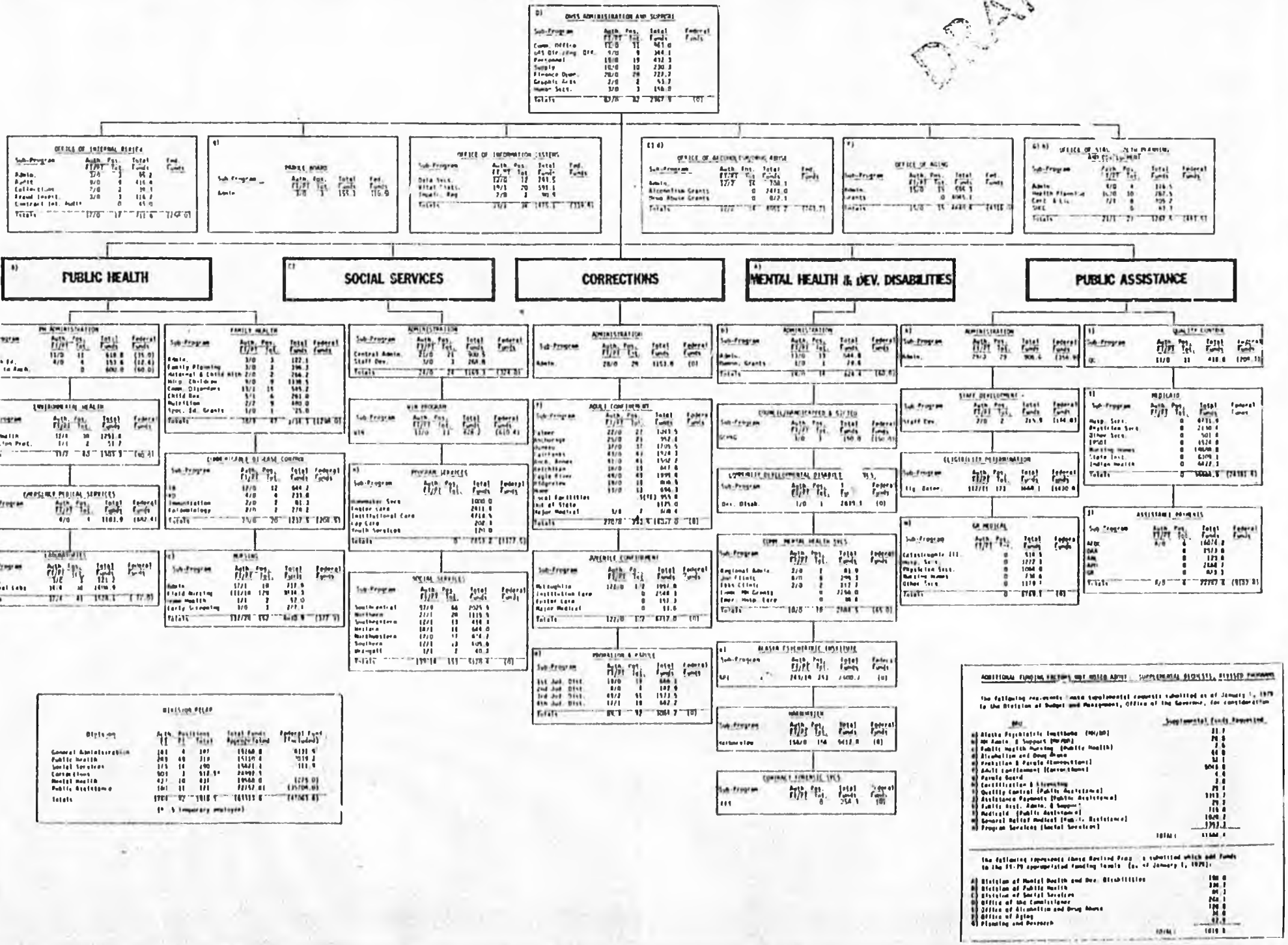
	F/T
Commissioner's Office	11
Director/Regional Offices	9
Personnel Operations	19
General Services/Supply	10
Financial Management	28
Graphic Arts	2
TOTAL POSITIONS	79

DEPARTMENT OF HEALTH AND SOCIAL SERVICES

BUDGET ORGANIZATION CHART - FY 1979

(THOUSANDS OF DOLLARS)

DRAFT



Division Detail

Division	Auth. Positions FT	PT	Total	Total Funds Recommended	Federal Fund (Included)
General Administration	101	6	107	1916.8	1031.9
Public Health	303	48	319	15139.4	7019.2
Social Services	375	15	490	13421.1	111.9
Corrections	503	3	518.5*	20992.5	
Mental Health	427	10	431	19468.0	1275.0
Public Assistance	161	11	171	72157.0	(25704.0)
Totals	1900	93	1918.5	163115.8	(34765.0)

(* 5 temporary employees)

Additional Funding Factors Not Noted Above - Supplemental Requests, Projected Increases

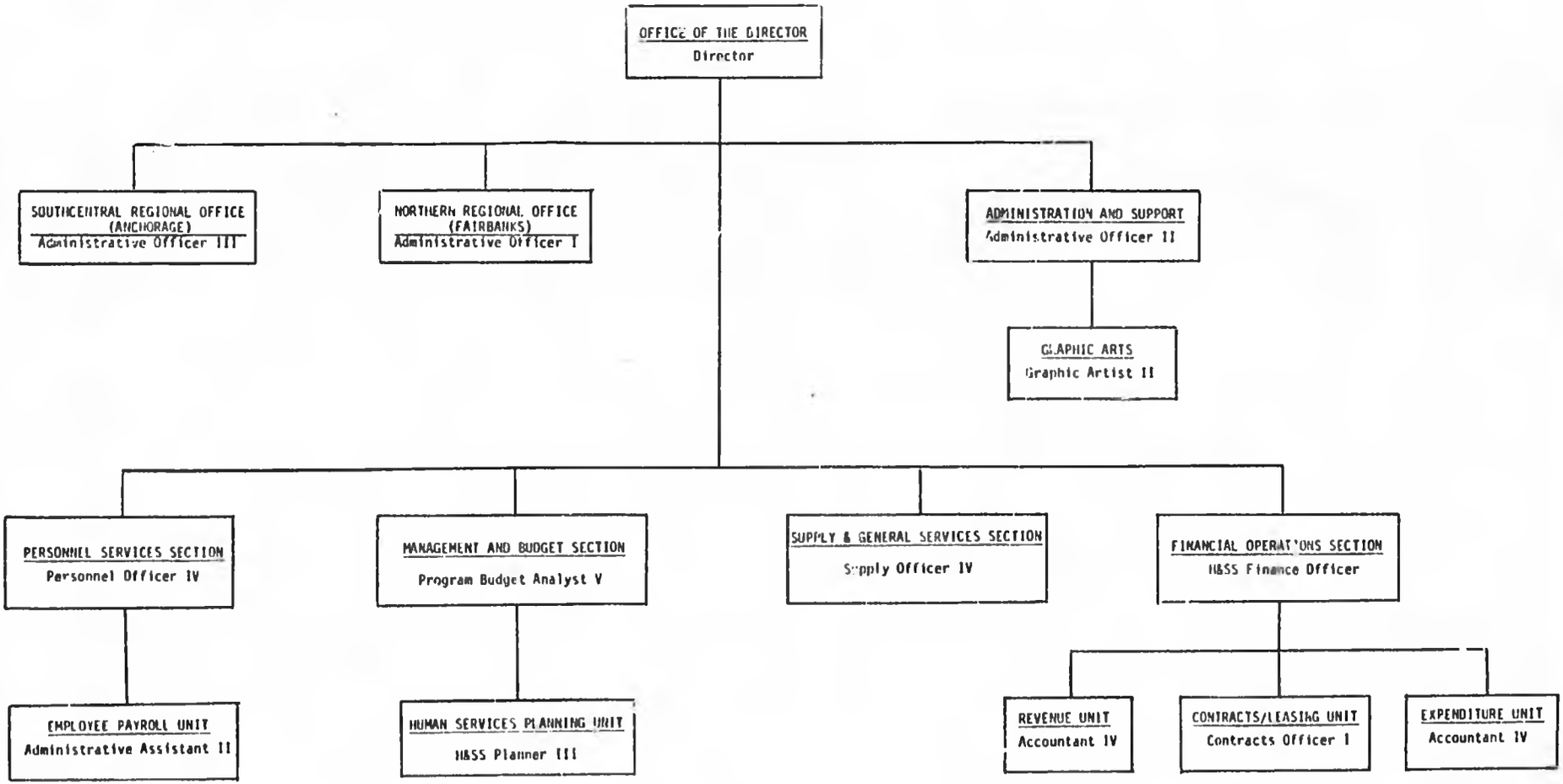
The following represents those supplemental requests submitted as of January 1, 1979 to the Division of Budget and Management, Office of the Governor, for consideration

Div	Supplemental Funds Requested
a) Alaska Psychiatric Institute (MH/DD)	21.7
a) MH Admin & Support (MH/DD)	74.5
a) Public Health Nursing (Public Health)	7.6
a) Alcoholism and Drug Abuse	64.0
a) Probation & Parole (Corrections)	52.1
a) Adult Confinement (Corrections)	1045.0
a) Parole Board	4.6
a) Certification & Licensing	2.0
a) Quality Control (Public Assistance)	89.3
a) Assistance Payments (Public Assistance)	1393.7
a) Public Regl. Admin. & Support	29.3
a) Medicaid (Public Assistance)	116.0
a) General Relief Medical (Public Assistance)	1045.2
a) Program Services (Social Services)	1393.6
TOTAL:	11464.4

The following represents those Revised Progs submitted which add funds to the FY-79 appropriated funding levels (as of January 1, 1979):

a) Division of Mental Health and Dev. Disabilities	198.0
b) Division of Public Health	336.3
c) Division of Social Services	89.3
d) Office of the Commissioner	268.1
e) Office of Alcoholism and Drug Abuse	126.0
f) Office of Aging	34.0
g) Office of Aging	67.0
h) Planning and Research	1019.5
TOTAL:	

DEPARTMENT OF HEALTH AND SOCIAL SERVICES
DIVISION OF ADMINISTRATIVE SERVICES
UNIT ORGANIZATION CHART



Helen O. Brister
Commissioner, Health and Social Services

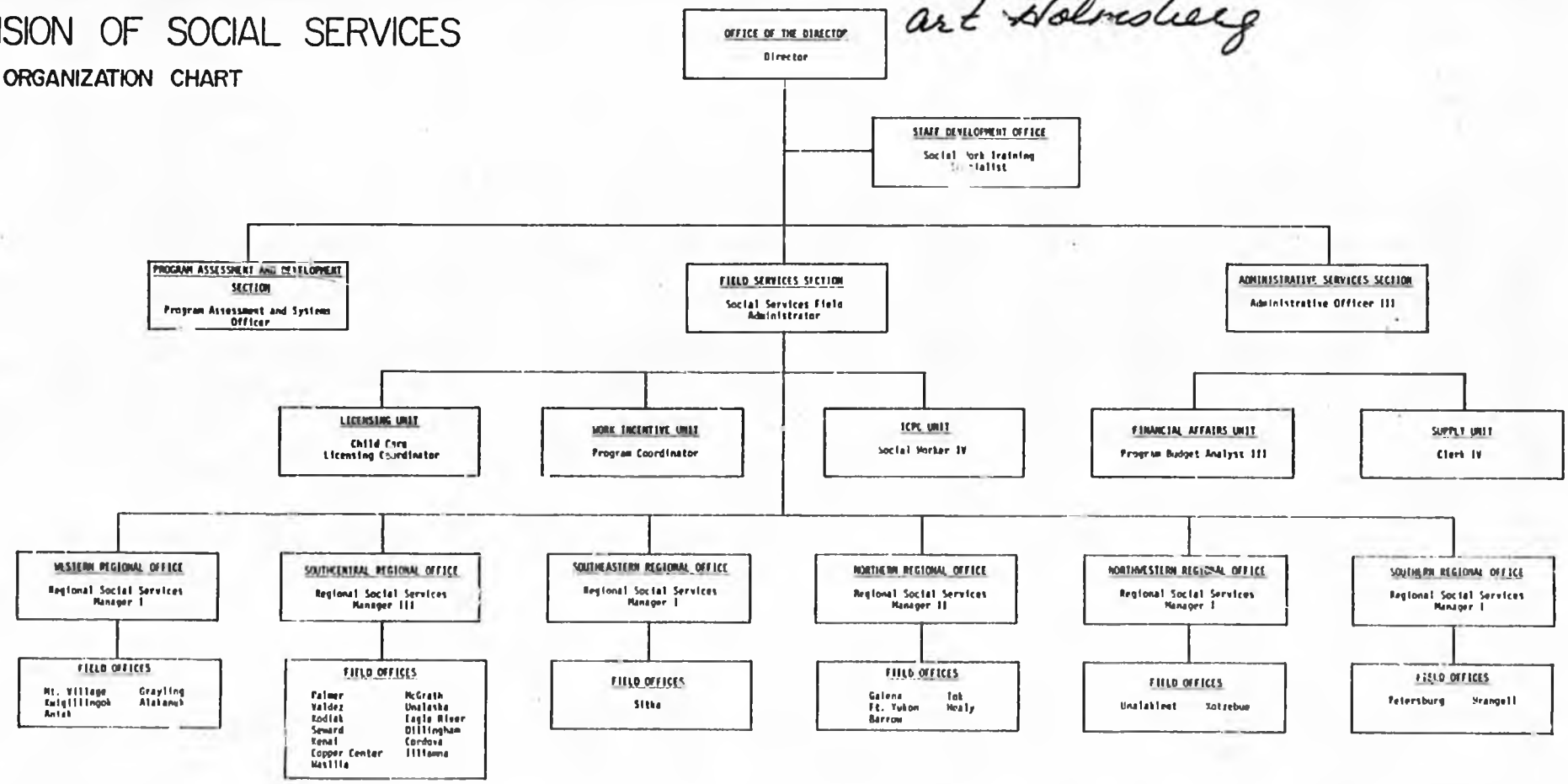
January 1, 1979

DEPARTMENT OF HEALTH AND SOCIAL SERVICES

DIVISION OF SOCIAL SERVICES

UNIT ORGANIZATION CHART

art Holmes berg



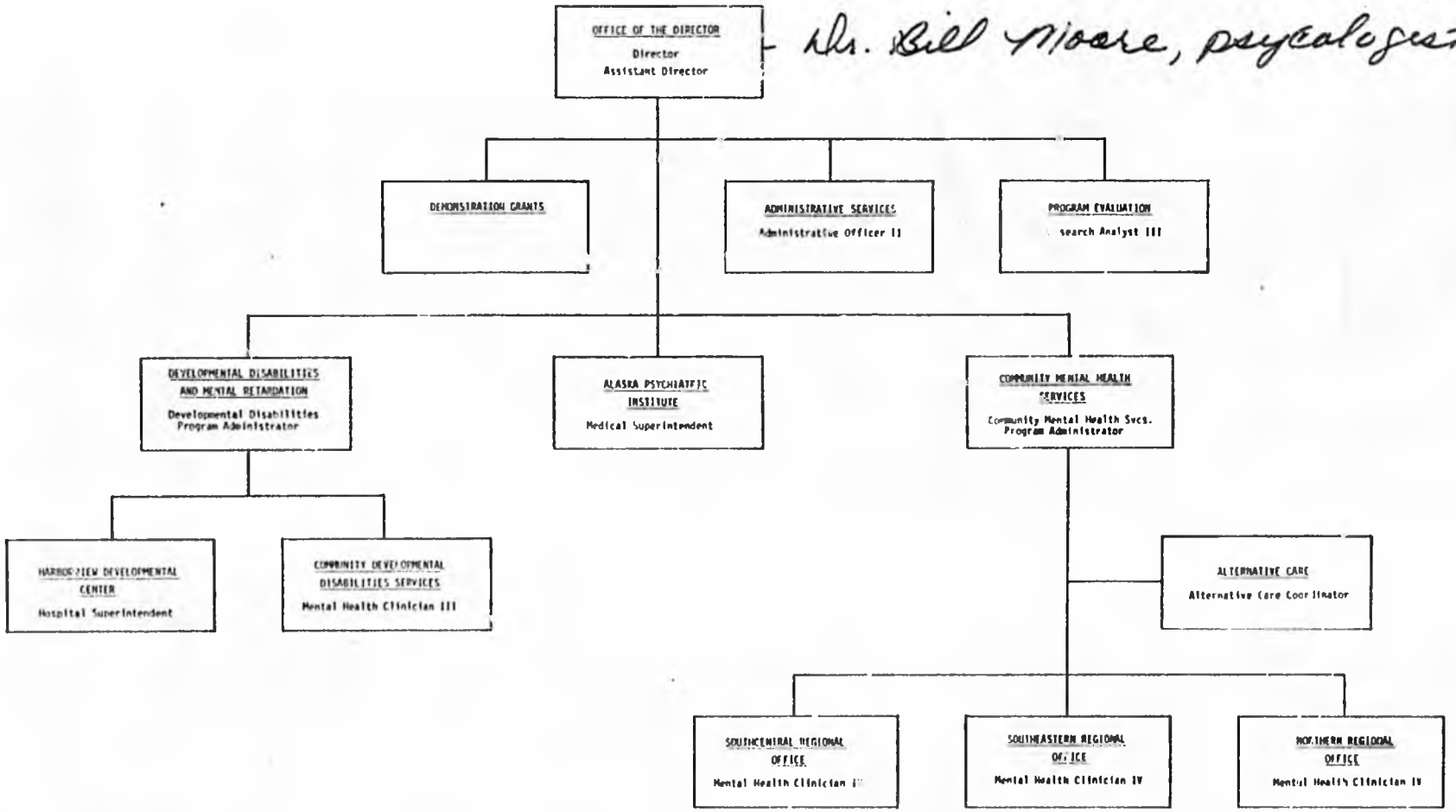
Helen D. Bentley
Commissioner, Health and Social Services

January 1, 1979

DEPARTMENT OF HEALTH AND SOCIAL SERVICES

DIVISION OF MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES

UNIT ORGANIZATION CHART



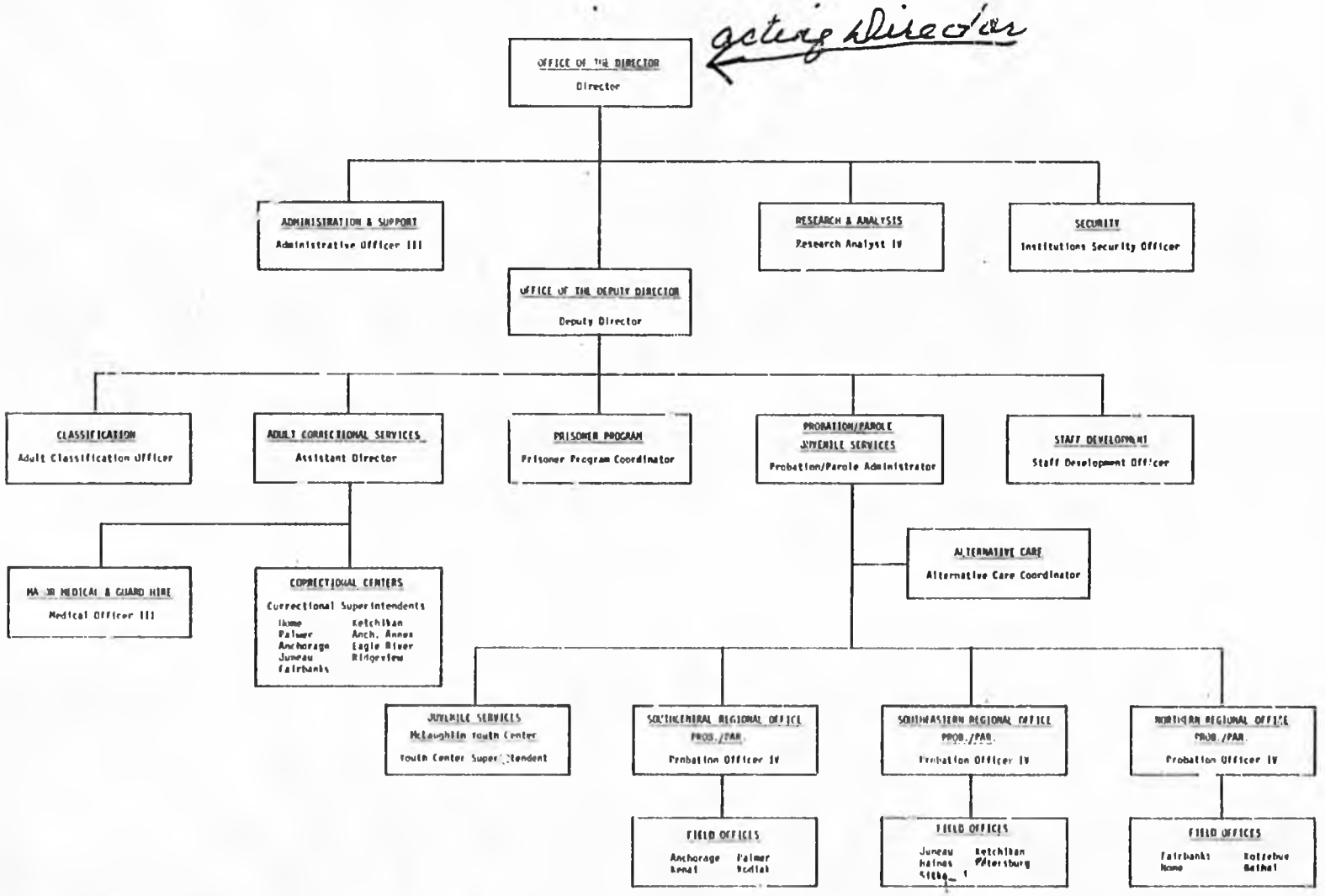
Commissioner, Department of Health and Social Services

January 1, 1979

DEPARTMENT OF HEALTH AND SOCIAL SERVICES

DIVISION OF CORRECTIONS

UNIT ORGANIZATION CHART



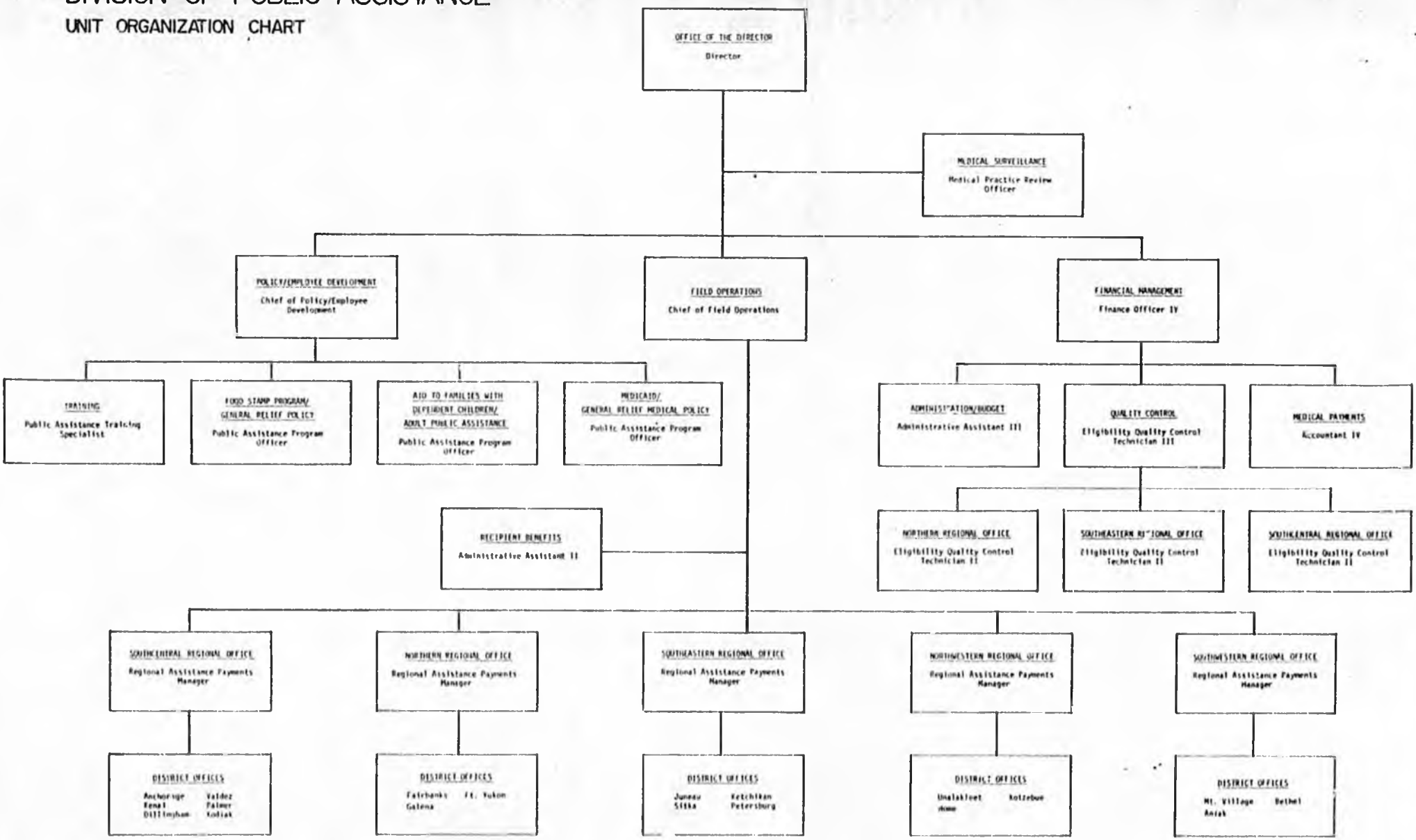
Commissioner, Department of Health and Social Services

January 1, 1970

DEPARTMENT OF HEALTH AND SOCIAL SERVICES

DIVISION OF PUBLIC ASSISTANCE

UNIT ORGANIZATION CHART



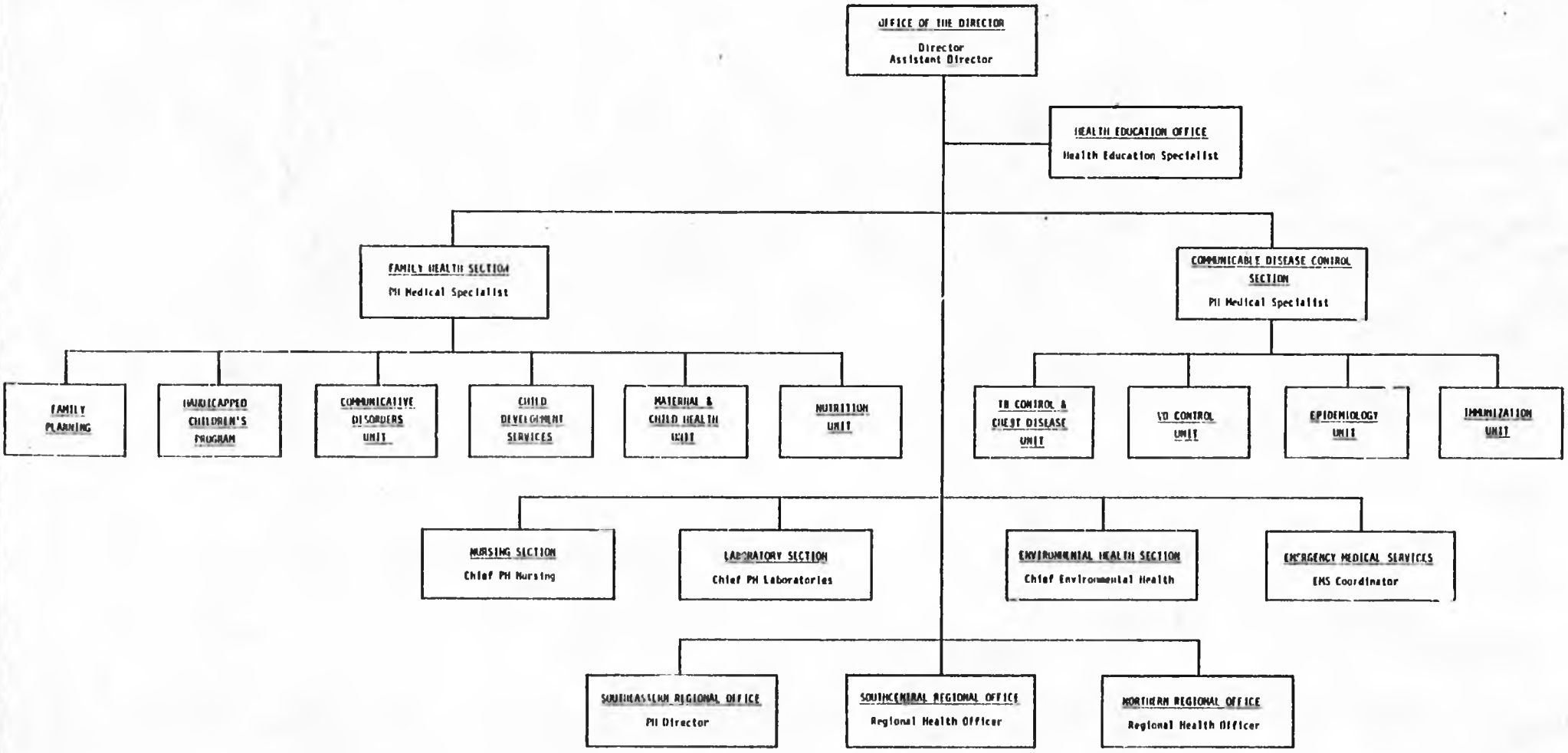
Commissioner, Department of Health and Social Services

January 1, 1979

DEPARTMENT OF HEALTH AND SOCIAL SERVICES

DIVISION OF PUBLIC HEALTH

UNIT ORGANIZATION CHART

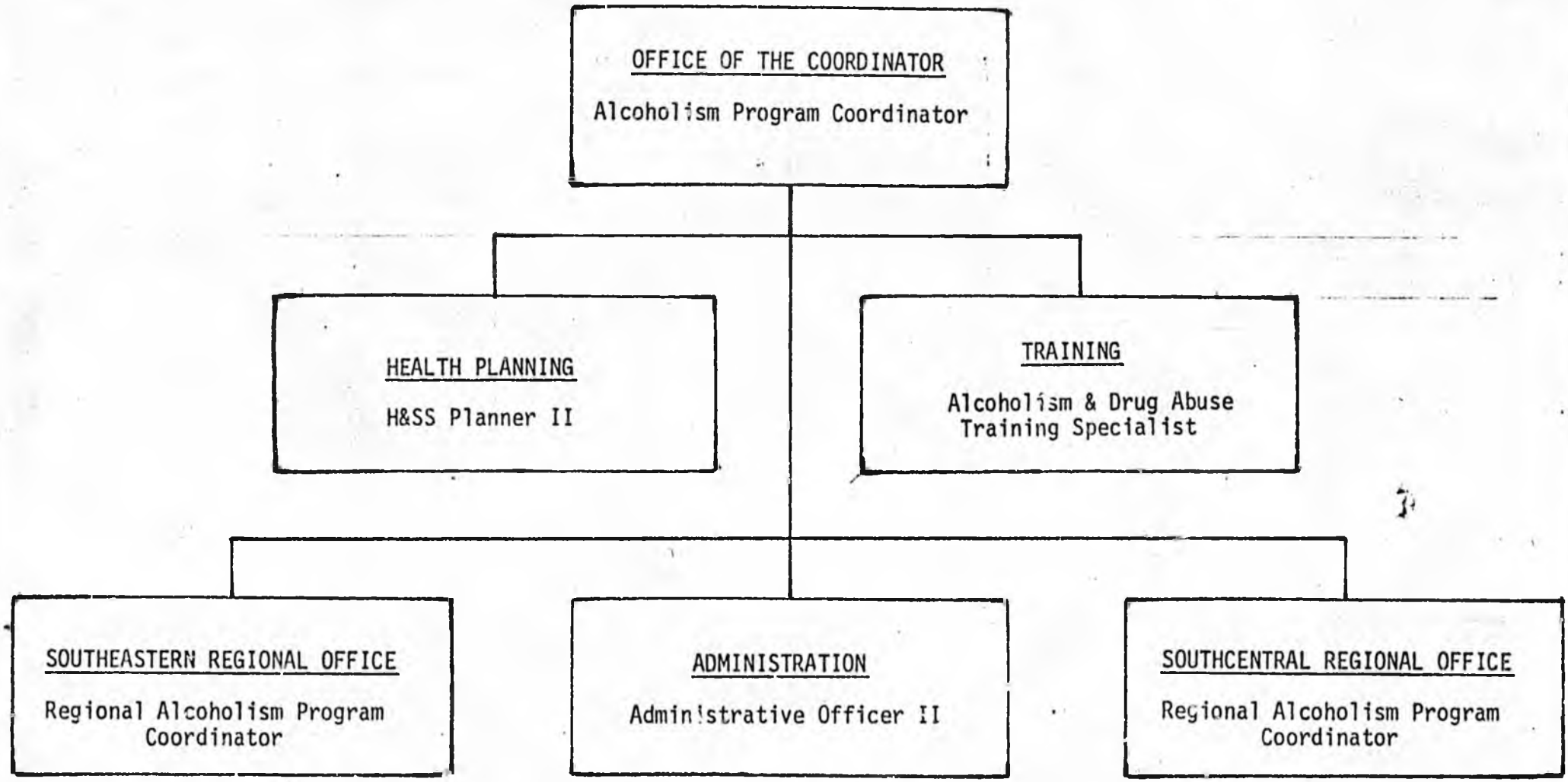


Helen D. Bair

Commissioner, Department of Health and Social Services

January 1, 1979

DEPARTMENT OF HEALTH AND SOCIAL SERVICES
OFFICE OF ALCOHOLISM AND DRUG ABUSE
UNIT ORGANIZATION CHART



Commissioner, Health and Social Services

January 1, 1979

DEPARTMENT OF HEALTH AND SOCIAL SERVICES
ALASKA BOARD OF PAROLE
UNIT ORGANIZATION CHART

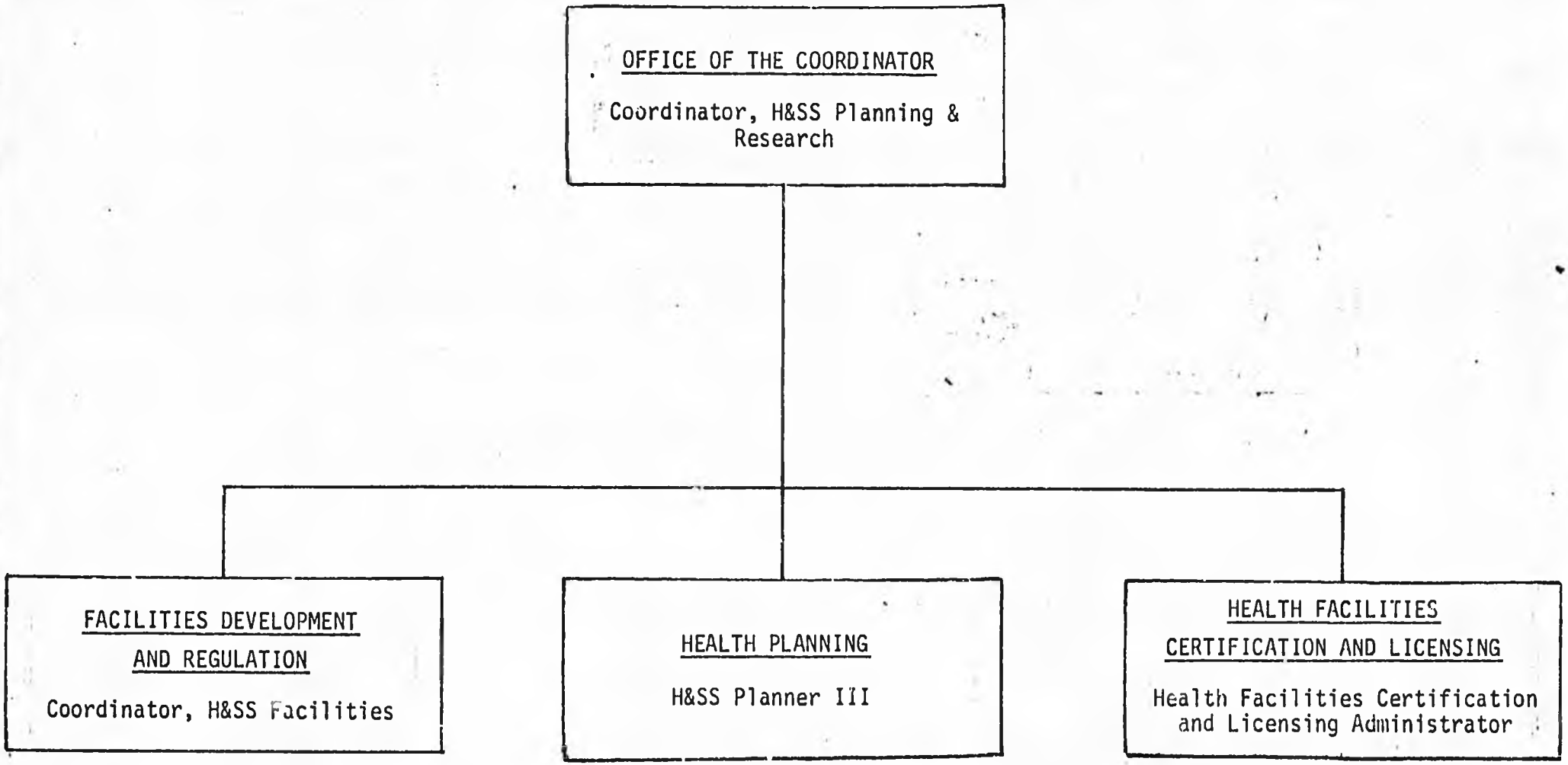
PAROLE ADMINISTRATION

Executive Director, Alaska
Parole Board

Helen D. Beistel
Commissioner, Health and Social Services

January 1, 1979

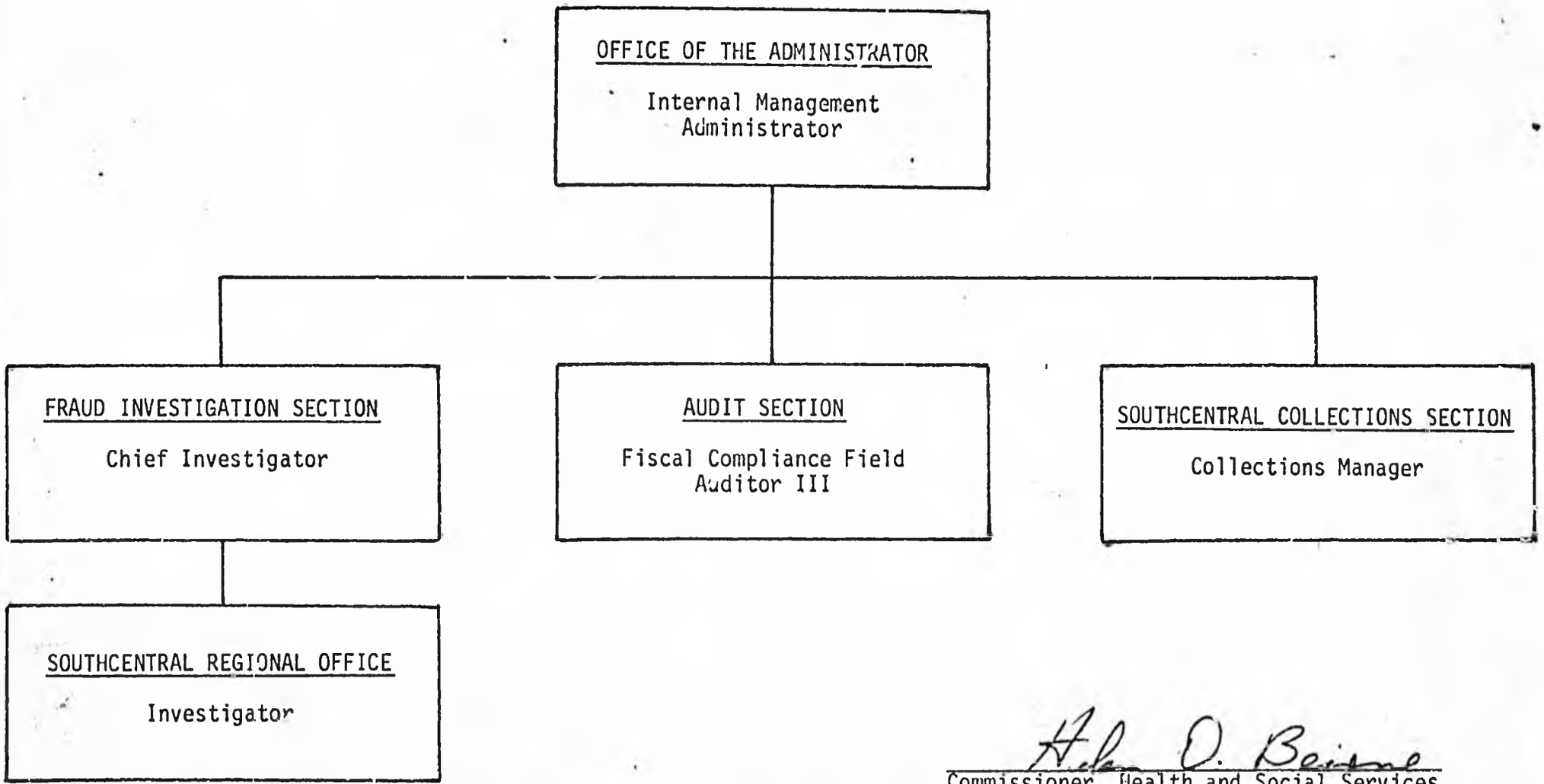
DEPARTMENT OF HEALTH AND SOCIAL SERVICES
OFFICE OF STATE HEALTH PLANNING AND DEVELOPMENT
UNIT ORGANIZATION CHART



Helen D. Bosomworth
Commissioner, Health and Social Services

January 1, 1979

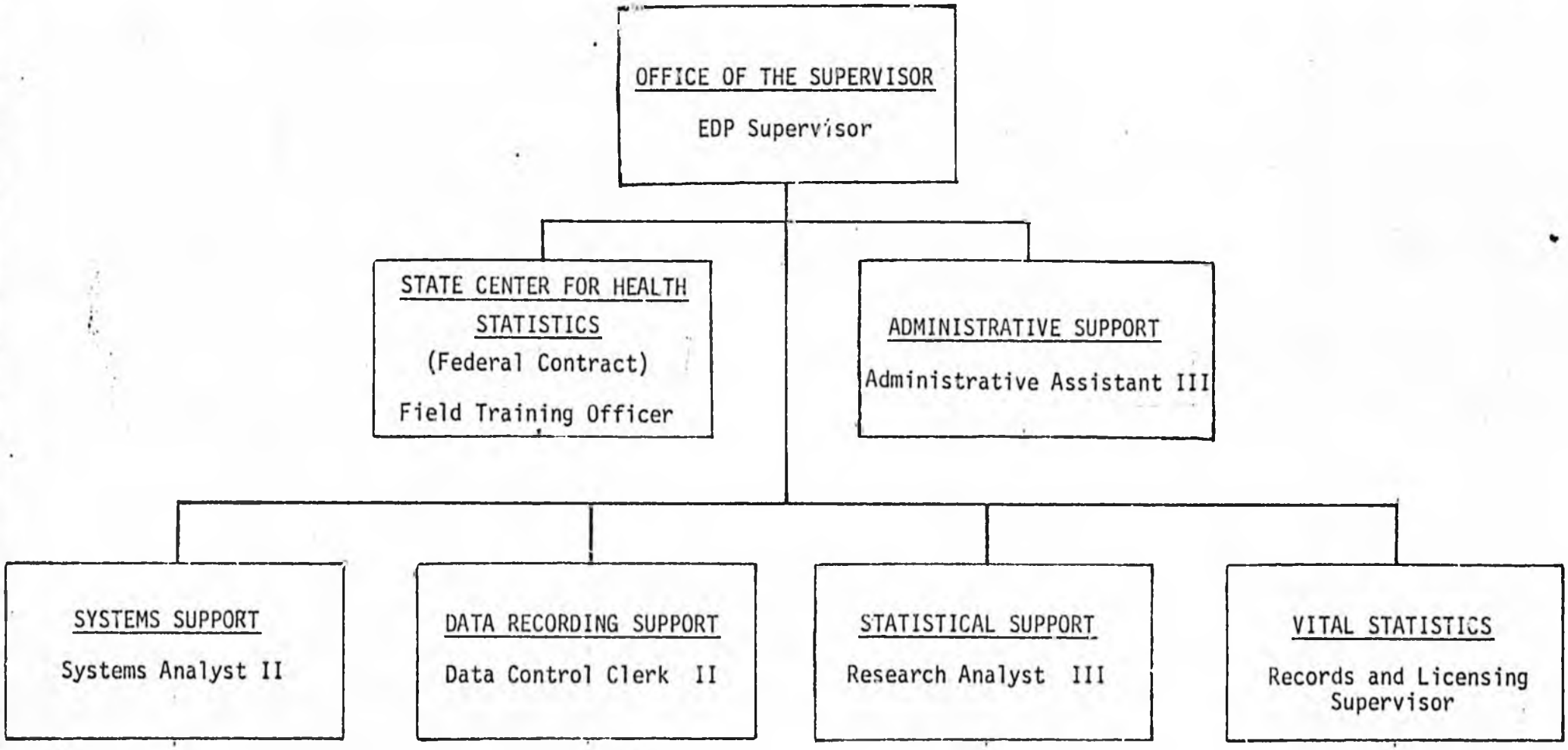
DEPARTMENT OF HEALTH AND SOCIAL SERVICES
OFFICE OF INTERNAL REVIEW
UNIT ORGANIZATION CHART



Helen O. Beirne
Commissioner, Health and Social Services

January 1, 1979

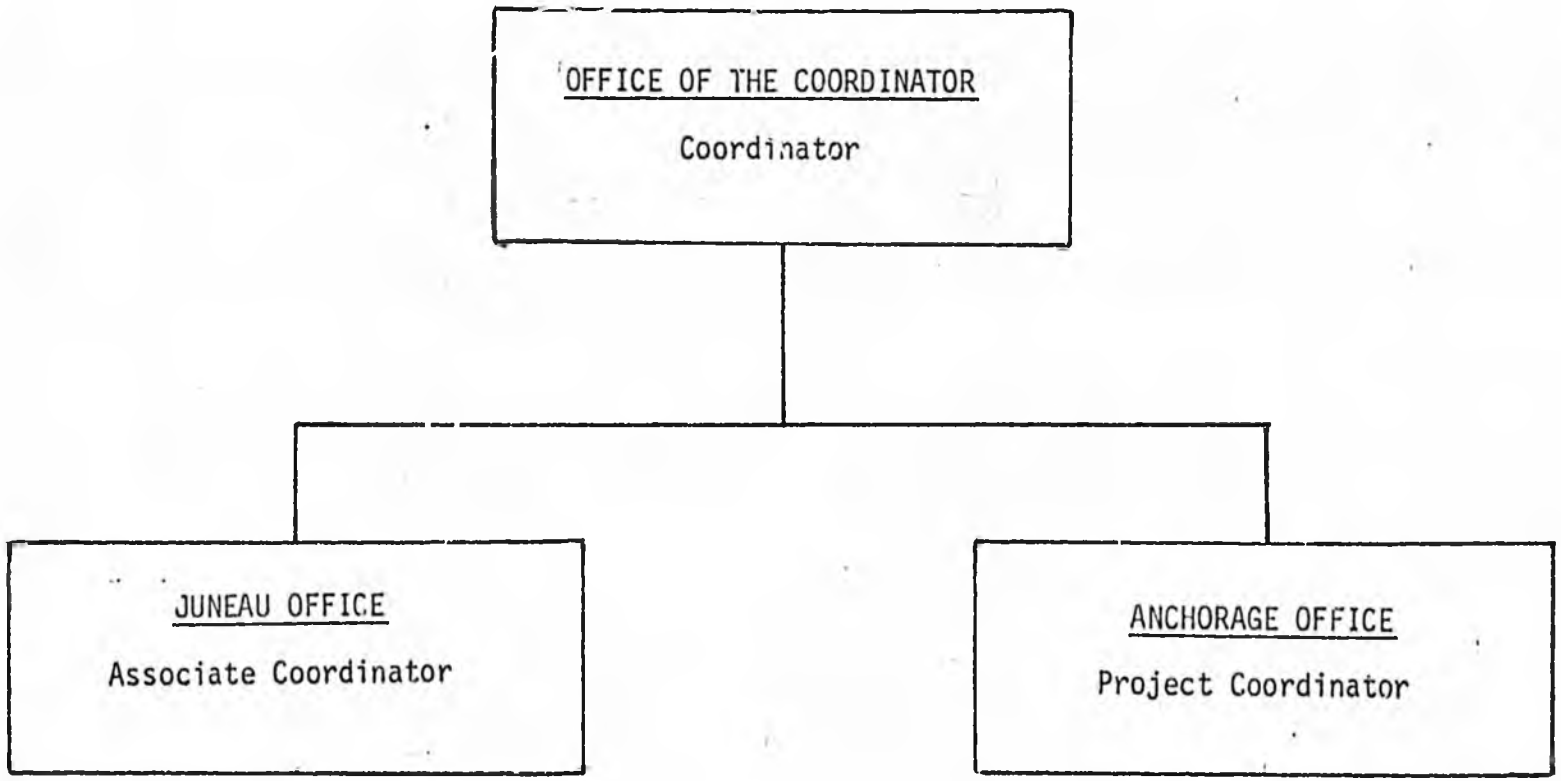
DEPARTMENT OF HEALTH AND SOCIAL SERVICES
OFFICE OF INFORMATION SYSTEMS
UNIT ORGANIZATION CHART



Helen D. Bentley
Commissioner, Health and Social Services

January 1, 1979

DEPARTMENT OF HEALTH AND SOCIAL SERVICES
OFFICE OF AGING
UNIT ORGANIZATION CHART



Helen D. Bain
Commissioner, Health and Social Services

January 1, 1979

DEPARTMENT OF EDUCATION

2-2-79

Dept. of Education Commissioner Marshall Lind gave an overview of the Dept. of Education. They have a 7 member state board and a 2 member advisory board: a student and a military person.

Nat Cole -- soon to retire
Dick Engen -- Library and Museum
Marilou Madden -- education
Bill Thompson -- not present
Ernest Polley -- Research and Planning
Bill Branble -- Educational TV
Harry Gamble -- public information
Bob Green -- Superintendant of Schools
Susan Stichell -- teachers

The role of DOE is a "nebulous area". They work closely with school boards. There is no statutory relationship between DOE and U of A.

DICK ENGEN - Film library has 14,000 films available (regional coordinator in Anchorage and Fairbanks. Serves all age groups. Direct service.
MARILOU MADDEN - Director, Educational Program. Division that works with teachers. Elementary and secondary. Correspondence studies, assisting school districts. Vocational rehabilitation. Provides information to schools to better their programs. 12 districts run their own correspondence study programs aside from the statewide program. The Alaska Skill Center falls under this program. In 1969 it was tied with federal dollars.
$110 million construction passed last session.
CHAT: Asked about the Alaska Skill Center. Said that some people feel we do not have adequate training facilities for Alaskan jobs.
LIND: We don't have to rely so much on federal money, we now have state General Fund money and the program is open to anyone who has the money to attend.
NAT COLE: Division of Management, Law and Finance.

This Division pays bills, administrative functions, record keeping, distributes statutes, all funding to public schools. Takes care of the planning, implementation and school construction and school transportation.

NAT COLE: This Division also takes care of accounting manuals and certification of teachers. The basic procedure -- expenditure of funds, makes plans, REAA recommendations to Governor, reimbursements to districts.

REP. HURLBERT: Does the certification of teachers supercede school board certificates?

COLE: All teachers must be certified by the Dept. of Education. Must have B.A. Bacheler's Degree. All papers submitted are reviewed. It is the responsibility of the individuel to have certificate.

BARNES: Molly Hootch case?

Consent of court-- option of local community to say whether they want a school or not. Settled out of court.

BARNES: Said she would like a list of schools that have been built under Molly Hootch. On a square foot basis and how many students.

COLE: We just received information. Some available statistics.

BILL BRAMBLE -- Educational Telecommunications.

Jennifer Wilke is the Director of project-video tape. Satellite Demonstration Porject. 20 to 25 hours a week in demo project.

Three major facets: 1. Administrative Communications Network. Takes care of administrative problems. Has electronic mail system -- connects all schools to pass information. On national basis too. 2. Facilitate 3. Preparing support component for small high schools. Gives them a broader circulum for schools with limited teachers. Student management system.

MUNSON: Asked if there were evaluations on the use of television instruction and education.

BRAMBLE: J. Wilke put together a package on the use of television. Cost effective apprcach.

BUCHHOLDT: No contributions from Local Districts?

LIND: Yes. They are making contributions. At one time we were asking for cash contributions, but not direct cash. Either they contribute or they pay the extra costs assumed in telecomm. lines.

ERNEST POLLEY: State Dept. of transportation and public facilities: State operated network from Fairbanks to Kenai. Have to pay t[illegible]ecommunications line costs. Local costs went up after the RCA increases.
CONCLUSION: Review Task Force was put together and working for almost one year. They have completed their review. One review done by feds the others are state agencies.
Dept. of Education not asking for any new monies. They are concerned with the present format.

University of Alaska

Coop Ex. } 789-
Community College } 2101

Arch. - Nursing School
Mr. Martin, Dean
263-1272

Name	Organization	Address	Bill N
BOB EUGENE	ASSN OF ALASKA SCH. BDS.	204 NORTH FRANKLIN ST.	
Bill Bramble	DOE	Project ETA	

2-2-79

Education

Dept of Education, Commissioner Marshall Smith
Bob Green, Dept. of Ed.

M.T. – Libraries
museums Dick Engahorn
Mike morgan – not here.
Ernest Polly –
Bill Bramble
Harry Bramble – ?

Bob Green
Susan Stettner } Dept of Education

Runs Seward Skill Center
Responsibilities – Life cycle costing.
Funding projects.
Descriptions

3rd Statewide Items – telecommunication
bilingual – st. Skill Centers.

Don't run schools in Unorganized Borough

Munson – Relationship w/ U of A.

Com. Smith – no ~~official~~ statutory relationship
Thelma Langdon – President
Beverly Holmes.

Board of Education

Munson - state operated schools - your Dept.

Col. Lind Both - Become Separate.

Chet - Student Assessment Program. wants to see 2/1st part of diagnostic test.

Lind 2 step process

Chet At. Skill Centers

Lind An oversite.

Polly 2 tests - where weak & strong - Reading/math
Takes local perception & make it more.
(Beirne - comes in)

Dick Engalam - Libraries & Museum
Film libraries (2) / in Arch, Juneau.
Regional Coordinators in Fbks/Arch.
March 1977 — At. Blue book.

~~Dept~~ - Alan Monroe Dept. Director
State museums

Flyers - available on larger scale >
At. Health Sciences: Library Vg & Arch.

Mary Lou Madsen - Skill Centers - Division
Works w/ teachers - Elementary & Secondary.
Correspondence - Assisting school districts
provisions of adequate training. Vocational
Provide info to school to better program.
Service teachers

Munson - print teacher's guide

Madden - no. stopped doing it.

Hurlbert - Kuseguvin - 600 students
Correspondence - 12
Madden 12 Districts run their own correspondence.

Chet: Ak. skill center - oil well drilling.
Seward - Production phase
Community College getting into Vocat ions
Kenai
Madden - Sort out less than (2) yr. programs.

Chet Assoc. Degree. Political arena. Some people feel not adequate training/faculties for Ak. jobs. Don't share feelings.

Lind - Don't have to rely so much on Fed $
Now have state General Fund $.
Open to anyone who has $
morgan (not here)

Nat Cole - Div. management law & finance
Paying bills adm. functions Record keeping.
Distribute (statutes) all Funding's & Public schools. 110 m. $ school Construction
Planning, implimentation school
Construction

School Transportation
" Districts keep accounts. manuals accounting
Certification of teachers.
Not how they construct - Bond issues
Procedure - expenditure of funds.
Plans REAA Recommendation to Governor.
Reimbursement to districts - plans
must be submitted.

Hurlbert – Cert of teachers – Supercede school Board certificate

Cole all teachers must be certified by Dept. of Ed. Regulations B.A. Bachelor's Degree papers submitted are reviewed.

Responsibility of individual to have certificate.

Barnes Dept. determine Kutchukan? Molly Hooch 21 REAA

Consent of Court / option of local Community to say whether they want a school

Barnes List of schools H have been built under Molly Hootch. (Just received info.) Sq. ft. basis. How many students

Some available statistics

Berns Homestead Act goes through Will you ready for bush schools?

Cole Leaving – 23rd Feb.

out of Court Settlement Molly Hootch.

To enrich Education in Bush. Rural A.K. Education Telecommunications
Funded jointly Fed & State

Bill Bramble - Telecommunications
Jennifer Wilke - Dir. of project - Video tapes.
Satellite Demonstration project.
20-25 hrs. a week in Demo project.
2nd Educational Tele. Projects -
Narrow band - Data & voice communications.
3 major facets (1.) admin & nature problems communic. of w. network
Electronic mail system - connects all schools to pass info. National basis too.
(2)
(3) Preparing support component for small high schools - broader curriculum for schools with limited teachers.
Ak. History Courses.
Student management system

Munson - Have these not been developed.? Educational Evaluations on use of television in Instruct.
Bramble Package. Cost effective approach.
J. Wilke put together package on the use of television

Thelma no contributions from local districts

Enid yes - are making contributions.
at one time wanted Cash Contributions, but not direct Cash. or either costs assumed in telecom. lines

Polly State Dept of Trans. & Public Safety
Each Zone - State Operated network from PBKS to Kenai.
Have to pay telecom. line costs.
Local - went up after RCA increases.

Chat - Adm. communications network. ITE

Jennifer Wilke

Conclusion

Review Task Force - put together one
working for almost 1 year. Have
Completed review. 1 done by Fed.
Govt & State Agencies.
Enthused.
Not asking for any new monies.
Concerned about present format.

To provide funding to Schools
To help Local schools

Munson How many people

Lunch { about 400 100 Voc Rehab.

Chat - Consent - D'Trec Cree - Education
- other than brick & mortar Schools

Barnes - doing research on this matter.

Meeting with DOE

Commissioner Marshall invited:

Unique in state govt. 7-member state board
2-member advisory: student
(military
Carolyn Barry
Colonel Jones

Nat Cole — retiring
Dick Engen — library
Marilou Madden — education
Bill Thompson — not present
Ernest Polley — research + planning
Bill Bramble — educational TV
Harry Gamble — public info
Bob Green — D Superintendent of Schools
Susan Stickell — teachers

Role of DOE is a "nebulous area"
work closely with school boards
no statutory relationships between DOE + U. of A.

Dick Engen —
Film library 14,000 films available < regional coordinators in Anch + Fairbanks
serves all age groups
direct service

Marilou Madden — Director, Education~~al~~ Program Support
all federal program
2 main function — money distributed to school district
12 districts run their own correspondence Study programs
↓
aside from the statewide program

Alaska Skill Center — 1969 tied w/ federal dollars
↳ per student cost —
funding distributed according to
$110 million construction passed last session — cost reimbursement / rural transportation

Bonding = DOE reviews plans & REAA + makes recommendation to the gov.

↓

Molly Hootch case — consent decree settled out of court

Bill Bramble — fed govt. + state funding over 5 yr. period

Telecommunications instructional project

Video program w/ teachers within state

workable procedures for teacher input in video tape materials.

9x – 25 hrs./wk educational program

Educational telecommunications

1) attempt to solve the "distance" problem

San Mateo instructions of guide school

1) administrative
2) facilitate
3) support component for small high schools.

Alaska history courses

Ninth grade

Task Force or Review DOE (outside review)

↓

100 VR rehab

70 lib + museum

45 Seward Skill Center

↓

Copy of consent decree —

ITV

INTERIM

Alaska State Legislature

House of Representatives

Committee on Judiciary

Pouch V
State Capitol
Juneau, Alaska 99811

Official Business

MEMO: March 29, 1979

TO: Representative Ramona Barnes

FROM: Charlie Parr, Chairman CP

RE: Interim Participation

During the interim the Committee will be investigating a number of areas in the broad fields of law enforcement and justice. I need to prepare a proposed schedule and budget for submission to the Legislative Council.

The amount of work we do (and the budget) will depend in large measure on how many members of the Committee are available for hearings and work sessions in various parts of the state. The areas of concentration will be largely determined by your perception of what the problems are.

Please let me know:

1. Whether you wish to participate.

2. Whether there are any periods when you will not be able to attend Committee meetings.

3. Your recommendations as to specific matters to be investigated.

4. The names of any groups or individuals who should be notified of Committee hearings.

5. Any other information which you think will be useful in planning the Committee's interim work.

1. Yes
2. Yes When I know an operation, but I can't tell you exactly when that will be -
3. Enclosed a letter I received from Fairbanks Judges re: Thelma Dominion Clerk and the role of Tribal Court Prosecutor.

Alaska State Legislature

REPRESENTATIVE
NELS A. ANDERSON, JR.
BOX 234
DILLINGHAM, ALASKA 99576
HOME PHONE 842-5302

WHILE IN JUNEAU
POUCH V
JUNEAU, ALASKA 99811
PHONE 465-3736 OR 3739
HOME PHONE 789-7897

REPRESENTING DISTRICT 16
BRISTOL BAY — LOWER KUSKOKWIM

HOUSE MAJORITY LEADER
VICE CHAIRMAN JUDICIARY COMMITTEE
MEMBER, RULES COMMITTEE
MEMBER, SPECIAL COMMITTEE
ON SUBSISTENCE

House of Representatives

March 28, 1979

MEMORANDUM

TO: Representative Charlie Parr, Chairman

FROM: Representative Nels A. Anderson, Jr.

SUBJECT: Interim Committee Activity

1. I do wish to participate in an interim investigatory review of the entire law enforcement and justice system.

2. July and August would be difficult for me.

3. a) We should conduct an oversight review of the Judicial Sentencing Study to assure ourselves that legislative intent is being followed if HB 195 and HB 196 pass and are approved by the Governor.

   b) We should follow the history of several cases from the time of arrest through to final sentence and place of confinement.

   c) We should determine whether or not judges recommendations for rehabilitation are being followed after incarceration.

   d) We should visit the policemen, judges, public defenders, district attornies, law clerks, correctional officers, and the public Safety and Health and Social Services Commissioner.

4. Groups to contact:

   Anchorage Black Caucus
   Anchorage Native Caucus
   Fairbanks Native Association
   Alaska Federation of Natives
   Non-profit Regional Native Associations
   Human Rights Commission
   Ombudsman

cc: Judiciary Committee Members

NAA/ah

Alaska State Legislature

IN SESSION:
POUCH V
JUNEAU, ALASKA 99811
(907) 465-4949

BOX 142
EAGLE RIVER, ALASKA
99577

Representative Randy Phillips
HOUSE DISTRICT 8

March 28, 1979

The Honorable Charles Parr, Chairman
House Judiciary Committee
Pouch V, Mail Stop 3100
Anchorage, AK 99811

RE: YOUR MEMO TO ME OF MARCH 29, 1979 CONCERNING INTERIM PARTICIPATION

Thank you for your memo dated March 29, 1979.

In answer to your questions:

1. Yes, I do wish to participate.

2. I work during the summer months and it is hard for me to get away to attend meetings during that time. For me, the best month is probably November; however, if adequate notice is given, I could make arrangements to attend meetings.

3. Specific matters to be investigated: Selection of jury and judges as a whole; slowness of the process; administration of court system in Anchorage.

4. Names of groups of individuals to be notified: Lee Jordan, Editor, Chugiak-Eagle River Star, PO Box 1007, Eagle River, AK 99577; Robbie Robinson, Chugiak Community Council, Box 309, Chugiak, AK 99567; Bob Johnson, Eagle River Community Council, PO Box 456, Eagle River, AK 99577; Stephen Dunning, Eagle River Valley Community Council, Box 1644, Anchorage, AK 99510; Tom Henry, Birchwood Community Council, SRA Box 760, Chugiak, AK 99567; Rex Campbell, North Mt. View Community Council, 819 N. Klevin, Anchorage, AK 99504; Fred Selkregg, Northeast Anchorage Community Council, 5811 Radcliffe, Anchorage, AK 99504; Gene Buck, Russian Jack Park Community Council, 5222 East 24th Avenue, Anchorage, AK 99504; Kathleen Bush, 6631 East Eighth, Anchorage, AK 99504; The Brown Family, 442 South Flower, Anchorage, AK 99504; Clifford and Jane Bissell, Box 656, Eagle River, AK 99577; Marion E. Daley, PO Box 108, Chugiak, AK 99567; Mike Briggs, Esq., Ely, Guess & Rudd, 510 L Street, Anchorage, AK 99501.

5. Other information: I would like to have hearings at following areas in House District 8 -- Eagle River, Mt. View, Muldoon, Nunaka Valley.

If you need further information, please do not hesitate to contact me.

Best Regards,

Randy Phillips
State Representative

RP:js

Alaska State Legislature
House of Representatives

April 2, 1979

To Rep. Charlie Parr

From Rep. Thelma Buchholdt

Subject Judiciary Committee Interim Activity

Yes, I'd like to participate in the interim work of the House Judiciary Committee.

I'll be available to attend hearings in and out of the state, except during the following:

June 16-30; July 1-13; August 20-26; September 16-30;

October 1-6; November 21-24; December 22-31.

Specific topics that I want considered include the following:

POLICE: Ethics, Recruitment, Training, Organization, Funding Source.

Because of the importance of public confidence in our policemen/state troopers, we must be sensitive to how the general public views our police. Working with respected policemen from all parts of Alaska, the Committee should review police behavior, recruitment policy, training programs and staffing, working relations of local and state officers, budgetary needs and sources.

Additionally, the Committee should become familiar with law enforcement priorities, and how such priorities get set.

PRISON: Public policy in Alaska has historically opposed the construction of a maximum security prison, and prison classification staff has awesome power to transfer men and women to outside facilities. Is this power being used wisely? Because of the importance of public confidence in fair and just punishment, the Committee should discuss prisoner classification with respected correctional officials with a view of recommending appropriate legislative action.

The Committee should also research ways at expanding reliable alternatives to institutionalizing convicted felons, including penitential employment on public works projects.

PAROLE: Parole is the most commonly-used alternative to jail, and our parole system should be reviewed by the Committee to see if it is functioning effectively as a re-entry program.

EQUAL JUSTICE: We know from recent judicial studies that certain groups of people wind up in jail faster than others. The Committee should strive to determine the degree to which justice now obtains in law enforcement, in the courts, and in the correctional institutions.

There is that hope in the New Criminal Code which may help to correct previous inequities in the system. But the Committee should maintain that there is plenty of work yet to be done to straighten out the problems spelled out in the sentencing studies.

GROUPS TO BE NOTIFIED OF HEARINGS:

Commission on the Status of Women
League of Women Voters
Alaska Legal Services
N.A.A.C.P.
Alaska Black Caucus
All Alaska Native organizations
PTA groups
AkPIRG
Other minority group organizations
In District 9 for hearings in Anchorage:

Spenard Community Council (Myron Igtanloc)
Turnagain Community Council (Wilda Marston)

Note: I'm particularly interested in working on the topics listed on the first page, as what happens between the arresting officer and the suspect, I believe, may determine the trend that follows thereafter to the defendant, the inmate, the parolee.

Needless to say, public confidence with the correctional/judicial system has to be maintained, perhaps restored.

Here's to hard labor during the interim!

****

Judiciary Committee Interim Activity

Questions Need Answers

Police Ethics: Are Alaskan police behaving as they should? Hear and review complaints about police behavior and administration.

Police Training: Review of training programs and opportunities. What can be learned of police attitudes from training curricula and training staff?

Police Organization: Relationships between local police and state troopers; probation officers; federal marshall and other law enforcement officers (FBI, etc.)

Communication systems; cooperation between agencies.

Police Funding Sources: Personnel; equipment; state and federal budget;(LEAA, Peace Officers groups, etc.)

Law enforcement priorities: How crimes get classified (when does it suit the victim, the offender?); How are police handling narcotic-related crimes(alcohol-related crimes) in order of priorities?

Public Defender Agency: How much time is spent by a Public Defender with his client during pre-trial, during trial, etc.

Judges: qualifications; selection; early retirement incentives(?); Constitutional changes on salary schedule; etc.

Bails: how set are they for specific crime; bail bonding agencies;

Parole Board: criteria in releasing an inmate for parole; quality of decisions made by the board.

Jury: how much influence on punishment for crime committed; selection, certain groups of people seem to be serving more often than others (except those excused due to professional constraints).

General Public: What is the public perception of certain crimes and appropriate punishment; priorities in law enforcement.

(1)

EDUCATION

It is time now for the Legislature to investigate what has become a steady stream of complaints about the state in which ~~the~~ Alaska's education industry finds itself after several years of generous fiscal support. Now, after years of being fairly unanimously urged to fund without much question ~~all of~~ the budget requests submitted by education progarm administrators, the Legislature is being asked to adopt a more critical view of ~~the education priorities we are having to fund~~ education as we must ~~face~~ begin to ~~have to~~ deal with problems of widespread adult illiteracy. This is a real political problem because the education industry does not ~~accept~~ gracefully accept critical views. However, the House ~~Education Sub~~ HESS Committee will accept responsibility to bring the following aspects of public education under critical review during the interim:

1) Federal and State and local Funding Sources. There must be more public understanding of funding sources available to local school districts. Some critics feel these are so numerous and uncoordinated as to make education program administrators unaccountable to ~~political~~ our political leadership on our local school boards, borough assemblies, and the Legislature. The Committee will focus upon the school systems of the Ketchikan Gateway ~~Borough, the Anchorage Unified Municipality~~ selected REAA's, and the North Slope Borough to learn how improved education program funding systems might contribute to improved education. ~~formula (Gateway, Anchorage, Juneau)~~ ~~weight~~ the base instructional unit

~~)//Children in K to 12 - The Committee will try to evaluate the problems of education in our communities. Are our kids learning to read and write? How many are not? Is there a growing attendance problem? Is illiteracy part of this problem? How well do our kids do compared with other parts of the country? What about these educational achievement~~

2) Children in K to 12 grades - The Committee will try to evaluate the problems of education in our communities. Are our kids learning to read and write? How many are not? Is there a growing attendance problem? Is illiteracy part of this problem? How well do our kids do compared with other parts of the country? What about these educational achievement

tests? Can they be trusted, or are they written to mask the failure of our schools as many feel? What do our kids think of their schools? And our truants and drop-outs - what do they think of our schools? What do their parents think? What educational alternatives are there to help them continue their education?

3) Teacher Recruitment and Pay. There are many questions being asked about how teachers are recruited, and how much they are paid. The public's image of teaching has moved from one of an inadequately paid profession to one of a well-paid profession, one in which too few Alaskans have been encouraged to enter as Alaska's education industry has become a $000-million industry employing _____ teachers and administrators, as well as _____ non-professional support personnel. What about local hire in education, one of Alaska's largest industries? How can this be improved? And for those teachers we must continue to recruit from outside, how can we improve recruitment to insure we employ only the best teachers available? How might the University of Alaska help toward the training and employment of Alaskan teachers, and improved outside teacher recruitment?

4) School Administration. There is a widely-shared perception of rapid growth of the number of educational program administrators employed in Alaska's education industry whose combined strength has weakened the role of the School Board as a moderating influence in the growth of this industry. What is the truth of these perceptions? How well are the School Boards making educational policy? Is rapid growth in the ranks of school administrators a sign of School Board weakness to resist inflationary costs? How many administrators are there? What are they paid? What do they do? How are they typically recruited, and from where? How do they relate with classroom teachers? What do classroom teachers think about the rapidly expanded corps of administrators? The Committee will focus upon educational administration as a much-complained of problem affecting influencing educational failure in Alaska.

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Right here

Additionally, until the creation ~~The creation~~ and funding of REAA's, ~~has severely~~ compounded this trend into a serious fiscal problem ~~at a time when~~ anticipated ~~unknown~~ educational costs have contributed to State budget growth ~~must be effected sharply reduced.~~ ~~What are the factors contributing to annual increases in State foundation~~ for FY 88 up to 10% bi annually.

Is the Foundation Program in need of overhaul? The Committee will seek answers to this question in an effort to ~~retain/prevent~~ make Foundation support equitable to everyone.

6) Rural School Construction, Operation and Maintenance - The Committee will undertake to study and comprehend the economic and problems of rural village school construction, operation and maintenance as it has become a major budget consideration ~~in future~~ about which too little is understood. What are the politics and economics of village high school construction? Have village school construction and O&M estimates proved reliable in the past? What has been the experience with cost-overruns, and what caused them? ~~What information does the state have projections~~ ~~Any~~ What is the real square-foot cost of village school operation and maintenance? How have village high school stood up to wear and tear so far? What are the outstanding and most difficult O&M problems? What about heat. How will new village high schools affect rural Alaska's need for fuel? ~~Is~~ Will there be enough, or will village homes have to compete with

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Professional businessmen throughout the State have argued they should not have to compete with the University of Alaska for consultant planning, program evaluation, industrial, economic, and environmental analysis, and architectural and engineering, and other services. Yet many of our University's best programs flourish because of their involvement in the real competitive world of private industry. Should restrictions be placed on this involvement? Should the U. of A. be allowed to compete with private industry for State contracts? If so, under what terms? This is a public policy question of growing importance, and the Committee will work to prepare a policy recommendation.

Official Business

Alaska State Legislature

House of Representatives

Committee on

Health, Education & Social Services

Pouch V
State Capitol
Juneau, Alaska 99811

TO: Rep. Terry Gardiner,
Speaker of the House

FROM: Rep. Thelma Buchholdt
HESS Committee Chair

SUBJECT: Proposed Interim Work of the HESS Committee

Traditionally, a legislator who winds up on the Health, Education and Social Services Committee is labelled a "bleeding heart" who approves, with great ease, the funding of everything that comes along, from day care to senior citizens programs, schools and numerous other social and human services needs.

During these penny-pinching times, even programs that tug at the heartstrings require as much scrutiny and justification as all others. In fact, more so than others, because historically, nobody wants to check them out for fear of treading into "sacred grounds". The H.E.S.S. Committee recognizes that in poking around for facts and public input during the interim, there will be some treading on tender, sensitive areas which will need to be addressed delicately as much as possible. But at the same time, to quote a recently-expired newspaper, "Sacred Cows make the best hamburger", and certainly, the H.E.S.S. Committee will not spare any sacred cow that cannot justify its existence.

The H.E.S.S. Committee proposes to work on certain bills presently in committee and others that will be introduced next session. Additionally, work topics will include, but will not be limited to, the following:

HEALTH AND SOCIAL SERVICES ISSUES

Alcoholism programs - review of local agencies and educational programs. (HB-219)

Senior Citizens Programs:

Multipurpose Senior Citizens Center
Alternative residential facilities

The H.E.S.S. Committee will work with the Judiciary Committee in its review of the program under the Division of Corrections.

1) Police: Ethics, Recruitment, Training, Organization, Funding Source.

Because of the importance of public confidence in our policemen/state troopers, we must be sensitive to how the general public views our police. Working with respected policemen from all parts of Alaska, the Committee should review police behavior, recruitment policy, training programs and staffing, working relations of local and state officers, budgetary needs and sources.

Additionally, the Committee should become familiar with law enforcement priorities, and how such priorities get set.

2) Prison: Public policy in Alaska has historically opposed the construction of a maximum security prison, and prison classification staff has awesome power to transfer men and women to outside facilities. Is this power being used wisely? Because of the importance of public confidence in fair and just punishment, the Committee should discuss prisoner classification with respected correctional officials with a view of recommending appropriate legislative action.

The Committee should also research ways at expanding reliable alternatives to institutionalizing convicted felons, including penitential employment on public works projects.

jail, and our parole system should be reviewed by the Committee to see if it is functioning effectively as a re-entry program.

EDUCATION

1) Federal and State Funding Sources

2) Children in Grades K to 12:

   Attendance
   Basics
   Extracurricular activities
   Special Education alternatives

3) Teacher Recruitment and Pay

   Local hire first
   Outside recruitment
   (Employ the best from outside)

4) School Administration

   School Boards and Policy
   Positions and Pay Structure

5) Foundation Program (HB-126; HB-222; HB-333)

   Urban support
   Rural support

6) School Construction, Repairs and Improvement

   a) Urban schools
      Rural schools
      Problems of village school construction in the unorganized borough; in the organized borough.

   b) Review of small high schools

      Design
      Curriculum
      Staffing
      Organization and Management
      Alternatives

7) Youth Centers (HB-125)

8) Adult Basic Education

Alaska State Legislature

House of Representatives

Committee on

Health, Education & Social Services

Official Business

Pouch V
State Capitol
Juneau, Alaska 99811

April 10, 1979

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The Committee should also research ways at expanding reliable alternatives to institutionalizing convicted felons, including penitential employment on public works projects.

3) Parole: Parole is the most commonly-used alternative to jail, and our parole system should be reviewed by the Committee to see if it is functioning effectively as a re-entry program.

EDUCATION

It is time now for the Legislature to investigate what has become a steady stream of complaints about the State in which Alaska's education industry finds itself after several years of generous fiscal support. Now, after years of being fairly unanimously urged to fund without much question, the budget requests submitted by education program administrators, the Legislature is being asked to adopt a more critical view of education as we must begin to deal with problems of widespread adult illiteracy. This is a real political problem because the education industry does not gracefully accept critical views. However, the House HESS Committee will accept responsibility to bring the following aspects of public education under critical review during the interim:

1) Federal, State and Local Funding Sources. There must be more public understanding of funding sources available to local school districts. Some critics feel these are so numerous and uncorrdinated as to make education program administrators unaccountable to our political leadership on our local school boards, borough assemblies, and the Legislature. The Committee will focus upon the school systems on the base instructional unit formula (Gateway, Anchorage, Juneau), selected REAA's and the North Slope Borough to learn how improved education program funding systems might contribute to improved education.

2) Children in Grades K to 12. The Committee will try to evaluate the problems of education in our communities. Are our kids learning to read and write? How many are not? Is there a growing attendance problem? Is illiteracy part of this problem? How well do our kids do compared with other parts of the country? What about these

educational achievement tests? Can they be trusted, or are they written to mask the failure of our schools as many feel? What do our kids think of their schools? and our truants and drop-outs -- what do they think of our schools? What do their parents think? What educational alternatives are there to help them continue their education?

3) Teacher Recruitment and Pay. There are many questions being asked about how teachers are recruited, and how much they are paid. The public's image of teaching has moved from one of an inadequately paid profession to one of a well-paid profession, one in which too few Alaskans have been encouraged to enter as Alaska's education industry has become a $500,000,000 industry employing 4,000 teachers and administrators, as well as 4,000 non-professional support personnel. What about local hire in education, one of Alaska's largest industries? How can this be improved? And for those teachers we must continue to recruit from outside, how can we improve recruitment to insure we employ only the best teachers available? How might the University of Alaska help toward the training and employment of Alaskan teachers, and improved outside teacher recruitment?

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6) Rural School Construction, Operation and Maintenance. The Committee will undertake to study and comprehend the economic and problems of rural village school construction, operation and maintenance as it has become a major budget consideration about which too little is understood. What are the politics and economics of village high school construction? Have village school construction and Operation and Maintenance estimates proved reliable in the past? What has been the experience with cost-overruns, and what caused them? What is the real square-foot cost of village school operation and maintenance? How have village high schools stood up to wear and tear so far? What are the outstanding and most difficult operation and maintenance problems? What about heat? How will new village high schools affect rural Alaska's need for fuel? Will there be enough, or will village homes have to compete with schools for fuel? What is the life-cycle cost estimate of village schools, and what is being done to try to reduce it? Why are these schools so important to rural Alaska? How is a village school used? Against the background of perceptible political reaction against capital expenditure for new village high schools, the Committee will try to determine their real monetary cost, as well as the costs to be incurred if the schools are not built and operated as planned.

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11) University of Alaska Research Programs. As the industrialization of knowledge develops throughout Alaska, the role of the University of Alaska as a subsidized competitor in the private knowledge market must be fairly defined and possibly restricted if the market benefits of free enterprise are to be realized by our State. Professional businessmen throughout the State have argued they should not

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VII APPENDIX

TABLE I - SUMMARY OF STATE LEGISLATIVE OPTIONS TO EXPAND COMPREHENSIVE HEALTH CARE COVERAGE

	Program	Who It Would Cover	State Administrative Tasks	Estimated Annual Premium Costs To The State*	Other Payers
1.	Universal State sponsored coverage	All state residents without federal health coverage (267,500)	Verification of residency, enrollment, accounting, and financing	$87 million (if 100% subsidized)	Taxpayers (optional cost sharing with subscribers)
2.	State sponsored coverage for the uncovered	All state residents not covered under other public or private plans and their dependents (56,000-71,000 estimated)	Eligibility determination, enrollment, accounting, and financing	$27 - $41 million (if 100% subsidized)	Taxpayers (optional cost sharing with subscribers)
3.	State sponsored coverage for non-wage earners without coverage from public sources	The unemployed, self-employed, and the non-labor force and their dependents (60,000 estimated)	Eligibility, determination, enrollment, accounting, and financing	$25 million (if 100% subsidized)	Taxpayers (optional cost sharing with subscribers)
4.	Income tax credit	All residents filing tax returns (124,000 estimated) and their dependents	Negligible	$21 million (assuming a flat $250 credit)	Taxpayers and subscribers
5.	Medicaid medically needy program	Categorically needy with income above the public assistance level (1,580 estimated)	Eligibility determination, enrollment, accounting, and financing	$1.1 - $1.4 million (cost savings in GRM not included)	Federal government, federal taxpayers, and Alaska taxpayers
6.	Mandatory employer coverage	All non-agricultural wage and salary employed people, and their dependents (200,000 estimated)	Regulation of Employers	$0 (state cost sharing optional)	Employers and their clients (optional cost sharing with subscribers)
7.	High risk reinsurance pool	People who are unable to obtain health insurance at a reasonable premium due to health conditions	Investigation on a complaint basis	$0 (state cost sharing optional)	Subscribers, insurance companies and their clients
8.	Health insurance regulation	Better coverage for current subscribers; possible decline in the number of low-income subscribers	Regulation of carriers	$0	Subscribers (including employers and other sponsors)

* These estimates are based on estimates of the current extent of coverage. Presumably alternatives 2, 3, & 4 would provide incentives for increasing health coverage, and therefore the state's premium costs would tend to rise over time.

Prepared by Legislative Affairs Agency Research Division 2/17/78

TABLE II ESTIMATED PREMIUM COSTS OF STATE-WIDE HEALTH COVERAGE WITH BENEFITS EQUIVALENT TO THE STATE EMPLOYEE HEALTH PLAN

Total FY '77 Civilian Population	398,000
U. S. Public Health Service Eligibles	(70,000)
CHAMPUS Eligibles	(55,000)
Medicaid Eligibles (excluding USPHS)	(5,500)
Eligible Population	267,500

	19 and Under (32.5%)	Over 19 (67.5%)
Number eligible	86,900	180,600
Premium Rate	$12.40	$34.10
Monthly Premium	$1,078,000	$6,158,000

ESTIMATED ANNUAL PREMIUM $86,800,000

TABLE III ESTIMATED RANGE OF INITIAL[1] PREMIUM COSTS OF HEALTH COVERAGE FOR THE UNCOVERED POPULATION

	High	Low
Uncovered Population	71,000	56,000
19 and Under (32%)	23,000	18,000
Premium Rate[2]	$22.00	$19.00
Monthly Premium	$506,000	$342,000
Over 19 (68%)	48,000	38,000
Premium Rate [2]	$60.00	$51.00
Monthly Premium	$2,880,000	$1,938,000
ESTIMATED ANNUAL PREMIUM	$41,000,000	$27,000,000

1. These costs would approach the cost of universal coverage over time, as private subscribers opt for state subsidized coverage.

2. The estimated premium rate for state wide coverage, +50 to 75%. See Blue Cross memo which follows.

TABLE IV ESTIMATED RANGE OF PREMIUM COSTS OF HEALTH COVERAGE FOR NON-WAGE EARNERS AND DEPENDENTS WITHOUT HEALTH COVERAGE FROM PUBLIC SOURCES

Unemployed	18,300
Self-employed	15,000
Non-labor Force	244,000
Wage earner dependents	(105,000)
CHAMPUS eligibles	(46,000)
Medicaid eligibles	(14,800)
U. S. Public Health Service Eligibles	(31,500)
TOTAL	60,000

	High (+20%)	Low (+20%)
19 and Under (32.5%)		19,500
Premium Rate	$16.12	$14.88
Monthly Premium	$314,000	$290,000
Over 19 (67.5%)		40,500
Premium Rate	$44.33	$40.92
Monthly Premium	$1,795,000	$1,657,000
TOTAL ANNUAL PREMIUM	$25,300,000	$23,400,000

TABLE V ESTIMATED COST OF INCOME TAX CREDIT FOR PRIVATE HEALTH COVERAGE

Tax Returns Filed	124,000
Filers with Private Health Coverage (68.5%)	85,000
Annual Tax Credit	$250.00
TOTAL	$21,000,000

Blue Cross®
of Washington and Alaska

John M. Hopkins
Vice President, Marketing

15700 Dayton Avenue North/P O Box 327
Seattle, Washington 98111
206/361-3586

November 30, 1977

Ms. Sharman Haley
Research Analyst
Legislative Affairs Agency
State of Alaska
Pouch Y, State Capitol
Juneau, Alaska 99811

Dear Sharman:

On September 29, you requested information concerning projected costs of a Blue Cross medical package for various classifications of State residents.

Three alternative approaches were requested in your letter. The attached proposal is applicable only for the first alternative, "coverage for all residents". The second alternative, to cover "all residents not currently covered under comprehensive group health plans", would present problems in defining and administering eligibility and in developing a controlled risk. Rates for the second alternative would probably be 50% to 75% higher than the rates for the first alternative.

The third alternative, to cover "the unemployed, the temporarily or seasonally employed, and the self-employed (mandating employer-sponsored coverage for all regular employees and their dependents)", would present fewer problems in controlling risk but would still require rates 20% to 30% higher than the first of the three alternatives and probably would have the least economic impact on the State's health care system.

We recognize that you may have many questions concerning the information contained in this letter. Please give me a call and we will try to help in any way we can.

Sincerely,

John M. Hopkins

JMH:bc

EXHIBIT 'A'

Blue Cross medical coverage extended from the Alaska State Employees to eligible residents of Alaska, given the following assumptions:

I. A resident is a person whose primary residence has been within the State of Alaska for a continuous period of at least six months.

II. An eligible resident is a resident not eligible for medical care benefits available through the following entities:

a. Federal Employee Health Programs
b. United States Armed Forces
c. CHAMPUS
d. Medicaid
e. United States Public Health Service

III. Healthcare benefits would be provided as primary coverage, with the sole exception that the Program be coordinated as secondary coverage to Medicare. Any persons eligible for Medicare and not enrolling in the Medicare Program will receive the same coordinated benefits had they been covered under Medicare.

IV. The State of Alaska would identify all eligible residents and submit necessary eligibility data to the Blue Cross Plan monthly on a computer tape in order that an updated eligibility file could be maintained for the Program. Administration and enforcement of eligibility rules would be the responsibility of the State of Alaska.

V. The State of Alaska would remit, monthly, funds due the Plan based on the eligibility file and contract rates.

VI. At the end of each contract year the Plan would provide a summary of Income, Incurred claims and administrative expenses under the Program. Any surpluses would be refunded to the State of Alaska. Any deficits would become due and payable to the Plan by the State of Alaska. The Plan would provide monthly reports to the State of Alaska during each contract year, itemizing year-to-date income and expense data.

VII. During the initial years of the Program it is likely that abnormally high rates of inflation and increases in utilization of healthcare services will occur. In an attempt to control these anticipated trends and their effects on the cost of the Program, it would be desirable for the State of Alaska to enact legislation to control the expansion of healthcare facilities and to set reasonable limits on the rate of return healthcare providers may be allowed.

continued . . .

VIII. If the first contract year is from 7-1-78 through 6-30-79, one of the following options could be used in determining the monthly funds due to the Plan:

A. Rates by eligible resident-

1. Adult (age 19 and over) = $34.10/month
2. Child (under age 19) = $12.40/month

B. Rates by type of family unit-

1. Single Adult = $34.10/month
2. Husband & Wife = $68.20/month
3. Husband,Wife & one or more Children = $96.70/month
4. Husband,or Wife and one or more Children = $62.60/month

C. Rate for any Family Unit = $71.40/month
Each family unit would coincide with one of the categories itemized in section VIII, B., above. Children must be unmarried and meet the IRS definition of a dependent to be considered an eligible member of any covered family unit.

The above rates assume all eligible residents will participate in the Program.

IX. To minimize the chance of duplicate coverage and benefit payments each eligible resident should be assigned a unique membership number under the Program. This procedure would also facilitate computerized surveillance of medical utilization under the Program. Surveillance programs could be used to detect abnormal utilization of benefits by covered members and abnormal patterns of service by healthcare providers.

X. The Program should provide coverage for services rendered within the State of Alaska. For services outside the state, coverage should be limited to emergencies and to referrals by Alaska physicians for conditions that, in the opinion of the attending physician, cannot be adequately treated in the State's healthcare facilities.

MINUTES
House HESS Committee Meeting
3/31/80

Members present:

All members were present at the start of the meeting.

758 The Chair stated that the Committee would be hearing testimony on HB 977, providing comprehensive health care in the state, for most of the week. The first witness would be John Ingrassia, from Minnesota, to talk about how the Minnesota plan resembles one part of HB 977. A Mr. Ching from Hawaii would be with the Committee tomorrow to discuss another section of the bill (he was originally scheduled to come before the Committee today but was unable to get here on time).

802 John G. Ingrassia, Supervisor, Life and Health, Insurance Division, Dept. of Commerce, State of Minnesota

Mr. Ingrassia described the Minnesota health insurance for the Committee. He began his testimony by stating that the most important part of the Minnesota plan that is included in HB 977 is the creation of an association to control expenses incurred through the provision of catastrophic illness coverage. All health insurance carriers would participate in the association and thereby share the risks of the plan. The state would cover the losses of the carriers by allowing them to deduct any losses taken from their tax liability to the state.

There would be three different categories of plans that employers could provide. Insurance carriers could develop several different options for employers to chose from within each category. However, an employee could not pick and choose which items he or she would like his insurance to cover, rather, he or she would have to choose one of the preplanned packages that the insurance company or the employer would present to him. $250,000 would be the maximum life time benefit.

Mr. Ingrassia stated that Alaska might want to consider mandating that all plans include "chemical dependency" coverage as well as coverage for alcoholism. The plans cover treatment for "conditions" such as pregnancy, obesity, etc., as well as coverage for illnesses and diseases.

There would also be a state plan providing minimum benefits that an individual could pay for if he could not find someone to cover him because he had a heartattack or some other serious illness that no one wished to provide further insurance against.

1300 Rep. Miles left the Committee.

The self employed would be covered because they would also qualify for the state plan since they would not be getting a plan from their employer in the private sector.

There would also be a provision in the Act that would allow employees to receive coverage when they are in a period of unemployment.

Mr. Ignassio stressed the point that everyone could get coverage through one form or another, even those who traditionally are not able to because they are high risk investments.

There were several questions from the Committee members on the above subjects. In addition, Rep. Chatterton asked if the Minnesota law was not presently embroiled in a court battle to have its constitutionality determined. Mr. Ingrassia explained that this was indeed the case.

new tape
00 Rep. Munson stated that the Minnesota plan did not require employers to provide insurance but that it required employers to make insurance available.

Mr. Ingrassia stated that there has not been a major influx of people into Minnesota to profit from the Act. This had been a fear before enactment that has never materialized.

There were other questions, and the meeting was eventually adjourned for lack of further time to carry on the discussion.

Mr. Ching stated that he was not very optimistic about national health insurance legislation passing Congress because there are too many diverse geographical interests to resolve. Rather, he feels that states should attack the problem on their own and that if a plan does develop that would benefit the country as a whole, then that plan can be lobbied for on a national level. He reiterated his earlier point that maybe the Alaska plan will develop into a prototype for national legislation, or for implementation on a statewide basis in other states. He stated that only time would tell, however, if administrative and other problems would develop.

Mr. Ching stated that the Committee was very likely to run into opposition from insurance companies and that he did not think that there was any way to avoid it.

The Chair asked if there were any people about on the teleconference network that would like to ask a question of Mr. Ching. A person from Nome asked why state employees were exempted from the Act. Mr. Ching stated that they are already covered under a program designed especially for state employees.

1000 Rep. Hurlburt left the Committee room.

Mr. Ching stated that if there was any further assistance that the State of Hawaii could offer in the area of administration of the program or in any other area, it would be forthcoming.

The Chair asked if there was anyone in the audience in Juneau who wished to testify. Since no one responded, the meeting was adjourned.

MINUTES
House HESS Committee
4/1/80

Members present:

Buchholdt, Chair
Munson
Chatterton
Miles
Beirne
Hurlburt

00 The Chair brought the meeting to order. The meeting consisted of a hearing on HB 977, comprehensive state health insurance, that was broadcast over the teleconference network.

95 Donald Ching, Hawaii State Legislator

Mr. Ching came from the State of Hawaii to talk about the similarities and the differences between the existing Hawaii statute and HB 977. He prefaced his remarks by stating that HB 977 was comprehensive and "far reaching" and that it could represent an answer to the people's problems regarding health insurance. He stated that the following provisions were what made the bill comprehensive and more complete than the Hawaii statute: (1) coverage for employee dependents, (2) medicare coverage, (3) coverage for the uninsurable, (4) the establishment of a joint underwriting association, and (5) the allowance of deductibles.

Mr. Ching explained that the Hawaii statute was currently under litigative attack by Standard Oil Company. That suit is presently before the 9th Circuit Appeals Court.

He noted that Hawaii had set up a supplementation fund to pay premiums for employees unable to meet that obligation. He stated that that fund had hardly been touched and that through its investments it had made over $800,000 for the State of Hawaii. He used this as an example of how little money the Hawaii statute was costing the state. He stated that employers pay the biggest chunk of the health insurance costs in Hawaii.

There was a discussion about the fact that around 97% of Hawaii's population is covered by some type of health insurance.

Rep. Hurlburt asked if natives would be able to opt out of the Alaska plan due to existing coverage by the Indian Health Service. Mr. Ching stated that it was his understanding that that would be a "political and social" decision that the Alaska legislature would have to make and that costs would need to be taken into account. The Chair explained that native groups had indicated that they would introduce an amendment to the Act to have the Act treat them as individuals, not as members of a racial group, so that they could receive coverage under it.

Rep. Chatterton asked about dependent coverage. Mr. Ching explained that employees who wish to have dependents covered must pay for the additional premiums themselves. However, he noted that most employers will pick up this tab for their employees.

80C Rep. Miles left the Committee room.

Rep. Beirne asked if Mr. Ching thought that Alaska, given its oil wealth, should pick up 100% of the cost of the bill. Mr. Ching cautioned that the legislators should provide as much as they could, but that they should not get themselves into a position that they could not extricate themselves from without extreme political costs. He stated that they should provide a level of funding that they could support in the bad times as well as the good. "Don't pay too much of the tab in the beginning...", he stated, "you can still be heroes further down the road."

Angie Hague, National Association of Social Workers

She stated that she did not have sufficient time to review the bill but that she supported timely reimbursement of payments to providers of services, dental, prenatal and high risk coverage, coverage for the medically needy, and buying private insurance with medicaid funds.

Penny Hladna, Anchorage

Ms. Hladna supports provisions for the medically needy, alcoholism treatment, routine exams, high risk, cash advance and interest. She also stated that doctors routinely refuse to handle medicaid patients.

Gordon DePew, Fairbanks Life Underwriters Association

Mr. DePew was angry that he had not been informed about the bill; he stated that he received the legislation summary by accident. He said that it was the most inflationary piece of legislation that he had even seen and that it called for coverage exceeding mandatory coverage in six states. He said that the bill woud bankrupt employers. He said that mandatory coverage in a state with so little population would mean that many insurers would leave the state and that small companies would go under.

Bernie Barr, International Rehabilitation Association, Anchorage

Mr. Barr was curious about what coverage for rehabilitation services would be provided. Debby Behr, from H&SS answered that she thought that physical therapy and similar services would be covered.

Gil D'Ihnorente, Anchorage

Mr. D'Ihnorente complained about the short notice given for the hearing. He stated that insurance rates would rise by $100-150 per person.

Candice Berry, Welfare Rights Organization, Anchorage

Ms. Berry voiced her support for the bill. She stated that uninsured poor women currently suffer the most and that only 6% of ob-gyns accept medicaid patients.

Pudge Kleinkoff, National Association of Social Workers

Ms. Kleinkoff supported coverage for poor and otherwise needy people. She stated that she would like to receive a copy of the bill's fiscal note. She also questioned whether coverage for the medically needy would elimiate their coverage under General Relief Medical.

Frank Austin, CEJ, Black Caucus, Anchorage

Mr. Austin endorsed the concept of the bill and stated that he would try to write a position paper for the Committee.

Susan Johnson, Chris Billington, NOW

The witnesses voiced their support for the bill.

Nancy Lander, WPA

Ms. Lander expressed support for the bill. She stated that it should include coverage for mental health problems.

1437 The meeting was adjourned.

MINUTES
House HESS Committee
4/1/80
evening session

Members present:

Buchnoldt, Chair
Munson
Miles
Beirne
Chatterton
Barnes

1219 The meeting consisted of a teleconference on HB 977, an Act providing comprehensive health insurance for the state.

1264 Bill Weimer, Anchorage

Mr. Weimer proposed comprehensive health and dental programs that each citizen would be enrolled in. The programs would be subject to competitive bid proceedings and the state could pay monthly premiums. If there was an adverse impact on employers, state could provide some form of supplementation. This would be a way to distribute the state's wealth equally. Processing of the bill in Alaska would provide more jobs.

There was discussion between the members, the audience and the witness about how much oil wealth the state really has, and how much of it should be spent on health insurance.

Nick Noll, Fairbanks Eye, Ear, Nose & Throat Clinic

Mr. Noll stated that he hadn't had enough time to review the bill.

The Chair asked if he could send written comments, when he has time, especially regarding the proposed medicaid plan and how that would effect the present payment system.

Donald Thieman, Fairbanks Medical Association

Mr. Thieman stated that he had so little notice on the bill that he hadn't had time to prepare any comments.

Chris Beardsly, Providence Hosp., Anchorage

Ms. Beardsley stated that she had just received the bill but she made several comments anyway. She said that it seemed that some employers' liability for premium and withholding payments would be greater than others because of the discrepancy in wage levels. She also stated that the Medicaid sections would reward the physicians and that further work was needed to improve this section. She made several other comments and stated that these would be incorporated into a position paper which she would present to the Committee.

David Mather, Tanana Chiefs Conference

Mr. Mather stated that he had only had time for a cursory review of the bill, but that he very definitely supported its goals.

new tape

Margaret Wolfe , Anchorage

Ms. Wolfe noted that the bill would exclude outpatient mental health care coverage. She also stated that small employers would be severely impacted by the bill. She said that she supports a penalty for late payment of premiums.

page two.

He said that there may be a problem finding enough domestic carriers in the state to provide enough competition to bring about reasonable insurance rates for employers.

new tape 00 There would also be problems with having outside carriers, in terms of getting immediate payments to providers.

There would be cost problems with this outside carrier situation, and also cost problems for the employers.

He concluded his remarks by stating that there may also be other conflicts of law which called for further research, including the possibility that Blue Cross could be excluded from providing coverage in Alaska if HB 977 was enacted.

200 Rep. Miles left the Committee room.

Mr. Koch provided testimony for the Committee that consisted of a section-by-section analysis of the bill. He noted several areas of proposed language change and suggested several interpretations for policy changes that the bill would bring about. He was unable to complete his analysis because of time constraints, and so the Chair asked him to come back and continue his analysis at another hearing. He completed comments on Section 1 of the bill, only.

1350 The meeting was adjourned.

MEETING
House HESS Committee
4/2/80

Members present:

Buchholdt, Chair
Chatterton
Munson
Miles

The meeting consisted of a public hearing on HB 977, an Act providing comprehensive health insurance on a statewide basis.

1442 Don Koch and Jim Jordan, Division of Insurance, Dept. of Commerce

Mr. Koch stated that the Division is not in favor of the bill although it applauds the concept of providing health insurance for all Alaskans. He stated that though the bill was like Hawaii's and Minnesota's legislation, combining those two states' plans and adding a new "Alaskan" section made the bill entirely different from either states' plans and allowed for very little comparison between the other states' plans and HB 977. He stated that the experience of the other two states would not be the same as what would happen in Alaska if HB 977 were enacted.

Mr. Jordan then made several statements to the Committee, addressing several problem areas of the bill from the Division's point of view. He stated that litigation pending against the Minnesota and Hawaii statutes involved issues that were also addressed in HB 977. This would mean that if enacted, HB 977 could also be subjected to litigation. The Hawaii suit centers around who can be considered a self insurer and therefore exempt from the law.

Mr. Jordan brought up two areas of statutory conflict that would be created by enactment of the bill. He said that creation of an underwriting association would conflict with existing law that states that a group may not form for the purpose of becoming insured. The other area of conflict involves the proposed provision to give the director 90 days to certify qualified plans. This conflicts with an existing statute stating that the director can have only 30 days to complete filing of forms.

He further stated that the provisions for determining amounts of employers' contributions to pay for the health insurance are discriminatory. Also, the method of making a determination would be cumbersome, time consuming and costly for the employer.

He said that there could be a problem with a couple that could receive dual coverage. One partner could work for the state and get coverage and the other could work for a private employer and also get coverage. Since coverage in both instances would include dependents, both people would be covered twice. They could conceivably get 100% of their health costs paid under dual coverage, instead of the 80% allowed. They would have to pay double premiums, but conceivably this could be worth it to them if they would get all their health care costs paid.

He stated that the term "prepaid health care" as used in the bill should be changed to provide more specific language to better mesh with the provisions that the phrase is currently found in. The same comments were made about "defray or reimburse".

He asked how employers would be able to comply with the President's wage guidelines and comply with HB 977.

He noted several problems with the premium supplementation section of the bill. He stated that the section may provide payments too late and that there was not enough data to know how often and how much supplementation would be necessary.

Official Business

Alaska State Legislature

House of Representatives

Committee on

Health, Education & Social Services

Pouch V
State Capitol
Juneau, Alaska 99811

SUMMARY OF HEALTH CARE LEGISLATION
HB 977

The first section of the bill requires employers to provide health coverage for their regular employees and to pay at least 50% of the premium cost of such coverage. The health coverage must meet or exceed the standards for a "number two qualified plan" as established in the second section of the bill, and must cover the employee's dependents as well. The employer may choose the type of health plan (insurance, self insurance, medical service contract, etc.) and the carrier, provided that employers with 100 or more employees offer each employee a choice of an insurance type plan or a health maintenance organization contract, where a health maintenance organization exists. The employee's share of the premium is automatically withheld from his or her paycheck and may not exceed the amount the employee would have paid if the employer had chosen the most prevalent type of health care plan in the state. The employer is obligated to continue paying his or her share of the premium even if the employee is sick and unable to work, for up to three months or the period for which the employer must continue to pay wages, which ever is larger. Any employee who works for at least twenty hours per week on the average, and has been employed for at least four consecutive weeks, is to be covered. If the employee has health coverage from another source, such as another employer, a government program, or coverage as a dependent under someone else's health plan, the employer is not liable for health coverage for that employee. The bill specifically provides that employees retain the freedom to bargain collectively for health benefits which may differ from those provided under this legislation.

A small employer who can demonstrate undue financial hardship resulting from the mandatory health coverage is entitled to premium supplementation from the state. To qualify (1) the employer must employ fewer than eight employees, (2) the premium for which the employer is liable must exceed 1.5 percent of the total payroll, and (3) the amount that the employer's cost exceeds 1.5 percent of the payroll must exceed five percent of the employer's income from that business, before taxes. A qualifying employer is entitled to subsidy in the amount that his or her costs exceed these standards.

Employers who cover their Alaska employees in a group plan in which the majority of the covered employees are out-of-state and not covered by the act, are given, in section eight of the bill, an additional year to bring the coverage of their Alaska employees up to the standards mandated in the act.

The law mandating employer sponsored coverage would terminate when it is superseded by federal health insurance legislation.

Section two of the bill establishes state standards for "qualified" health insurance plans, and requires insurance carriers to offer qualified plans to all eligible applicants. The bill does not prohibit the offering or sale of unqualified plans. Qualified plans must include benefits for the following: hospital services, professional services rendered by a physician or at his or her direction, prescription drugs, nursing home services, home health agency services, radium, oxygen, anesthetics, prostheses, medical equipment, x-rays and laboratory tests, oral surgery, physical therapy services, medically necessary transportation, well baby care, routine physical exams, multiphasic screening, and other diagnostic testing. The plan must cover at least 80% of the usual and customary charges for covered services, must limit out-of-pocket expenses at least to $3000 per person annually, and may provide a limit on maximum lifetime benefit of not less than $250,000. A number one qualified plan may have a deductible not exceeding $150 per person or $450 per family. A number two qualified plan may have a deductible not exceeding $500 per person or $1500 per family. A number three qualified plan may have a deductible not exceeding $1000 per person or $3000 per family. A qualified Medicare supplement plan must provide coverage of at least 50% of the Medicare deductible and copayment, provide at least 80% coverage of the services required in a qualified plan which are not covered be Medicare, limit out-of-pocket expenses to no more than $1000 per person per year, and provide for a maximum lifetime benefit of not less than $100,000. The director has authority to upgrade minimum benefit standards by regulation.

The act also offers health insurance coverage to high risk "uninsurable" clients under the state plan. The state plan provides number one, number two, and Medicare supplement qualified plans at premium rates which may not exceeed 125% of the average premium for a normal risk individual. To qualify, a person must present evidence that they have been refused coverage which is available to a person of standard risk by at least two carriers. The person is not covered for a preexisting condition during the first six months of coverage under the state plan if the person was diagnosed or treated for that condition during the 90 days preceeding the filing of an application.

All health insurance carriers in the state are required to participate in a joint underwriting association to pool the risk of the state plan, to publicize the state plan, and to reinsure other coverage mandated by the act. Losses incurred by the association due to the state plan are to be covered through assessments on association members proportional to their volume of health insurance business in the state. Assessments on members may in turn offset the income tax or premium tax payable by that member to the state. Thus the state is ultimately liable for the losses incurred by the operation of the state plan. The association selects one carrier to act as its agent in writing and issuing each type of state plan insurance for a period of at least three years, and reimburses the carrier or carriers for their expenses.

The act requires that all group health insurance policies written in the state include the right to convert to an individual coverage qualified plan without the addition of underwriting restrictions, regardless of the reason for leaving the group. It also requires that individual policies include a provision that covered dependents may continue coverage following the death of the primary insured, under that or a different contract, without additional underwriting restrictions.

The remaining sections of the bill amend the state's medical assistance programs. The bill provides that the Department of Health and Social Services will purchase health care services for its clients through health insurance policies or through health care service contracts which provide some or all of the services covered by state medical assistance programs.

The bill authorizes the Department to pay a cash advance to providers who serve a large volume of state medical assistance clients. It also requires the state to pay interest on unpaid bills which have been presented by providers which satisfy program requirements for payment. If payment of the bill is delayed more than thirty days from the date it becomes payable, interest is charged at the rate of one percent per month. If payment of the bill is delayed more than six months from the date it becomes payable, interest is charged at the rate of two percent per month.

The bill extends Medicaid coverage to all optional eligible groups under the federal program and expands covered services to include prescription drugs, adult dental care, dentures, physical therapy, prosthetic devices, chiropractors' services, private duty nursing, podiatrists' services, and other optional services under the federal Medicaid program. Eligibility for Aid to Families with Dependent Children and Medicaid is expanded to cover unborn children.

The bill establishes a medically needy program under the state General Relief program. The monthly income threshold for eligibility is set at 150 percent of the poverty guidelines for Alaska, and includes a spend down provision such that a person who is over income qualifies when the amount of their excess income has been spent on medical bills.

LIMITS ON EMPLOYEE SHARE OF PREMIUM COST

Hourly Wage	Gross Monthly Wage (172 hrs.)	Maximum employee share (HB 977) 1.5%	2%	3%
$3.60	$619	$9.29	12.38	18.57
4.00	688	10.32	13.76	20.64
6.00	1032	15.48	20.64	30.96
8.00	1376	20.64	27.52	41.28
10.00	1720	25.80	34.40	51.60
15.00	2580	38.70	51.60	77.40
20.00	3440	51.60	68.80	103.20

WRITTEN COMMENTS TO HOUSE BILL NO. 977

Presented by: Denise L. Knapp, Executive Director
Delta Dental Plan of Alaska

April 10, 1980

First of all, I would like to mention that I was informed of the bill and the teleconference at 5:08 p.m. on Tuesday, April 1, the time of the teleconference. I, therefore, did not have time to prepare a formal testimony. The next day I checked with the Alaska State Dental Society to see if they had received any information on the bill or the hearing, and their response was negative.

I would like to respond to the bill wearing not only the hat of Executive Director of a small company with 6 full-time employees (over 32 hours a week) and four part-time employees (under 32 hours a week but paid more than the minimum hourly wage), but also that of a prepaid dental service corporation (and therefore a member of the insurance industry).

Section 18.12.010. The last sentence of this section indicates the "Number two qualified plan" includes coverage for dependents, but I was unable to find any further reference in the bill as to who is to pay the cost for dependent coverage. This perhaps should be clarified.

Section 18.12.030. This section seems to benefit the part-time, lower paid employee and discourage the incentive of an employee to be full-time and earn a higher salary. Under the approach in the bill, the way I read it, a full-time employee due to the fact of working longer hours, or a long-time employee having worked several years, would be paying a higher portion of the premium than a part-time or new employee. Where then is the incentive for employees to want to stay with a company for a long period of time if they are penalized by paying more premium for the same benefits as a newcomer? As an example,

	Example I Part-time Employee	Example II Full-time Employee
Salary	$5.05/hr.	$7.50/hr.
Number of hours	x 32	x 40
Weeks a year	x 52	x 52
Yearly Salary	$8403.20	$15,600
Bill Percent	x 1.5%	x 1.5%
	$ 126.05	$ 234
Insurance Yearly Premium	$ 457.56	$457.56
One-half	$ 228.78	$228.78
Employee's Portion	$ 126.05	$228.78

Section 18.12.040. Under Delta's present program, there is a 90-day waiting period for eligibility for medical, life, and A,D&A benefits. Changing the eligibility period to four weeks would encourage an individual to join a company just to get medical benefits, and then quit once treatment was completed. In the past few months, Delta has had two employees terminate after two months with the firm. They would not have been eligible for benefits under Delta's program, but we would have been paying for them under your bill, and most likely they would have taken advantage of the benefits and cost the insurance company more money.

Section 18.12.050. By your provision of continuing coverage if prevented from working by sickness, Delta could be paying up to three months for any employees who worked only one and one-half months and up to six years if an employee worked six years before becoming ill. Wouldn't it be better to have the employee transfer to the State risk-plan fund or Medicaid if without sufficient funds to continue self-paying?

Section 18.12.060. Perhaps the decision of which company is prime should be left up to the present insurance industry rule; i.e., whichever company has employed the individual the longest. Is this really the type of decision which should be left up to an employee?

Section 18.12.070, paragraphs (2), (3), and (4). Clarification is needed as to what types of employees are included under this paragraph. Would this be natives covered under the Indian Health Service, or those employees eligible and presently receiving Medicaid coupons? Are State of Alaska employees exempted by this paragraph?

Section 18.12.100. Not all employees wish medical coverage presently under Delta's program; one, because her husband is in the military and another because she says she cannot afford even her share of the premiums. Would this bill make it mandatory for these two cases?

Section 18.12.140. (Do we qualify under 1 and 2?)

Section 18.12.200, paragraph (3) (B) (i). Does this mean that employees treated by the Indian Health Service may not bill for services provided?

Section 18.12.200, paragraph (6) (A). Perhaps the term "restorative appliances" should be clarified. Does this mean dentures and partials? What is meant by the ability to charge a "nominal per services charge"? Is this charged to the patient by the provider, or does this mean an additional charge can be made if the company wishes to add "restorative appliances" as a covered benefit?

Section 21.50.010 (d). If an applicant (I presume applicant is an employer rather than an individual employee) elects not to offer major medical coverage to its employees, would the employees be able individually to obtain major medical at their own cost or by applying to the State "high risk" plan? This is not clear.

Section 21.50.030 (a). Mention is made for the first time of "number three qualified plan". Is this a typographical error, since the employer, as I read the bill, is only required to offer the "number two" or "number one" plan.

Section 21.050.030 (a) (1) (I). Would "prostheses" include dental prosthesis such as dentures, partials, or bridges? Typically the medical insurance carrier would not cover such services under its program.

Section 21.50.030 (a) (1) (L). Oral surgery of the "gums and tissues of the mouth" would mean periodontal surgery to Delta. Is this what is intended? Normally in the insurance industry, this type of service is not covered by the medical carrier. It would only be included in dental insurance coverage.

Section 21.50.030 (a) (3) (B) and (C). Inclusion of coverage for annual physicals and multiphasic screening would raise the insurance rates to an extraordinary level, which would be beyond the reach of most employers to pay and most insurance companies to pay, and still keep rates down.

Section 21.50.050. The section on the State Plan Premium could use further clarification of definitions and intent. It is confusing as to whether all employers will be members of the "association" and pay premiums directly to the State Plan instead of an individual insurance carrier. From your "summary", it would appear this State Plan is only for "high-risk" employees; however, I did not get that from reading the bill itself.

Section 21.50.070 (b). Lines 6-10 on page 19 appear to be contradictory. On the one hand, the members of the board may be reimbursed for expenses incurred, but must pay for the costs of conducting meetings themselves. Would they be reimbursed for transportation mileage, hotel plus a per diem? This section needs clarification.

Section 21.050.070 (h). On lines 22-25 of page 20, I question why the "Association" should be allowed to make a 110% profit on expenses of "reinsuring". Perhaps I don't understand the intent of this paragraph, but this is the way I interpret it. Perhaps it needs to be clarified.

Section 21.50.080. Again, I find this section very confusing. Is the "State Plan" an alternative choice for the employer to dealing through a private insurance company directly, or is it only for "high-risk" employees? What about individuals who do not qualify under an "employer" group? Would self-insured individuals be eligible for the State Plan? This is unclear in my reading of the bill.

Under paragraph (e) of this section, are all employers required to join the State Plan even if they have no "high-risk" employees and required then to share the risk for companies who happen to hire "high-risk" employees?

Section 21.50.100 (c). If the writing carrier is to agree to provide these services of administrative and claims payment functions for a period of three years, would there be any provision in the contract for review of the administrative fee paid for these services, or would the carrier be held to one rate for three years?

Section 21.50.110 (a) (2). Again, it is unclear whether only high-risk individuals may enroll dependents under the "State Plan" or whether any employee eligible under the employer group could elect to enroll his/her spouse and children and at what cost to the employee or employer.

Section 21.50.130 (b). This paragraph is unclear. If an individual dies, why would his medical coverage be passed on to his beneficiary, or why would he need extended coverage? If this refers to the life coverage, perhaps it should be spelled out that way?

Section 21.50.200 (3). Definition of dependent includes "a household member who is financially dependent on the primary insured." Is the intent of this to cover a non-related individual who happens to be living in the household of another? This paragraph could be interpreted to mean the "old lady" or "old man" (the popular terminology for the live-in boyfriend or girlfriend) or any friend of the opposite or same sex who happens to be living in the household of the insured. Also, would the employer be required to pay for this dependent, or is this only on "high-risk" individuals?

Section 47.05.070 (a) and (b). Is the intent of this section to have employers with employees presently on medical assistance receive the employee's portion of the premium from the State? If the employer is paying for a portion of the medical benefits for a Medical Assistance eligible person, does that mean the individual who is working will no longer be on Medical Assistance? If they can continue receiving free benefits through the Medical Assistance coupon, what is the purpose of having the employer cover them also through a private carrier?

Section 47.05.090. As the fiscal intermediary for the dental portion of the State Medicaid and General Relief Medical programs, we applaud this section. However, in Delta's case, we would like to see the State consider paying interest to Delta when Delta is not reimbursed within 30 days of its billings to the State.

Section 47.07.030. Benefits added include "dental services and dentures" and "prosthetic devices". Does this mean the same dental services presently available to children under the Medicaid program, except with the addition of dentures? Or, does it mean all "dental services"? We personally feel partial dentures should be covered, but not porcelain/gold crowns or fixed bridges. Also, periodontal surgery and orthodontic services should be limited to only the most severe cases. If all the aforementioned services were included in a State funded program, it could bankrupt the State and the taxpayers.

Overview - Mandatory health insurance is a good concept and it is evident a lot of thought and time have gone into this bill. However, mandatory health insurance, to the extent written into this bill, will jeopardize the free enterprise system in that many companies would be unable to afford to provide this maximum coverage. May we suggest a minimum benefits coverage excluding some of the services written into the bill. If the employer wishes to offer more, he could do so. If the employee wished to purchased additional coverage, it would be optional, but could be handled through payroll deduction by the employer and require one-year's signup.

Apr. 11, 1981

Dear Rep. Buchholdt:

If this letter is in time to be made a part of the public testimony concerning HB 977, I would like for the paragraphs marked to be entered. If not, I hope you'll take a few minutes to read the letter and the enclosed article.

Thank you,
Eileen Herring

April 10, 1980
Anchorage

Rep. Bill Parker
Bouch V
99811

Dear Bill;

Thank you for taking the time to tell me about HB977 and for soliciting my comments. It is an area of great concern to me, as you know, and I welcome the opportunity to opine.

I think that the measure is well-intended but poorly conceived. Insurance is not the way to improve health care because the problem goes much deeper than that. The reason that health care is so expensive is that it is controlled, almost monopolized, by a single profession, that of the M.D.'s, who have a strong political organization, the A.M.A. The A.M.A. runs doctors, runs medical schools, collaborates with pharmaceutical companies to lobby Congress, collaborates with insurance companies, and generally acts to keep power within the M.D. profession. Until this conglomerate is dealt with in some way, health care will not improve.

You're probably aware that there's a growing grass-roots movement, loosely known as the holistic health field, making a vigorous, though uphill, struggle to provide viable and professional alternatives to the power monopoly in health care. A person wanting to improve health care for the public would do well to support this movement, especially since the holistically-oriented treatments are often much cheaper and more effective than those of the medical establishment.

HB977 unfortunately plays right into the hands of the power maniacs. Insurance policies only cover certain "acceptable" modes of treatment, administered in the usual manner by the usual "acceptable" M.D.'s. Giving a whole lot of people a chance to get the standard treatments for free or cheap will just send a lot more business and money their way. It will leave chiropractic and naturopathy and some other struggling professions out in the cold, dealing them a low blow while strengthening the position of the monopoly that is getting rich on illness.

Since I'm working real hard at becoming a naturopathic physician, you can understand my absolute opposition to HB977. You might like to know that there is a group of naturopaths in Alaska who are working for the establishment of a naturopathic licensing board in this state. If you want to help get cheap and effective professional medical care to the proles, support this effort.

I am enclosing an article written by someone much more knowledegeable and articulate than me. The man's a genius, so please read it. Then sit down and figure out a new plan.

The health care problem is serious and pervasive and will not be solved by passing a bill. HB977 would do more harm than good, and I think we can do better. Thanks for listening.

Sincerely,

Eileen

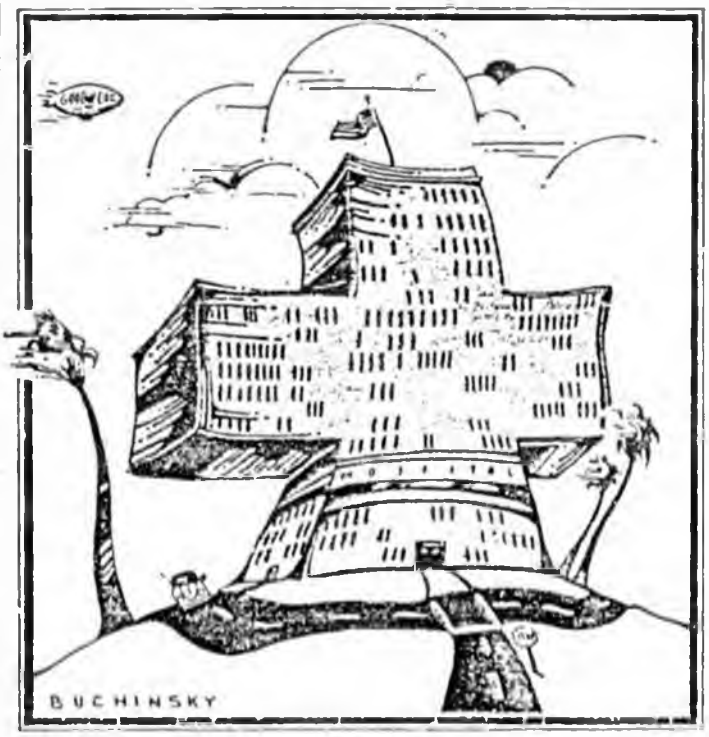
cc: Thelma Buchholdt
Mike Beirne

Eileen Herring
3407 Peterkin St. #4
Anchorage 99504

Mother's Healer

YOUR HEALTH AT TOO HIGH A PREMIUM

by Hugh Drummond, M.D.



SOME FORM OF national health insurance seems inevitable. It has been an almost sacred tenet of American liberalism since the New Deal. The Great American Center has shifted its hemorrhoidal bottom in this direction, and even organized medicine has begun to calculate the finger-lickin' goodies involved in a $60 billion-plus federal program.

Insurance is, of course, the American way of dealing with life's terror. No institution better describes a population trying to save its ass. It is a vestige of the medieval myth that moats and castle walls could keep out the plague. Insurance buildings are designed to convey immortality; steel and granite, sheathed in glass, they are meant to look like the executives who minister to them—vigorous, phallic, Apollonian. If God should break his contract with Noah, those buildings will endure the flood to pay the claims of a well-covered, if dead, constituency.

So it is inevitable that as we grow more anxious we will develop a form of universal health insurance, propped up by the federal government and its corporate underpinnings. About the only people left who are opposed to it are a few herbalists and that peculiar gaggle of paranoids on the Left and the Right, who cannot believe that anything compassionate or rational can emerge from the heart of this nation.

I have great respect for paranoia. So let me count myself among the crazies this time and suggest that, like the massive public housing projects that were another vision of American liberalism, national health insurance as currently conceived will someday be subjected to euthanasia.

Health insurance is really not health insurance at all, but sickness insurance. The major premise behind it is that we are all terrified by cancer and heart disease, which can be treated by such techniques as transplants, by-pass procedures and radiotherapy. These are enormously expensive technologies that the government will be expected to underwrite.

Overlooked are the pervasive diseases of the young and poor, such as lead poisoning, which affects a quarter of the kids in low-income neighborhoods, and malnutrition, which affects even more. Insurance doesn't touch these problems because their control has to do with social and environmental conditions. You can't fight hunger with pocketa-pocketa machines in medical centers.

In fact, when you get right down to it, you can't stop cancer and heart disease that way either. They are just as much social and environmental diseases as they are medical ones.

Since 1900, the ratio of cancer deaths to all deaths has increased five times; the same is true for heart disease. Together they will kill more than half of us. It is calculated by the American Heart Association and the Department of Health, Education and Welfare (HEW) that in a life of 65 years, we lose 1,300 days for being 25 per cent overweight, 1,800 days for living in a city and 3,300 days for smoking a pack a day. Yet we have virtually no information on the relative impact of bad housing, polluted air and water, Muzak and Twinkies. If we did, we would know we were losing the battle.

To really stop cancer we would need to control all industrial pollutants, such as asbestos, vinyl chloride and sulphur dioxide. The huge numbers of synthetic additives poured into our bodies every day would have to be eliminated. If we wanted to control heart disease we might have to do something about unemployment, which has been documented to increase nor-epinephrine and cholesterol excretion to murderous levels. We might also have to eat less, drink less, smoke less and drive less. If a serious effort were made in this country to prevent cancer, strokes and heart disease, the economy would collapse—a fact not lost on the pilots of the empire, many of them now supporting some form of national health insurance.

There have been amazingly few studies on the actual "outcome" of medical care in this country, but when they have been done the results are invariably depressing. A Johns Hopkins University doctor found that only 27 per cent of emergency room patients at Baltimore City Hospital received effective medical care. When the doctor's superiors insisted that the results would be radically different at a more "prestigious" hospital, namely Johns Hopkins, the doctor checked out the patients there who had gastrointestinal symptoms. He found that only 28 per cent of these Johns Hopkins patients received quality treatment. In other words, more insurance will help more people get lousy care.

With Medicaid and Medicare, the forerunners of national health insurance, the more we spent the less we got. In the first year of the programs, doctors' fees rose two and a half times as fast as the cost of living. In the last two years from September 1974 to September 1976, physicians' fees rose 23.3 per cent, while the Consumer Price Index increased by only 13.7 per cent. According to a report released in February by the Health Research Group, Medicare and Medicaid pay out more than $6 billion yearly in doctors' charges. Hospital costs have climbed even faster—a four-and-a-half-fold increase since the programs started. Where did all the extra money go?

Not to new services; there were hardly any of those. A lot of doctors got richer. There was expensive and "interesting" medical technology to utilize, such as the hyperbaric chamber at Mount Sinai, which is operated on an average of only once or twice a day. The money

spent on buying and running it could finance 20,000 outpatient visits a year, or a huge lead poisoning program in East Harlem. But that's not as much fun. Unfortunately, there is no assurance that similarly wasteful health care programs will not be funded by massive national health insurance.

Upper-level hospital personnel increased their salaries as the federal programs took hold. Hundreds of thousands of dollars were spent in efforts to prevent hospital employees from organizing unions. Much of the extra money went for outrageously expensive drugs and supplies. As long as the government was willing to underwrite the cost, the hospitals and doctors didn't care. Most of them welcomed the bucks the federal bonanza brought, no longer convinced that their salaries would decrease under the "socialized medicine" of Medicare and Medicaid.

And for the people the programs were supposed to serve? More people had access to bad health care. But one-third of Americans living below the poverty level remained untouched by Medicare and Medicaid. There was still no medical care for the poor. Enter national health insurance.

With national insurance, the $140 billion-a-year health industry could *really* rake it in. There would be the kind of guaranteed security the defense industry enjoyed during the height of the Cold War. Just think—no more people skipping out on their bills. The whole country as paying customers, and for each person, another prescription filled out, another piece of hardware needed, another disposable whatnot disposed of.

Under national health insurance, the poor still will not have quality medical attention. The health care system is not radically changed under the program, only subsidized fully. There will be no improved doctor-patient relationships, no health clinics that are community controlled. National health insurance does not mean better hospitals, with staffs responsive to the special problems of poor people. No fundamental change for the rich either. As usual, they will buy their way to priority.

We can also look forward to the government entering into some sort of alliance with private insurance companies, as it has with Medicare and Medicaid. Blue Cross is the leading contender for the job of administering a national health insurance system. That's the same Blue Cross that has allowed runaway hospital fees to multiply in the last ten years, while the average length of hospital stay has *decreased*. You might be interested in knowing that Blue Cross is controlled by the hospitals themselves. The hospitals created it during the Depression to ensure that their bills were paid, and you can be sure that with national insurance, hospital bills—no matter how ridiculously high—will be found "reasonable" by Blue Cross.

> "With national health insurance, the $140-billion-a-year health industry could really rake it in—as the defense industry did during the Cold War."

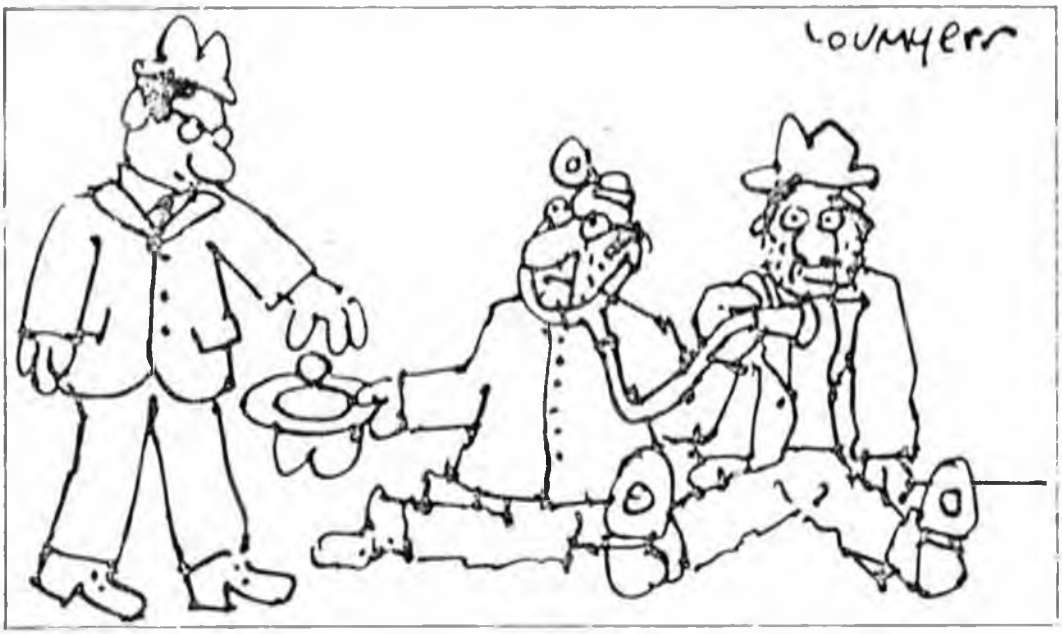
My real anxiety about national health insurance isn't only economic; it is philosophical. There is something wrong with a social policy that so irrevocably consigns to a single profession something so subtle and profound as human health. For all the wonders of Western medical science, it has no understanding of and little interest in the meaning of health. It is possible that when you set out to "conquer disease," no less than when you set out to "conquer space," you can't win. Western medicine tries to throttle its patients into well-being. It relies on the military model of technology, the invention of hammers and the subsequent search for heads to bang with them. It has only given us a new ecology of disease with the smell of progress.

I am not suggesting that we dismantle all the cobalt units, computer assisted tomographs and heart-lung machines. But national health insurance will retard a more pluralistic approach to health, which might include self-help programs, herbal remedies and even faith healing. Is it antiscientific to permit the existence of activities that may have centuries of traditional practice and pure empiricism behind them? They may be conceptualized in less mechanistic terms than we have been trained to believe truthful. However, dying empires have always insisted that their vision of the truth is eternal when their artifacts barely survive.

Do I have the courage of my own convictions? Of course not. If I awake tonight with a right lower quadrant pain, shall I not call one of my surgical confreres rather than a Navajo healer? Would I deny that preference to anyone else? No. But neither would I deny the preference of someone for a Navajo healer. Yet with national health insurance, like all the other medical programs, Navajo healers will not be licensed to accept government money. National health insurance grants access to one kind of health care, and if a bill is passed, the "right" to medical care established will be a right to bad medicine.

Think of China for a moment. It has brought health to 800 million people, who were as mutilated, starved, infected and demoralized as any who have ever lived. And in that nation, where pragmatism is almost religious, where waste is murder, they brought health to the people with as much respect for the ancient and the traditional as for the modern and innovative.

Needless to say, there were other changes.



If you have any medical or psychiatric questions you'd like Dr. Hugh Drummond to address in this column, please write Mother's Healer, c/o Mother Jones, 607 Market Street, San Francisco, CA 94105.

ESTIMATED PREMIUM COSTS FOR NUMBER TWO QUALIFIED PLANS[1]

Individual Plans - Employee Only	Minnesota Rate November 1979 (Quarterly)	Area Differential[2]	Est. Rate in Alaska (Quarterly)	Est. Rate in Alaska (Monthly)
low: Blue Cross/Blue Shield, Male age 20-24	$31.47	+12%	$35.25	$11.75
high: State Farm, Male or Female age 60-64	214.40	+ 7%	229.41	76.47
Average of 5 carriers[3], Male age 35-39	55.42	+11%	61.52	20.51
Average of 5 carriers[3], Female age 35-39	87.13	+11%	96.71	32.24
Individual Plans - Employee and Dependents				
low: Blue Cross/Blue Shield, M 20-24 + F 20-24 + children	$128.27	+13%	144.95	$48.32
high: State Farm, M 60-64 + F 60-64 + children	487.68	+ 7%	521.82	$173.94
Average of 5 carriers[3], M 35-39 + F 30-34 + children	185.80	+11%	206.24	$68.75

Group plan premiums are roughly 8% less than individual plan premiums.

1 The Minnesota minimum standards for a number two qualified plan are the same as those specified in HB 977 except that the requirements for coverage for well baby care, physical exams, and multi phasic screening have not yet taken effect in Minnesota, and Minnesota does not cover medically necessary transportation (other than an ambulance) or treatment for alcoholism or chemical dependence.

2 Derived from the area schedule of premiums of the CARE group insurance trust for all Alaska and for Anoka, Dakota, Hennepin, Ramsey, and Washington counties in Minnesota.

3 Blue Cross/Blue Shield, Prudential, State Farm, National Farmers Union, and Massachusetts Mutual. This is a straight average and not a weighted average. Since Blue Cross/Blue Shield has by far the lowest rates and covers 96% of the people covered by these five Minnesota carriers, the straight average used here is substantially higher than the weighted average would be.

a bitter pill to swallow...

Issues In Health Care Financing

MAY 8-9, 1980
NEW ORLEANS

National Conference
of State Legislatures

ISSUES IN HEALTH CARE FINANCING

MAY 8-9, 1980 — NEW ORLEANS, LOUISIANA

The National Conference of State Legislatures will hold a seminar on "Issues in Health Care Financing" at the Monteleone Hotel in New Orleans, Louisiana on May 8-9, 1980. This meeting is supported in part by a grant from the Health Care Financing Administration, U.S. Department of Health and Human Services (formerly U.S. Department of Health, Education and Welfare).

Public officials at the state level continue to face demands for action on a number of important issues in the health care field: the high rate of inflation; the provision of services to the elderly and disabled; protection against the catastrophic costs of a major illness; and access to care for the medically underserved, both rural and urban. This conference will focus on these major issues and some solutions that the states have developed to deal with them. Key legislators and administrators involved in the enactment, operation and oversight of these programs will serve as seminar faculty.

This program promises to be a useful tool of assistance for legislators as they deal with these and other important health financing issues.

The NCSL has reserved a block of rooms at the Monteleone Hotel, located in the New Orleans French Quarter at 214 Rue Royale. The main hotel telephone number is (504) 523-3341 and the toll free number for reservations is 1-800-535-9595. When arranging for hotel accommodations, please indicate that you are attending the NCSL "Issues in Health Care Financing" Seminar to receive the above conference room rates. The following are rates for the block of rooms NCSL has reserved:

SINGLE ROOM: $48.00 DOUBLE ROOM $56.00

EACH PERSON IS RESPONSIBLE FOR CONTACTING THE HOTEL AND MAKING NECESSARY ARRANGEMENTS FOR HOUSING. RESERVATIONS MUST BE MADE NO LATER THAN APRIL 16, 1980 AND WILL BE HELD ONLY UNTIL 4:00 P.M. ON THE DAY OF ARRIVAL. If you do not plan to arrive by 4:00 p.m., you must guarantee your room for late arrival. If you guarantee your room and do not arrive or fail to cancel your reservation, you will be responsible for payment of one night's stay. NCSL can not be responsible for any guarantees.

Registration Fee: $ 75.00—Legislators and Legislative Staff
$150.00—Non-Governmental Persons

The registration fee is payable in advance of the seminar or due at registration. NCSL cannot bill you or your legislature without advance approval. Expenses of attending an NCSL seminar are deductible for income tax purposes if the "taxpayer is benefiting or advancing the interests of his trade or business by such attendance."

For additional information contact Russ Hereford or Susan Ponder with NCSL, 1405 Curtis Street, 23rd Floor, Denver, Colorado 80202—(303) 623-6600.

AGENDA

Thursday, May 8

8:45-9:00 am	**Welcome and Introduction**
9:15-9:45 am	State Legislatures' Interest in Health Care Financing
10:00-12:00 am	Approaches to Health Care Cost Containment: Competition vs. Regulation
12:00-2.00 pm	Luncheon and Luncheon Address: The Federal Role in Health Financing
2:15-4:15 pm	**TRACK A:** Long Term Care: Nursing Home Reimbursement; Alternatives to Institutional Care
	TRACK B: Catastrophic Health Insurance: Overview of Issues; State Approaches

Friday, May 9

9:00-9:15 am	**Introduction to Day's Activities**
9:15-11:45 am	**TRACK A:** State Hospital Cost Containment Programs: Overview of Efforts; State programs
	TRACK B: Health Manpower: Federal Activities Impacting on the States; State Programs
12:00-2:00 pm	Luncheon and Luncheon Address: Congressional View of Health Financing
2:00-3:00 pm	**Closing Session**

The National Conference of State Legislatures, the official representative of the country's 7,600 state legislators and their staffs, works to help lawmakers meet the challenges of the complex federal system. Headquartered in Denver, Colorado with an office of state-federal relations in Washington, D.C., the NCSL is a nonpartisan organization funded by the states and governed by a 43-member Executive Committee.

The NCSL has three basic objectives:

To improve the quality and effectiveness of state legislatures.

To assure states a strong, cohesive voice in the federal decision making process.

To foster interstate communication and cooperation.

Denver Office
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Denver, Colorado 80202
(303) 623-6600

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Earl S. Mackey
Executive Director

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Reservations must be received no later than April 16th and will be held only until 4:00 p.m. on the day of arrival. Later arrivals must have first night's deposit. (Checkout time is 1:00 p.m.)

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MAY 8-9, 1980

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Please Return this Form by April 16, 1980

HEALTH INSURANCE ASSOCIATION OF AMERICA

CHICAGO NEW YORK WASHINGTON

LEGAL DEPARTMENT
Charles D. Kuhnen, *Counsel*

Chicago Office
332 South Michigan Avenue
Chicago, Illinois 60604
(312) 322-0800

April 15, 1980

The Honorable Thelma Buchholdt
Chairman, House Health, Education and
Social Services Committee
Alaska House of Representatives
State Capital
Juneau, Alaska 99811

Dear Representative Buchholdt: Re: Alaska H.B. 977

We wish to thank you for sending us a copy of this bill, which arrived only last week because of its recent introduction.

Portions of this bill are of vital interest to health insurance companies. I would be there to testify on the bill, but for a recent injury which temporarily prevents me from traveling. I am sorry to miss the pleasure of visiting Juneau again, and of testifying again before your committee, as I did last year in connection with a bill on another subject.

I would appreciate your including the attached HIAA Statement on H.B. 977 in the record, and, if possible, providing copies of it to committee members.

Sincerely,

Charles D. Kuhnen
Counsel

CDK/erc
enclosure

STATEMENT
of the
HEALTH INSURANCE ASSOCIATION OF AMERICA
concerning
ALASKA H. B. 977 ESTABLISHING
A STATE MAJOR MEDICAL INSURANCE PLAN

The Health Insurance Association of America is a trade association consisting of 311 insurance companies which write 85% of the health insurance written by insurance companies in the United States.

We are opposed to this bill, which is badly conceived and poorly drafted. We believe that its enactment would have serious adverse effects on the Alaska business of insurance companies, causing many insurance companies to stop writing health insurance in Alaska, to the detriment of Alaska residents.

Our remarks are directed to Sections 1, 2, and 8 of the bill, which are the sections affecting insurers. We understand that your Insurance Department has prepared a detailed analysis of the bill's section-by-section defects, and so our remarks will mostly be of a more general nature.

GENERAL PLAN

The general plan of the bill is to require employers of one or more regular employees in Alaska to provide at least a specified level of medical expense benefits, through a prepaid health care plan contractor, to employees and their dependents, with the costs shared by the employees (Section 1 of the bill). Health insurers would be required to make available to employers (if the insurers write group health insurance) and to individuals (if the insurer's write individual health insurance), three specified ("qualified") plans of major medical expense insurance, and must add to any health insurance policy which is not a "qualified" plan a fourth plan of specified benefits, unless the "applicant" declines it (Section 2 of the bill). There is a fifth standard plan for qualified Medicare supplements. There would also be a State Plan for persons not otherwise insurable at standard rates for qualified plan benefits, under a pooling arrangement funded by health insurers and self-insurers, with a tax offset for the inevitable losses of the pool (Section 2 of the bill).

The purpose of these sections of the bill seems to be to provide more major medical insurance to Alaska residents, by requiring all health insurers to furnish major medical insurance, by requiring certain employers and their employees to purchase it, and by requiring a pool for substandard risks.

GENERAL COMMENTS

Section 1 of the bill is derived from a Hawaii law. That law, together with a premium tax differential between insurance companies on the one hand, and Blue Cross-Blue Shield and the Kaiser HMO (Health Maintenance Organization)

plans on the other, makes it virtually impossible for insurance companies to compete for qualified plan business. There is likewise a substantial premium tax differential in Alaska between insurance companies and Blue Cross-Blue Shield. Alaska has no HMO's.

Section 2 of the bill is derived from a Minnesota law, which is the subject of several lawsuits and is on its way to being declared unconstitutional. One case has been tried and the Federal Magistrate who tried the case has, in an 85-page opinion, found the law to be unconstitutional on at least five different grounds. Among other things, the Magistrate's opinion says:

> "The Court is convinced that, in spite of exemplary effort by able counsel, no one knows what the Legislative intended or what this Act really means. . ." Insurers' Action Council Inc. et al. v Heaton et al., U.S. District Court, District of Minnesota, c.v. No. 3-76-440 (p. 84 of the Magistrate's decision dated October 1, 1979).

Some provisions of the law are so impractical that they are being ignored in administering it. Other provisions are confusing. Some qualified plan benefits are so expensive that the Minnesota legislature just recently passed a bill modifying or eliminating them.

Many insurance companies have either writhdrawn from Minnesota, or have stopped or limited their writing of health insurance in that State. Unless the law is finally held invalid, more companies can be expected to do so.

Because of its poor design and drafting the Minnesota law has resulted in much difficulty for the insurance department, insurers, and the courts. The law has never been fully implemented. The State Plan is operating partially (it is not reinsuring insurers or administering qualified plans for them), and incurring substantial losses. That it operates at all is due to the presence in the State of several large domestic insurers, and to the ready availability of qualified people from out-of-State compaines. This ready availability of insurer help is not the case in Alaska, since Blue Cross-Blue Shield has its principal office in Seattle and all the other large Alaska writers have their principal offices even further away.

SECTION 2

1. No law is needed to make major medical insurance available in Alaska. Coverage in a wide variety of plans is already available from a sufficient number of insurers. This includes some plans with higher policy maximums than the $250,000 of HB 977's "qualified" plans.

Most Alaskans are already covered by some type of major medical protection. Persons age 65 or over are covered by Medicare or other government programs.

Of the under-age-65 civilian, noninstitutionalized population, my own rough projection is that about 70% have some form of major medical coverage from insured and noninsured plans. Some of the remainder have government plan coverage (Medicaid, Public Health Service, etc.), a small number are uninsurable as individuals not covered under group plans, and a larger number just plain can't afford it. We think that the subsidy plan in Section 1 will make only a dent in the affordability problem.

2. The insurers which do not write major medical coverage do not have the knowledge or assets to write this broadest, most complex, and costly of health insurance coverages, or have chosen other health insurance coverages as their proper products, or both. If, HB 977 is enacted, any of them writing coverage for hospital, surgical, or medical care will be forced out of the health insurance business in Alaska. We cannot think of a single valid reason for the bill requiring these companies to write major medical insurance.

3. All of the five plans of insurance which section 2 would require health insurers to write are nonstandard -- the three "qualified" major medical plans, the supplementary major medical plan to be added to existing policies, and the "qualified" Medicare supplement plan. While some companies can get by with some of their standard plans on an equivalency test, there seems to be no good reason to disrupt the health insurance business by requiring nonstandard plans of benefits. The bill's major medical plans will not even be the same as Minnesota's, in view of the latter state's recent amendment to the law. Using nonstandard forms just adds unnecessarily to administrative costs, which are reflected in premium rates.

4. The required plans are too expensive.

5. The method of determining State Plan rates is impractical. The corresponding Minnesota statutory provision is not followed by the Minnesota State Plan.

Charging 125% of standard rates for the substandard persons in the State Plan is inadequate, and will always produce losses, as Minnesota discovered. The provision that rates are also to be self-supporting is illusory.

The Minnesota State Plan, together with the costs of the Association governing body, lost $1,000,000 in 1979. We do not know how much in additional costs insurance companies incurred in attempting to comply with the law.

SECTION 1

1. Whoever drafted this section does not know what a prepaid plan is. Insurance companies do not write them, except for a few companies that market

prepaid dental or vision care plans. As a result, insurance companies do not qualify, under the section 1 definitions, as "prepaid health care plan contractors" from which employers can purchase qualified plans. Neither do employers, which cannot self-insure under the provisions of this section.

2. The dual option of proposed section 18.12.030 is impractical in Alaska, because there are no HMO's in the State. Before employers are asked to offer such an option you need a sufficient number of good operating HMO's in appropriate locations in the State.

Self-insurance by employers of HMO benefits is mentioned in paragraph (b) of that proposed section. This is impossible, except for an employer that is an HMO.

If, in the future, you do get a sufficient number of operating HMO's in Alaska so that you then want an HMO option, the requirement should be drafted to be in accord with the amended Federal law on this subject.

3. It seems to us that eligibility for premium supplementation may also be needed by employers of more than seven employees.

4. Where the legislature sets minimum standards for "qualified" plans, these tend to be the standard plans employers provide for their employees (absent a collective bargaining agreement calling a different plan). Insurance companies cannot compete on premium costs with Blue Cross-Blue Shield on standardized benefits where Blue Cross-Blue Shield has substantially lower premium taxes to pay. In Alaska, the premium tax is 3% of health insurance premiums for out-of-State insurance companies (there are no or few Alaska companies which write health insurance). Whereas Blue Cross-Blue Shield pays 6% on the difference between premiums and claims. It is a reasonable guess that major medical claim payments are about 90% of premiums, with a resulting effective tax rate for Blue Cross-Blue Shield of six-tenths of one percent of premiums (.06 times 10% of premiums). This is more than sufficient differential to make insurance companies noncompetitive on premiums which must be charged on standardized major medical plans.

UNCONSTITUTIONALITY

The Federal Magistrate in the case cited earlier involving the Minnesota law found that law to be unconstitutional on several grounds, all but one of which apply to HB 977. Section 1 of this bill, which does not appear in the Minnesota law, may raise additional constitutional questions.

The Federal Megistrate found the Minnesota law to be unconstitutional on these grounds: (1) it violates the due process clause of the constitution by requiring insurers to write major medical coverage, which many of them do not or can not do; (2) it violates the Constitutional provision prohibiting impairment of

the obligation of contracts, by requiring insurers to add major medical coverage to existing policies unless the policyholder declines such coverage; (3) it violates the commerce clause of the Constitution by attempting to regulate policies validly issued outside the State; (4) it is vague and ambiguous and unconstitutionally delegates legislative authority to the insurance commissioner; and (5) denies the required equal protection of the law, because of an amendment (not in HB 977) concerning the pool. The Magistrate also found that there was, as yet, too little experience under the law to determine whether the law was unconstitutionally confiscatory.

The validity of the Minnesota law is also in question on other grounds in other lawsuits which have not yet reached trial.

CONCLUSION

The foregoing critical comments, together with the more detailed ones we expect you will receive from others, should be sufficient indicators that HB 977 is contrary to the public interest and should not be enacted.

Charles D. Kuhnen
Counsel

/erc

April 28, 1980

Mr. Dale Strowbridge
State Liaison Officer
DHEW, Region X
Arcade Plaza Building
1321 Second Avenue
Seattle, Washington 98101

Dear Dale:

I appreciate all your efforts assisting the Department in obtaining HEW comments on relevant pending legislation. I am in need of receiving further clarification regarding the scope of the Medicaid option - diagnostic, screening, prevention, and rehabilitation services. In particular, House Bill 977, if passed would add that option to the State's Medicaid program (see page 33 of the enclosed bill). I have received correspondence from International Rehabilitation Associates, Inc. inquirying whether they would be covered under that Medicaid option. The letter is enclosed for your reference and outlines that organization's services and the background of its employees. Would you please have your Medicaid Bureau review this material to determine whether that new option would cover International Rehabilitation Associates, Inc.?

I appreciate your assistance in this matter. If you need additional information on this inquiry, please do not hesitate to contact me. I would appreciate a response by May 7, 1980.

Sincerely,

Deborah E. Behr
Special Assistant to
the Commissioner

cc: International Rehabilitation Associates, Inc.
Representative Thelma Buchholdt

DEB:lar
bcc: Rod Betit, Division of Public Assistance
Bob Tanna, DHEW

ANHC
ANCHORAGE NEIGHBORHOOD HEALTH CENTER
1217 EAST 10TH AVENUE · ANCHORAGE, ALASKA 99501 · 907-279-9586

April 21, 1980

Thelma Bucholdt
House HESS
State Capital Bldg.
Juneau, Ak 99811

Dear Thelma:

I've been meaning to respond to HB 977 in more detail as it has been on my mind ever since I received the copy of the bill. While I generally agree with the intent of the bill, I've had this uneasy feeling about it and have finally realized the source of my concerns.

The major deterrent to good health care in the United States, as I see it, is the fee-for-service philosophy, which rewards the doctor for performing more as well as more expensive procedures.

Physicians engage in benevolent (for them) price fixing. They set their fees high enough to make a sizable profit, then agree as a group not to let the factors of supply and demand interfere.

Physicians (and hospitals) have institutionalized this practice via the creation of health insurer intermediaries, who have grown so powerful in the health industry that even Senator Kennedy has retracted in the face of their opposition.

In the health field, the federal government (and to a degree, state governments) has legitimized restraint of trade (by allowing physicians to control supply and access), price fixing (by reimbursing providers at the prevailing rates) and boycotts (by allowing physicians to refuse to see Medicaid patients).

While HB 977 has noble intentions, i.e., the mandatory insurance for high risk patients, employees, etc., it institutionalizes:

1) The health insurance industry and creates the potential for a greater political alliance by creating a

mechanism to further their power (The Association) while giving them a cause to rally around (more government regulations).

2) Price fixing. By reinforcing the fee-for-service mechanism, physicians will continue to set fees at a high profit level and health insurers will continue to ally with their clients (the physicians) as opposed to the State's clients (the patients).

3) Boycotts. HB 977 sanctions the present physician boycott of Medicaid patients by placing the blame on the State bureaucracy. There are very few physicians around whose medical school or education is not subsidized by the federal government. It is unconscionable, to me, for them to refuse to treat Medicaid patients.

I oppose the payment of interest or advance payments to physicians to treat Medicaid patients. The money should be put into the State Medicaid office. After my visit with the State Medicaid people in March, I'm convinced that the problem will not be resolved for another 6 - 9 months, in spite of claims to the contrary by the legislature and the Commissioner. They are still understaffed and 6 months behind in their reimbursements.

I feel that the State of Alaska has a chance to really excell in the area of health policy. I think that HB 977 is a very progressive attempt to do just that. However, I think that we can do better and would take the liberty of making a few suggestions.

1) That the legislature proceed with a study (such as HB 793) to investigate new and innovative methods of health care financing. Further, this study should be international in scope, with regards to determining true alternatives to the present methods of financing health care in the United States.

2) That Section 47.05 070 of HB 977 be studied further. While the HMO concept has many inherent limitations, there are a few successful consumer controlled HMO's that may be successful in Alaska (with State subsidy). Certainly Anchorage is a potential candidate and the situation at Alaska Hospital suggests some interesting alternatives. It is my hope that within a year, the Anchorage Neighborhood Health Center will be a candidate for such a program, and potentially a model for attempting alternative sources of health care financing.

Again, I want to emphasize that I basically support the intent of the bill.

I realize that my comments may not be politically palatable, but I still have the hope that Alaska can take an innovative lead in the health policy arena. It is in the spirit of this optimism (and my high regard for you) that I have made these comments.

I know that you will weigh their merit (if any) and political acceptability, and I thank you for the opportunity to respond to the bill.

Sincerely,

Don Bantz
Executive Director

DB/jw

THE UNIVERSITY OF MICHIGAN

SCHOOL OF PUBLIC HEALTH

DEPARTMENT OF HEALTH PLANNING AND ADMINISTRATION

ANN ARBOR, MICHIGAN 48109

March 24, 1980

Richard L. Block, Director
Division of Insurance
Department of Commerce and Economic
Development
State Office Bldg.
Pouch D
Juneau, Alaska 99811

Dear Mr. Block:

Please find enclosed a reprint of an article describing a new approach to the structuring of Health Insurance Policy Information. The article describes an information frame based on seven major issues or goals (Table 1, p. 129). There is a preliminary listing of program options to pursue these goals (Table 2, pp. 136-157) as well as identification of problems related to these program options relevant to the other issues. A limited range of possible solutions to these problems so far identified are suggested.

The proposed information frame aims at eventually establishing a health insurance policy information base. It is postulated that when completed, the comprehensive information frame alone would provide a qualitative tool for policy analysis.

Before proceeding with further development of the information frame, I consider it desirable to explore its potential utility. I would therefore appreciate your completing the attached very short questionnaire and returning it as soon as possible. I will arrange for you to receive a compilation of the replies to this questionnaire.

In addition, I would appreciate your comments on the enclosed article once you have had time to go over it. I would particularly like to know whether you might be interested in participating in a review of a first draft of the information frame and, at a later stage, in contributing to the information base.

Yours sincerely,

J. L. de Vries, M.D.

JLdV:jsk
Enclosures

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Pergamon Press Ltd., 1979. Printed in Great Britain

A SYSTEMS APPROACH TO HEALTH INSURANCE POLICY INFORMATION

A PRELIMINARY TAXONOMY OF HEALTH INSURANCE ISSUES, PROGRAM OPTIONS, PROBLEMS AND SOLUTIONS

J. L. DE VRIES and B. H. PERRY
Department of Health Planning and Administration, University of Michigan School of Public Health, Ann Arbor, MI 48109, U.S.A.

(*Received* 20 *August* 1978; *received for publication* 15 *January* 1979)

Abstract—A methodology is proposed for assisting health insurance policy analysts by developing a systems approach to health insurance information and literature. The general approach is to supply a link between the quantitative and qualitative information available, and the analytic needs of policy analysts. There is a great deal of information available, but traditional cataloging and indexing techniques do not adequately meet the policy researcher's and analyst's information needs. The most important of these once goals and limitations are identified, is knowledge of the interrelationships between program options in terms of expected results (problems, solutions) in a wide range of settings.

The key element of the approach used is the concept of an information frame, based on considering health insurance as systems of issues, program options, problems, and solutions with interrelationships explicitly defined. This approach would provide initially qualitative identification of these interrelationships and make them available via a machine readable taxonomy of the components. With substantiating literature references, preliminary work on the building of the taxonomy is based on seven major health insurance issues, and over 70 program options, 325 problems, and 350 solutions so far identified for 170 of the problems. The implementation of this methodology would provide analytically structured information for policy analysts in a format not presently available. The multi-country information to be included would allow consideration of alternatives which might otherwise be neglected. The result would improve an important element of the analytic process, and reduce the lead time required for inquiries by health insurance policy analysts, legislators, health planners and administrators.

1. INTRODUCTION

In a rational model, policy analysis, as a search for ways of determining preferred policies, should be able to consider as many options as possible. Recognition of the desirability of expanding the range of policy options as a means to more rational policy outcomes has led to an increasing interest in cross-national studies. The number of such studies has greatly increased in the past decade and shows every indication of continuing to do so[1]. A recent publication by HEW and NSF indexes some 4000 selected books and articles on the effectiveness and efficiency of alternative programs in health and social welfare[2]. The growing amount of information available in health insurance and health system programs is, however, inadequately structured for easy access particularly with regard to actual experience with various program options.

Thus, the policy analyst is still faced with the task of having to make decisions based on whatever information he is able to assimilate. To the extent that the information can be systematically structured his burden can be lightened. Jay Forrester has maintained that without an integrating structure, information remains a hodge podge of fragments. "When a structure and governing principles for systems have been accepted, they should go far to explain the contradictions, clarify the ambiguities and resolve the controversies in the social sciences"[3].

Faced with the challenge to review health insurance in an extremely concise manner, one of the writers developed for teaching purposes a conceptual listing of health insurance issues, problems and solutions in early 1975. Subsequently this approach was encouraged as well as assisted by the academic environment† of the authors and expanded into a project to establish a systematic information frame for eventual indexing of literature and other reports relevant to health insurance. The usefulness of the information frame was tested by collecting a set of references for application of program options and solutions in several European countries and linking them to the information frame. Eighty-five of these earlier generated solutions were thus verified in practice in various European countries. This trial run proved encouraging as a potentially useful method for structuring information about alternative approaches in health insurance policy in the countries examined. This paper describes an attempt to apply this basic concept of a systematic structure to the organizing of information on comparative health insurance policies. While specific to a particular substantive area, the framework should also be generally applicable to comparative policy analysis.

Comparative policy analysis provides material for evaluating alternatives among possible choices by looking at their recorded or probable effects. Comparative research many times will reveal what is possible under certain conditions rather than what is explicitly desirable

†Special thanks are due to Dean Wilbur J. Cohen and Prof. R. N. Grosse for major contributions to the conceptual development.

or transportable directly to another social setting. The overall goal of the present activity is to improve the decision making process by improving on one important input to the analytic process—comparative information on alternative solutions and problems in health insurance policy. The detailed objectives of the project are as follows:

(1) To establish a computer stored taxonomy of major issues, program options, problems, and potential solutions involved in health insurance policy decisions.

(2) To establish a capacity to identify for health insurance policy analysts qualitative interdependencies among issues, program options, problems and solutions.

(3) To establish a comprehensive identification of actual applications of program options and potential solutions by health insurance systems, within the U.S. and abroad.

(4) To establish a selective listing of references from published literature and annual and other reports of health insurance systems linked to a taxonomy created and coded to indicate the type of information contained therein (e.g. resource requirements, program outcomes, theoretical references, etc.).

2. BACKGROUND

One of the most important health and social policy questions today in many countries is that of the choice of the preferred mode of financing and delivering health care to the population. In the broadest view a country's health insurance scheme is a projection of its overt and covert social goals in all the modes of financing and delivering health and medical care and health related activities, as contributions to overall social welfare. A range of societal goals is involved which often conflict with each other in actual implementation, such as the trade-off between equity and efficiency. While Roemer and Axelrod considered four possible combinations of modes of financing and delivery for *broad* policy consideration[4], many more alternatives could be generated for purposes of mapping a new health insurance system and its actual application.

While some issues and several program options are determined by the social-political environment, other issues and many program options are compatible with different yet related social-political systems, particularly with regard to equity considerations and to incentives and disincentives for both providers and consumers. Furthermore, the commonality of problems encountered in implementing program options and solutions to cope with such problems is probably greater than often recognized, possibly because of the lack of comparative studies.

Because of the close interdependencies among the various possible options and their resultant positive or negative effects, health insurance or health care financing policies which address a single problem, for example easing the financial burden of hospital care only, may fail to achieve these objectives or may even have counterproductive results[5, 6]. Nor can health insurance policy be considered in isolation from many other social service needs and provisions, such as care for the elderly, workmen's compensation benefits, child day care facilities, etc., extending the interdependencies beyond health insurance per se.

The issues, encompassing a complex range of concerns, vary among countries and often within one country. Major obstacles in implementing or managing a health insurance program can arise from neglected differences in socio-political values among sub-groups in a particular society. It is often overlooked that while it is technically possible to impose a uniform health insurance program on a society in which diverse social values are held, value conflicts among competing interest groups may remain unresolved. These latent conflicts are likely later to lead to unplanned consequences of implemented programs (e.g. Medicaid's excessive cost-escalation [7], Canada's growth of hospital beds and their costs over the past two decades[8]). Unanticipated consequences of the sort experienced in the U.S. and Canada are less likely to occur when a very strong, centralized governmental authority imposes one set of values on all. (China[9], U.S.S.R.[10]).

If the need of the policy analyst is correctly postulated as particularly directed to the interrelatedness of program options and their effects, then the scope of much of the available literature does not address itself to that specific need. There are many comprehensive studies of a descriptive nature (Roemer[11], Simanis[12], Fry and Farndale[13], Fulcher[14], Van Langendonck[15], U.S. Congressional Studies[16], K. Davis[17]), while others endeavor to explore interrelationships of a range of issues and program options Donabedian[18], Berki[19], M. Feldstein[20], Somers[21]). However, the problem of the interdependence of health insurance activities has not been adequately addressed from a comprehensive systems point of view. The complexity of health insurance problems *per se* and the considerable interrelationships among health insurance options and other social programs and systems make health insurance systems well beyond individual investigation[22].

Thus, health care system analysis requires a considerable amount of manpower time to explore sources of information for each policy issue at the varying levels of decision making--federal or central, state, county and city. Many approaches to analysis are used. In health and social planning, it has been common to look extensively at data collected from within one's own country and, by modifying or adjusting for different assumptions about such variables as population mix, incomes, age distributions, use rates, etc. to make rational decisions about the preferred course action[23].

A recent approach, proposed by some as an improvement over merely attempting to extrapolate from existing data to reach rational conclusions, is the controlled field experiment or special study. The experimental model approach has been used in the United States in attempts to estimate the probable effects of income maintenance programs[24], and of housing allowances[25]. The experimental model has even been proposed as a useful tool for evaluating national health insurance proposals[26]. However, the use of controlled experiments as tools for social planning has been criticized since so many of the necessary criteria and assumptions of controlled experiments are violated in complicated social action and health related programs[27]. In fact, some maintain that the modern techniques in policy analysis which have been pursued with such great optimism in the areas of public housing, manpower training, etc have had few if any striking successes, partially due to a failure of the analysts to appreciate the complexity of the tasks they were facing[28]. The complexity arises because, inevitably, goals, the resultant programs and their results are all highly interrelated and interdependent. Levin, Roberts

and Hirsch in a more recent approach to policy analysis, applied the theory of systems dynamics to complex social problems, in particular to the specification of the U.S. heroin problem in terms of a closed, or feedback, dynamic system[29].

Useful information has come from the above approaches in some settings, however, they primarily focus on activities and observations within a single society or section of the country. Improved generation of alternatives could result from the consideration of a wider range of possible alternatives, particularly those which tap cross-national experience. The proposed methodology not only would offer more observations than are currently available to the above approaches, but would include qualitative and descriptive evaluative data collected for a wide range of alternative activities. This, along with qualitatively determined interrelationships between the alternatives will serve to complement and assist the above and other approaches, adding alternatives and relationships for testing and scrutiny.

A central component for this process is the development of a systems framework for health insurance issues, program options, problems and solutions on which to build an information base containing structured data elements on a broad range of alternative activities, derived from literature searches and other sources.

3. A SYSTEMS CONCEPT FOR A HEALTH INSURANCE POLICY INFORMATION FRAME

The essence of the presented activity lies in the recognition of two important factors: (1) the need to recognize the interactions that characterize health insurance as a system, and (2) the need for analysts and decision makers to try to consider as many reasonable alternative activities as possible. A principle rationale behind the present attempt at defining health insurance as a system relates to the importance which Forrester gives to systems as the building blocks for understanding complex dynamic behavior by way of the theory of system dynamics[3].

In this view of health insurance the dynamics of the system are initially set in motion by the broad health insurance goals determined by the social values and political will of a society. A health insurance goal here is a category of concerns less specific than the term objectives as used in the usual planning and evaluation context, but yet more operational than a mere statement of societal values. Seven areas or issues have been used to define goals within the current project and are intended to be the basic categories for the major grouping of alternative activities which aim toward the ultimate goal of a healthy society. These goals are listed in Table 1.

The primary means by which attainment of a society's health insurance goals is attempted is by implementation of various program options. The health insurance goals can be thought of as requiring program options aiming at their fulfillment. On the other hand, the very existence of certain programs may serve as a controlling or guiding factor in terms of which broad goals are pursued and with what degree of intensity. In this way there is a kind of synergism between program options and goals so that in most cases neither can be looked at separately, and it may become very difficult to separate out which force has brought a certain set of program options into being. The program options are broad sets of activities, and in the context of this project, may also include many activities not necessarily already in existence.

From the program options, we can project subsequent outcomes either empirically or hypothetically. Some of the outcomes will, it is hoped, be positive and to that extent some attainment of the major goal is achieved. Because all social programs have a variety of impacts, however, the results of any one of them may be felt in areas other than the specific one initially intended. The consequences of a program may be beneficial and expected, but with most activities, because it is inherently impossible for one activity to be all things for all segments of a population, some of the consequences of a program may be undesirable and these undesirable effects may need to be counteracted or corrected by other activities. The undesirable consequences are grouped under the broad category *problems*, and the various attempts at their correction, under *solutions*. There is an interaction between each of these levels of activities—the issues and program options affecting each other, while program options and "problems" shape each other, equally as do problems and the solutions tried to correct them. The success or failure of the solutions affect in turn the continued or modified pursuit of the original and other goals. Desirable effects of a program option often constitute a solution to a problem inherent in some other program option. A few examples may illustrate the concept.

There are many different kinds of problems that arise when implementing programs for health insurance goals. A restricted categorization of them would be deficiencies, negative results and constraints. A deficiency would be a structural inadequacy resulting in failure to obtain fulfillment of an objective because of neglect or exclud-

Table 1. Seven major goals of health insurance

1)	Promote access to medical care.
2)	Contain indirect financial burden of illness on the individual consumer.
3)	Contain direct financial burden of illness on the individual consumer.
4)	Promote efficient remuneration of providers.
5)	Containment of overall cost of medical care.
6)	Secure appropriate medical care.
7.	Promote preventive health care.

ing a segment of the population or area of concern. For example, lack of coverage of the unemployed is a deficiencies in health insurance schemes linked to employers. Negative results are process outcomes resulting from implementation of a program option, e.g. some undesirable impacts either directly or indirectly to some segment of the target population or area of concern, or with respect to some other issue under consideration in this activity. An example would be excessive laboratory or surgical procedures resulting from expanded coverage. One class of problems more difficult to identify without ambiguity would be program constraints. These would be limitations in the environment of a program option, which imply the need for avoidance of compensation. Problems in this category may flow from such social factors as regional or cultural patterns of health care utilization and health behavior practices which may constrain access or stimulate overutilization of services.

Problems, and indeed solutions as well, can be defined only in the context of an existing set of criteria for their classification and identification. These criteria depend almost totally for their definition on the social values and priorities of the society. The criteria of equity, efficiency and illness cost risk sharing have been proposed for the current project. Identification of health insurance system components in the above format, along with literature references linked to them, form the basis for a health insurance information base to serve as an important but currently lacking input into the policy analysis process.

Figure 1 shows a summary of the proposed health insurance project, emphasizing that the analytic process is served by the project rather than subsumed within it.

Obviously the boundaries in any attempt at a systems view can not always be formulated definitively, and in social policy even less so. In health promotion many other social activities play a crucial, if not overriding role, the contribution of medical services to overall health status being increasingly questioned[8]. Yet health insurance's main concern is medical care, even preventive care being often totally or partially provided by public health activities. Many important preventive activities are partly or completely outside the reach of medical care in different areas of social action, be it the behavior of the individual or family, the compliance with immunization provisions, the use of destructive weapons in inter-personal conflict, the safety at work, the protection of the environment, etc. all of which can affect health and the cost of medical care and health insurance considerably. From this point of view it becomes all the more apparent that medical care is but one of the contributors to social welfare (Margot Jeffereys[31]) and that the socio-political values entertained by any society are basic to health behavior and health care. This paper does not pretend to extend its boundaries into these manifold areas of social concern, yet does not intend to neglect their existence. A projection of the interdependencies of these various social concerns with health insurance policy design is provided in Fig. 2.

The uniqueness of the present approach lies in the existence of well defined cross linkages among the four elements within the formulated system. Indeed, not only can an activity appear as a "solution" for many "problems", but in some cases an activity may be a valid program option under consideration of one issue, and the undesirable result, or problem, in another with its particular solutions.

4. PROPOSED DEVELOPMENT OF A HEALTH INSURANCE INFORMATION FRAME SCOPE

Current state of the art work in library science has developed several comprehensive multi-coordinate word indexes for many fields of study. The most elaborate of these have been prepared for the areas of medicine and biological sciences (MEDLARS, *Science Citation Index*). Word indexes also exists for the social sciences but to date are not as comprehensive as those for the exact sciences[32]. These extensive data collections may be based on multiple keywords from previously written abstracts, title keywords, or subject content of the current literature. Such abstracting and indexing, while immensely worthwhile and essential in medical and scientific fields for many purposes, is not what the current activity proposes to do. Rather, it is the creation and use of a taxonomy of health insurance issues, options, problems, and solutions that forms a key element of the proposed information frame.

It is clear that the development of consistent typologies in the social and political sciences lags far behind such development in the natural sciences. This is no doubt related to the difficulty of trying to relate complex social problems and solutions to a clearly categorized indexing scheme. Also, the time frames for problem solving, policy analysis, and decision making in the highly politicized social structures is considerably shorter than in such academic disciplines as mathematics, statistics, or biology, discouraging the considerably time-demanding efforts in this direction.

Establishing a taxonomy of categories of knowledge is a laborious endeavor in any field, and for health insurance problems as a part of the social sciences possibly more so than in some other sciences. On the other hand the first application of a discipline to a field so far untouched usually appears more complex than already existing applications, without necessarily being so, since the earlier applications have partly lost their image of complexity and laboriousness as a result of work already accomplished.

The establishment and maintenance of indexed reference collections is labor intensive and costly, due to the tremendous volume of information indexed. However, as emphasized earlier, comprehensiveness in the mode of indexes such as MEDLARS and Scientific Citations Index is not envisaged here. Rather only articles and reports containing information relevant to the information frame or for expanding this frame would be selected. As a result it is expected that the information base will be much smaller in size than those currently in use and maintained for the more conventional library searchers. In contrast to conventional indexes, the coding of the information will require more careful attention and understanding of the contents of the references found, since the aim is not to create merely a keyword reference, but to identify the kind of information contained in the reference (e.g. type of political system, resources identified, quantitative results) and link it logically to the information frame (see Fig. 3).

It is expected that such indexing will require more specially trained indexers than normally used for abstracting of articles, etc. and that extra attention will have to be given to the crucial problems of inter-coder reliability. Much use will be made of the existing multi-coordinate indexed systems, but this will by no means be the only source of input to the information base. Actual experience with health insurance options is not always

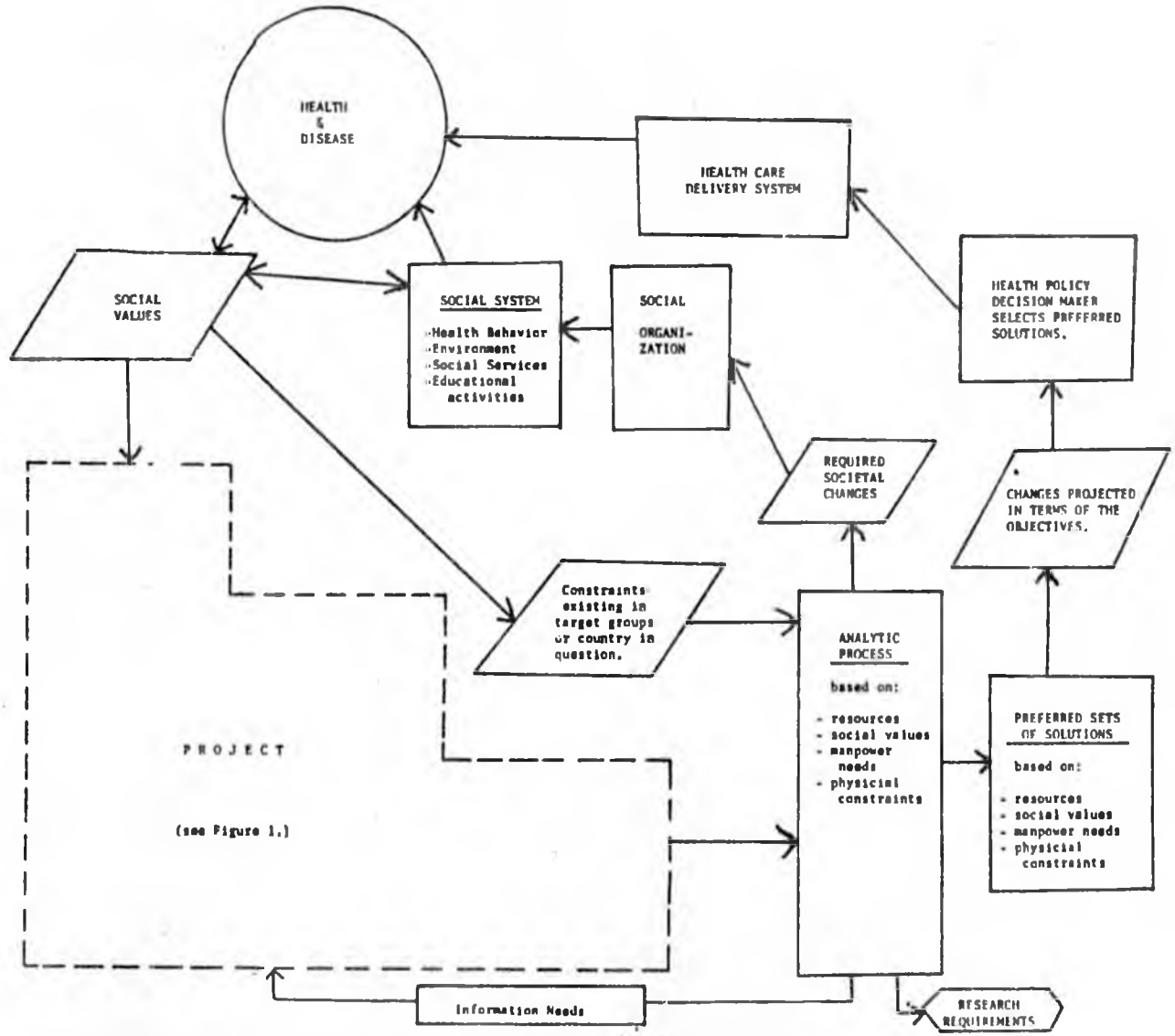

Fig. 2. A systems appraoch to health insurance policies: Delineation of project boundaries within total system of health and disease.

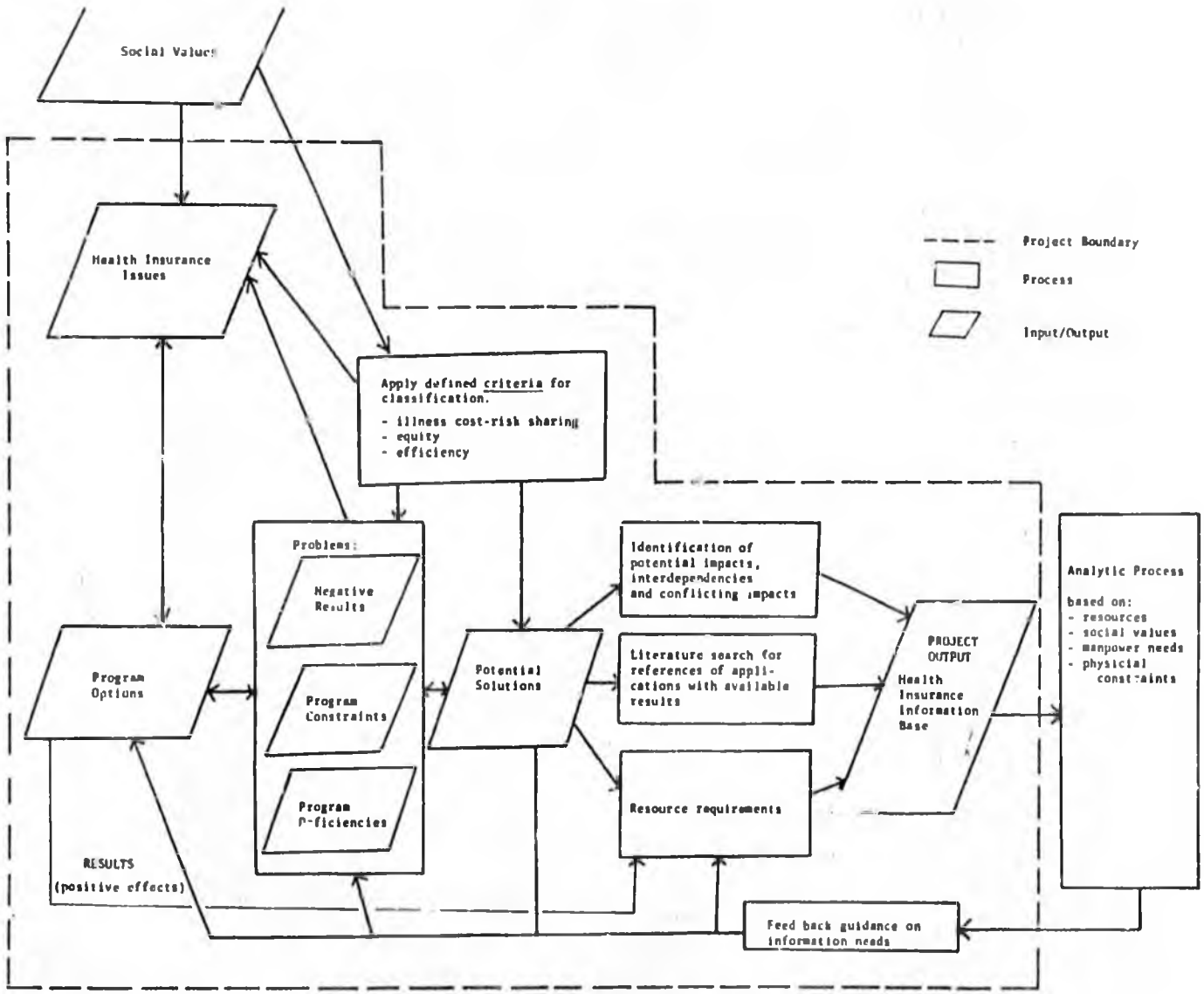

Fig. 1. Systems approach to health insurance policy analysis information.

1.8.3.2
Ombudsmen

U.S. Congress. House. Committee on Ways and Means. National Health Insurance Resource Book. Washington, D.C.: U.S. GPO, 1974
Part III, Chapt. 5: United Kingdom - Appendix II p. 397

kind of information contained in this reference

1) Type of ref.: theoretical | X applied | legislative | regulatory

2) Country & system: Britain -- National Health Service

3) Resources: X Manpower | Investment Cost | X Operating Cost | Facility

4) Results:

	Quantitative Outcomes	Postulated Outcomes	Positive Results	Negative Results
Health				
Other _____				

5 Financing mechanism: NHS financing - general taxation & contributions

6) Additional information:

Fig. 3 Example of coding card for summarizing references.

readily available from publications normally included in multi-coordinate indexed systems and is more likely to be found in internal documentation of health insurance systems both in the U.S and abroad. These normally unpublished sources would be a significant source of much of the information for the proposed health insurance information base.

The exact costs of establishing and maintaining the information base can only be approached after the information frame has been evolved to a workable degree. The test for the workability of the frame lies in the use of the frame for exploring qualitatively interrelationships among issues, program options, problems and solutions. It is postulated that the capacity to explore such qualitative relationships within this information frame is adequate justification for further developing and using the proposed systems approach to health insurance.

Methods

(1) *Initial exploration.* The activity reported now has been pursued by the authors, assisted through occasional review by colleagues at the School of Public Health in Ann Arbor. An information frame was internally generated using only the three categories—issues, problems and solutions. The listings for these three categories were subsequently partly confirmed as well as expanded through literature search. Further development of the concept led to the recognition of the need to identify program options for the selected issues and to clearly specify criteria for identification of problems and solutions. This recognition led to the outline of the information frame as shown in Fig. 1, using as the basis for the taxonomy the hypothesized operational sequence—issues, program options, problems and solutions. Figure 4 shows the format for listing the program

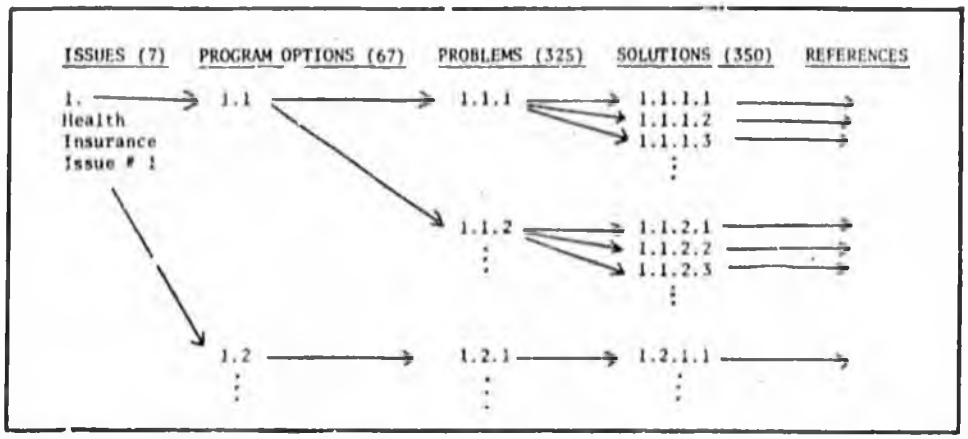

Fig. 4. Format for listing of health insurance taxonomy.

options, problems and solutions based on the proposed taxonomy. The sixty-seven program options so far generated for the postulated issues are provided in Table 2. An example of the worksheets using this format for one problem, under one program option, under Issue 1, *Promote Access to Medical Care*, is shown as Fig. 5. This example lists the codes for problem class (reference Fig. 1) and for the criteria used for identification of the individual problem and solution. It is anticipated that this identification will provide one of the tools to explore qualitative interrelationships between solutions and problems and issues. Also an attempt is being made to identify for each solution one or more of the seven levels assumed for most health care systems at which the solution is directed. Known applications of solutions are linked to these levels of care by country of application with references.

The relevancy of generated program options, problems and solutions should be tested by submitting the preliminary frame, once completed, to a larger group of health insurance experts here and abroad. It is likely that this testing process will generate a considerable number of additional program options, problems and solutions easily incorporated in the established data file. The design for a computerized information base using the health insurance information frame as described has been done with the anticipation of easy expansion resulting from such tests[33].

(2) *Access to an interrelated taxonomy.* To establish data manipulation capability the list of health insurance issues, program options, problems and solutions is used as a starting point. From this list a single file of raw data consisting of two types of records, identification records and reference records, has been constructed.

The identification portion of the files contains one set of data (one record) for each program option, problem and potential solution. The reference records would be made up of one additional data record for each country where, for a given program option or solution, an application reference or a literature reference(s) to a theoretical application was found. The exact contents of these two kinds of records is flexible, however, the basic format is as shown in Fig. 6. The machine readable data base has been described in more detail elsewhere[33].

Identification of individual problems and solutions is done by use of a computer generated word index for each relevant term in the program option, problem, and solution description. This facilitates initial location of specific elements of the taxonomy without requiring prior knowledge of the structure.

It is probable that explicit definitions of levels of care and areas of impact, both from the provider and client perspective, can be used with concepts from set theory to provide a framework to structure analyses of the interdependence problem. The procedure to be followed involves identifying additional variables for each solution based on their expected outcomes with regard to other issues of the health insurance system. The inter-linkage would be identified at two levels—the first level will be the impact, beneficial or otherwise, of each solution on each of the other major issues, the second level will be the identification of solutions which may be incompatible with other specific solutions for this same objective. Each solution can effect the other issues positively, negatively, or not at all, and this gives enough classification to define an additional categorical variable for each solution.

For identification of program options, problems and solutions occurring more than once, all such solutions will be listed with an additional four level value made up of variables 1–4. For the first or primary occurrence of a solution this would be just a duplication of the first four variables: but where this solution was one repeated from a previous location, it would contain the issue, program option, problem and solution number of that solution (see Fig. 6).

Once such a data frame has been assembled, a variety of questions and comparisons can be made. A major element of flexibility arises from being able to cross reference any of the variables in the data frame. This can be done very easily without yet having all the variables defined, by using only those of most immediate concern (issue number, problem number, solution number, country and level of care) on an interactive computer system. Cross referencing would be accomplished by using packaged software (already available without immediate production of new or special computer programs), to perform sorts and/or counts of the various elements. For example, if identification of solutions applied for various problems was desired, the computer can perform a sort operation on the solution identification field which would group all occurrences of each solution, and show the different problems to which it has been applied. Similarly, counts or cross references by country, or any of the other variables, could also be obtained rapidly and inexpensively by a simple computer command. However, as additional descriptive variables (as well as other constraints) are examined special programs can then be written.

Interrelationships among the program options, problems and solutions will be explored through "signed descriptors" for the individual problem or solution qualitatively indicative of the direction of the effect on the criteria other than the one used for identifying a problem or solution as well as on the issues other than that in which the problem or solution occurs. "Signed descriptor" is used to refer to additional variables associated with each program option and solution to indicate the effect of this activity on the other issues and the other criteria. The effect is intended to be shown by giving a plus or minus *sign* or a zero to indicate the probable direction of the effect relative to that issue (positive, negative, or neutral), as for example in Table 3. The concept of a signed descriptor as an aid in the grouping of social science literature has also been observed elsewhere though not exactly in the present context[32]. For example, a program option which promoted access (Issue 1), but increased the indirect financial burden (Issue 2) and also failed to contain overall costs (Issue 5) might have three signed descriptors of +−− for these three issues.

Another means for identifying qualitative relationships is the tabulation of repeated occurrence of options as problems or solutions and vice versa. Analysis of such multiple occurrences will give some indication of the range of possible effects of the different activities. As an example, co-insurance may constitute both a program option and a potential solution in attempts to contain overall costs, but will emerge as a problem violating equity when considering the issue of promoting access to medical care. Thus it will be more easily recognized that selection of solutions to, for instance, co-insurance as a problem, mitigates negative effects on the accepted goal of equity. The power of any given solution may in this

Program Option		Problem	Problem Class	Problem Criteria		Potential Solutions	System Level	Applications
1.8 Compulsory health insurance for those with an income below a defined level. (also in: 4.7)	1.8.3	Additional charges over agreed fees in fee-for-service systems.	2	2	1.8.3.1	Supplemental insurance for increased charges (not including additional benefits). (also in: 1.9.2.1)	02 03 04	Belgium France Italy
					1.8.3.2	Ombudsmen (also in: 1.9.4.1.)	06	Sweden United Kingdom
					1.8.3.3	Press publicity on complaints of overcharging.		
					1.8.3.4	Providers association watch.	07	Sweden
					1.8.3.5	Capitation fee for G.P.'s (also in: 1.7.4.1)	02	Holland Italy United Kingdom

Codes Used:

System Level	Problem Class	Problem Criteria
01 Self-care	1 = negative result	1 = illness cost-risk sharing
02 Primary	2 = program constraint	2 = equity
03 Secondary	3 = deficiency	3 = efficiency
04 Tertiary		
05 Preventive Medical Care		
06 Social Services		
07 Administrative		

Fig. 5. Issue 1: Promote access to medical care.

Table 2.

1. Promote access to medical care.	2. Reduce indirect financial burden of illness on consumer.	3. Reduce direct financial burden of illness on consumer.
Program Options	Program Options	Program Options
1.1 Employment/occupation/ group health insurance. (also in: 3.5, 5.10)	2.1 Social security package including sickness insurance, maternity benefits.	3.1 Private health insurance. (also in: 1.9)
1.2 Insurance for persons over 65.	2.2 Voluntary sickness insurance for lost income.	3.2 Catastrophic insurance. (also in: 5.7)
1.3 Insurance for children under 6 years.	2.3 Voluntary insurance for home care.	3.3 Employment/occupation/ group health insurance. (also in: 1.1, 5.10)
1.4 Government sponsored services for pregnancy.	2.4 Voluntary agency providing home care nursing and home aids.	3.4 Prepaid group practice; HMO. (also in: 5.8)
1.5 Health insurance for entire population — National Health Insurance. (also in: 3.8, 5.15)	2.5 Local or central government funded home care services.	3.5 P.S.R.O. (also in: 5.9, 6.1)
1.6 Catastrophic health insurance administered by private insurance companies.	2.6 Volunteer home care assistance.	3.6 Medicredit health plan (tax credits to families).
1.7 Fee-for-service for all care levels. (also in: 4.1, 5.14, 6.2)	2.7 Consumer awareness programs.	3.7 Local government provided ambulance and transport service.
1.8 Compulsory health insurance for those w/income below a defined level. (also in: 4.7)		3.8 Health insurance for entire population — Nat'l Health Insurance. (also in: 1.5, 5.15)
1.9 Private (individual) h.i. (also in: 3.1, 6.8)		3.9 National health service. (also in: 5.11, 6.5)
1.10 Care for medically indigent (medicaid).		3.10 Use of co-insurance (% of cost). (also in: 5.1)
1.11 National Health Service. (also in: 3.9, 5.11, 6.5)		
1.12 Health care services available at schools.		
1.13 Health care services available at work sites.		

4. Promote efficient remuneration of providers.	5. Containment of overall cost of medical care.	6. Secure appropriate medical care.	7. Promote preventive health care.
Program Options 4.1 Fee-for-service for all care levels. (also in: 1.7, 6.2) 4.2 Capitation fee for primary care providers (including pharmacists). (also in: 5.3, 7.5) 4.3 Capitation fee for primary care providers (including pharmacists) with salaried specialists. (also in: 5.4, 7.6) 4.4 Capitation fee for primary care providers (including pharmacists) with fee-for-service specialists. (also in: 5.5) 4.5 All care level providers salaried. (also in: 5.6, 7.7) 4.6 Episode of illness payment for specialist care (within health insurance schemes). (also in: 5.12, 6.6) 4.7 Compulsory health insurance for those with income below a defined level. (also in: 1.8)	Program Options 5.1 Use of co-insurance (% of cost). (also in: 3.10) 5.2 Rate and fee regulation by state or federal government. 5.3 Capitation fee for primary care providers (including pharmacists). (also in: 4.2, 7.5) 5.4 Capitation fee for primary care providers (including pharmacists) with salaried specialists 5.5 Capitation fee for primary care providers (including pharmacists) with fee-for-service specialists. 5.6 All care level providers salaried. 5.7 Catastrophic insurance. (also in: 3.2) 5.8 Prepaid group practice; HMO. (also in: 3.4) 5.9 P.S.R.O. (also in: 3.5, 6.1) 5.10 Employment/occupation/ group health insurance. (also in: 1.1, 3.3) 5.11 National Health Service. (also in: 3.9, 6.5) 5.12 Episode of illness payment for specialist care (within health insurance schemes. (also in: 4.6, 5.12) 5.13 Insurance for persons over 65. 5.14 Fee-for-service for all care levels. (also in 1.7, 4.1, 6.2) 5.15 Health insurance for the entire population-- National Health Insurance. (also in: 1.5, 3.8)	Program Options 6.1 P.S.R.O. (also in: 3.5, 5.9) 6.2 Fee-for-service for all care levels. (also in: 1.7, 4.1, 5.14) 6.3 Health insurance regulatory control of reimbursement for appropriate medical care. 6.4 Health insurance for entire population; National Health Insurance. (also in: 1.5, 3.8, 5.15) 6.5 National health service. (also in: 1.11, 5.11, 3.9) 6.6 Episode of illness payment for specialist care (within health insurance schemes) (also in: 4.6, 5.12)	Program Options 7.1 Health education programs. 7.2 No charge MCH programs (including immunizations). 7.3 Social programs for environment: food, housing. 7.4 Environmental health programs: air, water, transport safety. 7.5 Capitation fee for primary care providers (including pharmacists) (also in: 4.2 5.3) 7.6 Capitation fee for primary care providers (including pharmacists) with salaried specialists. (also in: 4.3, 5.4) 7.7 All care level providers salaried. (also in: 4.5, 5.6) 7.8 Occupational safety regulation programs. 7.9 Disease control programs.

Program, Problem, or Solution Identification:

- one record for each									
V1 Issue Code Number	V2 Program Option Code Number	V3 Problem Code Number	V4 Solution Code Number	V5 Program, Problem, or Solution I.D.	V6 Text description of solution	V7 Potential system impacts	V8 System Level 1-2-3-4-5-6	V9 # of application refs.	V10 # of theoretical references.

Program, Problem, or Solution References:

- one record for each published literature reference (or other references) found										
								Kind of information:		
V1 Issue Code Number	V2 Program Option Code Number	V3 Problem Code Number	V4 Solution Code Number	V5 Program, Problem, or Solution I.D.	V6 Ref. Seq. Code Number	V7 Country	V8 Systems Impacts	V9 Code for theo. or applied refs.	V10 Bibliographic identifier (numeric code*)	V11 Code for type of information contained therein

*to be matched with similar numerically coded list of bibliographic citations.

Fig. 6. Record contents for implementation of a health insurance system data base.

Table 3. Signed descriptors forsolutions to Problem 1.1.1. (no coverage when unemployed) of program option 1.1. (employment/occupation/group health insurance) of Issue I (promote access to medical care)

		Issue I - access	Issue II - indirect financial burden	Issue III - direct financial burden	Issue IV - remuneration	Issue V - cost containment	Issue VI - appropriateness	Issue VII - prevention	Problem Criterion 1 - illness cost risk sharing	Problem Criterion 2 - equity	Problem Criterion 3 - efficiency
1.1.1.1	Unemployment insurance (social security) includes payment of health insurance.	+	0	+	+	+	0	-	+	+	+
1.1.1.2	Unemployed allowed to pay government health insurance (normally considerably lower than voluntary health insurance rates) from own resources.	+	0	+	+	+	0	-	+	-	+
1.1.1.3	Unemployed allowed to choose reduced coverage (catastrophic illness only) at reduced premium rates out of pocket.	+	0	+	+	+	-	+	+	-	+
1.1.1.4	Provider levels provide free care to unemployed with commensurate increase of payment to providers (primary, secondary, tertiary) by either city, state, or federal contributions.	+	0	+	+	-	-	-	-	+	-
1.1.1.5	Governmental institutions (federal, state, city) provide free care to unemployed.	+	0	+	-	+	+	-	-	+	+

way be measured by the frequency with which it addresses different problems.

Quantitative interrelationships are not intended to be produced within the policy information frame itself, but are expected to become available from literature references.

5. PRELIMINARY RESULTS

For the seven selected issues, 78 program options have so far been listed. For these 78 options 325 problems have been identified. Over 350 solutions generated earlier for the more than 75 problems at that time listed have been rearranged for the newly identified problems. So far applications in 8 European health insurance systems have been identified for 85 solutions. To test the feasibility of creating a computerized health insurance information base, the available issues, program options, problems and solutions have been transferred to computer storage according to the design provided in Fig. 6.

The first preparation of the information frame cannot at all be considered complete. Completion will require intensive collaboration from future users, particularly in government, and health insurance specialists, both in this country as well as in other countries with experience in health insurance, so as to complement and adapt the frame accordingly. In addition, the literature search, once started, is expected to provide additions to elements of the information frame, without need to change the design of the frame itself.

6. DISCUSSION

The preliminary character of this report relates to the recognition that the information frame, once worked out for all four categories, needs further testing by health insurance specialists and policy analysts for confirmation or adaptation. A structured survey of policy information-needs should form a part of such a testing phase for the project. Contributions must also be obtained from existing health insurance systems outside the U.S.A.

In addition, it is obvious that the authors by themselves can never expect to establish an adequate information frame. A search for additions and corrections and a need-survey would eventually complete a workable information frame for the purposes identified earlier. Apart from adaptation, addition to the frame will be necessary, particularly on the basis of information available through reports, including internal reports from health insurance agencies, both government and private. The information frame as designed allows for expansion within the established four categories, and also for possible expansion of the categories if considered necessary. The establishment of the information base would be a much larger endeavor, requiring considerable and long-term support or might be undertaken in another environment altogether.

7. CONCLUSION

So far the development of the information frame has been conducted in a university setting with assistance from experienced health policy analysts. But even with a relatively limited exposure, the potential usefulness of the approach has been demonstrated. The increasing importance of comparative analysis of health insurance alternatives, plus the increasing interest in international comparisons of experience, and the time saving such a resource could provide policy analysts are the justifications for the present efforts.

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QUESTIONNAIRE

1. Do you have an information framework for Health Insurance Policy Information available to you on the following issues?

	YES	NO
a) Access to medical care.	☐	☐
b) Contain in direct financial burden of illness on the individual consumer.	☐	☐
c) Contain direct financial burden of illness on the individusl consumer.	☐	☐
d) Efficient renumeration of providers.	☐	☐
e) Containment of overall cost of medical care.	☐	☐
f) Secure appropriate medical care.	☐	☐
g) Promote preventive health care.	☐	☐

2. Would an information frame with all of the above issues increase your (agency's) analytical capacity,

	YES	NO
both in scope	☐	☐
and in time efficiency? . . .	☐	☐

3. If a complete information frame was made available to you, would your organization/agency use it? (Please indicate on scale.)

Never Always

4. What factors would limit your (agency's) use of such a taxonomy?

	YES	NO
a) inadequate staff	☐	☐
b) actual policy problems do not relate to this kind of analysis	☐	☐
c) time efficiency not important enough	☐	☐
d) policy choices are not related to interdependencies among issues, program options and problems	☐	☐
e) political, administrative, and other constraints limit consideration of interdependencies	☐	☐
f) other (specify) _____	☐	☐

5. Would you expect an information frame to require

	YES	NO
a) expansion of issues	☐	☐
If yes, which? _____		
b) frequent updating	☐	☐

6) Does your agency have the resources to engage in policy analysis? ☐ ☐

If yes, please identify number of manpower in categories

(i) ____ health economists

(ii) ____ public administrators

(iii) ____ sociologists

(iv) ____ health care administrators

(v) ____ policy analysts

(vi) ____ financial analysts

(vii) ____ systems analysts

(viii) ____ actuarial specialists

(ix) ____ information systems specialists

(x) ____ health insurance experts

(xi) ____ other (specify) _____ _____

____ _____

____ _____

THE UNIVERSITY OF MICHIGAN
HEALTH PLANNING AND ADMINISTRATION
SCHOOL OF PUBLIC HEALTH
Ann Arbor, Michigan 48109

USA 15c

Dr. J. L. de Vries
Dept. Hlth. Plan. & Admin.
School of Public Health
University of Michigan
Ann Arbor, Mi. 48109

52

Blue Cross
of Washington and Alaska

15700 Dayton Avenue North/P.O. Box 327
Seattle, Washington 98111
206/361 3000

April 23, 1980

Representative Thelma Buchholdt
Pouch V M.S. 3100
Juneau, Alaska 99811

Dear Representative Buchholdt:

While I was in Alaska a week ago, the Health Education & Social Services Committee requested information concerning the costs for health care coverage in H.B. 977. A similar request was received by phone from Jack Kreinheder in the House Research Agency, who asked for a comparison between the $106 cost of coverage for state employees and the cost per member of coverage for all Alaskans.

I have spent a week on the project and the answer cannot be derived from our data. When coverage is figured for all Alaskans, the group makeup changes radically. For instance, a group of employees is younger than a group composed of all Alaskans since persons leave the employment group upon reaching retirement age. A group of employees is healthier since that group is composed of working people and persons who are disabled or not healthy enough to be employed would be a part of a group of all Alaskans. A group of all Alaskans would have to include all the persons who are in institutions in the state and these persons are not included in any employed group and usually have health characteristics which would result in higher utilization. Because these characteristics are different from the characteristics of an employed group and because these characteristics will have a direct effect on the utilization of benefits, the extrapolation of cost from a given cost for the state employees would be inaccurate and misleading.

The Health Education & Social Services Committee may want to consider asking that an independent consultant be employed during the interim to make an estimation of the cost of coverage. While that study will give you only an approximation of the costs, that approach seems to be the only way that a reasonable estimate will be available.

Sincerely,

Joan H. Gaumer

JHG:kg

cc: Representative Joyce Munson
Representative Vern Hurlbert
Representative Bill Miles
Representative Ramona Barnes
Representative M.F. Beirne
Representative C.V. Chatterton
Sharman Haley
Jack Kreinheder
Wes Coyner

POSITION PAPER/Department of Health & Social Servi

POSITION PAPER
ON
HOUSE BILL NO. 977

"An Act relating to the health of residents of the state."

I. Departmental Overview of House Bill 977

House Bill 977 appears designed to accomplish the following reforms to health care delivery in Alaska:

a. Section 1 and 2 of House Bill 977 provides for a comprehensive plan for coverage of certain health care costs for all Alaskans who are otherwise not covered under a private or public health plan. The bill requires employers to provide health insurance coverage for their regular employees and their dependents and to pay at least 50% of the premium cost of such coverage. The Bill defines the standards and designs of the health plans including covered services and deductibles. The bill also offers health insurance coverage to high risk, "uninsurable" clients under the state plan.

b. Section 3 of H.B. 977 directs the Commissioner to use available medical assistance funds to purchase health care service through health insurance policies or contracts, if the Commissioner of the Department of Health and Social Services find them to be cost effective.

c. Section 4, 6, and 7 of H.B. 977 would expand current Medicaid and General Relief-Medical programs to cover new groups of persons specifically the unborn child group and the medically needy group.

d. Section 5 of H.B. 977 would expand covered services under Medicaid to add many of the optional services not offered under the program in Alaska.

II. General Departmental Comments/Recommendations

The Department of Health and Social Services will primarily reserve its comments to Section 3 through 8 of the bill, as the earlier sections are primarily concerned with employers and insurance and it is our understanding that these issues are planned to be addressed by the Department of Commerce and Economic Development, Division of Insurance and the Department of Labor. We do wish though to bring the Committee's attention to Section 18.12.070 on pages 4 and 5 of the bill. That section in part relieves an employer of his obligations for employees who already have health coverage through state medical assistance or state prepaid health care plan for the needy. It requires the Commissioner of Labor to notify the employer of

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that fact. We find some administrative problems with the release of this information, which is generally classed as confidential under state or federal laws. We could release to the Department of Labor the names of public assistance recipients who are employed only if the individual recipient has signed a release form permitting the Department of Health and Social Services to do so. We believe this to affect only a small percentage of clients, as most public assistance clients are not employed outside of the home, due to age, disability or dependent children in the home.

However, the Department believes that H.B. 977 takes a many faceted approach to a complex problem. It appears to move in too many directions and at a too rapid time frame, which could potentially jeopardize the successful accomplishment of the worthwhile goals that H.B. 977 seeks to achieve. The Department's specific comments which follow in Part III of this Position Paper support this observation. The Department's general comments regarding Section 3 through 8 of H.B. 977 are, as follows:

1. We support in concept the purchase of health care services through health insurance policies or contracts when judged by the Commissioner of the Department of Health and Social Services to be cost-effective for Medicaid and other medical assistance programs;

2. We recognize the need for the addition of the unborn child group as eligible for cash assistance and medical services under AFDC and Medicaid respectively. The Department views this as a positive step to providing necessary medical care, food, clothing, and other necessities at a time critical to the development of the child in effort to prevent future problems. The State covered at one time unborn children under AFDC. This option was dropped by the Legislature in 1975. The Department found little cost impact to overall AFDC expenditures as a result of the addition or deletion of this option.

3. We propose that additions of new Medicaid service options (such as drugs or podiatry) should be phased in, rather than all remaining services being added at a single time. Each service could be evaluated on its own merits, rather than in mass to determine whether it is cost-effective to do so at this time.

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III. Specific Departmental Recommendations on Section 3 through 8

Section 3 - AS 47.05.070 (a)

The Department is in favor of purchasing services through health insurance policies or contracts if more cost effective than traditional methods. The Department has no problem with the mandatory nature of the language in this section. "Medical assistance" should be redefined and a definition added for "remedial care".

Section 3 - AS 47.05.070 (b)(1)

Language appears to confuse the role of Commissioner, Department of Health and Social Services. Commissioner of Department of Health and Social Services purchases services under the same standards in place for all others competing for these medical services. There is nothing unique about the DHSS medical programs which would set professional standards different for them than exists for all other persons purchasing these services. Recommend 47.05.070 (b)(1) be reworded as follows: "to provide those medical and remedial care and services allowed under Alaska law."

Section 3 - AS 47.05.070 (b)(2)

Language is confusing and adds no additional authority to the Commissioner. Recommend deletion entirely or simply cross-referencing to existing state laws. Adequate safeguards exist in present law to insure fair reimbursement of medical providers.

Section 3 - AS 47.05.070 (b)(3)

No change recommended.

Section 3 - AS 47.05.070 (b)(4)

No change recommended.

Section 3 - AS 47.05.080

Recommend deletion of this section entirely. The Commissioner is not a rate setting authority in this instance. Rates are governed by competitive purchase of services on a bid basis with all competitors abiding by the same bidding principles set by Department of Administration and Division of Insurance. The only authority vested with the Commissioner is rejection of all bids which exceed the federally prescribed upper limits used by Medicare. Again, adequate safeguard and bid rules exist in this area in both federal and state regulations.

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Section 3 - AS 47.05.090 (a) and (b)

No change recommended

Section 3 - AS 47.05.100

No change recommended

Section 3 - AS 47.05.110

Recommend this section be re-titled "Interim Payment." The Department is presently working towards installation of a more sophisticated claims processing system by July 1, 1981. An interim payment mechanism will be part of that new system for certain large volume providers.

Section 3 - AS 47.05.120

Under present Medicaid law the Department is required to pay 90% of "clean claims" within 30 days of receipt, and 99% of "clean claims" within 90 days of receipt. The Department supports the idea that medical providers should not suffer financially because of bill payment delays after a reasonable period. Therefore, the Department supports the intent of 47.05.120 with the following changes:

1. Interest entitlement should be limited to "clean claims" only. In Section 47.05.120 the phrase "clean claim" should be substituted for the phrase "a bill."

2. Interest entitlement should not commence until the 91st day after receipt of a clean claim. Interest entitlement should accrue in monthly increments, not in daily increments, and providers should receive a full months' interest entitlement if the bill is paid after the 15th day of any calendar month.

3. "Clean claim" should be defined in Section 47.05.130.

Section 3 - AS 47.05.130

1. Add definition for "remedial care," "non-exclusive" contract, health care service contracts.

2. Define "medical assistance" to mean Medicaid, GR Medical, Catastrophic Illness, Crippled Children's and Maternal/Child Health.

3. Define 'clean claim' to mean one that can be processed without obtaining additional information from the provider of the service or from a third party; it includes a claim with errors

FOSITION PAPER/Department of Health & Social Service

originating in the department's claims processing system, but does not include claims from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.

Section 4 - AS 47.07.020 (b)

This Section would amend Medicaid law to provide coverage for all optional groups not currently entitled to Medicaid benefits, primarily the unborn child group, the unemployed father, and the medically needy group. We recognize the value of the addition of the unborn child group to Medicaid to assist in proper health and low income women's development of child through the receipt of necessary prenatal care. We believe the addition of this group to Medicaid will have little impact on programs' expenditures. We can see the need for health care coverage to the medically needy and to the unemployed fathers but the cost impact of these options would be substantial and would be covering a greatly expanded group of clients. The Department supports the concept of a limited medically needy program including only the aged, blind, and disabled until such time that we can develop the monetary and administrative burdens.

Section 5 - AS 47.07.030

This section as amended would change Medicaid law to dramatically expand medical services offered under the Medicaid program. The Department recommends that each service should be evaluated on its own merit, perhaps adding only those where it appears cost-effective, in terms of saving general fund dollars, to do so. Also, all services added in mass would cause administrative problems. A phase-in model would be more appropriate if the Legislature decides to pursue this section.

Section 6 - AS 47.25.120

This section as amended would add broad medically needy coverage under the State General Relief-Medical Program. The Department supports the concept of a limited medically needy program including only the aged, blind, and disabled until such time that we can develop the monetary and administrative burndens.

Section 7 - AS 47.25.410 (3)

This section as amended would add the unborn child group under the AFDC program and entitle them to monthly cash assistance payments. Eligibility for cash payments under AFDC is a not prerequisite for the unborn child group to receive medical coverage under Medicaid.

Approved by: Helen D. Beirne

Helen D. Beirne, Commissioner
Department of Health and Social Services

4/4/80
(DATE)

MEDICAID SERVICES

Currently Covered Services

Hospital-Inpatient & Outpatient

Skilled Nursing Facility (SNF)

Intermediate Care Facility (ICF)

Intermediate Care Facility for Mentally Retarded persons and persons with related conditions (ICF/MR)

Laboratory and X-ray Services

Physician Services

Visual Care Services, dispensing and ophthalmic materials

Medical Transportation

Psychiatric Facility Services

Home Health Care Services

Early Periodic Screening, Diagnosis, and Treatment of Individuals under 21 years of age (EPSDT)
- a. dental services
- b. prosthetic devices and medical supplies
- c. physical therapy

Community Mental Health Clinics

Family Planning Services

Outpat[illegible] Surgical Care Centers

Rural [illegible]h Clinics

Services Added By HB 977

Podiatrist Services

Chiropractic Services

Private Duty Nursing

Personal Care Services

* Physical Therapy

* Occupational Therapy

* Prescribed Drugs

Dentures

* Prosthetic Devices and Medical supplies

Other Diagnostic, Screening, Preventive & Rehabilitative Services

Services to Individuals over 65 years of age in Institutions for Mental Diseases

Services to Individuals over 65 years of age in Institutions for tuberculosis

Non-Covered Services

Other Practitioner Services
- a. private psychologist
- b. nurse practitioner
- c. physician assistant

Clinic Services-other than Community Mental Health Clinics

Services by Christian Science Nurses

Services by Christian Science Sanatoria

* Accessible through General Relief-Medical

April 22, 1980

Dear Legislator

We are strongly opposed to House Bill 977. State health insurance would not only be very expensive, but it would crowd private insurance carriers out of the market, and therefore, greatly interfere with free enterprise. Additional information is included on second page.

Sincerely,

FREE Committee
Anchorage Woman's Club

Teddy Cartwright 7714 Penny Dr. Anch. 99502
Marlene Agajanian 1241 St. Dotthard 99504
[illegible]
Esther R. Boatman, 3616 Arlington " " 99503
Bobbye Young 3535 Hampton Dr. Anch. AK. 99504
[illegible]
[illegible]
Priscilla Johnson 2315 Lassen Dr. Anch 99503
[illegible]
Jennie Barbe Talley SRA Box 28-N Anch. 99507

1539 West Ninth Avenue • Anchorage, Alaska 99501 • 272-5015

A committee of the Anchorage Woman's Club

Addendum to FREE Committe's position on House Bill 977.

We are opposed to HB 977 for the following reasons:

1. Insurance premiums will be higher than many small business people can afford.

2. History has proven that the level of care will decrease due to the increased demand.

3. We do not need another health care program in addition to Medicare and Medicaid. We have not heard patient complaints or of problems.

4. Large losses may result which the state would have to underwrite.

5. State health insurance would force insurance companies to cover even "bad" risk persons.

6. Over a period of 5-10 years all private companies will pull out of the state program because of the losses to them.

7. This is the first step towards socialized medicine because the premiums will be high; therefore there will be pressure to lower premiums so the state will pay to make up the difference.

8. The State cannot run the Medicaid program effeciently so how can they administer this program. The State had to hire an outside firm to manage Medicaid billing and the payments are still late.

1539 West Ninth Avenue • Anchorage, Alaska 99501 • 272-5015

A committee of the Anchorage Woman's Club

FREE Committee Addendum HB 977 continued:

9. This bill is another form of standardization in which everyone lives in the same house, wears the same uniform, has the same insurance plan. This bill deprives the individual of his free choice.

10. An increase in the bureaucracy to administer this bill will be necessary.

11. The General Federation of Women's Clubs opposes all forms of socialized medicine.

1539 West Ninth Avenue • Anchorage, Alaska 99501 • 272-5015

A committee of the Anchorage Woman's Club

April 22, 1980

Dear [illegible]

We oppose House Bill 412 relating to minimum standards for hospital care. If such a bill were enacted the cost of hospital care could rise dramatically. We feel that this bill puts an unnecessary burden on the physician as well as on the relatives of the patient.

Sincerely,

FREE Committee
Anchorage Woman's Club

Marlene Gaff
1341 W. Bothhand 99504

Jennie Carne Dolley
Star Rt. 28-N Anch. 99507

Priscilla J Thoroman
2315 Lobsang Dr. Anch 99503.

Teddy Cartwright 3714 Terrace Dr. Anch. 99502

Zelda P Gantzon, 2016 Colgate Dr 99503

Zabelya Young -3833 Hampton Anch. 99504

1539 West Ninth Avenue • Anchorage, Alaska 99501 • 272-5015
A committee of the Anchorage Woman's Club

April 23, 1980

POSITION PAPER

To: Legislators of the State of Alaska

From: FREE Committee of the Anchorage Women's Club

Re: House Bill 412 "An Ac providing for minimum standards for hospit care."

The FREE Committee of the Anchorage Women's Club opposes HB 412 for the following reasons:

1. Recruitment and retention of physicians in our rural communities could be impaired.

2. The bill appears to regulate the physicians through the hospital. Hospitals do not practice medicine, but rather provide the setting in which medicine can be practiced. Doctors work at the hospital, not for the hospital.

3. The cost of health care will rise even higher.

4. This bill appears to ignore the training of nurses who are specifically prepared to work on the intensive care ward.

5. Very few doctors will allow another doctor to interfere with his patients' care. We as patients would not like a strange "night" doctor taking over our case.

6. Malpractice insurance probl ms may result if one doctor treated another doctor's patient without permission.

7. This bill regulates and interferes even further with a profession whose primary goal is excellence in their services and relationships with their clients.

1539 West Ninth Avenue • Anchorage, Alaska 99501 • 272-5015

A committee of the Anchorage Woman's Club

STATE OF ALASKA

JAY S. HAMMOND, GOVERNOR

DEPT. OF HEALTH AND SOCIAL SERVICES

DIVISION OF PUBLIC ASSISTANCE

POUCH H-07
JUNEAU, ALASKA 99811

April 14, 1980

To: The Honorable Thelma Buchholdt
Alaska State Legislature
House of Representatives
Pouch V
Juneau, Alaska 99811

Thru: Helen D. Beirne, Commissioner
Department of Health and Social Services

Thru: Rod Betit, Director
Division of Public Assistance

From: Robert M. Ogden, Chief
Medical Assistance Section

Dear Ms. Buchholdt:

We have not been able to develop a comprehensive and complete fiscal note for HB 977. In order to adequately develop a responsive fiscal note more time is needed.

To date we have developed fiscal notes for three sections of the bill and will outline them as follows:

		Millions
a.	Dental Services and Dentures:	2,800
b.	Limited Medical Needy program for Blind, Disabled and Elderly (persons over 60):	5,600
c.	Prescription Drugs for the Elderly (65 years or older):	2,499
		10,899

These three portions are a very small part of the cost involved in the implementation of House Bill 977.

Acquiring cost figures on the many other services that would be added will take lengthy study and research and the Deaprtment has not had time to accomplish that which is required.

06-F81LH

Other services added that need cost analysis are as follows:

1. Diagnostic, Screening, Preventive and Rehabilitative Services: This type of program can be very costly if not controlled in a reasonable manner.

2. Podiatrist Services: Should not cost a great deal due to the small number of podiatrists in the State.

3. Chiropractic Services: This also could be a very costly addition.

4. Private Duty Nursing: Could in the long run with development reduce costs currently incurred in health facilities expenses.

5. Physical Therapist Services: This addition would be of moderate cost to the State.

6. Occupational Terapy: Also of moderate costs, depending upon controls of usage.

7. Personal Care Services: Costly to implement but may in the long run actually save costs.

8. Prosthetic Devices: Should be of little cost.

Greater Fairbanks

CHAMBER OF COMMERCE

FAIRBANKS
ALASKA

A RESOLUTION RELATIVE TO HEALTH INSURANCE IN THE STATE OF ALASKA

EREAS the Alaska House of Representatives Committee on Health, Education and Social Services (HESS) has introduced House Bill No. 977, and

EREAS HB 977 ignores the fact that most employers in the State of Alaska provide health insurance for their employees, and

EREAS the provisions of HB 977 place an additional cost burden on small business, both for premium and administrative cost, and

EREAS the provisions of HB 977 require additional regulations to be promulgated in large quanity by the State of Alaska, and

EREAS HB 977 would create an additional cost burden to the insurance carriers to bring their current plans into compliance with the provisions of HB 977, and this cost would be passed over to the consumer, and

EREAS these cost burdens would be a disincentive to have employees, and

EREAS currently there is a sufficient number and quality of insurance carriers licensed in the State of Alaska to provide adequate coverage as outlined in the provisions of HB 977, and

EREAS the provisions of HB 977 require the State of Alaska to add substantial additional staff to administer this local version of a "National Health Care Plan", now

EREFORE BE IT RESOLVED that the Greater Fairbanks Chamber of Commerce is opposed to HB 977 in its entirety.

ssed by the Board of Directors of the Greater Fairbanks Chamber of mmerce on April 8, 1980.

ATTEST

C.W. Baer
General Manager

Terry Palczer, President

From: Fairbanks Chamber of Commerce
Terry Palczer

FBX/L10/MW 4/9/80 [illegible]:55PM via #209 copier

Kenai Chamber of Commerce
Box 497
Kenai, Alaska 99611
(907) 283-7989

April 11, 1980

State of Alaska
House of Representatives
Health, Education & Social Services Committee
Pouch V
Juneau, Alaska 99811

Re: House Bill 997

Dear Committee Members:

The Greater Kenai Chamber of Commerce has requested that I communicate to you in writing the Chamber's position with regard to House Bill 997. The Chamber opposes the Bill for the following reasons:

The great majority of our members carry some type of health insurance for the benefit of their employees. It therefore appears that only a relatively few regularly employed Alaskan employees would benefit from the plan.

As to those employers who do not carry insurance for their employees, there appear to be three basic types of employers. The first category of such employers are businesses who primarily employ seasonal workers, many of whom are transient. A prime example of such employers would be canneries. The canneries employ seasonal workers who would be benefited by the plan for only a month or so, and have no reasonable expectations of being insured while in the employ of the cannery.

The employers of such an industry would be saddled with the expenses of additional overhead and premium expenses with little net benefit to Alaska employees generally.

The second classification of employers who do not carry insurance are those employers, generally small businesses, who have employees who have chosen the occupation, fully aware that no health plan exists, but who have elected to stay with the job for whatever reason. They may have spouses who are covered under alternative plans; they may receive wages or bonuses in a sufficient amount to pay for their

own medical coverage; or, they may have elected to take the additional wages in lieu of insurance plans. Examples of such workers are those usually single workers whose perceived health insurance needs are not of significant concern to them, but who are in the stage of their lives where the additional income is more significant to them.

The final obvious classification is those employers, again primarily small businesses, who cannot afford to provide health care plans for their employees, but who are nevertheless able to attract employees because of other attractive aspects of the working conditions offered.

The Bill as presently written would result as noted above in a net benefit to only a small portion of the Alaska work force. The provision of the Bill which requires mandatory coverage by employers is its most objectionable feature. We question whether it is the function of the State to make such an economic decision for employers and employees. If health care is of concern to an employee, then that employee can seek employment with an organization which offers such a benefit, or can join an organization which offers a group health care plan to its individual membership. Even our Chamber of Commerce has such a plan which is available to all members and their employees.

If an employer is able to attract qualified employees for whom a health care plan is not of significant concern, then it should not be the function of the State to amend the employment contract by adding a provision which may be of little consequence to an employee, but is an added burden to an employer through increased overhead expenses.

The Bill appears to focus primarily on the small business entities of the State who are already overburdened with governmental reporting and record keeping requirements. The small benefit to the Alaskan employee from the Bill appears to be substantially outweighed by the additional costs and administrative problems with wh ch the Bill saddles the small employer.

The administrative features of the Bill make it obvious that an increased state bureaucracy is going to be required to supervise and administer the plan. This bureacracy does not seem to be justified by the limited needs which are addressed by the plan.

We view the Bill in its present form as being an unnecessary intrusion into the affairs of employers and employees, and of limited benefit generally when compared to the hardship with which it saddles the small business.

Thank you for your attention to our concerns.

Very truly yours,

C. R. BALDWIN
Director

CRB:jh

IMPACT ON INSURANCE CARRIERS

Minnesota Experience

The Minnesota Comprehensive Health Act took effect January 1, 1977. At year end, 1976, the following statistics were compiled:

Out of

751 carriers licensed to write health and accident insurance in the state,

42 carriers withdrew from the state rather than comply with the law. Of these,

25 never wrote any health insurance in the state anyway. The remaining

17 carriers that withdrew had a combined volume of

$888,000 in health insurance premiums in Minnesota (less than 0.2% of the total) or an average of

$52,200 in premiums per carrier. The largest carrier that withdrew reported a volume of

$428,000 in accident and health premiums.

Since the time these statistics were compiled, other carriers have dropped their accident and health business in Minnesota, and some that originally withdrew have resumed their accident and health line of business in the state again.

Mr. Caroll Calloway, Assistant General Counsel for the Health Insurance Association of America, discussed several reasons that carriers might have preferred to stop doing accident and health business in Minnesota rather than comply with the Comprehensive Health Act.

The first objection was that many carriers specialize in a particular type of insurance and do not underwrite comprehensive policies. The law requires them to offer comprehensive plans, and does not allow them to refuse a client for reasons other than that the client is an uninsurable risk. Another objection was that the required conversion privileges obligates a carrier that specializes in group policies to also write individual conversion policies.

Mr. Calloway stated that the insurance carriers like the Connecticut comprehensive health act, because in Connecticut the underwriting burden for the mandated coverage is not placed on the induvidual carriers, but on the association. The association in Connecticut develops and underwrites the comprehensive health plan which the carriers are obligated to make available to their clients. The Minnesota law also provides for reinsurance and administration by the association of all required types of coverage, and the association has the ability to develop prototype plans for use by any carrier which does not choose to develop and issue its own qualified plans. The Minnesota carriers association has refused, however, to reinsure lines of coverage mandated by the act, other than the state plan for high risk clients, according to Mr. Calloway. Thus it is not the provisions of the law which place an insurmountable burden on the carriers, but the practice of the assocaition, which of course is run by the carriers themselves.

The third objection was the "major medical roll on" which requires carriers to offer major medical coverage to their client with unqualified plans. They regard this as an impairment of contract. This section to which the carriers strenuously object could easily be deleted without significantly weakening the bill, in light of the requirement that carriers must offer their client a comprehensive qualified plan with major medical coverage anyway.

STATE
HEALTH
INSURE.
#1

HOUSE RESEARCH AGENCY
Pouch Y - State Capitol
Juneau, Alaska 99811
465-3991

MEMORANDUM March 18, 1980

TO: Representative Bill Parker
Attn: Mr. Jim Erickson

FROM: Jack Kreinheder, Issues Analyst JK

RE: State Health Care Programs
Research Request No. 61

You have asked that we: (1) provide any available studies on Medicaid, state health insurance, and the State's health care program in general; and (2) determine whether the State could provide medical care for low-income groups in medically underserved areas of the state. The enclosed materials represent all the relevant materials we were able to locate, with the exception of past copies of the State Health Plan and the Medicaid Annual Status Report. These reports were not included because of their bulk and uncertain value to you; should you wish to review these documents, please let us know.

Our major findings with regard to direct State delivery of medical services are the following:

1. There appear to be no legal reasons why the State could not hire doctors to treat low-income groups or any other class of people; however, four major practical difficulties with such an approach were raised during the course of our research. The first problem is that everyone we contacted believed the medical community would oppose the competition which direct State participation in the delivery of medical services would represent. Second, the State would need to purchase malpractice insurance for doctors in its employment, thus incurring substantial costs. Third, if the legislature approved funding for such a program, and later discontinued it, or if State physicians' services were to be provided on a temporary basis, the problem of "medical abandonment" could result in lawsuits against the State unless adequate arrangements were made for the further treatment of patients handled under the program. Fourth, it appears that medical services provided by State physicians would not be eligible for federal Medicaid funds

except on a temporary or special situation basis; therefore, the State would have to bear the full cost of the program unless State-provided services were demonstrated to qualify for a waiver from the usual federal Medicaid requirements.

2. Withdrawal from the Medicaid program is not, however, a prerequisite to the establishment of a State physician program. My understanding of the alternative health care system you are considering is that the State would not necessarily provide all the medical services now administered by private physicians under the Medicaid program, but would instead make State doctors available in areas which are medically under-served either because of the lack of physicians, the lack of specific medical services, or because of the refusal of available physicians to accept Medicaid patients. It is clear that the State could continue to receive federal Medicaid funds for medical services provided by private physicians; and, in addition, it appears that funds could also be received for State-provided services if a federal waiver from certain regulations could be obtained. The State currently receives over $22 million per year in federal Medicaid funds.

3. It may be possible to improve medical care for low-income persons by means other than, or in addition to, direct State health care delivery, and without opting out of the Medicaid program. The principal problem with the Medicaid program, from the recipient's point of view, appears to be that many doctors in Alaska refuse to accept Medicaid patients. This reluctance to take Medicaid patients is, in turn, largely attributable to the extensive paper-work requirements and the extremely slow payment process of the current Medicaid system in Alaska. However, these problems are not inherent in the federal Medicaid system, and it appears that more rapid and efficient reimbursement of medical providers could substantially improve low-income access to medical care by encouraging more doctors to participate in the program. Of course, there may be other problems with the Medicaid program which might make withdrawal from the system desirable.

4. The expanded use of fiscal intermediaries may be one option for making more doctors available to low-income persons. Delta Dental Plan of Alaska is currently the only organization of this type in Alaska and handles only dental services, but all parties involved--the Department of Health and Social Services, the participating dentists, and the Medicaid recipients--seem to be very satisfied with the program. About 96 percent of the dentists in Alaska are members of Delta Dental and 95 percent of these participate in Medicaid. The fact that reimbursement to dentists by

Delta Dental for Medicaid cases usually occurs within two weeks, as compared to up to several months for other Medicaid claims handled by the State, is the main reason for the almost universal acceptance of Medicaid cases by Alaska dentists.

In an administrative review of the Alaska Medicaid program completed in 1979, HEW officials recommended that the Division of Public Assistance contract with a fiscal intermediary for Medicaid processing. The Division is planning to solicit within the next six months requests for proposals for the processing of all Medicaid claims by a fiscal intermediary, although H&SS may still elect to process claims in-house. Robert Ogden, Chief of Medical Assistance for the Division, stated that a fiscal intermediary handling all Medicaid claims could probably process claims as rapidly as Delta Dental currently does for dental claims, thus improving the prospects for physicians accepting Medicaid patients. However, the choice between the use of a fiscal intermediary and processing the Medicaid claims in-house will depend on administrative decisions made within the department.

Each of the four points summarized above will now be discussed in more detail.

State Medical Care

According to the sources we contacted, the basic answer to your second question is yes, the State could hire doctors to treat low-income groups. Eligibility could be determined in a number of ways and would not need to parallel the federal Medicaid system. Placement of the State-employed doctors throughout the state could be based on whatever criteria were deemed appropriate by the State.

The State already provides direct delivery of medical services to a limited degree. Nurses employed by the Division of Public Health administer the Early Periodic Screening, Diagnosis, and Treatment Program (EPSDT) for children throughout the state. The program is small in comparison to other medical services, but it does provide a precedent on the State level for direct delivery of services.

Political resistance by the medical community was cited by several persons with whom we spoke as the greatest obstacle to the direct employment of doctors by the State. Our contacts believed that many doctors would view such an action as State competition with the private sector,

and as "socialization" of the medical profession. The apparent acceptance by the medical community of the EPSDT program suggests that opposition to the State physician approach would not be as strong if the approach were used only in a few selected areas or were clearly temporary in nature. For example, if the State adopted a procedure similar to that which was employed by the federal Department of Health, Education, and Welfare (HEW) to identify and designate the low-income population of Anchorage as a Critical Health Manpower Shortage Area (see Attachment A), doctors might be more willing to accept the State delivery approach than if it were part of a comprehensive, state-wide system.

Under the HEW system, which is authorized by section 332 of the Public Health Service Act, an area or population group of an area may be designated as a Health Manpower Shortage Area if the population-to-primary care physician ratio exceeds a certain level. An area is also given a degree-of-shortage classification based on this ratio. The population-to-physician ratio takes account of physician accessibility, rather than simply dividing the population by the number of physicians. For example, in Anchorage, the ratio of Medicaid eligible persons to all primary care practioners is estimated at 161:1, but when HEW adjusted for the fact that most of these physicians do not accept Medicaid patients, the final population-to-primary care physician ratio was determined to be 3,041:1.

This ratio qualified the low-income population of Anchorage as a degree-of-shortage group 4, which makes the area eligible to: (1) apply for placement of National Health Service Corps (NHSC) physicians; (2) be an eligible service area for purposes of repayment of health professions student loans and for the NHSC scholarship program; and (3) apply for grant funds under various sections of the Public Health Act.

A similar approach to improving medical care for medically underserved areas or population groups could be utilized by the State. Designation under the program might qualify an area for the placement of State-hired physicians, for grants to improve health care delivery, or perhaps for a special streamlined medicaid process which would encourage doctors to accept Medicaid patients. The latter option might be effective in a case like Anchorage's, in which the number of practicing physicians in an area is sufficient to meet the medical needs of the population, but the physicians will not accept Medicaid patients because of dissatisfaction with the reimbursement system.

Attachment B, which is a letter to Representative Martin from Commissioner Beirne, suggests other questions which should be considered if the State elects to provide medical care directly and/or withdraw from the Medicaid program. As Duncan Read indicated in his earlier memo, Dr. Frederick McGinnis, Deputy Commissioner of H&SS, has proposed a major study of health care financing options which would address questions relating to

State provision of health care, such as who would be eligible for the program, and what services should be provided. Dr. McGinnis has apparently expanded the scope of the proposed study and is attempting to obtain about $170,000 for the project. If the study is conducted, the results would be submitted to the 1981 legislature.

If the State physician health delivery system is to be pursued, the problems of malpractice insurance and medical abandonment must be considered. Neither of these problems would prevent the State from hiring doctors, but their cost and legal implications may have some bearing on the issue. The State currently carries a small amount of malpractice insurance for doctors employed in administrative capacities, apparently in the event that they are called upon in an emergency situation. To fully insure doctors employed by the State who regularly provided medical services would require a substantial expenditure. The magnitude of the insurance cost would depend on the number of doctors employed the service provided, and the scope of the program, but the cost could be significant.

Medical abandonment appears to be a relatively easy problem to avoid, but it could present legal problems if it is not considered in the design of any State-provided medical care program. Under state and federal law, physicians are responsible for arranging for continued medical care for their patients if, for any reason, they discontinue their treatment. A doctor not fulfilling this responsibility may be sued by a patient. The two ways in which the issue of medical abandonment could arise are: (1) if the legislature suddenly discontinued funding for the program, and (2) if the program were discontinued in an area because it was determined that the private physicians in the area could now adequately serve the population. In both instances, the problem of medical abandonment could be avoided by ensuring that adequate arrangements were made for the continuing treatment of patients after the State ceased providing service directly.

A final point to be considered regarding direct State delivery of medical care is the Medicaid funding question. I contacted officials with the Northwest regional office of the HEW Medicaid Bureau in Seattle to determine if federal Medicaid funding could be provided for medical services delivered by State-employed physicians. A firm answer could not be secured within the time frame of this project, but it appears that a waiver from certain federal regulations pertaining to reimbursement procedures and other matters would be required for federal funding to be given for State-provided services. The necessary conditions for such a waiver are also unclear at this time, but HEW officials indicated that the designation of an area or population group having a severe shortage of medical care might meet the waiver requirements.

You have indicated an interest in the possibility of the State withdrawing entirely from the Medicaid program, and the question of Medicaid support for State-provided services may therefore not be a major concern. However, the State currently receives over $22 million each year in federal Medicaid funds. It may, therefore, be desirable to retain these funds if a State medical care program could meet, or be exempted from, the necessary federal regulations without compromising the program. Please let us know if you would like a more concrete response to the Medicaid funding question. A written request to HEW would be required and their response could take two weeks or more, but we would be glad to pursue this issue if you would like.

Medicaid Issues

Although we were not asked to specifically address the Medicaid program in this memorandum, we obtained information on Medicaid during our research which may be of value to you in considering health care options. The greatest problem with the current Medicaid program in Alaska is that the claims processing system is inefficient, requires excessive paperwork, and results in long delays in provider reimbursement. It is the paperwork and the payment delays which have been the primary cause of Alaska physicians refusing to accept Medicaid patients. Attachments C and D provide a physician's perspective on the problems of the Medicaid system. In many cities, most notably Anchorage, the number of physicians seems to be adequate, but a Medicaid patient cannot see a doctor because the majority of physicians refuse to take Medicaid cases. It therefore appears that a more efficient and rapid claims processing system could do much to alleviate the difficulty of obtaining medical care for low-income Alaskans.

The current program of Medicaid dental services lends strong support to this premise. Medicaid claims for dental care do not go through the State system used for other medical services, but instead are handled by the Delta Dental Plan of Alaska, which acts as a fiscal intermediary between the providers and the State. The pertinent statistics regarding Medicaid participation by dentists were cited in the findings section, but the importance of Delta Dental in this discussion is that the vast majority of the state's dentists accept Medicaid patients. The two-week Medicaid reimbursement time which Delta Dental provides for dentists is the primary reason for the high degree of cooperation by Alaska dentists with the Medicaid program.

The obvious question, then, is if Delta Dental is so efficient, why doesn't the State use Delta or another fiscal intermediary to process all its Medicaid claims. There are a number of reasons why fiscal intermediaries do not represent an easy solution to the Medicaid and low-income health care problems.

The first is that Delta Dental does not appear eager, and may not have the capability to take on the processing of medical claims. Attachment D is a letter from the Pediatricians' Association to Representative Martin suggesting that the State contract with Delta Dental for payment of Medicaid claims for pediatric services. However, I spoke with Denise Knapp, Executive Director of Delta Dental, and she indicated that Delta has not agreed to process pediatric claims and is still only discussing the idea. Robert Ogden, Chief of Medical Assistance for H&SS, stated that while he has been very pleased with Delta's performance, he is not sure if Delta could handle the large volume of Medicaid claims for medical services, and knows of no other in-state firms who could.

A second possible problem with the expanded use of fiscal intermediaries is cost. Each claim processed by Delta Dental costs the State an average of more than $14, while the medical claims processed under the current system cost only about $1.45 each. However, Mr. Ogden was quick to point out that the current system does not meet federal requirements, and meeting these requirements is likely to increase the cost of processing claims whether a fiscal intermediary is used or not. In addition, Delta's cost is much higher than would be that of a fiscal intermediary handling all medical claims, because the fixed costs of the Delta claims processing system are spread over a relatively small number of claims (8,000 per year). A fiscal intermediary handling all Medicaid claims for medical services would process about 144,000 claims per year; cost per claim would therefore be much lower, perhaps in the $2.50 range, according to Mr. Ogden.

HEW has mandated that the Division of Public Assistance implement a new claims processing system by September, 1980. In an administrative review completed a year ago, HEW officials recommended that the Division contract with a fiscal intermediary for the processing of all Medicaid claims. (See Attachment E, Chapter 7, for more detail on this recommendation.) However, it is still uncertain whether this recommendation will be followed. The Division plans to solicit requests for proposals (RFP) for claims processing within the next six months. At least six to eight firms are expected to bid on the contract, but it appears that the decision to use a fiscal intermediary or to process Medicaid claims in-house will be more dependent on administrative decisions within H&SS than on the results of the RFP process.

We hope the information we have provided is useful to you. This memorandum is a brief treatment of a complex subject, so please let us know if you would like additional research, or if we may be of further assistance in any other way.

JK/dp

cc: Representative Terry Martin

Attachments:

A. HEW designation of Anchorage as a Health Manpower Shortage Area, from the Anchorage Neighborhood Health Center.

B. Letter from Commissioner Beirne to Representative Martin on Medicaid/State Health Care issues.

C. Letter from Dr. Lillibridge to HEW discussing Medicaid problems.

D. Letter from Dr. Lillibridge to Representative Martin on Medicaid problems and the Delta Dental program.

E. HEW administrative review of the Alaska Medicaid program.

F. H&SS task force recommendations on the Medicaid program.

G. Information supplied by Delta Dental on their program.

H. Alaska and National Health Insurance--report by Dr. McGinnis of H&SS.

I. Third Party Health Coverage in Alaska--1978 report by the former Legislative Affairs Research Division.

J. Opting-A Study of Medicaid Client Need--1977 report by the former Research Division.

K. H&SS 1977 Medicaid Annual Status Report.

L. January, 1980 State Health Plan.

Attachment A

ANCHORAGE NEIGHBORHOOD HEALTH CENTER
1217 EAST 10TH AVENUE · ANCHORAGE, ALASKA 99501 · 907-279-9586

February 18, 1980

Duncan Read, Director
House Research Agency
Pouch "Y"
State Capital Building
Juneau, Alaska 99811

Dear Mr. Reed:

As per request from your staff person, Carol Biggs, I am sending you a copy of the application which I submitted to the Bureau of Health Manpower, which resulted in a Critical Health Manpower Shortage Area designation for the low income population of Anchorage. Also enclosed, is a letter from the Bureau, in which they accepted the evidence we presented in the application, thus making the designation.

Sincerely,

Don Bantz
Executive Director

DB/jw
Enclosures

RECEIVED
FEB 22 1980
HOUSE RESEARCH AGENCY

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
HEALTH RESOURCES ADMINISTRATION
HYATTSVILLE, MARYLAND 20782

BUREAU OF HEALTH MANPOWER

JAN 17 1980

Mr. Don Bantz
Executive Director
Anchorage Neighborhood Health Center
1217 East 10th Avenue
Anchorage, Alaska 99501

Dear Mr. Bantz:

We have reviewed your request as amended for designation of the low-income population of Anchorage as a population with a shortage of primary medical care manpower. In addition, we have contacted the Health Systems Agency for your area, the State Health Planning and Development Agency, and the Governor's office for their comments.

From this review, we have determined that the area appears to be rational for the delivery of primary medical care, and it has a population-to-primary care physician ratio of 3,034:1 and has unusually high needs for primary medical care services.

Therefore, we are designating the low-income population of the Municipality of Anchorage as a population group with a shortage of primary medical care manpower, under the authority of section 332 of the Public Health Service Act. The designated population is defined to include:

County	Parts
Anchorage Division	Municipality of Anchorage-low-income population

This area is assigned to degree-of-shortage group 4, as defined in the regulations for Designation of Health Manpower Shortage Areas.

As you probably know, designation under section 332 makes this area (1) eligible to apply for placement of National Health Service Corps personnel, (2) an eligible service area for purposes of repayment of health professions student loans, (3) an eligible obligated service area under the National Health Service Corps Scholarship Program, and (4) eligible to apply for (or to receive preference for) grant funds under various sections of the Public Health Service Act.

Applications for NHSC personnel are available from Dr. Art Lagace, NHSC Regional Program Consultant, in Seattle.

We appreciate your efforts to assist us in identifying health manpower shortage areas.

Sincerely yours,

Howard V. Stambler

Howard V. Stambler
Director
Division of Manpower Analysis

cc:
Office of the Governor
Health Systems Agency
State Health Planning and Development Agency

APPLICATION FOR THE MUNICIPALITY OF ANCHORAGE FOR DESIGNATION OF THE LOWER INCOME POPULATION AS A CRITICAL HEALTH MANPOWER SHORTAGE AREA GROUP

In April of 1977, the Municipality of Anchorage was designated as a Medically Underserved Area. This designation was based upon four indices:

1) percentage of population below the poverty level,
2) percentage of population over age 65,
3) infant mortality rate, and
4) primary care physicians per 1,000 population.

It is the contention now that the lack of access to primary care practitioners for the low income population group of Anchorage qualifies this group to be designated as a Critical Health Manpower Shortage group.

This application includes the following:

1) population methodology
2) primary care practitioners
   (a) background
   (b) primary care practitioner summary
   (c) Anchorage Human Resources Department survey
   (d) Anchorage Neighborhood Health Center survey
   (e) adjustments of the ratio: population group to primary care practitioners serving them
3) additional documentation
4) appendices

POPULATION METHODOLOGY

According to the Municipality of Anchorage Human Resource Planning Department, the population of Anchorage is 202,101 persons. Subtracting the Alaska native and military populations from this total leaves a non-federal population of 165,517 persons:

202,101	
- 28,500	military
- 8,084	Alaska native
165,517	

The 1978 Population Profile prepared by The Municipality of Anchorage lists the distribution of annual household incomes for Anchorage but the data is not broken down by number of persons in the household.

Table 1. DISTRIBUTION OF INCOME OF ENTIRE HOUSEHOLD BY SUBCOMMUNITY

Annual Household Income	Total Population
$ 0-$ 9,000	10.0%
$10,000-$14,999	9.2
$15,000-$19,999	9.5
$20,000-$24,999	10.9
$25,000-$29,999	10.1
$30,000-$34,999	12.2
$35,000-$39,999	7.7
$40,000-$49,999	12.8
$50,000-$59,999	9.0
$60,000 & Above	8.6
(n)	(1,177)
Mean	32,998
Median	30,155
Standard Deviation	20,555

The median household size in Anchorage is 3.0. (Population Profile - Municipality of Anchorage, Page 4 table I-1).

The Medicaid eligible population of Anchorage can be estimated by using the poverty guidelines for Alaska, issued by the Community Services Administration on May 7, 1979 in the Federal Register. (For a complete breakdown of these figures, see Appendix).

By these guidelines a family of 3 persons who makes $7,008 per year or less is Medicaid eligible. Using the

household incomes in Table 1, approximately 8% of the 165,517 non-federal population of Anchorage, 13, 241 persons, live below the poverty levels and are Medicaid eligible.

PRIMARY CARE PRACTITIONERS

There are, at present, 82 practicing primary care non-federal physicians in the Anchorage Municipality. The breakdown is as follows:

Family practice/general practice	42
Pediatrician	14
OB/GYN	17
Internists	9
Total	82

Source: Alaska State Medical Association. 1978-9 Medical Directory.

Background

The State of Alaska's Medicaid Program has experienced problems with its reimbursement system to the degree that a nine month lag in physician reimbursement is not uncommon. The Alaska Medical Society, at their annual meeting in 1979 went on record as rejecting any mandatory medical obligation to care for people who cannot pay. This resolution was written and sponsored by the Anchorage Medical Society (see attached newspaper article). It appears that this resolution was directed at efforts by the State to legally prohibit doctors from refusing to treat poor patients in retaliation to tardiness in paying Medicaid bills.

This has lead to the situation whereby Medicaid patients are being denied access to primary care practitioners in Anchorage. This has been documented by a number of independent surveys conducted by various health agencies in Anchorage during the past year. The situation is particularly acute with regards to prenatal care. The initial survey was done by the South Central Health Planning and Development Agency who concluded that a "shortage of OB services does exist, and that the economically disadvantaged patients are those who are most likely to directly experience that shortage" (December 12, 1978).

Anchorage Human Resources Department Survey

The Anchorage Human Resources Planning Department surveyed 38 of the 42 Family Practice physicians in March, 1979 and 33% responded that they do not accept Medicaid patients for any type of services. In a further study commissioned for the Human Resources Planning Department, the Anchorage Urban Observatory found that the primary care physicians have on an average 57 Medicaid patients per practice. This

would indicate that approximately 4731 Medicaid patients (57 x 83 physicians) are being seen on a regular basis by Anchorage primary care physicians. This represents about 36% of the Medicaid eligible population in Anchorage, and would seem to indicate that 64% of the Medicaid eligible population in Anchorage is not being seen regularly by primary care practitioners except for the two physicians at the Anchorage Neighborhood Health Center.

ANHC Survey

To further clarify the situation, the Anchorage Neighborhood Health Center conducted its own telephone survey in October, 1979. ANHC called 17 OB physicians, 36 family practice physicians, and 14 pediatricians in Anchorage.

Summary of results (see appendix for complete survey results).

1) Five OB practices are completely closed to new OB patients or Medicaid patients.

2) Six OB practices accept new OB patients but do not accept Medicaid patients.

3) The remaining four OB practices all require cash payments by the patients, up front, before they will be seen, thus limiting access to low income patients. Further, they will only accept a limited number of Medicaid patients.

4) None of the 36 family practice physicians accept new OB Medicaid patients.

5) Twelve of the fourteen pediatricians will not accept Medicaid patients. Two pediatricians who accept Medicaid patients do so on an extremely limited basis.

Adjustments To Primary Care Practitioners

1) Beginning Ratio $\frac{13,241}{82}$

2) Adjusting for physicians with closed practices to Medicaid patients. $\frac{13,241}{21}$

11 obstetricians (ANHC Survey - see appendix)
12 pediatricians (ANHC Survey - see appendix)
38 family practice (Anchorage Municipal Human Resource Planning Survey)

3) a) Adjusting for limited access to Medicaid patients - 36% of Medicaid eligible population, currently has access to primary care practitioners. This means that the 4,766 Medicaid eligible persons have access to the 21 remaining primary care physicians. $\frac{4,766}{21}$

b) The remaining 64% (8,475) of the Medicaid eligible population, in effect, has a total of 2 physicians (Anchorage Neighborhood Health Center) available to them on a full-time basis. $\frac{8,475}{2} = 1:4,236$

Thus, according to the data presented, a Critical Health Manpower Shortage area ratio exists in the Anchorage low income population. For the reasons outlined in this report, we are requesting that the Bureau of Health Manpower provide this designation immediately. A critical need in the area of prenatal care is particularly apparent, and the Anchorage Neighborhood Health Center intends to apply for a Family Practice National Health Service Corp Physician to help alleviate this problem.

ADDITIONAL DOCUMENTATION IN SUPPORT OF THIS APPLICATION

There is some evidence that the group above the Medicaid eligible population of Anchorage also lacks regular access to primary care practitioners. This "medically indigent" category is not well defined. However, using the HUD "Section 8" guidelines (the most generally accepted income guidelines for Anchorage), low and moderate income levels and target populations can be enumerated.

Table 2. HUD Section 8 Income Guidelines for Anchorage, July 31, 1979*

Number in Family	Low Income	Moderate Income	Median Income
1	8,960	11,200	14,000
2	10,240	12,800	16,000
3	11,520	14,400	18,000
4	12,800	16,000	20,000
5	13,600	17,000	21,250
6	14,400	17,800	22,500
7	15,200	19,000	23,750
8	16,000	20,000	25,000

* Source: Al Robinson, HUD Economist, Anchorage

According to HUD figures, an Anchorage family of 3 that makes $11,520 or less is considered to be low income. Referring again to Table 1, approximately 4% of the total Anchorage population falls above the poverty level, yet below the low income level (extrapolation of the 2 categories 0-9,000 and 10,000-14,999 per year). By this calculation, there are about 6,620 persons who fall within this medically

indigent category. end: 8876

Again, using the HUD figures, the moderate income level population can be estimated. This amounts to approximately 7%, or 11,586 persons in the low to moderate income range.

In summary, the income populations are shown below.

Anchorage Target populations

Poverty level (Medicaid eligible)	13,241
Low income	6,620
Moderate income	11,586
Total	31,447

Lack Of Access To Medical Care Services

Another indicator of the problem is the emergency room utilization. Providence Hospital had 27,000 emergency room visits during the past year. According to the administration office at Providence, 60% to 80% of these visits were non-emergency problems. This is one of the major indicators of the lack of access to a regular physician by a large segment of the Anchorage population.

Perceived Needs

The perceived needs of Anchorage health consumers seems to support the physician access problem. In a recent survey done for the Anchorage Municipality, the Anchorage Urban Observatory* found that 25.4% of the persons surveyed had difficulty paying for the uninsured cost of medical care.

*Ender, Richard. "Anchorage Health Needs Assessment Study: A Consumer's Health Survey", May, 1979.

Attachment B

STATE OF ALASKA

JAY S. HAMMOND, GOVERNOR

DEPT. OF HEALTH AND SOCIAL SERVICES

OFFICE OF THE COMMISSIONER / POUCH H 01 – JUNEAU 99811

February 6, 1980

The Honorable Terry Martin
Alaska State Representative
Pouch V
Juneau, Alaska 99811

Dear Mr. Martin:

Recently you requested information regarding key questions that might be addressed in a study analyzing the advantages and disadvantages of State of Alaska withdrawing from the federal Medicaid and Aid to Families with Dependent Children (AFDC). Our primary information sources for your request were Deputy Commissioner Frederick McGinnis, who has been designated to coordinate a special project on health care financing, and members of the Division of Public Assistance. They offered the following list of pertinent questions:

Medicaid Issues

1. What would be the impact of withdrawing from Medicaid without withdrawing from AFDC?

2. Which option services (such as eyeglasses) and mandatory services (such as doctor's visits) would be advantageous to the State to continue in a state designed and financed medical program?

3. Who would be eligible for the state replacement program? Would the State be interested in expanding its eligible group to cover certain needy or middle income persons now not routinely eligible for state assistance?

4. How would the issue of prior medical resources (Indian Health Service, Blue Cross coverage, etc.) be handled? Would the state only cover those persons with no other available resource to pay for or provide care? As is the case currently with General Relief Medicaid program.

5. Should the Medicaid requirement of "free choice of provider" be continued under any new state medical assistance program?

6. Would the services be offered in all areas of the state in the same manner? Or would regional planning and delivery of services be utilized?

7. How will National Comprehensive Health Insurance or National Catastrophic Medical Insurance programs now discussed on federal fronts impact the design of this program?

8. Other points to consider regarding loss of federal Medicaid funds if the State withdrew from Medicaid:

   a. 50% federal funds for medical services covered under Medicaid for persons eligible for a cash payment under AFDC, SSI and/or APA.

   b. 50% to 90% federal funds for medical services covered under Medicaid for persons not eligible for a cash assistance payment but who are in state institutions, in long-term care facilities and hospitals, and children in foster homes and private child-caring institutions.

   c. 100% federal funds which flow through the Medicaid program to the Alaska Area Native Health Services to provide funds to raise the quality of care of those facilities under the Indian Health Care Improvement Act.

   d. 75% to 90% federal funds for the development and operation of a computerized Medicaid claims payment and management information system to provide prompt payment of medical providers and detailed information necessary to do adequate budget projections.

   e. 75% to 100% federal funds for program management safeguards to assure that cost effective payment is being made to licensed providers for medically necessary services through a professional standards review organization for hospital care, medical utilization review for long term care and outpatient medical services and supplies, and medical provider fraud investigation.

   f. 75% to 100% federal funds for certification and licensing of health care facilities under Medicare and Medicaid to assure adequate care is being provided in safe and sound facilities.

   g. 50% to 75% federal funds to the Division of Public Health for nursing services provided to Medicaid eligible children for the detection, identification and treatment of diseases and deformities.

   h. 100% federal funds for federal program oversight, technical assistance, and program review to assist the Department in an effort to provide payment for cost-effective, high quality medical care.

   i. 50% to 90% federal funds for program administration costs claimable by the Department for the department-wide and

statewide cost allocation system designed to maximize federal receipts to offset state general fund expenditures.

AFDC Issues

An exhaustive study of this subject was completed by the former Research Division, Legislative Affairs Agency. The Department participated actively in this research project and has reviewed the draft. The Legislative Affairs Agency's Research Division was disbanded before the final report was approved for printing. We recommend you obtain a copy of this report to determine whether your current initiative may duplicate the massive effort required in that project.

Though the draft report discussed the features of the AFDC program that may make it desirable for Alaska to opt out and upon the costs of dropping the program, considerable attention was given to possible alternatives to replace AFDC. Among the topics covered in the study were:

(1) history of Alaska's assistance programs;

(2) problems in administering a federal program in Alaska;

(3) federal welfare reform proposals and their potential effects on Alaska;

(4) fiscal impact of withdrawal;

(5) alternatives to AFDC (including negative income tax and a universal child allowance);

(6) legislative and administrative alternatives and options within the current federal AFDC program; and

(7) work requirements for welfare recipients.

You may wish to contact Deputy Commissioner McGinnis directly at 278-4668 (Anchorage) and Rod Betit, Director of the Division of Public Assistance at 465-3355, for further clarification. For your information, Deputy Commissioner McGinnis has just begun the planning for a study with the Governor's approval to take a comprehensive look at the total health care financing picture in Alaska, of which Medicaid is a vital part. He plans to submit the results of his study to the 1981 Legislature.

We appreciate the opportunity to offer some input on your possible project.

Sincerely,

Helen D. Beirne

Helen D. Beirne
Commissioner

Attachment C

The Children's Clinic
3300 Providence Drive
Anchorage, Alaska 99504

907/279-8571

October 12, 1979

Mr. Leonard D. Schaeffer, Administrator, HCFA
Department of HEW
Mary E. Switzer Building, Room 5006
330 "C" Street, S.W.
Washington, D.C. 20201

Dear Mr. Schaeffer:

The purpose of this letter is to outline the difficulties The Children's Clinic has experienced in dealing with the Medicaid system in the State of Alaska. In addition, we are outlining some of the recommendations that would alleviate some of these problems.

(1.) Failure of Medicaid to pay anything in less than four months, with many accounts unpaid in 16 months. An example is given in Table 1.

(2.) The cost of processing Medicaid paperwork is excessive. For example, The Children's Clinic pays $1,700.00 in combined staff salaries to process Medicaid paperwork. The current disallowance rate pays us $ .62 for each $1.00 billed. In the month of September 1979 our doctors each made an average of 1,355 patient visits in the hospital and office. Thirty-eight percent of these visits or procedures are for Medicaid recipients. After correcting for the disallowed rate, the secretarial time to process paperwork, less office overhead of 55%, net receipts was $489.00. The average net is $3.62 to the doctors per patient procedure or visit. If this is converted into a net hourly rate, the amount is $4.31 per hour for Medicaid patients. Compare this with the net income per doctor per visit or procedure of $19.29 per visit or $28.30 per hour for patients having private insurance.

(3.) The fact that a doctor will be reimbursed $3.62 nine months after he provides the treatment is not conducive to his opening his practice to any new Medicaid patients. The fact that a Medicaid coupon is relatively worthless from the financial viewpoint means the Medicaid patient is, in effect, a second-class citizen in his attempts to obtain medical care.

(4.) The Medicaid office has repeatedly failed to advise the providers of changes in the system prior to the change taking place. This results in a great waste of time for the State employees, the providers, staff, and the Medicaid patient in generating and processing outdated forms.

(5.) The Medicaid office fails to keep Medicaid recipients notified of coverage to which they are entitled and the system by which they are to obtain these benefits.

(6.) The supervisory and clerical staff in Juneau change very often. A supervisor with whom we might have discussed various cases is no longer there when we telephone back a month later. The people who are now handling the account know nothing of what is going on and they request reapplication of the entire account. After a particular invoice is handed from one clerk to another, 6 months may have elapsed. If the paperwork must be resubmitted, coupons for the service provided 6 months ago cannot be provided by Medicaid. The patients themselves do not keep old coupons.

(7.) Although private insurance carriers will coordinate benefits between one another, when the patient has coverage by more than one company, Medicaid expects the doctor's office to do this. The physician's offices are skilled at providing Medicaid care, but not for employing insurance personnel for this type of activity.

(8.) The Medicaid office is not verifying whether or not the Medicaid recipients have insurance coverage. The social worker will determine that a divorced mother is working for a company that has insurance available. Many of these mothers choose not to have the insurance as it will reduce their take-home pay. This mother will be recorded by the Medicaid office as having private insurance when, in actual fact, no private insurance exists. It takes an average of 5 months of letter writing between the insurance company, employer, and the doctors to prove that no insurance coverage existed at the time. Again, when 5 months have elapsed, the patient does not have a coupon covering the appropriate time period. The Medicaid office refuses to provide the coupons or authorize payment for those services.

(9.) The Medicaid office in Juneau requires a separate coupon be obtained for each provider. When the patient comes to the hospital in the middle of the night for an emergency, often times the patient forgets to bring the coupon. The hospital will be reimbursed on a basis of a coupon number typed on the emergency room services sheet. The private physician who provides the service at the time of the visit is expected to obtain a coupon rather than use the same system as the hospital.

(10.) Payment vouchers are presently identified only by invoice numbers. They lack corresponding patient names. Transition errors are being made by Medicaid personnel in typing invoice numbers on the vouchers, consequently the doctors cannot find the invoice that should be credited with the payment. We need patient names included as well as the invoice numbers.

(11.) Lump sum payemnts are made, which do not give Explanation of Benefits that state what services are being paid and what date. For example, we will have provided 20 services for a family over a period of one year. Because of the reimbursement for Medicaid being delayed 6 to 12 months - some services are disallowed, others are questioned, and others are paid - we cannot properly credit the lump sum payment to the proper services. This particular procedure is necessary because invoices are constantly being lost in Juneau and we must reapply two or three times. We must have an itemization accompanying each payment voucher so that accounts can be properly credited and duplicate charges will not be submitted in error.

(12.) A mother who is pregnant is not permitted to get a coupon for the unborn child until after the birth of the child. In this office an average of 2 months elapses following the birth of a child before the mother can provide us with a coupon for that child. Medicaid mothers are a high risk for having premature infants and newborns with a high degree of sickness. The whole process of initiating paperwork to obtain reimbursement is delayed an additional two months, in addition to the five or six months already mentioned. If the social worker thinks that the mother has maternity benefits from her employer, the situation stretches out for a year.

(13.) Medicaid recipients only recieve 5 coupons per month which may be used in 2 visits to the doctor (one coupon for the doctor, one for the lab, one for the x-ray, and one for the pharmacy). Recipients tell us they go to the Medicaid office, but are unable to get any more coupons; as a result, patient care suffers.

The following recommendations are offered to IMPROVE MEDICAID.

(1.) It is time for the state and federal government to get out of the insurance business. The CHAMPUS program works very satisfactorily in Alaska. In Alaska, private insurance companies competitively bid to obtain one-year contracts for the CHAMPUS funds. The companies compete with one another to provide the government with more health care for less dollars. The insurance carriers are already very good at coordinating benefits for recipients having multiple coverage, and consistently accompany the voucher with the explanation of benefits for each individual patient. We would strongly urge that the federal government look at the actual cost in dollars per service to the patient, including the overhead for the cumbersome duplicating, inefficient system we have in Alaska. If the Medicaid in Juneau was to bid competitively with Blue Cross, Aetna, Metropolitan to obtain federal funds for the administration of reimbursement for medical care, the Medicaid would either shape up or lose the contract to a private carrier.

(2.) An alternative system to do away with reimbursing doctors altogether: Doctors would simply document the services provided and apply the patient fees for Medicaid patients as a tax credit to the Internal Revenue Service. The IRS already has an effective system of cross-checks and could audit office records simply and avoid suspicion of fraud on the part of the doctors. The amount of monies saved by doing away with salaries, equipment and rent for the Medicaid system could be reallocated into education, food, etc.

(3.) We understand from Mr. William Collings, of the D.H.E.W., that the Medicaid office in each state is to have a medical advisory committee in each state. The committee has not been functional in Alaska to our knowledge. The Alaska American Academy of Pediatrics and the Anchorage Medical Society have doctors who are knowledgeable and are willing to contribute their time and efforts to such a committee. These representatives could report back any changes in the system to the doctors in the communities.

(4.) To curbe the current widespread abuse of the Medicaid system by the patient, each patient should be required to make "token" payments in cash ($2.00) each visit. Children are being brought into the doctor's office for hang nails, etc., because they are on Medicaid and think they must be seen. If they paid $2.00 of their own slender dollars they would think carefully before going to the doctor or health clinic unnecessarily.

To prevent user abuse of the hospital emergency room, patients would be required to make a cash payment of $20.00 in advance if the emergency triage nurse determined that this visit is not an emergency. It is not unusual for a Medicaid mother to bring a 4-year-old to the emergency room at 3 a.m. because he has been crying for two weeks and cannot sleep. If his mother had to pay $20.00 in cash prior to the service she would make more efficient use of her Medicaid coupon and the medical services available to her. Thus, Medicaid would be charged only $28.00 for an office visit, instead of $100.00 for an emergency room visit.

(5.) As an interim measure, move the state Medicaid offices from Juneau to Anchorage or Fairbanks. These are the areas where the majority of the recipients live and the majority of the care is provided. This would facilitate communications between recipients, providers and administrators. Each area must have a strong manager who has the authority to authorize payment, issue coupons, etc.. locally.

The pediatricians of The Children's Clinic appreciate the opportunity to bring their ideas and concerns for caring of the Medicaid recipients to you at the Annual Meeting of the American Academy of Pediatrics. We hope that this type of dialogue will continue to benefit the Nation's Medicaid children.

Sincerely,

(Signed)

Clinton Lillibridge, M.D.—
The Children's Clinic
3300 Providence #112
Anchorage, Ak. 95504

cc: James Nesbitt, M.D.
Gerry Schriever, M.D.
Dion Roberts, M.D.
Elizabeth Hatton, M.D.

CL/pkd
(Retyped 10/22/79 -AAP-
AAP - TPR/ms)
(Attachments)

Attachment D

CHAIRMAN
MARIAN T. WITT, M.D.
3300 PROVIDENCE DRIVE
ANCHORAGE, ALASKA 99504

ALASKA CHAPTER
American Academy of Pediatrics

February 6, 1980

Representative Terry Martin
Pouch V
Juneau, Alaska 99811

Dear Sir:

By way of introduction, I am the alternate chairman of the Alaska Chapter of the American Academy of Pediatrics. The Academy represents 90 per cent of all of the pediatricians in Alaska. We have been struggling to develop new solutions to the Medicaid problems. It is our desire to provide excellent care for every child in Alaska, regardless of the ability to pay.

Many physicians (including some pediatricians) have refused to accept Medicaid patients simply because the entire fee for the office visit is expended in clerical time to process the paper work. To add insult to injury, after processing (and reprocessing) the paper work, payment is not forthcoming. From a financial standpoint, we would be better off to see Medicaid patients for free and not bother to process any paper work.

If we do this, however, an ethical problem arises with the patients who have jobs (and thus are not eligible for Medicaid) but do not earn enough to pay for medical care. If we give free care to one part of the population, we are ethically bound to do that for others. With no end in sight, this is not a viable solution.

We have been impressed with the capability of Delta Dental as an intermediary for handling Medicaid payments for dentists. We would strongly recommend that pediatric care, including handicapped children, and early screening for Medicaid recipient patients be contracted through Delta Dental.

Our experience with third party payers who are out of state has been dismal. Close and frequent communication is mandatory to facilitate understanding between the provider of care and the third party payer. This is simply impossible when the offices are out of state.

The carriers very effectively can set aside or delay payment, knowing there is no effective way we can communicate with them. As a result, our clerical costs are quite high and the costs to the system (because they do not understand what is going on in our offices, or any of Alaska for that matter) are quite high. It may seem on the surface that an outside carrier would be cheaper, but this is only in the short run. A close working relationship with open communications will greatly reduce costs, in the long run. Delta Dental has proven itself to be effective, and even if they have higher costs than an outside carrier, we firmly believe that the cost to the system will be much lower with Delta Dental carrying Medicaid for pediatrics.

Enclosed is a letter which gives you background information. It was originally presented for our discussions with Mr. Leonard Schaeffer of HEW.

Dr. James Nesbitt and I are willing and prepared to help you understand what is going on with the Mecicaid program as it presently exists and would like to work with you in developing new solutions so that needy children in our state can receive proper care and physicians can be reimbursed for the care they provide.

Sincerely yours,

C B Lillibridge MD

Clinton B. Lillibridge, M.D.
Alternate Chairman
Alaska Chapter
American Academy of Pediatrics

CL:sh

Enclosure

It's a shame that in a state as rich as ours, a lot of children receive poor medical care, simply because the State Does NOT PAY ITS Bills !

CL

THE FOLLOWING DOCUMENT(S) MAY NOT FILM LEGIBLY BECAUSE OF POOR QUALITY OF THE ORIGINAL.

REPORT ON

REGION X REVIEW OF MEDICAID OPERATIONS

DEPARTMENT OF HEALTH AND SOCIAL SERVICES

STATE OF ALASKA

Prepared by

MEDICAID MANAGEMENT BUREAU

HEALTHCARE FINANCING ADMINISTRATION

REGION X - SEATTLE

MARCH 1979

THE PRECEDING DOCUMENT(S) MAY NOT FILM LEGIBLY BECAUSE OF POOR QUALITY OF THE ORIGINAL.

Attachment E

CHAPTER I

EXECUTIVE SUMMARY

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I. EXECUTIVE SUMMARY

Introduction

This is a report of a review of Alaska's Medicaid program conducted during the week of January 15-20, 1979 by members of the Region X Medicaid Bureau staff. This review was conducted at the request of the Division of Public Assistance.

Chapters II through VII present the major findings, conclusions, and recommendations of the review. These are summarized in the next pages. Detailed reports from the members of the review team follow Chapter VII.

Summary of Findings, Conclusions, and Recommendations

Any review of this type tends to focus on weaknesses of present operations. At the same time, it must be recognized that, despite very considerable difficulties of staff turnover, budget limitations, and the problems of travel and communication within Alaska, the State's staff have made valiant efforts to keep the program functioning and to be responsive to recipients and providers.

There is no doubt, however, that Alaska'a Medicaid program has very serious problems. Staff turnover, staff shortages, and the need to deal with day-to-day crises have combined to place the program in a situation in which there are few controls over costs and the program is seriously vulnerable to fraud or human error.

The major changes recommended in the next six chapters cover:

- reorganization of the Division of Public Assistance to establish a clearly defined Medical Assistance Unit
- addition of staff in eligibility determination, medical policy, third-party liability areas, claims processing (unless fiscal agent employed), Medicaid quality control, and medical surveillance unit
- more emphasis on training efforts

- contracting for development of manuals and procedures
- improvements in accounting controls
- enhancement of the TPL collection function
- improvements in the maintenance of the claims history file
- improvements in control over provider enrollment
- establishment of a provider training program
- development of closer relationships with the provider community
- development of eligibility determination procedures and associated training
- improvements in gathering eligibility data, including a new Basic Eligibility Form
- implementation of a reasonable cost-related reimbursement system, incorporating a 90 percent minimum occupancy level
- re-establishment of admission review for API cases
- renegotiating the memorandum of understanding with APRO and developing an associated monitoring system
- increased emphasis on alternatives to institutional long-term care
- contracting for development of a new provider manual and claims processing procedures
- development of, or contracting for, a new claims processing system (preferably through use of a fiscal agent or facilities manager who would also operate the system)

Implementation Plan

Three of the recommendations potentially involve the use of contractors. Given the seriousness of the Alaska Medicaid program's problems, this is

an appropriate approach, since it provides some assurance that changes can be accomplished at a known cost, without dependence on the very limited -- and desperately busy -- existing staff of the Division of Public Assistance. The recommendations are for use of outside organizations to:

- develop manuals and procedures for providers, claim examiners, eligibility workers, etc.
- develop training materials
- develop a new claims processing system (preferably through use of a fiscal agent or facilities manager, who would also operate the system)

Contracting for the first should be done immediately. Contracting for the second should be done as soon as the manuals and procedures are developed. The feasibility of using a fiscal agent should be investigated immediately.

All the recommendations are urgent. Those involving adding staff should be examined immediately so that personnel can, if funds are available, be hired. Responsibilities for implementation of each recommendation should be assigned as rapidly as possible and detailed schedules and cost estimates developed.

II. ADMINISTRATION AND MANAGEMENT

Overview

This chapter discusses the administration and management of Alaska's Medicaid program in terms of organization, staffing, hiring, training, and operational procedures. The next five sections of this chapter present findings, conclusions, and recommendations for these five areas.

Organization

Alaska's Medicaid program is administered by the Department of Health and Social Services through the Public Assistance Division, which is designated as the State's Medical Assistance Unit. Other components of the Department with significant involvement in Medicaid administration are the Office of Information Systems, the Office of Internal Review, the Division of Public Health, the Division of Mental Health and Developmental Disabilities, and the Division of Administrative Services.

Major Findings and Conclusions

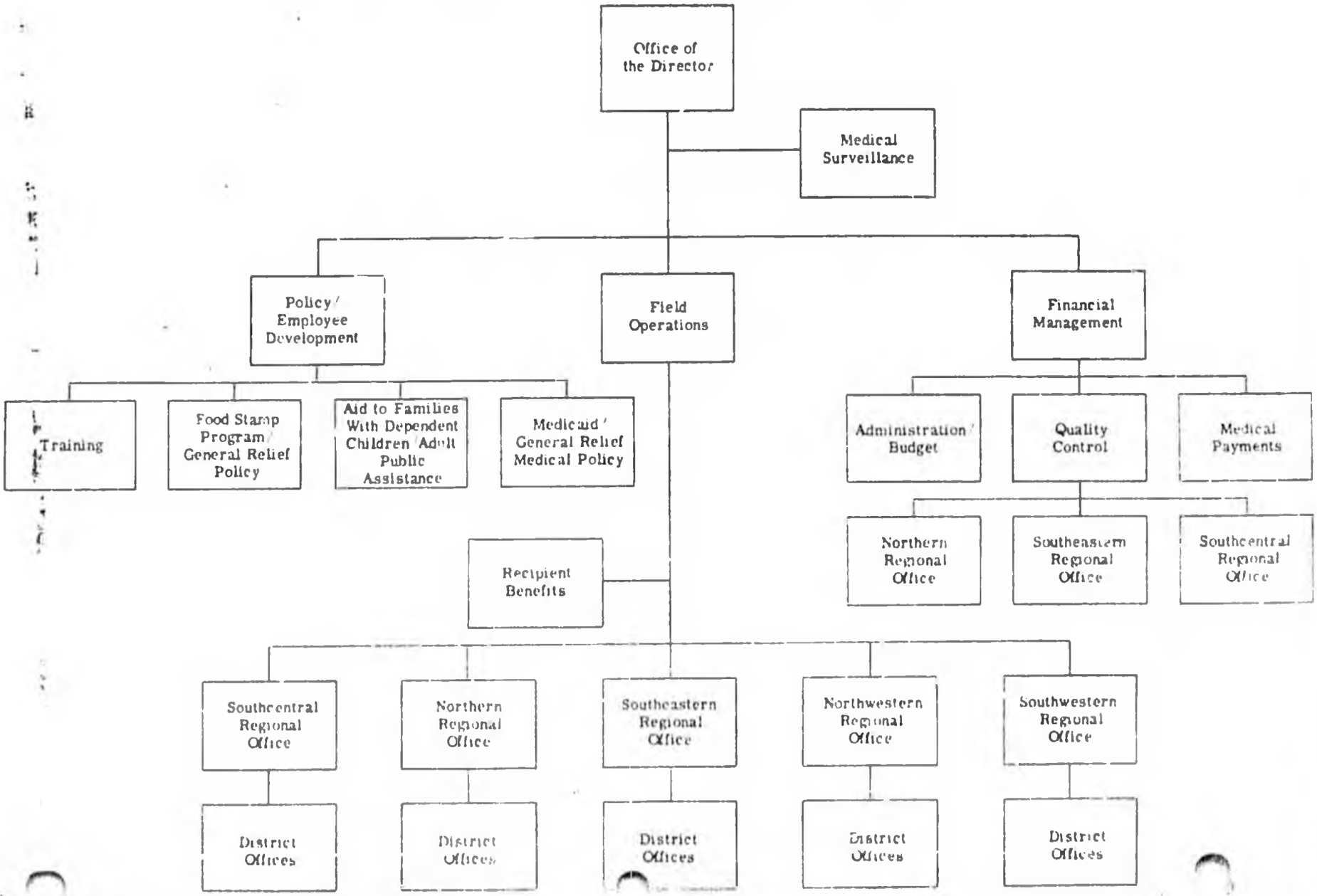
While the Department's organization structure is comparable to that of other states, the Division of Public Assistance's organization is significantly different and appears to result in a number of problems:

- The definition of the Public Assistance Division as the State's Medical Assistance Unit appears not to comply with the relevant Federal regulations (45 CFR 205.101 (b) and (c) and Part 2-40 of the Medical Assistance Manual), since the Division and its Director are responsible for a variety of other programs in addition to Medicaid. Thus it is doubtful that the Division meets the requirement that a State Medical Assistance Unit "provide a central point of responsibility for professional and technical aspects of medical services and medically related programs of the agency". The present organization is shown in Exhibit 1.

EXHIBIT 1

DHSS - DIVISION OF PUBLIC ASSISTANCE

UNIT ORGANIZATION CHART - JANUARY 1979



- From an organizational point of view, the dispersing of Medicaid functions, including policy-making, through a division which also administers other important programs, leads to a lack of direction of the Medicaid program. There is no part of the Division of Public Assistance whose sole responsibility is Medicaid policy. In practice, Medicaid policy decisions are made by the Medical Surveillance Section, the Medicaid/General Relief Medical Policy Section, and the Medical Payments Section. Each section performs a variety of other functions as well as Medicaid policy-making. Medicaid functions must compete with the AFDC, Adult Payment, Catastrophic Illness, and Food Stamp programs for the time and attention of the Division Director as well as for other Division resources. Directing and coordinating the varied elements of the Medicaid program is extremely difficult in this organizational arrangement.

- Responsibility for Medicaid claims processing is split between the Division of Public Assistance and the Division of Administrative Services. This leads to difficulties in controlling service utilization and in developing accurate financial and statistical data for the program. (This problem is discussed further in Chapter VII, Claims Processing.)

Recommendations

- Restructure the organization of the Division of Public Assistance to establish a clearly identifiable Medical Assistance Unit with responsibility only for Medicaid administration. The Medical Assistance Unit should be established either as a separate division or, preferably, as a major subdivision of Public Assistance co-equal with Field Operations and Financial Management. The Medical Assistance Unit should include the following present groups:

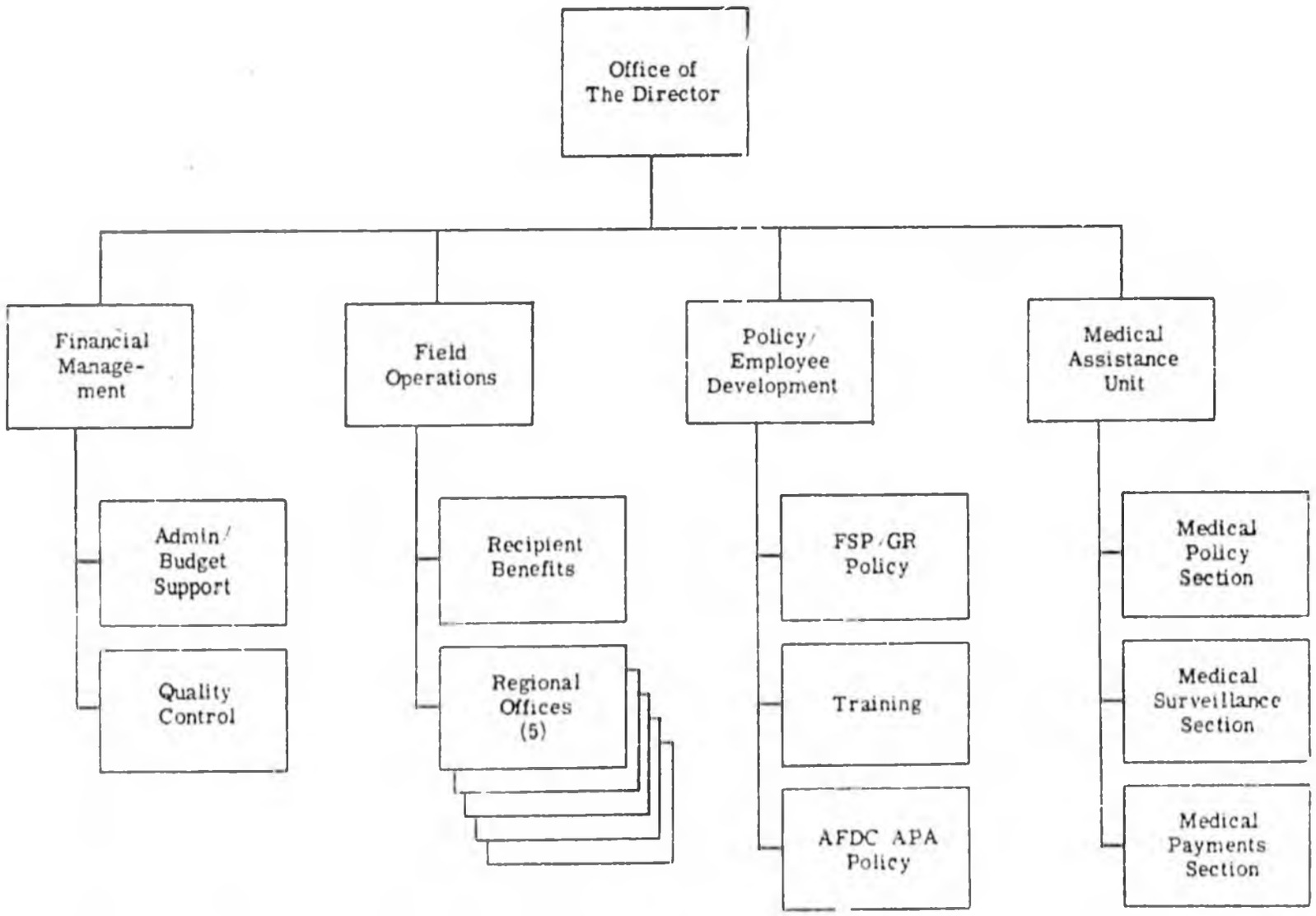
  Medicaid/General Relief Medical Policy Section
  Medical Surveillance Section
  Medical Payments Section
  Medical Assistance Administrator (Anchorage Regional Office)

The proposed organization structure is shown in Exhibit 2.

EXHIBIT 2

DIVISION OF PUBLIC ASSISTANCE

PROPOSED ORGANIZATION STRUCTURE FOR MEDICAL ASSISTANCE UNIT



- Provide clear definitions of policy-making and other responsibilities within the revised structure. Policy-making functions should be located in one section, not dispersed through the Medical Assistance Unit.

- Contain all Medicaid claims processing functions in one unit.

Staffing

Any examination of staffing in DHSS must take into consideration two factors: first, the State of Alaska is in a period of considerable budgetary constraint; second, most State agencies and many private sector businesses in Alaska experience problems of high staff turnover.

At the time of the review (January 6, 1979), the authorized versus actual staffing of the Division of Public Assistance was as follows:

Authorized	Actual
163 full-time	133 full-time
(plus 11 part-time)	(plus 8 part-time and 15 temporary)

It should be noted, however, that the 163 authorized positions are not fully funded; that is, some vacancies are assumed.

Major Findings and Conclusions

The effectiveness of Alaska's Medicaid program is currently hampered by insufficient staffing in some key areas and by high levels of staff turnover.

- DPA management anticipates a considerable staff shortage in the eligibility determination area in FY

1980, due to expected increases in numbers of eligibles without a corresponding staff increase. The staffing formula used by DPA indicates a need for an additional ten FTE personnel for eligibility determination.

- The Medicaid/GR Medical Policy Section is severely understaffed. At present, a program officer and an administrative assistant are responsible for developing Medicaid policy, GR Medical policy, and catastrophic illness program policy, provider enrollment, fair hearings, writing the Alaska Medicaid program regulations, drafting a Medicaid eligibility manual, consulting to field offices, and other ad hoc administrative activities.

- Only one person is currently assigned to third-party liability collection. Since Alaska's experience to date (borne out by that of other states) is that this is a highly cost-effective activity, there is a need for increased staffing to provide additional recoupment from third parties.

- High levels of staff turnover have undoubtedly contributed to problems in Medicaid administration. An analysis of two BRUs within DPA showed turnover rates of 44 percent within each during FY 1978. This is assumed to have resulted in too low experience levels in too many positions within the Division.

Recommendations

- Examine ways of increasing the eligibility determination staff for FY 1980. Possible approaches include:

  a supplemental request to the Governor's Office for ten eligibility positions

  use of CETA positions in District and Regional offices to carry out eligibility and/or clerical duties

  use of temporary hires in the District and Regional offices (the least desirable approach)

- Examine ways of increasing effectiveness of the eligibility determination staff. Possible approaches include:

  enhancement of automated systems for eligibility determination

  provision of additional training (discussed in a later section)

  provision of improved procedure manuals (discussed in a later section)

- Add one professional and one clerical position to the Medicaid/GR Medical Policy Section. It may be possible to add the professional position through reassignment of a vacant position elsewhere in the Division. One function of the new positions should be maintenance of manuals and procedures.

- Reassign the position of Medical Assistance Administrator from the Anchorage Regional Office to the Medicaid/GR Medical Policy Section in Juneau, since, although the Anchorage position is currently needed, implementation of other recommendations will allow its elimination.

- Add up to three additional positions to the third-party liability collection function in order to increase third-party reimbursement of Medicaid payments. Additional staff may be required to maximize these reimbursements.

- Examine ways of reducing staff turnover, including:

  acceleration of the Department of Administration's planned classification review of eligibility positions to the earliest possible date in 1979

  provision of improved training throughout DPA (discussed in a later section)

  provision of improved procedure manuals so that tasks are easier to perform and job pressures are somewhat eased (discussed in a later section)

Hiring

Hiring for new or vacant positions presents some unique problems in Alaska State government. The practical difficulties of attracting out-of-state personnel, combined with a policy of preference for State residents, and a limited State population, considerably constrains the available pool of persons qualified for open positions. It is important, then, that Division of Public Assistance hiring problems be examined in the light of these constraints.

Major Findings and Conclusions

At least in part for the reasons noted above, DPA has and is experiencing hiring problems.

- There have been some delays in filling positions, particularly in view of the high turnover rate. Currently the average time to fill an existing position is one month, and for new positions is up to six months.

- There has been a tendency to promote staff with minimal experience in their existing jobs, with new personnel hired only at low levels. While this has some positive aspects, it can lead both to "inbreeding" and to inadequately experienced supervisory staff.

Recommendations

There are obvious practical difficulties in solving DPA's hiring problems. The following recommendations, however, should alleviate the problems to some extent.

- Work with DHSS personnel staff and Department of Administration personnel staff to reduce the length of time to fill vacant positions.

- Aggressively utilize the "flexible" staffing authority for filling eligibility worker positions.

- For managerial positions, ensure the position requirements are sufficiently specific to allow recruiement of qualified employees.

Training

The preceding sections indicate weaknesses in staffing which might be, at least partly, alleviated by more extensive training. In fact, as discussed below, DPA's training efforts have been much reduced as a result of other pressures on the Division.

Major Findings and Conclusions

- The position of Training Specialist is currently filled only in name, since the incumbent is temporarily assigned to management of the Southeast Regional Office.
- Partly as a result of this temporary assignment, minimal training activities are currently being performed.
- As discussed earlier, the high level of staff turnover, combined with inadequate or nonexistent manuals and procedures, makes the need for training very urgent.

Recommendations

- Fill the Training Specialist position on a full-time basis.
- Contract for development of Medicaid training courses for Division staff.

Operational Procedures

The Medicaid Program is one of considerable complexity, and its proper administration depends on the availability of current, accurate, and understandable manuals and procedures for use by State and provider personnel. These manuals and procedures should meet the needs of providers, claims examiners, policy-makers, and management.

Major Findings and Conclusions

Development and maintenance of Medicaid manuals and procedures has suffered due to staff shortages and the need to deal with more immediate critical problems. Specifically:

- Medicaid regulations have been drafted but have not yet been adopted. Implementation is anticipated in May 1979.
- The Provider Manual is not current. The version available to providers was developed in 1974.
- There is no current eligibility worker manual for Medicaid.
- There are no procedures for use by claims examiners.
- There is no medical policy or staff operational manual for use by DPA management and staff.

Recommendations

- Complete the current review process and hearing on draft program regulations and implement by March 1979.
- Contract with a consulting firm to develop:

  provider manual(s)
  claims examiner desk procedures
  medical policy manual
  Medicaid eligibility manual

  At least the provider manual(s), claims examiner desk procedures, and medical policy manual should be completed by July 1, 1979.
- Establish a position in the Medicaid/GR Medical Policy Section to be responsible for maintenance of manuals and procedures (recommended also under Staffing).

Summary

The major changes recommended in the preceding sections cover:

- reorganization to establish a clearly defined Medical Assistance Unit
- addition of staff in eligibility determination, medical policy, and third-party liability areas
- more emphasis on training efforts
- contracting for development of manuals and procedures

In terms of costs, the reorganization should have minimal impact, the staff additions and training efforts (except for TPL) will increase costs in the short run but should contribute toward a more effective and better controlled program, and the development of manuals and procedures should pay for itself in reducing claims payment errors.

III. FINANCE AND ACCOUNTING

Overview

This chapter discusses the accounting systems and controls relevant to the Medicaid program, the third-party liability collection function, contracts management and financial reporting.

Accounting Systems and Controls

Accounting systems and controls for the Medicaid program are the responsibility of three groups within the Department of Health and Social Services: Financial Management Section (Division of Public Assistance), Finance Operations (Division of Administrative Services), and Office of Information Systems. Certain functions are also performed by the Department of Administration, which provides computer services and operates the Statewide accounting system (PBA).

Major Findings and Conclusions

Possibly in part because of the ongoing staffing problems, and more urgent situations such as claims backlogs, there are a number of weaknesses in accounting for the Medicaid program.

- There is a lack of control over Medicaid claims documents and over the entire claims payment process (discussed in more detail under Claims Processing).

- Specific weaknesses include: payment vouchers can be completed and certified by the same individual, provider enrollment can be completed without certification by an independent person, there is no system for verifying that recipients actually receive the services billed, remittance advices do not necessarily match warrants, batch integrity is not maintained over claims in data entry, and the PBA file does not match claims history file.

- While most Medicaid invoices are processed by the Division of Public Assistance, certain invoices (State institutions, other State agencies, certain non-medical claims) are processed by the Division of Administrative Services. The systems of controls, document storage, and invoice-to-warrant reconciliation processes used by the two divisions are all dissimilar. More important, the invoices paid by Administrative Services do not become part of the claims history file and are not checked for overlapping or duplicated services against the invoices processed by DPA. This fragmentation of processing makes projecting Medicaid costs extremely difficult.

Recommendations

- Provide organized secure storage for all accounting documents (medical coupons, invoices, vouchers, etc.).
- Eliminate the practice of persons certifying vouchers they have prepared.
- Implement a batch control system to provide complete batch integrity.
- Implement a system to provide reconciliation of warrants versus invoices.
- Contain payment of all Medicaid claims within one unit.
- Post all claims payments to the claims history file (discussed also under Claims Processing).
- Request a full-scope audit by the Office of Internal Review of the Title XIX program with specific emphasis on internal controls.

Third-Party Liability Collection

Third-party liability collection efforts provide an opportunity to achieve significant reductions in Medicaid program costs by collecting from (or

redirecting claims to) other medical insurers or a liable party in an accident case.

Major Findings and Conclusions

Alaska's TPL Collection function has only recently been established and is only beginning development. Limitations of the function include:

- Eligibility workers may not obtain details of other coverage from a newly eligible person.
- Only some claims are examined (manually) for possible third-party liability.
- Neither the eligibility nor claims processing computer systems are used in TPL detection.
- Insufficient staff are available to handle the potential volume of TPL collections.

Despite these limitations, over $30,000 has been recovered by the one person currently assigned in the short time this function has been in existence.

Recommendations

- Provide training to eligibility workers to enable them to obtain details of any other coverage.
- Add edits to claims processing computer system to identify potential TPL cases.
- Increase TPL collection staff to two professional and one clerical.

(The experience to date suggests that further cost-benefit analysis may justify a greater increase than this.)

Contracts Management

The contracts management function covers contracts with fiscal agents, consultants, and other contractors. The function is the responsibility of the Division of Public Assistance, although routine processing is performed by the Department of Administrative Services.

Major Findings and Conclusions

Comprehensive written policies regarding contracts management have recently been developed by the State. These policies are generally satisfactory. A few minor weaknesses are noted in the corresponding Detailed Review Report.

Financial and Statistical Reporting

Three groups of financial reports are prepared by the State which have relevance to the Medicaid program: monthly and annual reports of disbursements (generated by the Department of Administration's PBA System), internal State reports (prepared by DHSS), and Federal reports (prepared by DHSS). Only the Federal reports were reviewed in detail during the review, so the following findings and conclusions are limited to Federal reporting.

Major Findings and Conclusions

- Financial reports are out of phase with statistical reports.
- Expenditures by eligibility category are incorrectly reported.
- Expenditure projection reports are incomplete and inaccurate.

Recommendations

- Adopt written procedures covering preparation of Federal reports.

- Consolidate all claims processing in the Division of Public Assistance, to eliminate multiple sources of financial and statistical data (discussed elsewhere).

- Modify the claims processing system to provide a claims history file which reflects warrants issued, not merely claims adjudicated (recommended also under Claims Processing).

Summary

The major changes recommended cover:

- improvements in accounting controls

- enhancement of the TPL collection function

- improvements in the maintenance of the claims history file

Each of these changes involves increased expenditures. Each is important. The accounting control improvements are essential to avoid fraud and protect the integrity of the program. The additional staffing of the TPL collection function should more than pay for itself, based on other states' experience. The changes to claims history file maintenance are essential to provide proper controls and reporting.

IV. PROVIDER RELATIONS

Overview

This chapter discusses provider enrollment, provider education and training, and other provider relations activities.

Provider Enrollment

New providers are enrolled in the Medicaid program by the completion by provider, and the signing by the State, of a provider application and agreement, in accordance with 42 CFR 431.107.

Major Findings and Conclusions

The provider enrollment process is generally straightforward and effective except that:

- Under some conditions a fictitious provider could be enrolled.
- Out-of-State providers are not enrolled, nor is there any verification of the validity of their participation.
- Three different provider application/agreement forms are used: for mental health clinics, for audio/speech therapists, and for all other providers. These forms do not reflect all current Federal regulation citations.

Recommendations

- Direct the Department of Administration's Pre-Audit Unit to reject provider updates without an appropriate countersignature. (This is generally done now, but has not been formally or consistently applied.)
- Establish a verification process for out-of-State providers, including obtaining of state license number and social security or employer ID number.

- Consolidate the three provider application forms into a single common form, and update the references to Federal regulations.

Provider Education and Training

An ongoing program of provider education and training is important to the Medicaid program to ensure new (and existing) providers understand the requirements and constraints of the program and to help maintain good provider relations.

Major Findings and Conclusions

Alaska's Medicaid provider education and training is extremely limited:

- In the six months prior to the review only two training sessions, each for specific providers, were given.

- Responsibility for provider training is not clearly assigned to any one group.

Recommendations

- Establish an ongoing provider training program with more frequent provider workshops throughout the State.

- Assign responsibility for provider training to a specific unit in the Division of Public Assistance.

Other Provider Relations Activities

Other provider relations activities include attendance at professional society meetings, publication of newsletters, etc.

Major Findings and Conclusions

- Because of limited staff availability and the pressures of more immediate and urgent problems, few other provider relations activities have been performed.

Recommendation

- Develop closer relationships with the provider community, through participation in professional meetings, etc.

Summary

The major changes recommended cover:

- improvements in control over provider enrollment
- establishment of a provider training program
- development of closer relationships with the provider community

The cost increase associated with these changes is probably equivalent to the addition of one person. The result should be improved controls against fraud and a provider community with a better understanding of the program and its constraints.

V. ELIGIBILITY

Overview

This chapter discusses eligibility organization, eligibility policy, and eligibility procedures.

Eligibility Organization

The Medicaid eligibility organization consists of eligibility workers in district and regional offices, a central Recipient Benefits section, and a network of fee agents in the villages.

Major Findings and Conclusions

Alaska's eligibility program has some unique aspects. The fee agent network covers some 90 percent of the villages and provides an efficient mechanism for identifying potential eligibles and assisting in the application process.

In common with other parts of the Division, the eligibility organization suffers from the problems of high turnover and lack of training, identified in Chapter II. Since these problems are covered there, further details and recommendations are not presented here.

Eligibility Policy

Clear and correct understanding of Medicaid eligibility policy is essential to Medicaid cost control, to compliance with Federal regulations, and to ensure that potential Medicaid eligibles receive appropriate benefits.

Major Findings and Conclusions

For reasons similar to those for other problems -- lack of staff, high turnover, more urgent problems -- a number of weaknesses exist in the area of eligibility policy.

- Current Medicaid eligibility determination forms and manuals do not exist.

- Determination of eligibility appears to be based almost entirely on AFDC, SSI, and Adult Supplement eligibility, although Federal law and regulations provides many eligibility provisions peculiar to the Medicaid program. Thus, for persons not receiving cash grants, eligibility may be determined incorrectly.

- Particular misunderstandings of eligibility policy appear to exist for Alaska Psychiatric Institute cases, for which no Medicaid agency review of a need for admission (as required by 42 CFR 456.171) was occurring.

Recommendations

- Assign one person the responsibility of developing Medicaid eligibility policy. This is at least a half-time job on a continuing basis because of the frequent changes in Federal policy. This function could be combined with responsibility for training staff in Medicaid eligibility policy.

- Develop (or contract for) a Medicaid eligibility manual reflecting current State and Federal laws and regulations (also discussed in Chapter II).

- Develop a training plan for Medicaid eligibility training to be given to each eligibility worker within the first six months of employment, and for refresher courses.

Eligibility Procedures

Eligibility procedures must be adequate to ensure that eligibility is rapidly and accurately determined and the information correctly incorporated in appropriate files.

Major Findings and Conclusions

- The Basic Action Form used to convey information from the field to the State Office is in need of updating. Combined with the absence of up-to-date written procedures, the form is liable to be incorrectly completed.

- The Office of Information Systems, which has responsibility for the data processing system used for maintaining and reporting eligibility, has little documentation for the system and no one designated as responsible for its maintenance.

- For Alaska Psychiatric Institute cases, a form other than the Statement of Income and Resources normally used for AFDC eligibility was being used for gathering information. So little financial information is gathered via this other form that the eligibility of many children in API must be considered suspect.

Recommendations

- Update the Basic Eligibility Form and develop adequate instructions for using the new form.

- Designate an individual within the Office of Information Systems to be responsible for the eligibility system. Improve the quality of documentation of the system.

- Use the form used to gather eligibility data from AFDC recipients to gather data for children at API, or use some other form with adequate questions regarding financial status.

- Update the written instructions for determining the eligibility of children at API.

Summary

The major changes recommended cover:

- development of eligibility determination procedures and associated training
- improvements in gathering eligibility data, including a new Basic Action Form

The costs are a one-time cost for new procedures (already noted in Chapter II) and the addition of one staff person to have ongoing responsibility for maintenance of eligibility policy and related training. Savings should result from more accurate eligibility determination.

VI. UTILIZATION CONTROL AND RATE SETTING

Overview

This chapter discusses details of Alaska's rate-setting processes for long-term care, monitoring of appropriateness of care, utilization control, and the development of alternatives to long-term care.

Rate Setting for Long-Term Care

Long-term care costs represent the largest single component of Alaska's Medicaid costs. The generally high costs of labor, goods, and services in Alaska and the desirability of availability of long-term care in major communities present some constraints to cost reductions; nevertheless, any reductions which can be achieved will have a significant impact on overall program costs.

Major Findings and Conclusions

Long-term care costs in Alaska are very high, ranging from $40 to $170 per day with a weighted average daily rate of $75-80 per day. The following appear to be the major non-economic causes of the high rates.

- Responsibilities for interim rate setting are not clearly defined. This has led to at least one situation in which interim reimbursement rates were approved which included unallowable costs.
- There has been no systematic approach to rate setting, nor do any detailed procedures currently exist. Interim rates, in particular, have been approved as requested.
- Field audits have not always been performed. Settlement activity has been inadequate and has generally been a "rubber stamping" of reported costs.
- Current occupancy levels in SNF/ICF facilities average 70 percent. No occupancy minimums are included in the State reimbursement process.

Recommendations

- Define interim rate setting responsibilities clearly and provide adequate staffing.

- Implement a reasonable cost-related reimbursement system, incorporating a 90 percent minimum occupancy level. Because of the extent of the disparity currently existing, it may be necessary to phase in this occupancy level requirement.

- Expand the Medicaid Audit Section to ensure that, at least for the next three years, field audits of all facilities are performed annually.

Appropriateness of Care

From the viewpoints both of the Medicaid recipients and the State and Federal governments, it is important to ensure that recipients receive appropriate levels of care.

Major Findings and Conclusions

The State is currently in the process of developing Medicaid regulations which would include enforceable policies regarding levels of care determination and the placement of patients in long-term care. Accordingly, at least some of the following problems may be expected to be resolved with implementation of the new regulations.

- Generally, the approval process for admission to nursing homes works well and appears to be effective in ensuring appropriate care. However, there is currently no admission review for eligibles entering Alaska Psychiatric Institute. This is the responsibility of the Division of Mental Health and Developmental Disabilities but has not been done following the resignation of the psychiatrist assigned to the function.

- Monitoring of continued stays involves both periodic monitoring of patients' long-term stays and an annual review by the Medicaid Surveillance Unit of all patient

records in long-term care facilities. Both functions appear to be generally effective, except that patients have not been sent "adequate notice" of changes in their level of care as specified in 45 CFR 205. 10(a)(4)(14).

Recommendations

- Re-establish admission reviews for API, either by having the Medicaid Surveillance Unit reassume responsibility or by development of a clear memorandum of understanding with the Division of Mental Health and Developmental Disabilities. If the latter is chosen, some form of periodic monitoring by the Medicaid Surveillance Unit should occur.

- Ensure that adequate notice is sent to Medicaid recipients whenever a change is made in their level of care.

Utilization Control

Utilization control for Medicaid patients in acute care hospitals in Alaska is delegated to the Alaska Professional Review Organization (APRO). Utilization control for patients in long-term care facilities is the responsibility of the Medical Surveillance Unit and is covered in part in the preceding section.

Major Findings and Conclusions

Utilization control activities are performed for both hospital and nursing home patients. Weaknesses are listed in the following paragraphs:

- There is some indication that APRO's review procedures are inadequate and tend to "rubber stamp" hospital physicians' decisions. A current proposal by APRO to move to "sample review" could intensify the problem.

- The Division of Public Assistance has no mechanism for monitoring the APRO review process.

- The State is not performing the review of a sample of hospital claims agreed to in the memorandum of understanding with APRO.

- Long-term care utilization control is partly covered under the previous section on appropriateness of care. Utilization control efforts in nursing homes appear to be very much limited by staffing availiability and the absence of procedures.

Recommendations

- Renegotiate the current memorandum of understanding with APRO, to specify relative responsibilities, assurances that APRO will carry out a full review, and the monitoring system to be used by the State in reviewing APRO activities.

- Develop the monitoring system for reviewing APRO performance.

- Perform a review of a sample of hospital claims.

- Increase staffing in the Medical Surveillance Unit to enhance long-term care utilization control efforts.

Alternatives to Long-Term Care

The costs of long-term care in Alaska are such that, if alternatives can be developed, substantial savings could result.

Major Findings and Conclusions

The State has recognized the need to develop alternatives to long-term care and has recently established a committee to work on the issue. At present, however, the only possible alternative covered by the Medicaid program is home health agency services (available only in Anchorage). Use of these services appears to be discouraged by two factors:

- Many Medicaid recipients are Alaska natives, who have tended to use the Indian Health Services Hospital in Anchorage, which was until recently not subject to professional standards review and did not actively discourage long-term stays.

- There is an excess of ICF and SNF beds, which suggests there is a tendency to admit patients to long-term facilities although they could be served in their homes by an HHA.

Recommendations

- Continue to develop alternatives to long-term care, and critically examine any further plans to certify additional long-term care beds until plans are in place to offer a continuum of care which includes non-institutional placements.

Summary

The major changes recommended cover:

- implementation of a reasonable cost related reimbursement system, incorporating a 90 percent minimum occupancy level

- re-establishment of admission reviews for API cases

- renegotiating the memorandum of understanding with APRO, and developing an associated monitoring system

- increased staffing in the Medical Surveillance Unit

- increased emphasis on alternatives to institutional long-term care

Each change should have a significant impact on program costs. Only the fourth item involves an ongoing cost increase, of one staff member's salary. The other items will each take considerable short-term effort to achieve, however.

VII. CLAIMS PROCESSING

Overview

This chapter discusses the entire claims processing function, including plans for an improved data processing system and the use of AMOEBA.

Hospital, Physician, HHA, and Pharmacy Claims Processing Flow

Medicaid claims from hospitals and physicians (including crossover claims), home health agencies, and General Relief/Medical claims from pharmacies follow essentially the same overall claims flow:

- Claims are received in the DHSS mail room, normally with eligibility coupons attached, stamped with date of receipt, and passed to the claims receipt area in the Division of Public Assistance.

- Claims are checked for eligibility coupon. If coupon is attached, information will be transferred from coupon to claim. If there is no coupon, the on-line eligibility file is accessed to obtain eligibility data. If the recipient is not on file, the claim is returned to the provider.

- Claims are sorted by type of service and passed to a claims examiner for adjudication (they may be temporarily filed in the examiner's area).

- Adjudication is performed manually. Payment allowed is based on:

  lowest of actual charge, median charge, and Medicare reasonable charge (for physicians)

  percentage of charges (for hospitals)

  amount billed (for pharmacies)

- Claims are batched, "certified", and forwarded to data entry.

- Following data entry to diskette, the claims data is read into the Department of Administration computer system and processed through the Claims Processing System.

- The outputs from the Claims Processing System include remittance advices, an updated claims history file, punched cards for entry to the PBA accounting/warrant system, and various reports.

- Warrants are produced from the PBA system, matched with the remittance advices, and mailed to the providers.

Major Findings and Conclusions

There are significant problems with the present claims processing operations:

- No record is currently made of the number and type of claims received, making workload scheduling very difficult.

- The on-line eligibility file is for inquiry only and will not supply historical data on eligibility. If no coupon is attached, and the recipient is now eligible but was not at the time of service, the claim will be paid in error.

- Procedure coding is converted from 1969 RVS or 1974 RVS to 1964 RVS for comparison with Medicare profiles. The conversion and subsequent adjudication process is complex, time-consuming, and error-prone.

- There are no procedure manuals for claims processing.

- Where services are limited (e.g., x services per year), the manual system cannot determine when the limitation is met.

- Crossover claims are paid even when a Medicare EOB is not provided. This may result in overpayments.

- The experience level of the claims processing staff is low. The senior examiner has one year of experience, the other examiners only two to three months. (It is generally accepted that six months' experience is necessary for a claims examiner to become accurate and efficient).

- No validation of the reasonableness of pharmacy claims is made. (This finding applies to the GR/Medical program only.)

- Data entry is performed from the less legible carbon copies of the claims.

- Claims may be altered or removed from a batch during the data entry process.

- Data may be substituted in a field in data entry if the data is missing from the claim.

- The claims history file is updated before it is known that warrants can be or have been issued. Moreover, PBA cards created by the claims processing system may be altered prior to processing through PBA. Thus the claims history file does not reflect claims paid.

- The claims processing system does not provide an acceptable level of duplicate checking, does not verify coverage of procedures or services, and does not check for recipient eligibility.

Recommendations

Generally, the problems listed above have obvious solutions. Each problem must be eliminated if Alaska is to have a workable claims processing operation. The major changes which must be made are:

- Contract for development of adequate claims processing procedures (see also Chapter II).

- Contract for development of a new provider manual to reduce the errors created by providers.

- Develop, or contract for (preferably through use of a fiscal agent or facility manager), a new claims processing system incorporating automated claims pricing and adjudication.

- Update the claims history file with amount paid after the warrant is created by PBA.

- Examine the feasibility of turning over the entire claims processing function to a fiscal agent or facility manager. The feasibility would depend on:

  availability of interested qualified companies

  potential cost

  political acceptability

Claims Flow for Other Claims Types

Other types of Medicaid claims which do not follow the typical claims flow are nursing home claims, EPSDT screening claims, State institutional claims, transportation claims, other miscellaneous services claims, and out-of-State claims. The major exceptions to the claims flow described in the preceding section are noted in the following paragraphs:

- Nursing home claims are checked for prior authorization, a voucher prepared and forwarded via data entry to the PBA system, without editing, to create a warrant. Nursing home claims data is added to the claims history file at a later date, without processing through the full claims processing system.

- EPSDT screening claims are processed by the Nursing Section of the Division of Public Health. Except for screenings performed by a physician, no claim is submitted, only details of screening results. Screenings performed by Public Health nurses (95 percent of the total) are reimbursed on the basis of an annual time study. Nurse screenings are not added to the claims history file.

- Claims for miscellaneous services (e.g., wheelchairs, oxygen), some transportation claims (those not processed by the Division of Administrative Services), and out-of-State claims, generally follow the claims flow for hospital and physician claims.

Major Findings and Conclusions

The most important conclusion regarding processing of these other claims types is that the fragmentation of claims processing leads to inaccurate claims history and the possibility of incorrect payment.

Many of the problems identified for hospital and physician claims processing are valid for these other types also.

Recommendations

The same recommendations listed for hospital and physician claims flow apply to the other types of claims. In addition, the following recommendation made also in Chapter II is extremely relevant:

- Consolidate all claims processing in a single area.
- Ensure that all adjudicated claims update the claims history file.

Claims Data Processing System

The preceding sections have identified some problems with the present claims data processing system. The Office of Information Systems has developed plans for, and has programmed part of, a new claims processing system. The following findings and conclusions relate primarily to the possible new system, or to some alternative system.

Major Findings and Conclusions

- The new system which has been partially developed by OIS is based on the use of a schedule of maximum allowables which has been rejected by the provider community.
- The new system, as currently designed with a single fee schedule, is anticipated to be completed in December 1979, based on a development group of three analysts/programmers (two present staff plus one planned). However, the forthcoming conversion of the State's computers may delay this schedule.
- The present design for the new system, while offering substantially enhanced capabilities, does not provide for processing of all claims types.

- Whether or not the new system is implemented, there will be a substantial increase in computer processing costs for Medicaid as the Department of Administration installs a new larger computer and implements a charge-back system.

Recommendation

- The problems with the present claims processing system are so serious that development of a new system, whether that planned by OIS, or a system designed and developed by a contractor, must be a major priority.

Use of AMOEBA

The State has been considering for some time the use of AMOEBA, a set of computer programs designed to list questionable claims and identify symptoms of unusual utilization.

Major Findings and Conclusions

To date, one pilot run of AMOEBA has been made using the claims history file for a 30-month period. The experience leads to the following findings and conclusions:

- To use AMOEBA properly requires a significant amount of training and experience, particularly the latter. Without an understanding of the AMOEBA system, the output is likely to be so voluminous and misdirected as to be useless.

- Use of AMOEBA requires staff to be available to conduct detailed research of the claims listed by the system.

- AMOEBA should not be used by anyone not totally familiar with State Medicaid policy.

- If the preceding constraints can be overcome, AMOEBA can be extremely valuable.

Recommendation

- Use of AMOEBA should be delayed until plans for a new claims processing system are finalized. However, such plans should, at least tentatively, involve the use of AMOEBA once the new system is stabilized and provided adequate support staff can be provided.

Summary

The major changes recommended are:

- contracting for development of a new provider manual and claims processing procedures

- development of, or contracting for, a new claims processing system (preferably through use of a fiscal agent or facilities manager who would also operate the system)

Costs for new manuals and procedures are discussed in Chapter II.

Attachment F

DHSS MEDICAID TASK FORCE RECOMMENDATIONS

I. Authority: By memorandum dated May 4, 1979, Deputy Commissioner Catherine M. Lloyd appointed a task force specifically to develop recommendations to correct identified deficiencies in the Medicaid payments system. This task force was comprised of the following persons:

Rod Betit, Director, DPA
Tom Haas, Chief of Financial Management, DPA
Chris Dooley, Accountant IV, DPA
Lloyd Pukis, EDP Supervisor, Information Systems
Doug Goldbach, Finance Officer, Div. of Admin. Services
Ken Sather, Office of Interal Review.

II. Overview: The Medicaid payments system has been a constant source of problems for several years now. When originally installed the system was adequate to meet the billing demands of Medicaid/GR Med providers statewide. However, since 1972 billing demand has steadily grown to the point that the present manual system cannot keep current with billing activity. For purposes of the task force's review, "current" was defined as making payment in 30 days or less from the date of receipt of a billing. This 30 day timeframe is required by current federal regulations. At the time of review, processing timeframes were averaging 49 days and increasing.

Given this situation, the Division of Public Assistance requested and received a complete review of all Medicaid operations by representatives of the federal Medicaid agency in DHEW. This review generally disclosed no startling discoveries; but rather reinforced conclusions already reached by the Division with respect to what was wrong, and what was needed to correct the problem. The recommendations that follow come from careful consideration of the DHEW report, individual experiences from different agency representatives and consideration of the fact that additional manpower and funding were not made available by the Legislature to deal with the problem.

III. Task Force Recommendations

Recommendation #1

The Department should adopt regulations effecting a shift from the current profile pricing method to a schedule of maximum allowances. Adoption of a schedule is viewed the only viable means of reaching the target processing timeframe of 30 days. This recommendation is also most desirable for the following additional reasons; 1) timeliness of implementation will permit on-line operation by August 1 at the latest due to previous start-up work already completed, and 2) many of the deficiencies noted in the DHEW report would be corrected concurrent with installation of a schedule of maximum allowances. Other alternatives considered by the task force included:

- Contracting with a fiscal intermediary. This would provide no short-term relief to payment difficulties and could not be purchased without additional funds. With adequate funding committed, this would be a viable long term alternative.

- Contracting with Aetna Insurance, the current fiscal intermediary for Medicare claims processing. Discussions with Aetna data processing staff indicate that their system, although similar to what we desire for Medicaid claims processing, would not be readily convertable to the needs of a Medicaid processing system in terms of invoice handling, audits, and controls. Any potential for this alternative would require the expenditure of time and money for a long-range benefit. Again, no immediate benefits would be derived from this alternative.

- Automation of the current individual profile pricing system in-house. The work required of DHSS Information Systems to program such a system is estimated at approximately 12 man months. This would not bring immediate relief to the payment problem, nor would the final product be as maintenance free as a schedule of maximum allowances. Again, this could be a viable long term alternative.

- Adapting Aetna's claims processing system to Alaska's needs. The time involved in converting the programs and the expense of purchasing the software from Aetna would be prohibitive under our current budget constraints. Again, the needed expenditure of time and energy would prevent any short range benefits.

Recommendation #2

Although implementation of a schedule of maximum allowances would permit sending invoices directly to Data Processing's keypunch center, it is recommended that DPA maintain responsibility for batch control of all billing documents. This will leave the burden of batch accountability, provider relations and records retention with the Division of Public Assistance.

Recommendation #3

It is expected that the Department could potentially recover the time of two full time adjudicators with transition to a schedule of maximum allowances. It is recommended that one of these two positions be reclassified as a Third Party Liability Technician, and the other an Administrative Assistant II to provide support to the Medicaid Program Officer.

Recommendation #4

Until the current card-deck payment system can be replaced with a tape payment system, written procedures should be developed to place the card-deck system under tighter security controls. This may require a Memo of Agreement between DHSS and the Department of Administration.

Recommendation #5

That the Department renegotiate the Delta Dental contract for FY80 and not attempt to take this responsibility in-house until at least FY81, thereby permiting time to clean-up current operations once the schedule of maximum allowances is adopted.

Recommendation #6

That the Department locate funds to purchase development of new providers manuals and a staff manual for field workers on a contract basis. The present burden on DPA Medicaid staff is such that other critical projects will have to be deferred unless such a contract is arranged. Even then, a staff manual could not be produced prior to October 1, 1979.

Recommendation #7

That the Department should consolidate payment of all DHSS medical bills in the current DPA Medicaid Payments Section. Currently, medical payments are made throughout the Department with little or no system integration.

Recommendation #8

That the office of Information System should draw up an APD to request 90/10 match from DHEW to pay for completion of the new Medicaid DP system.

Recommendation #9

That installation of the new Medicaid system and any funds necessary to purchase hardware such as computer terminals receive top DHSS priority. This determination should be made immediately to permit purchase of needed equipment, and to isure DP staff concentration on installation of the new Medicaid system.

6/5/79
DATE

TASK FORCE MEMBERS

Rod Betit

Tom Haas

Christine Dooley

Lloyd Pukis

Doug Goldbach

Ken Sather

Attachment G

DELTA AND THE MEDICAID PROGRAM - Denise Knapp - director

I. History: Delta was organized in 1973, selected as fiscal intermediary for State Medicaid programs in 1973.

II. Participation: 96% of the dentists in the State are members of Delta, and 95% of these participating in the Medicaid program.

III. Significance to dentists for Delta in fiscal intermediary role.
- A. Prompt payment; bi-monthly.
- B. Payment on usual fee; not to exceed 75% percentile.
- C. Dental profession has a direct voice in program through Delta.
- D. Direct government intervention is avoided.

IV. Significance to State of Alaska for Delta in fiscal intermediary role.
- A. Professional dental services in providing review (pre- and post-operative) and quality assurance.
- B. Local processing, using Alaska employees who invest in Alaska to improve Alaska economy.
- C. Higher utilization by and satisfaction of patients through cooperation of the dental profession to allow free choice.
- D. Increased efficiency of processing and payment.
- E. Cost containment (verification made with dentists' fees on file) and utilization checks and balances.
- F. Provider agreements between Delta and the dentists.

V. Claims Cost Information:

	No. Claims	Total Amount	Av. Cost Per Claim	No. Eligibles
1975	1900	$250,600	$132	11,500
1978	7100	$887,000	$125	15,000

Attachment H

From: Report presented by Fredrick McKinnis at the Future Frontiers Conference.

ALASKA AND NATIONAL HEALTH INSURANCE

From time to time, as many as ten or twelve measures have been introduced simultaneously in the United States Congress proposing a variety of national health insurance programs. For a number of years, Alaska health leaders have been concerned with regard to the fragmentation of health delivery systems within Alaska as well as the escalating costs for all health services in the state. Delays have been encountered in active planning for an improved financing system for Alaska health programs because of the prospect of a national health insurance program being enacted by the federal Congress. Numerous discussions continue to go forward with regard to a national health insurance program for the entire United States. It now appears that the enactment of and implementation of such a plan are receding further and further into the future. Three of the more popular approaches to national health insurance have been those which have been introduced into the federal Congress by President Carter, Senator Edward Kennedy and Senator Russell Long. Appendix Number One at the end of this document outlines the "Three Approaches to National Health Insurance" as set forth by these national leaders. The topics covered in the table include coverage, benefits, administration, financing, cost, cost controls and timing for implementation of the respective plans.

There are several reasons why Alaska should consider developing, as rapidly as good planning will permit, a model health system for all the citizens of our state. With our extremely small population and with the numerous extensive health delivery plans in place already, it would seem that Alaska could adjust its present programs and add thereto in order to create a truly comprehensive and effective health system for Alaska. It will take bold, creative and extensive work to develop such a system.

Governor Jay S. Hammond, Lieutenant Governor Terry Miller, and the Commissioner of the Department of Health and Social Services, Helen D. Beirne, have expressed strong support for a revised and improved model health plan for Alaska. The Department of Health and Social Services leaders are taking certain initiatives at the present time in order to explore further the possibilities of changes within the present systems. In due course, numerous parties within the government and in the private sector will be invited to participate in the creation of a new health services financing system, as far as outlays of the state government are involved or will be involved in the future.

Recommendations:

1) It is recommended that the health planning organizations in the state, as well as the health agencies and providers in the state, embark on a joint program to make reasonable efforts at cost containment of health services. A detailed examination should be made for the reasons of the dramatic increases in hospital charges to patients and third-party payers, as well as the escalation in rates of physician fees, prescription drugs, and nursing home rates. Efforts at cost containment, while notable, have not been effective to any substantial degree. Ceilings proposed from time to time applied to specific parts of the health care system do not appear to be equitable, since all of the goods and services related to the delivery of health care have not been proposed for inclusion in the cost ceilings. One of the more urgent matters facing Alaskans, as well as the citizens of other states, is the rapid escalation of health service costs. Detailed attention should be given to any cost of a health service in the state of Alaska which begins to exceed approximately 60% over and above what the average for such cost would be elsewhere in the nation.

2) The Alaska Revenue Sharing Program provided by Alaska Statutes, as it relates to health services, hospitals, health facilities and construction aid, should be reviewed with the possibility of major revisions in order to create a more equitable revenue sharing basis as related to other municipal services. In some communities in Alaska where the local government is responsible for the operation of hospitals, the generous revenue sharing dollars flowing to those hospitals seem to be well justified. In some of the urban areas, in cases where hospital income dramatically is excessive over operational expenditures, an adjustment may be found to be in order. In those cases, the local government should have the freedom to utilize the revenue sharing dollars for those health services deemed to be the local government's priorities for expenditures.

3) A detailed study should be undertaken in Alaska of the 458,305 third-party coverages or non-fee for service coverages when projected on a population base of 411,211 in 1977. The cost benefit ratio of the double coverages should be examined in some length in some depth. At the same time, data seem to reveal that numerous Alaskans are not covered by any third-party coverage or non-fee for service program at all. Scientific research and detailed studies which may be undertaken with regard to the possibility of a model health system for the state could include the study recommended herein.

4) That a detailed review be made of the medicaid eligibles, medicaid coverages and medicaid expenditures in an effort to determine whether or not Alaska wishes to continue the escalation of covered groups, covered services and financial outlays experienced from 1973 to 1979. From a basic coverage of eight services in 1973, the coverage services have gone to 17 services. Minor changes in covered groups have been made by federal and state laws since 1973 and the initially covered groups have contributed substantially to the increase in financial outlays.

5) In the event studies are undertaken with regard to the covered services and the covered eligible groups under medicaid, consideration is recommended with regard to the cost effectiveness of implementing the "medically needy option" under the medicaid program. If Alaska is going to improve health financing assistance to the medically needy, if provided under the medicaid program, the federal government would match all expenditures on the basis of 50% federal and 50% state funds.

6) Regardless of what may develop in the near term with regard to other changes in medicaid, general relief medical coverage or under a model health system, immediate attention should be given to expanding coverage for catastrophic illnesses for Alaskans. This could be accomplished with an amendment to the present catastrophic statute, as well as additional appropriations for the catastrophic illness program.

The design of any amended catastrophic illness program should be undertaken in such a way as to fit in with the State's goal of a comprehensive revision of its health financing plans.

7) That immediate detail and urgent study be continued with regard to broadening the range of services to prevent premature institutionalization in long-term care facilities and more appropriate placements for some who may at present be institutionalized in nursing homes.

8) That the State of Alaska move ahead as rapidly as good planning will permit to develop a model health services financing program geared to the needs of Alaskans, whether or not such a revised program includes the federal medicaid program. In the event it is not possible for the State to carry out an extensive study and mature plans to revise its present financing programs for medical assistance, as a minimum it is recommended that the State consider dropping the medicaid program and rebuild a program with the State's current 50% of medicaid dollars furnished to the State, combined with the State's general relief medical funds, and thereby render services to the limit of funds available to a revised group of eligibles based on new priorities.

9) That the State consider a revised plan of reimbursement for physician services and hospitals in the early part of the 1980's, whether or not the medicaid program remains or is dropped. Strong emphasis should be placed then upon the free enterprise and competitive systems in order the market forces will be generally operable in the health care field as is demanded in all other fields of endeavor.

Attachment J

STATE OF ALASKA

Legislative Affairs Agency

OPTING

A Study of Medicaid Client Need

February 1977

O P T I N G

A Study of Medicaid Client Need

PREPARED BY

LEGISLATIVE AFFAIRS AGENCY
DIVISION OF RESEARCH

FEBRUARY, 1977

Foreword

In the fall of 1972, Alaska entered the national Medicaid program, providing certain of its citizens thereby a limited spectrum of medical care services.

Since this modest beginning, the legislature has increased Medicaid coverage by the addition of a few services above those which the state is required to cover in order to participate in the federal program. These optional services allowed the state to earn addition "matching" federal funds, some of which were a direct one-for-one offset to medical care expenditures that the state itself had been previously paying for in their entirety. Other program additions resulted in increased state expenditures, but provided a more complete medical coverage package.

In order to maximize the benefits from the additional expenditures, optional service additions must undergo careful scrutiny to insure that the options chosen return the greatest level of benefits in terms of meeting the health needs of the approximately seven percent of Alaska's population served by the Medicaid program. During 1976, a number of legislators indicated their desire to have better information upon which to base their decisions concerning the addition (or deletion) of various possible optional services. In order to meet this need, Miss Deborah Behr of the Research Division staff began, in June of 1976, an extensive effort directed at reviewing public assistance eligibility supervisors' perceptions of client requirements, analyzing written denials of additional client service requests, and obtaining information from various states regarding their experience with selected options. The present study is the result of this effort.

Gregg K. Erickson
Director of Research
Legislative Affairs Agency

Juneau, Alaska
February, 1977

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O P T I N G

A Study of Medicaid Client Need

PART I. OVERVIEW OF THE MEDICAID PROGRAM

INTRODUCTION TO THE PROGRAM

Medicaid is a program funded jointly by the federal and state governments which aids certain needy Alaskans in providing payments for them to receive medical services. It helps assure that medical services are available to those needy eligible persons when they are ill or injured. It also assists in guaranteeing that the highest quality care of the kind required by the patient's condition is available, by mandating certain medical reviews of patient care and treatment. Medicaid also attempts to make services available by utilizing the present system of private practitioners, facilities, and institutions to provide the care required at the lowest possible cost to the taxpayer.

STATE PLAN FOR MEDICAID

The Medicaid program in Alaska is administered by a single state agency, the Department of Health and Social Services, which is required to submit a state plan to the Secretary of the federal Department of Health, Education, and Welfare for his review and approval.

The state plan is essentially a contract between the state department and the federal Department of Health, Education, and Welfare specifying conditions to be met in order to qualify for federal financial participation. Some topics included in it are:

1. eligibility determination
2. recipient eligibility
3. eligibility verification
4. medical services
5. health care
6. quality control
7. fair hearings
8. methods of administration
9. utilization review
10. fraud

Many of these items are required be included in the plan (mandatory), but others the state may decide whether or not to include (optional). The optional portions allow the state to shape a medical assistance program to the needs and financial resources of its citizens.

DIFFERENCES BETWEEN MEDICAID AND MEDICARE

Medicaid is often confused with the Medicare program in the state. Medicaid is a medical assistance program for certain needy low-income people. In Alaska, Medicaid is administered by the Division of Public Assistance, an agency of the Alaska Department of Health and Social Services. It is authorized under Title XIX of the federal Social Security Act and AS 47.07.010-.080 of the Alaska statutes. States can design their own programs within set federal guidelines to meet the needs and resources of its citizens. Medicaid programs can and do vary from state to state.

In comparison, Medicare is a medical insurance program for those people, rich or poor, covered by Social Security. It is administered by the Social Security Administration of the federal government. The program is the same in all fifty states. Almost everyone over 65 and some younger persons who have been receiving Social Security disability payments for at least two years qualify for the program.

BRIEF HISTORY OF MEDICAID PROGRAM IN ALASKA

On July 6, 1972, Alaska became the 49th state to provide the Medicaid program for its residents. The state had, since the mid-60's, provided for such services under the General Relief - Medical program. Costs had risen from $1.8 million to $8.7 million in FY 72. This dramatic increase was due to many factors, the major ones being:

1. The number of eligibles had increased, but the rate of expenditure was increasing at even a faster pace.

2. The scope of the program had been liberalized and expanded with a related increase in utilization of services.

3. Medical care costs were rising at a rate disproportionate to that of other costs of living.

In light of this situation, the administration and the legislature came to basic conclusions that the General Relief - Medical program, which was supported 100% with state monies, had need of administrative controls to review services and, hopefully, reduce health care expenditures. There was a general consensus that either the General Relief - Medical program had to be upgraded or research should be done to investigate the possibility of the implementation of the Medicaid program. In April, 1972, the Department of Health and Social Services contracted with Touche Ross and Company, a public accounting firm, to develop a cost benefit study of the Medicaid program. Budgets were developed and testimony was made to the legislature that session. On June 17, 1972, the enabling bill for the Medicaid program passed the legislature and was later signed into law with an effective date of July 6, 1972. (The history of the program can be traced on Table 1: Medicaid History Timeline.)

TABLE 1

State of Alaska
Medicaid History Timeline

Date	Occurrence
April 10, 1972	Touche Ross & Company begin Medicaid System Design
April 18-June 9, 1972	Departmental Presentation to Legislature
May 10, 1972	Department of Health and Social Services' Steering Committee Established
June 17, 1972	Enabling Bill Passes Legislature
July 6, 1972	Medicaid Becomes Law
September 1, 1972	Medicaid Implemented
September 28, 1972	State Plan Submitted to Federal Department of Health, Education and Welfare
April 4, 1973	Effective date of Intermediate Nursing Home Care Option
May 16, 1974	Effective date of Inpatient Psychiatric Hospital Option for Eligible Persons 65 or Over and Under 22
May 16, 1974	Effective Date of Miscellaneous Minor Eligibility Groups (Primarily needy children under 21 in foster care under supervision by Department of Health and Social Services)
July 13, 1974	Effective date of 60 day limit on filing Medicaid claims
April 15, 1975	New Division of Public Assistance Formed
September 2, 1975	Effective date of Intermediate Nursing Home Care for Mentally Retarded Under 21 who Meet AFDC Need Standards Option
March 12, 1976	Effective date of Eye Glasses and Optometrist Service Options
June 21, 1976	Effective Date of New Nursing Home Group of Eligibles
July 1, 1976	Effective Date of Limited Clinic Services Option (Primarily Community Mental Health Centers and State Operated Mental Centers)
July 1, 1976	Effective date of Treatment of Speech, Hearing, and Language Disorders Option

The Department of Health and Social Services worked during the interim period to provide the necessary procedures and organization to make Medicaid an administrative reality in Alaska. A new Division of Medical Assistance in the Department of Health and Social Services was formed to administer the new program, as well as the remnants of the General Relief - Medical program. On September 1, 1972, the Medicaid program was actually implemented. (The Division continued to administer the program until April, 1975, when the new Division of Public Assistance was formed. This new division combined the eligibility determination, income maintenance, and medical assistance functions into one organizational grouping in the state.) Later that month, the official state plan was submitted to the federal Department of Health, Education and Welfare for its approval.

With the approval of the state plan, Alaska realized the benefits due to implementation of the Medicaid program:

1. Federal matching funds for medical expenditures became 50%, thereby allowing the continuation of the level of medical services without further increase in state general fund expenditure.

2. Federal match for categorical assistance programs under the Social Security Act increased from 30% to 50%.

3. Administrative controls, seen as necessary, were implemented to fulfill Medicaid requirements in order to receive federal financial participation.

When the legislature approved the Medicaid program, it included a restriction in statute mandating that all new services or eligibility group additions must receive its approval. At time of passage, the enabling legislation included those services and eligibility groups mandated by the federal government in order to receive federal financial participation. Since that time, the legislature has added few additional services or eligible groups.

The legislature added the first additional service option in 1973. At that time, intermediate nursing home care was selected. This option permitted the coverage of a lower and less expensive level of nursing home care. This addition allowed many Medicaid recipients in skilled nursing, who did not require that level of treatment, to be properly placed in intermediate nursing care thus "saving" state general fund dollars.

In 1974, the inpatient psychiatric hospital services option was added for eligible persons 65 years of age or over and 21 or under. This allowed the state to claim federal reimbursement for some persons at Alaska Psychiatric Institute, who were eligible for Medicaid coverage and were at that time receiving their care 100% from state monies. Also, other small groups of new eligibles were added at that time. Primarily they consisted of certain needy foster care children under 21 supervised by the Department of Health and Social Services. Prior to

that time these children had, in most cases, received coverage for their health care through the General Relief-Medical program. Also, legislation was passed requiring that medical assistance claims be submitted promptly, no later than six months after date of service or third party payment was received. This permitted more administrative control of expenditures and allowed for greater accuracy in budget projections.

The option to include a new group of needy eligibles under 21 who were in intermediate nursing homes for the mentally retarded became effective in 1975. This permitted a group of children at Harborview Memorial Hospital, Alaska Psychiatric Institute, and Hope Park to receive Medicaid coverage and, hence, additional federal dollars could be earned for their care.

In 1976 the legislature chose to add four new items to the program. A new group of needy persons became eligible for Medicaid coverage for their nursing home care due to an addition of an option. Also, that session, prescription eyeglasses and optometrist's services were added to the program. The legislature also approved the addition of limited clinic services which allowed state operated mental health centers and state approved community outpatient mental health centers receiving grants under A.S. 47.30.520 - 47.30.620 to be covered. This permitted federal funds to be earned in these state general fund supported projects. Also, at that time, the coverage of treatment of speech, hearing, and language disorders was added to the Medicaid program.

The legislature has shown interest in examining and evaluating the available Medicaid options, as seen by the recent history of the program in the state. Many of these options, especially in the case of coverage of nursing home care for certain needy eligible persons, actually "saved" state money. By adding them to the Medicaid program, federal funds could be realized for some of those services, which were being paid at that time 100% from state general funds. Also, by increasing the scope of the service package, a more consistent medical treatment program could be offered to these needy persons. For example, prior to the 1976 addition, eyeglasses were not generally available to all Medicaid eligibles who needed them. Only Medicaid eligible children who had been seen in early screening programs and referred for eyeglasses could be reasonably assured of coverage under the program for their lenses. Needy adults, such as those in nursing homes, had no such guarantee.

Alaska was one of the last states to join the Medicaid program and has been cautious in increasing the scope of the program in the state. In comparison with many other states in the program, Alaska's program is limited, with few service and eligibility group options beyond those basic services and groups required to maintain compliance with the program. This paper will later examine the current scope of the program and the options available under it that the legislature may be called upon to evaluate in 1977 and thereafter.

PART II. CURRENT STATUS OF MEDICAID PROGRAM IN ALASKA

ELIGIBILITY OF CLIENTS

The Alaska Medicaid program provides coverage for certain needy persons receiving or eligible to receive public assistance under:

Federal Supplemental Security Income (SSI),

Alaska Old Age Assistance (OAA),

Alaska Aid to the Blind (AB),

Alaska Aid to the Disabled for Persons who Meet Federal Criteria for Disability (AD), or

Aid to Families with Dependent Children (AFDC),

and certain others (mostly children)

Alaska does not cover the medically needy under its Medicaid program.

In general to be eligible for Medicaid in Alaska, an individual must:

(1) Be physically present in Alaska at time of application and citizen of U.S. or lawfully admitted alien;

(2) Not be in a public institution such as a jail (a person may however be in chronic disease facility such as a nursing home);

(3) Not have more than $1,500 in non-exempt personal property; this excludes a home (there is no lien requirement), personal belongings, in certain cases, a necessary automobile and some types of income producing property;.

(4) Not have transferred property to qualify for assistance;

(5) Meet program requirements such as blind, disabled, aged over 65, or dependent child

The Division of Public Assistance examines the financial and living situation to determine if a person is eligible. As a basic rule, if a family of four meets general program requirements, has monthly net income of no more than $400 earned (excluding reasonable work related expenses) and unearned income, the family would qualify for assistance under Aid to Families With Dependent Children program. There is no geographical differential on the total amounts allowed. The amounts vary for the adult programs (OAA, AB, AD) but generally, if household expenses (excluding fuel) are over $35 a month and the net income is no more than $334 a month of earned (excluding reasonable work-related expenses) and unearned income, a single person family would qualify if other program requirements are met. The $334 figure can vary annually

in accordance with cost of living adjustments required in AS 47.25.640; 47.25.430; 47.25.810. Eligibility for categorical assistance programs automatically makes one eligible for Medicaid.

SERVICES COVERED UNDER MEDICAID

The State of Alaska covers basically two types of services: mandatory, which the states are required to provide, and optional, wh.ch the state may provide and receive federal reimbursement. Alaska provides all mandatory services, but optional services are limited.

Mandatory Services

Alaska must provide the following services: 1) inpatient hospital services; 2) outpatient hospital services; 3) physician's services; 4) x-ray and laboratory services; 5) skilled nursing home services; 6) nome health services; 7) early and periodic screening, diagnosis, and treatment of children under 21; and 8) family planning services. Alaska also is required to cover transportation necessary to receive medical service, if unavailable from any other source, but it is not listed as a federal requirement.

Optional Services

In addition to the mandatory services, Alaska provides and receives federal reimbursement for the following services:

(1) Inpatient psychiatric hospital services for individuals age 65 or older or under age 22
(2) Intermediate care facility services
(3) Skilled nursing for those persons under 21 years of age
(4) Emergency hospital services
(5) Eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist
(6) Services for individuals with speech, hearing, and language disorders
(7) Services through state approved out-patient community mental health clinics which receive grants under AS 47.30.520-47.30.620 and state-operated mental health clinics
(8) Optometrist's services and limited dental and prosthetic devices as required under EPSDT regulations

Other services that the state could choose to provide for certain of its needy individuals, but which has not yet opted for, include:

(1) Prescribed drugs
(2) Dental Serv.ces (for persons over 21 not covered under the early screening program)
(3) Dentures
(4) Prosthetic devices (for persons over 21 not covered under the early screening program)

(5) Private duty nursing
(6) Physical therapy and related services
(7) Chiropractor's services and other practitioners
(8) Podiatrist's services
(9) Care for patients aged 65 or older in Institutions for Tuberculosis
(10) Other diagnostic services, screening, preventive services, rehabilitative services

Parts III through V of this report deal later with these optional services in more depth, examining the need and aspects to consider in the evaluation of these alternatives to the program.

FINANCIAL PARTICIPATION BY FEDERAL GOVERNMENT

The federal government financially participates in the Medicaid program by means of matching state dollars for allowable administrative and medical expenditures. Services to eligible clients receive 50% reimbursement, except for family planning supplies and services which are matched at 90% level. Administrative costs are generally matched at 50%. Professional medical review staff are reimbursed at 75% level. (Certain other administrative services receive special match rates, such as 100% for certification and survey of nursing homes. These special rates are itemized in federal law and regulation.)

At the present time there is no "ceiling" or set limit for Alaska on the amount of federal funds available for reimbursement. There has, in recent years, been much discussion on the federal level to restrict such reimbursement, as was indicated in President Ford's budget address in January, 1976. At that time, he mentioned the possibility of placing the Medicaid program in a block grant package with other federally assisted health care programs. By this method, a dollar limit would have been set on the available federal funds for those purposes. Generally, though, the prospects for major funding modifications in the Medicaid program appear slim, although tighter management and administrative mechanisms to control fraud and quality of services seems to be a continued interest.

NEW DEVELOPMENTS IN MEDICAID

In the fall of 1976 the federal government placed additional responsibilities on the Medicaid program, through the passage of Public Law 94-437. That bill, known as the Indian Health Care Improvement Act, mandated closer coordination of Medicaid and Indian health services and required that all services for Medicaid eligible Alaska Natives in Indian health facilities be billed to Medicaid. The federal government would then reimburse the state's Medicaid program at 100% for such services. Additional administrative functions would receive normal federal reimbursement rates. The services eligible for reimbursement under Public Law 94-437 are only those included in the approved Medicaid state plan and provided to Medicaid eligible Alaskan Natives.

Total ramifications of the bill are yet unknown. Federal officials report though that Alaska is far ahead of other affected states in implementing the new law. For example, seven of Alaska's nine Indian Health Service hospitals currently meet statutory requirements for participation in Medicaid without further action. State officials note though that unless there is a major shift in procedures for handling people covered under Indian Health Improvement Act, field office work will increase greatly (e.g., issuing medical coupons, arranging necessary transportation, answering client and provider questions). These state officials voiced concern that estimates of the number of new Alaska Native clients attracted to apply for Medicaid coverage are unknown. The attachment of a dollar figure to the cost of medical services for these persons would be just a rough estimation.

PART III. GENERAL INFORMATION REGARDING OPTIONAL SERVICES

CONTROLS THAT STATES MAY IMPOSE ON MEDICAID OPTIONAL SERVICES

Since the addition of optional services is at the discretion of the state, the federal government allows great flexibility for states to determine the scope of the option that they wish to provide for their Medicaid clients. Generally, federal law and regulation define the basic objectives and requirements of the options, all of which must be met in order to obtain federal financial participation. Some of the requirements address equal offering of services to all eligibles, the qualifications of persons providing the services, and degree of supervision required for paraprofessionals. Within those broad parameters states can shape optional services to fit their unique needs and resources.

Alaska can limit optional services by (1) qualifying coverage, (2) requiring prior authorization, (3) limiting usage frequency, (4) requiring clients to share in cost of services, or (5) limiting the amount of provider reimbursement:

(1) *Qualifying Coverage*

Medicaid law and regulation permit the limiting of coverage of optional services. For example, dentures can be selected as a separate service without having to cover other prosthetic devices such as hearing aids, crutches, etc, or without having to cover other dental services. The Medicaid program does require that the option limitations be applied equally to all eligible clients. (There are certain exceptions to this policy. Some options are defined in federal law to include only specific age groups such as persons under 21 or over 65.) The state, for example, cannot as a general rule limit eligibility for optional service to only those persons receiving aid under a particular program such as Old Age Assistance. If a state chooses an optional service, it must be covered for all groups (except as noted in federal law or regulation) or federal reimbursement will be jeopardized.

(2) *Requiring Prior Authorization*

States can control inappropriate overutilization of optional services by requiring the client to receive approval from the Medicaid agency prior to obtaining certain medical care. Preauthorization is usually based on medical need for services and appropriateness of the care requested to the condition being treated. The Division of Public Assistance has, since the beginning of Medicaid, required preauthorization of all nursing home placements. This mechanism serves to reduce unnecessary placements, place clients at appropriate levels of care, and suggest alternative, and usually cheaper, methods of treatment.

(3) *Limiting Usage Frequency*

Optional services can also be limited by restricting client use. This is generally done by limiting the number of treatments or services paid by Medicaid in a specific time period. For example, Maryland limits adults to one eye examination and one pair of eyeglasses every two years. Arkansas limits Medicaid clients to three prescriptions per month. These restrictions must be applied though uniformly to all clients receiving assistance. Limitations of the amount of services should take into account unusual emergency situations. States cannot impose barriers to needed minimum levels of health care, or risk federal sanction.

(4) *Requiring Clients to Share in Cost of Services*

Some states require Medicaid clients to participate in sharing the costs of certain optional services. Federal regulation sets certain maximum allowable limits on the amount of payment that clients can be required to cover. Those regulations also specify the mechanisms that states can use to allow clients to share in the cost of certain services. Fees are generally limited to small amounts such as $.50 per prescription drug and $2.00 per pair of eyeglasses. Originally, this procedure was instituted to control overutilization of services and not to generate funds. California, along with some other states which elected this option, has found that the cost of administration of this mechanism generally did not offset the revenues gained. The charges did not significantly affect client use of services, and the states found that the collecting and controlling of such small fees were bothersome to both client and provider.

(5) *Limiting the Amount of Provider Reimbursement*

Costs of optional services can also be reduced by limiting the amount of provider reimbursement. Often this comes in the form of reducing reimbursement by a set percentage or by "freezing" payment levels at the current standards. (Medicaid pays "reasonable" rates to its providers. The costs allowable under its definitions often differ greatly from those accepted by Blue Cross and other insurance companies. Fees paid under Medicaid are often lower than fees paid by the general public for the same services.) The state of Michigan, for example, recently implemented an 11% reduction in normal fees paid to practitioners, dentists, laboratories, and other providers. Often such changes receive strong provider reaction and sometimes jeopardize the continued participation of those providers in the program. Federal officials also note the potential use of low bid health providers. For example, the state could solicit bids for a contract to supply Medicaid clients with specific services, such as eyeglasses. The state could select the most advantageous bid and award the contract without jeopardizing federal reimbursement.

OTHER ISSUES TO CONSIDER IN EVALUATING MEDICAID OPTIONAL SERVICES

Although this study focuses primarily on client need, there are other factors that must be considered in evaluating the merits of any given Medicaid option. Three of these major considerations are: availability of funds, costs versus benefits of options, and ease of administration.

The availability of funds plays a major role in the scope of services that a state believes it can provide for its citizens. The high cost of medical care demands an in-depth analysis of cost before any new service is added. Although this study does not discuss this financial issue, it is a major part of any decision to modify the program. Legislators who have a well defined proposal for additional option(s) may request the Research Division of the Legislative Affairs Agency to prepare an analysis of its costs, both direct and administrative.

The costs versus benefits of an option can be an important consideration in deciding whether or not the state should participate in it. For example, certain Medicaid options sometimes "save" state money, if that service is currently paid entirely from state funds or if it allows a client to receive less specialized and less expensive type of service that are more appropriate to this medical condition or problem. In 1976, the Alaska State Legislature added coverage of new limited group of needy eligibles who currently reside in nursing homes. The care for those persons at that time was paid for 100% from state general funds through the General Relief-Medical program. By adding that option, the state was able to claim 50% federal reimbursement for their care. Also, in 1973, the state added the intermediate nursing home care option. By covering this lower and less expensive level of nursing home care, many Medicaid recipients in skilled nursing, who did not require that level of treatment, could be placed in intermediate nursing care. The cost per day for each patient was reduced considerably.

The ease of administration is important also in evaluating the merits of certain options. The drug option, for example, requires that strict payment procedures regarding maximum allowable charges be in place. These are spelled out in some detail in the federal regulations, and the state must meet those requirements or risk loss of federal participation. Federal officials note that many of these cost containment mechanisms would normally be in place in any efficiently administered pharmaceuticals program, regardless of source of funding for it. The transfer of a program from state-only funding to federal assistance should cause minimal additional administrative expenses if adequate cost containment measures are in place in the existing program.

IV. MEDICAID CLIENT NEEDS

QUESTIONNAIRE OF PUBLIC ASSISTANCE SUPERVISORS

In Fall, 1976, a questionnaire was prepared to poll public assistance supervisors (eligibility work supervisors) on their estimation of client need for certain services based on their actual experience in the field. The questionnaire, prior to mailing, was reviewed by both the Division of Public Assistance and Department of Health and Social Services Commissioner's Office. The questionnaires were mailed to nineteen supervisors, many of whom had worked with public assistance clients for a significant period of time. (That sample of supervisors was chosen under the guidance of the Division of Public Assistance's Chief of Field Operations.) Approximately one month after mailing, a follow-up questionnaire was sent.

Fourteen, or 75%, of the supervisors polled responded to the questionnaire. All areas of the State were represented, including Anchorage, Fairbanks, Fort Yukon, Juneau, Kenai, Ketchikan, Nome, and Sitka. Each supervisor was asked specific questions concerning his or her evaluations of client need for Medicaid options not yet selected by the State.

QUESTION #1: In your experience, what optional services currently not covered under Medicaid do you feel your Medicaid eligible clients need most?

Table 2 shows the rank order obtained from the supervisor's responses to question #1. Interestingly, the top four items for each category (Adult Public Assistance and Aid to Families with Dependent Children program recipients) were the same. The ranking for dentures option differed slightly, being seen more necessary for older persons receiving Adult Public Assistance than the younger Aid to Families with Dependent Children recipients.

Since the Medicaid program requires that services included in the State Plan be offered equally to all eligible persons (except for certain specialized programs such as early childhood screening) the similar ranking of need options for both Adult Public Assistance and Aid to Families with Dependent Children Program is particularly meaningful. If it were called upon to evaluate new options, the legislature could be reasonably sure that any of the top four options (prescribed drugs, adult dental services, dentures, and physical therapy and related services) would be "needed" by both categories of clients.

QUESTION #2: On the average, how many Medicaid clients a month ask you if they can receive certain services?

Table 3 shows the responses by the supervisors concerning the requests of Medicaid eligibles for additional services. The responses to question #2 did not match the pattern formed from the supervisor's responses

TABLE 2

Average Ranking of Selected Medicaid Options by Type of Public Assistance Client

Rank	Recipients of Adult Public Assistance	Recipients of Aid to Families with Dependent Children
1st	Prescribed Drugs	Prescribed Drugs
2nd	Adult Dental Services	Adult Dental Services
3rd	Dentures	Physical Therapy and Related Services
4th	Physical Therapy and Related Services	Dentures
5th	Hearing Aids [1]	Chiropractor's Services
6th	Prosthetic Devices	Hearing Aids [1]
7th	Chiropractor's Services	Prosthetic Devices
8th	Private Duty Nursing	Private Duty Nursing
9th	Podiatrist's Services	Podiatrist's Services
10th	Care for Patients 65 or Over in Tuberculosis Institutions	Care for Patients 65 or Over in Tuberculosis Institutions

[1] *Hearing aids, at the time the survey was conducted, were not included in the coverage program offered to all Medicaid clients. An interpretation of Medicaid law and regulation by federal officials allowed hearing aids to be covered as part of the treatment of speech, hearing, and language disorders option. This policy change was implemented by the Division of Public Assistance in November.*

to question #1. For example, the Medicaid prescribed drug option which was ranked as needed first for both program categories, received less than 50% of the requests made for adult dental services, which was ranked as needed second by the supervisors. This could be anticipated for Medicaid clients who do not have prior health resources equal or better in coverage to General Relief-Medical automatically receive their drugs through GRM. One Juneau public assistance supervisor noted that for these persons, eligibility for prescription drugs under GRM is automatically determined at the time that Medicaid eligibility is confirmed. Therefore, few Medicaid clients would ask for prescription drugs, since coverage is established at the time they enter the Medicaid program.

Aid to Families with Dependent Children recipients requested fewer services than did the Adult Public Assistance recipients. This was expected, for the recipients of AFDC tend to be young and thus often have less need for diverse health services. Also, many AFDC recipients are eligible for a wider range of treatment service through the Early Periodic, Diagnosis and Treatment Program (EPSDT), a child check-up program. For example, dental care is available to public assistance recipients under 21 as a referral through EPSDT, but currently persons over 21 who are mostly on Adult Public Assistance programs cannot routinely receive preventative dental care under any of the state medical assistance programs.

Many of the Medicaid options available under the federal program do not match with Alaska's availability of services. In rural Alaska, it would be difficult to obtain chiropractor's or podiatrist's services close to home. Also, the option of care for patients 65 or over in tuberculosis institutions is not really relevant to Alaska, since there are no tuberculosis sanatoriums in the State. Care for such conditions would have to be provided in nursing homes, hospitals, and physicians' offices, all of which are currently covered under Medicaid.

The low number of requests in all categories may be due to lack of client awareness that these additional services sometimes can be covered under the state funded medical assistance program, General Relief-Medical. Because of limited funds under that program, the Division of Public Assistance has not actively conducted an outreach program to inform clients of eligibility requirements and services covered. Also, many clients may be reluctant to ask for services, which they feel they stand a likelihood of being rejected. Dentures are a good example of this. Because of funding limitations, dentures can only be covered in extreme hardship situations. Clients often are informed of this policy from their dentists, public health nurses, or social workers, before a formal request is made to the Division of Public Assistance.

SURVEY OF "DENIALS" OF SERVICE RECORDS

The needs of clients were also analyzed through a survey of all denials of requests for additional services for Medicaid clients. Medicaid clients sometimes require services that are not included in the Medicaid

TABLE 3

Total Average Number of Medicaid-Eligibles Requesting Optional Services Monthly by Program Category

Option	Recipients of Adult Public Assistance	Recipients of Aid to Families with Dependent Children	Total
Adult Dental Services	81.5	88.0	169.5
Dentures	60.5	21.0	81.5
Prescribed Drugs	38.0	39.0	77.0
Physical Therapy and Related Services	20.5	23.0	43.5
Hearing Aids [1]	27.0	16.0	43.0
Prosthetic Devices	25.5	12.0	37.5
Chiropractor's Services	15.5	15.0	30.5
Private Duty Nursing	13.5	5.5	19.0
Podiatrist's Services	4.0	1.5	5.5
Care for Patients 65 or Over in Tuberculosis Institutions	1.0	0.0	1.0
Total	287.0	221.0	508.0

[1] *Hearing aids, at the time of the survey, were not included in the coverage program offered to all Medicaid clients. An interpretation by federal officials of the treatment of speech, hearing, and language disorders options allowed hearing aids to be covered as part of a treament plan. This policy change was implemented in November.*

TABLE 4

Denials of Optional Services for Medicaid-Eligibles
(September 1, 1972 to July 31, 1976) [1]

1.	Dental Services	140 [2]
2.	Therapy	63
3.	Dentures	44 [2]
4.	Prosthetic Devices	37
5.	Prescription Drugs	28
6.	Hearing Aids	15 [3]
7.	Chiropractor's Services	3
8.	Podiatrist's Services	2
9.	Private Duty Nursing	1
10.	Tuberculosis Institution for 65 or Over	0

[1] *The figure includes only denials of requests submitted in writing to the Division of Public Assistance, Central Office. That Division also handles numbers of informal telephone requests, which are not included in these figures.*

[2] *The figure excludes Delta Dental Corporation denials. Delta Dental Corporation currently reviews and evaluates all public assistance clients requests for care. These records were not readily available in Juneau for the study period. In FY76, Delta Dental denied 454 Medicaid adults for dental services and 20 Medicaid adults for dentures.*

[3] *Hearing aids were added to the Medicaid program as of November, 1976. An interpretation by federal officials of the treatment of speech, hearing, and language disorders option added last session allowed hearing aids to be covered as part of the treatment plan.*

program. If the client has no other prior health care resource equal or better in coverage to that of General Relief-Medical (GRM) Program, that client may be able to receive those services through GRM. Since GRM is funded entirely by state general funds, monies are strictly controlled and extremely limited. In order to insure the equitable use of the funds, many services require pre-authorization by the Central Office of the Division of Public Assistance before they can be provided and paid for by the General Relief-Medical Program.

Requests for service can come in two forms: letters and phone calls. The Division of Public Assistance maintains files of only written requests for service. During the month of July, 1976, a tabulation of those records was performed. Table 4 shows the number of denials of optional services which were requested by Medicaid clients during the period September 1, 1972 to July 31, 1976.

Note that the top four options that eligibility work supervisors felt their clients needed appeared within the top five items requested for those clients. Thus, the public assistance supervisors confirm the client perceived need for dental services, therapy, dentures, and prescription drugs. The survey also revealed a client perceived need for prosthetic devices (such as artificial limbs, crutches, canes, etc.).

These tabulations of requests for service represent only written requests. Because of the "emergency" nature of some services and the ease of telephoning for approval, many denials of services are not represented in the written files. Also, many clients will not request a service which they know is unavailable or which they stand a likelihood of being denied. Clearly, then, these figures substantially under-represent client need.

RESULTS OF STUDY

1. Basically State of Alaska eligibility work supervisors feel that their Medicaid-eligible clients most need:

1. Prescription Drugs
2. Adult Dental Services
3. Dentures*
4. Physical Therapy and Related Services*

* *The rank order of these services varies by program which client is receiving aid. The adult public assistance clients are seen to need dentures much more frequently than do clients of Aid to Families with Dependent Children.*

2. The top four services that eligibility work supervisors feel that their Medicaid-eligible clients ask for most frequently are:

1. Adult Dental Services
2. Dentures
3. Prescription Drugs
4. Physical Therapy and Related Services

3. Records of "denials" of requests for services to be provided from the General Relief-Medical Program to Medicaid recipients indicate that the following services are requested and denied most frequently:

1. Dental Services
2. Therapy
3. Dentures
4. Prosthetic Devices

4. The records for the number of client requests generally underestimate client need because only written records are available and because many public assistance clients will not request a service which they know is unavailable or which they stand a likelihood of being denied.

PART V. ANALYSIS OF OTHER STATES' EXPERIENCE WITH SELECTED OPTIONS

OVERVIEW OF STATES PARTICIPATING IN SELECTED OPTIONS

The survey of denials of requests for services and tabulation of the responses to the questionnaire sent to the public assistance supervisors point to four service options which clients are perceived as needing most. These are: prescription drugs, adult dental services, dentures, and physical therapy and related services.

These optional services have been elected by many other states. For example--

- 96% of all states and United States protectorates have Prescription Drug Option *
- 64% of all states and United States protectorates have Dental Services Option *
- 60% of all states and United States protectorates have Physical Therapy and Related Services Option *

**Only states participating in Medicaid program are included in total figures. Data are as of June 1, 1976 and were obtained from United States Department of Health, Education and Welfare. (Data are unavailable on the number of states offering denture service to their eligibles.)*

Many states added these services in the mid-1960's when Medicaid first began. However, it was found that some states eliminated or restricted some of these options during the period January 1, 1975 to July 1, 1976. With the skyrocketing cost of medical care and the increasing demand upon state dollars, we decided to review the options that were selected as needed by public assistance supervisors and contact those states that had recently modified them.

QUESTIONNAIRE OF STATES MODIFYING SERVICES

In early December, the Research Division of the Legislative Affairs Agency prepared a questionnaire to ask the views of state Medicaid program administrators regarding the options they had recently restricted. Fourteen states that had recently modified optional services included in this survey were contacted. Eleven states (or 79%) responded to the questionnaire. Since existing federal reports do not pinpoint the number of states modifying their denture coverage, that option was not included in the discussion.

State Experience With Prescription Drug Option

Of the 51 states providing prescription drugs, 11 states (or 22%) reduced their coverage during the period of January 1, 1975 - July 1, 1976. Seven of those states responded to the questionnaire. The majority of those states reduced coverage of drugs in order to reduce expenditure of state dollars. They noted that it created a hardship, but most clients felt coverage of only certain drugs was better than no coverage at all of them. Basically, controls were maintained by limiting the number of monthly prescriptions any one client could obtain and by limiting the types of drugs covered.

It is interesting to note that one state, Oklahoma, added the drug option during this period. In responding to the questionnaire, the director of the Oklahoma program stated that the option was added at the direction of their legislature. Certain administrative restrictions were imposed when the option was added. Prescriptions were limited to three per client per month and the different categories of drugs were also restricted. The director noted that public reaction to the addition of services has been generally favorable.

State Experience With Dental Services Option

13% of the states which chose the dental services option eliminated it during the period January 1, 1975 to July 1, 1976. (Recently two states, Massachusetts and New Jersey, have reinstated coverage of this option). Five of the seven states eliminating this option responded to the survey.

Generally, these five states found that the adult dental services option was needed by clients and was easy to administer. Restrictions on the option were basically due to lack of state funds. In one instance, New Hampshire, the legislature set a priority list of services that were to be provided. Since adult dental services received a low priority and funds were limited, the option was dropped. The dropping of the option generated considerable negative client reaction, as evidenced primarily by an increased number of client administrative appeals on this issue.

State Experience With Physical Therapy and Related Services Option

Michigan was the only one of 32 states which included physical therapy and related services in their programs and chose to modify that option during the period January 1, 1975 to July 1, 1976. The Michigan Medicaid program responded to the questionnaire and noted its experience with the option. The respondent found that the option was needed by clients; however, the cut, an elimination of physical therapy in long term care institutions, was made in response to lack of sufficient funding. To date, this change in the program has not been rescinded.

RESULTS

1. At least 60% of all states participating in the Medicaid program also cover some form of prescription drugs, dental services, and physical therapy and related services options for their clients. These services were among the top four requested by Alaska public assistance clients and seen as needed most for them according to a survey of Alaska public assistance supervisors. (Nationwide data on the numbers of states covering dentures in their programs are not available.)

2. Two of the top four services seen as needed for public assistance clients, prescription drugs and dental services, were also the top two services restricted or eliminated by other states during the period January 1, 1975 - July 1, 1976. (See Part IV for survey results.)

3. Most states modified the options to reduce expenditure of state funds. They did not drop or restrict them because of lack of client need or complexities in administration.

4. Restrictions of service options were generally done in four ways: limiting coverage of service, limiting client access, reducing provider fee payments, and charging clients small fees.

5. Reduction of fees generally brought strong reaction by the provider sector.

6. The states believe that limiting coverage to certain number of services allowable per month and restricting coverage of type of service allowable under the option was generally more acceptable than totally eliminating it.

7. In most cases, states modifying these options chose to restrict prescription drug coverage but they chose to eliminate dental services (except as was required under the early screening program).

8. In some cases states reinstated changes in options a short time after they were made. This was generally due to the strong reaction received from the groups affected.

PART VI. CONCLUSIONS TO THE STUDY

From the responses to the questionnaire sent to public assistance supervisors concerning client need, the survey of denial records of requests for additional services, and the responses from other states regarding their experience with the program, the following conclusions can be drawn:

1. Of Medicaid optional services available that Alaska does not currently provide under its program, public assistance clients appear to need most(in descending order of need).

   (1) Prescription Drugs
   (2) Dental Services
   (3) Dentures*
   (4) Physical Therapy and Related Services*

   * *The rank order of these services varies by program under which client is receiving aid. The adult public assistance clients are seen to need dentures as a higher priority than do clients of Aid to Families with Dependent Children.*

2. hree of the optional services listed in Item #1 are included by over 60% of the states participating in Medicaid. Prescription drugs, for example, are included in 95% of all state programs. (Data on coverage of dentures are generally unavailable on nationwide basis.)

3. Two of the options that clients "need" most--prescription drugs and dental services--topped the list of options that states reduced or eliminated during the period January 1, 1975 - July 1, 1976. These modifications were done as cost containment measures and not as a response to lack of client need or to complexities of administering the options.

4. Alaska could be reasonably assured that services listed in Item #1 would be needed and used by clients. The choice to include them appears to be a decision based primarily on the state's availability of state funds. The state could choose to cover an option, but restrict that option in many ways to meet funding limitations.

GLOSSARY OF TERMS

AB - See Aid to the Blind.

AD - See Aid to Disabled.

ADC - See Aid to Families with Dependent Children.

AFDC - See Aid to Families with Dependent Children.

APA - See Adult Public Assistance.

APD - See Aid to Disabled. Stands for Aid to Permanently Disabled.

Adult Public Assistance - A cash supplemental program administered by the state in cooperation with the U.S. Department of Health, Education, and Welfare. Designed to provide a state-legislated level of cash assistance to aged, blind, and disabled persons who meet certain income and resource requirements, and who are predominately eligible for Supplemental Security Income (SSI) payments. State administrative costs as well as actual cost payments are 100% state only costs.

Aid to the Blind - A cash supplemental program administered by the state in cooperation with the U.S. Department of Health, Education, and Welfare. Designed to provide a state legislated level of cash assistance to those eligible blind persons who meet certain income and resource requirements, and who are predominately eligible for SSI payments. It is considered an "Adult Public Assistance" program.

Aid to Disabled - A cash supplemental program administered by the state in cooperation with the U.S. Department of Health, Education and Welfare. Designed to provide a state legislated level of cash assistance to those eligible disabled persons who meet certain income and resource requirements and who are predominately eligible for SSI payments. It is considered an "Adult Public Assistance" program.

Aid to Families with Dependent Children - A federal program administered by the state through an approved state plan filed with the U.S. Department of Health, Education, and Welfare. Designed to provide a state-legislated level of cash assistance to dependent children who have been deprived of one or both parents, and who meet certain income and resource requirements. Both administration costs and the actual cash payments provided to recipients are shared equally (50%) by the state and federal government.

Categorical Assistance - Aid, in form of income maintenance, to certain needy persons who receive assistance under Old Age Assistance, Aid to the Blind, Aid to the Disabled, Supplemental Security Income, and Aid to Families of Dependent Children programs.

Compliance - In a federal program, the act of performing certain set program functions in accordance with those requirements outlined in the state plan, federal law, and regulation. Generally, meeting all federal program requirements is necessary to receive federal financial participation in the program.

DHSS - See Department of Health and Social Services.

Department of Health and Social Services - A department of the executive branch designated to be single state agency to administer the Medicaid program for the state of Alaska.

EPSDT - See Early and Periodic Screening, Diagnosis and Treatment.

Early and Periodic Screening, Diagnosis and Treatment - A mandatory service under Medicaid which provides for special check-ups at set intervals for certain needy children, in order to find and treat health problems before they become serious. Coverage includes only those Medicaid eligibles under 21 years of age.

Eligible - A person qualified to receive assistance funded under particular program. Eligibility criteria can vary, so that eligibility must be established on program by program basis.

FFP - See Federal Financial Participation.

Federal Financial Participation - The means by which the federal government asssists in supporting certain specific program. The federal government generally provides aid by two methods: 1) matching dollars by set percentage or 2) formula money grants.

GRM - See General Relief-Medical.

General Relief-Medical - A state emergency medical program designed to respond to immediate medical needs of Alaskan families in time of extreme financial crisis. All assistance rendered under this program is in the form of vendor payments to medical providers. State administrative costs as well as actual cash payments to vendors are 100% state only costs.

Intermediate Nursing Care - An optional service available to be provided under Medicaid program. Denotes a less intensive and less expensive level of around-the-clock nursing care, in comparison to skilled nursing.

Mandatory Coverage - A portion of the Medicaid program that is required to be covered by each and every state in the program, in order for the state to be entitled to federal financial participation. Mandatory coverage items concern persons eligible to receive services and the services provided to those persons. States can still administratively "control" mandatory services and not jeopardize federal financial participation by controlling the amount of service available to client, amount of financial participation (deductible required to be paid by client) in order for the client to receive such services, and other mechanisms.

Medicaid - A federal assistance program established by Title XIX of the Social Security Act and administered by the state through an approved state plan filed with U.S. Department of Health, Education, and Welfare. Designed to provide medical coverage for recipients of Aid to Families With Dependent Children; Supplemental Security Income, elderly and blind recipients of Adult Public Assistance and those disabled persons who meet federal definitions of disability; and certain other groups. State administrative costs are shared equally (50%) by the state and federal governments, except for professional medical support personnel who are funded at 75% federal reimbursement. Actual medical vendor payments are shared equally (50%) by the state and federal government, except for family planning which is funded at 90% federal reimbursement.

Medically Needy - An optional group of eligibles for whom federal reimbursement for necessary medical care may be covered under the Medicaid program. Generally includes individuals who have insufficient income and resources to meet the costs of necessary medical or remedial care and services. Presently Alaska does not include the medically needy under its Medicaid program.

Medicare - An insurance program administered solely by the federal government to provide payments for necessary medical care for those people, rich or poor, who receive Social Security payments.

OAA - See Old Age Assistance.

Old Age Assistance - A cash supplemental program administered by the state in cooperation with the U.S. Department of Health, Education, and Welfare. Designed to provide a state legislated level of cash assistance to those eligible persons 65 and over who meet certain income and resource requirements and who are predominately eligible for Supplemental Security Income payments. It is considered an "Adult Public Assistance" program.

Option - A portion of the Medicaid program that is discretionary on the part of the state. Options generally deal with persons eligible for coverage or medical services available for those eligible persons. Options are set out in federal law and regulations and are generally eligible for federal financial participation. Since the choice of options is up to each state, options can generally be designed to fit the state's unique needs and available resources, but each option chosen must meet certain broad federal program requirements.

Public Assistance - A division of Department of Health and Social Services, responsible for administration of the Medicaid, General Relief-Medical, and Income Maintenance programs. This division determines the eligibility of state's residents for such services by carefully reviewing the person's income, resources, and other factors according to state and federal standards.

Quality Control - An office of the Department of Health and Social Services which is assigned the responsibility to verify that

randomly selected cases are eligible to receive services in month that service was rendered. The verification consists of check of files, client contact, and collateral sources.

Recipient - A person receiving income maintenance or assistance services funded under a particular program.

SSA - See Social Security Administration.

SSI - See Supplemental Security Income.

Skilled Nursing Care - A mandatory service required to be provided under the Medicaid program. Denotes highly professional round-the-clock nursing care and monitoring. Generally more expensive and more specialized care than intermediate care.

Social Security Administration - An agency of the federal Department of Health, Education and Welfare assigned the responsibility to administer Social Security, Medicare, and Supplemental Security Income programs.

State Plan - A contract between the single state agency to administer the Medicaid program and the federal Department of Health, Education and Welfare, specifying conditions to be met in order to be eligible for federal financial participation.

Supplemental Security Income - An assistance program funded and administered by federal government which provides payments to certain needy persons who are aged, blind, or disabled and meet program and financial requirements. Payments are uniform nationwide and are based on need.

Title XIX - A portion of the federal Social Security Act which outlines the Medicaid program.

Title XVIII - A portion of federal Social Security Act which outlines the Medicare program.

Utilization Review - Random records check of sample institutional Medicaid billing to insure that services rendered match with those billed to the program. Verifies that institutional records are complete, accurate, and up-to-date. Examines for overuse or misuse of treatment and professional resources and the patient's duration of stay relating to those resources.

Attachment K

Medicaid Annual Status Report

FISCAL YEAR 1977

Jay S. Hammond, Governor
State of Alaska

Helen D. Beirne, Commissioner
Department of Health and
Social Services

Richard R. Wilson, Director
Division of Public Assistance

MEDICAID ANNUAL STATUS REPORT

FISCAL YEAR 1977

JAY S. HAMMOND

GOVERNOR

STATE OF ALASKA

HELEN D. BEIRNE

COMMISSIONER

DEPARTMENT OF HEALTH AND SOCIAL SERVICES

RICHARD R. WILSON

DIRECTOR

DIVISION OF PUBLIC ASSISTANCE

SPECIAL CREDITS

REPORT PREPARED BY:

David M. Davidson, Administrative Officer

Division of Public Assistance

STATISTICAL INFORMATION

Dan Zobrist, Research Analyst

Research and Statistical Section

MANUSCRIPT PREPARATION

Evelyn L. Lee, Secretary

Division of Public Assistance

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ABSTRACT OF MEDICAID FY 1977
STATUS REPORT

Medical Assistance Budget FY 1977 (not including supplemental appropriations):

Medicaid	$16,908,500
General Relief-Medical	2,542,100
Total	$19,450,600

Medical Assistance disbursements for FY 1977 (through February 28, 1978):

Medicaid	$18,608,568
General Relief-Medical	3,743,128
Total	$22,351,696 1/

Medicaid	50% federal funding for services and administration
	75% federal funding for professional staff (medical)
	90% federal funding for family planning services
GR Med	100% state funding
Catastrophic Illness	100% state funding

Savings to the State of Alaska through participation in Medicaid (vendor payments only):

Federal financial participation	$ 9,450,261
State financial participation	9,158,307
Total Medicaid payments	$18,608,568

Total number of persons receiving Medicaid services FY 1977: 11,815 2/
Total number of persons receiving GR Med services FY 1977: 2,631

Who is eligible for Medicaid? Persons eligible for cash assistance payments under any categorical assistance program: Old Age Assistance, Aid to the Blind, Aid to the Disabled meeting federal disability criteria, Aid to Families with Dependent Children. Additional eligibility criteria exist for persons in nursing facilities and children in foster care or juvenile care situations.

Who is eligible for GR Med? Persons having no prior Medical resources and who meet financial eligibility (need) requirements for the assistance programs listed above but do not meet other qualifications for Medicaid coverage (not blind or disabled under federal definition, under 65, both parents in the home are physically able to work).

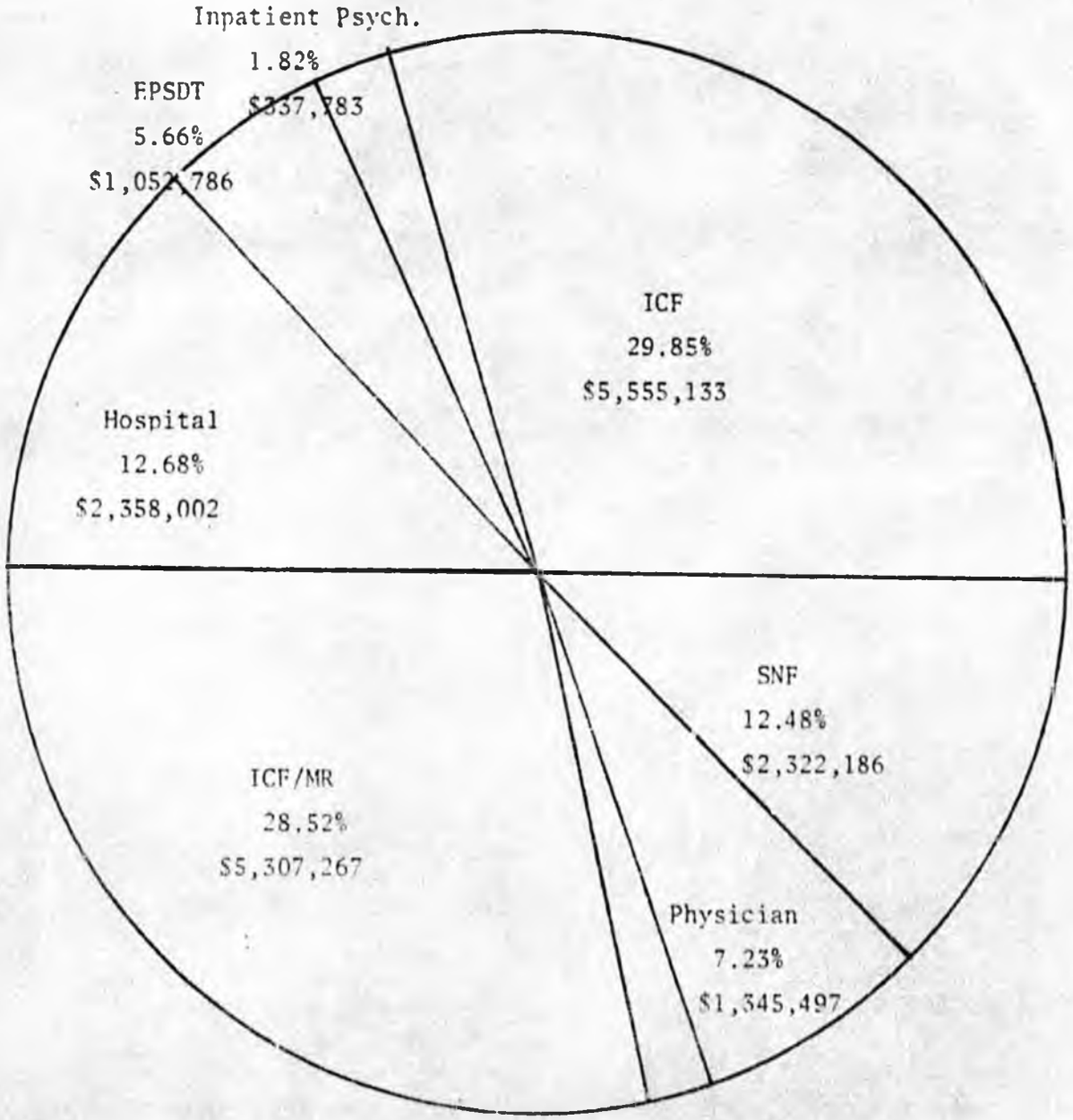
1/ - Not included in these statistics were approximately $500,000 worth of FY 1977 invoices which had not yet been paid as of 2/28/78, pending decision on the FY 1978 supplemental appropriation request.

2/ - Statistics based on federal report during the federal fiscal year October 1, 1976 to September 30, 1977.

DISTRIBUTION OF MEDICAID PAYMENTS BY TYPE OF SERVICE

BY DATE OF SERVICE

FISCAL YEAR 1977



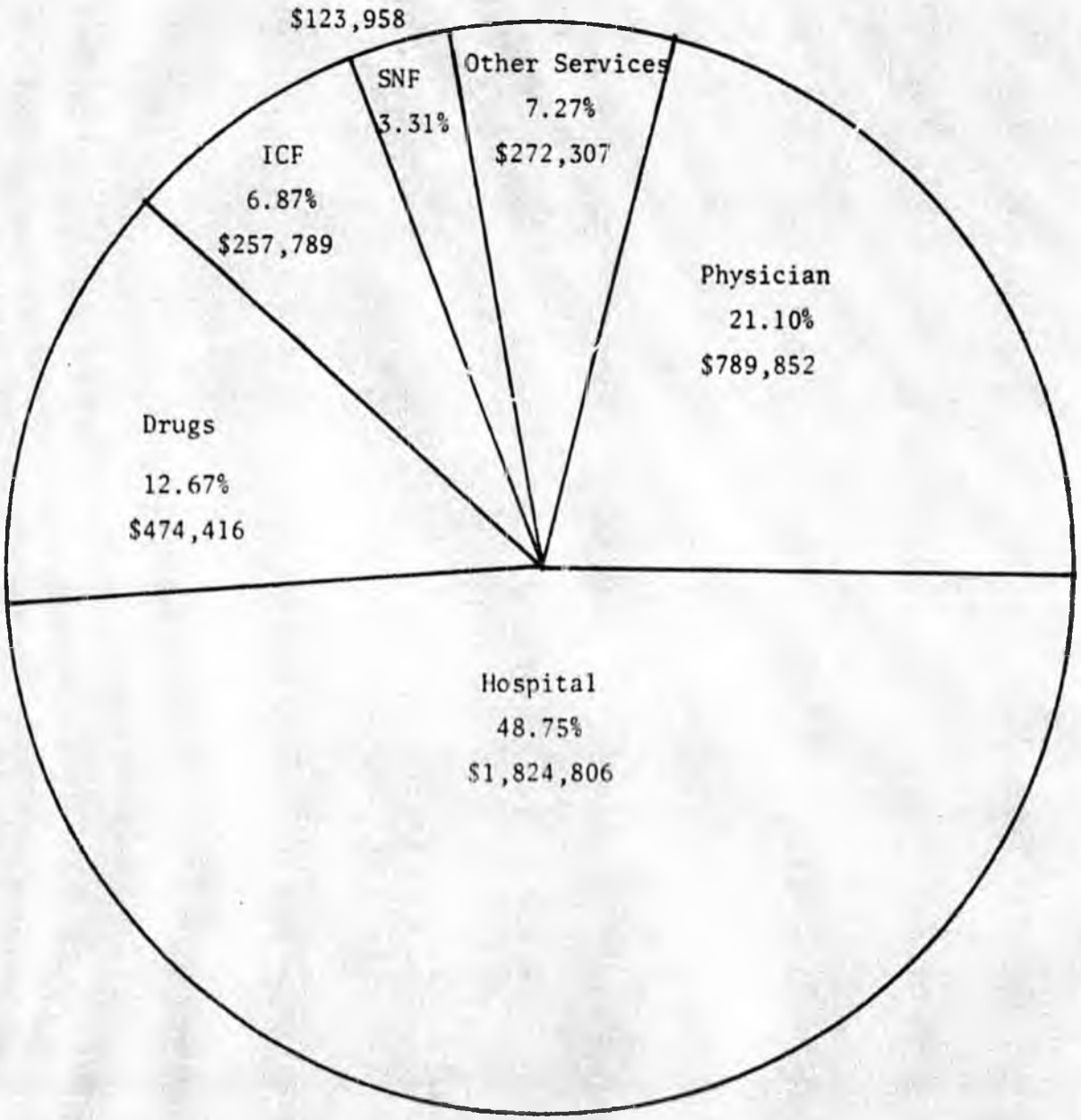
Total Medicaid Payments

$18,608,568

DISTRIBUTION OF GR MED PAYMENTS BY TYPE OF SERVICE

BY DATE OF SERVICE

FISCAL YEAR 1977



Total GR Med Payments

$3,743,128

MEDICAL ASSISTANCE EXPENDITURES - FY 1977 - BY PROVIDER BY DATE OF SERVICE

	MEDICAID	GENERAL RELIEF MED	TOTAL	STATE SHARE TOTAL	FEDERAL SHARE TOTAL
Hospital - Inpatient	$ 2,047,906	$ 1,718,698	$ 3,766,604	$ 2,742,651	$ 1,023,953
Outpatient	310,096	106,108	416,204	155,047	261,157
Laboratory & X-ray	13,247	4,279	17,526	10,903	6,623
Skilled Nursing (SNF)	2,322,186	123,958	2,446,144	1,285,051	1,161,093
Intermediate Care (ICF)	5,555,133	257,789	5,812,922	3,035,356	2,777,566
Intermediate Care for Mentally Retarded (ICF/MR)	5,307,267	-0-	5,307,267	2,653,633	2,653,634
Physician Services/Incl. EPSDT	1,353,097	789,852	2,142,949	1,466,400	676,549
Drugs	-0-	474,416	474,416	474,416	-0-
Home Health Services	11,798	-0-	11,798	5,899	5,899
Dental Care EPSDT Serv.	392,704	-0-	392,704	196,352	196,352
EPSDT Admin.	35,552	-0-	35,552	17,776	17,776
Other	-0-	81,828	81,828	81,828	-0-
Transportation/Inc. EPSDT	82,916	16,386	99,302	57,844	41,458
Family Planning	99,917	92,481	192,398	102,473	89,925
EPSDT Admin./RSA	503,913	-0-	503,913	251,956	251,957
Inpatient Psychiatric Hospital	337,783	-0-	337,783	168,891	168,892
Eyeglasses/Inc. EPSDT	160,576	15,725	176,301	96,013	80,288
Prosthetic Devices/Inc. EPSDT	12,244	21,014	33,258	27,136	6,122
Mental Health Clinics	40,151	-0-	40,151	20,075	20,076
Other/Inc. EPSDT	22,082	40,594	62,676	51,635	11,041
TOTAL	$18,608,568	$ 3,743,128	$22,351,696	$12,901,335	$ 9,450,261

ALASKA MEDICAID PROGRAM

Medicaid Objectives

Medicaid is based on three basic premises:

(1) That medical services are available to needy eligible persons when ill or injured;

(2) That the highest quality care is provided;

(3) That care is provided at the lowest possible cost to the taxpayers through existing health care providers.

Development of the Program

Medicaid is a state-administered medical assistance program funded by both federal and state sources. The program was implemented in Alaska on September 1, 1972. Since that time Medicaid expenditures have grown tremendously as a result of population growth, inflation, increased availability of services, rising cost of services, and increased utilization of federal revenues for programs that were previously (funded by state revenues alone).

FISCAL YEAR	MEDICAID EXPENDITURES	GR MED EXPENDITURES	ADMINISTRATION AND SUPPORT
1973	$ 4,447,219	$ 3,675,277	$ 481,890
1974	7,876,759	2,607,112	631,129
1975	9,309,702	2,358,080	722,778
1976	14,328,201	2,881,213	1,085,086
1977	18,608,568	3,743,128	1,253,002
1978 1/	25,915,719	6,213,100	1,346,800
1979 2/	38,811,695	6,769,100	1,423,950

1/ Projected expenditures

2/ Total of budget request including supplemental requests--includes $6,422,300 for Indian Health Care Improvement Act billings by ANHS; this is 100% federal funds.

Medical Care Advisory Committee

The Medical Care Advisory Committee is composed of health care providers, consumers (including Medicaid recipients), and government agency representatives. The committee is mandated by federal Medicaid regulations and deals with issues concerning Medicaid services, performs studies and makes recommendations for action by the Division of Public Assistance or legislature. The purpose of the committee is to provide oversight for implementation of the Medicaid program as well as provide an opportunity for input by both the provider and consumer communities.

Members of the Medical Care Advisory Committee are:

ALASKA'S MEDICAL CARE

ADVISORY COMITTEE

Charles Rush, Chairman	Anchorage	Pharmacist
Ann Maioriello Vice Chairman	Anchorage	Coordinator Home Health Care
Jimmy Anaver	Kipnuk	Consumer
Gloria Barclay	Juneau	Consumer
Sam Granato	Juneau	Director, Division of Social Services
Rose Davis	Fairbanks	Consumer
Robert Gregovich, MD	Juneau	Program Administrator Developmental Disabilities
J. Ray Langdon, MD	Anchorage	Physician
Sister Kathy McGinty, MD	Ketchikan	Catholic Community Services
Mildred Pelch, RN	Ketchikan	Nursing Home Administrator
Mary Wolcoff	Anchorage	Consumer

Health Care Providers

Health care providers in Alaska must be enrolled with the Division of Public Assistance to be eligible to bill the Division's Medical Assistance programs. Enrollment requires that the provider: (1) be licensed or eligible to provide a service covered under the Division's medical assistance programs; (2) have on file with the Division a signed and approved Division provider agreement form; (3) abide by the regulations and policies governing the Division's medical assistance programs; and (4) comply with TitIe VI of the Civil Rights Act of 1964.

Medical providers are required to keep records and furnish billing information when requested by state or federal officials for services provided to the Division's medical assistance recipients.

Provider Reimbursement

The Division sets maximum allowable fees for services provided outside of hospitals and nursing facilities. Maximum allowable fees must not exceed Medicare payment for the same service in Alaska. Providers are required to bill the Division for the lesser of: (1) their usual and customary charge to the public, or (2) the Division's maximum allowable fee (or Medicare upper limit, whichever is applicable).

For hospitals (both acute care and psychiatric), skilled nursing and intermediate care facilities and intermediate care for the mentally retarded, payment is based on reasonable cost reimbursement for services rendered. Interim payments are made and, after the close of a facility's fiscal year, settlement is made between the Division and a facility based on the cost report filed by a facility. In order for reasonable cost reimbursement to be effective the following aspects of the Division's Medicaid program must be functioning at maximum efficiency:

(1) Division policy must be organized and kept current to give adequate notice to providers;

(2) Utilization review of medical services--both by statistical survey and on-site review;

(3) Thorough audit of the financial reports and operations of each hospital and nursing facility.

Number of Medical Providers in Alaska

Hospitals	27
Nursing Facilities	14
Physicians	368
Dentists	135
Optometrists	24
Speech, hearing and language therapists	13
Home Health Agencies	1
Laboratories	5
Ambulance services	8
Opticians	12
Community Mental Health Clinics	10
Physical Therapists	16 1/
Pharmacies	68 1/
Others	35 1/

General Relief Medical Program

General Relief Medical (GRM) provides state-only coverage for two distinct classes of recipients: (1) those persons eligible for Medicaid who require services not included under the Alaska Medicaid program: and (2) those financially needy persons not eligible for Medicaid coverage who require medical care.

Under the first group, GRM only provides coverage for those medical services and supplies not covered under Medicaid (such as prescription drugs, prosthetic devices, and medical equipment). For the second group, GRM provides state-only funding for coverage under all Medicaid service categories as well as certain medical services and supplies not covered by Medicaid (drugs, prosthetic devices and medical equipment).

Catastrophic Illness

This program was created by the 1976 legislature to provide post-care financial assistance to Alaskans with large medical bills who did not meet the financial eligibility criteria for Medicaid or GRM at the time the person received the medical care. The Catastrophic Illness Committee is composed of a medical officer of the Department of Health and Social Services, a member of the insurance community appointed by the Governor and a lay member who has previously suffered a catastrophic illness.

SUMMARY OF SERVICES COVERED UNDER THE ALASKA MEDICAID PROGRAM

Medicaid is a federal-state program administered by the states. As a condition of participation states must provide coverage for a minimum number of services prescribed by federal law. Beyond this minimum, each state has the opportunity to add or delete other "optional services" described in federal regulations.

The advantages of Medicaid optional services are: (1) they allow compensation for services provided by tax-paying providers who may be suffering a loss on services currently provided to low-income customers, and (2) they allow states currently providing services using state-only funds to tap federal money as partial funding for programs funded soley by the state.

The following mandatory and optional services are covered under the Medicaid program in Alaska:

Mandatory Services

(1) Inpatient Hospital services. Public or private facilities, not including hospitals for mental diseases or tuberculosis; services must be physician-ordered; non-emergency out-of-state hospitalization must be prior authorized by the Division.

(2) Outpatient Hospital services. Emergency medical services; on-going ambulatory care; public or private facilities.

(3) Laboratory and X-ray services. Independent facility or one connected with a physician; services must be physician-ordered.

(4) Skilled nursing facility care (SNF). High level nursing and/or rehabilitative care; alternative to extended hospital care; must be prior authorized by the Division.

(5) Physician services. Inpatient and outpatient services performed by private physicians; cosmetic surgery must be prior authorized by the Division.

(6) Home Health Services. Provides an alternative to nursing home care by covering services to clients at home rather than in a nursing facility. Covered services under this category include nursing; medical supplies and equipment; physical, occupational and speech/hearing therapy when provided by a licensed home health agency.

(7) Family planning services and supplies. These services receive 90% federal financial participation; covers hospital and surgical procedures as well as contraceptive devices.

(8) Transportation. To or from a facility or provider of medical services; locally handled by Divisional offices except where cost is in excess of $250.00 or travel is out-of-state, in which case it must be prior authorized by the Division's Medical Practice Review Officer.

(9) Early Periodic Screening, Diagnosis and Treatment (EPSDT). Currently limited by the Department to federal minimum requirements for covered services; provides screening for all Medicaid-eligibles under 21 years of age; optional at client's choice; as a result of screening, referral is made to physician, audiologist, optometrist, dentist or therapist for further treatment; covered services include all mandatory services plus services for eyeglasses, hearing aids, treatment for visual and hearing defects, and dental services.

Optional Services

(1) Intermediate Care Facilities (ICF). Lower level nursing home care; alternative to skilled nursing and/or hospitalization; requires prior authorization by the Division.

(2) Intermediate Care for the mentally retarded or persons with related disabilities (ICF/MR). Lower level nursing home care for persons with mental retardation or developmental disabilities; requires prior authorization.

(3) Inpatient psychiatric hospital services. Acute care for persons suffering from psychological trauma or impairment; limited to persons under 21 years of age or over 65 years of age; prior authorization is required.

(4) Eyeglasses. Must be prescription glasses; new, repaired or replacement; no photogrey tints; cataract contact lenses must be prior authorized by the Division.

(5) Optometrists. Coverage is provided for both eye care and dispensing.

(6) Clinic services. Currently limited by state statute to state-operated and state-funded outpatient community mental health clinics enrolled for Medicaid; must be supervised by a physician.

(7) Services for speech, language and hearing disorders. Services rendered by speech pathologists or audiologists; requires prior authorization by the Division; must be ordered by a physician.

MEDICAID OPTIONAL SERVICES--INCLUDING THOSE NOT CURRENTLY COVERED BY THE ALASKA MEDICAID PROGRAM

The following is a list of all optional services under the Medicaid program. Optional services may be selected by the individual states for inclusion in their Medicaid program if a state decides to make those services available to all categories eligible for the basic Medicaid coverage. A brief description of each option is provided below followed by a comparison of optional services that are offered in Alaska, Idaho, Oregon and Washington, the four states comprising federal Region X. Those services covered in Alaska are indicated.

(1) Podiatrist services. Manipulation of the feet and treatment of corns, bunions, callouses, etc., by a licensed podiatrist.

(2) Optometric services. Covered under Alaska Medicaid.

(3) Chiropractic services. Treatment by a licensed chiropractor limited to manual manipulation of the spine.

(4) Other practitioner services. Naturopaths, homeopaths, herbalists, faith healers.

(5) Private duty nursing. Care by a registered nurse or licensed practical nurse under a physician's supervision in home, hospital or nursing facility when a person requires exceptional individual and continuous care.

(6) Clinic services. Under the Alaska Medicaid program this is currently limited to state-operated and state-funded community mental health clinics. This option could also include such other services as health care clinics, alcoholism treatment centers, ambulatory surgical centers, and rural health care clinics. Rural health clinics are now a mandatory service pursuant to Public Law 95-210.

(7) Physical therapy. Physician-prescribed services provided by a licensed or certified physical therapist (depending upon state licensing procedures).

(8) Occupational therapy. Physician-prescribed services provided by a licensed or certified occupational therapist (depending upon state licensing procedures).

(9) Services for speech, hearing, and language disorders. Included under the Alaska Medicaid program.

(10) Prescribed drugs. Covered by state-only General Relief Medical. Alaska is one of only two states without Medicaid coverage for this option.

(11) Dentures. Replacement of a full or partial set of teeth.

(12) Prosthetic devices. Physician-prescribed replacement, corrective or supportive devices that artificially replace a missing part of the body, to prevent deformity or malfunction, to support a weak or deformed portion of the body.

(13) Eyeglasses. Covered by Alaska Medicaid.

(14) Other diagnostic, screening, preventive and rehabilitative services. Identification of illness, injury or other health deviation; preventive and rehabilitative services to restore patient to functional level.

(15) Services to individuals over 65 years of age in institutions for tuberculosis. Facility providing services could be ICF, SNF or inpatient hospital.

(16) Services to individuals over 65 years of age in institutions for mental diseases. (a) Inpatient psychiatric care for persons over 65 is covered under the Alaska Medicaid program. (b) ICF and SNF care for persons over 65 with mental diseases is not covered in Alaska. Under this provision, it would be possible to provide nursing care for persons with mental disabilities who may not otherwise qualify for nursing care due to a lack of physical health problems requiring nursing home care.

(17) Intermediate care facilities (ICF). Covered under the Alaska Medicaid program.

(18) Inpatient psychiatric services for persons under 22 years of age. Covered by the Alaska Medicaid program.

(19) Transportation. Covered under the Alaska Medicaid program.

(20) Services by Christian Science nurses.

(21) Services by Christian Science Sanatoria.

(22) Skilled nursing facility care (SNF) for persons under 21 years of age. Covered by the Alaska Medicaid program.

(23) Emergency hospital services. Covered under the Alaska Medicaid program.

(24) Dental services. Adult dental services are not covered by Medicaid in Alaska.

(25) Personal care services. Physician-ordered services provided to a person in their home by a non-relative and supervised by a registered nurse.

(26) Intermediate care for the mentally retarded and persons with related conditions (ICF/MR). Covered under the Medicaid program in Alaska.

OPTIONAL SERVICES

OPTIONAL SERVICES	ALASKA	IDAHO	OREGON	WASHINGTON
Podiatrist Services	No	Yes	Yes	Yes
Optometric Services	Yes	Yes	Yes	Yes
Chiropractic Services	No	Yes	Yes	Yes
Other Practitioner Services	No	No	Yes	Yes
Private Duty Nursing	No	No	Yes	Yes
Clinic Services	Yes	Yes	Yes	Yes
Physical Therapy	No	Yes	Yes	Yes
Occupational Therapy	No	No	No	No
Services for Speech, Hearing & Language Disorders	Yes	No	No	Yes
Prescribed Drugs	No	Yes	Yes	Yes
Dentures	No	No	Yes	Yes
Prosthetic Devices	No	No	Yes	Yes
Eyeglasses	Yes	No	Yes	Yes
Other Services				
Diagnostic	No	No	Yes	Yes
Screening	No	No	No	Yes
Prevention	No	No	No	Yes
Rehabilitation	No	No	Yes	Yes
Services to Individuals Over 65 in Institutions for T.B.				
Inpatient	No	No	Yes	Yes
Skilled	No	No	Yes	Yes
ICF	No	No	Yes	Yes
Services to Individuals Over 65 in Institutions for Mental Diseases				
Inpatient	Yes	No	Yes	Yes
Skilled	No	No	Yes	Yes
ICF	No	Yes	Yes	Yes
Intermediate Care Facilities	Yes	Yes	Yes	Yes
Inpatient Psychiatric Services for Under 22	Yes	No	Yes	Yes
Transportation	Yes	Yes	Yes	Yes
Services for Christian Science Nurses	No	No	No	No
Services for Christian Science Sanitoria	No	No	Yes	No
SNF for Under 21	Yes	Yes	Yes	Yes
Emergency Hospital Services	Yes	Yes	Yes	Yes
Dental Services	No	No	Yes	Yes
Personal Care Services	No	No	No	No
ICF/MR	Yes	Yes	Yes	Yes

MEDICAID

A LOOK TO THE FUTURE

The federal government through the Department of Health, Education and Welfare (DHEW) continues to put greater emphasis on cost containment and accountability in the operation of the Medicaid program nationwide. This places added burdens on state-administered Medicaid programs to provide swift and accurate information to DHEW--while providing information about the program and prompt payment to medical providers.

In Alaska, the Division of Public Assistance is attempting to upgrade the overall operation of the Medicaid program in an effort to control costs as well as provide more adequate notice to providers about their rights and responsibilities under the program.

Several tools are necessary to accomplish that end--state administrative regulations, staff operational manual, provider manuals, schedules of maximum allowable fees, and a more efficient mechanized claims payment and data reporting system.

Program Tools

After five and one-half years of Medicaid participation, state administrative regulations are in the drafting stage with hearings tentatively scheduled for the summer of 1978. Federal statutes and federal regulations provide only a broad sketch of the Medicaid program. The Department of Health, Education, and Welfare assumes that states develop the details of the Medicaid program through state administrative regulations and agency policy. Without state regulations it is impossible to begin a program of effective cost containment to insure that improper and excessive utilization does not occur.

Federal law mandates that states have systems for investigation and prosecution of fraud and abuse by Medicaid providers. Without notice to providers through state administrative regulations and provider manuals, it is impossible for the state to control provider fraud and abuse. Broad state statutes and federal laws and regulations lack the detail necessary to insure that providers have specific notice of program requirements and limitations. Additionally, states must have a mechanism that allows providers to appeal decisions on invoices where payment is denied.

Provider manuals offer an organized structure within which notice is given to providers of recurrent changes in the program. Frequent updating of both regulations and manuals help assure that the state and provider are in compliance with federal requirements as well as guarantee that the state receives the maximum allowable federal matching funds afforded to Alaska.

Federal Accountability

Greater emphasis is being placed on state accountability to the federal government. States no longer have the luxury of running their Medicaid programs on an open account. Fraud and abuse control are being emphasized, and overall state management is being scrutinized. During the summer or fall of 1978, DHEW staff will be reviewing the entire Alaska Medicaid program as part of a nationwide management assessment program. Information from this review will be helpful in assessing the deficiencies and operational needs of the Division of Public Assistance, as well as providing DHEW information upon which it can base specific program improvement requests.

Federal budgeting is being revised to require more accurate quarterly expenditure and estimating reports. Revision is being made in part because DHEW is shifting its budgeting from one-year to three-year projection cycles, which places a greater burden on states to arrive at more accurate cost and utilization projections. The Division of Public Assistance must develop more accurate data to fulfill this budgeting requirement; with the present computer system, it will be extremely difficult to insure compliance in Alaska.

Increasing Efficiency in Claims Processing

A new federal statute that will have great impact on the Division's current operation requires that 90% of all "clean claims" (those invoices which require no correction or additional information from providers prior to payment) must be paid within 30 days of receipt. Given the present manual claims payment system, it will be virtually impossible to comply with this requirement.

In an attempt to speed up the claims processing system, the Division is seeking to shift to a schedule of maximum allowable fees for physician services rather than continuing with the present fee profile system. The basic difference between the two is that with maximum allowable fees, an upper limit is established for all providers for a particular medical or surgical procedure. The state pays the lesser of a provider's usual and customary billing or the maximum allowable fee.

With the current fee profile system, the amount paid varies from provider to provider--even within the same city or clinic! Also, with the fee profile system, providers submit invoices with the amount they normally charge for a service. This is then "adjudicated"--that is, reduced--if the charge exceeds the maximum fee for that procedure as established on the physician's fee profile.

A schedule of maximum allowable fees will guarantee: (1) that all physicians receive equal pay for equal work; (2) that they will receive a fair wage for their work; (3) that their invoices will be paid in a more timely manner; and, (4) that they will have notice at the time they perform the medical or surgical procedure of the amount they can expect to be paid.

Fraud and Abuse

More intensive fraud and abuse controls have been mandated by Public Law 95-142. Post-payment utilization review of medical services has been a requirement for several years. The Division is currently computerizing claims payment information and statistical analysis of that information. This computerized system is necessary in order to comply with the reporting and investigative requirements mandated by this new fraud and abuse legislation.

Medicaid Management Information System (MMIS)

Federal law provides for 90% federal funding for development and 75% funding for operation of MMIS. The funding level for a non-MMIS claims payment and information system is only 50%. Alaska has not yet taken advantage of this offer of funding by HEW. All new federal requirements for budgeting, reporting, claims payment, and fraud and abuse are geared to an MMIS operation. Without such a system, or at least the reporting and statistical analysis portion of that system (surveillance/utilization review), the State of Alaska faces several crises in the Medicaid system which could well result in withholding of federal matching money.

It may be possible for the Division to interface with an MMIS operation in another state, and the Division is currently preparing proposals to make this interface possible. This might be the least expensive means of securing an MMIS program. Another alternative would be the purchase of a surveillance/utilization review system to accompany the present claims payment system. If this latter alternative were used, it would allow the state to comply with reporting and budgeting requirements as well as providing statistical information needed for fraud and abuse control.

Indian Health Care Improvement

Public Law 94-437 (the Indian Health Care Improvement Act) provides for reimbursement of services rendered to Medicaid eligible persons by Indian Health Service (IHS) hospitals by allowing the facilities to bill Medicaid. There will be no impact on the State's portion of Medicaid program costs as all money paid to IHS providers will be 100% federal funds. However, there will be an impact on state administration costs as states must pay their percentage of the cost of processing these additional invoices (in Alaska, without MMIS, this is 50% of cost).

In Alaska, IHS has not yet begun to bill the Division for services provided to Medicaid eligible Natives. Start-up has been postponed as IHS is still in the process of establishing billing mechanisms for each of their facilities in Alaska. Several facilities are now ready to begin billing and full implementation of IHS participation may be achieved by July 1978.

Rural Health Clinics

Public Law 95-210 provides for Medicaid and Medicare reimbursement to rural health clinics.

Under P.L. 95-210, states will be required to provide Medicaid coverage for services provided to eligible recipients by a rural health clinic once a clinic has been certified for participation in the federally-administered Medicare program. In Alaska, this certification is performed by the Division of Public Health Office of Certification and Licensing.

Clinics are staffed by nurse practitioners and physicians assistants trained to provide services traditionally performed by physicians. Although there is need for physician supervision, it may be indirect supervision.

The earliest that Medicaid can cover rural health clinic services is July 1, 1978. In order for this required coverage to be implemented in Alaska it will be necessary for AS 47.07.030 to be amended to include rural health clinics. Also, implementing regulations will be needed to allow provision of medical services by physician assistants and nurse practitioners.

Child Health Assessment Program (CHAP)

A bill is presently in Congress (HR 6706 and SB 1392), which, if enacted, would expand eligibility under the Early Periodic Screening, Diagnosis and Treatment (EPSDT) program to include a larger number of children through modification of eligibility criteria. Medicaid coverage would be extended to children whose families meet some definition of low income but do not qualify for cash assistance payment as currently required for eligibility under the Medicaid program. Under the CHAP proposal, federal financial participation would be increased to 75% federal funding.

This amendment would greatly expand the EPSDT program beyond its current level of operation in Alaska, though the full impact of the proposal cannot be accurately projected until a decision is made on what age limit will be imposed on the low income children to be added to the program.

The amendment points out the necessity for the Division of Public Assistance to identify more accurately all services provided under the existing EPSDT program. The present billing system does not identify all services provided to children as a result of EPSDT screenings. With passage of the CHAP amendment, states will need to be able to identify all CHAP claims in order to receive the 75% federal matching funds. Changes must be made to allow a child to be "tracked" from the time of screening through completion of services performed by licensed providers for medical problems identified by the screening. This is not being done in Alaska currently.

Summary

The Carter administration's emphasis in medical care is gradually moving toward some form of national health insurance program. It appears that before Congress will take any step in that direction it must be proven that the existing Medicaid/Medicare system will operate efficiently. Rising cost of service, over-utilization, improper utilization and provider fraud and abuse must be controlled.

In order for the State of Alaska to fulfill its role within the nationwide framework of health care, and for the Medicaid program in particular, the following broad goals have been set out for our program.

(1) Assessment of services covered or potentially covered under Medicaid and General Relief Medical (including the Medicaid "medically needy" option and the state catastrophic illness program);

(2) Streamlining the claims payment system;

(3) Updating and expanding computer capability to provide for federal and state requirements in reporting and utilization review;

(4) Improvement of procedures to give more accurate notice of the existing program and changes as they occur (regulations, provider manuals, staff manual);

(5) Simplification of structure within the Department of Health and Social Services to allow for more independent operation of the Medicaid program by the Division of Public Assistance;

(6) Adequate staffing of the Division to allow for control of the medical programs within the framework of good management practice.

STATE

HEALTH

ISURE.

#2

Consumer Director of Insurance
Kim Moore
Not advised I was coming

TESTIMONY PREPARED
for
HOUSE OF REPRESENTATIVES
COMMITTEE ON HEALTH EDUCATION & SOCIAL SERVICES
ALASKA STATE LEGISLATURE

March 31, 1980

I apologize publicly to him for this breach of protocol

It is indeed a pleasure for me to appear before you today to discuss legislation which I believe will promote the health of residents of your great state and this great country. I am very pleased that a state legislature is seriously considering enactment of a bill which will guarantee citizens' access to third party payment for health care. It is also very comforting for Minnesotans who have championed this sort of legislation to know that Minnesota is not out of step in fighting for this enlightened program.

I have come a long way to be with you today. It is an awesome responsibility to represent the State of Minnesota, our Governor, Al Quie, and our Insurance Commissioner, Michael D. Markman. I also feel I represent the hundreds of people who toiled for many months before and after the enactment of our law. We had great cooperation from our local insurance people and although the insurance industry continues to be assaulted from many quarters, this is one area in which some of the industry can be justifiably proud.

What success our law has had in promoting access to comprehensive health care to Minnesotans lies in the willingness of the State and the insurance people within that state to join forces to effect the goal of the legislation. Although I could not bring the experts who have made our program work smoothly with me, I did bring some of their work product which I shall leave with you with the hope that it will ease the implementation of the bill upon enactment.

My role here today as I see it is to share with you the experiences and knowledge gained in four years of working with our legislation which is similar to your proposed legislation. The provisions which are similar or nearly identical will of course, lend themselves to a recitation of historical fact. Those that ar unique to your bill will require a forecast.

(2) QUALIFIED MEDICARE SUPPLEMENT PLAN 21 50 040

STATE PLAN PREMIUM 21 50 050

125% of the 5 LARGEST
INSURERS FOR QUALIFIED PLANS

HMO ONLY — GEN ACCEPTED
ACTUARIAL PRINCIPLES.

DUTIES OF DIRECTOR 21 50 060

SAME AS MINN.

COMPREHENSIVE HEALTH ASSOCIATION 21 50 070

INSURERS
SELF INSURERS
FRATERNALS
HMO'S

BOARD (9) ELECTED BY
WEIGHTED VOTE

MANDATORY MEMBERSHIP AS A CONDITION OF
DOING BUSINESS.

ASSOCIATION MAY EXERCISE POWERS (SAME AS MINN

INCLUDES PROVISION
FOR REINSURANCE SAME AS MINN

21 50 110 ENROLLMENT BY ELIGIBLE PERSON

NO PRESUMPTIVE CONDITIONS

6 MONTH WAITING PERIOD ON
90 DAY PRE EXISTING CONDITIONS

21 50 120 SOLICITATION OF ELIGIBLE PERSONS

DISSEMINATE INFO

PUBLIC AWARENESS

25% REFUSALS

NOTIFICATION BY INSURER OF
EXISTANCE OF STATE PLAN UPON
REJECTION FOR COVERAGE

21 50 130 CONVERSION PRIVILEGES

POLICIES WRITTEN OR RENEWED IN
THIS STATE (NOT EXTRATERRITORIA

RIGHT TO CONVERT FOR ANY REASON

~~DISCOUNT~~

INDIVIDUAL COVERAGE MUST BE
QUALIFIED PLAN. (NO CHOICE?)

OPERATION OF STATE PLAN 21 50 080

PROVIDES FOR ENROLLMENT BY ELIGIBLE PERSON

EMPLOYER MAY PAY DIRECT TO W/C

87½ MIN TO PAY CLAIMS
12½ MAX TO W/C

MEMBERS SHARE LOSSES DUE TO CLAIMS EXPENSES.

ADMINISTRATION EXPENSES?

WHY CALL IT REINSURANCE PAYMENTS?

PAYMENTS ASSESSED MAY BE OFFSET BY INCOME TAX OR PREMIUM TAX

21 50 090 MINIMUM BENEFITS OF STATE PLAN

#1 #2 & QUALIFIED MED SUPPLEMENT

HMO WHERE AVAILABLE

(ACTUARIAL EQUIVALENT NOT OFFERED IN MINNESOTA)

21 50 100 ADMINISTRATION OF PLAN

PROPOSED PLANS MAY BE SUBMITTED
(PROTOTYPE OR AE)

Alaska State Legislature

House of Representatives

Committee on

Health, Education & Social Services

Official Business

Pouch V
State Capitol
Juneau, Alaska 99811

21 March 1980

MAR 26 1980

To All Parties Interested in Health Care Coverage:

Hearings for legislation dealing with various health care issues are scheduled for March 31, April 1 and April 2 before the House Health, Education and Social Services Committee.

We are interested in your comments on this important piece of legislation which is presently in draft form. Therefore, we felt that it was necessary to prepare the following summary of the issues contained in the legislation to aid in the preparation of your testimony.

We expect that the legislation will be introduced in the House on March 25 or 26. The bill will be available at Legislative Information Offices throughout the state on the following day.

On March 31 and April 2, the Committee will be hearing testimony in Room 112 of the Capitol at 1:30 pm. On April 1 we will be holding teleconference hearings from Anchorage and Fairbanks from 7:00 - 9:00 pm Juneau time (5:00 - 7:00 pm Anchorage and Fairbanks time) and from all other sites from 1:30 - 3:00 pm Juneau time.

We regret that the bill is not available in its final form at this date. However, we would like to stress that all of the information necessary to formulate comments/testimony is included in the attached summary. Thank you for your cooperation.

Sincerely,

Thelma

Thelma Buchholdt
State Representative
Chair, House HESS Committee

Official Business

Alaska State Legislature

House of Representatives

Committee on

Health, Education & Social Services

Pouch V
State Capitol
Juneau, Alaska 99811

SUMMARY OF HEALTH CARE LEGISLATION

The first section of the bill requires employers to provide health coverage for their regular employees and to pay at least 50% of the premium cost of such coverage. The health coverage must meet or exceed the standards for a "number two qualified plan" as established in the second section of the bill, and must cover the employee's dependents as well. The employer may choose the type of health plan (insurance, self insurance, medical service contract, etc.) and the carrier, provided that employers with 100 or more employees offer each employee a choice of an insurance type plan or a health maintenance organization contract, where a health maintenance organization exists. The employee's share of the premium is automatically withheld from his or her paycheck and may not exceed the amount the employee would have paid if the employer had chosen the most prevalent type of health care plan in the state. The employer is obligated to continue paying his or her share of the premium even if the employee is sick and unable to work, for up to three months or the period for which the employer must continue to pay wages, which ever is larger. Any employee who works for at least twenty hours per week on the average, and has been employed for at least four consecutive weeks, is to be covered. If the employee has health coverage from another source, such as another employer, a government program, or coverage as a dependent under someone else's health plan, the employer is not liable for health coverage for that employee. The bill specifically provides that employees retain the freedom to bargain collectively for health benefits which may differ from those provided under this legislation.

A small employer who can demonstrate undue financial hardship resulting from the mandatory health coverage is entitled to premium supplementation from the state. To qualify (1) the employer must employ fewer than eight employees, (2) the premium for which the employer is liable must exceed 1.5 percent of the total payroll, and (3) the amount that the employer's cost exceeds 1.5 percent of the payroll must exceed five percent of the employer's income from that business, before taxes. A qualifying employer is entitled to subsidy in the amount that his or her costs exceed these standards.

Employers who cover their Alaska employees in a group plan in which the majority of the covered employees are out-of-state and not covered by the act, are given, in section eight of the bill, an additional year to bring the coverage of their Alaska employees up to the standards mandated in the act.

The law mandating employer sponsored coverage would terminate when it is superseded by federal health insurance legislation.

Section two of the bill establishes state standards for "qualified" health insurance plans, and requires insurance carriers to offer qualified plans to all eligible applicants. The bill does not prohibit the offering or sale of unqualified plans. Qualified plans must include benefits for the following: hospital services, professional services rendered by a physician or at his or her direction, prescription drugs, nursing home services, home health agency services, radium, oxygen, anesthetics, prostheses, medical equipment, x-rays and laboratory tests, oral surgery , physical therapy services, medically necessary transportation, well baby care, routine physical exams, multiphasic screening, and other diagnostic testing. The plan must cover at least 80% of the usual and customary charges for covered services, must limit out-of-pocket expenses at least to $3,000 per person annually, and may provide a limit on maximum lifetime benefit of not less than $250,000. A number three qualified plan may have an annual deductible not exceeding $150 per person or $450 per family. A number two qualified plan may have an annaul deductible not exceeding $500 per person or $1500 per family. A number three qualified plan may have an annual deductible not exceeding $1,000 per person or $3000 per family. A qualified Medicare supplement plan must provide coverage of at least 50% of the Medicare deductible and co-payment, provide at least 80% coverage of the services required in a qualified plan which are not covered by Medicare, limit out-of-pocket expenses to no more than $1,000 per person per year, and provide for a maximum lifetime benefit of not less than $100,000. The director has authority to upgrade minimum benefit standards by regulation.

The act also offers health insurance coverage to high risk "uninsurable" clients under the state plan. The state plan provides number one, number two, and Medicare supplement qualified plans at premium rates which may not exceeed 125% of the average premium for a normal risk individual. To qualify, a person must present evidence that they have been refused coverage which is available to a person of standard risk by at least two carriers. The person is not covered for a preexisting condition during the first six months of coverage under the state plan if the person was diagnosed or treated for that condition during the 90 days preceeding the filing of an application.

All health insurance carriers in the state are required to participate in a joint underwriting association to pool the risk of the state plan, to publicize the state plan, and to reinsure other coverage mandated by the act. Losses incurred by the association due to the state plan are to be covered through assessments on association members proportional to their volume of health insurance business in the state. Assessments on members may in turn offset the income tax or premium tax payable by that member to the state. Thus the state is ultimately liable for the losses incurred by the operation of the state plan. The association selects one carrier to act as its agent in writing and issuing each type of state plan insurance for a period of at least three years, and reimburses the carrier or carriers for their expenses.

The act requires that all group health insurance policies written in the state include the right to convert to an individual coverage qualified plan without the addition of underwriting restrictions, regardless of the reason for leaving the group. It also requires that individual policies include a provision that covered dependents may continue coverage following the death of the primary insured, under that or a different contract, without additional underwriting restrictions.

The remaining sections of the bill amend the state's medical assistance programs. The bill provides that the Department of Health and Social Services will purchase health care services for its clients through health insurance policies or through health care service contracts which provide some or all of the services covered by state medical assistance programs.

The bill authorizes the Department to pay a cash advance to providers who serve a large volume of state medical assistance clients. It also requires the state to pay interest on unpaid bills which have been presented by providers which satisfy program requirements for payment. If payment of the bill is delayed more than thirty days from the date it becomes payable, interest is charged at the rate of one percent per month. If payment of the bill is delayed more than six months from the date it becomes payable, interest is charged at the rate of two percent per month.

The bill expands Medicaid coverage to include prescription drugs, adult dental care, dentures, physical therapy, prosthetic devices, chiropractors' services, private duty nursing, podiatrists' services, and other optional services under the federal Medicaid program. Eligibility for Aid to Families with Dependent Children and Medicaid is expanded to cover unborn children.

The bill establishes a medically needy program under the state General Relief program. The monthly income threshold for eligibility is set at 150 percent of the poverty guidelines for Alaska, and includes a spend down provision such that a person who is over income qualifies when the amount of their excess income has been spent on medical bills.

Proofed 3-21

IN THE HOUSE

BY THE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

HOUSE BILL NO.

IN THE LEGISLATURE OF THE STATE OF ALASKA

ELEVENTH LEGISLATURE - SECOND SESSION

A BILL

For an Act entitled: "An Act relating to the health of residents of the state; and providing for an effective date."

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

* Section 1. AS 18 is amended by adding a new chapter to read:

CHAPTER 12. PREPAID HEALTH CARE.

Sec. 18.12.010. COVERAGE OF REGULAR EMPLOYEES BY GROUP PREPAID HEALTH CARE PLAN. (a) An employer who pays to a regular employee monthly wages amounting to 86.67 times the minimum hourly wage established in AS 23.10.065 shall provide coverage for the employee with a prepaid group health care plan or combination of plans which have been certified under AS 21.50.040 as a number two qualified plan including coverage for dependents with a prepaid health care plan contractor in accordance with this chapter.

(b) If the plan of health coverage does not meet the requirements of AS 21.50.040 for a number two qualified plan, the employer shall make available a supplemental plan of health benefits which, when combined with the existing plan of health benefits, constitutes a number two coverage plan.

Sec. 18.12.020. CHOICE OF PLAN TYPE AND OF CONTRACTOR. (a) An employer required to provide coverage for his employees by a prepaid group health care plan under this chapter shall determine whether coverage is provided by

(1) a plan which obligates the prepaid health care plan contractor to furnish the required health care benefits;

(2) a plan which obligates the prepaid health care plan contractor to defray or reimburse the expenses of health care; or

(3) ~~a plan which complies~~ plans under both (1) and (2) in compliance with AS 18.12.030(a).

(b) The election made under (a) of this section is binding for one year.

(c) Whether the employer elects a plan type described in (a)(1) or (2) of this section, the employer may elect the particular contractor but the employee is not obligated to contribute a greater amount to the premium than he would have to contribute had the employer elected coverage with the contractor providing the prevailing coverage of the respective type in the state.

(d) The employer shall provide coverage with the prepaid health care plan contractor selected under (c) of this section for all his employees in the state electing the type of coverage who are covered by the provisions of this chapter, except for employees covered by the health care provisions of an applicable collective bargaining agreement and except as provided in AS 18.12.110.

Sec. 18.12.030. DUAL OPTION. (a) An employer who employs 100 or more persons in the state on the average during a calendar quarter other than employees engaged in seasonal employment, shall, upon the next renewal of the health benefits plan contract, offer his employees an option to obtain health benefits through either an accident and health insurance policy or a health maintenance organization contract if one is available. An option need not be provided if fewer than 25 employees select that option.

(b) An employer may make the offers through an insurer, a health maintenance organization or on a self-insured basis. If an offer is made on a self-insured basis, the accident and health insurance type of coverage or health maintenance organization type of coverage shall meet

the requirements of the laws of the state as to the services covered or benefits provided but is not required to be approved by the director.

(c) An insurer may not make acceptance of its offer to provide insurance coverage contingent on acceptance by the employer of health maintenance organization coverage by a particular health maintenance organization. A health maintenance organization may not make acceptance of its offer to provide health maintenance organization coverage contingent on acceptance by the employer of insurance coverage by a particular insurer. An offer to provide the accident and health insurance policy and the health maintenance organization contract may not combine the two offers in a single price package.

Sec. 18.12.040. LIABILITY FOR PAYMENT OF PREMIUM AND FOR WITHHOLDING. (a) Unless an applicable collective bargaining agreement provides otherwise, an employer shall contribute at least one-half of the premium for the coverage required by this chapter and the employee shall contribute the balance. The employee may not be required to contribute more than 1.5 percent of his wages. If the amount of the employee's contribution is less than one-half of the premium, the employer is liable for the remaining portion of the premium.

(b) The employer shall withhold the employee's share from his wages.

Sec. 18.12.050. COMMENCEMENT OF COVERAGE. The employer shall provide the coverage required by this chapter for any regular employee who has been in his employ for four consecutive weeks at the earliest time after the fourth week at which coverage may be provided with the prepaid health care plan contractor selected in accordance this chapter.

Sec. 18.12.060. CONTINUATION OF COVERAGE. If an employee is prevented by sickness from working, the employer shall enable the employee to continue his coverage by contributing to the premium the amount paid

by the employer toward the premium before the employee's sickness for the period that the employee is prevented by sickness from working. The obligation established by this section may not exceed a period of three months following the month during which the employee became disabled from working or the period for which the employer has paid regular wages to the employee, whichever is longer.

Sec. 18.12.070. LIABILITY OF SECONDARY EMPLOYER. An employer who has been notified by an employee on a form prescribed by the commissioner that he is not the principal employer is relieved from the duty to provide coverage required by this chapter until he is notified by the employee under /S 18.12.090 that he has become the principal employer. A secondary employer shall notify the commissioner on a form prescribed by the commissioner that he is relieved from the duty of providing coverage and of any change in that status.

Sec. 18.12.080. EXEMPTION OF CERTAIN EMPLOYEES. (a) In addition to the exemption granted by AS 18.12.070, an employer is relieved of his obligations under AS 18.12.010 to an employee who has notified him on a form specified by the commissioner that the employee is

(1) protected by health insurance or a prepaid health care plan established under a law of the United States;

(2) covered as a dependent under a prepaid health care plan, entitling him to the health benefits required by this chapter;

(3) a recipient of public assistance or covered by a prepaid health care plan established under the laws of the state governing medical assistance.

(b) An employer receiving notice of a claim of exemption under this section shall notify the commissioner of the claim on a form prescribed by the commissioner.

Sec. 18.12.090. TERMINATION OF EXEMPTION. (a) If an exemption

claimed by an employee under AS 18.12.080 terminates the employee shall notify the principal employer promptly of the termination of the exemption and the employer shall provide coverage as required by this chapter.

(b) If a principal employer becomes a secondary employer or a secondary employer becomes the principal employer because of a change in the employment situation of an employee or a redetermination by an employee under AS 18.12.100, the employee shall promptly notify the employers affected of the change and the new principal employer shall provide coverage required by this chapter.

Sec. 18.12.100. PRINCIPAL AND SECONDARY EMPLOYERS. (a) If an individual is concurrently a regular employee of two or more employers, the principal employer is the employer who pays him the most wages. If the employer who does not pay the most wages employs the regular employee for at least 35 hours per week, the employee shall determine which of the employers is his principal employer and his other employers are secondary employers. An employer designated as the principal employer remains the principal employer for one year or until change of employment, whichever occurs first.

(b) If an individual is concurrently a regular employee of a public entity which is not an employer under this chapter and of an employer under this chapter, the latter is a secondary employer.

(c) An employer who directly or indirectly interferes with or coerces or attempts to coerce an employee in making a determination under this section is guilty of a class B misdemeanor.

Sec. 18.12.110. FREEDOM OF COLLECTIVE BARGAINING. (a) This chapter may not be construed to limit the freedom of employees to bargain collectively for different prepaid health care plan coverage or for a different allocation of the costs of the coverage. A collective

bargaining agreement may provide that the employer will provide the health care specified in an agreement.

(b) If certain employees are not covered by the health care provisions of an applicable collective bargaining agreement to which their employer is a party, this chapter applies to them. An employer or group of employers has complied with this chapter if the employer or group of employers undertakes to provide health care services under a collective bargaining agreement and the services are available to all employees not covered by the agreement.

Sec. 18.12.120. INDIVIDUAL WAIVERS PROHIBITED. An employee as an individual may not waive the required health care benefits or agree to pay a greater share of the premium for the benefits than is required by this chapter.

Sec. 18.12.130. JOINT PROVISION OF COVERAGE. For the purpose of providing prepaid health care protection under this chapter for their employees, employers may form associations with the contractors authorized to provide coverage in the state.

Sec. 18.12.140. POWERS OF THE COMMISSIONER. The commissioner may adopt regulations necessary for the administration and enforcement of this chapter.

Sec. 18.12.150. PENALTIES. (a) An employer who fails to comply with AS 18.12.010 - 18.12.040 shall pay a penalty of not less than $25 or of $1 for each employee for every day during which the failure continues, whichever is greater. The penalty shall be assessed under regulations adopted by the commissioner under the Administrative Procedure Act (AS 44.62) and shall be collected by the commissioner and paid into the general fund. The commissioner may, for good cause shown, remit all or a part of the penalty.

(b) An employer, employee, or prepaid health care plan contractor

who wilfully fails to comply with this chapter or a regulation adopted under it may be fined not more than $200 for each violation.

Sec. 18.12.160. ENTITLEMENT TO PREMIUM SUPPLEMENTATION. (a) An employer who employs less than eight employees entitled to coverage under this chapter and who provides coverage to the employees under AS 18.12.010 is entitled to premium supplementation if the employer's share of the cost of providing the coverage as determined under AS 18.12.040 and 18.12.060 exceeds 1.5 percent of the total wages payable to the employees and if the amount of the excess is greater than five percent of the employer's income before taxes directly attributable to the business in which the employees are employed.

(b) The amount of the supplementation shall be that part of the employer's share of the premium cost which exceeds the limits specified in (a) of this section.

Sec. 18.12.170. CLAIM OF PREMIUM SUPPLEMENTATION. An employer entitled to premium supplementation may file a claim in the manner provided by regulation of the commissioner. The employer has the burden of establishing his entitlement.

Sec. 18.12.180. EXISTING PLANS. This chapter may not be construed to interfere with or diminish protection already provided under collective bargaining agreements or employer-sponsored plans more favorable to the employees benefited by them than the protection provided by this chapter.

Sec. 18.12.190. TERMINATION OF CHAPTER. This chapter terminates on the effective date of federal legislation that provides for voluntary prepaid health care for the people of this state in a manner at least as favorable as the health care provided by this chapter or upon the effective date of federal legislation that provides for mandatory prepaid health care for the people of this state.

Sec. 18.12.~~1~~2~~5~~50. DEFINITIONS. In this chapter

(1) "commissioner" means the commissioner of labor;

(2) "employer"

(A) means an individual or any type of organization, including a partnership, association, trust, estate, joint stock company, insurance company, or corporation, whether domestic or foreign, a debtor in possession or receiver or trustee in bankruptcy, or the legal representative of a deceased person, who has one or more regular employees in his employment

(B) does not mean

(i) the state, a municipality of the state or an instrumentality of the state or its municipalities;

(ii) the United States government or an instrumentality of the United States;

(iii) another state or municipality or instrumentality of another state or municipality;

(iv) a foreign government or instrumentality wholly owned by a foreign government, if the service performed in its employ is of a character similar to that performed in foreign countries by employees of the United States government or of an instrumentality of the United States, and the United States Secretary of State certifies to the United States Secretary of the Treasury that the foreign government, with respect to whose instrumentality exemption is claimed, grants an equivalent exemption for similar service performed in the foreign country by employees of the United States government and instrumentalities of the United States;

(3) "employment"

(A) means service, including service in interstate

commerce, performed for wages under a contract of hire, written or oral, expressed or implied, with an employer, either inside or both inside and outside the state if:

(i) the service is localized in the state; or

(ii) the service is not localized in any state but some of the service is performed in the state and the individual's base of operation, or, if there is no base operation, the place from which the service is directed or controlled, is in the state; or the individual's base of operation or place from which the service is directed or controlled is not in any state in which some part of the service is performed but the individual's residence is in the state;

(B) does not mean service

(i) performed by an individual in the employ of an employer who, under the laws of the United States, is responsible for care and cost in connection with the service;

(ii) performed by an individual in the employ of his spouse, son, or daughter, and service performed by an individual under the age of 21 in the employ of his father or mother;

(iii) performed in the employ of a voluntary employee's beneficiary association providing for the payment of life, sickness, accident, or other benefits to the members of the association or their dependents or their designated beneficiaries, if admission to membership in the association is limited to individuals who are officers or employees of the United States government, and no part of the net earnings of the association inures (other than through such payments) to the benefit of a private shareholder or individual;

(iv) performed by an individual for an employer as an insurance agent or as an insurance solicitor, if all the service performed by the individual for the employer is performed for remuneration solely by way of commission;

(v) performed by an individual for an employer as a real estate salesman or as a real estate broker, if all the service performed by the individual for the employer is performed for remuneration solely by way of commission;

(4) "income directly attributable to the business"

(A) means gross profits from the business less deductions for

(i) compensation of officers;

(ii) salaries and wages, except wages paid by an individual proprietor to himself;

(iii) repairs;

(iv) taxes on business and business property;

(v) business advertising;

(vi) amounts contributed to employee benefit plans;

(vii) interest on business indebtedness;

(viii) rent on business property; and

(ix) other expenses necessary for the current conduct of business;

(B) does not mean

(i) bad debts;

(ii) contributions or gifts, other than those listed under (A)(vi) of this paragraph;

(iii) amortization and depreciation; or

(iv) losses by fire, storm, casualty, or theft;

(5) "premium" means an amount payable to a prepaid health

care plan contractor as consideration for his obligations under a prepaid health care plan;

(6) "prepaid health care plan" means an agreement by which a prepaid health care plan contractor undertakes in consideration of a stipulated premium

(A) to furnish health care, including hospitalization, surgical, medical or nursing care, drugs or other restorative appliances, subject to, if at all, only a nominal per service charge; or

(B) to defray or reimburse, in whole or in part, the expenses of health care;

(7) "prepaid health care plan contractor" means

(A) a medical group or organization which undertakes under a prepaid health care plan to provide health care;

(B) a nonprofit organization which undertakes under a prepaid health care plan to defray or reimburse in whole or in part the expenses of health care; or

(C) an insurer who undertakes under a prepaid health care plan to defray or reimburse in whole or in part the expenses of health care;

(8) "regular employee" means a person employed in the employment of any employer for at least 20 hours per week;

(9) "wages"

(A) means cash remuneration for services from whatever source, including commissions, bonuses, and tips and gratuities paid directly to an individual by a customer of the employer; if the employee does not account to his employer for the tips and gratuities received and is engaged in an occupation in which he customarily and regularly receives more than $200 a month in tips,

the combined amount received by him from his employer and from tips is considered to be at least equal to the wage required by AS 23.-10.065 or a greater sum as determined by regulation of the commissioner;

(B) does not mean the amount of a payment

(i) specified in AS 23.20.530(b);

(ii) received for nonoccupational sickness or accident; or

(iii) received as workers' compensation.

* Sec. 2. AS 21 is amended by adding a new chapter to read:

CHAPTER 50. COMPREHENSIVE HEALTH INSURANCE.

Sec. 21.50.010. DUTIES OF INSURERS. (a) For each type of qualified plan described in AS 21.50.030, an insurer or fraternal issuing individual policies of accident and health insurance in the state other than group conversion policies shall develop and file with the director an individual policy which meets the minimum standards of that type of qualified plan. An insurer or fraternal issuing individual policies of accident and health insurance in the state shall offer each type of qualified plan to each person who applies and is eligible for accident and health insurance from that insurer or fraternal.

(b) An insurer or fraternal issuing Medicare supplement plans in the state shall develop and file with the director a Medicare supplement policy which meets the minimum standards of a qualified Medicare supplement plan. An insurer or fraternal issuing Medicare supplement plans in the state shall offer a qualified Medicare supplement plan to each person who is eligible for coverage and who applies for a Medicare supplement plan.

(c) For each type of qualified plan described in AS 21.50.040, an insurer or fraternal issuing group policies of accident and health

insurance in the state shall develop and file with the director a group policy which provides for each member of the group the minimum benefits required by that type of qualified plan. An insurer or fraternal issuing group policies of accident and health insurance in the state shall offer each type of qualified plan to each eligible applicant for group accident and health insurance.

(d) Each insurer and fraternal shall include coverage of major medical costs in every unqualified policy of accident and health insurance, unless the applicant for a new or renewal policy declines the coverage in writing. The coverage shall provide that when a covered individual incurs out-of-pocket expenses of $5,000 or more in a calendar year for services covered under AS 21.50.030(a), benefits shall be payable, subject to any copayment authorized by the director, up to a maximum lifetime limit of $250,000.

(e) A policy of accident and health insurance may not be issued or renewed in the state after January 1, 1981, by an insurer or a fraternal which has not complied with this section.

(f) An insurer or fraternal may fulfill its obligations under this section by issuing the required coverages in its own name and reinsuring the risk and administration of the coverages with the association in accordance with AS 21.50.030(g)(5) and (6).

(g) This section does not require an insurer or fraternal to offer or issue a policy to a person who does not meet the underwriting or membership requirements of the insurer or fraternal.

Sec. 21.50.020. CERTIFICATION OF QUALIFIED PLANS. On application by an insurer, fraternal, or employer for certification of a plan of health coverage as a qualified plan or a qualified Medicare supplement plan for the purposes of AS 21.50.010 - 21.50.130 the director shall determine within 90 days whether the plan is qualified. Each plan of

health coverage shall be labeled as "qualified" or "nonqualified" on the front of the policy or evidence of insurance. A qualified plan shall indicate whether it is a number one, two, or three coverage plan.

Sec. 21.50.030. MINIMUM BENEFITS OF QUALIFIED PLAN. (a) A plan of health coverage shall be certified as a number three qualified plan whether or not the policy is issued in the state if it meets or exceeds the following minimum standards:

(1) The minimum benefits for a covered individual shall, subject to the other provisions of this subsection, be equal to at least 80 percent of the cost of covered services in excess of an annual deductible which may not exceed $150 per person, or $450 per family. The coverage shall include a limitation of $3,000 per person on total annual out-of-pocket expenses for services covered under this subsection. The coverage may be subject to a maximum lifetime benefit of not less than $250,000. Covered expenses shall be the usual and customary charges for the following services and articles when prescribed by a physician:

(A) hospital services;

(B) professional services for the diagnosis or treatment of injuries, illnesses, or conditions, other than outpatient mental or dental, which are rendered by a physician or at his direction;

(C) drugs requiring a physician's prescription;

(D) services of a nursing home for not more than 120 days in a year if the services begin within 14 days following confinement of at least three days in a hospital for the same condition;

(E) service of a home health agency up to a maximum of 180 visits per year;

(F) use of radium or other radioactive materials;

(G) oxygen;

(H) anesthetics;

(I) prostheses;

(J) rental or purchase, as appropriate, of durable medical equipment;

(K) diagnostic x-rays and laboratory tests;

(L) oral surgery for partially or completely unerupted impacted teeth, a tooth root without the extraction of the entire tooth, or the gums and tissues of the mouth when not performed in connection with the extraction or repair of teeth;

(M) services of a physical therapist;

(N) medically necessary transportation.

(2) Covered expenses for the services and articles specified in this subsection do not include the following:

(A) a charge for care for an injury or disease either arising out of an injury in the course of employment and subject to a worker's compensation law or for which benefits are payable under another policy of accident and health insurance or Medicare;

(B) a charge for treatment for cosmetic purposes other than surgery for the repair of an injury or birth defect;

(C) a charge for confinement in a private room to the extent it is in excess of the institution's charge for its most common semi-private room, unless a private room is prescribed as medically necessary by a physician;

(D) that part of a charge for services or articles rendered or prescribed by a physician, dentist, or other health care personnel which exceeds the prevailing charge in the locality where the service is provided;

(E) a charge for services or articles the provision of which is not within the scope of authorized practice of the in-

stitution or individual rendering the services or articles.

(3) The minimum benefits for a qualified plan shall include, in addition to those benefits specified in (a)(1) of this section, benefits for the following services subject to applicable deductibles, coinsurance provisions, and maximum lifetime benefit limitations:

(A) well baby care;

(B) physicians' services for routine checkups and annual physicals when prescribed by a physician;

(C) multiphasic screening and other diagnostic testing.

(b) The director shall prescribe by regulation reasonable limits on the reimbursement required for the services specified in (a) of this section.

(c) A plan of health coverage shall be certified as a number two qualified plan if it meets the requirements established by the laws of the state and provides for payment of 80 percent of the covered expenses required by this section in excess of a deductible which does not exceed $500 per person. or $1500 per family

(d) A plan of health coverage shall be certified as a number one qualified plan if it meets the requirements established by the laws of the state and provides for payment of 80 percent of the covered expenses required by this section in excess of a deductible which does not exceed $1,000 per person. or $3000 per family

(e) A health maintenance organization which provides the services required by (a) of this section is providing a number three qualified plan.

Sec. 21.50.040. QUALIFIED MEDICARE SUPPLEMENT PLAN. A plan which provides benefits to persons over the age of 65 years may be certified as a qualified Medicare supplement plan if the plan is designed to supplement Medicare and provides coverage of 50 percent of the deduc-

tible and copayment required under Medicare and 80 percent of the charges for covered services described in AS 21.50.030(a) which charges are not paid by Medicare. The coverage shall include a limitation of $1,000 per person on total annual out-of-pocket expenses for the covered services. The coverage may be subject to a maximum lifetime benefit of not less than $100,000.

Sec. 21.50.050. STATE PLAN PREMIUM. (a) The association shall establish the following premiums to be charged for membership in the state plan:

(1) The premium for the number one qualified plan may not exceed 125 percent of the average of rates charged by the five insurers with the largest number of individuals in a number one individual qualified plan of insurance in force in the state.

(2) The premium for the number two qualified plan may not exceed 125 percent of the average of rates charged by the five insurers with the largest number of individuals in a number two individual qualified plan of insurance in force in the state.

(3) The premium for a qualified Medicare supplement plan may not exceed 125 percent of the average of rates charged by the five insurers with the largest number of individuals enrolled in a qualified Medicare supplement plan.

(4) The charge for health maintenance organization coverage shall be based on generally accepted actuarial principles.

(b) The schedule of premiums for coverage under the state plan shall be designed to be self-supporting and based on generally acce actuarial principles.

Sec. 21.50.060. DUTIES OF DIRECTOR. The director may

(1) formulate general policies to advance the purposes of AS 21.50.010 - 21.50.140 and may adopt regulations under the Admin

tive Procedure Act (AS 44.62) to carry out AS 21.50.010 - 21.50.140.;

(2) adopt regulations revising minimum benefit standards under AS 21.50.010 - 21.50.040 as may be appropriate due to inflation or changes in prevailing industry standards;

(3) supervise the establishment of a comprehensive health association within the limits described in AS 21.50.050;

(4) approve the selection of the writing carrier by the association and approve the association's contract with the writing carrier including the state plan coverage and premiums to be charged;

(5) appoint advisory committees;

(6) conduct periodic audits to assure the general accuracy of the financial data submitted by the writing carrier and the association;

(7) contract with the federal government or another unit of government to ensure coordination of the state plan with other governmental assistance programs;

(8) undertake directly or through contracts studies or demonstration programs to develop awareness of the benefits of AS 21.50.010 - 21.50.140, so that the residents of the state may avail themselves of the health care benefits provided by these sections.

Sec. 21.50.070. COMPREHENSIVE HEALTH ASSOCIATION. (a) There is established a comprehensive health association with membership consisting of all insurers, self-insurers, fraternals, and health maintenance organizations licensed or authorized to do business in this state.

(b) The board of directors of the association shall be made up of seven individuals selected by participating members, subject to approval by the director. To select the initial board of directors and to initially organize the association, the director shall give notice to all members of the time and place of the organizational meeting. In

determining voting rights at the organizational meeting, each member shall be entitled to vote in person or by proxy. The vote shall be a weighted vote based on the member's cost of self-insurance, accident and health insurance premium, subscriber contract charges, or health maintenance contract payment derived from or on behalf of residents in the previous calendar year, as determined by the director. If the board of directors is not selected within 60 days after notice of the organizational meeting, the director may appoint the initial board. In approving or selecting members of the board, the director shall consider, among other things, whether all types of members are fairly represented. Members of the board may be reimbursed from the money of the association for expenses incurred by them as members, but may not otherwise be compensated by the association for their services. The costs of conducting meetings of the association and its board of directors shall be borne by members of the association.

(c) Members shall maintain their membership in the association as a condition of doing business in the state. The association shall submit bylaws and operating rules to the director for approval.

(d) Meetings of the association, its board, and committees of the association shall comply with AS 44.62.310.

(e) Members shall enter into a contract with the association according to terms specified in AS 21.50.080. The contract of reinsurance shall be executed for a period of one year and may be renewed annually. A company which ceases to do business in the state remains liable under the contract for the reinsurance contracted for during that calendar year.

(f) In the performance of their duties as members of the association, the members are exempt from the provisions of AS 45.52.

(g) The association may

(1) exercise the powers granted to insurers under the laws of the state;

(2) sue or be sued;

(3) enter into contracts with insurers, similar associations in other states, or other persons for the performance of administrative functions including the functions provided for in (5) and (6) of this subsection;

(4) establish administrative and accounting procedures for the operation of the association;

(5) provide under (h) of this section for the reinsuring of risks incurred as a result of issuing the coverages required by AS 21.50.010 and 21.50.120 by members of the association;

(6) provide under (i) of this section for the administration by the association

of policies which are reinsured under (5) of this subsection.

(h) Each member which elects to reinsure its required risks under (g)(5) of this section shall determine the categories of coverage it elects to reinsure in the association. The categories of coverage are: (1) individual qualified plans, excluding group conversions; (2) group conversions; (3) group qualified plans with fewer than 50 employees or members; and (4) major medical coverage. A separate election may be made for each category of coverage. If a member elects to reinsure the risks of a category of coverage, it must reinsure the risk of the coverage of every life covered under every policy issued in that category. Members electing to administer the risks which are reinsured in the association shall comply with the benefit determination guidelines and accounting procedures established by the association. The fee charged by the association for the reinsurance of risks may not be less than 11 percent of the total anticipated expenses incurred by the association

for the reinsurance.

(i) Each member electing to reinsure one or more categories of coverage in the association under (g)(6) of this section may elect to have the association administer the categories of coverage on the member's behalf under (g)(6) of this section. If a member elects to have the association administer the categories of coverage, it must do so for every life covered under every policy issued in that category. The fee for the administration shall not be less than 110 percent of the total anticipated expenses incurred by the association for the administration.

see page 37 discussion

Sec. 21.50.080. OPERATION OF STATE PLAN. (a) Upon certification as an eligible person under AS 21.50.110, an eligible person may enroll in the state plan by payment of the state plan premium to the writing carrier.

(b) An employer which has in its employ one or more eligible persons enrolled in the state plan may make all or a portion of the state plan premium payment to the state plan directly to the writing carrier.

(c) Not less than 87-1/2 percent of the state plan premium paid to the writing carrier shall be used to pay claims and not more than 12.1/2 percent shall be used for the payment of agent referral fees authorized in AS 21.50.120(c) and for payment of the writing carrier's direct and indirect expenses, as specified in AS 21.50.100(g).

(d) Income in excess of the costs incurred by the association in providing reinsurance or administrative services shall be held at interest and used by the association to offset losses due to claims expenses of the state plan or allocated to reduce state plan premiums.

(e) Each member of the association shall share the losses due to claims expenses of the state plan according to the terms of the individual reinsurance contracts executed by the association with each

member in accordance with AS 21.50.070(e). Deviations in the claim experience of the state plan from the premium payments allocated to the payment of benefits shall be the liability of the association members. Association members shall share in the excess costs of the state plan in an amount equal to the ratio of the member's total cost of self-insurance, accident and health insurance premium, subscriber contract charges, or health maintenance organization contract charges received from or on behalf of state residents as divided into the total cost of self-insurance, accident and health insurance premium, subscriber contract charges, and health maintenance organization contract charges, received by all association members from or on behalf of state residents, as determined by the director. The reinsurance contract shall provide for a retroactive determination of each member's liability and payment due within 30 days after each renewal date of the re-insurance contract. Failure by a member to tender to the association the assessed reinsurance payment within 30 days of notification by the association is grounds for termination of the member's membership. Net gains from the operation of the state plan shall be held at interest and used by the association to offset future losses due to claims expenses of the state plan or allocated to reduce state plan premiums.

(f) The assessed reinsurance payment levied against a member may be offset against the income tax or the premium tax payable under this title by the member payable under AS 43.20 for the year in which the payment is assessed. The commissioner of revenue shall report not later than the 10th day of a regular session to the legislature the total amount of income tax or premium tax offset claimed by members during the preceding calendar year.

Sec. 21.50.090. MINIMUM BENEFITS OF STATE PLAN. The association through its state plan shall offer policies which provide the benefits

of a number one qualified plan, a number two qualified plan, and a qualified Medicare supplement plan. It shall offer health maintenance organization contracts in those areas of the state where a health maintenance organization has agreed to make the coverage available and has been selected as a writing carrier.

Sec. 21.50.100. ADMINISTRATION OF PLAN. (a) A member of the association may submit to the director the policies of accident and health insurance or the health maintenance organization contracts which are being proposed to serve in the state plan. The time and manner of the submission shall be prescribed by regulation of the director.

(b) On the director's approval of the policy forms and contracts submitted under AS 21.50.070, the association shall select policies and contracts submitted by a member or members of the association to be the comprehensive health insurance plan. This selection shall be based on criteria including the member's proven ability to handle large group accident and health insurance cases, efficient claim paying capacity, and the estimate of total charges for administering the plan. The association may select separate writing carriers for the two types of qualified plans, the qualified Medicare supplement plan, and the health maintenance organization contract.

(c) The writing carrier shall perform all administrative and claims payment functions required by this section. The writing carrier shall provide these services for a period of three years, unless a request to terminate is approved by the director. The director shall approve or deny a request to terminate within 90 days of its receipt. The failure to approve or deny a request to terminate within 90 days of its receipt constitutes an approval. Six months before the expiration of each three-year period, the association shall invite submissions of policy forms from members of the association, including the writing

carrier. The association shall select a writing carrier for the following three-year period under (b) of this section.

(d) The writing carrier shall provide to all eligible persons enrolled in the plan an individual certificate which contains a clear and easily understandable statement as to the insurance protection to which he is entitled, with whom claims are to be filed, and to whom benefits are payable. The certificate shall indicate that coverage was obtained through the association.

(e) The writing carrier shall submit to the association and the commissioner on a monthly basis a report on the operation of the state plan. Specific information to be contained in this report shall be determined by the association before the effective date of the state plan.

(f) All claims shall be paid by the writing carrier under the provisions of AS 21.50.010 - 21.50.140 and shall indicate that the claim was paid by the state plan. Each claim payment shall include information specifying the procedure to be followed in the event of a dispute over the amount of payment.

(g) The writing carrier shall be reimbursed from the state plan premiums received for its direct and indirect expenses. Direct and indirect expenses include but are not limited to a pro-rata reimbursement for the portion of the writing carrier's administrative, printing, claims administration, management and building overhead expenses which are assignable to the maintenance and administration of the state plan. The association shall approve cost accounting methods to substantiate the writing carrier's cost reports consistent with generally accepted accounting principles. Direct and indirect expenses may not include costs directly related to the original submission of policy forms before selection as the writing carrier.

(h) The writing carrier is an agent of the association and the director with civil liability subject to the provisions of AS 09.50.250 09.50.300 when carrying out its duties under AS 21.50.010 - 21.50.140.

(i) Premiums received by the writing carrier for the state plan are exempt from the requirements of AS 21.50.130(c).

Sec. 21.50.110. ENROLLMENT BY ELIGIBLE PERSON. (a) The state plan is open for enrollment by eligible persons. An eligible person may enroll by submission of a certificate of eligibility to the writing carrier which provides:

(1) name, address, age, and length of time at residence of the applicant;

(2) name, address, and age of spouse and children, if any, if they are to be insured;

(3) evidence of rejection, or a requirement of restrictive riders, or a preexisting conditions limitation on a qualified plan by at least two association members within six months of the date of the certificate, the effect of which is to reduce coverage substantially from that received by a person considered a standard risk;

(4) a designation of the coverage desired.

(b) Within 30 days of receipt of the certificate described in (a) of this section, the writing carrier shall either reject the application for failing to comply with the requirements in (a) of this section or forward the eligible person a notice of acceptance and billing information. Insurance is effective immediately upon receipt of the first month's state plan premium and shall be retroactive to the date of application if the applicant otherwise complies with the requirements of AS 21.50.010 - 21.50.140. An eligible person may not purchase more than one policy from the state plan.

(c) A person who obtains coverage under this section is not

covered for a preexisting condition during the first six months of coverage under the state plan if the person was diagnosed or treated for that condition during the 90 days immediately preceding the filing of an application.

Sec. 21.50.120. SOLICITATION OF ELIGIBLE PERSONS. (a) The association shall disseminate appropriate information to the residents of the state under a plan approved by the director regarding the existence of the state plan and the means of enrollment.

(b) The association shall maintain public awareness of the provisions of AS 21.50.010 - 21.50.140 and shall administer this chapter in a manner which encourages public participation in the state plan.

(c) The writing carrier shall pay an agent's referral fee of $25 to each insurance agent who refers an applicant to the state plan if the application is accepted. Selling or marketing of qualified state plans may not be limited to the writing carrier or its agents. The referral fees shall be paid by the writing carrier from money received as premiums for the state plan.

(d) Every insurer which rejects or applies underwriting restrictions to an applicant for accident and health insurance shall notify the appplicant of the existence of the state plan, the requirements for being accepted in it, and the procedure for applying to it.

Sec. 21 50.130. CONVERSION PRIVILEGES. (a) Each program of self-insurance and each policy of group accident and health insurance or contract of coverage by a health maintenance organization written or renewed in the state shall include the right to convert to an individual coverage qualified plan without the addition of underwriting restrictions regardless of the reason for leaving the group. A person leaving the group may exercise his right to conversion within 30 days of leaving the group.

(b) Plans of health coverage shall include a provision which, upon the death of the individual in whose name the contract was issued, permits an individual then covered under the contract to elect, within the period specified in the contract, to continue coverage under the same or a different contract without the addition of underwriting restrictions until he would have ceased to be entitled to coverage had the individual in whose name the contract was issued lived.

Sec. 21.50.200. DEFINITIONS. In this chapter,

(1) "accident and health insurance policy" or "policy"

(A) means insurance or nonprofit health service plan contracts providing benefits for hospital, surgical, and medical care;

(B) does not mean coverage which is

(i) limited to disability or income protection coverage,

(ii) automobile medical payment coverage,

(iii) supplemental to liability insurance,

(iv) sold by fraternals and provides payments on a per diem, daily indemnity or nonexpense-incurred basis;

(2) "association" means a comprehensive health association established under AS 21.50.070;

(3) "dependent" means a spouse or unmarried child under the age of 18 years, a child who is a student under the age of 25 years and financially dependent upon the parent, a dependent child of any age who is disabled, or a household member who is financially dependent on the primary insured;

(4) "director" means the director of insurance;

(5) "eligible person" means an individual who is a resident of the state and meets the enrollment requirements of AS 21.50.110;

(6) "fraternal" means a corporation, society, order, or voluntary association without capital stock which sells health and accident insurance in accordance with AS 21.84;

(7) "gross income" means income under AS 43.20;

(8) "health benefits" means benefits offered to employees on an indemnity or prepaid basis which pays the costs of or provide medical, surgical, or hospital care;

(9) "health maintenance organization" means a nonprofit corporation organized and operated under 42 U.S.C. sec. 300e;

(10) "insurer"

(A) means a company offering, selling, issuing or renewing policies or contracts of accident and health insurance;

(B) does not mean health maintenance organization;

(11) "Medicare" means Part A and Part B of the United States Social Security Act, Title XVIII, as amended, 42 U.S.C. sections 1394, et seq;

(12) "Medicare supplement plan" means a plan of insurance protection which provides benefits for the costs of medical, surgical, or hospital care and which is marketed as providing benefits which complement or supplement the benefits provided by Medicare;

(13) "plan of health coverage" means a plan or combination of plans of coverage, including combinations of self-insurance, individual accident and health insurance policies, group accident and health insurance policies, coverage under a nonprofit health service plan, or coverage under a health maintenance organization subscriber contract;

(14) "qualified expense" means a charge incurred for a health service which is included in the list of covered services described in AS 21.50.040(a) and for which no third party is liable;

(15) "qualified Medicare supplement plan" means a health

benefit plan which has been certified by the director as providing the minimum benefits required by AS 21.50.050 or the actuarial equivalent of those benefits;

(16) "qualified plan" means those health benefit plans which have been certified by the director as providing the minimum benefits required by AS 21.50.040 or the actuarial equivalent of those benefits;

(17) "self-insurance" means a plan of health coverage offered by a self-insurer;

(18) "self-insurer"

(A) means an employer who directly provides a plan of health coverage to his employees and administers the plan of health coverage himself or through an insurer;

(B) does not mean an employer engaged in the business of providing health care services to the public who provides health care services directly to his employees at no charge to them;

(19) "state plan" means policies of comprehensive health insurance and contracts of health maintenance organization coverage offered by the association through the writing carrier under this chapter;

(20) "state plan premium" means a premium determined under AS 21.50.060;

(21) "third party" means a person other than the eligible person or his dependents;

(22) "writing carrier" means an insurer or insurers and a hospital or medical service corporation or corporations selected by the association and approved by the director to administer the comprehensive health insurance plan.

* Sec. 3. AS 47.07 is amended by adding new sections to read:

ARTICLE 2. INSURANCE AND SERVICE CONTRACTS.

Sec. 47.07.100. MEDICAL ASSISTANCE BY INSURANCE OR SERVICE CONTRACTS. (a) The commissioner shall use available medical assistance funds to purchase and pay premiums on policies of insurance or pay the expenses on health care service contracts or medical or hospital service contracts that provide one or more of the medical and remedial care and services available under medical assistance for the benefit of the categorically or the medically needy.

(b) The policy of insurance or the contract must by its terms guarantee

(1) to provide medical and remedial care and services of the type and according to the standards prescribed under AS 47.07.030;

(2) to pay providers of medical and remedial care and services the amount due, based on the number of days of care and the fees, charges, and costs established under AS 47.04.030 except as to medical or hospital service contracts issued by a hospital association which employs a method of accounting or payment on other than a fee for service basis;

(3) to provide medical and remedial care and services under policies of insurance or contracts in compliance with applicable laws and regulations;

(4) to provide the statistical data, records, and reports relating to the provision, administration, and costs of providing medical and remedial care and services as required by the commissioner.

Sec. 47.07.110. RATES ON INSURANCE OR SERVICE CONTRACTS. (a) The commissioner shall establish uniform areawide rates for the payment on policies of insurance or service contracts from available medical assistance funds.

(b) The commissioner may not pay a premium or other periodic charge on a policy of insurance, health care service contract, or

hospital service contract unless the insurer or contractor issuing the policy or contract is authorized to do business in the state.

Sec. 47.07.120. CONTRACTS WITH DIRECT PROVIDERS OF CARE AND SERVICE. (a) The commissioner may enter into nonexclusive contracts under which funds available for medical assistance may be administered and disbursed by the contractor to direct providers of medical and remedial care and services available under medical assistance for services rendered and supplies furnished by them under this chapter. Payment shall be made under AS 47.07.030.

(b) A contract under this section shall

(1) oblige the contractor to make payments under the contract promptly and not later than 30 days after receipt of the proper evidence of the claim; and

(2) provide data, records, and reports required by the commissioner.

Insert. Pick up Secs. 130 & 150 from page 32

* Sec. 4. AS 47.07.0~~X~~0 is amended to read:

Sec. 47.07.030. MEDICAL SERVICES TO BE PROVIDED. Medical services to be offered to eligible persons include inpatient hospital, outpatient hospital, rural health clinic, outpatient surgical care centers, laboratory and ~~X~~-ray, refractions and eye examinations by ophthalmologists or optometrists, eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist, podiatrist services chiropractic services, private duty nursing, physical therapist services occupational therapy services, dental services and dentures, personal care services, prosthetic services, prescribed drugs, inpatient psychiatric hospital, skilled nursing and intermediate care facility services for persons age 65 or older and persons under age 21, skilled and intermediate nursing home, physician, home health care services, early periodic screening diagnosis and treatment of persons under 21

years of age, inpatient, skilled nursing, and intermediate care facility services for persons 65 years of age or older, clinic services, treatment of speech, hearing and language disorders, diagnostic, screening, prevention, and rehabilitation services and reasonable transportation to and from the point of medical care. No additional services may be provided unless approved by the legislature.

Sec. 47.07.130. IMPLEMENTATION. The commissioner shall implement the provisions of AS 47.07.100 - 47.07.130 when the commissioner determines that comparable benefits at equal or less cost than direct payments by the department to the providers of medical assistance.

Sec. 47.07.150. DEFINITIONS. In AS 47.07.100 - 47.07.150

(1) "commissioner" means the commissioner of health and social services;

(2) "department" means the Department of Health and Social Services.

* Sec. 5. AS 47.07.070 is amended by adding a new subsection to read:

(b) In providing reimbursement to providers of services under (a) of this section, the state shall pay

(1) interest on unpaid ~~medical~~ Medicaid bills presented by providers at the rate of one percent per month when payment is delayed more than 30 days after presentation of the billing; and

(2) interest on unpaid ~~medical~~ Medicaid bills presented by providers at the rate of two percent per month when payment is delayed more than six months after presentation of the billing.

* Sec. 6. AS 47.25.120 is amended to read:

Sec. 47.25.120. ELIGIBILITY FOR ASSISTANCE. Financial assistance may be given under AS 47.25.120 - 47.25.300 [, SO FAR AS PRACTICABLE UNDER THE CONDITIONS IN THIS STATE,] to

(1) a needy person who is eligible under the regulations of

the departmen'; and

(2) a medically needy person who has incurred medical expenses which equal or exceed the difference between the person's monthly income and 150 percent of the current Federal Community Services Administration poverty income guidelines for Alaska (45 C.F.R.,sec. 1060.2).

* Sec. 7. AS 47.25 is amended by adding a new section to read:

Sec. 47.25.175. INTEREST ON LATE PAYMENTS. In providing reimbursement to providers of medical services under AS 47.25.120 - 47.25.300, the state shall pay

(1) interest on unpaid medical bills presented by providers at the rate of one percent per month when payment is delayed more than 30 days after presentation of the billing; and

(2) interest on unpaid medical bills presented by providers at the rate of two percent per month when payment is delayed more than six months after presentation of the billing.

* Sec. 8. ADJUSTMENT OF EMPLOYER-SPONSORED PLANS. When employees subject to the requirements of AS 18.12 enacted in sec. 1 of this Act are included in the coverage provisions of an employer-sponsored prepaid health care plan covering similar employees employed outside the state and the majority of the employees are not subject to the requirements of AS 18.12, the benefits applicable to the employees covered by AS 18.12 shall be adjusted within one year after the effective date of this Act so as to meet the requirements of AS 18.12.

* Sec. 9. This Act takes effect January 1, 1981.

"CHAPTER
PREPAID HEALTH CARE ACT
PART I. SHORT TITLE; PURPOSE; DEFINITIONS

Sec. -1 **Short title.** This chapter shall be known as the Hawaii Prepaid Health Care Act.

Sec. -2 **Findings and purpose.** The cost of medical care in case of sudden need may consume all or an excessive part of a person's resources. Prepaid health care plans offer a certain measure of protection against such emergencies. It is the purpose of this chapter in view of the spiraling cost of comprehensive medical care to provide this type of protection for the employees in this State. Although a large segment of the labor force in the State already enjoys coverage of this type either by virtue of collective bargaining agreements, employer-sponsored plans, or individual initiative, there is a need to extend that protection to workers who at present do not possess any or possess only inadequate prepayment coverage.

This chapter shall not be construed to interfere with or diminish any protection already provided pursuant to collective bargaining agreements or employer-sponsored plans that is more favorable to the employees benefited thereby than the protection provided by this chapter or at least equivalent thereto.

Sec. -3 **Definitions generally.** As used in this chapter, unless the context clearly requires otherwise:

(1) "Department" means the department of labor and industrial relations.

(2) "Director" means the director of labor and industrial relations.

(3) "Employer" means any individual or type of organization, including any partnership, association, trust, estate, joint stock company, insurance company, or corporation, whether domestic or foreign, a debtor in possession or receiver or trustee in bankruptcy, or the legal representative of a deceased person, who has one or more regular employees in his employment. "Employer" does not include:

(A) The State, any of its political subdivisions, or any instrumentality of the State or its political subdivisions;

(B) The United States government or any instrumentality of the United States;

(C) Any other state or political subdivision thereof or instrumentality of such state or political subdivision.

(D) Any foreign government or instrumentality wholly owned by a foreign government, if (i) the service performed in its employ is of a character similar to that performed in foreign countries by employees of the United States government or of an instrumentality thereof, and (ii) the United States Secretary of State has certified or certifies to the United States Secretary of the Treasury that the foreign government, with respect to whose instrumentality exemption is claimed, grants an equivalent exemp-

n with respect to similar service performed in the foreign ..untry by employees of the United States government and of instrumentalities thereof.

(4) "Employment" means service, including service in interstate commerce, performed for wages under any contract of hire, written or oral, expressed or implied, with an employer, except as otherwise provided in sections -4 and -5.

(5) "Premium" means the amount payable to a prepaid health care plan contractor as consideration for his obligations under a prepaid health care plan.

(6) "Prepaid health care plan" means any agreement by which any prepaid health care plan contractor undertakes in consideration of a stipulated premium:

(A) Either to furnish health care, including hospitalization, surgery, medical or nursing care, drugs or other restorative appliances, subject to, if at all, only a nominal per service charge; or

(B) To defray or reimburse, in whole or in part, the expenses of health care.

(7) "Prepaid health care plan contractor" means:

(A) Any medical group or organization which undertakes under a prepaid health care plan to provide health care; or

(B) Any nonprofit organization which undertakes under a prepaid health care plan to defray or reimburse in whole or in part the expenses of health care; or

(C) Any insurer who undertakes under a prepaid health care plan to defray or reimburse in whole or in part the expenses of health care.

(8) "Regular employee" means a person employed in the employment of any one employer for at least twenty hours per week but does not include a person employed in seasonal employment. "Seasonal employment" for the purposes of this paragraph means employment in a seasonal pursuit as defined in section 387-1 by a seasonal employer during a seasonal period or seasonal periods for the employer in the seasonal pursuit or employment by an employer engaged in the cultivating, harvesting, processing, canning, and warehousing of pineapple during its seasonal periods. The director by rule and regulation may determine the kind of employment that constitutes seasonal employment.

(9) "Wages" means all cash remuneration for services from whatever source, including commissions, bonuses, and tips and gratuities paid directly to any individual by a customer of his employer.

If the employee does not account to his employer for the tips and gratuities received and is engaged in an occupation in which he customarily and regularly receives more than $20 a month in tips, the combined amount received by him from his employer and from tips shall be deemed to be at least equal to the wage required by chapter 387 or a greater sum as determined by regulation of the director.

"Wages" does not include the amount of any payment specified in section 383-11 or 392-22 or chapter 386.

Sec. -4 **Place of performance.** "Employment" includes an individual's entire service, performed within or both within and without this State if:

(1) The service is localized in this State; or

(2) The service is not localized in any state but some of the service is performed in this State and

(A) the individual's base of operation, or, if there is no base of operation, the place from which such service is directed or controlled, is in the State; or

(B) the individual's base of operation or place from which the service is directed or controlled is not in any state in which some part of the service is performed but the individual's residence is in this State.

Sec. -5 **Excluded services.** "Employment" as defined in section -3 does not include the following services:

(1) Service performed by an individual in the employ of an employer who, by the laws of the United States, is responsible for care and cost in connection with such service.

(2) Service performed by an individual in the employ of his spouse, son, or daughter, and service performed by an individual under the age of twenty-one in the employ of his father or mother.

(3) Service performed in the employ of a voluntary employee's beneficiary association providing for the payment of life, sick, accident, or other benefits to the members of the association or their dependents or their designated beneficiaries, if

(A) admission to membership in the association is limited to individuals who are officers or employees of the United States government, and

(B) no part of the net earnings of the association inures (other than through such payments) to the benefits of any private shareholder or individual.

(4) Service performed by an individual for an employer as an insurance agent or as an insurance solicitor, if all such service performed by the individual for the employer is performed for remuneration solely by way of commission.

(5) Service performed by an individual for an employer as a real estate salesman or as a real estate broker, if all such service performed by the individual for the employer is performed for remuneration solely by way of commission.

(6) Service performed by an individual who, pursuant to the Federal Economic Opportunity Act of 1964, is not subject to the provisions of law relating to federal employment, including unemployment compensation.

Sec. -6 **Principal and secondary employer defined; coercion, interference, etc. prohibited.** If an individual is concurrently a regular employee of two or more employers as defined in this chapter, the employee shall deter-

mine which of the employers shall be his principal employer. His other employers are secondary employers. The determination by the employee of his principal employer is binding for one year or until change of employment, whichever is earlier.

If an individual is concurrently is regular employee of a public entity which is not an employer as defined in section -3 and of an employer as defined in section -3 the latter shall be deemed to be a secondary employer.

An employer who, directly or indirectly, interferes with or coerces or attempts to coerce an employee in making a determination under this section shall be subject to the penalty provided under subsection -33(b).

Sec. -7 Required health care benefits. (a) A prepaid health care plan shall qualify as a plan providing the mandatory health care benefits required under this chapter if it provides for health care benefits equal to, or medically reasonably substitutable for, the benefits provided by prepaid health plans of the same type, as specified in section -12(a) (1) or (2), which have the largest numbers of subscribers in the State. This applies to the types and quantity of benefits as well as to limitations on reimbursability, including deductibles, and to required amounts of co-insurance.

The director, after advice by the prepaid health care advisory council, shall determine whether benefits provided in a plan, other than the plan of the respective type having the largest numbers of subscribers in the State, comply with the standards specified in this subsection.

(b) A prepaid group health care plan shall also qualify for the mandatory health care benefits required under this chapter if it is demonstrated by the health care plan contractor offering such coverage to the satisfaction of the director after advice by the prepaid health care advisory council that the plan provides for sound basic hospital, surgical, medical, and other health care benefits at a premium commensurate with the benefits included taking proper account of the limitations, co-insurance features, and deductibles specified in such plan. Coverage under a plan which provides aggregate benefits that are more limited than those provided by plans qualifying under subsection (a) shall be in compliance with section -11 only if the employer contributes at least half of the cost of the coverage of dependents under such plan.

(c) Subject to the provisions of subsections (a) and (b) without limiting the development of medically more desirable combinations and the inclusion of new types of benefits, a prepaid health care plan qualifying under this chapter shall include at least the following benefit types:

(1) Hospital benefits:

(A) In-patient care for a period of at least one hundred twenty days of confinement in each calendar year covering:

(i) Room accommodations;

(ii) Regular and special diets;

(iii) General nursing services;

(iv) Use of operating room, surgical supplies, anesthesia services, and supplies;

(v) Drugs, dressings, oxygen, antibiotics, and blood transfusion services.

(B) Out-patient care:
(i) Covering use of out-patient hospital;
(ii) Facilities for surgical procedures or medical care of an emergency and urgent nature.

(2) Surgical benefits:
(A) Surgical services performed by a licensed physician, as determined by plans meeting the standards of subsections (a) and (b);
(B) After-care visits for a reasonable period;
(C) Anesthesiologist services.

(3) Medical benefits:
(A) Necessary home, office, and hospital visits by a licensed physician;
(B) Intensive medical care while hospitalized;
(C) Medical or surgical consultations while confined.

(4) Diagnostic laboratory services, x-ray films, and radio-therapeutic services, necessary for diagnosis or treatment of injuries or diseases.

(5) Maternity benefits, at least if the employee has been covered by the prepaid health care plan for nine consecutive months prior to the delivery.

(d) The prepaid health care advisory council shall be appointed by the director and shall include representatives of the medical and public health professions, representatives of consumer interests, and persons experienced in prepaid health care protection. The membership of the council shall not exceed seven individuals.

PART II. MANDATORY COVERAGE

Sec. -11 Coverage of regular employees by group prepaid health care plan. Every employer who pays to a regular employee monthly wages in an amount of at least 86.67 times the minimum hourly wage, specified in chapter 387, as rounded off by regulation of the director, shall provide coverage of such employee by a prepaid group health care plan qualifying under section -7 with a prepaid health care plan contractor in accordance with the provisions of this chapter.

Sec. -12 Choice of plan type and of contractor. (a) Every employer required to provide coverage for his employees by a prepaid group health care plan under this chapter shall elect whether coverage shall be provided by:

(1) A plan which obligates the prepaid health care plan contractor to furnish the required health care benefits; or

(2) A plan which obligates the prepaid health care plan contractor to defray or reimburse the expenses of health care.

His election is binding for one year.

(b) Whether the employer elects a plan type described in subsection (a) (1) or in subsection (a) (2), the employer may elect the particular contractor but the employee shall not be obligated to contribute a greater amount to the premium than he would have to contribute had the employer elected coverage with the contractor providing the prevailing coverage of the respective type in the State.

Subject to the provision of section -20, the employer shall provide coverage with the prepaid health care plan contractor selected pursuant to this subsection for all his employees in the State electing this type of coverage who are covered by the provisions of this chapter, except for employees covered by the health care provisions of an applicable collective bargaining agreement as provided in section -19(b) first sentence.

Sec. -13 Liability for payment of premium; withholding. Unless an applicable collective bargaining agreement specifies differently every employer shall contribute at least one-half of the premium for the coverage required by this chapter and the employee shall contribute the balance; provided that in no case shall the employee contribute more than 1.5 per cent of his wages; and provided that if the amount of the employee's contribution is less than one-half of the premium, the employer shall be liable for the whole remaining portion of the premium.

The employer shall withhold the employee's share from his wages with respect to pay periods as specified by the director.

Sec. -14 Commencement of coverage. The employer shall provide the coverage required by this chapter for any regular employee, who has been in his employ for four consecutive weeks, at the earliest time thereafter at which coverage may be provided with the prepaid health care plan contractor selected pursuant to this chapte

Sec. -15 Continuation of coverage in case of inability to earn wages. If an employee is hospitalized or otherwise prevented by sickness from working, the employer shall enable the employee to continue his coverage by contributing to the premium the amounts paid by the employer toward such premium prior to the employee's sickness for the period that such employee is hospitalized or prevented by sickness from working. This obligation shall not exceed a period of three months following the month during which the employee became hospitalized or disabled from working, or the period for which the employer has undertaken the payment of his regular wages in such case, whichever is longer.

Sec. -16 Liability of secondary employer. An employer who has been notified by an employee, in the form prescribed by the director, that he is not the principal employer as defined in section -6 shall be relieved of the duty of providing the coverage required by this chapter until he is notified by the employee pursuant to section -18 that he has become the principal employer. He shall notify the director, in the form prescribed by the director, that he is relieved from the duty of providing coverage or of any change in that status.

Sec. -17 Exemption of certain employees. (a) In addition to the exemption specified in section -16, an employer shall be relieved of his duty under section -11 with respect to any employee who has notified him, in the form specified by the director, that the employee is:

(1) Protected by health insurance or any prepaid health care plan established under any law of the United States;

(2) Covered as a dependent under a prepaid health care plan, entitling him to the health benefits required by this chapter;

(3) A recipient of public assistance or covered by a prepaid health care plan established under the laws of the State governing medical assistance.

(b) Employers receiving notice of a claim of exemption under this section shall notify the director of such claim in the form prescribed by the director.

Sec. -18 **Termination of exemption.** (a) If an exemption which has been claimed by an employee pursuant to section -17 terminates because of any change in the circumstances entitling the employee to claim such exemption, the employee shall promptly notify the principal employer of the termination of the exemption and the employer thereupon shall provide coverage as required by this chapter.

(b) If because of a change in the employment situation of an employee or a redetermination by an employee as provided in section -6, a principal employer becomes a secondary employer or a secondary employer becomes the principal employer, the employee shall promptly notify the employers affected of such change and the new principal employer shall provide coverage as required by this chapter.

Sec. -19 **Freedom of collective bargaining.** (a) In addition to the policy stated in section -2, nothing in this chapter shall be construed to limit the freedom of employees to bargain collectively for different prepaid health care plan coverage or for a different allocation of the costs thereof. A collective bargaining agreement may provide that the employer himself undertakes to provide the health care specified in the agreement.

(b) If the employees rendering particular types of services are not covered by the health care provisions of the applicable collective bargaining agreements to which their employer is a party, the provisions of this chapter shall be applicable with respect to them. An employer or group of employers shall be deemed to have complied with the provisions of this chapter if they undertake to provide health care services pursuant to a collective bargaining agreement and the services are available to all other employees not covered by such agreement.

Sec. -20 **Adjustment of employer-sponsored plans.** Where employees subject to the coverage of this chapter are included in the coverage provisions of an employer-sponsored prepaid health care plan covering similar employees employed outside the State and the majority of such employees are not subject to this chapter, the benefits applicable to the employees covered by this chapter shall be adjusted within one year after the effective date of this chapter so as to meet the requirements of this chapter.

Sec. -21 **Individual waivers prohibited; additional withholding for dependents.** An employee may not waive individually all or part of the required health care benefits or agree to pay a greater share of the premium for such benefits than is required by this chapter.

Subject to section -7(b), an employee may consent to pay a greater

share of his wages and to a withholding of such share by the employer for the purpose of providing prepaid health care benefits of his dependents under the plan providing such benefits for himself.

Sec. -22 **Exemption of followers of certain teachings or beliefs.** This chapter shall not apply to any individual who pursuant to the teachings, faith, or belief of any group, depends for healing upon prayer or other spiritual means.

Sec. -23 **Joint provision of coverage.** Employers may form associations for the purpose of jointly providing prepaid health care protection under this chapter for their employees with the contractors authorized to provide such coverage in the State.

PART III. ADMINISTRATION AND ENFORCEMENT

Sec. -31 **Enforcement by the director.** Except as otherwise provided in section -7 the director shall administer and enforce this chapter. The director may appoint such assistants and such clerical, stenographic, and other help as may be necessary for the proper administration and enforcement of this chapter subject to any civil service act relating to state employees.

Sec. -32 **Rule making and other powers of the director.** The director may adopt, amend, or repeal, pursuant to chapter 91, such rules and regulations as he deems necessary or suitable for the proper administration and enforcement of this chapter.

The director may round off the amounts specified in this chapter for the purpose of eliminating payments from the premium supplementation fund in other than even dollar amounts or other purposes.

The director may prescribe the filing of reports by prepaid health care plan contractors and prescribe the form and content of requests by employers for premium supplementation and the period for the payment thereof.

Sec. -33 **Penalties.** (a) If an employer fails to comply with sections -11, -12, -13, or -15 he shall pay a penalty of not less than $25 or of $1 for each employee for every day during which such failure continues, whichever sum is greater. The penalty shall be assessed under rules and regulations promulgated pursuant to chapter 91 and shall be collected by the director and paid into the special fund for premium supplementation established by section -41. The director may, for good cause shown, remit all or any part of the penalty.

(b) Any employer, employee, or prepaid health care plan contractor who wilfully fails to comply with any other provision of this chapter or any rule or regulation thereunder may be fined not more than $200 for each such violation.

PART IV. PREMIUM SUPPLEMENTATION

Sec. -41 **Establishment of special premium supplementation fund.** There is established in the treasury of the State, separate and apart from all public moneys or funds of the State, a special fund for premium supplementation which shall be administered exclusively for the purposes of this chapter. All premium supplementations payable under this part shall be paid from the

fund. The fund shall consist of (1) all money appropriated by the State for the purposes of premium supplementation under this part and (2) all fines and penalties collected pursuant to this chapter.

Sec. -42 Management of the fund. The director of finance shall be the treasurer and custodian of the premium supplementation fund and shall administer the fund in accordance with the directions of the director of labor and industrial relations. All moneys in the fund shall be held in trust for the purposes of this part only and shall not be expended, released, or appropriated or otherwise disposed of for any other purpose. Moneys in the fund may be deposited in any depositary bank in which general funds of the State may be deposited but such moneys shall not be commingled with other state funds and shall be maintained in separate accounts on the books of the depositary bank. Such moneys shall be secured by the depositary bank to the same extent and in the same manner as required by the general depositary law of the State; and collateral pledged for this purpose shall be kept separate and distinct from any other collateral pledged to secure other funds of the State. The director of finance shall be liable for the performance of his duties under this section as provided in chapter 37.

Sec. -43 Disbursements from the fund. Expenditures of moneys in the premium supplementation fund shall not be subject to any provisions of law requiring specific appropriations or other formal release by the state officers of money in their custody. All payments from the fund shall be made upon warrants drawn upon the director of finance by the comptroller of the State supported by vouchers approved by the director.

Sec. -44 Investment of moneys. With the approval of the department the director of finance may, from time to time, invest such moneys in the premium supplementation fund as are in excess of the amount deemed necessary for the payment of benefits for a reasonable future period. Such moneys may be invested in bonds of any political or municipal corporation or subdivision of the State, or any of the outstanding bonds of the State, or invested in bonds or interest-bearing notes or obligations of the State (including state director of finance's warrant notes issued pursuant to chapter 40), or of the United States, or those for which the faith and credit of the United States are pledged for the payment of principal and interest, or in federal land bank bonds or joint stock farm loan bonds. The investments shall at all times be so made that all the assets of the fund shall always be readily convertible into cash when needed for the payment of benefits. The director of finance shall dispose of securities or other properties belonging to the fund only under the direction of the director of labor and industrial relations.

Sec. -45 Entitlement to premium supplementation. (a) An employer who employs less than eight employees entitled to coverage under this chapter and who provides coverage to such employees pursuant to section -7(a) shall be entitled to premium supplementation from the fund if the employer's share of the cost of providing such coverage as determined by sections -13 and -15 exceeds 1.5 per cent of the total wages payable to such employees and if the amount of such excess is greater than five per cent of the employer's

income before taxes directly attributable to the business in which such employees are employed.

(b) The amount of the supplementation shall be that part of the employer's share of the premium cost which exceeds the limits specified in subsection (a).

Sec. -46 **Income directly attributable to the business.** (a) "Income directly attributable to the business" means gross profits from the business minus deductions for:

(1) Compensation of officers;
(2) Salaries and wages, except wages paid by an individual proprietor to himself;
(3) Repairs;
(4) Taxes on business and business property;
(5) Business advertising;
(6) Amounts contributed to employee benefit plans;
(7) Interest on business indebtedness;
(8) Rent on business property; and
(9) Other expenses necessary for the current conduct of business.

(b) Deductions shall not include:

(1) Bad debts;
(2) Contributions or gifts, other than those listed under subsection (a) (6);
(3) Amortization and depreciation; or
(4) Losses by fire, storm, casualty, or theft.

(c) The director may promulgate rules and regulations necessary to define income directly attributable to business for the purpose of section -45.

Sec. -47 **Claim of premium supplementation.** An employer entitled to premium supplementation shall file a claim therefor in the manner provided by regulation of the director. The employer shall have the burden of proof of establishing his entitlement."

SECTION 2. This Act shall take effect upon its approval, except that the coverage by group prepaid health care plans required by this Act and the payment of premiums for such coverage shall commence January 1, 1975; provided that this Act shall terminate upon the effective date of federal legislation that provides for voluntary prepaid health care for the people of Hawaii in a manner at least as favorable as the health care provided by this Act, or upon the effective date of federal legislation that provides for mandatory prepaid health care for the people of Hawaii.

(Approved June 12, 1974.)

ACT 211 H.B. NO. 3018-74

A Bill for an Act Relating to Mental Health Services for Children and Youth.

Be It Enacted by the Legislature of the State of Hawaii:

51 Amend.

SLH 1975

rial is underscored. In printing this Act, the revisor of statutes need not include the brackets, the bracketed material, or the underscoring.*

SECTION 9. This Act shall take effect upon its approval.

(Approved May 6, 1975.)

ACT 51 H.B. NO. 419

A Bill for an Act Relating to Prepaid Health Care.

Be It Enacted by the Legislature of the State of Hawaii:

SECTION 1. Section 393-6, Hawaii Revised Statutes, is amended to read:

"**Sec. 393-6 Principal and secondary employer defined; coercion, interference, etc. prohibited.** If an individual is concurrently a regular employee of two or more employers as defined in this chapter, the principal employer shall be the employer who pays him the most wages; provided that if one of the employers, who does not pay the most wages, employs the regular employee for at least thirty-five hours per week, the employee shall determine which of the employers shall be his principal employer. His other employers are secondary employers. An employer so designated as the principal employer shall remain as such principal employer for one year or until change of employment, whichever is earlier.

If an individual is concurrently a regular employee of a public entity which is not an employer as defined in section 393-3 and of an employer as defined in section 393-3 the latter shall be deemed to be a secondary employer.

An employer who, directly or indirectly, interferes with or coerces or attempts to coerce an employee in making a determination under this section shall be subject to the penalty provided under subsection 393-33(b)."

SECTION 2. Statutory material to be repealed is bracketed. New material is underscored. In printing this Act, the revisor of statutes need not include the brackets, the bracketed material or the underscoring.*

SECTION 3. This Act shall take effect upon its approval.

(Approved May 6, 1975.)

ACT 52 H.B. NO. 442

A Bill for an Act Relating to Taxation of Banks and Other Financial Corporations.

Be It Enacted by the Legislature of the State of Hawaii:

SECTION 1. Section 241-4, Hawaii Revised Statutes, is amended by amending subsection (b) to read:

*Edited accordingly.

and may be leased by it as provided in chapter 171, Hawaii Revised Statutes, or may be retained for management by the department.

Any lease by the board of land and natural resources of Hawaiian home lands hereafter entered into shall contain a withdrawal clause, and the lands so leased shall be withdrawn by the board of land and natural resources, for the purpose of this Act, upon the department giving at its option, not less than one nor more than five years' notice of such withdrawal; provided, that the minimum withdrawal-notice period shall be specifically stated in such lease.

In the management of any retained available lands not required for leasing under section 207(a), the department may dispose of such lands to the public, including native Hawaiians, on the same terms, conditions, restrictions and uses applicable to the disposition of public lands as provided in chapter 171; provided, that the department may not sell or dispose of such lands in fee simple except as authorized under section 205 of this Act.

(3) The department shall not lease, use, nor dispose of more than twenty thousand (20,000) acres of the area of Hawaiian home lands, for settlement by native Hawaiians, in any calendar five-year period.

(4) The department may, with the approval of the governor and the Secretary of Interior, in order to consolidate its holdings or to better effectuate the purposes of this Act, exchange the title to available lands for land, publicly owned, of an equal value. All land so acquired by the department shall assume the status of available lands as though the same were originally designated as such under section 203 hereof, and all lands so conveyed by the department shall assume the status of the land for which it was exchanged. The limitations imposed by section 73(1) of the Hawaiian Organic Act and the land laws of Hawaii as to the area and value of land that may be conveyed by way of exchange shall not apply to exchanges made pursuant hereto. No such exchange shall be made without the approval of two-thirds of the members of the board of land and natural resources."

SECTION 2. Statutory material to be repealed is bracketed. New material is underscored. In printing this Act, the revisor of statutes need not include the brackets, the bracketed material, or the underscoring.*

SECTION 3. If any portion of this Act is declared invalid, the remaining portions of this Act shall not be affected thereby.

SECTION 4. This Act shall take effect upon its approval.

(Approved April 28, 1976.)

ACT 25 H.B. NO. 2194-76

A Bill for an Act Relating to Prepaid Health Care.

Be It Enacted by the Legislature of the State of Hawaii:

*Edited accordingly.

SECTION 1. The legislature finds that alcoholism and drug problems are the medical problems most disruptive of family life and employment, with alcoholism ranking, in addition, as the third highest medical cause of death in the United States today. Alcoholism and drug addiction are illnesses, and like other illnesses, their treatment should be uniformly covered by prepaid health care plans. The legislature further finds that such inclusion in prepaid health care plans will provide visibility to alcoholism and drug addiction benefits, and as a result, may encourage more accurate diagnosis of health problems related to alcoholism and drug addiction, because of health plan coverage. Moreover, employees may be encouraged to seek early diagnosis and treatment because of such coverage. Effective treatment will reduce substantially the great economic loss to employers. The purpose of this Act is to ensure adequate treatment for alcoholism and drug addiction by requiring its inclusion in prepaid health care plans, including coverage for appropriate detoxification and treatment facilities.

SECTION 2. Section 393-7, Hawaii Revised Statutes, is amended by amending subsection (c) to read as follows:

"(c) Subject to the provisions of subsections (a) and (b) without limiting the development of medically more desirable combinations and the inclusion of new types of benefits, a prepaid health care plan qualifying under this chapter shall include at least the following benefit types:

(1) Hospital benefits:
  (A) In-patient care for a period of at least one hundred twenty days of confinement in each calendar year covering:
    (i) Room accommodations;
    (ii) Regular and special diets;
    (iii) General nursing services;
    (iv) Use of operating room, surgical supplies, anesthesia services, and supplies;
    (v) Drugs, dressing, oxygen, antibiotics, and blood transfusion services.
  (B) Out-patient care:
    (i) Covering use of out-patient hospital;
    (ii) Facilities for surgical procedures or medical care of an emergency and urgent nature.

(2) Surgical benefits:
  (A) Surgical services performed by a licensed physician, as determined by plans meeting the standards of subsections (a) and (b);
  (B) After-care visits for a reasonable period;
  (C) Anesthesiologist services.

(3) Medical benefits:
  (A) Necessary home, office, and hospital visits by a licensed physician;
  (B) Intensive medical care while hospitalized;
  (C) Medical or surgical consultations while confined.

(4) Diagnostic laboratory services, x-ray films, and radio-therapeutic services, necessary for diagnosis or treatment of injuries or diseases.

(5) Maternity benefits, at least if the employee has been covered by the

prepaid health care plan for nine months prior to the delivery.

(6) Substance abuse benefits:

(A) Alcoholism and drug addiction are illnesses and shall receive benefits as such. In-patient and out-patient benefits for the diagnosis and treatment of substance abuse, including but not limited to alcoholism and drug addiction, shall be specifically stated and shall not be less than the benefits for any other illness, except as provided in this subsection. Medical treatment of substance abuse shall not be limited or reduced by restricting coverage to the mental health or psychiatric benefits of a plan. However, any psychiatric services received as a result of the treatment of substance abuse may be limited to the psychiatric benefits of the plan.

(B) Out-patient benefits provided by a physician, psychiatrist, or psychologist, without restriction as to place of service; provided that health plans of the type specified in section 393-12(a) shall retain for the contractor the option of:

(i) Providing the benefits in its own facility and utilizing its own staff, or

(ii) Contracting for the provision of these benefits, or

(iii) Authorizing the patient to utilize outside services and defraying or reimbursing the expenses at a rate not to exceed that for provision of services utilizing the health contractor's own facilities and staff.

(C) Detoxification and acute care benefits in a hospital or any other public or private treatment facility, or portion thereof, providing services especially for the detoxification of intoxicated persons or drug addicts, which is appropriately licensed, certified, or approved by the department of health in accordance with the standards prescribed by the Joint Commission on Accreditation of Hospitals. In-patient benefits for detoxification and acute care shall be limited in the case of alcohol abuse to three admissions per calendar year, not to exceed seven days per admission, and shall be limited in the case of other substance abuse to three admissions per calendar year, not to exceed twenty-one days per admission.

(D) Prepaid health plans shall not be required to make reimbursements for care furnished by government agencies and available at no cost to a patient, or for which no charge would have been made if there were no health plan coverage."

SECTION 3. New statutory material is underscored. In printing this Act, the revisor of statutes need not include the underscoring.*

SECTION 4. This Act shall take effect on July 1, 1976; provided that prepaid health care contracts due for renewal after July 1, 1976 may defer

*Edited accordingly.

inclusion of these substance abuse benefits until such renewal date, or January 1, 1977, whichever occurs earlier.

(Approved April 28, 1976.)

ACT 26 H.B. NO. 2533-76

A Bill for an Act Relating to Day Care Centers.

Be It Enacted by the Legislature of the State of Hawaii:

SECTION 1. Section 346-19, Hawaii Revised Statutes, is amended to read:

"**Sec. 346-19 Day care centers defined.** A "day care center" is defined as a place maintained by any individual, organization, or agency for the purpose of providing care for a child or children with or without charging a fee during any part of a twenty-four hour day. The term day care center includes any place where group care is provided for six or more children, and any family home providing care for two to five children.

Nothing in sections 346-18 to 346-25 shall be construed to include an individual person caring for a related child, a neighbor or friend caring for a child or children if the person does not regularly engage in such activity, a kindergarten or school conducted solely for educational purposes or specialized training, or an organization established to conduct athletic or social group functions."

SECTION 2. Statutory material to be repealed is bracketed. New material is underscored. In printing this Act, the revisor of statutes need not include the brackets, the bracketed material, or the underscoring.*

SECTION 3. This Act shall be effective July 1, 1976.

(Approved April 28, 1976.)

ACT 27 H.B. NO. 2880-76

A Bill for an Act Relating to the State Environmental Policy.

Be It Enacted by the Legislature of the State of Hawaii:

SECTION 1. The purpose of this Act is to propose an amendment to Section 344-4 of the Hawaii Revised Statutes to provide for guidelines relating to solid wastes.

SECTION 2. Section 344-4 (2) is amended to read as follows:

"(2) Land, water mineral, visual, air and other natural resources.

(A) Encourage management practices which conserve and fully utilize all natural resources;

*Edited accordingly.

ACT 78 Amend.

SECTION 3. Statutory material to be repealed is bracketed. New material is underscored. In printing this Act, the revisor of statutes need not include the brackets, the bracketed material, or the underscoring.*

SECTION 4. This Act shall take effect upon its approval.

(Approved , 12, 1976.)

ACT 78 S.B. NO. 1820-76

A Bill for an Act Relating to the Prepaid Health Care Act.

Be It Enacted by the Legislature of the State of Hawaii:

SECTION 1. Section 393-3, Hawaii Revised Statutes, is amended by amending the definition of "Wages" to read:

"(9) "Wages" means all remuneration for services from whatever source, including commissions, bonuses, and tips and gratuities paid directly to any individual by a customer of his employer, and the cash value of all remuneration in any medium other than cash.

The director may issue regulations for the reasonable determination of the cash value of remuneration in any medium other than cash.

If the employee does not account to his employer for the tips and gratuities received and is engaged in an occupation in which he customarily and regularly receives more than $20 a month in tips, the combined amount received by him from his employer and tips shall be deemed to be at least equal to the wage required by chapter 387 or a greater sum as determined by regulation of the director.

"Wages" does not include the amount of any payment specified in section 383-11 or 392-22 or chapter 386."

SECTION 2. Statutory material to be repealed is bracketed. New material is underscored. In printing this Act, the revisor of statutes need not include the brackets, the bracketed material or the underscoring.*

SECTION 3. This Act shall take effect upon its approval.

(Approved May 12, 1976.)

ACT 79 S.B. NO. 1832-76

A Bill for an Act Relating to Civil Service and Exemptions.

Be It Enacted by the Legislature of the State of Hawaii:

SECTION 1. Section 76-16, Hawaii Revised Statutes, is amended to read:

"**Sec. 76-16 Civil service and exemptions.** The civil service to which this part applies comprises all positions in the state service not existing or hereafter established and embraces all personnel services performed for the State, except the following:

*Edited accordingly

brackets, the bracketed material, or the underscoring.*

SECTION 10. This Act shall take effect upon its approval.

(Approved May 12, 1976.)

ACT 81 S.B. NO. 2225-76

A Bill for an Act Relating to Prepaid Health Care.

Be It Enacted by the Legislature of the State of Hawaii:

SECTION 1. Section 393-21, Hawaii Revised Statutes, is amended to read as follows:

"**Sec. 393-21 Individual waivers; additional withholding for dependents.** (a) An employee may waive individually all of the required health care benefits pursuant to this chapter by:

(1) Requesting the waiver by a writing submitted to the employer; and

(2) Receiving approval of the waiver from the director upon the director determining that the employee has other coverage under a prepaid health care plan which provides benefits that meet the standards prescribed in section 393-7.

(b) The employer who receives from an employee a written request for a waiver under this section shall transmit to the director a copy of the waiver, on a form prescribed by the director, and a copy of the prepaid health care plan on the basis of which the waiver is requested.

(c) A waiver under this section is binding for one year and is renewable for subsequent one-year periods.

(d) An employer who, directly or indirectly, coerces or attempts to coerce an employee in making a waiver under this section shall be subject to the penalty provided under subsection 393-33(b).

(e) An employee may not agree to pay a greater share of the premium for such benefits than is required by this chapter.

(f) Subject to section 393-7(b), an employee may consent to pay a greater share of his wages and to a withholding of such share by the employer for the purpose of providing prepaid health care benefits of his dependents under the plan providing such benefits for himself."

SECTION 2. Statutory material to be repealed is bracketed. New material is underscored. In printing this Act, the revisor of statutes need not include the brackets, the bracketed material, or the underscoring.*

SECTION 3. This Act shall take effect upon its approval.

(Approved May 12, 1976.)

*Edited accordingly.

ACT 206 Amend.

brackets, the bracketed material, or the underscoring.*

SECTION 4. This Act shall take effect upon its approval.

(Approved June 7, 1976.)

ACT 206 S.B. NO. 1821-76

A Bill for an Act Relating to the Prepaid Health Care Act.

Be It Enacted by the Legislature of the State of Hawaii:

SECTION 1. Section 393-13, Hawaii Revised Statutes, is amended to read:

"Sec. 393-13 Liability for payment of premium; withholding; recovery of premium. Unless an applicable collective bargaining agreement specifies differently every employer shall contribute at least one-half of the premium for the coverage required by this chapter and the employee shall contribute the balance; provided that in no case shall the employee contribute more than 1.5 per cent of his wages; and provided that if the amount of the employee's contribution is less than one-half of the premium, the employer shall be liable for the whole remaining portion of the premium.

The employer shall withhold the employee's share from his wages with respect to pay periods as specified by the director.

If an employee separates from his employment after his employer has prepaid the employee's share of the cost of providing health care coverage, the employer may deduct an amount not to exceed one-half of the premium cost but without regard to the 1.5 per cent limitation, from the last salary or wages due the employee, or seek other appropriate means to recover the premium."

SECTION 2. Statutory material to be repealed is bracketed. New material is underscored. In printing this Act, the revisor of statutes need not include the brackets, the bracketed material or the underscoring.*

SECTION 3. This Act shall take effect upon its approval.

(Approved June 7, 1976.)

ACT 207 S.B. NO. 1899-76

A Bill for an Act Relating to the Establishment of an Office of Children and Youth.

Be It Enacted by the Legislature of the State of Hawaii:

SECTION 1. The legislature finds that securing the well-being of all of Hawaii's children should continue to be a policy concern of the highest order for state government. Hawaii has long been a leader among the states in the development of innovative undertakings in behalf of children and youth as evidenced, in part, by the enactment of Act 294, Session Laws of Hawaii 1949, which estab-lish-

*Edited accordingly

SOME ANSWERS TO HAWAII PREPAID HEALTH CARE LAW

FOR EMPLOYERS AND EMPLOYEES

STATE OF HAWAII
Department of
Labor and Industrial Relations
DISABILITY COMPENSATION DIVISION
P.O. Box 3769
Honolulu, Hawaii 96812

Form No. HC-2 10M

INTRODUCTION

This leaflet has been prepared in question-and-answer format to help employers and employees understand the Hawaii Prepaid Health Care Law. The new law sets up a compulsory health insurance program for the workers of Hawaii. Since every employer has a major role in the program, it is hoped that the information contained herein will enable employers to implement the law with minimal difficulty. For detailed information of this new program, refer to the law.

WHAT IS THE HAWAII PREPAID HEALTH CARE LAW?

This landmark legislation (the first in the nation) requires Hawaii employers to provide health care services for their employees, thus assuring them of needed protection against the high costs of hospital and medical care.

WHEN WILL THIS NEW LAW TAKE EFFECT?

The law took effect on June 12, 1974, but the required coverage by group prepaid health care plans and the payment of premiums for such coverage will not commence until January 1, 1975.

WHEN DOES AN EMPLOYER BECOME SUBJECT TO THE LAW?

An employer becomes subject to the law when he has one or more regular employees. A regular employee is one who works twenty or more hours per week and is paid a monthly wage of at least 86.67 times the prevailing Hawaii minimum hourly wage. A regular employee does not include a person employed in seasonal employment (e.g., harvesting and canning of pineapples) or one who works less than twenty hours a week. The Federal, State and County governments are excluded from the law.

ARE THERE EMPLOYEES EXEMPT FROM COVERAGE?

Yes, besides employees working in seasonal employment, employers need not cover insurance and real estate salesmen or brokers paid solely on commission basis, parent working for son/daughter, wife/husband working for spouse, son/daughter under twenty-one years of age working for father/mother, and others specifically exempted by the law. Also exempt are employees who are covered as dependents under another health care plan.

CAN A REGULAR EMPLOYEE WORKING CONCURRENTLY FOR TWO OR MORE EMPLOYERS HAVE COVERAGE FROM ALL EMPLOYERS?

No.

WHO HAS TO PROVIDE COVERAGE IN ABOVE CASE?

The employee is required to name which of the two or more employers is the principal employer and which the secondary employer(s) on the employee notification form (HC-5). The principal employer is required to provide coverage. An employee's determination of principal employer is binding for one year or until change of employment occurs. A secondary employer can buy out the principal employer if the employee so chooses or if the employee no longer holds two or more jobs concurrently. The employer is prohibited from coercing, interfering or influencing an employee in making a determination.

WHEN IS AN EMPLOYER A PRINCIPAL OR SECONDARY EMPLOYER?

An employee is required to complete Form HC-5 for the purpose of naming his principal and secondary employers, or when ever he chooses to make a change with respect to the status of each employer. The employer and employee each retains a copy, with the original going to the Department of Labor.

MUST AN EMPLOYER COVER AN EMPLOYEE WHO IS ALREADY COVERED AS A DEPENDENT UNDER A HEALTH CARE PLAN?

No. Besides such dependents, others who are exempt are employees protected by health insurance or any prepaid health care plan established under any law of the United States and recipients of public assistance or those covered by a State-legislated health care plan governing medical assistance.

WILL AN EMPLOYER BE NOTIFIED OF AN EMPLOYEE'S EXEMPT STATUS?

Yes. An exempt employee in any of the three categories mentioned above is required to complete Form HC-5 to notify the employer of the exemption, with a copy filed with the Department of Labor. Also, when the employee terminates exemption, the employer must be notified using the same form. When an employer receives notification that the employee has terminated exemption, the employee should be covered under the employer's health care plan.

WHAT PLANS ARE AVAILABLE FOR PROVIDING HEALTH CARE SERVICES?

There are two types of prepaid health care plans: (1) A plan by which a prepaid health care plan contractor would furnish health care, including hospitalization, surgery, medical or nursing care, drugs or other restorative appliances; and (2) a plan by which the contractor would defray or reimburse, in whole or in part, the expenses of health care.

WHAT IS MEANT BY PREPAID HEALTH CARE PLAN CONTRACTOR?

A prepaid health care plan contractor may fall in one of three groups. (1) Any medical group or organization which undertakes under a prepaid health care plan to provide health care benefits (e.g., Kaiser Medical Center); (2) any nonprofit organization which undertakes under a prepaid health care plan to defray or reimburse in whole or in part the expenses of health care (e.g., HMSA); or (3) any insurer who undertakes under a prepaid health care plan to defray or reimburse in whole or in part the expenses of health care (e.g., Aetna Life Insurance Company). Note: The names of contractors cited above do not constitute an endorsement. They are used strictly as illustrations.

WHO SELECTS THE PLAN TYPE AND CONTRACTOR FOR THE EMPLOYEES?

The employer selects the plan type and the contractor. The plan type may be either a plan which requires the prepaid health care plan contractor to furnish the required health care benefits, or a plan which requires the prepaid health care plan contractor to defray or reimburse the expenses of health care. This election is binding for one year.

IS SHARING OF PREMIUM COSTS PERMITTED?

While the employer has the option of paying the entire premium, an employee may be required to share the cost. The employer must pay at least one-half of the premium and the employee the balance. The employee's share, however, cannot exceed 1.5% of his wages. If the employee's share constitutes less than one-half of the premium, the employer must pay the entire remaining portion. The employer is permitted to withhold the employee's share from the employee's wages.

WHAT TYPES OF BENEFITS MUST BE PROVIDED IN A PREPAID HEALTH CARE PLAN?

An approved prepaid health care plan must include at least the following types: (1) hospital benefits, including in-patient care for at least 120 days of confinement in each calendar year; (2) surgical benefits; (3) medical benefits; (4) diagnostic benefits; and (5) maternity benefits if the employee has been covered by the prepaid health care plan for at least nine consecutive months prior to the delivery. Note: For detailed breakdown of above five types of benefits, see the law.

HOW SOON MUST AN EMPLOYER COVER AN EMPLOYEE?

Any regular employee who has been employed for four consecutive weeks by an employer must be covered at the earliest time thereafter.

WHAT HAPPENS TO AN EMPLOYEE'S COVERAGE IF THE EMPLOYEE IS UNABLE TO WORK BECAUSE OF DISABILITY?

If an employee is disabled and unable to work, the employer must continue the coverage by paying for the employer's share of the premium costs. The obligation is to continue the longer of the following periods: Three months following the month during which the employee became disabled, or following the period for which the employer has undertaken the payment of the employee's regular wages. An employee must keep up the employee's payments.

WHAT EFFECTS WILL THIS NEW LAW HAVE ON AN EXISTING PREPAID HEALTH CARE PLAN?

A prepaid health care plan shall qualify as a plan providing the required mandatory benefits (see above) if it provides health care benefits equal to, or medically reasonably substitutable for, the benefits provided by prepaid health care plans specified above, or if it provides sound basic hospital, surgical, medical and other health care benefits as determined by the director after advice by the prepaid health care advisory council.

WHO DETERMINES WHETHER OR NOT A PREPAID HEALTH CARE PLAN MEETS THE LAW'S REQUIREMENTS?

This determination is made by the Director of the State Department of Labor after advice by a seven member prepaid health care advisory council consisting of representatives of the medical and public health profession, representatives of consumer interests and persons experienced in prepaid health care protection.

WHAT EFFECTS WILL THIS NEW LAW HAVE ON COLLECTIVE BARGAINING?

(1) Employees will be free to bargain collectively for different prepaid health care plan coverage or for a different allocation of the costs thereof, or for the employer to provide the health care specified in the agreement. (2) An employer or group of employers will be deemed to be in compliance with the law if they provide health care services pursuant to a collective bargaining agreement and the services are available to all other employees not covered by such agreement. (3) An employer will be required to provide coverage for employees not covered by the health care provisions of the applicable collective bargaining agreement to which the employer is a party.

WHAT ABOUT EXISTING EMPLOYER-SPONSORED PLANS COVERING HAWAII-BASED EMPLOYEES?

Any out-of-state employer sponsored health care plan affecting employees of this state must be adjusted by June 11, 1975, so as to meet the law's requirements.

CAN AN EMPLOYEE'S RIGHT TO BE COVERED BY A HEALTH CARE PLAN BE WAIVED?

An employee may not waive individually all or part of the required health care services.

CAN AN EMPLOYEE AGREE TO PAY A GREATER SHARE OF THE PREMIUM COST?

An employee cannot agree to pay a greater share from wages except for the purpose of paying for the added cost of providing prepaid health care benefits for the employee's dependents ... for the same plan.

MUST AN EMPLOYEE BELONGING TO A FAITH-HEALING GROUP BE COVERED?

No.

CAN EMPLOYERS FORM ASSOCIATIONS FOR THE PURPOSE OF PROVIDING PREPAID HEALTH CARE PROTECTION?

Yes, as long as such health care protection is obtained from an authorized health care contractor.

ARE THERE PENALTIES FOR ANY INFRACTION OF THE LAW?

(1) An employer who fails without good cause to comply with the coverage provisions of the law shall be penalized not less than $25 or $1 for each employee for every day during which such failure continues, whichever sum is greater, and (2) an employer, employee or prepaid health care contractor who willfully fails to comply with any other provisions of any rules or regulations shall be fined not more than $200 for each such violation.

WHAT IS THE PREMIUM SUPPLEMENTATION FUND?

This is a special fund financed and administered by the State for the purpose of assisting certain eligible employers in paying for the cost of providing the required health care benefits.

WHAT ARE THE ELIGIBILITY REQUIREMENTS FOR PREMIUM SUPPLEMENTATION?

An employer is entitled to premium supplementation if: (1) less than 8 workers are employed; (2) the employer's share of the cost of providing health care services exceeds 1.5% of the total wages payable to employees, and (3) the amount of such excess is greater than 5% of the employer's income before taxes directly attributable to the business (see below for definition).

HOW MUCH CAN AN EMPLOYER RECEIVE FROM THE PREMIUM SUPPLEMENTATION FUND?

The amount of premium supplementation shall be that part of the employer's share of the premium cost which exceeds the limits specified above.

HOW DOES AN EMPLOYER CLAIM PREMIUM SUPPLEMENTATION?

The employer must complete a prescribed claim form furnishing information that the employer's share of the premium cost exceeds the limits specified above.

WHAT IS MEANT BY INCOME DIRECTLY ATTRIBUTABLE TO THE BUSINESS?

Income directly attributable to the business means gross profits from the business minus deductions for: (1) compensation of officers, (2) salaries and wages, except wages paid by an individual proprietor to himself, (3) repairs, (4) taxes on business and business property, (5) business advertising, (6) amounts contributed to employee benefit plans, (7) interest on business indebtedness, (8) rent on business property, and (9) other expenses necessary for the current conduct of business.

WHAT DEDUCTIONS ARE EXCLUDED FROM INCOME DIRECTLY ATTRIBUTABLE TO THE BUSINESS?

These are: (1) bad debts, (2) contributions or gifts, other than those listed under 6 above, (3) amortization and depreciation, and (4) losses by fire, storm, casualty, etc.

WHAT AGENCY ADMINISTERS THE HAWAII PREPAID HEALTH CARE LAW?

The Disability Compensation Division of the Department of Labor and Industrial Relations administers the Hawaii Prepaid Health Care Law. If you need further information, please contact the following offices:

Address all inquiries to:

Dept. of Labor & Industrial Relations
Temporary Disability Insurance Division

Oahu	P.O. Box 3769 825 Mililani Street, Room 201 Honolulu, Hawaii 96812 Phone 548-7821
Hawaii	P.O. Box 671 State Office Building 75 Aupuni Street Hilo, Hawaii 96720 Phone 961-7391
West Hawaii	P.O. Box 97 Kealakekua, Hawaii 96750 Phone 322-2775
Maui	P.O. Box 580 State Office Building 54 South High Street Wailuku, Hawaii 96793 Phone 244-4322
Kauai	P.O. Box 891 State Office Building 3060 Eiwa Street Lihue, Hawaii 96766 Phone 245-4351

19 March 1980

To: Representatives Buchholdt, McKinnon, Parker, Gardiner

From: Sharman Haley
Alaska Public Interest Research Group

Subject: Policy Options in Proposed Health Legislation

The health bill which is presently being drafted at Representative Buchholdt's request is largely modeled after Hawaii and Minnesota laws. These laws do not necessarily conform in detail to the situation in Alaska nor the interests of the Alaska sponsors. This memo calls to your attention various points in the model legislation which you may wish to consider modifying for Alaska. Certain policy considerations in the proposed Medicaid amendments and medically needy program are also discussed.

Health Insurance Minimum Standards and Risk Pooling

The Comprehensive Health Insurance Act adapted from Minnesota law and published in 1980 Suggested Legislation Vol. 39, by the Council of State Governments, is the model for the minimum benefits and risk pooling portions of the proposed legislation. One section in the model bill requires health insurance carriers to offer certain kinds of conversion privilages. For example, when an individual drops out of a group plan (such as with the termination of employment) the carrier must offer an individual plan to continue coverage without the addition of underwriting restrictions. Also, when the primary insured dies, the carrier must allow other individuals covered under the plan to continue coverage. This issue was not addressed in our drafting request. You may wish to consider including language on conversion privilages in the bill.

The model legislation also contains a provision known as "dual option" which requires major employers of 100 or more employees who offer health benefits to their employees, to offer both insurance or membership in a health maintenance organization where both are available. This in part is a policy to promote HMOs. This provision was not included in the drafting request. Since Anchorage may have an HMO in the near future, you may wish to consider a similar provision in the legislation for Alaska.

The model legislation sets out standards for three types of qualified plans. You should be aware that the legislation does not require that only qualified plans can be sold; it merely requires of all carriers that qualified plans be offered to each eligible customer.

The model legislation sets numerous specific dollar amounts. Presumably these amounts will have to be periodically updated for inflation or changes in standards. You may wish to consider adding the provision that the specified amounts are applicable for the first year and subsequently the commissioner may revise and update all the dollar amounts by regualtion.

The model legislation initially sets premiums for the high risk coverage at the average premium level among the five largest carriers in the state for comparable standard risk coverage, and provides that in subsequent years the premiums are to be set such that the plan pays for itself according to actuarial principles. In Minnesota's experience however, the claims in the first 18 months were so high that they feared premiums would have to be raised 100% to cover the claims. To keep the premiums at an affordable level, the legislature amended the statute to limit the premiums to 125% of the standard risk premiums, and provided that assessments made against the carriers by the carriers association to cover the losses due to claims, could offset any income or premium taxes owed to the state by that carrier. Thus the state was made responsible for the losses incurred by the plan. You may wish to consider these amendments for the Alaska legislation as well.

The model act defines dependent as spouse, unmarried child under the age of 19, dependent child under the age of 25 who is a student and

is financially dependent on the parent, or a dependent child of any age who is disabled. You may wish to consider the addition of any household member who is financially dependent on the head of household, in order to include other relatives or non-relatives who may be members of that family unit.

The model legislation, in its itemization of minimum services covered and not covered, states that transportation costs other than ambulance are not covered, This is not well suited to Alaska, since medically necessary travel is frequent and expensive in most parts of the state.

The model legislation includes well baby care, routine physicals, and multi-phasic screening. It should be understood that since these are routine, predictable expenses, they do not fall within the central prupose of insurance -- that is, to insure against risk. Requiring coverage of basic medical care such as these in a consumer-paid plan does no service whatsoever to the consumer, since he or she will pay the full cost of routine care through higher premiums anyway, Requiring coverage of them in an employer-paid plan does offer an advantage to the consumer, of course, because it shifts the costs of these medical services from the consumer to the employer. Arguably there is a public purpose served in this requirement even for consumer-paid coverage -- namely to promote the utilization of these services in the interests of preventive medicine. Since the services have already been paid for, the consumer may as well utilize them. There are experts who claim, however, that routine physical exams, other than pap smears, blood pressure checks, or other procedures tailored to the health risks of the individual patient, are not cost effective; that overall they do not save more expense through the early detection of disease than they consume.*

Mandatory Employer Sponsored Coverage

The Hawaii Prepaid Health Care Act is the model for the mandatory employer sponsored coverage portions of the proposed legislation. The Hawaii

* One school of thought maintains that a more effective approach to preventive medicine would be promoting health education, self-awareness and self-responsibility for maintaining health among consumers. This would also promote early detection and reporting of symptoms when they do occur.

act excludes seasonal employees, in particular the pineapple pickers. The only explanation for this offered by the Hawaii program administrator was that the plantation owners had the political clout to get their employees exempted. Seasonal employees are a large component of Alaska's labor force, and often lack health coverage. You may wish to consider including seasonal employees in the Alaska legislation, or perhaps some form of hour bank for seasonal and temporary employees similar to the union health plans in the construction trades.

The model legislation mandates coverage of the employee only, and coverage of dependants is optional (unless the plan is of lower standard than the largest plan and is approved by the commissioner). You may wish to consider making coverage of dependents mandatory in employer-sponsored plans.

The Hawaii model sets up a separate fund for premium supplementation for qualifying employers. Several sections of the bill are devoted to defining the fund and how it is to be managed. Since the fund is not going to be self-supporting and will require annual appropriations anyway, there is little apparent advantage in terms of management or oversight in establishing a separate fund. You may wish to consider making premium supplementation part of the general fund.

The Hawaii model appears to make employee participation, including payment fo the employee share of the premium, mandatory. The advantage in this is that more people will have coverage and employers cannot pressure employees to decline such coverage. The disadvantage is that employees may be required to contribute to the premium and have no choice whether or not to participate. You may wish to consider making participation voluntary on the part of the employee.

Linkage Between Hawaii and Minnesota Models

The Hawaii and the Minnesota models take two different approaches toward defining the minimum benefit standards for qualified health coverage plans. The Hawaii law is setting standards for mandatory employer coverage. In addition to meeting the very general benefit guidelines itemized in the

law, a qualified plan must meet one of two alternative benefit standards: (1) the benefits must meet or exceed the benefits of the largest plan in the state (in Alaska this would be either the Alaska State employees plan or possible the Teamsters plan); or (2) the benefits must provide a level of coverage deemed satisfactory by the Commissioner. If these benefit plans are more limited than the largest plan, the employer must pay half the premium for dependents as well as the primary insured. The bill also establishes a prepaid health care council to advise the Commissioner on benefit levels. The law is administered by the Department of Labor.

The Minnesota law is setting standards for state qualified plans which all carriers are required to offer. The law specifies the scope of required benefits as well as minimum or maximum limits, copayments, and deductibles for three levels of qualified plans. The law is administered by the Division of Insurance.

While there is no direct conflict between these two laws which are proposed for Alaska, there is some duplication. Since the Alaska Department of Labor has no expertise in the arena of health insurance benefits, you may wish to consider centralizing all responsibility for benefit standards under the Division of Insurance, and leave only the employer compliance responsibilities with the Department of Labor. You should be aware that the Alaska Division of Insurance is already seeking authority to regulate minimum standards for insurance of all kinds in HB882 and SB513.

Consideration should also be given to the question of what standards employer coverage should meet and how they should be set. The Minnesota model specifies the standards for three levels of qualified coverage in law, and requires that employers who offer health coverage provide at least a number two qualified plan. The Hawaii model only provides general guidelines of minimum services to be covered, and leaves the other details up to the Commissioner, or else ties the standard to the benefits provided by the largest plan in the state. The state employees plan and the Teamsters plan are both more comprehensive than the minimum standards for the number two qualified plan, but of course would also be more expensive. The Minnesota approach is much simper than the Hawaii approach and gives the legislature

greater control over the minimum standards. The standard required for employer plans does not necessarily have to be the same standard required for a qualified plan offered to individual consumers, particularly in the area of routine care for the r asons discussed in an earlier section.

Medicaid Medically Needy

Federal financial participation requirements in the Medicaid medically needy program set the maximum income threshold for medically needy program eligibility at 133% of the Aid to Families with Dependent Children income standard for a household of equivalent size. The minimum income threshold is set equal to the Adult Public Assistance standard or the AFDC standard, whichever is higher, for a household of equivilent size. Since in Alaska the AFDC standard is so much lower than the APA standard, $350 for an AFDC family of two compared to $608 for two APA elibibles, the federally mandated minimum medically needy income threshold for a family of two, $608, is higher than the federally mandated maximum income threshold of $466.55 ($350 x 1.33). These are clearly impossible criteria. The federal policy manual appears to resolve the contradiction in favor of the lower standard. The result is that for adult elibibles the Medically needy income threshold is not much higher, and for a two person household is actually lower, than the income standard for the regular Adult Public Assistnace program. (See attachment) This inconsistency could be left as is, or resolved in one of two ways: (1) the AFDC standard (which is lower than AFDC standards in many other states and a virtually impossible budget for a family in Alaska) could be raised; or (2) the medically needy income threshold could be set higher than 133% of the AFDC standard and the program could by financed entirely by the state.

Medicaid Optional Services

The Medicaid optional services included in the drafting request were the nine uncovered services most often requested by Medicaid clients and most recommended by social workers, as reported in OPTING: A Study of Medicaid Client Need. A copy of Table 2 from this report is attached. A complete listing of Medicaid optional services is attached should you wish to consider other optional services.

THELMA
BUCHHOLDT
Alaska State Legislature
House of Representatives
Juneau, Alaska 99811

May 22, 1980

To: Representatives Gardiner, Meekins, McKinnon, Parker

From: Representative Thelma Buchholdt

Re: HCS CS SS SB 227 - Health Legislation

HCS CS SS SB 227, "An Act relating to the health of residents of the state," was passed out of the House HESS Committee on Wednesday, May 21. I am supplying you with a copy of the bill summary and the accompanying fiscal note. I am also enclosing a copy of the work draft that was passed out of Committee. I expect that the final version of the bill will be printed this afternoon.

Very briefly, Section 1 of the bill establishes a carrier reinsurance pool which would make health insurance available at a reasonable premium to every resident and every employer group in the state. This section of the bill is designed to pick up high-risk persons and other uninsurables in the state for whom health coverage is now unavailable.

Sections 4 through 7 of the bill comprise the original CS SS SB 227, sponsored by Senators Coletta, Hohman and Stimson, and require state employee health insurance to include coverage for alcoholism and drug dependence.

Section 8 of the bill requires the Commisssioner of Health and Social Services to provide services under medical assistance programs through health insurance policies or health service contracts when cost effective. The bill authorizes the Department to make interim peyments to providers who serve a large volume of state medical assistance clients. The bill also requires the state to pay interest to providers on overdue medical assistance bills.

Sections 9 and 10 of the bill expand the state's Medicaid program to include all services and eligibles qualifying for federal financial participation.

Finally, in Section 11, a medically needy program is established under the state General Relief program with an income standard set at 150% of the poverty guideline. Persons whose income exceeds the standard become eligible when they spend their excess income on medical bills.

The fiscal note for the bill includes approximately $ 8 million from the state's General Funds, $ 22,800 from other state funds and approximately $ 8 million in federal funds.

HCS CSSS SB 227 (HESS)

BILL SUMMARY

(revised 5/21/80)

The basic concept of the first section of the bill is to establish a carrier reinsurance pool which would make health insurance available at a reasonable premium to every resident and every employer group in the state, regardless of underwriting risk. This section is modeled after Connecticut law.

AS21.50.010 Each carrier in the state which offers individual health coverage is required to make an ndividual comprehensive health care plan available to each resident of the state who is not eligible for Medicare. Each carrier in the state which offers group health coverage is required to make a group comprehensive health care plan available to every resident employer of three or more employees. The required coverage may be provided by a carrier or through the reinsurance association, but in the former case the premium charged may not exceed the applicable association premium. The bill does not preclude a carrier from carrying other kinds of health insurance nor does it require a carrier to provide coverage to a person or group who already has coverage.

AS21.50.020 The required comprehensive health plans must cover the services itemized. A choice of $100, $500, or $1000 deductible is provided, and the maximum co-payment is set at 20%. The sum of co-payment and deductibles may not exceed $1000 for an individual or $2000 for a family before benefits

are paid at 100%. The maximum lifetime benefits limit may not be less than $1,000,000. Pre-existing conditions may only be excluded if the condition was treated or medical advice was sought within six months prior to the effective date of coverage, but in any case may not be excluded from coverage for more than twelve months. The plans need not cover occupational injuries, cosmetic treatment, custodial care, services which are not medically necessary, services which are covered under an automobile liability policy, or other specified expenses. Group comprehensive health care plans must also cover dependents.

AS21.50.030 The Health Reinsurance Association is established consisting of all licensed health insurance carriers in the state. The board of governors and a plan of operation which addresses itemized issues are both subject to approval by the director. The authority to issue health insurance, to establish rates, to administer reinsurance, to pool risks, and other general powers are granted the association.

Each association member must designate the classes of risk which it elects to have written by or reinsured by the association. Individual lives may not be selected out of a group for reinsurance. Premium rates may not be excessive, inadequate, or unfairly discriminatory, nor may they exceed 125% of rates for standard risk groups. All rates are promulgated through the association by an actuarial committee.

Losses of the association are assessed to members. Members in turn may credit the assessed claims losses, but not

assessed administrative losses, against their premium or income tax. If the assessment exceeds their tax liability, the Commissioner of Revenue reimburses the carrier for the excess loss. Periodic audits are required.

AS21.50.040 Hospital or medical service corporations (such as Blue Cross) are given the option of participating in the Health Reinsurance Association or of setting up their own parallel residual market association under the same guidelines and standards.

AS21.50.050 The regulatory and oversight powers and administrative duties of the director of insurance are enumerated.

AS21.50.100 Definitions

Sections 2 and 3 are technical amendments to other chapters of the insurance code to bring them in conformity with Section 1.

Sections 4 through 7 of the bill amending AS39.30 comprise the original CSSSSB 227 and require state employee health insurance to include coverage alcoholism and drug dependence. Minimum benefits in the state employees plan are defined to include inpatient detoxification, inpatient treatment and outpatient treatment. Coverage may not exclude dependents or pre-existing alcoholism conditions.

Section 8 of the bill amending AS47.05 requires the Commissioner of Health and Social Services to provide services under medical assistance programs through health insurance policies or health service contracts when this would be cost effective. In a separate section, the department is authorized to make interim payments to providers who serve a large volume of state medical assistance clients. And finally, the bill requires the state to pay interest to providers on overdue medical assistance bills at the rate of one percent per month after 30 days and two percent per month after 90 days.

Sections 9 and 10 expand the state's Medicaid program to include all services and eligibles qualifying for federal financial participation.

Section 11 creates a medically needy program under the state General Relief program with an income standard at 150% of the poverty guideline. Persons whose income exceeds the standard become eligible when they spend their excess income on medical bills.

FISCAL SUMMARY

HCS CSSSSB 227 (HESS)

(in thousands of dollars)

FY 81	General Funds	Federal Funds	Other	Total
Sections 1-3: Health insurance pool	99.0			99.0
Sections 4-7: Alcoholism benefits	138.6	7.8	22.8	169.2
Sections 8-12: Medicaid & GR Med	7,728.7	7,858.5		15,587.2
TOTAL	7,966.3	7,866.3	22.8	15,855.4

FY 82				
Sections 1-3: Health insurance pool	83.8		45.0	128.8
Sections 4-7: Alcoholism benefits	332.6	18.7	54.8	406.1
Sections 8-12: Medicaid & GR Med	17,003.0	17,288.7		34,291.7
TOTAL	17,419.4	17,307.4	99.8	34,826.6

Prepared by HESS staff 5/22/80

I. REQUEST

Bill/Resolution No. HCS CSSSSB 227 (HESS) SECTIONS 1-3

Title An Act relating to the health of residents of the state

Requested by Health Education and Social Services Comm Date 5/20/80

II. FISCAL DETAIL

Agency Affected Division of Insurance

Program Category Affected Public Protection

BRU, Program, or Subprogram(s) Affected Division of Insurance

(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 80	FY 81	FY 82	FY 83	FY 84	FY 85
100 PERSONAL SERVICES		48.3	53.2	58.2		
200 TRAVEL		5.0	3.0	3.3		
300 CONTRACTUAL		40.9	26.8	29.4		
400 COMMODITIES		.8	.8	.9		
500 EQUIPMENT		4.0	--	--		
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC.						
Reduct. of Unrestric. tax Rcpt #019		--	45.0	99.0		
TOTAL		99.0	128.8	190.8		

FUNDING (Thousands of Dollars)

GENERAL FUND		99.0	83.8	91.8		
FEDERAL FUNDS						
OTHER (Specify Fund Source)						
Reduct. of Unrestric. tax Rcpt #019		--	45.0	99.0		

POSITIONS

FULL TIME Market Analyst II		1	1	1		
PART TIME Clerk Typist III		1	1	1		
TEMPORARY						

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

This note assumes a half year of implementation and a half year of operation in FY81. It assumes 10% inflation for FY82 and FY83.

prepared by HESS staff 5/20/80

PREPARED BY

FISCAL NOTE

PERSONAL SERVICES

The law in Connecticut on which this bill is based was implemented with no additional staff. Most of the substantive work was performed by the industry. One new position with clerical support may be justified, however, for drafting the regulations, reviewing the organization of the Health reinsurance Association and approving the rates and policy forms developed by the carriers for the comprehensive health plan.

Market Analyst	III	Range 18A	12 months	$29,580
Clerk Typist	III	Range 8A	half-time, 12 months	8,162
				$37,742
			benefits (.1529)	5,771
			FICA (.0665 x 8162 + 1985)	2,528
			health insurance (127 x 1.5 x 12)	2,286
				$48,327

TRAVEL

Travel to Connecticut and Minnesota and to Health Reinsurance Association board meetings	$ 5,000

CONTRACTUAL

Rent 2 positions x 150 sq. ft. x $1.70 x 12 mo.	$ 6,120
Phone (80 install + 600 local + 3,000 long distance)	3,680
Postage	1,000
Printing and Xerox	2,000
Equipment Rental (typewriter)	2,500
Consulting	25,000
Other	600
	$40,900

COMMODITIES (1.5 x 500)

$ 750

EQUIPMENT

desks, chairs, bookcase, filing cabinet, caculator, etc.	$ 4,000

PREMIUM TAX OFFSET

Total Comprehensive Health Plan Premiums in Connecticut for 1979: $2,785,367

Total HMA Assessment since April 1, 1976: $ 80,000

Alaska population*/Connecticut population* = 395,000/2,746,000 = .144

Alaska rates/Connecticut rates: 1.35

Factor for change in deductions: 1.05

Factor for change in pregnancy benefits: 1.05

Factor for change in transportation benefits:? fudgefactor: 1.20

Loss factor: (135% - 125%)/135% = .074

Inflaction factor '79 - '81: 1.21

$2,785,367 x .144 x 1.35 x 1.05 x 1.05 x 1.20 x .074 x 1.21 + ($80,000/345) = 87,402

This estimating procedure will tend to overestimate the costs. Nevertheless, there are many difference between Connecticut and Alaska which we cannot account for, and the margin for error is large. Rounding up to an even $90,000 should produce a safe high estimate of the tax loss to the state in a full year of operation. Since FY '81 includes only a half year of operation, only half that amount would be claimed in FY '82.

* Civilian noninstitutionalized population under age 65.

ELEVENTH LEGISLATURE

FISCAL NOTE

I. REQUEST

Bill/Resolution No. HCS CS for SS Senate Bill 227 (HES) Sections 4-7

Title Insurance for Alcoholism and Drug Dependence

Requested by _____ Date _____

II. FISCAL DETAIL

Agency Affected Administration - Division of Retirement and Benefits

Program Category Affected Retirement and Benefits (Other Benefits)

BRU, Program, or Subprogram(s) Affected 02-96-8-01-02-00

(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

		FY 79	FY 80	FY 81	FY 82	FY 83	FY 84
100	PERSONAL SERVICES						
200	TRAVEL						
300	CONTRACTUAL						
400	COMMODITIES						
500	EQUIPMENT						
600	LAND & STRUCTURES						
700	TRS STATE MATCH						
100	BENEFITS		282.0	338.4	406.1	487.3	584.8
	TOTAL		282.0	338.4	406.1	487.3	584.8

FUNDING (Thousands of Dollars)

GENERAL FUND		230.8	277.1	332.6	399.2	478.9
FEDERAL FUNDS		13.0	15.6	18.7	22.4	26.9
VETERAN'S FUND		0.6	0.7	0.8	1.0	1.2
FISH & GAME FUND		1.7	2.0	2.4	2.9	3.5
HIGHWAY FUND		3.7	4.4	5.3	6.3	7.6
AIRPORT FUND		8.2	9.8	11.8	14.1	17.0
CAPITAL FUND		24.0	28.8	34.5	41.4	49.7
PERS						
TRS						

POSITIONS NONE

FULL TIME						
PART TIME						
TEMPORARY						

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

1. Approximately 8,900 State employees are currently covered under the State Group Health Care Plan.

2. The cost to implement the provisions of this bill will be $2.64 per employee per month.

3. Estimate that the cost to provide continued coverage will increase 20% each year for the immediate future. However, an effective alcoholism/drug dependency program should help to reduce overall health care claim experience in the future.

4. Cost for coverage of political subdivisions (approximately 50 subdivisions) participating in group insurance not included; recommend that the Alaska Municipal League, 204 Franklin St., Juneau, AK 586-1325, be contacted for input.

Paul B. Arnoldt

IV. DATE 3/30/79 PREPARED BY Paul B. Arnoldt, Director

AGENCY Division of Retirement & Benefits

PHONE 465-4460

Original: Legislative Finance

cc: Budget and Management

Prime Sponsor (First Legislator Named) Senator Colletta & Senate HESS

Summary Sheet

House CS for CS for Sponsor Substitute for Senate Bill No. 227
(In thousands of dollars) SECTIONS 8-12

		Total	Federal	State	New Positions
1.	Addition of Medicaid Services and New Eligibles	$24,194.5	$15,717.0	$ 8,477.5	17
2.	Decrease of GR-Med. as Result of Adding Medicaid Svcs. and Eligible Groups	4,471.8	-0-	4,471.8	-0-
3.	State Only Medically Needy	11,169.4	-0-	11,169.4	16
4.	Interest Payment	282.2	-0-	282.2	-0-
	TOTAL	$31,174.3	$15,717.0	$15,457.3	33

[NOTE: THESE AMOUNTS PREPARED BY THE DEPARTMENT ARE FOR A FULL YEARS'S OPERATION. THE SUMMARY SHEET PREPARED BY HESS STAFF ASSUMES A HALF YEAR OF OPERATION IN FY81 AND 10% INFLATION FOR FY82. --HESS STAFF]

FISCAL NOTE

I. REQUEST

Bill/Resolution No. House CS for CS for Sponsor Substitute for Senate Bill No. 227

Title An Act relating to the health of residents of the State.

Requested by The Hess Committee Date May 2, 1980

II. FISCAL DETAIL

Agency Affected Department of Health and Social Sevices

Program Category Affected Health/Social and Economic Assistance

BRU, Program, or Subprogram(s) Affected Medicaid/Eligibility Determination/PAA

(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 80	FY 81	FY 82	FY 83	FY 84	FY 85
100 PERSONAL SERVICES		448.3				
200 TRAVEL		17.0				
300 CONTRACTUAL		175.5				
400 COMMODITIES		8.5				
500 EQUIPMENT		17.5				
600 LAND & STRUCTURES		-0-				
700 GRANTS, CLAIMS, ETC.		23,527.7				
TOTAL		24,194.5				

FUNDING (Thousands of Dollars)

GENERAL FUND		8,477.5				
FEDERAL FUNDS		15,717.0				
OTHER (Specify Fund Source)		-0-				

POSITIONS

FULL TIME		17				
PART TIME		-0-				
TEMPORARY		-0-				

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

Medical benefits would be provided to approximately 3,065 new cases under the Medicaid program. Administration of program benefits would require 15 field staff positions and 2 central office positions, office space, and additional computer time to be divided between the Eligibility Determination and Public Assistance Administration BRUs. Funding is 50% federal except for the Indian Health Care program which is funded at 100% federal funds. Since the bill proposes to add new coverage groups and new categories of coverage to Medicaid, there will be a reduction in General Relief Medical program expenditures as indicated on page 2. Thus, the actual increase in state General fund revenues needed for this increased Medicaid coverage is 8,477.5 - 4,471.8 = 4,005.7.

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)

Prepared by: David M. Davidson Date: May 2, 1980
Division/Office: Public Assistance PH: 465-3347
Department of Health & Social Services

33-001 (Rev. 12/79)
Modify by DHSS (11-20-79)

Approval DHSS Mgt. & Bdgt: _____ Date: _____

ELEVENTH LEGISLATURE

FISCAL NOTE

I. REQUEST

Bill/Resolution No. House CS for CS for Sponsor Substitute for Senate Bill No. 227

Title An Act relating to the health of residents of the State.

Requested by The Hess Committee Date May 2, 1980

II. FISCAL DETAIL

Agency Affected Department of Health and Social Sevices

Program Category Affected Health

BRU, Program, or Subprogram(s) Affected General Relief Medical

(Note: If more than one budget component is affected, separate line-item amount and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 80	FY 81	FY 82	FY 83	FY 84	FY 85
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL						
400 COMMODITIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC.		(4,471.8)				
TOTAL		(4,471.8)				

FUNDING (Thousands of Dollars)

GENERAL FUND		(4,471.8)				
FEDERAL FUNDS						
OTHER (Specify Fund Source)						

POSITIONS

FULL TIME		-0-				
PART TIME		-0-				
TEMPORARY		-0-				

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

Decrease in General Relief Medical program expenditures due to the transfer of coverage for certain service categories from state funding to coverage under the Medicaid program, and the addition of certain groups under Medicaid that are currently covered by General Relief Medical.

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)

Prepared by: David M. Davidson Date: May 2, 1980
Division/Office: Public Assistance PH: 465-3347
Department of Health & Social Services

33-001 (Rev. 12/79)
Modify by DHSS (11-28-79)

Approved DHSS Mgt. & Bdgt: _____ Date: _____

FISCAL NOTE

I. REQUEST

Bill/Resolution No. House CS for CS for Sponsor Substitute for Senate Bill No. 227

Title An Act relating to the health of residents of the State.

Requested by The Hess Committee Date May 2, 1980

II. FISCAL DETAIL

Agency Affected Department of Health and Social Sevices

Program Category Affected Health/Social and Economic Assistance

BRU, Program, or Subprogram(s) Affected General Relief Medical/Eligibility Determination/PAA

(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 80	FY 81	FY 82	FY 83	FY 84	FY 85
100 PERSONAL SERVICES		423.3				
200 TRAVEL		16.0				
300 CONTRACTUAL		154.0				
400 COMMODITIES		8.0				
500 EQUIPMENT		16				
600 LAND & STRUCTURES		-0-				
700 GRANTS, CLAIMS, ETC.		10,551.6				
TOTAL		11,169.4				

FUNDING (Thousands of Dollars)

GENERAL FUND		11,169.4				
FEDERAL FUNDS		-0-				
OTHER (Specify Fund Source)		-0-				

POSITIONS

FULL TIME		16				
PART TIME		-0-				
TEMPORARY		-0-				

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

Medical benefits would be provided to approximately 2,821 new cases under a state-only medically needy program as part of the General Relief Medical program. Administration of program benefits would require 14 field staff positions and 2 central office positions, office space, and additional computer time to be divided between the Eligibility Determination and Public Assistance Administration BRUs. Funding is indicated as 100% state funds, but it may be possible to receive federal funding for certain individuals with income less than 133% of the state need standard for the particular eligibility categorical group to which they are related.

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)

Prepared by: David M. Davidson Date: May 2, 1980
Division/Office: Public Assistance PH: 465-3347
Department of Health & Social Services

33-001 (Rev. 12/79)
Modify by DHSS (11-28-79)

Approval DHSS Mgt. & Bdgt: _____ Date: _____

FISCAL NOTE

I. REQUEST

Bill/Resolution No. House CS for CS for Sponsor Substitute for Senate Bill No. 227

Title An Act relating to the health of the residents of the State.

Requested by The Hess Committee Date May 2, 1980

II. FISCAL DETAIL

Agency Affected Department of Health and Social Sevices

Program Category Affected Health

BRU, Program, or Subprogram(s) Affected General Relief Medical

(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 80	FY 81	FY 82	FY 83	FY 84	FY 85
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL		282.2				
400 COMMODITIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC.						
TOTAL		282.2				

FUNDING (Thousands of Dollars)

GENERAL FUND		282.2				
FEDERAL FUNDS		-0-				
OTHER (Specify Fund Source)						

POSITIONS

FULL TIME		-0-				
PART TIME		-0-				
TEMPORARY		-0-				

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

Funding necessary to make interest payments to providers for Medicaid and General Relief Medical clean claims not processed within 30 days of receipt by the Department. Federal law requires states to process 90% of Medicaid clean claims within 30 days of receipt, however no provision is made under federal law for funds to be used to make interest payments. Thus, all interest payments must be made using state funds only.

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)

Prepared by: David M. Davidson Date: May 2, 1980
Division/Office: Public Assistance PH: 465-3347
Department of Health & Social Services

Approval DHSS Mgt. & Bdgt: _____ Date: _____

33-001 (Rev. 12/79)
Modify by DHSS (11-28-79)

HCS CSSS SB 227

BILL SUMMARY

The basic concept of the first section of the bill is to establish a carrier reinsurance pool which would make health insurance available at a reasonable premium to every resident and every employer group in the state, regardless of underwriting risk. This section is modeled after Connecticut law.

AS21.50.010 Each carrier in the state which offers individual health coverage is required to make an individual comprehensive health care plan available to each resident of the state who is not eligible for Medicare. Each carrier in the state which offers group health coverage is required to make a group comprehensive health care plan available to every resident employer of three or more employees. Every self-insured employer group is required to make an individual comprehensive health care plan available as a conversion privilege to each group member. The required coverage may be provided by a carrier or through the reinsurance association, but in the former case the premium charged may not exceed the applicable association premium. The bill does not preclude a carrier from carrying other kinds of health insurance nor does it require a carrier to provide coverage to a person or group who already has coverage.

AS21.50.020 The required comprehensive health plans must cover the services itemized. A choice of $100, $500, or $1000

deductible is provided, and the maximum co-payment is set at 20%. The sum of co-payment and deductibles may not exceed $1000 for an individual or $2000 for a family before benefits are paid at 100%. The maximum lifetime benefits limit may not be less than $1,000,000. Pre-existing conditions may only be excluded if the condition was treated or was apparent and should have been diagnosed or treated within six months prior to the effective date of coverage, but in any case may not be excluded from coverage for more than twelve months. The plans need not cover occupational injuries, cosmetic treatment, custodial care, services which are not medically necessary, services which are covered under an automobile liability policy, or other specified expenses.

AS21.50.030 Group comprehensive health care plans must also cover dependents and must include the privilege to continue coverage for a specified period of time upon leaving the group by reason of layoff, leave, termination, death or illness. Unmarried children remain eligible as dependents as long as they are under 19, under 23 and a full-time student, or disabled. Spouses and resident household members who are financially dependent on the employee are also covered as dependents up until they become elegible for Medicare. Group members must also be provided the privilege to convert to an individual plan immediately on the termination of group coverage.

AS21.50.040 Individual comprehensive health care plans must provide the privilege for dependents to continue coverage after the death of the primary insured until the coverage would have otherwise ceased.

AS21.50.050 The Health Reinsurance Association is established consisting of all licensed health insurance carriers in the state. The board of directors and a plan of operation which addresses itemized issues are both subject to approval by the director. The authority to issue health insurance, to establish rates, to administer reinsurance, to pool risks, and other general powers are granted the association.

Each association member must designate the classes of risk which it elects to have written by or reinsured by the association. Individual lives may not be selected out of a group for reinsurance. Premium rates may not be excessive, inadequate, or unfairly discriminatory, nor may they exceed 125% of rates for standard risk groups. All rates are promulgated through the association by an actuarial committee.

Losses of the association are assessed to members. Members in turn may credit the assessed claims losses, but not assessed administrative losses, against their premium or income tax. If the assessment exceeds their tax liability, the Commissioner of Revenue reimburses the carrier for the excess loss. Periodic audits are required.

AS21.50.060 Hospital or medical service corporations (such as Blue Cross) are given the option of participating in the

Health Reinsurance Association or of setting up their own parallel residual market association under the same guidelines and standards.

AS21.50.070 The regulatory and oversight powers and administrative duties of the director of insurance are enumerated.

AS21.50.080 The conversion privileges required for group comprehensive health care plans under AS21.50.030 are also required for all group health policies issued in the state after January 1, 1981.

AS21.50.090. A voluntary health premium supplementation program is established for employers who choose to provide health benefits for their employees and meet certain financial hardship criteria. Premium supplementation is at the rate of 80% of the premium cost which exceeds 1.5% of the payroll plus 4% of the employer's income before taxes from that business. This section is modeled after Hawaii law.

AS21.50.200 Definitions.

Sections 2 through 5 of the bill amending AS39.30 comprise the original CSSSSB 227 and require group health insurance to include coverage for alcoholism and drug dependence. Minimum benefits are defined to include inpatient detoxification,

inpatient treatment and outpatient treatment. Coverage may not exclude dependents or pre-existing alcoholism conditions.

Section 6 of the bill amending AS47.05 requires the Commissioner of Health and Social Services to provide services under medical assistance programs through health insurance policies or health service contracts when this would be cost effective. In a separate section the department is authorized to make interim payments to providers who serve a large volume of state medical assistance clients. And finally, the bill requires the state to pay interest to providers on overdue medical assistance bills at the rate of one percent per month after 30 days, and two percent per month after 90 days.

Section 7 and 8 expand the state's Medicaid program to include all services qualifying for federal financial participation.

Section 9 creates a medically needy program under the state General Relief program with an income standard at 150% of the poverty guideline. Persons whose income exceeds the standard become eligible when they spend their excess income on medical bills.

IMPACT ON INSURANCE CARRIERS

Minnesota Experience

The Minnesota Comprehensive Health Act took effect January 1, 1977. At year end, 1976, the following statistics were compiled:

Out of

751 carriers licensed to write health and accident insurance in the state,

42 carriers withdrew from the state rather than comply with the law. Of these,

25 never wrote any health insurance in the state anyway. The remaining

17 carriers that withdrew had a combined volume of

$888,000 in health insurance premiums in Minnesota (less than 0.2% of the total) or an average of

$52,200 in premiums per carrier. The largest carrier that withdrew reported a volume of

$428,000 in accident and health premiums.

Since the time these statistics were compiled, other carriers have dropped their accident and health business in Minnesota, and some that originally withdrew have resumed their accident and health line of business in the state again.

Mr. Caroll Calloway, Assistant General Counsel for the Health Insurance Association of America, discussed several reasons that carriers might have preferred to stop doing accident and health business in Minnesota rather than comply with the Comprehensive Health Act.

The first objection was that many carriers specialize in a particular type of insurance and do not underwrite comprehensive policies. The law requires them to offer comprehensive plans, and does not allow them to refuse a client for reasons other than that the client is an uninsurable risk. Another objection was that the required conversion privileges obligates a carrier that specializes in group policies to also write individual conversion policies.

Mr. Calloway stated that the insurance carriers like the Connecticut comprehensive health act, because in Connecticut the underwriting burden for the mandated coverage is not placed on the induvidual carriers, but on the association. The association in Connecticut develops and underwrites the comprehensive health plan which the carriers are obligated to make available to their clients. The Minnesota law also provides for reinsurance and administration by the association of all required types of coverage and the association has the ability to develop prototype plans for use by any carrier which does not choose to develop and issue its own qualified plans. The Minnesota carriers association has refused, however, to reinsure lines of coverage mandated by the act, other than the state plan for high risk clients, according to Mr. Calloway. Thus it is not the provisions of the law which place an insurmountable burden on the carriers, but the practice of the assocaition, which of course is run by the carriers themselves.

The third objection was the "major medical roll on" which requires carriers to offer major medical coverage to their client with unqualified plans. They regard this as an impairment of contract. This section to which the carriers strenuously object could easily be deleted without significantly weakening the bill, in light of the requirement that carriers must offer their client a comprehensive qualified plan with major medical coverage anyway.

The carriers which might find compliance with HB 977 most difficult perhaps are those who write only accident or illness indemnity policies with fixed reimbursement rates (for example, $50 per day for every day in the hospital). These companies are not set up to handle claims based on expenses incurred as required of a qualified plan under HB 977. The largest carrier of this type in Alaska has a premium volume of $723,000. It is not known how many other carriers of this type there are, nor what their premium volume might be. While it is perhaps undesirable to adversely affect any Alaska business with this legislation, it is notable that those for whom compliance with HB 977 would be most difficult are precisely those carriers who specialize in limited types of accident and health coverage which afford the least financial and medical protection to consumers.

POSITION PAPER
ON
HOUSE CS FOR CS FOR SPONSOR SUBSTITUTE FOR SENATE BILL NO. 227 (FINANCE)

"An Act relating to the health of residents of the State; and providing for an effective date."

1. Departmental Overview of House CS for CS for SS for SB 227 (Finance)

The Department of Health and Social Services will primarily reserve its comments to Sections 5-15 of the bill, as the earlier sections are concerned with health insurance. It is our understanding that these issues are planned to be addressed by the Division of Insurance in the Department of Commerce and Economic Development.

The Department, in general, believes that House CSCSSSSB 227 (Finance) takes a multi-faceted approach to a complex problem. It appears to move in too many directions and at too rapid a time frame, which could potentially jeopardize the accomplishment of the goals that the bill seeks to obtain. We recommend that all sections of the bill, except for Sections 5-8, be studied further during the interim to insure that the plan on which the insurance section of the bill is modeled is workable, affordable, and in the best interest of clients and the insurance industry. Sections 5-8 (pilot project for alcoholism insurance coverage for state and other participating government employees) which were the body of CSSSSB 227 (HESS) and the result of over a year's planning. That pilot project concept is supported by state government and the insurance companies that serve Alaska. We, therefore, recommend that the pilot project sections of the current committee substitute be addressed separately in their original piece of legislation. We are concerned that the fiscal impact of the expansion of the Medicaid program and the uncertainities of the health insurance section may outweigh serious consideration of the pilot project for alcohol insurance, which has been studied for a significant period of time.

The Department is also concerned about the massive increase to the Medicaid and General Relief-Medical programs, if House CSCSSSSB 227 (Finance) were to pass. The bill would increase the budgets of these programs by over 50% (if implemented for a full fiscal year) and would require a monumental effort on the part of our Division of Public Assistance to gear up for implementation by the January, 1981 effective date. We are concerned that the current Medicaid service program might suffer during the transition period as a result of such a significant increase. We would, therefore, recommend that if new options to Medicaid or General Relief-Medical were to be added that they be phased-in, rather than adding all remaining services and eligibility groups at a single time. Each service could be evaluated on its own merits, rather than in mass, to determine whether it is cost effective to do so at that time. If options are to be added, the Department is interested in exploring the coverage of the AFDC-unborn child under Medicaid and a limited medically needy program under General Relief-Medical. We are also interested in exploring the addition of prescription drugs to the list of covered Medicaid services, if it can be determined to be cost effective.

We also support in concept the purchase of health insurance policies or contracts for our current Medicaid or other state medical assistance clients when the Department determines that such a purchase would be cost effective. The purchase of such insurance or contracts would allow our clients to be integrated into the normal mainstream of the health delivery system, rather than be stigmatized by having to reveal his or her welfare status each time a medical assistance coupon is presented as payment in the medical provider's office.

II. Departmental Comments on Sections 5-8 (Mandatory State and Other Participating Government Employee Alcoholism and Drug Dependence Coverage)

Sections 5-8 of the bill are essentially the contents of CSSSSB 227 (HESS) which passed from House HESS Committee on April 26, 1979. Sections 5-8 were the result of over a year's work involving insurance companies which serve Alaska, the Division of Insurance, and the Department's Office of Alcoholism and Drug Abuse. The sections authorize a limited pilot project to mandate health insurance coverage for the diagnosis and treatment of alcoholism and drug dependence for state and other participating government employees. The Department of Health and Social Services continues to support this concept. The Department of Administration in 1979 estimated the cost of such coverage for state employees to be $338,400 for FY 81.

Authorization of such a pilot project would allow for the testing of the cost effectiveness and merits of mandatory employee alcoholism and drug dependence treatment coverage on a statewide basis. The project will test if coverage were available, would state employees in need of such services would seek them earlier in illness and thus potentially reduce costs for later medical care. The benefits to the employer through the early diagnosis and treatment of alcoholism or drug dependence could be increased employee productivity, reduced absenteeism, decreased sick leave utilization, fewer disability benefit payments, and reduced cost for hospitalization for injury- or disease-related problems.

We support Sections 5-8 of the bill.

III. Specific Department Comments on 9 Through 10 (Medical Assistance)

Section 9 - AS 47.05.070(a) - (Page 9, line 18)

The Department, as mentioned earlier in the position paper, is in favor of purchasing services through health insurance policies or contracts for medical assistance clients only if such purchase is more cost effective than traditional methods. The Department has no problem with the mandatory nature of the language in this section, but notes that there is currently no statutory prohibition against such purchase. Therefore, although these sections would facilitate the purchase of insurance for medical assistance clients, it is not absolutely essential to authorize it.

Section 9 - AS 47.05.110 - (Page 10, lines 24-29 and page 11, lines 1-4)

Under present Medicaid law, the Department is required to pay 90% of "clean claims" within 30 days of receipt, and 99% of "clean claims" within 90 days of receipt. The Department supports the idea that medical providers should not suffer financially because of payment delays after a reasonable period. We would though recommend that payment of interest commence at 60 days rather than 30 days after presentation of "clean claims." This is generally considered reasonable turnaround in Alaska by health providers for payments from private insurance carriers due to uncertainty of mail deliveries. Also, we have been informed by the federal Medicaid program that federal funds are not available for interest payments on late Medicaid claims.

Section 9 - AS 47.05.120 - (Page 11, lines 5-19)

Add definitions for "remedial care," "non-exclusive contract," and "health care service contracts."

Section 10 - AS 47.07.020(b) - (Page 11, lines 20-23) and Section 13 - (Page 12, line 13)

This section would amend Medicaid law to provide coverage for all optional groups not currently entitled to Medicaid benefits in Alaska, primarily the unborn child group, the unemployed fathers, and the medically needy group.

Also, Section 13 removes the requirement that future additions of optional eligible groups to Alaska's Medicaid program must be approved by the Alaska State Legislature. Therefore, when Congress authorizes a new Medicaid optional eligibility group in the future, Alaska statutes do not require revision in order for the State to be required to automatically begin covering the groups.

The Department recognizes the value of the addition of the unborn child group to Medicaid to assist in proper health and development of children to low income women through access to necessary pre-natal care. We believe the addition of this group to Medicaid will have little impact on the program's expenditures. We can see the need for health care coverage to the medically needy and to the unemployed fathers under Medicaid but the cost of these options would be substantial and would be covering a greatly expanded group of clients. The Department supports the concept of a limited medically needy program under General Relief-Medical including only the aged, blind, and disabled until such time that we can fully assess the monetary and administrative costs of more expanded coverage.

Section 11 - AS 47.07.030 - (Page 11, lines 24-28)

This section as amended would change Medicaid law to dramatically expand medical services offered under the Medicaid program. It also removes the requirement that future additions to Alaska's Medicaid services must be approved by the Alaska State Legislature. Therefore, when Congress authorizes a new Medicaid optional service in the future, the Alaska statutes need not be amended in order for the State to be required to automatically offer the service.

Legislative Affairs Agency Department of Health and Social Service

The Department recommends that each service addition should be evaluated on its own merit, perhaps adding only those services where it appears cost effective, in terms of saving general fund dollars to do so. Also, all services added in mass would cause administrative problems. A phase-in model would be more appropriate if the Legislature decides to pursue this section.

Section 12 - AS 47.25.120 - (Page 11, line 29 and Page 12, lines 1-12)

This section as amended would add broad medically needy coverage under the State General Relief-Medical program. The Department supports the concept of a more limited medically needy program including only the aged, blind, and disabled until we can gain some experience regarding monetary and administrative burdens.

Section 14 - (Page 12, lines 14-15 and Page 12, line 16)

Sections 10-12 would add all remaining optional eligibility groups and services to Medicaid and add a broad medically needy program to General Relief-Medical. The bill provides for an effective date of January 1, 1981 for these sections. In light of the size of these additions (over $31 million for a full fiscal year), we would recommend a phase-in model over a period of years, beginning July 1, 1981, in order to administratively prepare for these changes with the minimum of adverse impact during the transition period to clients and providers.

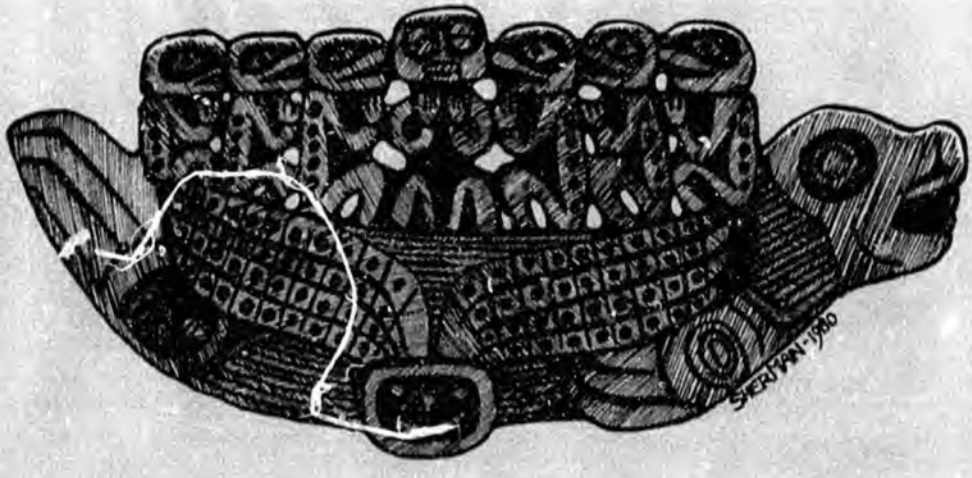
Approved by: _____ 5/30/80
Helen D. Beirne, Commissioner (DATE)
Department of Health and Social Services

POSITION PAPER/Department of Health & Social Services

Medical
Diagnosis
information

MEDICAID PROGRAM

in Alaska



Administered by:

STATE OF ALASKA
DEPARTMENT OF HEALTH AND SOCIAL SERVICES
DIVISION OF PUBLIC HEALTH

Jay S. Hammond, Governor Helen D. Beirne, Commissioner

The Medicaid Program pays medical expenses for eligible, low-income people. Under agreement with the U.S. Department of Health, Education, and Welfare, the Alaska Division of Public Assistance runs the program through its local offices and fee agents. This booklet explains the rules, and tells you how to apply for and use Medicaid coupons. For more information, ask your local public assistance office or village fee agent.

1 FILE AN APPLICATION FORM

* To be eligible for Medicaid you must usually be eligible for the:

  Aid to Families with Dependent Children Program (AFDC)
  OR
  Adult Public Assistance Program (APA)
  OR
  Supplemental Security Income (SSI)

* Certain people not eligible to receive benefits under the AFDC, APA, or SSI programs may still be eligible to receive Medicaid. This special group of people includes:

  1. Juveniles who are in the protective custody of the Department of Health & Social Services whose available financial resources do not exceed the AFDC need standard for a single person;

  2. Persons in health care facilities on an inpatient basis whose income does not exceed 300 percent of the current SSI payment standard;

  3. All individuals under age 21 who would be, except for age or attendance requirements, dependent children under the AFDC program;

  4. Certain families who become ineligible for AFDC payments due to increased earnings;

  5. Those reasonably classified individuals under age 21 who are in an intermediate care facility for the mentally retarded or persons with related conditions;

  6. Those reasonably classified individuals age 21 and under who are receiving active treatment in an inpatient psychiatric facility;

  7. Individuals under age 18 who meet the SSI eligibility requirements.

* The public assistance office or village fee agent will give you an application for either AFDC or APA. Your local federal Social Security Administration office or their traveling representative will help you apply for SSI. Addresses for Social Security offices are listed in Section 13 of this booklet.

* If you qualify for AFDC or APA, you will be mailed a check and Medicaid coupons within approximately 30 days from the date the office received your application.

* If you qualify for SSI, you must still apply separately at the public assistance office for APA cash benefits and for Medicaid coverage.

* You can apply for food stamps at the same time you apply for AFDC or APA and Medicaid.

2 AFDC, APA, AND SSI

* Aid to Families with Dependent Children (AFDC) is a program which gives money for children of eligible low-income families who are deprived of one or both of their natural or adopted parents.

* Adult Public Assistance (APA) is a program that includes three categories of eligibility (Old Age Assistance, Aid to the Blind, and Aid to the Disabled) and provides a supplemental payment to low-income adults whose income is not enough to provide for their own basic needs. All adults who qualify for APA must be either blind, OR 65 or older, OR physically or mentally disabled.

* Supplemental Security Income (SSI) is a federal program for low-income adults who are either blind, OR 65 or older, OR physically or mentally disabled. It also provides cash assistance for low-income children who are either blind or disabled.

3 HAVE AN INTERVIEW

* When you turn in your application, a worker will usually hold a confidential interview with you.

* At the interview, the worker will explain the program rules and go over the information on your application. The worker will help you complete any of the application form you have not been able to fill out. Ask the worker to explain anything that you do not understand. It's important that you understand the rules.

* Interviews are held at the public assistance office or at the fee agent's location. If no one in your household can go the interview, an adult friend or relative who knows your circumstances may go to be interviewed for you.

* If you are disabled or are unable to go to the interview and no one can go for you, let the office know. It may be possible to arrange an interview at your home or by telephone.

* If you live too far from an office or a fee agent, if you are ill, or if you do not have any transportation to an office, you won't have to have an interview.

4 MEET ELIGIBILITY RULES AND PROVIDE PROOF THAT YOU ARE ELIGIBLE

When you apply, you must show the Division of Public Assistance certain papers and give them information to prove you are eligible. Papers you need for proof may include birth certificates, paycheck stubs, fish tickets, recent income tax returns or other proof of your age, relationship, and income.

You should also be prepared to list your resources (property other than your home) such as cars, boats, savings accounts, and other valuables.

If you have trouble getting the documents or information you need, the division will help you. If the papers are not available, you may give the name of someone outside of your household and family, such as employer, who can confirm your statements.

Eligibility rules and proofs you may have to provide to support your application are different for each type of assistance. Your eligibility worker or fee agent will tell you what documents and information are necessary.

5 RECEIVE A NOTICE THAT THAT TELLS YOU IF YOU QUALIFY

* After reviewing your application, the public assistance office will send you a Notice of Finding.

* If you do not qualify, the Notice will explain why.

* If you do qualify, the Notice will explain when your cash and Medicaid benefits will begin. It's possible that your bills from past months may also be paid by Medicaid.

* If you think your application has been wrongly denied, you should tell the public assistance office. If they do not agree, you can ask for a fair hearing. For more information about fair hearings, see Section 10.

6 RECEIVE YOUR MEDICAID COUPONS

* If the office finds that you are eligible, you will get your Medicaid coupons no later than 30 days from the date you first applied.

* Medicaid coupons are either handwritten or printed by machine. Both types of coupons are equally valuable.

* You will receive five Medicaid coupons. They will be printed with the names of everyone in your household who is eligible for Medicaid. Everyone listed can legally use the coupons.

* Medicaid coupons are dated for one month and can only be used to pay for medical care received during that month.

* If you need more Medicaid coupons, you can request them from the public assistance office.

* Medicaid is a "last pay" program. This means that Medicaid will only pay your health provider for the part of his bill that isn't paid by your private or union health insurance, by Medicare, (see Section 13) or other insurance programs. When you apply for Medicaid, you must list any other sources of medical payments you have. You should also tell your doctor, hospital, etc. about them when you get service.

* To use your Medicaid coupons you must give them to the doctor, hospital, or other health care provider when you receive medical care. It is very important to remember to give your Medicaid coupon to your health care provider. The coupon tells the doctor, clinic, etc. that you are eligible for that month for Medicaid benefits. Without the coupon, your bill cannot be correctly submitted for payment.

7 USE YOUR MEDICAID COUPONS

Most health care providers in Alaska participate in the Medicaid program. This means you can usually choose the doctor you would like to visit. If you are eligible for both Public Health Service and Medicaid, you also have the choice of going to the local Alaska Area Native Health Service (AANHS) or a private doctor.

If the medical treatment you need is not available in your area, payment for transporation may be provided to the nearest location where you can receive the necessary medical care.

When you are Medicaid-eligible and receive a Medicaid-covered service from a doctor or other health practitioner who is enrolled in the Medicaid program, he cannot ask you to pay for all or for any part of that service--even if Medicaid and any other health coverage you have doesn't pay all of his charges. If he bills the Division of Public Assistance, he must accept the Medicaid fee as the total payment for your bill.

Medicaid doesn't pay for every kind of medical and psychological care. If you want to be sure that Medicaid will pay for the services you want or need, your medical provider can tell you. The following list of services are paid by Medicaid:

1. hospital--inpatient and outpatient
2. skilled nursing facility
3. intermediate care facility
4. intermediate care facility for mentally retarded persons and persons with related conditions
5. laboratory and X-ray services
6. physician services
7. visual care services and dispensing
8. opthalmic materials
9. medical transportation
10. speech, hearing, and language services
11. psychiatric facility services (if you are under 21 or over 65)
12. home health care services
13. community mental health clinics
14. family planning services
15. outpatient surgical care centers
16. rural health clinics
17. early periodic screening, diagnosis, and treatment (EPSDT) of individuals under 21 years of age

Payment of service is made directly to doctors, hospitals, and other providers of health care based on invoices submitted by the provider. Invoices must be accompanied by a coupon which you must surrender at the time service is provided.

8 SERVICES NOT COVERED BY MEDICAID

Most Medicaid-eligible people automatically qualify for coverage under the General Relief-Medical program (GRM). Payment is available through the GRM program for all Medicaid-eligible people for the medical services and supplies listed below when those services are not otherwise available under the Medicaid program :

(1) dental care-limited to emergency treatment for relief of pain and acute infection;

(2) family planning services;

(3) pharmaceuticals and over-the-counter drugs;

(4) physical and occupational therapy;

(5) prosthetic devices and medical supplies.

More information about the GRM program is provided in Section 13 of this booklet.

It is your responsibility to pay for any medical treatment not covered by Medicaid or GRM.

The following services are NOT covered by Medicaid :

(1) Any medical expense which is not reasonably necessary for the diagnosis and treatment of illness or injury or for the correction of an organic system;

(2) Items and services not properly prescribed or determined necessary by a health care practitioner;

(3) Expenses incurred for evaluative or periodic check-ups, examinations, or immunizations in connection with the participation, enrollment, attendance, or accomplishment of a program or activity not related to your physical or mental health or rehabilitation which does not meet the criteria of (1) above, is not provided as part of an EPSDT screeening (see Section 12), or is not a physical examination required by the Division of Public Assistance for the purpose of determining eligibility :

(4) Any expense which is for or in connection with cosmetic therapy or cosmetic surgery, except that Medicaid coverage is available when required for repair of accidental injury, for the improvement of the functioning of a malformed body member, or for the correction of a visible disfigurement which would materially affect your acceptance in society, and when performed within the normal course of treatment or otherwise beginning no later than one year after the event which caused the need for that corrective action;

(5) Any expense which constitutes a non-medical charge imposed by a friend or relative, except when payment is made for medical transporation ;

(6) Any medical expense which is for persons who are in the care and custody of federal, state, or local penal facilities, including juveniles in detention facilities.

* The services of the following practitioners are NOT covered under the Medicaid program in Alaska :

(1) chiropractors;

(2) Christian Science practitioners or theological healers;

(3) naturopaths;

(4) podiatrists;

(5) private psychologists;

(6) any other licensed or unlicensed practitioners not enrolled in the Medicaid Program as providers.

9 YOU MUST REPORT CHANGES IN YOUR CIRCUMSTANCES

* You must report changes promptly.

* You can report changes by contacting the public assistance office or your fee agent. However, it is better to fill out the change report form included with your AFDC or APA check and mail it to the office.

IT IS EXTREMELY IMPORTANT THAT YOU REPORT CHANGES, SO THAT YOUR HOUSEHOLD RECEIVES THE RIGHT AMOUNT OF BENEFITS.

Changes that you must report include :

- Changes in mailing or residence address;
- Movement of a related person into or out of the household;
- Increase, decrease, or change in source of income in the household;
- Any change in resources of the household;
- Any change in the costs of rent, mortgage payment, taxes or insurance;
- Change in eligibility status of any household member for other benefits;
- Death of a household member;
- Change in marital status of any household member;
- Change in school attendance of any household member;
- Placement of a child in the custody of the Department of Health & Social Services;
- Improvement in the condition of a blind or disabled person;
- Refusal to accept vocational rehabilitation services;
- Departure from the state, the United States, or both;
- Refusal to accept treatment, or discontinuing treatment for drug addiction or alcoholism; and
- Admission to or discharge from a public institution, hospital, or nursing home.

10 YOUR RIGHTS

YOU HAVE THE RIGHT TO.....

* Apply for or request information about any assistance payments program or social service available from the Department of Health & Social Services including the following:

  — Family Planning
  -- Child Protection
  --- Alcoholic Rehabilitation
  -- Family Counseling
  -- Homemakers
  --- Day Care
  -- Information and Referral Supportive Services for Children.

  (You are eligible for family planning services for three months from the date of your application for AFDC even if you are found ineligible.)

* Receive courteous and fair treatment with no discrimination because of race, color, creed, religion, political belief, marital status, national origin, age, or sex.

* Receive a prompt written decision of your eligibility.

* Receive help from the department in obtaining child support for your children, if you are requesting assistance for children.

* Receive free, regularly scheduled physical examinations, diagnosis, and treatment for most medical problems for all children and adults under 21 who are eligible for Medicaid, under a program called EPSDT.

* Understand that information you give to the Division of Public Assistance will not be disclosed or used for purposes other than those connected with the administration of the public assistance laws of Alaska.

* Request a hearing by a fair and impartial person if you are dissatisfied by a delay or with the decision on your eligibility or the amount of assistance provided to you.

At a fair hearing you can explain to a hearing official why you disagree with an action the public assistance office has taken on your case.

If the hearing official decides you are right, you will continue to receive, or will begin to receive, the correct amount of benefits. If the official decides the public assistance office is right, you will be asked to repay the value of any assistance you were not entitled to receive.

You can ask the public assistance office for a fair hearing in writing, in person, or over the phone.

You can ask a friend or a representative from Alaska Legal Services or anyone else to help you prepare for the hearing and to attend the hearing with you.

The hearing will be scheduled at a time and place that are reasonably convenient for you.

11 YOUR RESPONSIBILITIES

YOU HAVE A RESPONSIBILITY TO.....

* Provide correct and complete information on your application and on all other forms related to your application and your eligibility for assistance.

* Cooperate in providing information about absent parents who are responsible for the children in your care.

* Accept any medical examinations necessary to determine your eligibility.

* Cooperate with the Division of Public Assistance in verifying your situation and the information you provide.

* Register for the Work Incentive Program when your youngest child reaches six years of age.

* Never allow anyone to use your Medicaid coupons or ID card, unless the person is named on the card or coupon as an eligible recipient.

* Apply for and make use of any benefits which you, or those for whom you want help, may be eligible, such as Unemployment Compensation, Social Security, Veteran's Benefits, etc.

* Tell the Division of Public Assistance promptly as changes in your situation occur which may affect your eligibility or the amount of assistance you are paid.

* Advise the Division of Public Assistance of any settlement in your favor as a result of an accident, and grant permission to the State of Alaska, Division of Public Assistance to file a claim against the settlement for medical bills paid in your behalf.

12 EARLY AND PERIODIC SCREENING, DIAGNOSIS & TREATMENT

EPSDT is part of the Medicaid Program and is mainly a preventive health program for children. The goal is to find children who have diseases or abnormalities and to prevent or correct handicaps by giving them medical treatment and rehabilitation as early as possible.

EPSDT services are available to all persons under 21 who are receiving, or are eligible to receive, Medicaid benefits.

EPSDT offers all the coverage available under Medicaid as well as the following special services :

1. physical exam and diagnosis
2. dental care
3. prosthetic devices (leg braces, wheel chairs, etc.) and medical supplies
4. physical therapy
5. immunizations
6. health and nutrition counseling.

13 OTHER MEDICAL PROGRAMS

GENERAL RELIEF-MEDICAL (GRM)

The General Relief-Medical Program (GRM), which is administered by the Division of Public Assistance, is a 100% state-funded program that provides for the payment of providers of medical and emergency dental care for eligible low-income Alaskans.

GRM is considered a "last resort" assistance program. AFDC and APA recipients are automatically eligible for Medicaid and are therefore eligible for GRM benefits only for services not covered by Medicaid.

Applications for GRM are available at State Division of Public Assistance offices.

CATASTROPHIC ILLNESS PROGRAM

The Catastrophic Illness Program,which is administered by the Division of Public Assistance and a committee appointed by the Governor's Office, is a 100% state-funded program that pays providers of medical services.

The purpose of the program is to financially assist residents of Alaska who have suffered and received treatment for a catastrophic illness or injury. A catastrophic illness or injury is one which results in medical expenses of over $1000 during a period of not more than 12 months–after all other sources of medical payment (insurance, etc.) have been used.

Applications for the Catastrophic Illness Program can be obtained at State Division of Public Assistance offices or by writing to:

Catastrophic Illness Program
Division of Public Assistance
Pouch H-07D
Juneau, Alaska 99811

Medicare is a federal health insurance program for certain kinds of individuals regardless of the amount of their income and resources :

-- the aged (65 and older)
-- the blind
-- the disabled
-- persons with certain permanent kidney failure

Although the name of the program "Medicare" is very similar to the name of the program "Medicaid" which is administered by the state Division of Public Assistance, Medicare is a completely separate and different program, administered by private health insurance companies.

Medicare is a two part program. Part A, available to all Medicare beneficiaries without charge, provides coverage for inpatient hospital services. Part B, which is available for a small monthly charge, provides coverage for outpatient and physician services. Detailed information about the Medicare program is available at any Social Security Administration office. In Alaska, Social Security offices are located at the following addresses :

Social Security Administration
P.O. Box 5837
Ketchikan, Alaska 99901

Social Security Administration
P.O. Box 1327
Juneau, Alaska 99802

Social Security Administration
P.O. Box 2600
Anchorage, Alaska 99510

Social Security Administration
P.O. Box 1449
Fairbanks, Alaska 99701

Information about Medicare can also be obtained by calling these toll-free numbers :

Juneau.....Zenith 5000

Anchorage.....Zenith 7777

Fairbanks.....Zenith 8888

14 DIVISION OF PUBLIC ASSISTANCE OFFICES

ANCHORAGE . . . . . .4th and Gambell
Anchorage, Alaska 99501
Phone: 274-6524

ANIAK . . . . . .Box 63
Aniak, Alaska 99557
Phone: 675-4351 (Fee Agent)

BETHEL . . . . . .Box 365
Bethel, Alaska 99559
Phone: 543-2686

DILLINGHAM . . . . . .Box 221
Dillingham, Alaska 99576
Phone: 842-5961

FAIRBANKS . . . . . .675 7th Street, Section F
Fairbanks, Alaska 99701
Phone: 452-1637

FORT YUKON. . . . . .Box 149
Fort Yukon, Alaska 99740
Phone: 662-2327

GALENA. . . . . .Box 239
Galena, Alaska 99741
Phone: 656-1260

JUNEAU. . . . . .419 Sixth Street
Juneau, Alaska 99811
Phone: 465-3551

KENAI . . . . . .Box 3613
Kenai, Alaska 99611
Phone: 283-3124

KETCHIKAN. . . . . .222 NBA Building
Ketchikan, Alaska 99901
Phone: 225-2135

KODIAK. . . . . .Box 2515
Kodiak, Alaska 99615
Phone: 486-3783

KOTZEBUE. . . . . .Box 41
Kotzebue, Alaska 99752
Phone: 442-3451

NOME. . . . . .Box 221
Nome, Alaska 99762
Phone: 443-2237

PALMER. . . . . .Box 901
Palmer, Alaska 99645
Phone: 745-4217

PETERSBURG. . . . . .Box 1089
Petersburg, Alaska 99833
Phone: 772-3565

SITKA . . . . . .Box 1069
Sitka, Alaska 99835
Phone: 747-8234

UNALAKLEET . . . . . .Box 40
Unalakleet, Alaska 99684
Phone: 624-3601

VALDEZ. . . . . .Box 750
Valdez, Alaska 99686
Phone: 835-2535

In rural communities where there isn't a district office, the Division of Public Assistance has paid volunteers, called fee agents, who can assist people to apply for Public Assistance Programs.

ABOUT THE COVER:

Antler was used for this spirit canoe in the shape of a sea lion. The seven figures represent people who were drowned when their boat was seized by an octopus. Among Salish groups, shamans performed a ceremony in which they paddled a spirit canoe to the land of the dead to bring back the soul of a person who had become ill because he had lost his soul.

Tlingit design. from the Museum of the American Indian, Heye Foundation. From THE ART OF THE NORTHWEST COAST INDIANS by Shirley Glubok

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CURRENT STATUTE

HOUSE CS FOR CSSSSB 227 (FINANCE) REVISIONS

Chapter 07. Medical Assistance for Needy Persons.

Section
10. Purpose
20. Eligible persons
30. Medical services to be provided
40. State plan for provision of medical assistance
50. Implementation of the medical assistance program
60. Receipt of federal money
70. Reimbursement for cost settled providers
80. Definitions

Sec. 47.07.010. Purpose. It is declared as a matter of public concern that the needy persons of this state receive uniform and high quality medical care, regardless of race, age, national origin, or economic standing. Accordingly, this chapter authorizes the Department of Health and Social Services to apply for participation in the national medical assistance program as provided for under title XIX of the federal Social Security Act. (§ 1 ch 182 SLA 1972)

Sec. 47.07.020. Eligible persons. (a) All residents of the state for whom the Social Security Act requires medicaid coverage are eligible to receive medical assistance under title XIX of that Act (42 U.S.C. 1396 et seq.).

(b) In addition to the persons specified in (a) of this section, the following optional groups of persons for whom the state may claim federal financial participation are eligible for medical assistance:

(1) persons eligible for but not receiving assistance under any plan of a state approved under part A of title IV (aid to families with dependent children), or title XVI (supplemental security income), of the Social Security Act;

(2) persons in a general hospital, skilled nursing facility or intermediate care facility, who, if they left the facility, would be eligible for assistance under one of the federal programs specified in (1) of this subsection;

(3) persons under 21 years of age under supervision of the department for whom maintenance is being paid in whole or in part from public funds and who are in foster homes or private child-care institutions; and

(4) aged, blind, or disabled persons, who, because they do not meet income and resources requirements, do not receive supplemental security income under title XVI of the Social Security Act, and who do not receive a mandatory state supplement, but who are eligible, or would be eligible if they were not in a general hospital or skilled nursing facility or intermediate care facility to receive an optional state supplementary payment;

(5) persons under 21 years of age in an institution designated as an intermediate care facility for the mentally retarded who are financially

* Sec. 10. AS 47.07.020(b) is repealed and re-enacted to read:

(b) Residents of the state for whom the Social Security Act requires optional medical coverage qualifying for federal financial participation are eligible for medical assistance.

CURRENT STATUTE

(6) persons in a medical or intermediate care facility whose income while in the facility does not exceed 300 per cent of the supplemental security income benefit rate under title XVI of the Social Security Act but who would not be eligible for an optional state supplementary payment if they left the hospital or other facility.

(7) persons under 21 years of age receiving active treatment in a psychiatric hospital who are financially eligible as determined by the standards of part A of title IV (aid to families with dependent children) of the Social Security Act.

(c) Receipt of medical assistance under this chapter is considered to be an additional benefit to these individuals and does not affect other assistance payments, federal or state, for which the recipient is eligible.

(d) No additional groups may be added unless approved by the legislature. (§ 1 ch 182 SLA 1972; am § 1 ch 105 SLA 1974; am § 1 ch 117 SLA 1975; am § 1 ch 221 SLA 1976; am § 1 ch 11 SLA 1978)

Effect of amendments. — The 1975 amendment added paragraph (5) of subsection (b).

The 1976 amendment added paragraph (6) of subsection (b).

The 1978 amendment added paragraph (7) of subsection (b).

Legislative history reports. — For report on ch. 182, SLA 1972 (FCCS HCS CSSB 56), see 1972 House Journal, p. 1634. For report on ch. 105, SLA 1974 (CSSB 355), see 1974 Senate Journal, p. 525 and 1974 House Journal, p. 762.

Sec. 47.07.030. Medical services to be provided. Medical services to be offered to eligible persons include inpatient hospital, outpatient hospital, rural health clinic, outpatient surgical care centers, laboratory and X-ray, refractions and eye examinations by ophthalmologists or optometrists, eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist, inpatient psychiatric hospital for persons age 65 or older and persons under age 21, skilled and intermediate nursing home, physician, home health care services, early periodic screening diagnosis and treatment of persons under 21 years of age, clinic services, treatment of speech, hearing and language disorders, and reasonable transportation to and from the point of medical care. No additional services may be provided unless approved by the legislature. (§ 1 ch 182 SLA 1972; am § 1 ch 35 SLA 1973; am § 2 ch 105 SLA 1974; am § 1 ch 12 SLA 1976; am § 2 ch 221 SLA 1976; am § 1 ch 82 SLA 1978)

HOUSE CS FOR CSSSSB 227 (FINANCE) REVISIONS

* Sec. 13. AS 47.07.020(d) is repealed.

* Sec. 11. AS 47.07.030 is repealed and re-enacted to read:

Sec. 47.07.030. MEDICAL SERVICES TO BE PROVIDED. [illegible] to be offered to eligible persons include services eligible for financial participation under Title XIX of the federal Social Security Act.

Selection of Medicaid Optional Services by States *

Top 10 States With Most Number Of Optional Services

States	# of Optional Services Maximum = 32
1. Wisconsin	32
2. Minnesota	31
3. California	
4. Massachusetts	28
5. West Virginia	28
6. New Jersey	27
7. Kansas	26
8. Montana	26
9. Nebraska	26
10. Connecticut	24

Top 10 States with Least Number of Optional Services

States	# of Optional Services Minimum = 0
1. Wyoming	5
2. Delaware	9
3. Georgia	9
4. Mississippi	9
5. Alaska	10
6. Oklahoma	10
7. Rhode Island	10
8. Texas	10
9. Alabama	12
10. South Carolina	12

* Arizona currently does not participate in the Medicaid Program.

Most Selected Medicaid Optional Services
Not Included in Alaska's Medicaid Program

	Optional Service	No. of States, Terr., and Protectorates Selecting the Option. Maximum = 53
1.	Prescription drugs	51
2.	Prosthetic devices	45
3.	Podiatrist's services	38
4.	Physical therapy	36
5.	Dentures	33
6.	Dental services	30
7.	Other practioners' services	30
8.	Private duty nursing	30
9.	Mental treatment in ICF for person aged 65 or older	28
10.	Occupational therapy	27
11.	Rehabilitation service	27
12.	Chiropractic services	26
13.	TB treatment in inpatient hospital for persons aged 65 or older	26
14.	Mental health treatment in SNF for persons aged 65 of older	25
15.	Diagnostic services	23
16.	Prevention services	20
17.	Christian science sanitoria	18
18.	Screening	14
19.	Personal care	11
20.	TB treatment in SNF for persons aged 65 or older	11
21.	TB treatment in ICF for persons aged 65 or older	10
22.	Christian science nursing	6

Services provided only under the mandatory portion of the screening and treatment programs for individuals under 21 are not shown on this chart.

welfare offices and State Medicaid agencies.

CN[2]

Both CN and MN[3]

Optional services in State Medicaid programs

FMAP[1]	BASIC REQUIRED MEDICAID SERVICES SEE ABOVE		Podiatrists' Services	Optometrists' Services	Chiropractors' Services	Other Practitioners' Services	Private Duty Nursing	Clinic Services	Dental Services	Physical Therapy	Occupational Therapy	Speech, Hearing, and Language Disorder	Prescribed Drugs	Dentures	Prosthetic Devices	Eyeglasses	Diagnostic Services	Screening Services	Preventive Services	Rehabilitative Services	Services for Age 65 or Older in Tit Institutions A. Inpatient Hospital Ser.	B. SNF Services	C. ICF Services	Services for Age 65 or Older in Mental Inst. A. Inpatient Hospital Services	B. SNF Services	C. ICF Services	Intermediate Care Facility Services	For Mentally Retarded	Inpatient Psychiatric Service for Under Age 22	Christian Science Nurses	Christian Science Sanitoria	SNF for Under Age 21	Emergency Hospital Services	Personal Care Services	Total Additional Services
73		Alabama																																	13
70		Alaska																																	10
61		Arizona																																	
72		Arkansas																																	21
50		California																																	23
54		Colorado																																	14
50		Connecticut																																	14
50		Delaware																																	9
50		D.C.																																	13
57		Florida																																	5
72		Georgia																																	12
50		Guam																																	1
50		Hawaii																																	21
74		Idaho																																	13
50		Illinois																																	21
55		Indiana																																	14
62		Iowa																																	16
53		Kansas																																	15
70		Kentucky																																	17
70		Louisiana																																	14
50		Maine																																	14
50		Maryland																																	16
50		Massachusetts																																	19
50		Michigan																																	22
50		Minnesota																																	7
74		Mississippi																																	9
		Missouri																																	15
51		Montana																																	21
50		Nebraska																																	16
50		Nevada																																	20
50		New Hampshire																																	24
50		New Jersey																																	21
70		New Mexico																																	17
50		New York																																	21
65		North Carolina																																	14
51		North Dakota																																	14
		Ohio																																	7
71		Oklahoma																																	16
57		Oregon																																	23
50		Pennsylvania																																	13
50		Puerto Rico																																	6
57		Rhode Island																																	16
70		South Carolina																																	14
54		South Dakota																																	13
53		Tennessee																																	14
51		Texas																																	17
79		Utah																																	10
50		Vermont																																	15
50		Virgin Islands																																	9
57		Virginia																																	16
52		Washington																																	21
70		West Virginia																																	23
53		Wisconsin																																	14
63		Wyoming																																	5
	25	States	14	13	9	10	6	13	8	11	9	8	19	22	16	11		3	4	9	8	2	2	13	9	12	23	22	10	1	6	16	17	2	
	25		24	22	17	20	14	25	22	25	18	21	32	11	25	25	18	11	10	18	18	9	8	27	16	16	26	25	23	5	12	24	23	9	
Total	50	Total	38	35	26	30	19	42	30	36	27	29	51	33	45	36	23	14	14	27	26	11	10	43	25	28	49	47	32	6	18	42	40	11	

[1]FMAP Federal Medical Assistance Percentage. Rate of Federal financial participation in a State's medical vendor payment expenditures on behalf of individuals and families eligible under Title XIX of the Social Security Act. Percentages, effective from October 1, 1977, through September 30, 1979, are rounded.

[2]Categorically needy. People receiving federally supported financial assistance.

[3]Medically Needy. People who are eligible for medical but not for financial assistance.

Health Care Legislation

HCS CS SS SB 227

HCS CS SS SB 227 "An Act relating to the health of residents of the state" is an omnibus health bill extending health coverage to several new groups of people and expanding the scope of coverage available.

* STATE HEALTH INSURANCE

The first three sections of the bill establish a state comprehensive health plan and a premium supplement program. The comprehensive health plan is a major medical insurance policy offered by a private carrier under contract with the state to any resident who does not have public or group health coverage. The premium program provides state premium supplements on a sliding scale basis to residents who purchase qualifying individual major medical insurance policies.

* ALCOHOLISM COVERAGE FOR STATE EMPLOYEES

Model benefits for coverage of alcoholism, including inpatient detoxification, inpatient treatment and outpatient treatment are added to the state employees health insurance plan. While the original bill mandated these benefits for all health insurance policies, the HESS Committee substitute bill would field test these new benefits on state employees.

* MEDICAID BY INSURANCE POLICIES OR HEALTH SERVICE CONTRACTS

Section eight of the bill directs the commissioner of Health and Social Services to provide Medicaid coverage through the purchase of private health insurance policies or health service contracts on behalf of Medicaid recipients, when this is found to be cost effective.

* RELIEF FOR MEDICAID PROVIDERS

The bill requires that the state pay interest at the rate of one percent per month to Medicaid providers on bills that are more than one month overdue, and two percent per month on bills that are more than three months overdue. It also allows the state to make an interim payment to large volume Medicaid providers prior to billing and processing of the claims.

* EXPANSION OF SERVICES AND ELIGIBLE PEOPLE COVERED UNDER MEDICAID

Sections nine and ten of the bill expand the state's Medicaid program to include all groups and all services for which federal funding is available. New additions include such eligible and services as unborn children, unemployed fathers, prescription drugs, adult dental care and physical therapy.

* COVERAGE FOR THE MEDICALLY NEEDY

Section eleven of the bill creates a new program of medical assistance for medically needy people under the state's General Relief-Medical program. The income threshold for eligibility is set at 150% of the poverty guideline for Alaska. People whose income exceeds that amount can still become eligible for assistance after they spend their "excess" income on medical bills.

* FISCAL IMPACT

The fiscal note for all these programs includes approximately $8 million from the General fund and $8 million in federal funds for FY81.

House HESS Committee Hearings on
State Health Insurance

Teleconference Witnesses

Bill Weimar, Anchorage
Nick Noll, Eye, Ear & Nose Clinic, Fairbanks
Donald Thieman, Fairbanks Medical Association
Chris Bearsly, Providence Hospital, Anchorage
David Mather, Tanana Chiefs Conference, Fairbanks
Margaret Wolfe, Anchorage
Angie Hague, National Association of Social Workers, Anchorage
Penny Hladna, Anchorage
Gordon DePew, Fairbanks Life Underwriters Association
Bernie Barr, International Rehabilitation Association
Gil D'Innocente, Anchorage
Candice Berry, Welfare Rights Association, Anchorage
Pudge Kleinkoff, National Association of Social Workers, Anchorage
Frank Austin, Black Caucus Council for Economic Justice, Anchorage
Susan Johnson, Chris Billington, NOW, Anchorage
Nancy Lander, Women for Political Action, Anchorage
Rose Palmquist, Anchorage
Donna Hayes, Norton Sound Health Corporation, Nome
Herb Berkowitz, Anchorage
Mason Preston, Bethel
Rosy Porter, Bethel

Other Witnesses

Don Koch - Division of Insurance, Dept. of Commerce and Economic Development
Jim Jordan " " " " " " " " "
Donald Ching- Dept. of Regulatory Agencies, State of Hawaii
John Ingrassia - Life and Health Section, Insurance Division, State of Minnesota
Joan Gaumer - Director, Government Relations, Blue Cross of WA and AK
Dr. Helen Beirne - Commissioner, Dept. of Health and Social Services
Bob Ogden - Chief, Medical Assistance, Dept. of Health and Social Services

The House HESS Committee held a total of 12 hearings on HB977/SB227

THELMA
BUCHHOLDT
Alaska State Legislature
House of Representatives
Juneau, Alaska 99811

May 22, 1980

To: Representatives Gardiner, Meekins, McKinnon, Parker

From: Representative Thelma Buchholdt

Re: HCS CS SS SB 227 - Health Legislation

HCS CS SS SB 227, "An Act relating to the health of residents of the state," was passed out of the House HESS Committee on Wednesday, May 21. I am supplying you with a copy of the bill summary and the accompanying fis al note. I am also enclosing a copy of the work draft that was passed out of Committee. I expect that the final version of the bill will be printed this afternoon.

Very briefly, Section 1 of the bill establishes a carrier reinsurance pool which would make health insurance available at a reasonable premium to every resident and every employer group in the state. This section of the bill is designed to pick up high-risk persons and other uninsurables in the state for whom health coverage is now unavailable.

Sections 4 through 7 of the bill comprise the original CS SS SB 227, sponsored by Senators Coletta, Hohman and Stimson, and require state employee health insurance to include coverage for alcoholism and drug dependence.

Section 8 of the bill requires the Commisssioner of Health and Social Services to provide services under medical assistance programs through health insurance policies or health service contracts when cost effective. The bill authorizes the Department to make interim peyments to providers who serve a large volume of state medical assistance clients. The bill also requires the state to pay interest to providers on overdue medical assistance bills.

Sections 9 and 10 of the bill expand the state's Medicaid program to include all services and eligibles qualifying for federal financial participation.

Finally, in Section 11, a medically needy program is established under the state General Relief program with an income standard set at 150% of the poverty guideline. Persons whose income exceeds the standar become eligible when they spend their excess income on medical bills.

The fiscal note for the bill includes approximately $ 8 million from the state's General Funds, $ 22,800 from other state funds and approximately $ 8 million in federal funds.

CURRENT STATUTE

Chapter 07. Medical Assistance for Needy Persons.

Section
10. Purpose
20. Eligible persons
30. Medical services to be provided
40. State plan for provision of medical assistance
50. Implementation of the medical assistance program
60. Receipt of federal money
70. Reimbursement for cost settled providers
80. Definitions

Sec. 47.07.010. Purpose. It is declared as a matter of public concern that the needy persons of this state receive uniform and high quality medical care, regardless of race, age, national origin, or economic standing. Accordingly, this chapter authorizes the Department of Health and Social Services to apply for participation in the national medical assistance program as provided for under title XIX of the federal Social Security Act. (§ 1 ch 182 SLA 1972)

Sec. 47.07.020. Eligible persons. (a) All residents of the state for whom the Social Security Act requires medicaid coverage are eligible to receive medical assistance under title XIX of that Act (42 U.S.C. 1396 et seq.).

(b) In addition to the persons specified in (a) of this section, the following optional groups of persons for whom the state may claim federal financial participation are eligible for medical assistance:

(1) persons eligible for but not receiving assistance under any plan of the state approved under part A of title IV (aid to families with dependent children), or title XVI (supplemental security income), of the Social Security Act;

(2) persons in a general hospital, skilled nursing facility or intermediate care facility, who, if they left the facility, would be eligible for assistance under one of the federal programs specified in (1) of this subsection;

(3) persons under 21 years of age under supervision of the department for whom maintenance is being paid in whole or in part from public funds and who are in foster homes or private child-care institutions; and

(4) aged, blind, or disabled persons, who, because they do not meet income and resources requirements, do not receive supplemental security income under title XVI of the Social Security Act, and who do not receive a mandatory state supplement, but who are eligible, or would be eligible if they were not in a general hospital or skilled nursing facility or intermediate care facility to receive an optional state supplementary payment;

(5) persons under 21 years of age in an institution designated as an intermediate care facility for the mentally retarded who are financially eligible as determined by the standards of the Federal Aid to Families [illegible]

HOUSE CS FOR CSSSSB 227 (FINANCE) REVISIONS

* Sec. 10. AS 47.07.020(b) is repealed and re-enacted to read:

(b) Residents of the state for whom the Social Security Act all[illegible] optional medical coverage qualifying for federal financial participat[illegible] are eligible for medical assistance.

CURRENT STATUTE

(6) persons in a medical or intermediate care facility whose income while in the facility does not exceed 300 per cent of the supplemental security income benefit rate under title XVI of the Social Security Act but who would not be eligible for an optional state supplementary payment if they left the hospital or other facility.

(7) persons under 21 years of age receiving active treatment in a psychiatric hospital who are financially eligible as determined by the standards of part A of title IV (aid to families with dependent children) of the Social Security Act.

(c) Receipt of medical assistance under this chapter is considered to be an additional benefit to these individuals and does not affect other assistance payments, federal or state, for which the recipient is eligible.

(d) No additional groups may be added unless approved by the legislature. (§ 1 ch 182 SLA 1972; am § 1 ch 105 SLA 1974; am § 1 ch 117 SLA 1975; am § 1 ch 221 SLA 1976; am § 1 ch 11 SLA 1978)

Effect of amendments. — The 1975 amendment added paragraph (5) of subsection (b).

The 1976 amendment added paragraph (6) of subsection (b).

The 1978 amendment added paragraph (7) of subsection (b).

Legislative history reports. — For report on ch. 182, SLA 1972 (FCCS HCS CS-SB 56), see 1972 House Journal, p. 1641. For report on ch. 105, SLA 1974 (CSSB 465), see 1974 Senate Journal, p. 525 and 1974 House Journal, p. 763.

Sec. 17.07.030. Medical services to be provided. Medical services to be offered to eligible persons include inpatient hospital, outpatient hospital, rural health clinic, outpatient surgical care centers, laboratory and X-ray, refractions and eye examinations by ophthalmologists or optometrists, eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist, inpatient psychiatric hospital for persons age 65 or older and persons under age 21, skilled and intermediate nursing home, physician, home health care services, early periodic screening diagnosis and treatment of persons under 21 years of age, clinic services, treatment of speech, hearing and language disorders, and reasonable transportation to and from the point of medical care. No additional services may be provided unless approved by the legislature. (§ 1 ch 182 SLA 1972; am § 1 ch 35 SLA 1973; am § 2 ch 105 SLA 1974; am § 1 ch 12 SLA 1976; am § 2 ch 221 SLA 1976; am § 1 ch 82 SLA 1978)

HOUSE CS FOR CSSSSB 227 (FINANCE) REVISIONS

* Sec. 13. AS 47.07.020(d) is repealed.

* Sec. 11. AS 47.07.030 is repealed and re-enacted to read:

Sec. 47.07.030. MEDICAL SERVICES TO BE PROVIDED. Medical services to be offered to eligible persons include services eligible for federal financial participation under Title XIX of the federal Social Security Act.

Selection of Medicaid Optional Services by States *

Top 10 States With Most Number Of Optional Services

States	# of Optional Services Maximum = 32
1. Wisconsin	32
2. Minnesota	31
3. California	29
4. Massachusetts	28
5. West Virginia	28
6. New Jersey	27
7. Kansas	26
8. Montana	26
9. Nebraska	26
10. Connecticut	24

Top 10 States with Least Number of Optional Services

States	# of Optional Services Minimum = 0
1. Wyoming	5
2. Delaware	9
3. Georgia	9
4. Mississippi	9
5. Alaska	10
6. Oklahoma	10
7. Rhode Island	10
8. Texas	10
9. Alabama	12
10. South Carolina	12

* Arizona currently does not participate in the Medicaid Program.

Most Selected Medicaid Optional Services
Not Included in Alaska's Medicaid Program

	Optional Service	No. of States, Terr., and Protectorates Selecting the Option. Maximum = 55
1.	Prescription drugs	51
2.	Prosthetic devices	45
3.	Podiatrist's services	38
4.	Physical therapy	36
5.	Dentures	33
6.	Dental services	30
7.	Other practioners' services	30
8.	Private duty nursing	30
9.	Mental treatment in ICF for person aged 65 or older	28
10.	Occupational therapy	27
11.	Rehabilitation service	27
12.	Chiropractic services	26
13.	TB treatment in inpatient hospital for persons aged 65 or older	25
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15.	Diagnostic services	23
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18.	Screening	14
19.	Personal care	11
20.	TB treatment in SNF for persons aged 65 or older	11
21.	TB treatment in ICF for persons aged 65 or older	10
22.	Christian science nursing	6

under 21 are not shown on this chart.

welfare offices and State Medicaid agencies.

CN[2]

Both CN and MN[3]

Optional services in State Medicaid programs

FMAP[1]	BASIC[4] REQUIRED MEDICAID SERVICES SEE ABOVE		Podiatrists' Services	Optometrists' Services	Chiropractors' Services	Other Practitioners' Services	Private Duty Nursing	Clinic Services	Dental Services	Physical Therapy	Occupational Therapy	Speech, Hearing, and Language Disorder	Prescribed Drugs	Dentures	Prosthetic Devices	Eyeglasses	Diagnostic Services	Screening Services	Preventive Services	Rehabilitative Services	Services for Age 65 or Older in TB Institutions A. Inpatient Hospital Services	B. SNF Services	C. ICF Services	Services for Age 65 or Older in Mental Inst. A. Inpatient Hospital Services	B. SNF Services	C. ICF Services	Intermediate Care Facility Services	ICF for Mentally Retarded	Inpatient Psychiatric Service for Under Age 22	Christian Science Nurses	Christian Science Sanitoria	SNF for Under Age 21	Emergency Hospital Services	Personal Care Services	Total Additional Services
73		Alabama																																	12
60		Alaska																																	10
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52		Arkansas																																	21
50		California																																	23
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50		Connecticut																																	24
50		Delaware																																	9
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50		Hawaii																																	23
64		Idaho																																	13
50		Illinois																																	28
52		Indiana																																	14
52		Iowa																																	16
52		Kansas																																	25
73		Kentucky																																	17
73		Louisiana																																	14
50		Maine																																	22
50		Maryland																																	16
50		Massachusetts																																	29
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50		Minnesota																																	21
76		Mississippi																																	8
55		Missouri																																	15
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53		Nebraska																																	26
50		Nevada																																	20
50		New Hampshire																																	24
50		New Jersey																																	17
50		New Mexico																																	17
50		New York																																	1
65		North Carolina																																	16
50		North Dakota																																	24
50		Ohio																																	22
50		Oklahoma																																	22
57		Oregon																																	23
50		Pennsylvania																																	11
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50		Virgin Islands																																	9
50		Virginia																																	16
50		Washington																																	28
70		West Virginia																																	23
53		Wisconsin																																	22
51		Wyoming																																	5
	20		14	13	9	10	6	13	8	11	9	8	19	22	10	11		3	4	9	8	2	2	13	9	12	23	22	10	1	6	13	17	2	
	33		24	22	17	20	14	29	22	26	18	21	32	11	23	25	18	11	16	19	18	9	8	27	16	16	28	25	22	5	12	24	29	9	
[total]	53	Total	38	35	26	30	19	42	30	38	27	29	51	33	45	36	23	14	20	27	26	11	10	40	25	28	49	47	32	6	18	42	45	11	

[1]FMAP Federal Medicaid Assistance Percentage. Rate of Federal financial participation in a State's medical vendor payment expenditures on behalf of individuals and families eligible under Title XIX of the Social Security Act. Percentages, effective from October 1, 1977, through September 30, 1979, are rounded.

[2]Categorically Needy. People receiving federally supported financial assistance.

[3]Medically Needy. People who are eligible for medical but not for financial assistance.

National Conference of State Legislatures

Headquarters Office
(303) 623-6600

1405 Curtis Street
23rd Floor
Denver, Colorado
80202

President
George B. Roberts, Jr.
Speaker, New Hampshire
House of Representatives

Executive Director
Earl S. Mackey

January 28, 1980

Jan Sorice
House Committee on Health, Education
and Social Services
Pouch V
State Capitol
Juneau, Alaska 99801

Dear Ms. Sorice:

Enclosed, as you requested, is some information on state catastrophic health insurance programs.

Maine, Minnesota, Rhode Island, Connecticut, Hawaii and New York, in addition to Alaska, have enacted catastrophic health insurance legislation. Extensive analysis of these programs has not been performed, however.

Mr. Van Ellett at the Intergovernmental Health Policy Project is in the preliminary stages of preparing a background issue paper on catastrophic programs. He has indicated that he will be glad to offer further assistance in this area. Mr. Ellett can be contacted at:

The Intergovernmental Health Policy Project
Suite 505
1919 Pennsylvania Avenue, N.W.
Washington, D.C. 20006
(202)872-1445

I hope this information is useful. If I can be of further assistance, please feel free to call me.

Sincerely,

Russ Hereford

Russell W. Hereford
Project Director
Health Care Cost Containment

RWH/sep

enclosure

GR-MEDICALLY NEEDY PROGRAM

* 50% of all tax returns in Alaska for individuals and families reported 1978 Adjusted Gross Incomes of less than $20,000.

* 30% reported incomes less than $10,000; less than $833 per month on the average for 1978.

* Many more Alaskans do not file tax returns at all.

These statistics suggest that for a large number of Alaskans, medical care for age, illness or injury would be unaffordable without health insurance or medical assistance while some of these people may have group insurance or be eligible for Medicaid, Medicare, or Alaskan Native Health Service, many are not eligible for any third party health benefits. The medically needy program created by HCSCSSSSB 227 would be an important medical resource for these people.

The income threshold for the medically needy program is set at 150% of the poverty guidelines for Alaska for 1979, the poverty guidelines were as follows:

Non-farm poverty income guidelines

Family size	Annual	Monthly	150%
1	$4,270	356	534
2	5,640	470	705
3	7,010	584	876
4	8,380	698	1047
5	9,750	813	1219
6	11,120	927	1390

A person or family which is over income becomes eligible for medical assistance under this program if their income in excess of the threshold is spent on medical bills. Essentially, this provides a form of catastrophic coverage for all families, as well as a form of basic coverage for low-income families. The department estimates the new program would serve approximately 2,800 families and individuals.

ADJUSTED INCOME OF ALASKA TAXPAYERS FILING 1978 RETURNS

annual income	average monthly income	percent of taxpayers earning this much or less
$5,000	$ 416	16.5%
10,000	833	29.2
15,000	1,250	40.2
20,000	1,667	49.5
25,000	2,083	57.8
30,000	2,500	65.6

MEDICAID ELIGIBLES *

Currently Covered Eligibles

Child under 18 deprived of parental support or care

Parent or other caretaker relative

Child over 18 but under 21 who is school

All children in foster homes or institutions

All children in psychiatric hospitals

A child in an intermediate care facility for the mentally retarded

Aged, blind, or disabled persons

Eligibles added by HCSCSSSSB 227

Child deprived of support of father due to unemployment

Spouse of disabled parent

Spouse of unemployed father

Pregnant woman and unborn child

All other financially eligible children

Caretaker relative of child over 18 but under 21 and not in school

Individuals who would be eligible for AFDC except for child care costs

Individuals who meet categorical criteria and whose incomes, less medical bills, are below 133% of the need standard (medically needy)

* In addition to these categorical criteria, persons must be financially needy.

Currently Covered Services

Hospital-Inpatient & Outpatient

Skilled Nursing Facility (SNF)

Intermediate Care Facility (ICF)

Intermediate Care Facility for Mentally Retarded persons and persons with related conditions (ICF/MR)

Laboratory and X-ray Services

Physician Services

Visual Care Services, dispensing and ophthalmic materials

Medical Transportation

Psychiatric Facility Services

Home Health Care Services

Early Periodic Screening, Diagnosis, and Treatment of Individuals under 21 years of age (EPSDT)
- a. dental services
- b. prosthetic devices and medical supplies
- c. physical therapy

Community Mental Health Clinics

Family Planning Services

Outpatient Surgical Care Centers

Rural Health Clinics

* Accessible through General Relief-Medical

Services Added By HCS CSSSSB 227

Podiatrist Services

Chiropractic Services

Private Duty Nursing

Personal Care Services

* Physical Therapy

* Occupational Therapy

* Prescribed Drugs

Dentures

* Prosthetic Devices and Medical supplies

Other Diagnostic, Screening, Preventive & Rehabilitative Services

Services to Individuals over 65 year of age in Institutions for Mental Diseases

Services to Individuals over 65 years of age in Institutions for tuberculosis

Other Practitioner Services
- a. private psychologist
- b. nurse practitioner
- c. physician assistant

Clinic Services-other than Community Mental Health Clinics

Services by Christian Science Nurses

Services by Christian Science Sanatoria

House HESS Committee Hearings on
State Health Insurance

Teleconference Witnesses

Bill Weimar, Anchorage
Nick Noll, Eye, Ear & Nose Clinic, Fairbanks
Donald Thieman, Fairbanks Medical Association
Chris Bearsly, Providence Hospital, Anchorage
David Mather, Tanana Chiefs Conference, Fairbanks
Margaret Wolfe, Anchorage
Angie Hague, National Association of Social Workers, Anchorage
Penny Hladna, Anchorage
Gordon DePew, Fairbanks Life Underwriters Association
Bernie Barr, International Rehabilitation Association
Gil D'Innocente, Anchorage
Candice Berry, Welfare Rights Association, Anchorage
Pudge Kleinkoff, National Association of Social Workers, Anchorage
Frank Austin, Black Caucus Council for Economic Justice, Anchorage
Susan Johnson, Chris Billington, NOW, Anchorage
Nancy Lander, Women for Political Action, Anchorage
Rose Palmquist, Anchorage
Donna Hayes, Norton Sound Health Corporation, Nome
Herb Berkowitz, Anchorage
Mason Preston, Bethel
Rosy Porter, Bethel

Other Witnesses

Don Koch - Division of Insurance, Dept. of Commerce and Economic Development
Jim Jordan " " " " " " " " "
Donald Ching- Dept. of Regulatory Agencies, State of Hawaii
John Ingrassia - Life and Health Section, Insurance Division, State of Minnesota
Joan Gaumer - Director, Government Relations, Blue Cross of WA and AK
Dr. Helen Beirne - Commissioner, Dept. of Health and Social Services
Bob Ogden - Chief, Medical Assistance, Dept. of Health and Social Services

The House HESS Committee held a total of 12 hearings on HB977/SB227

*Section 1. AS 18 is amended by adding a new chapter to read:

CHAPTER 27. STATE HEALTH INSURANCE.

Sec. 18.27.010. STATE COMPREHENSIVE HEALTH PLAN

(a) The state comprehensive health plan shall be established by the Commissioner of Administration as provided in AS 18.27.030. The Commissioner shall provide for the underwriting and administration of the state plan through competitive bid. The state plan shall be made available to the public no later than July 1, 1981.

(b) A resident of the state is entitled to enroll in the state plan if:

(1) The resident is not eligible for Medicare or covered under a state or federal health program;

(2) The resident is not covered by a group health insurance plan.

Sec. 18.27.020. STATE HEALTH PREMIUM PLAN (a) A resident of the state is entitled to participate in the state health premium plan if:

(1) The resident is enrolled in the state comprehensive health plan or an individual health insurance policy which is certified by the director of the division of insurance as meeting or exceeding the benefit standards of the state plan; and

(2) the resident is not enrolled in a group health insurance policy or covered under a state or federal health program;

(3) the resident qualifies for a supplement under the formula in subsection (b) of this section.

(b) The amount of the supplement is equal to 80 percent of the monthly premium less 8 percent of the monthly premium for every $100 of the insured's adjusted gross income, as defined in regulation, over $1000 per month. The premium cost of the state plan is the maximum amount of monthly premium which may be used in the calculation of the supplement. The $1000 per month of adjusted gross income used in the calculation shall be adjusted periodically by the commissioner by regulation to correspond with the change in the consumer price index.

Sec. 18.27.030. The commissioner shall:

(a) hold statewide public hearings to determine the major medical insurance needs of Alaskans;

(b) determine the number and characteristics of persons currently not covered by a group health plan or federal or state health program, and estimate the number of persons eligible to participate in the state health premium plan;

(c) conduct an actuarial study to determine the cost of providing insurance covering the services in subsection (a), for the group in subsection (b);

(d) present state health insurance plan to the legislature by January 1, 1981 including:

(1) services to be covered in the state health insurance plan;

(2) the cost of the services to be provided;

(3) the estimated number of Alaskans eligible to purchase the plan and the estimated number of Alaskans eligible to participate in the state health plan; and

(4) the estimated cost of the state health premium plan;

(5) a plan of operation for the state health premium plan which provides for:

(i) eligibility determination;

(ii) prompt payment of premium supplement entitlements to eligible residents or to their insurer;

(iii) reasonable protection against fraud; and

(iv) public awareness of the benefits provided under this chapter.

(6) recommendations for amendments of this chapter;

AS 13.27.040 DEFINITIONS. In this chapter

(1) "commissioner" means the commissioner of administration;
(2) "state plan" means the state comprehensive health plan established under AS18.27.010;

Health Care Survey: Doctors and Medicaid

A survey of 113 Anchorage doctors was conducted in order to determine the percentage of Anchorage physicians presently accepting Medicaid recipients as patients. The surveyors, posing as prospective patients, called each physician's office in an attempt to schedule an appointment. After it had been determined if the physician had any openings available, the method of payment was discussed. The conversation was specifically structured this way, in order to provide an indication of the extent to which the method of payment altered accessibility to health care.

The results of the survey are delineated in the accompanying chart. The percentage break-down is as follows: Pediatrics 40% of the doctors will accept Medicaid coupons, 60% will not; OB/GYN 6% will accept, 94% will not; Family Practice 27% will accept, 73% will not; internal 52% will accept, 48% will not; cardiology 100% will not accept; radiology 100% will accept. The chart clarifies the results, for example, cardiologists are not accepting Medicaid coupons, but they will accept as little as $1.00 per month as payment.

The survey clearly shows the existence of a problem for Medicaid recipients seeking medical care. The brunt of the problem falls on women and children, not only because fewer pediatricians, obstetricians and gynecologists accept Medicaid patients, but also because most Medicaid patients are women and children. For example, in November 1979, 8,418 adults were eligible for Medicaid in Alaska; 6,193 of the total were women. The total number of Medicaid eligible children was 9,998.

There are no existing public facilities in Anchorage which provide prenatal care. There are no OB/GYN's in Anchorage who accept new Medicaid recipients needing gynecological care as patients; only one Anchorage OB/GYN will accept new Medicaid patients for obstetrical care. It has been suggested that those women in need of, and without access to, OB and/or GYN care elicit the assistance of a family practitioner. Presently 73% of the family practitioners will not accept coupons as the method of payment.

It has further been suggested that poor people use the emergency room as a recourse to health care. This is a non-solution; the function of an emergency room is crisis-oriented, it is not designed to provide on-going care. At Providence Hospital, business personnel estimate that up to 30% of the patients using the emergency room are Medicaid recipients. Reportedly, the number of recipients using the emergency room has incrementally increased as the number of doctors willing to accept coupons has decreased.

Physicians who have elected to exclude patients from health care base their refusal on claims that they receive unsatisfactory payment for their services from Medicaid and that the reimbursements they do receive are untimely. It is also felt that the state requires excessive amount of paperwork before reimbursements approved. Doctors further claim that they owe no ethical obligation to the poor.

Although the state has encountered numerous difficulties in making timely Medicaid payments, the recent implementation of a new computer system has succeeded in processing the vast majority of all pending claims.

Poor people, still waiting in long lines at the welfare office to procure Medicaid coupons, continue to lack accessible health care. As one recipient complained to a staff person at the welfare office, coupons in hand, "What am I supposed to do with these, if no doctors in town will take them?"

Availability of Health Care to Medicaid Recipients: Jan./Feb. 1980 Telephone Survey

I Will accept all forms of payment including medicaid	II Will not accept new medicaid patients/info on established caseload n/a	III Will not accept new medicaid patients; but carries an established medicaid caseload	IV Not accepting any new patients
OB/GYN			
Eastburn, Lydia	Gills, Raymond E. Nist, Richard Ekvall, David L. Ivy, William 1/ Ferucci, Leonard 1/ Newton, Burrit 1/ Orren, Jerry Wallner, Charles Stransky, George Curtis, Richard	Hanson, Hedric Erkman, John Renn, Claire Gibson, Sam	Compton, William
PEDIATRICS			
Keller, R. Tower, John C. Witt, Marian Zartman, Harvey P. Martin, Sarah	Lillibridge, Clinton Nesbitt, James Jr. Roberts, Dion Schriever, Gerry Hatton, Elizabeth Patterson, James Larson, William 1/	Kiehl, Phyllis Wallington, Joanne	

FAMILY PRACTICE

Agnew, Mark
Myers, Robert C.
Sydnam, Nancy E. 2/
Manwiller, Charles
Jones, Warren 3/
Billings, Robert
Feirtag, Mary
Martin, Asa
Lindhal, James
Sutherland, Richard

Arbow, Donald
Jones, Leland
Laufer, Kenneth
Kiessling, Bruce
Taylor, Richard
Cates, Vernon
Romig, Howard C.
Monlux, George
Mosley, Charles
Persons, Jean C.
Jackson, Marcell
Burgess, Joan
Bryan, Harold
Cormack, Allan
Nolan, Patrick
Smith, John
Colyar, A. B. 1/
Morgan, Royce 1/
Olsen, Harry 1/
Lang, Thomas 1/

St. John, Charles
Bosveld, Robert
Foland, Mary Ann
Wieland, Tyron

INTERNAL MEDICINE

Watson, III, James
Webb, Dale 4/
Ames, John
Hemry, David
Fish, Winthrop
Burtis, Buffington
Sonneborn, David
Armstrong, Michael
Ragle, William
Wilkins, Robert
Archer, Gary
Beechman, Sherman
Austin, Stanley
Stewart, George

Behymer, G. W.
Steer, Paul
Hall, Robert
Peach, David
Morris, Ann
Morris, Gerald
Princiville, Thomas
Blankinship, Gilbert 5/

Whaley, Robert

Buchanan, Richard
Schlosstein, Lee
Brownsberger, Keith 6/
Witt, Richard 6/
Wilson, Rodman 6/

RADIOLOGY

Gibbons, John
Hall, Randolph
Hendrics, Zeke
Pister, James
Coyle, Maurice J.
Kottra, John
Sternhagen, Charles

CARDIOLOGY

Baldauf, James 5/
Bustad, Leo 5/

Footnotes:
1/ Cash only
2/ Limited amount
3/ Will not take coupons for O.B. care
4/ For cancer patients only
5/ Will not accept medicaid coupons; will accept minimal monthly cash payments (i.e.: $1.00/mo.)
6/ Does have established medicaid caseload

Health Care Legislation

HCS CS SS SB 227

HCS CS SS SB 227 "An Act relating to the health of residents of the state" is an omnibus health bill extending health coverage to several new groups of people and expanding the scope of coverage available.

* HIGH RISK INSURANCE POOL

People who have high risk medical conditions often are considered "uninsurable" and cannot purchase comprehensive health insurance. Section one of the bill establishes a high risk insurance pool to be administered by the largest carrier in the state. Premiums would be limited to reasonable levels and the carrier would be allowed to pass excess claims losses from this coverage on to the state through the tax system.

* ALCOHOLISM COVERAGE FOR STATE EMPLOYEES

Model benefits for coverage of alcoholism, including inpatient detoxification, inpatient treatment and outpatient treatment are added to the state employees health insurance plan. While the original bill mandated these benefits for all health insurance policies, the HESS Committee substitute bill would field test these new benefits on state employees.

* MEDICAID BY INSURANCE POLICIES OR HEALTH SERVICE CONTRACTS

Section eight of the bill directs the commissioner of Health and Social Services to provide Medicaid coverage through the purchase of private health insurance policies or health service contracts on behalf of Medicaid recipients, when this is found to be cost effective.

* RELIEF FOR MEDICAID PROVIDERS

The bill requires that the state pay interest at the rate of one percent per month to Medicaid providers on bills that are more than one month overdue, and two percent per month on bills that are more than three months overdue. It also allows the state to make an interim payment to large volume Medicaid providers prior to billing and processing of the claims.

* EXPANSION OF SERVICES AND ELIGIBLE PEOPLE COVERED UNDER MEDICAID

Sections nine and ten of the bill expand the state's Medicaid program to include all groups and all services for which federal funding is available. New additions include such eligible and services as unborn children, unemployed fathers, prescription drugs, adult dental care and physical therapy.

* COVERAGE FOR THE MEDICALLY NEEDY

Section eleven of the bill creates a new program of medical assistance for medically needy people under the state's General Relief-Medical program. The income threshold for eligibility is set at 150% of the poverty guideline for Alaska. People whose income exceeds that amount can still become eligible for assistance after they spend their "excess" income on medical bills.

* FISCAL IMPACT

The fiscal note for all these programs includes approximately $8 million from the General fund, $23 thousand from other state funds and $8 million in federal funds for FY81.

THELMA
BUCHHOLDT
Alaska State Legislature
House of Representatives
Juneau, Alaska 99811

May 22, 1980

To: Representatives Gardiner, Meekins, McKinnon, Parker

From: Representative Thelma Buchholdt

Re: HCS CS SS SB 227 - Health Legislation

HCS CS SS SB 227, "An Act relating to the health of residents of the state," was passed out of the House HESS Committee on Wednesday, May 21. I am supplying you with a copy of the bill summary and the accompanying fiscal note. I am also enclosing a copy of the work draft that was passed out of Committee. I expect that the final version of the bill will be printed this afternoon.

Very briefly, Section 1 of the bill establishes a carrier reinsurance pool which would make health insurance available at a reasonable premium to every resident and every employer group in the state. This section of the bill is designed to pick up high-risk persons and other uninsurables in the state for whom health coverage is now unavailable.

Sections 4 through 7 of the bill comprise the original CS SS SB 227, sponsored by Senators Coletta, Hohman and Stimson, and require state employee health insurance to include coverage for alcoholism and drug dependence.

Section 8 of the bill requires the Commisssioner of Health and Social Services to provide services under medical assistance programs through health insurance policies or health service contracts when cost effective. The bill authorizes the Department to make interim peyments to providers who serve a large volume of state medical assistance clients. The bill also requires the state to pay interest to providers on overdue medical assistance bills.

Sections 9 and 10 of the bill expand the state's Medicaid program to include all services and eligibles qualifying for federal financial participation.

Finally, in Section 11, a medically needy program is established under the state General Relief program with an income standard set at 150% of the poverty guideline. Persons whose income exceeds the standard become eligible when they spend their excess income on medical bills.

The fiscal note for the bill includes approximately $ 8 million from the state's General Funds, $ 22,800 from other state funds and approximately $ 8 million in federal funds.

HCS CSSS SB 227 (HESS)

BILL SUMMARY

(revised 5/21/80)

The basic concept of the first section of the bill is to establish a carrier reinsurance pool which would make health insurance available at a reasonable premium to every resident and every employer group in the state, regardless of underwriting risk. This section is modeled after Connecticut law.

AS21.50.010 Each carrier in the state which offers individual health coverage is required to make an individual comprehensive health care plan available to each resident of the state who is not eligible for Medicare. Each carrier in the state which offers group health coverage is required to make a group comprehensive health care plan available to every resident employer of three or more employees. The required coverage may be provided by a carrier or through the reinsurance association, but in the former case the premium charged may not exceed the applicable association premium. The bill does not preclude a carrier from carrying other kinds of health insurance nor does it require a carrier to provide coverage to a person or group who already has coverage.

AS21.50.020 The required comprehensive health plans must cover the services itemized. A choice of $100, $500, or $1000 deductible is provided, and the maximum co-payment is set at 20%. The sum of co-payment and deductibles may not exceed $1000 for an individual or $2000 for a family before benefits

are paid at 100%. The maximum lifetime benefits limit may not be less than $1,000,000. Pre-existing conditions may only be excluded if the condition was treated or medical advice was sought within six months prior to the effective date of coverage, but in any case may not be excluded from coverage for more than twelve months. The plans need not cover occupational injuries, cosmetic treatment, custodial care, services which are not medically necessary, services which are covered under an automobile liability policy, or other specified expenses. Group comprehensive health care plans must also cover dependents.

AS21.50.030 The Health Reinsurance Association is established consisting of all licensed health insurance carriers in the state. The board of governors and a plan of operation which addresses itemized issues are both subject to approval by the director. The authority to issue health insurance, to establish rates, to administer reinsurance, to pool risks, and other general powers are granted the association.

Each asscaition member must designate the classes of r. which it elects to have written by or reinsured by the a 'ation. Individual lives may not be selected out of a group for reinsurance. Premium rates may not be excessive, inadequate, or unfairly discriminatory, nor may they exceed 125% of rates for standard risk groups. All rates are promulgated through the assocaition by an actuarial committee.

Losses of the assocaition are assessed to members. Members in turn may credit the assessed claims losses, but not

assissed administrative losses, against their premium or income tax. If the assessment exceeds their tax liability, the Commissioner of Revenue reimburses the carrier for the excess loss. Periodic audits are required.

AS21.50.040 Hospital or medical service corporations (such as Blue Cross) are given the option of participating in the Health Reinsurance Association or of setting up their own parallel residual market association under the same guidelines and standards.

AS21.50.050 The regulatory and oversight powers and administrative duties of the director of insurance are enumerated.

AS21.50.100 Definitions

Sections 2 and 3 are technical amendments to other chapters of the insurance code to bring them in conformity with Section 1.

Sections 4 through 7 of the bill amending AS39.30 comprise the original CSSSSB 227 and require state employee health insurance to include coverage alcoholism and drug dependence. Minimum benefits in the state employees plan are defined to include inpatient detoxification, inpatient treatment and outpatient treatment. Coverage may not exclude dependents or pre-existing alcoholism conditions.

Section 8 of the bill amending AS47.05 requires the Commissioner of Health and Social Services to provide services under medical assistance programs through health insurance policies or health service contracts when this would be cost effective. In a spearate section, the department is authorized to make interim apyments to providers who serve a large volume of state medical assistance clients. And finally, the bill requires the state to pay interest to providers on overdue medical assistance bills at the rate of one percent per month after 30 days and two percent per month after 90 days.

Sections 9 and 10 expand the state's Medicaid program to include all services and eligibles qualifying for federal financial participation.

Section 11 creates a medically needy program under the state General Relief program with an income standard at 150% of the poverty guideline. Persons whose income exceeds the standard become eligible when they spend their excess income on medical bills.

payments from public assistance, social security, unemployment and workmen's compensation, strike benefits from union funds, veterans benefits, training stipends, alimony, child support and military family allotments or other regular support from an absent family member or someone not living in the household; government employee pensions, private pensions and regular insurance or annuity payments; and income from dividends, interest, rents, royalties or income from estates and trusts. For eligibility purposes, income does not refer to the following money receipts, any assets drawn down as withdrawals from a bank, sale of property, house or car, tax refunds, gifts, one-time insurance payments or compensation for injury; also to be disregarded is non-cash income, such as the bonus value of food and fuel produced and consumed on farms and the imputed value of rent from owner-occupied farm or non-farm housing.

(2) *A Farm Residence.* Is defined as any dwelling on a place of 10 acres or more with $50 or more annual sales of farm products raised there; or any place less than 10 acres having product sales of $250 or more.

Poverty Income Guidelines for All States Except Alaska and Hawaii

	Non-farm family	Farm family
Size of family unit:		
1	$3,400	$2,910
2	4,500	3,840
3	5,600	4,770
4	6,700	5,700
5	7,800	6,630
6	8,900	7,560

For family units with more than 6 members, add $1,100 for each additional member in a non-farm family and $930 for each additional member in a farm family.

Poverty Guidelines for Alaska

	Non-farm family	Farm family
Size of family unit:		
1	$4,270	$3,650
2	5,640	4,810
3	7,010	5,970
4	8,380	7,130

Poverty Guidelines for Alaska—Continued

	Non-farm family	Farm family
5	9,750	8,29[illegible]
6	11,120	9,45[illegible]

For each family unit with more than 6 members, add $1,370 for each additional member in a non-farm family and $1,160 for each additional member in a farm family.

Poverty Guidelines for Hawaii

	Non-farm family	Farm family
Size of family unit:		
1	$2,930	$2,[illegible]
2	5,190	4,[illegible]
3	6,450	5,[illegible]
4	7,710	6,[illegible]
5	8,970	7,[illegible]
6	10,230	8,[illegible]

For family units with more than 6 members, add $1,260 for each additional member in a non-farm family and $1,070 for each additional member in a farm family.

[44 FR 26476, May 7, 1979]

Subpart 1060.3—Limitation on Benefits to Those Voluntarily Poor (CSA Instruction 6004-2)

§ 1060.3-1 Applicability of this subpart.

This subpart applies to all agencies receiving funds under Titles I-D, II and III-B of the Economic Opportunity Act for programs administered by OEO in which income criteria are used as admission standards (with the exception of Head Start and Upward Bound programs).

(Sec. 602, 78 Stat. 503; 42 U.S.C. 2942)

[34 FR 2419, Feb. 20, 1969]

§ 1060.3-2 Policy.

(a) Section 611 of the Economic Opportunity Act provides as follows:

The Director shall take such action as may be necessary to assure that, in determining a person's eligibility for benefits under this Act on account of his poverty such person will not be deemed to meet the poverty criteria if his lack of income results from his refusal, without good cause, to seek or accept employment commensurate with his health, age, education, and ability.

MEDICAID OPTIONAL SERVICES--INCLUDING THOSE NOT CURRENTLY COVERED BY THE ALASKA MEDICAID PROGRAM

The following is a list of all optional services under the Medicaid program. Optional services may be selected by the individual states for inclusion in their Medicaid program if a state decides to make those services available to all categories eligible for the basic Medicaid coverage. A brief description of each option is provided below followed by a comparison of optional services that are offered in Alaska, Idaho, Oregon and Washington, the four states comprising federal Region X. Those services covered in Alaska are indicated.

(1) Podiatrist services. Manipulation of the feet and treatment of corns, bunions, callouses, etc., by a licensed podiatrist.

(2) Optometric services. Covered under Alaska Medicaid.

(3) Chiropractic services. Treatment by a licensed chiropractor limited to manual manipulation of the spine.

(4) Other practitioner services. Naturopaths, homeopaths, herbalists, faith healers.

(5) Private duty nursing. Care by a registered nurse or licensed practical nurse under a physician's supervision in home, hospital or nursing facility when a person requires exceptional individual and continuous care.

(6) Clinic services. Under the Alaska Medicaid program this is currently limited to state-operated and state-funded community mental health clinics. This option could also include such other services as health care clinics, alcoholism treatment centers, ambulatory surgical centers, and rural health care clinics. Rural health clinics are now a mandatory service pursuant to Public Law 95-210.

(7) Physical therapy. Physician-prescribed services provided by a licensed or certified physical therapist (depending upon state licensing procedures).

(8) Occupational therapy. Physician-prescribed services provided by a licensed or certified occupational therapist (depending upon state licensing procedures).

(9) Services for speech, hearing, and language disorders. Included under the Alaska Medicaid program.

(10) Prescribed drugs. Covered by state-only General Relief Medical. Alaska is one of only two states without Medicaid coverage for this option.

(11) Dentures. Replacement of a full or partial set of teeth.

(12) Prosthetic devices. Physician-prescribed replacement corrective or supportive devices that artificially replace a missing part of the body, to prevent deformity or malfunction, to support a weak or deformed portion of the body.

(13) Eyeglasses. Covered by Alaska Medicaid.

(14) Other diagnostic, screening, preventive and rehabilitative services. Identification of illness, injury or other health deviation; preventive and rehabilitative services to restore patient to functional level.

(15) Services to individuals over 65 years of age in institutions for tuberculosis. Facility providing services could be ICF, SNF or inpatient hospital.

(16) Services to individuals over 65 years of age in institutions for mental diseases. (a) Inpatient psychiatric care for persons over 65 is covered under the Alaska Medicaid program. (b) ICF and SNF care for persons over 65 with mental diseases is not covered in Alaska. Under this provision, it would be possible to provide nursing care for persons with mental disabilities who may not otherwise qualify for nursing care due to a lack of physical health problems requiring nursing home care.

(17) Intermediate care facilities (ICF). Covered under the Alaska Medicaid program.

(18) Inpatient psychiatric services for persons under 22 years of age. Covered by the Alaska Medicaid program.

(19) Transportation. Covered under the Alaska Medicaid program.

(20) Services by Christian Science nurses.

(21) Services by Christian Science Sanatoria.

(22) Skilled nursing facility care (SNF) for persons under 21 years of age. Covered by the Alaska Medicaid program.

(23) Emergency hospital services. Covered under the Alaska Medicaid program.

(24) Dental services. Adult dental services are not covered by Medicaid in Alaska.

(25) Personal care services. Physician-ordered services provided to a person in their home by a non-relative and supervised by a registered nurse.

(26) Intermediate care for the mentally retarded and persons with related conditions (ICF/MR). Covered under the Medicaid program in Alaska.

OPTIONAL SERVICES

OPTIONAL SERVICES	ALASKA	IDAHO	OREGON	WASHINGTON
Podiatrist Services	No	Yes	Yes	Yes
Optometric Services	Yes	Yes	Yes	Yes
Chiropractic Services	No	Yes	Yes	Yes
Other Practitioner Services	No	No	Yes	Yes
Private Duty Nursing	No	No	Yes	Yes
Clinic Services	Yes	Yes	Yes	Yes
Physical Therapy	No	Yes	Yes	Yes
Occupational Therapy	No	No	No	No
Services for Speech, Hearing & Language Disorders	Yes	No	No	Yes
Prescribed Drugs	No	Yes	Yes	Yes
Dentures	No	No	Yes	Yes
Prosthetic Devices	No	No	Yes	Yes
Eyeglasses	Yes	No	Yes	Yes
Other Services				
Diagnostic	No	No	Yes	Yes
Screening	No	No	No	Yes
Prevention	No	No	No	Yes
Rehabilitation	No	No	Yes	Yes
Services to Individuals Over 65 in Institutions for T.B.				
Inpatient	No	No	Yes	Yes
Skilled	No	No	Yes	Yes
ICF	No	No	Yes	Yes
Services to Individuals Over 65 in Institutions for Mental Diseases				
Inpatient	Yes	No	Yes	Yes
Skilled	No	No	Yes	Yes
ICF	No	Yes	Yes	Yes
Intermediate Care Facilities	Yes	Yes	Yes	Yes
Inpatient Psychiatric Services for Under 22	Yes	No	Yes	Yes
Transportation	Yes	Yes	Yes	Yes
Services for Christian Science Nurses	No	No	No	No
Services for Christian Science Sanitoria	No	No	Yes	No
SNF for Under 21	Yes	Yes	Yes	Yes
Emergency Hospital Services	Yes	Yes	Yes	Yes
Dental Services	No	No	Yes	Yes
Personal Care Services	No	No	No	No
ICF/MR	Yes	Yes	Yes	Yes

STATE OF ALASKA
JAY S. HAMMOND, GOVERNOR
DEPT. OF HEALTH AND SOCIAL SERVICES
OFFICE OF THE COMMISSIONER
POUCH H 01 – JUNEAU 99811

April 9, 1980

Ms. Thelma Buchholdt
Chairperson, House HESS Committee
Alaska State Legislature
Pouch V
Juneau, Alaska 99811

Document# 68-80

Dear Ms. Buchholdt:

At the recent teleconference on House Bill 977, your Committee requested further information regarding the definition of the "other diagnostic, preventative, and rehabilitative services" option to the Medicaid program. The definition included in federal Medicaid regulations for this option is as follows:

§440.130 Diagnostic, screening, preventive, and rehabilitative services.

(a) "Diagnostic services," except as otherwise provided under this subpart, includes any medical procedures or supplies recommended by a physician or other licensed practitioner of the healing arts, within the scope of his practice under State law, to enable him to identify the existence, nature, or extent of illness, injury, or other health deviation in a recipient.

(b) "Screening services" means the use of standardized tests given under medical direction in the mass examination of a designated population to detect the existence of one or more particular diseases or health deviations or to identify for more definitive studies individuals suspected of having certain diseases.

(c) "Preventive services" means services provided by a physician or other licensed practitioner of the healing arts within the scope of his practice under State law to--

(1) Prevent disease, disability, and other health conditions or their progression;

(2) Prolong life; and

(3) Promote physical and mental health and efficiency.

(d) "Rehabilitative services," except as otherwise provided under this subpart, includes any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his practice under State law, for maximum reduction of physical or mental disability and restoration of a recipient to his best possible functional level.

As you can see the federal definition is quite general. The Medicaid program allows state flexibility to define optional services for operational purposes. Seven states currently have selected to include this service option in their Medicaid programs. These states have defined this option as follows:

1. California - Rehabilitation center outpatient services. Included are physical, occupational, and speech therapy and audiology. One visit in a six-month period is allowed, without prior authorization, for evaluation purposes and preparation of an extended treatment plan. The treatment plan must be signed by a physician. Subsequent visits are subject to prior authorization. A maximum of 30 visits may be authorized at any one time. Authorizations are valid for up to 120 days.

2. Idaho - The following are the core medical rehabilitative services provided on a statewide basis through facilities comparable to adult/child development centers: medical/social and psychological evaluations, speech and hearing evaluations, psychological therapy, patient centered psychological consultation, speech therapy, and patient centered psychological consultation, speech therapy, and patient centered development deficiency services related to particular diseases or health deviations.

3. Nevada - Limited to inhalation therapy prescribed by a physician and provided by a Certified Respiratory Therapist subject to the same limits that apply for Medicare. Prior authorization by the Medical Care Section is required.

4. North Carolina - Limited to diagnostic, preventive, and rehabilitative services when provided by mental health centers.

5. Oklahoma - Limited to blood. For inpatients, payment is made to blood banks for blood and blood fractions when the cost of blood is not included in the hospital per diem cost. For outpatients, payment is made for blood and blood fractions on behalf of an eligible recipient who is suffering from a congenital or acquired disease of the blood which requires the use of blood or blood fractions. Specifically eliminated is gammaglobulin, both the pooled and specific types. Payment may be made to physicians, clinics, out-patient hospitals or blood banks. Blood claims are screened through the computer stream against eligibility files to assure that no payment is made beyond the scope of the program.

6. Wisconsin - Includes psychotherapy provided or supervised by a psychiatrist or psychologist in the provider's office, the outpatient office of a hospital, an outpatient facility, a nursing home, a licensed child-caring institution, a school, or the recipient's home or foster home. A diagnostic examination and a physician's written prescription for therapy must be furnished before therapy is begun (a prescription is not needed for emergency treatment but must be obtained within 48 hours). Prior authorization is required for all therapy.

7. Washington - Diagnostic services - covered as needed and approved. Preventive services - (a) Rabies shots; (b) Fluoride painting; and (c) Immunizations when not otherwise available. Rehabilitative services - (a) Physical medicine and rehabilitation as requested and approved; (b) Alcohol detoxification limited to 3 days in certified facilities which may be within the physical location of a general hospital - however, narcotic detoxification is not covered; (c) Chemotherapy and consultation for drug addiction are provided in clinics approved to provide to services; and (d) Adult Day Health Care as provided and periodically reviewed.

I hope this clarifies your concerns. Alaska, if it choses to add this option, could define the option in a similar ways to those noted above, subject to federal approval in order to be eligible for federal financial participation.

If you have additional questions on this matter, please do not hesitate to contact the department at 465-3030.

Sincerely,

Deborah E. Behr

Deborah E. Behr
Special Assistant to
the Commissioner

Alaska State Legislature

House

JUNEAU ALASKA

To: Representative Thelma Buchholdt
Chair, House HESS

From: Jan Sorice, A.A.

Re: CSSSSB 227

Section One of CSSSSB 227,which creates a Health Reinsurance Association of all carriers in the state, is based on Connecticut's Health Care Act of 1975. Travelers Insurance Company is the administering carrier for Connecticut's Health Reinsurance Association.

According to Tim Lyons of Travelers Insurance Company in Connecticut, the law serves a positive public purpose and does not impose an unreasonable burden on the carriers. The law offers comprehensive health insurance coverage to any resident of the state and any employer group. In addition to providing coverage for high health risk peop who are uninsurable under standard policies, the state comprehensive health care plan provides coverage to people who are temporarily lacking coverage, such as a person who is in between jobs and temporarily not eligible for group coverage, and provides many young, low-risk people an attractive health coverage plan at very modest premiums as well. Except for a

few carriers who choose to write their own comprehensive health insurance plans, the carriers act as agents to sell the comprehensive health plans written by the Health Reinsurance Association.

Mr. Lyons found no legal or administrative problems with the law, though he feels that it would be preferable to have all carriers in one residual market rather than one for insurance carriers and another for hospital/medical service corporations (Blue Cross and Blue Shield, predominately). He felt that one association would provide a more equitable sharing of the costs of high risk coverage among all carriers and would avoid duplication of administrative overhead.

Blue Cross of Connecticut does not participate in the Health Reinsurance Assocaition, but instead chooses to operate a separate residual market mechanism and offer a competing comprehensive health plan as mandated by the law. Blue Cross' comprehensive health plan is offered at two-thirds the premium cost and has five times the enrollment of the comprehensive plan offered by the Health Reinsurance Association. Blue Cross prefers to operate a separate program because as a non-profit hospital/medical service corporation, they run their business a little differently than insurance companies do. Joe Kaluzynski, Director of Market Research and Product Development for Blue Cross, saw no administrative problems or other defects in the law.

Neither Mr. Kaluzynski nor Mr. Lyons saw any potential problems generated by the fact that most carriers operating in Alaska are not located here. Only one carrier in each association, the administering carrier, needs to have regular contact with the State or its residents.

A COMPARISON OF BENEFITS UNDER HB 977 AND THREE OTHER COMPREHENSIVE HEALTH PLANS

Benefit	State Employees Blue Cross Plan	Alaska #2 Qualified Plan (HB 977)	Minnesota #2 Qualified Plan	Connecticut Middle Option Plan
deductible	$50/person; $150/family	$500/person; $1500/family	$500/person	$500/person
co-payment	10%	20%	20%	20%
out-of-pocket limit	$2000	$3000	$3000	$1000/person; $2000/family
maximum lifetime benefit	$250,000	$250,000	$250,000	$1,000,000
pre-existing conditions limit	maximum benefit limited during 1st year of plan coverage to $1000 for any pre-existing condition which was treated during the 3 months prior to enrollment in the plan	not specified	not specified	conditions manifested or treated in the 6 months prior to enrollment excluded from coverage for one year
fee basis	usual, customary and reasonable charges	usual and customary charges	usual and customary charges	may not exceed reasonable charges or rates approved by the commission on hospital and health care
COVERED SERVICES:				
hospital services	yes	yes	yes	yes
physician services	care rendered by M.D., osteopath, psychologist, chiropractor, podiatrist or Christian Science practitioner	care rendered by or at the direction of a physician	care rendered by or at the direction of a physician	professional services rendered by an M.D., osteopath, chiropractor, podiatrist, psychologist, or naturopath
private duty nursing	RN services at the direction of a physician	professional services rendered at the direction of a physician	professional services rendered at the direction of a physician	professional services rendered by a registered nurse at the direction of a physician

Benefit	State Employees Blue Cross Plan	Alaska #2 Qualified Plan (HB 977)	Minnesota #2 Qualified Plan	Connecticut Middle Option Plan
Prescription drugs	yes	yes	yes	yes
radiation	yes	yes	yes	yes
x-ray & lab exams	yes	yes	yes	yes
oxygen	yes	yes	yes	yes
anesthetic	yes	yes	yes	yes
prostheses	yes	yes	yes	yes
medical supplies	bandages, crutches, wheel chairs, respirators, blood, hospital type beds, plasma	rental or purchase of durable medical equipment	rental or purchase of durable medical equipment	rental or purchase of durable medical equipment
pregnancy & childbirth	yes	yes	yes	$250 limit except for complications
travel	ambulance or commercial airline to nearest facility	medically necessary transportation	ambulance to nearest facility & mileage rate to kidney dialysis treatment center	ambulance to nearest facility
alcoholism treatment	yes, on inpatient basis, except limited to $1000 maximum if the facility does not have a contract with Blue Cross	yes	yes(required by law of all health insurance policies	yes
mental & nervous disorders	50% coverage up to $2500 maximum per year when rendered by and M.D., D.O., or licensed psychologist	____	____	50% coverage

Benefits	State Employees Blue Cross Plan	Alaska #2 Qualified Plan (HB 977)	Minnesota #2 Qualified Plan	Connecticut Middle Option Plan
Nursing home	___	120 days maximum if begun within 14 days of a hospital stay of at least 3 days	120 days maximum if it would qualify under Medicare	120 days maximum if begun within 14 days of a hospital stay of at least 3 days
home health care	____	up to 180 visits/year	if it would qualify under Medicare	up to 180 visits/year
oral surgery	yes	yes	yes	yes
physical therapist	___	yes	yes	yes
well baby care	___	yes, subject to deductibles, coinsurance and limits	effective July 1, 1980	_____
physical exams	___	yes, subject to applicable deductibles coinsurance and limits	effective July 1, 1982	_____
multiphasic screening & other diagnosis	___	yes, subject to coinsurance, deductibles & limits	effective July 1, 1982	_____
dental care	70 - 100% coverage up to a maximum of $1000 per year	_____	_____	_____
vision & optical	90% coverage for 1 exam and 1 set of lenses/year	_____	_____	_____
audio	80% coverage up to $400 over 3 years	_____	_____	_____
medical social services	_____	_____	_____	$200 limit

Benefit	State Employees Blue Cross Plan	Alaska #2 Qualified Plan (HB 977)	Minnesota #2 Qualified Plan	Connecticut Middle Option Plan
conversion privileges	yes	yes	yes	yes
dependent coverage	spouse, dependent children under 23, disabled children of any age who are financially dependent	spouse, children under 18, children under 25 who are students and financially dependent, disabled children of any age who are financially dependent and dependent household members	spouse, children under 19, children under 25 who are students and financially dependent, children of any age who are disabled and dependent	not specified

BRIEF SUMMARY OF CSSSSB 227

" AN ACT RELATING TO INSURANCE FOR ALCOHOLISM AND DRUG DEPENDENCE"

THIS BILL MAKES IT REQUIRED FOR GROUP INSURANCE POLICIES TO PROVIDE COVERAGE FOR ALCOHOLISM AND DRUG DEPENDENCE. THE MINIMUM REQUIREMENTS FOR THIS COVERAGE ARE DESCRIBED IN THE BILL AND INCLUDE:

1. 14 DAYS OF INPATIENT DETOXIFICATION CARE PER YEAR
2. 30 DAYS OF INPATIENT TREATMENT PER YEAR
3. 30 VISITS OF OUTPATIENT TREATMENT PER YEAR

ALL OF THE ABOVE MINIMUM REQUIREMENTS AS OUTLINED IN THE BILL ARE TO BE ADMINISTERED IN A/OF BY A

1. STATE APPROVED TREATMENT FACILITY
2. LICENSED HOSPITAL
3. LICENSED PHYSICIAN
4. STATE CERTIFIED PROFESSIONAL SUBSTANCE ABUSE COUNSELOR

THE INSURANCE AS REQUIRED BY THIS BILL WOULD INCLUDE BENEFITS FOR DEPENDENTS REGARDLESS OF AGE, SEX OR STATE OF ILLNESS.

HOSPITAL MEDICAL SERVICE CORPORATIONS IE. BLUE CROSS (THE LARGEST INSURANCE COMPANY WITH ALASKA) ARE REQUIRED BY THIS BILL TO INCLUDE ALCOHOLISM AND DRUG DEPENDENCE INSURANCE.

THIS BILL INSURES THAT ALL PERSONS COVERED BY A GROUP INSURANCE POLICY ARE COVERED FOR ALCOHOLISM AND DRUG DEPENDENCE WHETHER OR NOT SPECIFIED IN THE POLICY. (THE REASONING FOR THIS IS THAT SOME POLICIES ORIGINATE OUT OF STATE THERFORE THE POLICY MIGHT NOT SPECIFY ALCOHOLISM AND DRUG DEPENDENCE COVERAGE, SO THIS WOULD CHANGE THE LAW MAKING IT AUTOMATIC FOR ALASKAN EMPLOYEES COVERED BY INSURANCE.)

CSSSSB 227 PROVIDES FOR AN EFFECTIVE DATE OF NOVEMBER 1,1979 IN ORDER FOR INSURANCE COMPANIES TO COMPLY WITH THE NEW LEGISLATION.

SECTION ANALYSIS SS for SB 227 FROM THE DIVISION OF INSURANCE

Sec 1 AS 21.42

Requires that all group health insurance policies issued by insurance companies and all service or indemnity type contracts issued by non-profit corporations such as Blue Cross, provide as a minimum, specified coverages related to alcoholism and drug dependence.

COVERAGES are:

A. not less than 14 days detoxification benefit at a rate equal to other benefits provided in the policy.
B. not less than 30 days inpatient treatment benefit
C. not less than 30 visits to specified outpatient treatment facilities.

Alcoholism and drug dependence coverage is to be provided for all persons covered under the group policy without regard to age, sex, state of illness, or pre-existing condition.

Section 1 also provides key definitions of alcoholism and drug dependence.

Section 2 Amends AS 21.87.347 to provide that Hospital Medical Service Corporations ie. Blue Cross, are also subject to the provisions of AS 21.42 as created by this bill.

Section 3 Specifies that coverage for alcoholism and drug dependence shall automatically apply to all persons covered by a group policy issued for delivery, delivered or renewed in this state after the effective date of the act; whether the policy wording specifically provides coverage or not.

Section 4 Provides for an effective date of November 1, 1979 in order for insurance companies to amend policies and adjust rates prior to the effective date.

Robertson, Montagle,

STATEMENT
of the
HEALTH INSURANCE ASSOCIATION OF AMERICA
CONCERNING PROPOSED
ALASKA COMPREHENSIVE HEALTH CARE PLAN
(House CS for CS for SS for S.B. 227)

The Health Insurance Association of America (HIAA) is a trade association of 311 insurance companies which write about 85% of the health insurance written by insurance companies in the United States.

Section 1 of the proposed House Committee Substitute for this bill, now being considered by the House Health, Education and Social Services Committee, would establish a comprehensive health care plan, and would require health insurers to participate in it. Our comments will be primarily directed to Section 1.

GENERAL PLAN OF SECTION 1

The basic idea of Section 1 is to establish a pool to make three specified plans of major medical insurance available to Alaska residents, under age 65, who are uninsurable or are otherwise high risks for such coverage when furnished by individual insurers. Pooling of high-risk insureds makes the financial resources of all health insurers available to cover the large claim payments that must be made.

Because major medical insurance, with its broad coverage and high maximum benefits, is costly anyway -- and even more so for high-risk insureds -- Section 1 also limits the premium rates that can be charged for the three major medical plans to amounts that are less than are needed to pay claims and administer the program, and the State eventually pays the difference by means of a tax offset. [A State subsidy is available to certain small employers to help them pay for one of the three plans of major medical insurance for their employees.]

All health insurers (including self-insurers) would be required to be members of the Association which operates the pooled business, and to share in the losses, with one exception. Blue Cross - Blue Shield could establish its own separate pool, or could provide the three plans without participating in a pool.

Section 1 is an altered version of an existing Connecticut law, and the subsidy for small employers is an idea adapted from an existing Hawaii law.

GENERAL COMMENTS

Going to the Connecticut law for guidance results in a much better plan than in H.B. 977. The Connecticut law, unlike the Minnesota law on which H

is based, has not been a subject of great controversy or Constitutional challenge. It is, on the whole, a very workable law for that State. To be sure, it needs some alterations based on experience with it, and some additional ones if it is to be adapted for Alaska.

Before getting to that, it seems to us that the Alaska legislature should be asking, and getting answers to, some important questions:

(1) Is there a need for such a program in Alaska?
(2) How many Alaska residents can we expect to benefit from it?
(3) How much will it cost?
(4) Are the anticipated costs worth paying in view of the anticipated benefits?
(5) Would such a program work in Alaska?

These same questions should be asked and answered about any proposed health insurance program, whether it be patterned after the Connecticut law or the Minnesota law, or whether it is something untried elsewhere.

What you need, we think, is to have a thorough study made by a firm of consulting actuaries that has sufficient knowledge about State health insurance plans and access to sufficient Alaska claims data. This would be advisable for any State contemplating a program, and particularly so for Alaska which is so different from other States. Among other things are Alaska's vast area, small population, comparatively younger (and probably healthier) residents, and a large proportion of residents already covered by government health care plans.

Lacking such a study, we can only make some guesses.

Let's go to question (2), and see what we can guess from experience elsewhere about how many Alaskans who are high risks for major medical insurance might become insured under such a program. The answer to this will have some bearing on the answers to questions (1) and (4).

In Connecticut, the two pools (one "pool" operated by Blue Cross - Blue Shield, the other by insurance companies) together cover 9,680 people, which is about 35 ten-thousandths (.0035) of the under-age-65, civilian, noninstitutionalized population of about 2,746,000 people. But a large majority of the people covered by the pools consists of standard risks, who could get coverage without the program. This is primarily because Blue Cross - Blue Shield puts all of its non-group insureds, both standard and high-risk individuals, into its pool. So the Connecticut figures are not much help to us.

In Minnesota, the Association (pool) has 1,465 policies in force for people under age 65. While the records do not indicate numbers of people covered, the great bulk of the policies cover only one person each. We estimate that the pool covers

1,758 people, which is about 5 ten-thousandths (.0005) of the under-age-65, civilian, noninstitutionalized population of about 3,493,000 people. This enrollment was achieved only after a major, intensive publicity effort participated in by the Association and hospitals and other health care providers. Unlike Connecticut, only high-risk individuals are included in this figure.

Applying these Minnesota results to the estimated 395,000 under-age-65, civilian, noninstitutionalized Alaska population, we would ~~expect an Alaska~~ 2 rejections pool for high-risk individuals to cover somewhat under 200 Alaska residents. Some downward adjustment should be made for Alaska's comparatively younger and (at least partly for that reason) healthier population, and for the comparatively larger proportion of native Alaskans covered under government health care programs.

It should be kept in mind that a wide range of major medical insurance plans (including high-maximum plans) is already available from insurers to groups, and to standard and many substandard risk individuals, at premium rates that are lower than those to be charged by the pool. And Medicare, Medicaid, the Alaska catastrophic illness program, and other government programs provide coverage for many Alaskans.

The small number of people who can be expected to come into the pool is determined by a number of factors, including the small number of uninsurables, the inability of many to pay the costs of major medical insurance, the number of people already covered under major medical plans, and the number of people covered under other government programs.

COST OF PROGRAM

The Alaska Insurance Department has already given you an estimate of their anticipated costs, initially $250,000 per year we understand.

In Section 1, proposed AS Sec. 21.50.090 provides for the State to aid small employers in paying premiums for health insurance coverage for employees and their dependents. We do not have any estimate of what this may cost the State, but think that the costs may be quite substantial.

In addition, there would be a cost to the State due to the tax offset (or payment by the State to the carrier) for losses due to costs of the program which exceed the premiums on business written by the pool. The Minnesota program lost ~~$1,000,000~~ $500 in 1979, using the same limitation on premium rates that is in the proposed Alaska program. With only 10% or 11% as many insureds, but with considerable higher per person administrative costs, losses under the Alaska program might initially be $200,000, perhaps somewhat less but possibly considerably more -- the latter if a home office type operation must be established in Alaska, since no major health insurance writer has its home office in Alaska. Without a proper actuarial study, we cannot predict the range of this cost.

In addition, insurers will incur some costs for compliance with the law. The amount is unknown, but it will eventually be paid by Alaska policyholders and insureds.

COSTS TO EMPLOYERS

Proposed AS Sec. 21.50.080 would require all group "health policies" delivered or renewed in Alaska to contain the provisions called for in proposed AS Sec. 21.50.030(b). Those provisions deal principally with: (1) continuation of coverage under the group policy in specified circumstances for employees and/or dependents whose coverage would otherwise terminate; and (2) including a conversion to an individual policy, with benefits and terms at least as good as a comprehensive plan, when coverage under the group plan terminates.

Both proposed sections need careful redrafting in order not to interfere more than is intended with eligibility provisions of group policies, and to limit the conversion privilege so that it applies to the proper kinds of group policies and does not allow duplicate conversions.

After redrafting, the provisions should be considered in an actuarial study to determine the costs they will add to group plans, so that the Committee may consider whether it is avisable to add such cost burdens to employers who furnish health insurance coverage to employees under group policies or contracts.

PREMIUM RATES

An actuarial study is needed to determine the approximate premium rates that the pool will charge initially for coverage. This is essential if you are to make an informed, intelligent decision on the kinds of benefits and the amounts of benefits, including the deductibles, to be provided in the three plans. Section 1 of the proposed amendment already makes some changes in benefits from those provided under the Connecticut law. I do not know what reasons were involved in making the changes, but they have a significant effect on premium rates.

The decrease in the low option deductible to $100 from $200 will increase the premium rate for that plan by roughly 10%. The increase in the high option deductible to $1,000 from $750 will decrease the premium rate for that plan by roughly 7-1/2%. Removing Connecticut's $250 limit (and applying no limit) to the normal maternity benefit will increase the premium rate of all three plans for women of child-bearing age, by roughly 5% to 10%.

It seems to me that we should be looking for ways to lower premium rates, by decreasing some benefits, rather than for ways to increase them. We do not want to price the plans so high that even fewer people will be able to afford them.

Health insurance premium rates are already higher for Alaska residents because of the higher health care costs in Alaska. And health care costs are rising at a rapid rate generally. We know, for example, that the insurance company pool in Connecticut is about to raise its rates by 20%. We know that health care costs in Anchorage are about 35% higher than in Hartford, Connecticut.

When a small sampling of Connecticut rates for just two age groups is roughly adjusted to account for the changes inthe plans and to guess at what the pool rates might today be for Anchorage residents, and some of them indicate an annual rate, for one adult, of as much as $1,100, $1,300, or $1,500, I worry. And whatever the rates are now, they may have to be 15% or more higher by the time the program can be put into effect. per year?

After you have a proper actuarial study, you should consider what benefits the three plans should offer.

OTHER CONSIDERATIONS

1. The size of Alaska, and the distribution of its population over so large an area, create some problems, but they can be dealt with. Costs of the program will be higher, and communications (including the enrolling of individuals and payment of claims) will take somewhat longer than would be the case with Minnesota or Connecticut.

2. Because, unlike Connecticut and Minnesota, Alaska does not have within its boundaries the home office of a large insurer capable of administering the program, the Committee should investigate the practicality of having the program administered from outside the State, and the availability of insurers willing to participate as administrator and as board members of the Association.

3. The small size of the anticipated enrollment in the program does not obviate the need for a pool. It does, however, make it impractical to have more than one pool, even at the beginning of the program. The two pools under the present Connecticut law is somewhat of an historical accident, and isnot practical in the long run even with the larger enrollment in that State. The National Blue Cross-Blue Shield organization dropped its insistence on a separate pool about two years ago, and we think it is unlikely that another State will take a two pool approach.

Section 1 of the proposed amendment should be revised throughout to provide for one pool, all "health" insurers should be required to participate in it.

4. Section 1 of the proposed amendment should be amended to exempt the Association, and business written directly by insurers but reinsured in the Association, from the premium tax. This will help alleviate somewhat the higher premiums that Alaska residents will have to pay for the coverage (because of higher costs in Alaska) thus encouraging more people to participate in the plan. It will solve the problem of dealing with the premium tax differential between domestic and foreign insurance companies and service plans, and with the different manner in which the tax is computed for Blue Cross-Blue Shield business.

Because the program is certain to produce losses which the State will pay for (i.e., claims and other costs will exceed premiums), the State will wind up paying its own premium tax on this business anyway, so the premium tax exemption we suggest should not result in additional costs to the State.

5. Departures from the Connecticut law, other than those already mentioned, should be individually considered and, where appropriate, their effects on costs should be determined. Some examples are: applying the medical social services benefit to claims not involving terminal illness (proposed AS Sec. 21.50.020(a)(7); addition of a coverage for transportation other than local ambulance transportation (proposed AS Sec. 21.50.020(c)(3), omission of a coordination of benefits provision from group comprehensive plans (Conn. Ins. Law Sec. 38-374(c)); addition of household members other than spouse or child to persons who are to be covered as dependents (proposed AS Sec. 21.50.030 and .200) limiting the rate to be charged for coverage to 125% of small group rates, while Connecticut permits 125% (compare proposed AS Sec. 21.50.050(e)(4) with Connecticut insurance law Sec. 38-376(c)(3)).

6. A number of drafting corrections should be made. Examples: requiring all dependents to be covered under a group comprehensive plan, instead of just making them eligible for coverage (proposed AS Sec. 21.50.030(a)); clarying the fact that insurers may also offer other group and individual comprehensive health insurance plans to cover Alaska residents; rewriting Section 5 of the proposed substitute bill so that it clearly does not apply to plans other than the State employees' plan.

CONCLUSIONS

The proposed committee substitute bill is not, particularly as to the provisions of Section 1, ready for final action by the Committee. An actuarial study should be made to determine costs and feasibility of the program for Alaska. After such a study, the Committee will have more of the information needed to decide whether to adopt such a program and, if so, what provisions should be included in it.

Charles D. Kuhnen
Counsel

/erc

HCS CSSS SB 227 REVISED 5/16/80

BILL SUMMARY

The basic concept of the first section of the bill is to establish a carrier reinsurance pool which would make health insurance available at a reasonable premium to every resident and every employer group in the state, regardless of underwriting risk. This section is modeled after Connecticut law.

AS21.50.010 Each carrier in the state which offers individual health coverage is required to make an individual comprehensive health care plan available to each resident of the state who is not eligible for Medicare. Each carrier in the state which offers group health coverage is required to make a group comprehensive health care plan available to every resident employer of three or more employees. Every self-insured employer group is required to make an individual comprehensive health care plan available as a conversion privilege to each group member. The required coverage may be provided by a carrier or through the reinsurance association, but in the former case the premium charged may not exceed the applicable association premium. The bill does not preclude a carrier from carrying other kinds of health insurance nor does it require a carrier to provide coverage to a person or group who already has coverage.

AS21.50.020 The required comprehensive health plans must cover the services itemized. A choice of $100, $500, or $1000

deductible is provided, and the maximum co-payment is set at 20%. The sum of co-payment and deductibles may not exceed $1000 for an individual or $2000 for a family before benefits are paid at 100%. The maximum lifetime benefits limit may not be less than $1,000,000. Pre-existing conditions may only be excluded if the condition was treated or medical advice was sought within six months prior to the effective date of coverage, but in any case may not be excluded from coverage for more than twelve months. The plans need not cover occupational injuries, cosmetic treatment, custodial care, services which are not medically necessary services which are covered under an automobile liability policy, or other specified expenses. Group comprehensive health care palns must also cover dependents.

AS21.50.030 The Health Reinsurance Association is established consisting of all licensed health insurance carriers in the state. The board of governors and a plan of operation which addresses itemized issues are both subject to approval by the director. The authority to issue health insurance, to establish rates, to administer reinsurance, to pool risks, and other general powers are granted the association.

Each association member must designate the classes of risk which it elects to have written by or reinsured by the association. Individual lives may not be selected out of a group for reinsurance. Premium rates may not be excessive, inadequate, or unfairly discriminatory, nor may they exceed 125% of rates for standard risk groups. All rates are promulgated through the association by an actuarial committee.

Losses of the association are assessed to members. Members in turn may credit the assessed claims losses, but not assessed administrative losses, against their premium or income tax. If the assessment exceeds their tax liability, the Commissioner of Revenue reimburses the carrier for the excess loss. Periodic audits are required.

AS21.50.040 Hospital or medical service corporations (such as Blue Cross) are given the option of participating in the Health Reinsurance Association or of setting up their own parallel residual market association under the same guidelines and standards.

AS21.50.050 The regulatory and oversight powers and administrative duties of the director of insurance are enumerated.

AS21.50.200. Definitions.

Sections 2 and 3 are technical amendments to other chapters of the insurance code to bring them in conformity with Section 1.

Sections 4 through 7 of the bill amending AS39.30 comprise the original SSSSB 227 and require group health insurance to include coverage for alcoholism and drug dependence. Minimum benefits in the state employees plan are defined to include inpatient detoxification, inpatient treatment and outpatient treatment. Coverage may not exclude dependents or pre-existing alcoholism conditions.

Section 8 of the bill amending AS47.05 requires the Commissioner of Health and Social Services to provide services under medical assistance programs through health insurance policies or health service contracts when this would be cost effective. In a separate section the department is authorized to make interim payments to providers who serve a large volume of state medical assistance clients. And finally, the bill requires the state to pay interest to providers on overdue medical assistance bills at the rate of one percent per month after 30 days, and two percent per month after 90 days.

Section 9 and 10 expand the state's Medicaid program to include all services qualifying for federal financial participation.

Section 11 creates a medically needy program under the state General Relief program with an income standard at 150% of the poverty guideline. Persons whose income exceeds the standard become eligible when they spend their excess income on medical bills.

CURRENT STATUTE

Chapter 07. Medical Assistance for Needy Persons.

Section
10. Purpose
20. Eligible persons
30. Medical services to be provided
40. State plan for provision of medical assistance
50. Implementation of the medical assistance program
60. Receipt of federal money
70. Reimbursement for cost settled providers
80. Definitions

Sec. 47.07.010. Purpose. It is declared as a matter of public concern that the needy persons of this state receive uniform and high quality medical care, regardless of race, age, national origin, or economic standing. Accordingly, this chapter authorizes the Department of Health and Social Services to apply for participation in the national medical assistance program as provided for under title XIX of the federal Social Security Act. (§ 1 ch 182 SLA 1972)

Sec. 47.07.020. Eligible persons. (a) All residents of the state for whom the Social Security Act requires medicaid coverage are eligible to receive medical assistance under title XIX of that Act (42 U.S.C. 1396 et seq.).

(b) In addition to the persons specified in (a) of this section, the following optional groups of persons for whom the state may claim federal financial participation are eligible for medical assistance:

(1) persons eligible for but not receiving assistance under any plan of the state approved under part A of title IV (aid to families with dependent children), or title XVI (supplemental security income), of the Social Security Act;

(2) persons in a general hospital, skilled nursing facility or intermediate care facility, who, if they left the facility, would be eligible for assistance under one of the federal programs specified in (1) of this subsection;

(3) persons under 21 years of age under supervision of the department for whom maintenance is being paid in whole or in part from public funds and who are in foster homes or private child-care institutions; and

(4) aged, blind, or disabled persons, who, because they do not meet income and resources requirements, do not receive supplemental security income under title XVI of the Social Security Act, and who do not receive a mandatory state supplement, but who are eligible, or would be eligible if they were not in a general hospital or skilled nursing facility or intermediate care facility to receive an optional state supplementary payment;

(5) persons under 21 years of age in an institution designated as an intermediate care facility for the mentally retarded who are financially eligible as determined by the standards of the Federal Aid to Families with Dependent Children program;

House CS for CSSSSB227 (HESS) Revisions

* Sec. 7. AS 47.07.020(b) is repealed and re-enacted to read:

(b) Residents of the state for whom the Social Security Act allows optional medical coverage qualifying for federal financial participation are eligible for medical assistance.

(6) persons in a medical or intermediate care facility whose income while in the facility does not exceed 300 per cent of the supplemental security income benefit rate under title XVI of the Social Security Act but who would not be eligible for an optional state supplementary payment if they left the hospital or other facility.

(7) persons under 21 years of age receiving active treatment in a psychiatric hospital who are financially eligible as determined by the standards of part A of title IV (aid to families with dependent children) of the Social Security Act.

(c) Receipt of medical assistance under this chapter is considered to be an additional benefit to these individuals and does not affect other assistance payments, federal or state, for which the recipient is eligible.

(d) No additional groups may be added unless approved by the legislature. (§ 1 ch 182 SLA 1972; am § 1 ch 105 SLA 1974; am § 1 ch 117 SLA 1975; am § 1 ch 221 SLA 1976; am § 1 ch 11 SLA 1978)

Effect of amendments. — The 1975 amendment added paragraph (5) of subsection (b).

The 1976 amendment added paragraph (6) of subsection (b).

The 1978 amendment added paragraph (7) of subsection (b).

Legislative history reports. — For report on ch. 182, SLA 1972 (FCCS HCS CSSB 56), see 1972 House Journal, p. 1684. For report on ch. 105, SLA 1974 (CSSB 465), see 1974 Senate Journal, p. 525 and 1974 House Journal, p. 763.

Sec. 47.07.030. Medical services to be provided. Medical services to be offered to eligible persons include inpatient hospital, outpatient hospital, rural health clinic, outpatient surgical care centers, laboratory and X-ray, refractions and eye examinations by ophthalmologists or optometrists, eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist, inpatient psychiatric hospital for persons age 65 or older and persons under age 21, skilled and intermediate nursing home, physician, home health care services, early periodic screening diagnosis and treatment of persons under 21 years of age, clinic services, treatment of speech, hearing and language disorders, and reasonable transportation to and from the point of medical care. No additional services may be provided unless approved by the legislature. (§ 1 ch 182 SLA 1972; am § 1 ch 35 SLA 1973; am § 2 ch 105 SLA 1974; am § 1 ch 12 SLA 1976; am § 2 ch 221 SLA 1976; am § 1 ch 82 SLA 1978)

* Sec. 10. AS 47.07.020(d) is repealed.

* Sec. 8. AS 47.07.030 is repealed and re-enacted to read:

Sec. 47.07.030. MEDICAL SERVICES TO BE PROVIDED. Medical services to be offered to eligible persons include services eligible for federal financial participation under Title XIX of the federal Social Services Act.

Blue Cross
of Washington and Alaska

15700 Dayton Avenue North/P.O Box 327
Seattle Washington 98111
206/361-3000

May 7, 1980

Representative Thelma Buchholdt, Chairman
Health, Education & Social Services Committee
House of Representatives
Pouch V
Juneau, Alaska 99811

Dear Representative Buchholdt:

As I understand the House Committee substitute for the committee substitute for sponsor substitute for S.B. 227, the intent of this bill is to require an insurer or hospital/medical service corporation to make available in Alaska a health care plan with the comprehensive benefits outlined in this bill. An insurer would, however, be able to offer other contracts having different benefits to meet the requested coverages desired by employers and individuals in this state. This bill in no way mandates minimum coverages for all health care contracts.

In Section 21.50.020, I have several comments to make concerning some of the minimum benefits. Subsection (a)(3) concerns outpatient mental health benefits. I would hope that a maximum benefit level would be specified and that a maximum benefit would be described in this law for inpatient treatment for mental health as well. Both limits are needed to curb excessive utilization and high costs for the coverage.

Subsection (a)(6) includes home health benefits in the minimum benefits. In (6)(A) the number of visits per year is too high when you consider the limited availability of home health care in Alaska. A subscriber will be paying for a benefit which is usually not available in this state. Paragraph (6)(B) extends home health care to the terminally ill. This is usually defined as hospice services and is normally combined with the medical social services mentioned in (7). Hospice services are not available in Alaska to the best of my knowledge. This will add premium cost for services which may not be attainable.

Subsection (a)(7) adds medical social services, which are defined as being available to the patient or to his/her family. This creates a totally new category of care which may or may not be medically necessary. It is a benefit which is usually a part of home health care for the terminally ill. As a separate benefit it can be abused and can create unnecessary utilization. This benefit should be deleted.

Representative Thelma Buchholdt, Chairman May 7, 1980

Subsection (a)(16) needs to be combined with subsection (c)(3) in order to detail a benefit for medically necessary transportation which requires pre-authorization for travel and other safeguards to eliminate abuse of this benefit. I would suggest that the contract language in your benefit booklet for coverage of state employees might serve as a model. (See enclosed booklet, pages 10-12.) The existing language would seem to approve payment of air ambulance rather than payment of commercial airline transportation.

Subsection (a)(17) must be deleted. This section allows changes in benefits which can adversely affect contracts in effect when these benefits are added. It is not necessary to the bill.

The minimum benefits section does not mention pregnancy benefits. While P.L. 95-555 controls the pregnancy benefits for groups of more than 15 employees, it does not govern smaller work forces or individual contracts. Our particular concern is in individual contracts since our experience shows that these contracts are usually purchased by persons past the age of childbirth and complete coverage of pregnancy like any other illness creates an increased premium for an unusable benefit.

On page 6, subsection (b)(5)(A) speaks of exclusion for a pre-existing condition which "first manifests itself within a period of six months immediately before the effective date of coverage." While I understand the reason for this language and approve of the intent, in actuality this creates endless hassle about what is a first manifestation and whether a person prudently sought care. It makes administration difficult. I suggest you should change the language to a limitation similar to that applying to coverage for state employees. (See enclosed booklet, page 7.)

In Section 21.50.030 the state requires that a person leaving a group will have a continuation of that same coverage for 39 weeks. That will negate the ability of an insurer to set minimum group sizes and to eliminate coverage for a group which gets to be too small. With nine months continuation, you negate the factor of size in small group business.

More important, the experience of the person on continuation coverage will have to be applied to the original group. If, for instance, John Smith quits work because his wife, a covered dependent, suffers a stroke, the claims paid for Mr. and Mrs. John Smith during the continuation coverage will be credited to Mr. Smith's previous employer. That experience will affect the rates which will be charged upon renewal of the group contract. Mr. Smith is no longer an employee, but the company incurs higher cost because of his medical bills and, in theory, subsidizes the continuation program. That is a cost that should <u>not</u> be borne by business, but with continuation coverage it <u>is</u> borne by each employer.

Representative Thelma Buchholdt, Chairman May 7, 1980

The logistics of self-payments for continuation coverage from the terminated employee to the company and then to the insurer will also impact the administrative workload of the employer. Direct pay to the insurer cannot be handled because of the many different benefit plans which would be involved. Continuation coverage will be a big burden on businesses and an additional cost to them.

This bill specifies that all conversion insurance have the minimum comprehensive benefits outlined in this bill. That level of benefits is too extensive. It will intensify the adverse selection because only someone with a medical problem will purchase the conversion policy. The cost will be excessive and the healthy will "go bare" rather than pay a high premium.

In Sections 21.50.050 and 21.50.060 this bill recognizes the differences between commercial insurers and hospital/medical service corporations by providing an option for the latter in lieu of membership in the Health Reinsurance Association. The differences between for-profit and not-for-profit entities and the different methods used in claims payment, contractual agreements, and service to subscribers makes lumping the Blues and commercial insurers together unwise. This bill separates them while assuring that each provides his share of coverage to the poor risk market. This is a good feature of this piece of legislation.

However, in subsection (m) of Section 21.50.050 you allow a tax offset for those insurers who join the Health Reinsurance Association. The bill needs to be amended to add that offset in Section 21.50.060 (b) and (c) or the offset, of and in itself, destroys the viability of the option features of this bill.

Section 3 of this bill is the original committee's substitute for Senate Bill 227. The features of that alcoholism and drug dependence coverage differ from coverage provided under the minimum benefits for alcoholism and drug dependence. That difference may need to be resolved.

This bill will create additional requirements for insurers and for medical/hospital service corporations doing business in the state of Alaska. These requirements will increase costs.

This bill makes health care insurance available to any Alaskan. That insurance may not be affordable. The minimum benefits, patterned after Connecticut law, may be readily available in that state. Some of those benefits are not easily available in Alaska and the cost for them may be prohibitive. This bill could offer Alaskans a promise of help and, in reality, afford them no relief at all.

Sincerely,

Joan H. Gaumer, Director
Government Relations

JHG:eb
5B-10/11/12

Enclosure: State of Alaska Group Health Care & Life Insurance Benefits (dated July 1, 1979)

cc: Wes Coyner

January 9, 1980

Thelma Buchholdt
Pouch V
Juneau, Alaska 99811

Dear Thelma:

The following is an assessment of possible legislation in the area of state-subsidized health insurance. Two alternatives are discussed: the first calls for universal and comprehensive coverage, the second provides for a substantial improvement in health care services, but is not a comprehensive program. I would like to emphasize at the outset that the work done on this subject was done purely on my own time and does not, in any way, represent the opinions of the Alaska Public Interest Research Group.

Some form of state-subsidy in the area of health insurance has become necessary, in large part due to a nationwide problem with the availability of health care services. As medical costs spiral ever-upwards, more and more individuals are unable to procure adequate medical care. In Alaska, the problem is magnified by a limited number of physicians and substantially higher medical costs. In addition, numerous difficulties with Alaska's Medicaid system have limited the availability of health care even to those persons qualifying for state medical assistance.

Although various forms of government-subsidized health insurance have been proposed on a national level, cost considerations and intensive lobbying against such insurance by the medical and insurance communities have served to delay adoption of a national insurance plan. Subsidized health insurance on a state level was first proposed by you in 1977, however, at that time it was felt that the costs involved were prohibitive.

Since 1977, state oil revenues have accumulated in the treasury to the extent that the State of Alaska currently has a large amount of surplus revenue. Since the primary reason in the past for not funding some type of health insurance has been cost, and the state currently possesses the moneys to fund such a program, the time is now ripe to correct some of the glaring deficiencies in the area of health care.

The first approach to a solution of this problem involves universal and comprehensive state-subsidized health insurance. Adopting such coverage would be the most equitable manner of making health services available to Alaska's residents. However, this program would be extremely expensive (probably upwards of $100 million), and could probably expect to meet with a great deal of resistance. The resistance would come not only from the extremely well-organized medical and insurance lobbies, but also from opponents of increased government services and proponents of income tax repeal. I doubt whether it is feasible to get a program of this type approved, however, you are much more aware of the political climate than am I.

The second approach, therefore, is a piecemeal solution to the health care problem. It addresses specific problems which exist in the area of health care services. It combines minimum standard benefits requirements, insurance availability to Medicaid-medically needy qualified individuals, mandatory employer sponsored coverage, and reinsurance pools.

Minimum standard benefits: There is no regulation of the levels of service covered by providers of health insurance in Alaska. Many policies are not adequate to protect those covered from financial hardship. Individuals purchasing insurance outside of a "group policy" are subject to broad exclusions for pre-existing conditions, even though such a condition may have occured twenty years in the past (e.g. a previous back injury will give rise to an exclusion for any disease, defect or injury to the back even if totally unrelated). Many policies limit reimbursements to "reasonable charges" as defined by the insurance company, regardless of actual charges and the policy holder must pay the difference. This is especially a problem in Alaska where the "reasonable charge" determination is made in insurance company headquarters located outside the state.

In response to such problems, several states have adopted minimum standard benefits for health care plans. (see enclosed legislation). In addition, the National Association of Insurance Commissioners (NAIC) has developed model state health insurance legislation for minimum standard benefits (see 13 FORUM 680 (1978)). The standards set out the minimum acceptable level of service for health insurace policies in effect in the state.

Alaska should adopt minimum standard benefits requirements.

Insurance for Medicaid/medically needy: The Medicaid problem, in particular, must be addressed this session. Doctors are unhappy with the state's Medicaid program because they are not being paid. Recipients of state medical assistance are unhappy with the state's Medicaid program because doctors will not treat them because the doctors are not being paid. Both groups are clamoring for reform.

As an alternative to medical assistnace by direct payments to providers, the state of Oregon has adopted a program (see enclosed legislation), where medical assistance funds are used to pay health insurance premiums. Thus, the state provides health insurance for defined groups of people ~~(and [redacted] the marginally employed)~~ who have no practical access to private health care coverage.

At the same time, the state should opt in to the federal "medically needy" Medicaid program. This program would extend state medical assistance to those persons whose income exceeds the income standards of current assistance programs, but who have incurred medical expenses which equal or exceed the difference between the person's monthly income and the income standard applicable under the current program. In other words, the state would provide medical assistance to persons who otherwise would not have been eligible because they make too much money. The purpose of the "medically needy" program is to allow lower-middle-income person who can not afford to shoulder the full cost of medical care the opportunity to receive needed medical assistance. Under such a program, these individuals would "spend down" to the income limits, and the state would pick up the rest. This proposal is divisible from the rest of the insurance program discussed here and should be adopted even if no other aspect of my suggestions is appropriate for legislative action.

Alaska should utilize Medicaid funds to make health insurance available to qualified individuals:

Mandatory employer coverage: Hawaii has pioneered the area of requiring certain employers to carry health insurance on all employees. The specifics of their legislation are contained in Sharman Haley's report "Third Party Health Coverage in Alaska" and I therefore will not discuss the details here. Mandating employer sponsored coverage will dose a large gap in Alaskan health care, will not involve a great deal of expense on the part of the state and will not substantially increase state bureaucracy.

Alaska should require employers to provide health insurance meeting minimum standard benefits to employees.

Reinsurance pools: At the present time in Alaska, high-risk individuals can not purchase health insurance at any price. To combat this problem and also to protect insurance companies from having to bear too great a burden in insuring such individuals, several states have developed mandatory reinsurance pools to ensure health care coverage for high-risk persons. (see enclosed legislation). This is a relatively inexpensive program to implement.

Alaska should require insurance companies to form reinsurance pools to protect high-risk individuals.

By combining the above four programs, the state would ensure that some form of health insurance is available to nearly all Alaskan citizens. The only persons left substantially unprotected are the self-employed. Although a provision could be made whereby these people could have optional health insurance with a state subsidy, this type of program would be extremely expensive. Self-employed and self-insured persons benefit from the above described program through the minimum standard benefits requirement.

I hope my review of this issue has been of some use to you, it certainly has been of great interest to me. If there is anything further I can do, please let me know (preferably after February 28 and the traumas of the bar exam are over).

Enjoy the session!

Sincerely,

Laurie Otto

SUMMARY OF 1976 COMPREHENSIVE HEALTH INSURANCE ACT
Chapter 296, Minnesota Laws of 1976
Amended by Chapter 409, Minnesota Laws of 1977

Objectives

The 1976 law consists of three articles: Article I (a) establishes minimal standards for health insurance policies and (b) creates the Comprehensive Health Association which administers a "state insurance pool" for persons who are unable to buy insurance because of existing health problems. The objective of this article is to upgrade health insurance policies and to increase the availability of health insurance.

Article II establishes a hospital rate review system. This provision requires licensed hospitals to be subject to rate review by an approved voluntary, peer review organization. The Department of Health is authorized to "publicly review and comment" on the rates charged by hospitals. The objective of this article is to reduce rates charged by hospitals by monitoring those charges via a rate review system.

Article III provides financial assistance to persons who incur high medical expenses. The Catastrophic Health Expense Program is designed to protect households from being bankrupted by medical care expenses.

Summary

Article I - Minnesota Comprehensive Health Insurance Act of 1976

Part A - Minimum benefits for health insurance coverage

Duties of Insurance Companies

All health insurers doing business in the State of Minnesota are required to offer a "qualified" health policy to applicants for insurance. The article defines three levels of "qualified" plans--number one (low), number two (standard), and number three (high). The minimum benefits of a number three plan "shall be equal to at least 80 percent of the cost of covered services in excess of an annual deductible which does not exceed $150." The coverage shall also include a limitation of $3000 per person on total annual out-of-pocket expenses for covered services. The maximum lifetime benefit cannot be less than $250,000. The article also itemizes the services to be covered by the "qualified" plan. The three levels of "qualified" plans vary only in the amount of deductible required: number three - $150; number two - $500; and number one - $1000. A health maintenance plan is defined as a number three qualified plan. Insurers are not prohibited from developing and selling an "unqualified" plan, however, the insurance companies must "affirmatively" offer coverage for major medical expenses to an applicant for a new "unqualified" plan. This major medical coverage shall be payable, subject to any copayment, up to a maximum lifetime limit of $250,000 for out-of-pocket expenses incurred within a calendar year, exceeding $5000.

Any insurance company issuing a Medicare supplement plan shall offer a "qualified" Medicare supplement plan to each eligible applicant. A plan is deemed "qualified" if it provides coverage of 50 percent of the deductible and copayment required under Medicare and 80 percent of the charges for "qualified plan" covered services which are not paid by Medicare. This plan includes a $1000 per person limit on annual out-of-pocket expenses.

* Note: As of July 1, 1979, covered services must include a second opinion on surgical procedures expected to cost a total of $500 or more.

Duties of Employers

Each employer who makes available to his employees a health insurance plan must offer at least a number two plan. The employer does not necessarily have to finance the qualified plan. It can be financed from funds contributed solely by the employer or solely by the employees; or a combination thereof. For the purposes of this article, an employer is defined as employing ten or more residents of the state. The employer may supplement the existing health plan in order to meet the number two plan requirement.

The penalty for noncompliance is the exclusion of the employer's costs for health benefits as a state income deduction. A non-profit employer would lose its tax exempt status if the requirement is not met.

Any employer with 100 or more employees must offer a dual option to obtain either an accident and health insurance policy or a health maintenance organization contract, if one is available.

Conversion Privileges

The law requires group accident and health insurance policies and health maintenance organization contracts to include the right to convert to an individual coverage "qualified" plan without the addition of underwriting restrictions. The person leaving the group has 30 days in which to exercise his right to convert.

Each health insurance plan must also include a provision allowing, upon the death of an insurance holder, other individuals covered under the plan to continue coverage.

Part B - Comprehensive Health Insurance Plan

Article I also creates the Comprehensive Health Association which must offer policies which provide the benefits of a number one qualified plan, a number two qualified plan, and a qualified Medicare supplement plan to individuals who cannot otherwise obtain standard insurance coverage becuase of health problems. The Association is comprised of all insurers, self insurers, fraternals, and health maintenance organizations doing business in Minnesota. These policies are referred to as the Comprehensive Health Insurance Plan or State Plan.

Comprehensive Health Insurance Plan

The Comprehensive Health Association is responsible for selecting a writing carrier to administer the Comprehensive Health Insurance Plan. The Association may select separate writing carriers for each type of "qualified" plan.

The state plan is open for enrollment at all times. An eligible person may apply to the Association or to the writing carrier. For the first 18 months of the plan's operation, premiums were determined by averaging the premium rates charged by the five largest insurers in each plan category. Subsequent premium determination will be based on actuarial experience. Not more than 12.5% of the premiums may be expended by the writing carrier for administration costs.

Each member of the Association is responsible for sharing the losses due to claim expenses of the state plan. Members shall share those costs on a pro-rated basis, determined as a ratio of premiums received by a member to the total amount of total premiums received by the Association members.

If there are any net gains from the operation of the state plan, it shall be used to offset future losses or reduce premiums.

Public Education

The Association is responsible for disseminating information to the public regarding the availability of the state plan.

Referral Fee

The writing carrier shall pay an agent's referral fee of $25 to each agent who refers an applicant to the state plan. This fee is included in the 12.5% administration expense limit.

Pre-Existing Condition Clause

An enrollee of the state plan is not covered for any pre-existing condition during the first six months of coverage if the condition was diagnosed or treated within 90 days prior to the filing of an application.

Reinsurance

A member of the Association may elect to reinsure the risks involved with being required to offer (a) individual qualified plans, (b) group conversions, (c) group qualified plans with fewer than 50 members, or (d) major medical coverage. The member would be reinsured through the Association. The Association administers the policies that are reinsured by a member. Any income in excess of the costs incurred for providing the reinsurance service shall be used to offset losses in the state plan or reduce the premiums.

Article II - Hospital Administration Act

Article II establishes a system by which hospital rates are reviewed. A licensed hospital may agree to submit its financial reports and rate schedules to a voluntary, non-profit rate review organization

for review. If the hospital does not report to this rate review organization, it will be subject to review by the Department of Health, the administrative agency for this act.

The Department of Health shall prescribe standards for purposes of approving a rate review organization. The Department is authorized to collect financial information which includes (a) a balance sheet, (b) a statement of income and expenses, (c) a copy of the most recent Medicare cost report, and (d) a schedule of rates. The Department also has the right to inspect hospital records and audits. Any modifications to a hospital's rate schedule must be reported to the Department of Health 60 days in advance of their effective date. If a hospital is subject to review by the Department of Health, the Department may conduct a public hearing on any rate increases which they consider excessive and may publicly comment on any increase.

Insurance Rates

This article also requires actuarial justification of any premium increase for a nongroup policy at the time of filing the insurance plan with the Commissioner of Insurance.

Another provision directs the Commissioner of Insurance to disapprove a filed health plan "if the proposed premium rate is excessive because the insurer has failed to exercise reasonable cost control."

Article III - Catastrophic Health Expense Protection Act

This program offers financial relief to households which incur large medical expenses. The state will pay for 90% of "qualified" expenses, for which no third party is liable, in excess of a threshold figure which is calculated by an income-related formula. "Qualified" expenses are those charges for covered services itemized as minimum benefits in the Comprehensive Health Insurance Act (Article I).

The above mentioned formula is as follows: (a) calculate 40% of household income up to $15,000, plus 50% of household income up to $25,000, plus 60% of household income in excess of $25,000; or, (b) $2,500, whichever is greater. If, for example, the household income is $10,000 the threshold figure is $4000. In this case the state would pay 90% of "qualified" expenses in excess of $4000.

Nursing Home Provision

The 1977 Legislature amended the Catastrophic Act to provide assistance to persons under the age of 65 who have resided in a nursing home for more than three years. The state will pay for all nursing home expenses which exceed 20% of household income.

Reasonableness of Rates

The Commissioner of Public Welfare is granted the authority to determine the reasonableness of provider charges. The Commissioner may also determine the "medical necessity" of a health service. In order to carry out that authority, the Commissioner may contract with a professional standard review organization to make these determinations.

Experience

Article I - Comprehensive Health Insurance Plan

The state plan went into effect on January 1, 1977. As of June 30, 1978, the plan had 1,074 policies in force. The total premiums earned for the first 18 months of the plan's operation was $441,107.73. As indicated earlier, the premium rate for this time period was based on the average of premiums charged by the five largest insurers in each category. The total claims paid for this period is $392,412.93. A reserve for incurred but not reported claims has been set at $220,000.

The 1978 State Legislature appropriated $200,000 to reimburse the Comprehensive Health Association for the first $200,000 of claims expenses incurred after June 30, 1978 which are in excess of earned premiums. The premium will be determined by generally accepted actuarial principles subsequent to June 30, 1978 except that the new premium rate cannot exceed 125% of the average premium charged by the five largest insurers in each policy category. This premium limit was enacted by the 1978 Legislature.

Article II - Hospital Administration Act

All licensed hospitals have opted to be subject to review by a voluntary, non-profit rate review organization. This is the peer review organization of the Minnesota Hospital Association. It is estimated that if the hospitals comply to the proposed budgets developed through rate review the increase in hospital charges will be between 10% to 11% compared to an historical increase of nearly 14% per year.

Article III - Catastrophic Health Expense Protection Act

This Article went into effect July 1, 1977. Eighteen million dollars was appropriated for the biennium 1978-1979 for the medical care portion of the program. $900,000 was appropriated for the nursing home section. To date there have been 148 approved applications for the medical care program for an expenditure of $441,299. For fiscal year 1978, twelve applications were approved for the nursing home expense program, totaling $55,323.65.

Georgetown University Health Policy Center
Seminar on State Health Insurance Plans
Mayflower Hotel, Washington, D.C.

September, 1977

THE POLITICAL PLANNING OF A STATE HEALTH INSURANCE PROGRAM

By Senator Donald D. H. Ching
Majority Leader
Hawaii State Senate

The concept of prepaid health care based on mandatory employment-related coverage was a brand new idea when first introduced in the Hawaii Legislature in 1971. It became law three years later as Act 210 of the 1974 legislative session.

Enactment of our Prepaid Health Care Law climaxed several years of lively discussion in the Legislature, and for many of us who supported it, Act 210 marked yet another milestone in the growing body of progressive legislation placed in our statutes since our Islands became a sovereign state in 1959.

Measured against the national background, the law represented a significant achievement in terms of social progress. Yet, while there was much discussion between introduction and enactment, the proposal was not widely viewed as politically controversial by the public at large. As a matter of fact, in my nearly 20 years of experience in our Legislature, I have seen a lot more heat generated over issues of considerably lesser public import.

To be sure, there was resistance and opposition from the traditional opponents of so-called "social legislation." But there was not the hue and cry that one might expect, considering the novelty of the concept.

This is not to say that the spectrum of political thought in Hawaii does not cover any ground to the right of center. Let me assure you we do have traditional conservative views held by many in our State, and I, for one, believe this is a healthy condition. But to the credit of those who did not adhere to the concept, their opposition was not based on the emotionalism that too often attends and distorts vital public issues of the day.

I believe the law was generally accepted by the public because of the kind of political climate we have in Hawaii and because the law was viewed as a logical extension of the kinds of programs that were already in effect at the time.

Let me briefly describe our Prepaid Health Care Law, then attempt to present an account of its chronological place in the context of Hawaii's legislative history.

The Act requires virtually every employer in the State to provide regular employees a health insurance program and to contribute at least one-half the premium cost for the employees' coverage. The major categories of employees excluded are insurance and real estate salesmen paid entirely by commissions and individuals under 21 working under a parental relationship.

The employee's contribution is limited to no more than 1.5 per cent of his monthly salary. A "regular" employee is defined as one who works at least 20 hours a week, excepting seasonal hires in Hawaii's pineapple industry.

Health plans negotiated under collective bargaining agreements are exempt because such negotiated benefits are, for the most part, more liberal in coverage or employer contributions than required under the Act.

An employer can elect to provide a plan which obligates the insurer to either reimburse the expenses of health care or to directly furnish the required health care benefits. The level of benefits provided must be equal to or medically reasonably substitutable for those benefits provided by prepaid health care plans of each type -- direct or reimbursed -- which has the largest number of subscribers in the State. In Hawaii, the standards are thus based on the Kaiser Health Foundation's Plan I, in the case of direct services, and the Hawaii Medical Service Association's (Blue Shield) Plan IV, in the case of reimbursed expenses. Both the Kaiser and HMSA plans are basic, comprehensive medical plans emphasizing ambulatory care.

Plans offered by other insurers may be provided, upon review and approval of a seven-member advisory council comprised of consumer, employer, medical profession, and health plan representatives.

What kind of coverage is required by our law? Every qualifying plan must include the following:

-- 120 days of hospital benefits, plus outpatient services.

-- surgical benefits, including anesthesiologist services.

-- medical services, including home, office, hospital visits, and intensive medical care.

-- laboratory, x-ray, and radio-therapeutic services necessary for diagnosis and treatment.

-- maternity benefits, provided an employee has been covered for nine months prior to childbirth.

-- and, under an amendment added last year, substance abuse benefits for alcoholism and drug addiction, including outpatient services and detoxification and acute care benefits.

The foregoing summarizes the basic provisions of our law.

How, then, did we come to enact what some may view as an extremely liberal mandatory health insurance program?

First, it should be noted that we have a substantial body of progressive and advanced social legislation in Hawaii. This is true of our labor laws, our educational system, our public welfare program, and in our judicial system. For instance, our minimum wage law, wage and hour law, workers' compensation, temporary disability insurance, and unemployment insurance programs all have standards comparable to the highest in the Nation. In addition, we also have a public defender program and a criminal injuries compensation law. We also have a no-fault insurance law and a medical malpractice law, the latter amended this year to remove the mandatory feature and to permit doctors the option of forming cooperative indemnity plans to protect themselves against liability judgments.

Our public assistance program is so liberal it is causing us severe financial strains -- but that's another story, and I won't digress into it, except to note that we eagerly look forward to federal reform initiatives promised by the Carter Administration.

The political foundation for eventual enactment of our prepaid health care law was further set during the mid-sixties in a program popularly labeled "The New Hawaii," adopted jointly by the legislative majorities and the Administration.

During this period, dramatic changes were advanced in terms of Hawaii's social, economic, and political conditions. Basically, the stated objective was to enact laws and programs to insure equal treatment and equal opportunities for all citizens. If this sounds simplistic, it should be borne in mind that Hawaii was pretty much the political domain of the sugar and pineapple plantation interests up until the end of World War II and that when, for the first time in our history, we elected a Democratic Governor and Democratic majorities in both houses of the State Legislature in 1962, there were not a few who thought the revolution was at hand.

But the changes we sought were achieved in orderly, not revolutionary, fashion. And there was early ferment for novel and innovative legislation to extend equal opportunity in basic human concerns to all segments of our society.

It appeared logical to move toward some form of mandatory prepaid health care law. The question then was how best to extend coverage to the uninsured working men and women

of Hawaii and thereby provide them "equal treatment" as a matter of social equity. Moreover, how could this be best achieved without any substantial added costs to the State, bearing in mind that our centralized system imposes unusually heavy financial burdens on the State?

To determine cost factors and the numbers and classes of employees in the uncovered "gap group," a study was commissioned through the Legislative Reference Bureau, the Legislature's principal research arm. Dr. Stefan A. Riesenfeld, former University of California law professor and a widely recognized authority on social legislation, now counsel to the U.S. State Department, was selected to do the research. Professor Riesenfeld had prepared an earlier report for the Legislature on temporary disability insurance, which study was extremely valuable to us in enacting our TDI law in 1969.

The Riesenfeld report, published in 1971, was a thorough and comprehensive study. Acknowledging the difficulty of precisely quantifying need, the report generally concluded that, among the State's employed, 11.7 per cent did not have hospital coverage, 13.5 per cent lacked surgical coverage, and 17.2 per cent did not have regular medical insurance.

The existence of a significant number of otherwise uncovered potential beneficiaries of the proposed legislation formed the primary policy consideration of the program. Other factors considered included the rising costs of health care and the need to assue the most practical method of ensuring the financial availability of health care for Hawaii's working men and women. Thus, the overall health of our population was the over-riding concern; without ensuring the

ready accessibility of health care, how could optimum health care be maintained?

Data compiled and analyzed in the report were very thorough. Sources outside the State included the Health Insurance Association of America, the Health Insurance Institute, the Bureau of Labor Statistics, the Social Security Administration, and the Bureau of the Census. Information from State agencies included data from the State Statistician and the Departments of Taxation, Planning and Economic Development, Social Services and Housing, and Labor and Industrial Relations. Data was also gathered from labor unions, the Hawaii Employers Council, the HMSA, Kaiser Foundation, and through questionnaires mailed to all employers covered by the Hawaii Employment Security Law.

Data used included statistics relative to the following:

-- Population by age levels, civilian and military. The latter distinction was important because of the sizeable permanent military presence in Hawaii.

-- Labor force, public and private.

-- Population entited to Medicare.

-- Extent of prepaid health plan coverage for hospital, surgical, and medical benefits, both for subscribers and dependents.

-- Size and type of business of private employers.

-- Medical assistance recipients and expenditures.

As indicated by the sources of data, the full range of interest groups became involved in the process, whether employer or employee oriented.

During our legislative committee hearings, testimony was presented by representatives of the insurance industry, the health professions, the University of Hawaii Schools of Public Health and Social Work, the Comprehensive Health Planning Council, and a wide range of individual citizens.

There was very little question as to whether the plan proposed would be comprehensive or catastrophic in its approach. The Riesenfeld report recommended the comprehensive coverage plan and specifically recommended the adoption of prevailing coverages in the State, which then became the legal minimum. This reflected the health care habits and patterns of the State and set a floor without unduly disrupting the existing schedules of coverage.

The decision to make coverage mandatory was central to the legislation proposed. Before enactment of Act 210, voluntary participation was, in effect, the public policy of the State.

As to the question of affordability, the only new cost factors imposed upon the State weere founded upon the administrative requirements of the law and anticipated premium supplementation.

Administration of the new program proved to be quite easy, as it was smoothly meshed in as a responsibility of the Disability Compensation Division of the State's Department of Labor and Industrial Relations. Thus, three important employee benefits programs were placed under one umbrella: the well-established Worker's Compensation Law; the TDI law passed in 1969; and the 1974 Prepaid Health Care Act. (Incidentally,

you may have noticed that what used to be known as Workmen's Compensation is now referred to as Workers' Compensation in our State, reflecting the many similar amendments we have adopted consonant to our accepted policy on equal rights.)

Much to our pleasant surprise, the administrative expenses of Act 210 have been comparatively low. Initially, we authorized 11 new positions in the Disability Compensation Division, with an appropriation of $250,000 in General Funds to cover salaries and other expenses. Much to the division's credit, Act 210 was implemented with substantially the existing staff. The first appropriation thus lapsed, and it was renewed this year at the same annual level on the expectation that additional personnel will be recruited during the next biennium.

A feature of Act 210 is a provision for premium supplementation financed by the State to cover employer premium requirements caused by limits imposed on employee contributions. This feature subsidizing employer contributions was included to provide a cost protection for marginal small businesses. Initially, $375,000 was set aside in a trust fund for premium supplementation. Again, to our pleasant surprise, there has been little need to supplement premiums. It's estimated that, to date, only some $20,000 to $30,000 has been tapped from the trust fund in subsidies. Meanwhile, the fund is held in an interest-earning status.

What are the numbers that actually surfaced as a consequence of Act 210? The division reports that about 18,500 employers have thus far been registered. However, the extent

of newly covered workers has been difficult to establish because many of the registered employers had voluntary programs in effect before Act 210. Dr. Riesenfeld has estamated some 40,000 employees were not covered at the time he conducted his study. The Disability Compensation Division is of the opinion that actually more than 40,000 received new benefits becaus[illegible]e requirement that employers cover at least half [illegible]r the premium costs.

Of the 18,500 employers, all but some 1,000 have elected plans offered by the State's two major insurers -- HMSA and Kaiser. The approximately 1,000 employers who have opted for plans offered by other insurers are the major source of additional workload upon the division. Each submittal in this category must be reviewed by the advisory council.

The advisory council provision serves another purpose. During the course of legislative hearings on the act, public health advocates had expressed concern that the required benefits might be too rigid and unresponsive to changes in health care over the years. The Prepaid Health Care Advisory Council provisions were thus added to establish an appropriate agent to review medical equivalency of benefits.

To conclude, in light of Hawaii's experience, I believe any national health insurance plan should take into consideration the course that we have opted for. I am confident the standards we have set would meet any that a federal law would impose. As a means of encouraging other states to follow suit, or to adopt a true state plan such as Rhode Island's,

I suggest federal legislation provide support grants to at least cover administrative costs and any necessary premium supplementation expenses.

Finally, let me summarize the conditions that led to the successful adoption and implementation of Hawaii's Prepaid Health Care Act:

1 -- A political climate sympathetic to social needs.

2 -- Timeliness in terms of progressive improvements to the general body of social legislation already on the books.

3 -- A comprehensive study of a state's needs, to arm proponents with the information necessary to justify the proposed legislation.

4 -- Open discussion involving all interested elements within the public.

5 -- The last may be an element not very common to other jurisdictions, but I believe it was an important consideration in our own deliberations. This is the fact, well established in our study, that the majority of employees insured under voluntary plans or through government-employee programs were covered under plans offered by two major insurers in the State. Having a clear pattern to follow in prevailing benefits, it was easier to overcome resistance against extending similar benefits to all the State's working men and women.

I hope our experience and the foregoing thoughts presented for your discussion prove helpful to you in your own endeavors to develop plans for extending health care benefits to all others who need such coverage in our Nation.

Mahalo.

# # #

06-F1LH

STATE OF ALASKA

JAY S. HAMMOND, GOVERNOR

DEPT. OF HEALTH AND SOCIAL SERVICES

OFFICE OF DEPUTY COMMISSIONER

ROOM 214 MacKAY BUILDING
338 DENALI STREET
ANCHORAGE 99501

REPORT AND RECORD OF CONFERENCE

Region X - Department of Health, Education and Welfare

Federal Office Complex Seattle, Washington

Tuesday, October 30, 1979

Present: Mike Street; Ed Ross; Jim Van Hoomison; Boyd Kelley, Health Care Finance Administration; Bill Knestes, Indian Health Service; Mr. Moerlin, Health Research; Frederick McGinnis, Alaska Department of Health and Social Services.

Tentative agenda for the conference was distributed and accepted as the working program for the conference this date as follows:

Tentative Agenda

I. Review developments to date on Model Health Plan for Alaska

II. Review of discussions: Center for Health Services Research, University of Washington, on October 29, 1979. Discussion of report on that conference.

III. Federal questions: Region X and Washington, D.C.

A. Waiver possibility: Title XIX, Medicaid funding, for Experimental Program in a State.

B. Technical Assistance Potential--

Region X
Washington, D.C.

C. Grant Fund Assistance: H.E.W.

IV. Conferees: Recommended: H.E.W., Washington, D.C. Week of November 1 - 7, 1979.

V. Other

Full discussions were held on a part of the outline of topics and points raised in the discussions of October 29, 1979, with representatives of the Center for Health Services Research, School of Public Health and Community Medicine, University of Washington, as follows:

A complete discussion transpired with regard to:

Alaska Medicaid Program and costs;
Alaska General Relief Medical Program and costs;
Indian Health Service Delivery System in Alaska/ Medicaid Reimbursement policies;
Alaska Catastrophic Illness Program;
Alaska Military Health Programs;
Private insurance coverages in Alaska;
Other related topics bearing on current status of Alaska health programs.

McGinnis indicated his views of some of the important next steps in developing the anticipated program:

(1) Developing a Planning Task Force;
(2) Providing an Advisory Body;
(3) Creation of small staff and Director;
(4) Developing of Data Gathering and Research Projects:

*Survey/Gathering of published data from all sources bearing on related areas of concern;

*Determination of current total costs in current plan of health services delivery:

Department of Health & Social Services;
Indian Health Services;
Military forces;
Veterans Administration;
Native Health Corporations;
Private insurance premiums and payments on plans;
Labor insurance plans;
Private insurance plans;
Other identifiable costs;
Federal Government/other.

*Determination of gaps in data needed;

*Provide for research needed to meet data needs on expenditures of health funds in Alaska;

*Provide for research to determine number of citizens without adequate health services; estimate costs of providing needed services under agreed-upon options available.

*Synthesis and interpretation of all data on hand and provided through special research tasks;

*Other research components determined necessary as planning gets underway and new needs develop.

(5) Determination of human/personnel and financial resources available from all sources to finance the project of planning:

*Within Health and Social Services Department/ State of Alaska;

1979 Fiscal Year:

Divisions related to health; State Health Planning Agency; Governor's Policy/ Planning Budget; Governor's Contingency Fund.

*Center for Health Services Research University of Washington

*Institute of Social/Government Research University of Alaska

*Possible Demonstration Grants/ Department of Health, Education and Welfare

*Alaska Legislative Appropriation

1980 Fiscal (Supplemental) Year
1981 Fiscal Year

*Private Foundation Grant(s) and other private sources

*Other sources

(6) Preparation of Budget identifying available manpower and funds for 1980 fiscal year and 1981 fiscal year.

(7) Other tasks to be developed and assigned as necessary as project develops.

(8) Determination of technical assistance needs in economics, statistics, planning, accounting, legal and other assistance, and provision for securing needed assistance, including professional services contracts as deemed necessary.

The basic information shared with the Alaska State Health Coordinating Council and Governor Hammond in memoranda of August 3, 1978 and September 18, 1979 was discussed. The conferees had copies earlier of the information in the SHCC memorandum.

In general, the Region X conferees felt that the project was worthy of development and the following points were discussed:

1. The need to determine and state exactly the goals sought in the project. This will be especially important in presenting the project to H.E.W.

2. Recommendations were made to try to contact two officials of HEW in Washington on the forthcoming visit November 1 - 6, if possible; if not possible on this visit to Washington, then in the near future:

   Mr. Ron Carlson, Park Law Building, Rockville, Maryland,

   and

   Mr. Dale Serwer, Baltimore, Maryland.

   Discussions with those men should include funding possibilities and also what they would like to see Alaska demonstrate.

3. Oregon has submitted a "Concept Paper" to Region X expressing the need and desire of that state to reorganize their health funding and programming. Mike Street will attempt to get a copy and will mail to McGinnis when received. (Note: If not received in two weeks, then Alaska should contact Oregon to secure a copy of the concept paper.)

4. It was generally agreed that assistance from the University of Washington Center for Health Services Research would likely be available through a contract with that Center for specific component(s) of the project. Desirability of competetive bidding of any contracts was discussed.

5. The working group formed for the project should give priority to writing of clear specifications of "scope of work" needed and such should be presented to all chosen to present proposals.

6. Mike Street indicated that Region X would determine the best single contact person to represent Region X in keeping in touch with progress on the project. A prospectus should be prepared on the exact services needed from contractors when that information is needed.

General summary comments were made as the conference adjourned with the understanding that the State and Region X would keep in contact on the project.

FMcG/mag

cc for information:

Commissioner Helen D. Beirne
Deputy Commissioner Allen K. Korhonen
Deputy Commissioner Catherine M. Lloyd
State Health Planning & Development Agency
Karen Cory, Governor's Office, Juneau
Fran Ulmer, Governor's Office, Juneau

of ALASKA

TO: The Honorable Terry Miller
Lieutenant Governor
State of Alaska

DATE: September 21, 1979

FILE NO:

TELEPHONE NO: 465-3030

FROM: Helen D. Beirne, Commissioner
Dept. Health & Social Services

SUBJECT: MODEL HEALTH DELIVERY PROGRAM FOR ALASKA

You will recall that recently Deputy Commissioner McGinnis and I met with you in order to brief you as to developments to that time on the discussions regarding a model health delivery program for Alaska. We appreciate the time that you gave us to discuss the matter.

A memorandum was developed on September 18, 1979, from me to Governor Hammond. A copy of that summary memorandum is attached in order to share with you the latest developments in the Department's thinking regarding the proposed program.

At a meeting on September 19 in Governor Hammond's office, attended by Deputy Commissioner McGinnis, Jerry Reinwand, Karen Corey, Fran Ulmer and myself, the attached memorandum, having been read by the parties, was discussed.

At the conclusion of the conference, Governor Hammond did indicate to all of us that he had signed his approval to the recommendation made at the end of the memorandum. It will be the Department's plan to proceed with further exploration of the concept and we will plan to keep you informed, as well as others in the Governor's Office. Any comments or recommendations you may have with regard to this proposed program would be welcomed by the Department.

Attachment: Memo, 9/18/79, as indicated

of ALASKA

MEMORANDUM

TO: Helen D. Beirne, Commissioner
Dept. Health & Social Services

DATE: November 5, 1979

FILE NO:

TELEPHONE NO:

FROM: Frederick McGinnis
Deputy Commissioner
Dept. Health & Social Services

SUBJECT: Briefing Memorandum re Conference in Washington, D.C. with Lt. Gov. Terry Miller; Administrative Assistant to the Lt. Gov. Pete Rouse; and William Fullerton of the Firm of Health Policies Alternatives, Inc.

As you may remember, Lt. Gov. Terry Miller mentioned earlier his discussions in Washington, D.C. on a prior visit with Mr. William Fullerton of Health Policies Alternatives, Inc., with regard to Alaska's interest in developing a model health financing plan. You may recall also that Lt. Gov. Miller raised the question informally at a meeting with me and with Pete Rouse in the Governor's Office in Anchorage with regard to whether it might be possible to advance one part of our proposed programming for model programs to improve the catastrophic illness insurance program earlier.

In order to keep you abreast of later developments, at the request of Lt. Gov. Miller I met with him, Mr. Rouse and Mr. William Fullerton in Washington at the place of the Federal Health Policies Conference on Friday afternoon, November 2, at 2 PM. At that meeting, Alaska's plan to do a major study on alternatives in health financing programs was discussed.

No commitments were made to Mr. Fullerton and the following points were made by Lt. Gov. Miller.

1. The Lt. Gov. will discuss with Governor Hammond the possibility of a liberalized catastrophic illness program to assist people of middle to lower incomes who are above the poverty level income and therefore not eligible for relief programs (Medicaid, General Relief Medical).

2. Lt. Gov. Miller felt that the initiative for the short-range program, as well as the long-range program, should rest with the State Department of Health and Social Services.

3. Lt. Gov. Miller will brief Governor Hammond on his interest in improving the catastrophic illness assistance to a newly-defined group of Alaskans. It was understood that Deputy Commissioner McGinnis would brief Commissioner Beirne on these discussions in order that she may be fully aware at each step of the discussions.

4. Lt. Gov. Miller suggested that it might be well if the Governor's Office sponsored a small working party named by the Governor, including the Department of Health and Social Services as lead agency, the Department of Labor, the Department of Commerce (Insurance Division), and the Department of Law for legal counsel, to give guidance to developing some plan for the Governor to present to the Legislature at the forthcoming session.

Mr. McGinnis suggested that if the Fullerton firm should become involved in helping to do any of the research on the short-term or long-range project, it would be necessary for a Request for Proposal to be developed and that equal access to all information concerning Alaska's plan be made to at least three firms who may be interested in providing the professional assistance. It was also indicated that financial resources would have to be found for the additional research in order for either the short-term catastrophic illness program, as well as the longer range, fully innovated program anticipated.

It was indicated that Deputy Commissioner McGinnis would meet again with Mr. Fullerton on Monday afternoon, November 5, which conference did take place, and Mr. Fullerton made available certain materials from his firm as to their experience, which will be made available to you by mail.

Attached is a list of items that I believe the State Health Planning and Development Agency should begin assembling, with at least six copies of all the materials, as soon as possible in order that these materials may be made available to any firm considered as professional consultants to this short-range program, as well as the long-range problem.

I will be glad upon return to Alaska to comment further if you wish on the matters summarized ever so briefly in this briefing memorandum.

FMcG/mag
Attachment, as indicated above

ITEMS THAT THE STATE HEALTH PLANNING AND DEVELOPMENT AGENCY SHOULD ASSEMBLE IN CONNECTION WITH MODEL HEALTH DELIVERY PROJECT

1. General demographic information on the Alaskan population--income, age cohorts, cost of living, rates of inflation, family formation, birth rates, etc.

2. Medicaid Plan--plus all recent statistical data: eligibility, benfits by claim expenditures, administrative costs, etc.

3. Description of existing catastrophic plan, plus all recent statistical information on eligibles, payments and benefits.

4. Statistics on existing health insurance coverage--by plan, numbers of insured (any evidence of overlap?), government employee plan (federal, state and local), benefits covered, major medical or catastrophic provisions).

5. State Health Plan (under health planning law, plus statistical information on kinds, numbers and locations of all classes of health care providers.

6. Alaska Medicaid laws and regulations.

7. General Relief Medical laws and regulations.

8. Catastrophic Illness laws and regulations.

9. Department of Health and Social Services and Indian Health Services Memorandum of Agreement on Medicaid.

10. Any other related information deemed by SHPDA to be important to understand the clear status of health programs in Alaska today.

06-F1LH

STATE OF ALASKA

JAY S. HAMMOND, GOVERNOR

DEPT. OF HEALTH AND SOCIAL SERVICES

OFFICE OF DEPUTY COMMISSIONER

ROOM 214 MacKAY BUILDING
338 DENALI STREET
ANCHORAGE 99501

REPORT AND RECORD OF CONFERENCE

Center for Health Services Research
School of Public Health and Community Medicine

University of Washington Seattle

Monday, October 29, 1979

Present: Mr. Marc E. Provence, M.P.H. (HMO)
Ms. Shirley McEvoy, Research Assistant
Frederick McGinnis, Deputy Commissioner

The meeting between the above listed individuals began at 10:30 a.m. and concluded during early afternoon.

Mr. McGinnis outlined developments to date on the Alaska Model Health Program and reviewed earlier meetings with groups including the meeting with Dr. Stephen H. Shortell, Director of the Center, Ira Moscovic, Andy Dolan and Laura Beth Lawson last year, when the idea of a revised health plan for Alaska was first being discussed.

Copies of the Department memorandum dated August 2, 1978 to the Alaska State Health Coordinating Council and September 18, 1979 to Governor Jay S. Hammond were discussed as background papers to indicate the present thinking of Department leadership.

A complete discussion transpired with regard to:

Alaska Medicaid Program and costs;
Alaska General Relief Medical Program and costs;
Indian Health Service Delivery System in Alaska/ Medicaid Reimbursement policies;
Alaska Catastrophic Illness Program;
Alaska Military Health Programs;
Private insurance coverages in Alaska;
Other related topics bearing on current status of Alaska health programs.

McGinnis indicated his views of some of the important next steps in developing the anticipated program:

(1) Developing a Planning Task Force;
(2) Providing an Advisory Body;
(3) Creation of small staff and Director;
(4) Development of Data Gathering and Research Projects:

*Survey/Gathering of published data from all sources bearing on related areas of concern;

*Determination of current total costs in current Plan of health services delivery:

Department of Health & Social Services;
Indian Health Services;
Military forces;
Veterans Administration;
Native Health Corporations;
Private insurance premiums & payments on plans;
Labor insurance plans;
Private insurance plans;
Other identifiable costs;
Federal government/other.

*Determination of gaps in data needed;

*Provide for research needed to meet data needs on expenditures of health funds in Alaska;

*Provide for research to determine number of citizens without adequate health services; estimate costs of providing needed services under agreed upon options available;

*Synthesis and interpretation of all data on hand and provided through special research tasks;

*Other research components determined necessary as planning gets underway and new needs develop.

(5) Determination of human/personnel and financial resources available from all sources to finance the project of planning:

*Within Health and Social Services Department/ State of Alaska;

1979 Fiscal Year:

Divisions related to health;
State Health Planning Agency;
Governor's Policy/Planning Budget;
Governor's Contingency Fund.

*Center for Health Services Research
University of Washington

*Institute of Social/Government Research
University of Alaska

*Possible Demonstration Grants/
Department of Health, Education & Welfare

*Alaska Legislative Appropriation
1980 Fiscal (Supplemental Year)
1981 Fiscal Year

*Private Foundation Grant(s) and other private sources

*Other sources

(6) Preparation of budget identifying available manpower and funds for 1980 fiscal year and 1981 fiscal year.

(7) Other tasks to be developed and assigned as necessary as project develops.

(8) Determination of technical assistance needs in economics, statistics, planning, accounting, legal and other assistance and provision for securing needed assistance, including professional services contracts as deemed necessary.

Earlier, Dr. Shortell had indicated to the State of Alaska that possible assistance which might be arranged through the Center for Health Research included:

Informal counsel and assistance;
Guidance reviews;
Contracts for defined components of work;
Assistance in planning evaluation;
Systems design, policy formulation.

Mr. Provence and Ms. McEvoy restated some of the above listed points during the meeting, emphasizing the possibility of specific contracts for specific components of the necessary work. It was indicated that beyond the expertise available in the Center for Health Services Research the Center has access to many sources of expertise within the University of Washington which could be called on for participation.

It was agreed at the conclusion of the meeting that:

* Discussions would be held with Dr. Shortell, Director, on his return to Seattle and a report made of today's discussion.

* A careful review of the two memoranda referred to herein earlier and the concepts contained therein would be discussed in staff.

* Following the above steps they will prepare a letter to the Department with their observations and comments. Included in the comments will be a review and listings of the Center's potential involvement in the project and the bases (financial, personnel and otherwise) of such participation.

Following the outline of the conclusions and summaries listed above, the meeting was adjourned.

Frederick McGinnis
Deputy Commissioner

cc for information:

Commissioner Helen D. Beirne
Deputy Commissioner Allen K. Korhonen
Deputy Commissioner Catherine M. Lloyd
✓State Health Planning & Development Agency
Karen Cory, Governor's Office, Juneau
Fran Ulmer, Governor's Office, Juneau

STATE
of ALASKA

MEMORANDUM

TO: Karen Cory, Special Assistant
Office of the Governor
and
Fran Ulmer, Director
Division of Policy Development
and Planning
Office of the Governor

DATE: November 5, 1979

FILE NO:

TELEPHONE NO: 465-3030

SUBJECT: Model Health Delivery System for Alaska

FROM: Helen D. Beirne, Commissioner
Dept. Health & Social Services

Helen D. Beirne

As you will note from the enclosed material, the Department of Health and Social Services is moving rapidly ahead on a comprehensive study of a model health delivery system for Alaska. The Department's coordinator of this study is Deputy Commissioner Frederick McGinnis. As you are aware, Dr. McGinnis, who is at present located in Anchorage with a logistic responsibility for the Southcentral area, has had significant experience in the field of health and social services. His interest in the present topic dates back to when he served as the Commissioner of the Department of Health and Social Services for a period of four years. It could be stated that he has a greater depth of knowledge in this particular area than any other person in the state.

Deputy Commissioner McGinnis and I have met with Governor Hammond on two occasions and have received his concurrence that we should proceed on this matter as rapidly and thoroughly as possible with frequent informational and directional contacts with the Governor's Office.

In this packet you will find Dr. McGinnis' briefing memorandum regarding his conference in Washington, D.C., with Lieutenant Governor Terry Miller, which is their second meeting since the Governor's concurrence with the project. Also included are reports and records of the conferences he has recently attended to supplement our knowledge of model health delivery systems, to test the interest of those agencies with whom we must coordinate, and to determine from where assistance for such a program may come.

These reports, and those to follow, will express to you the Department's intense and dedicated interest in establishing a health delivery system for Alaska that will address the health and medical needs of all Alaskans in the most cost effective manner possible.

From this date on, and to expedite this study, Deputy Commissioner McGinnis will be copying you simultaneously with the Commissioner's Office as we move to a resolution of one of the state's most pressing problems in conjunction with the Governor's Office.

HDB/mag
Enclosures, as indicated above
cc: Governor Hammond
Lieutenant Governor Miller

TO: Honorable Jay S. Hammond
Governor
State of Alaska

DATE: September 18, 1979

FILE NO:

TELEPHONE NO:

FROM: Helen D. Beirne, Commissioner
Dept. Health & Social Services

SUBJECT: Model Health Delivery Program for Alaska

From time to time discussions have taken place within the Department and with others with regard to a "Model Health Delivery System" for the State of Alaska. For a number of years, delays have been encountered in active planning for an improved delivery system for Alaska because of the prospect of the National Health Insurance program being enacted by the Federal Congress. While numerous discussion continues to go forward with regard to a National Health Insurance program, it now appears that the enactment of and the implementation of such a plan are receding farther and farther into the future.

The question continues to be raised as to whether Alaska should consider the possibility of a Model Health Delivery System geared to the needs of our state. If such a system could be developed and become operative sometime before any National Health Insurance program is in place, it could serve as a prototype for the nation.

There are several reasons why Alaska should consider developing, as rapidly as good planning will permit, a Model Health Delivery Plan for all the citizens of our state. With our extremely small population and with the numerous extensive health delivery plans in place already, it would seem that Alaska could adjust its present program and add thereto in order to create a truly comprehensive and effective health delivery system. It will take bold, creative and extensive work to develop such a system for Alaska.

There are numerous parties at interest in such a proposed plan. In addition to the State of Alaska (executive and legislative branches), the Federal Department of Health, Education and Welfare and its several divisions have strong interests. The private physicians and hospitals of the state, which together become the strongest foundation stones of health delivery systems, would have substantial interests.

The Indian Health Service and the Alaska Native Health Corporations have strong interests, as would the insurance industry serving Alaska. Additional exploration will reveal other important interests to be considered, including the planning arm of our Department, the Office of Planning & Research of the Governor's Office, local, regional health planning agencies and the State Health Coordinating Council. As plans develop, all such segments with interest in such a program will need to be involved in the

planning, goal and objective setting, and implementation phases of any new program.

Apart from social and health policies concerned and apart from the different funding mechanisms and health providers, there is a national, as well as Alaskan, growing concern over the spiraling medical care costs. According to the U. S. Department of Labor, Bureau of Labor Statistics, the medical care costs in Anchorage, Alaska, in 1977 were 60% over the U. S. urban average costs. Los Angeles, California medical care costs were only 25% above the U. S. urban average costs.

A variety of studies has indicated that hospital charges and doctors' fees have been rising at higher rates throughout the nation than the Consumer Price Index has been accelerating.

Any new system planned should address (1) improved social policy, (2) improved health policy, (3) strong interest in prevention, (4) a more equitable access to health services, and (5) cost containment and cost effectiveness.

All of the above considerations, and others, have initiated certain discussions with regard to the prospects of the State of Alaska designing a new system and plan for the delivery of health services.

A careful analysis of a part of public spending for health in Alaska on the federal and state levels easily identifies approximately 183 million dollars being spent in FY 1980 for health programs (excluding capital expenditures) through our Department and the Indian Health Service alone. Other expenditures related to military personnel would be on top of that. In addition, special federal grants to the Native health corporations and other organizations in Alaska probably would bring the total into the 200 million annual range during FY 1980. Those figures exclude also the health care coverage of State, federal and local government employees covered under health insurance programs. Such costs represent an outlay of public funds on behalf of those employees of government at all levels in Alaska. Excluded also are industry, business and private insurance programs. In 1977, at least $84,822,000 in health care and accident insurance premiums were paid.

A considerable amount of research will need to be done before Alaska can develop a definitive statement as to the total actual expenditures for health services in the State. Such research should be undertaken and facts developed as completely and as accurately as possible as to the status of spending at the present time. Any proposal for a revised program of health delivery in the state should be based upon sound statistical and fiscal data and should be able to demonstrate an improvement over the present

system. Any proposal would need to be acceptable to private providers.

The following contacts have been made and conferences on the concepts presented herein have been held as follows:

I. Washington, D.C.

Dr. George Lythcott of the Health Services Administration. Dr. Emory joined the discussions.

Mr. Isadore Seeman of the Office of Health, Policy, Research & Statistics of the U. S. Public Health Service

Mr. Ronald Carlson of the Health Care Finance Administration.

II. Seattle, Washington - Region X

Dr. David Johnson
Mr. Michael Street
Mr. David Hanson
Mr. Jim VanHoomison
Deputy Commissioner Frederick McGinnis (DHSS)
Ms. Sharon Osborn (DHSS)

III. Juneau, Alaska

Department of Commerce, Division of Risk Management:
  John George
  Richard Reiner
Office of Planning and Research
  Virginia Stonkus
  Chris Pohl
Governor's Office
  Mike Harper
DHSS
  Commissioner Helen D. Beirne
  Deputy Commissioner Frederick McGinnis
  Special Assistant Janice Gates

IV. University of Washington - Seattle

Dr. Stephen M. Shortell, Director, Center for Health Services Research
Ira Moscovic, Rural Health Care and Manpower
Andy Dolan, Health Law, Regulation, Manpower
Laura Beth Lawson, Coordinator, Technical Assistance, Region X

V. State of Hawaii - Honolulu

Department of Labor
Department of Public Assistance
Department of Health

The purpose of this memorandum is to bring you up to date with the Department's present thinking and the explorations which have been going forward recently.

While your representatives at several meetings indicated that the concept should be explored further, the Department requests your formal approval to proceed further in development of the plan. Our plan would be to keep you advised at each phase and to seek your concurrence in any major commitments which would be needed as the study phase develops.

It is anticipated that the following steps will be taken in the near future by the Department, provided your approval to proceed is given at this time:

1. A survey of present planning and research funds available within the State of Alaska to assist in this planning effort. Included in the survey of financial resources will be the Office of Health Planning and Development of our Department, the budgets of the health divisions of our Department (Mental Health, Public Health, Alcoholism & Drug Abuse). Explorations may go forward with regard to resources which may be available from private foundations and the federal government.

2. A clarification of assistance that may be available through the University of Washington's Center for Health Services Research, Department of Health Services, under their contract with the federal government to assist states in Region X with health planning. In addition, explorations should be made with the University of Alaska's Institute of Social, Government and Economic Research as to any assistance they may be able to give the project.

3. If financial resources can be made available, the setting of criteria for and the naming of a project director for the plan. The project director and/or staff probably should be located within the Department's Office of Health Planning and Development, but given the specific task of working on this specific project.

4. Based on budget considerations and availability of funds, a small but competent staff should be identified

either to do the research or to contract for the research necessary to develop the data needed to carry forward the plan envisioned.

5. Preliminary conversations and/or discussions should be held with other parties at interest within Alaska, including:

   - Indian Health Service
   - Alaska Hospital Association
   - Alaska Medical Association
   - Alaska Legislature
   - Insurance industry
   - Governor's Planning Office
   - Consumer representatives

6. In due course, a broad-based advisory panel should be named to advise the project director and staff. Consideration will be given to whether or not the State Health Coordinating Council might serve as the advisory group to the project with possible provision for additional technical expertise if needed.

7. A proposed schedule of activities with time frames and objectives should be developed in order to plan realistically for the project.

Additional information will be provided to you if requests on any of the topics presented in this briefing memorandum.

RECOMMENDATION:

It is recommended that your approval be given to explore further the concept of a revised, improved and comprehensive health delivery system for Alaska with the goals of better services and cost efficiencies.

_____Approved

_____Not approved at this time

_____
Jay S. Hammond, Governor

Fiscal
Information

SUMMARY SHEET

House CS for CS for Sponsor Substitute for Senate Bill No. 227 (HESS)
(In Thousands of Dollars)

For Full Fiscal Year 1981

		Total	Federal	State	New Positions
1.	Addition of Medicaid Services and New Eligibles	$24,194.5	$15,717.0	$ 8,477.5	17
2.	Decrease of GR-Med. as Result of Adding Medicaid Svcs. and Eligible Groups	(4,471.8)	-0-	(4,471.8)	-0-
3.	State Only Medically Needy	11,169.4	-0-	11,169.4	16
4.	Interest Payment	282.2	-0-	282.2	-0-
	TOTAL for Full Fiscal Year	$31,174.3	$15,717.0	$15,457.3	33

House CS for CS for Sponsor Substitute for Senate Bill No. 227 (Finance)
For 6 Months Implementation
FY 81

January 1, 1981 - June 30, 1981

		Total	Federal	State	New Positions for 6 Months Only
1.	Addition of Medicaid Services and New Eligibles	$12,097.3	$7,858.5	$4,238.8	17
2.	Drecrease of GR-Med. as Result of Adding Medicaid Svcs. and Eligibility Groups	(2,235.9)	-0-	(2,235.9)	-0-
3.	State Only Medically Needy	5,584.7	-0-	5,584.7	16
4.	Interest Payment	282.2	-0-	282.2	-0-
	TOTAL for 6 Months	$15,728.3	$7,858.5	$7,869.8	33

FISCAL NOTE

I. REQUEST

Bill/Resolution No. House CS for CS for Sponsor Substitute for Senate Bill No. 227 (HESS)

Title An Act relating to the health of residents of the State.

Requested by The Hess Committee Date May 2, 1980

For Full Fiscal Year

II. FISCAL DETAIL

Agency Affected Department of Health and Social Sevices

Program Category Affected Health/Social and Economic Assistance

BRU, Program, or Subprogram(s) Affected Medicaid/Eligibility Determination/PAA

(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 80	FY 81	FY 82	FY 83	FY 84	FY 85
100 PERSONAL SERVICES		448.3				
200 TRAVEL		17.0				
300 CONTRACTUAL		175.5				
400 COMMODITIES		8.5				
500 EQUIPMENT		17.5				
600 LAND & STRUCTURES		-0-				
700 GRANTS, CLAIMS, ETC.		23,527.7				
TOTAL		24,194.5				

FUNDING (Thousands of Dollars)

GENERAL FUND		8,477.5				
FEDERAL FUNDS		15,717.0				
OTHER (Specify Fund Source)		-0-				

POSITIONS

FULL TIME		17				
PART TIME		-0-				
TEMPORARY		-0-				

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

Medical benefits would be provided to approximately 3,065 new cases under the Medicaid program. Administration of program benefits would require 15 field staff positions and 2 central office positions, office space, and additional computer time to be divided between the Eligibility Determination and Public Assistance Administration BRUs. Funding is 50% federal except for the Indian Health Care program which is funded at 100% federal funds. Since the bill proposes to add new coverage groups and new categories of coverage to Medicaid, there will be a reduction in General Relief Medical program expenditures as indicated on page 2. Thus, the actual increase in state General fund revenues needed for this increased Medicaid coverage is 8,477.5 - 4,471.8 = 4,005.7.

Original: Legislative Finance

cc: Budget and Management

Prime Sponsor (Hess Committee Name)

Prepared by: David B. Davidson Date: May 2, 1980

Division of Public Assistance

Department of Health & Social Services

Approved by: Date:

FISCAL NOTE

I. REQUEST

Bill/Resolution No. House CS for CS for Sponsor Substitute for Senate Bill No. 227 (HESS)

Title An Act relating to the health of residents of the State.

Requested by The Hess Committee Date May 2, 1980

For Full Fiscal Year

II. FISCAL DETAIL

Agency Affected Department of Health and Social Sevices

Program Category Affected Health

BRU, Program, or Subprogram(s) Affected General Relief Medical

(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 80	FY 81	FY 82	FY 83	FY 84	FY 85
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL						
400 COMMODITIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC.		(4,471.8)				
TOTAL		(4,471.8)				

FUNDING (Thousands of Dollars)

GENERAL FUND		(4,471.8)				
FEDERAL FUNDS						
OTHER (Specify Fund Source)						

POSITIONS

FULL TIME		-0-				
PART TIME		-0-				
TEMPORARY		-0-				

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

Decrease in General Relief Medical program expenditures due to the transfer of coverage for certain service categories from state funding to coverage under the Medicaid program, and the addition of certain groups under Medicaid that are currently covered by General Relief Medical.

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (Last Legislature Named)

Prepared by: David H. Davidson Date: May 2, 1980
Division/Office: Public Assistance Ph: 465-3347
Department of Health & Social Services

Approved by: Pers. & Plgt: Date:

FISCAL NOTE

I. REQUEST

Bill/Resolution No. House CS for CS for Sponsor Substitute for Senate Bill No. 227 (HESS)

Title An Act relating to the health of residents of the State.

Requested by The Hess Committee Date May 2, 1980

For Full Fiscal Year

II. FISCAL DETAIL

Agency Affected Department of Health and Social Sevices

Program Category Affected Health/Social and Economic Assistance

BRU, Program, or Subprogram(s) Affected General Relief Medical/Eligibility Determination/PAA

(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 80	FY 81	FY 82	FY 83	FY 84	FY 85
100 PERSONAL SERVICES		423.3				
200 TRAVEL		16.0				
300 CONTRACTUAL		154.0				
400 COMMODITIES		8.0				
500 EQUIPMENT		16.5				
600 LAND & STRUCTURES		-0-				
700 GRANTS, CLAIMS, ETC.		10,551.6				
TOTAL		11,169.4				

FUNDING (Thousands of Dollars)

GENERAL FUND		11,169.4				
FEDERAL FUNDS		-0-				
OTHER (Specify Fund Source)		-0-				

POSITIONS

FULL TIME		16				
PART TIME		-0-				
TEMPORARY		-0-				

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

Medical benefits would be provided to approximately 2,821 new cases under a state-only medically needy program as part of the General Relief Medical program. Administration of program benefits would require 14 field staff positions and 2 central office positions, office space, and additional computer time to be divided between the Eligibility Determination and Public Assistance Administration BRUs. Funding is indicated as 100% state funds, but it may be possible to receive federal funding for certain individuals with income less than 133% of the state need standard for the particular eligibility categorical group to which they are related.

Original: Legislative Finance Prepared by: David H. Davidson Date: May 2, 1980

cc: Budget and Management Division/Office: Public Assistance Phone: 465-3347

Phone Sponsor (Last Legislation Named) Department of Health & Social Services

33 (rev 12/79) Approval (OMB, Exec. Budget): Date:

FISCAL NOTE

I. REQUEST

Bill/Resolution No. House CS for CS for Sponsor Substitute for Senate Bill No. 227 (HESS)

Title An Act relating to the health of the residents of the State.

Requested by The Hess Committee Date May 2, 1980

For Full Fiscal Year

II. FISCAL DETAIL

Agency Affected Department of Health and Social Sevices

Program Category Affected Health

BRU, Program, or Subprogram(s) Affected General Relief Medical

(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 80	FY 81	FY 82	FY 83	FY 84	FY 85
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL		282.2				
400 COMMODITIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC.						
TOTAL		282.2				

FUNDING (Thousands of Dollars)

GENERAL FUND		282.2				
FEDERAL FUNDS		-0-				
OTHER (Specify Fund Source)						

POSITIONS

FULL TIME		-0-				
PART TIME		-0-				
TEMPORARY		-0-				

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

Funding necessary to make interest payments to providers for Medicaid and General Relief Medical clean claims not processed within 30 days of receipt by the Department. Federal law requires states to process 90% of Medicaid clean claims within 30 days of receipt, however no prevision is made under federal law for funds to be used to make interest payments. Thus, all interest payments must be made using state funds only.

[illegible] Legislative Finance Prepared by: David E. Davidson Date: May 2, 1980

[illegible] Budget and Management Division: Public Assistance Ph: [illegible]

Primary [illegible] (Last Legislative Contact) Department of Health & Social Services

[illegible] (Rev. 1) Approved by: [illegible] Date:

[illegible] (Rev. [illegible])

METHOD USED TO DEVELOP FISCAL NOTE FOR HCS for CS for SSSB 227(Fin.)

SB 227* proposes to add new coverage and new eligible categories to the Medicaid and General Relief Medical (GRM) programs administered by the Department of Health & Social Services through the Division of Public Assistance. The bill would add services and eligible beneficiaries not presently covered by a medical assistance program administered by the Department. In order to attempt to gauge the effect of SB227, it was necessary to do some projections based on the present Alaska Medicaid and GRM programs and the Medicaid programs in other similar states. In developing a fiscal note for SB 320, the Department acquired financial reports from five western states having medically needy programs. The financial reports covered the federal fiscal years 1977 and 1978 for Hawaii, Montana, North Dakota, Utah, and Washington. This information also was used to develop the fiscal note for SB 227.

The fiscal note is divided into four pages to allow for separate considerations of adding new services and eligible groups to Medicaid on the GRM program by the effect that addition to Medicaid, the creation of a medically needy program, and the payment of interest on past due medical claims.

The first page of the fiscal note covers the addition of new eligible groups and service categories under the Medicaid program. The basic Medicaid request for FY 81 minus the 100% federally-funded Indian Health Care Improvement Act coverage ($40,720,600) was used as a base. To that was added 17.1% additional funds for those new service categories that are not presently covered under the Alaska Medicaid program. This brings the total to $47,683,800. The 17.1% figure is derived from the average percentage in the five other states for those categories of service that are not covered under the Alaska Medicaid program that would be added by this bill. This subtotal was then multiplied by 1.5, the factor by which I believe the overall cost of the Medicaid program would increase ($71,525,700). Alaska has a lower percent of the total population participating in the Medicaid program than in other states, particularly in the groups of individuals under 21 and intact families.

To double check these perceptions, and to arrive at a more precise budget projection, the fiscal note was developed by budget components. It was projected that the Medicaid components would be affected in the following ways: hospital increase by 1.33, physicians increase by 1.33, other services increase by 1.33, EPSDT increase by 2.0, nursing homes remain constant, and Indian health increase by 2.0. The effect on the GRM budget, reflected by page two of the fiscal note, would be as follows: hospital reduced by .33, physicians reduced by .33, other services reduced by .50, and nursing homes and catastrophic illness remaining constant. These changes by specific component produced the total used for the fiscal note of $71,487,900 for Medicaid in FY 81.

The high amount of federal funds shown in the fiscal note is the result of a large increase predicted in the Indian health component which is 100% federal funding. This increase would not be a function of people receiving new services but the result of a funding change--the Alaska Area Native Health Service (AANHS) would be able to receive more federal

* In all cases, Senate Bill 227 means House CS for CS for SSSB227 (Finance)

Medicaid money for services that they are already providing to persons eligible for AAHHS, but who are not Medicaid eligible now simply because Alaska's Medicaid program does not provide coverage for intact families.

The third page of the fiscal note covers the effect of adding a medically needy program in Alaska. It is based on the projections done in developing the fiscal note for the Senate HESS Committee for SB 320. For purposes of SB 227, the amount in that fiscal note was doubled to reflect the fact that SB227would require medically needy coverage for not only adult cases but also for families and individuals under age 21, and would establish a higher cut-off point for eligibility.

The fourth page provides an analysis of the costs of providing interest payments on past due clean claims submitted to the Department. While SB 227does not say specifically that the provision would apply only to the Medicaid and GRH programs, that assumption has been made for purposes of the fiscal note. The amount projected is approximately one-half percent of the total Medicaid and GRH budgets, minus the Indian health component since that is merely a transfer of federal funds and not an actual payment for services rendered. The figure is based on the assumption that the Department will be able to continue to make improvements in its claims processing system, eventually obviating the need for any interest payments to be made. Of course, if the claims processing system would revert back to its previous condition, the amount of this fiscal note would be considerably greater.

The summary sheet totals the costs for the Department for SB 227. Since the fiscal notes were prepared based on the House Hers version of the bill, the budgets reflect costs for a full fiscal year implementation. The current House Finance version begins implementation at a later date on January 1, 1981. Therefore, we have reduced the costs by 50% to reflect only 6 months implementation for that fiscal year.

DIVISION OF PUBLIC ASSISTANCE

BRU	FY79 ACTUAL TOTAL AS OF 11/27/79	FY80 FCC AUTHORIZATION		FY80 SUPPLEMENTAL CURRENT REQUEST	FY80 PROJECTED TOTAL NEED		FY81 REQUEST	
GEN. POP:								
DISCRETIONARY			(GF)			(GF)		(GF)
Elig. Det.	$3718.3	4377.1	(2638.2)		4377.1		4695.9	(2831.0)
Staff Dev.	253.8	130.4	(40.8)		130.4		140.0	(69.1)
Quality Control	407.0	496.0	(248.5)		496.0		549.0	(274.5)
General Relief	707.1	650.0	(650.0)		650.0		650.0	(650.0)
TOTAL	5086.2	5653.5	(3577.5)		5653.5	(3677.5)	6034.9	(3824.6)
NON-DISCRETIONARY								
AFDC	21276.6	22734.5	(11367.2)	3447.9	26182.4	(13091.2)	31133.1	(15566.5)
AD	3130.2	3782.8	(3782.8)	202.7	3985.5	(3985.5)	4974.1	(4974.1)
AB	108.7	118.8	(118.8)		118.8	(118.8)	140.9	(140.9)
*OAA	2950.2	3141.4	(3141.4)	421.8	3563.2	(3563.2)	4344.9	(4344.9)
TOTAL	27465.7	29777.5	(18410.2)	4072.4	33849.9	(20758.7)	40593.0	(25026.4)
* AGED COVER PROGRAM								
HEALTH:								
NON-DISCRETIONARY								
MEDICAID								
Hospitals	6047.9	5617.7	(1160.7)	1066.7	6684.4	(1694.0)	8923.7	(2461.9)
Physicians	2872.4	2819.2	(621.9)	1217.6	4036.8	(1230.7)	5381.1	(2690.6)
Other Services	889.9	735.1	(276.6)	435.8	1170.9	(494.5)	1563.1	(671.1)
EPSDT	1600.8	1711.5	(855.7)	480.0	2191.5	(1095.7)	2925.7	(1462.8)
Nursing Home	12947.8	15825.6	(967.4)	1716.0	17541.6	(858.0)	21927.0	(3563.5)
Indian Health	1458.7	6557.6	-0-		6557.6	-0-	7239.6	-0-
TOTAL	25817.5	33266.7	(3882.3)	4916.1	33182.8	(5372.9)	47960.2	(10840.9)
GENERAL RELIEF MEDICAL								
Hospitals	4137.9	4147.9		1356.8	5504.7		7348.8	(7348.8)
Physicians	1443.4	1150.3		900.0	2050.3		2737.1	(2737.1)
Other	1338.0	1224.1		473.4	1697.5		2266.1	(2266.1)
Nursing Homes	328.8	683.9		231.7	915.6		1144.5	(1144.5)
Catastrophic Illness	801.8	754.2		-0-	754.2		977.3	(977.3)
Residential Nurse	-0-	166.4		-0-	166.4		166.4	(166.4)
TOTAL	8049.9	8126.8	(8126.8)	2961.9	11088.7	(11088.7)	14640.2	(14640.2)
DISCRETIONARY								
PA Admin & Support	970.4	910.9	(529.2)		910.9	(529.2)	979.8	(594.8)
Collections	42.8	44.8	(44.8)		44.8	(44.8)	47.4	(28.4)
SUBTOTAL	67432.5	77780.2	34570.8		89730.6	(41471.8)	110225.5	(54964.3)
+FEDERAL FOOD STAMPS	10400.0	14976.0			14976.0		18637.0	
+ENERGY ASSISTANCE PROGRAM	N/A	N/A			3636.7		unknown	

ELEVENTH LEGISLATURE

FISCAL NOTE

Title 4-5 mp

I. REQUEST
Bill/Resolution No. CS for SS Senate Bill 227
Title Insurance for Alcoholism and Drug Dependence
Requested by _____ Date _____

II. FISCAL DETAIL
Agency Affected Administration - Division of Retirement and Benefits
Program Category Affected Retirement and Benefits (OTHER BENEFITS)
BRU, Program, or Subprogram(s) Affected 02-96-8-01-02-00
(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 79	FY 80	FY 81	FY 82	FY 83	FY 84
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL						
400 COMMODITIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 TRS STATE MATCH						
100 BENEFITS		282.0	338.4	406.1	487.3	584.8
TOTAL		282.0	338.4	406.1	487.3	584.8

FUNDING (Thousands of Dollars)

GENERAL FUND		230.8	277.1	332.6	399.2	478.9
FEDERAL FUNDS		13.0	15.6	18.7	22.4	26.9
VETERAN'S FUND		0.6	0.7	0.8	1.0	1.2
FISH & GAME FUND		1.7	2.0	2.4	2.9	3.5
HIGHWAY FUND		3.7	4.4	5.3	6.3	7.6
AIRPORT FUND		8.2	9.8	11.8	14.1	17.0
CAPITAL FUND		24.0	28.8	34.5	41.4	49.7
PERS						
TRS						

POSITIONS NONE

FULL TIME						
PART TIME						
TEMPORARY						

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

1. Approximately 8,900 State employees are currently covered under the State Group Health Care Plan.

2. The cost to implement the provisions of this bill will be $2.64 per employee per month.

3. Estimate that the cost to provide continued coverage will increase 20% each year for the immediate future. However, an effective alcoholism/drug dependency program should help to reduce overall health care claim experience in the future.

4. Cost for coverage of political subdivisions (approximately 50 subdivisions) participating in group insurance not included; recommend that the Alaska Municipal League, 201 Franklin St., Juneau, AK 586-1325, be contacted for input.

Earl P. Arnold

IV. DATE 3/30/79 PREPARED BY Earl P. Arnold, Director
AGENCY Division of Retirement & Benefits
PHONE 465-4460

cc: Original - Legislative Finance
Budget and Management
Prime Sponsor (Senator Colletta & Senator Hilsc
Others as Chairman Specifies)

5/29/80
Bradley

Original sponsors: Colletta, Stimson
and Hohman

IN THE SENATE BY THE FINANCE COMMITTEE

HOUSE CS FOR CS FOR SPONSOR SUBSTITUTE FOR SENATE BILL NO. 227 (Finance)

IN THE LEGISLATURE OF THE STATE OF ALASKA

ELEVENTH LEGISLATURE - SECOND SESSION

A BILL

For an Act entitled: "An Act relating to the health of residents of the state; and providing for an effective date."

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

* Section 1. AS 21 is amended by adding a new chapter to read:

CHAPTER 50. COMPREHENSIVE HEALTH CARE PLANS.

Sec. 21.50.010. RESIDUAL MARKET HEALTH INSURANCE POOL. (a) The carrier which writes the largest premium volume of health insurance in the state as determined by the director shall, as a condition of transacting health insurance, establish and operate a residual market health insurance pool. Individual, group, and Medicare supplemental comprehensive health care plans as described in AS 21.50.020 shall be available through the residual market health insurance pool to every eligible individual or employer resident in the state. Applicants shall have a choice of the low option, the middle option, or the high option deductible established under AS 21.50.020.

(b) The administering carrier shall submit to the director for approval a plan of operation for the residual market health insurance pool which assures the fair, reasonable, and equitable operation of the pool. The plan shall establish procedures for administration, accounting, record keeping, and reporting for the pool, amendment of the plan, and advertising of the coverage provided. If the carrier fails to submit a plan within six months after the effective date of regulations implementing this Act, the director may adopt a plan to carry out the provisions of this section.

20A

(c) Rates for comprehensive health coverage issued through the residual market health insurance pool may not be excessive, inadequate, or unfairly discriminatory. The rate for a given classification or group in the pool may not be more than 125 percent of the rate for a classification or group of at least 25 persons with similar characteristics at standard risk, for equivalent coverage not written through the pool. All policy forms and rates shall be filed with the director and may be disapproved within 30 days from the filing.

(d) Following the close of a fiscal year, the administering carrier shall determine the net premiums, administrative expenses, and incurred losses for the year from the operation of the residual market health insurance pool. Net gains, if any, shall be held at interest to offset future pool losses or allocated to reduce future pool premiums. Net losses may be credited against the carrier's income tax payable under AS 43.20 or its premium tax payable under this title. If the administering carrier's total assessment exceeds its tax liability for the year, the commissioner of revenue shall directly reimburse the carrier in the amount of the excess.

Sec. 21.50.020. COMPREHENSIVE HEALTH CARE PLANS. (a) Each of the three types of comprehensive health care plans (individual, group, and Medicare supplemental) shall provide minimum standard major medical benefits required by regulation:

(b) A comprehensive health care plan shall provide for a choice of deductibles. The low option deductible is $100 per person, the middle option deductible is $500 per person, and the high option deductible is $1,000 per person. The $100 maximum, the $500 maximum and the $1,000 maximum established under this subsection shall be adjusted yearly by the director by regulation to correspond with the change in the medical care component of the consumer price index. The base year for the

computation is the first full year of operation of the plan.

(c) The sum of the deductible and copayments required in a calendar year under an option may not exceed a maximum limit of $1,000 per covered individual or $2,000 per covered family. The $1,000 and $2,000 maximums shall be adjusted yearly by the director to correspond with the change in the medical care component of the consumer price index.

(d) A comprehensive health care plan may limit lifetime benefits to a maximum of not less than $1,000,000 per insured person.

(e) The director shall adopt regulations establishing subrogation rights and coordination of benefits.

Sec. 21.50.030. ELIGIBILITY. (a) An individual comprehensive health care plan is open to enrollment by a resident of the state who is under 65 and can provide evidence, with respect to major medical coverage, of rejection, requirement of restrictive riders, a rate up, or a preexisting conditions limitation by a carrier within six months before the application for enrollment in an individual comprehensive health care plan, the effect of which is to substantially reduce coverage from that available to a person considered standard risk.

(b) A group comprehensive health care plan is available to a resident employer of three or more employees whom the employer seeks to enroll in a group plan, who can provide evidence, with respect to major medical coverage, of rejection, requirement of restrictive riders, a rate up, or a preexisting conditions limitation by a carrier within six months before the application for a group comprehensive health care plan, the effect of which is to substantially reduce coverage from that available to a group considered standard risk or a group of 25 members.

(c) A Medicare supplemental comprehensive health care plan is open to enrollment by a resident of the state who is enrolled in Medicare Parts A and B and who can provide evidence, with respect to major medi-

cal coverage, of rejection, requirement of restrictive riders a rate up, or a preexisting conditions limitation by ~~a~~ two carriers within six months before the application for enrollment in an individual comprehensive health care plan, the effect of which is to substantially reduce coverage from that available to a person considered a standard risk.

(d) An individual may not purchase or renew coverage under a comprehensive health care plan established under this chapter after ceasing to be a resident of the state.

Sec. 21.50.040. ADDITIONAL CRITERIA FOR ELIGIBILITY. The director may adopt by regulation supplemental or alternative eligibility criteria which reflect the inability of an applicant to obtain coverage substantially similar to that which may be obtained by an applicant who is considered a standard risk or by a group with 25 members.

Sec. 21.50.050. POWERS OF DIRECTOR. The director may

(1) formulate general policies to advance the purposes of AS 21.50.010 - 21.50.040 and may adopt regulations under AS 21.06.090 to carry out the provisions of AS 21.50.010 - 21.50.040;

(2) adopt by regulation reasonable limits on administrative expenses of the administering carrier which may be paid from comprehensive health care plan premiums, and minimum standards for the proportion of comprehensive health care plan premiums to be paid out in claims;

(3) examine and investigate the operation of the residual market health insurance pool and shall have reasonable access to the books, records, files, papers, and documents of the administering carrier that relate to the operaton of the pool;

(4) examine directors, officers, agents, brokers, or employees of the administering carrier for the purpose of determining if coverage is being adequately and fairly provided through the pool;

(5) contract with the federal government or with another unit

of government to ensure coordination of the comprehensive health care plan with other governmental assistance programs;

(6) undertake directly or through studies or demonstration programs to develop awareness of the benefits of AS 21.50.010 - 21.50.-040 so that residents of the state may avail themselves of the health care benefits provided by these sections.

Sec. 21.50.100. DEFINITIONS. In this chapter,

(1) "administering carrier" means the carrier with the largest premium volume of health insurance in the state which is obligated under AS 21.50.010 to establish and operate a residual market health insurance pool;

(2) "carrier" means an insurer, hospital service corporation, or medical service corporation;

(3) "comprehensive health care plan" means health insurance which provides the benefits required under AS 21.50.020;

(4) "director" means the director of the division of insurance in the Department of Commerce and Economic Development;

(5) "family" means the primary insured and the covered dependents of the primary insured;

(6) "health insurance"

(A) means hospital and medical expenses incurred policies written on a direct basis, nonprofit service plan contracts, and self-insured or self-funded employee health benefit plans;

(B) does not include accident only policies, disability income policies or casualty insurance coverages subject to regulation under AS 21.39;

(7) "Medicare supplement plan" means a health insurance plan which provides benefits which complement or supplement the benefits provided by Medicare;

(8) "Medicare supplemental comprehensive health care plan" means a plan which, in conjunction with Medicare Parts A and B coverage, provides the benefits required under AS 21.50.020;

(9) "resident employer"

(A) means a person, partnership, association, trust, estate, corporation, whether foreign or domestic or the legal representative, trustee in bankruptcy or receiver or trustee of one of these, or the legal representative of a deceased person, including the state and a municipality of the state which has in its employ one or more individuals during a calendar year;

(B) refers only to an employer with a majority of employees employed in the state.

* Sec. 2. AS 21.27.410(a) is amended by adding a new paragraph to read:

(10) if an agent, solicitor, or broker transacting health insurance in the state fails to refer an applicant for health insurance whom the agent, solicitor, or broker has reason to believe may be eligible for a comprehensive health plan through the residual market health insurance pool to the administering carrier.

* Sec. 3. AS 21.87.340 is amended by adding a new paragraph to read:

(17) AS 21.50.

* Sec. 4. The director of the division of insurance, Department of Commerce and Economic Development, shall adopt regulations implementing sec. 1 of this Act by January 1, 1981.

* Sec. 5. AS 39.30.090(1) is amended to read:

(1) A group insurance policy shall provide one or more of the following benefits: life insurance, accidental death and dismemberment insurance, weekly indemnity insurance, hospital expense insurance, surgical expense insurance, dental expense insurance, audio-visual insurance, alcoholism and drug dependency insurance, or other medical

care insurance.

* Sec. 6. AS 39.30 is amended by adding a new section to read:

Sec. 39.30.092. COVERAGE FOR ALCOHOLISM AND DRUG DEPENDENCE. (a) The group insurance policy required by AS 39.30.090(1)

(1) shall provide coverage for alcoholism and drug dependence to include

(A) inpatient detoxification benefits for not less than 14 days of benefit each calendar year in a state-approved treatment facility or licensed hospital; payment of institutional and professional benefits shall be equal to and payable as any other covered condition, except a covered condition which, by the terms of the policy, has an internal restriction;

(B) inpatient treatment coverage benefits for not less than 30 days of benefit each calendar year in a state-approved treatment program; payment of institutional and professional benefits shall be at the same level as any other covered condition, except a covered condition which, by the terms of the policy, has an internal restriction; and

(C) outpatient treatment coverage benefits of not less than 30 visits each calendar year if treatment is provided by a licensed physician, state-approved treatment program, or state-certified professional substance abuse counselor; coverage shall include individual, family or group therapy; benefits shall be paid at not less than 75 percent of the usual, customary and reasonable charge for a medical procedure, treatment or service in the geographic area;

(2) may not exclude dependents otherwise covered and may not limit coverage for alcoholism or drug dependence because of age, sex or state of illness;

(3) may not apply preexisting or named condition exclusions to deny coverage for alcoholism or drug dependence; and

(4) may require a physician's certification of necessity as a condition of payment for alcoholism or drug dependence treatment.

(b) The provisions of this section apply to group health insurance contracts and group service or indemnity type contracts issued to provide coverage for employees of the state and may apply to contracts for the benefit of employees of other participating governmental units only if the governing body of the governmental unit elects to have the provisions apply.

(c) In (a) of this section,

(1) "alcoholism" means an illness or condition characterized by the habitual lack of self control in the use of alcoholic beverages, or use of alcoholic beverages to the extent that health is substantially impaired or endangered, or social or economic function is substantially disrupted;

(2) "drug dependence" means the condition of being physically or psychologically addicted to an opiate, opiate derivative, tranquilizer, amphetamine, barbiturate, or similar substance, but excluding nicotine, caffeine and alcohol;

(3) "state" means any state in the United States and includes the District of Columbia.

* Sec. 7. AS 39.30.100 is amended to read:

Sec. 39.30.100 DEFINITIONS. In AS 39.30.090 - 39.30.100 [AS 39.30.090]

(1) "eligible employee" means

(A) an employee who has served in permanent full-time or part-time employment with the same governmental unit for 30 days or more, except an emergency or temporary employee, and

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(B) an elected or appointed official of a governmental unit, effective upon taking the oath of office;

(2) "governmental unit" means the state, a borough, municipal corporation, or other political subdivision of the state, and the North Pacific Fishery Management Council;

(3) "insurance", "insurance carrier" and "insurance policy" include health care services, health care service contractors and contracts.

* Sec. 8. The provisions of secs. 5 - 7 of this Act apply to group policies or contracts which provide coverage under AS 39.30.090 - 39.30.100 and which are delivered, issued for delivery, or renewed in this state after the effective date of this Act. A policy or contract providing coverage for eligible employees in this state delivered, issued for delivery, or renewed after the effective date of this Act provides the minimum coverage required by this Act even if the language of the policy or contract does not so specifically provide.

* Sec. 9. AS 47.05 is amended by adding new sections to read:

Sec. 47.05.070. MEDICAL ASSISTANCE BY INSURANCE OR SERVICE CONTRACTS. (a) The commissioner shall use available medical assistance funds to purchase and pay premiums on policies of insurance or pay the expenses on health maintenance organization service contracts or medical or hospital service contracts that provide one or more of the medical services available under state medical assistance programs.

(b) The policy of insurance or the contract must by its terms guarantee

(1) to provide the medical services allowed under state law;

(2) to provide medical services under policies of insurance or contracts in compliance with applicable laws and regulations;

(3) to provide the statistical data, records, and reports

relating to the provision, administration, and costs of providing medical services as required by the commissioner.

Sec. 47.05.080. CONTRACTS WITH DIRECT PROVIDERS OF CARE AND SERVICE. (a) The commissioner may enter into nonexclusive contracts under which funds available for medical assistance may be administered and disbursed by the contractor to direct providers of medical and remedial care and services available under medical assistance for services rendered and supplies furnished by them.

(b) A contract under this section shall

(1) oblige the contractor to make payments under the contract promptly and not later than 30 days after receipt of the proper evidence of the claim; and

(2) provide data, records, and reports required by the commissioner.

Sec. 47.05.090. IMPLEMENTATION. The commissioner shall implement the provisions of AS 47.05.070 - 47.05.090 when the commissioner determines that comparable benefits are available at equal or less cost than direct payments by the department to the providers of medical assistance.

Sec. 47.05.100. INTERIM PAYMENT. The department may make an interim payment before receipt of billing for service to providers who serve a large volume of state medical assistance clients under regulations of the department.

Sec. 47.05.110. INTEREST ON LATE PAYMENTS. When presented by a provider of medical services with a clean claim, the state shall pay

(1) interest at the rate of one percent per month when payment is delayed more than 30 days after presentation of the clean claim;

(2) interest at the rate of two percent per month when

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payment is delayed more than 90 days after presentation of the clean claim; and

(3) a full months interest entitlement if the claim is not paid by the 15th day of a calendar month.

Sec. 47.05.120. DEFINITIONS. In AS 47.05.070 - 47.05.120

(1) "clean claim" means a claim for payment which can be processed without obtaining additional information from the provider of the service or from a third party; it includes a claim with errors originating in the department's claims processing system, but does not include claims from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity;

(2) "commissioner" means the commissioner of health and social services;

(3) "department" means the Department of Health and Social Services;

(4) "medical assistance" means Medicaid (AS 47.07), general relief medical (AS 47.25.120), catastrophic illness (AS 47.08), and crippled children's and maternal and child health programs (AS 18.05.-010).

* Sec. 10. AS 47.07.020(b) is repealed and re-enacted to read:

(b) Residents of the state for whom the Social Security Act allows optional medical coverage qualifying for federal financial participation are eligible for medical assistance.

* Sec. 11. AS 47.07.030 is repealed and re-enacted to read:

Sec. 47.07.030. MEDICAL SERVICES TO BE PROVIDED. Medical services to be offered to eligible persons include services eligible for federal financial participation under Title XIX of the federal Social Services Act.

* Sec. 12. AS 47.25.120 is amended to read:

Sec. 47.25.120. ELIGIBILITY FOR ASSISTANCE. Financial assistance may be given under AS 47.25.120 - 47.25.300 [, SO FAR AS PRACTICABLE UNDER THE CONDITIONS IN THIS STATE,] to

(1) a needy person who is eligible under the regulations of the department; and

(2) a medically needy person whose income is less than the medically needy income standard or who has incurred medical expenses which equal or exceed the difference between the person's monthly income and the medically needy income standard; the medically needy income standard is 150 percent of the current Federal Community Services Administration poverty income guidelines for Alaska (45 C.F.R., sec. 1060.2).

* Sec. 13. AS 47.07.020(d) is repealed.

* Sec. 14. Sections 2 - 8 and 10 - 13 of this Act take effect January 1, 1981.

* Sec. 15. Sections 1, 9, 14, and 15 of this Act take effect July 1, 1980.

STATE HEALTH INSURE.

#3

GEORGE R. ARIYOSHI
GOVERNOR

TANY S. HONG
DIRECTOR
BANK EXAMINER
COMMISSIONER OF SECURITIES
INSURANCE COMMISSIONER

DONALD D. H. CHING
DEPUTY DIRECTOR

STATE OF HAWAII
OFFICE OF THE DIRECTOR
DEPARTMENT OF REGULATORY AGENCIES
1010 RICHARDS STREET
P. O. BOX 541
HONOLULU, HAWAII 96809

March 24, 1980

Representative Thelma Buchholdt
State Representative
District 9 (Spenard)
Chair, House HESS Committee
Alaska State Legislature
Pouch V, State Capitol
Juneau, Alaska 99811

Dear Representative Buchholdt:

This is to acknowledge receipt of your letter of March 18, 1980, inviting me to testify on proposed legislation similar to Hawaii's "Prepaid Health Care Act." Because the subject matter is not related at all with the state department which I am presently serving, I originally could not justify my going to Juneau as official State of Hawaii business. However, my Director and the Governor both feel that if my presence would assist Alaska in enacting progressive health care legislation, I would be given leave to go to Juneau with Hawaii's experience in this field.

I have spoken with Ms. Sorice of your office and am making plans to arrive in Juneau on Sunday, March 30, 1980, and will be available to testify on March 31 and April 1, 1980, if necessary.

I am looking forward to being of any assistance that I can possibly render in your efforts to enact such a bill. I think it has been of much benefit to the people of the State of Hawaii.

May I give you a short biographical sketch so that you may use this in further evaluation of my testimony next week:

1. Member of the Hawaii Legislature from 1959-1978 (8 years-House of Representatives; 12 years-Senate).

2. Attorney-at-Law.

3. Former Vice-President of the Bank of Hawaii (1963-1979).

4. Presently Deputy Director of the Dep rtment of Regulatory Agencies, State of Hawaii.

5. Member of the Board of Directors-Hawaii Medical Service Association (Blue Shield and Blue Cross Plan) (1965 to present), presently serving as its President.

I have never been to the great State of Alaska, and I am looking forward to my first visit.

Very truly yours,

Donald Ching

Donald D. H. Ching
Deputy Director

cc: Ms. Jan Sorice

by Tom Fink

THE ACME of legislation so far this session which interferes with our democratic way of life has been the introduction of House Bill 977. This bill is entitled "an act relating to the health of residents of the state". HB977 was introduced shortly before another similar bill was passed by the State House, Committee Substitute for House Bill 60.

The biggest trepidation many of us have in regard to the state's huge monetary wealth is that money will be used to interfere with our free and democratic society. It is for that reason that many of us suggested that the state use the surplus to pay off our debt and to build capital improvements which improve our economic viability and our conveniences of living.

We've all heard of national health insurance. The first part of HB 977 is state health insurance. The bill provides an employer must cover all employees with a certain type of insurance policy. An employee can only pay a limited amount for that policy so that the employer must pay the difference. Since the coverage is broad, the employer's cost is very substantial. Under certain circumstances an employer can obtain some reimbursement from the state.

IN THE NEXT section of the bill a state medical insurance corporation is set up in which all of the private carriers selling insurance in the state must become a part. Anyone who cannot buy standard coverage of the quality required may purchase insurance from this corporation. Any losses this corporation suffers must be paid for by the private carriers. The end result of this legislation is that the private carriers of medical insurance will be crowded out of the market and the state will be the sole insurer of health insurance. At that time the cost to the state treasury will be enormous.

CSHB60 is primarily a capital appropriations bill. Twenty pages of the 39-page bill and about $250 million is for the construction of all sorts of facilities throughout the state. Some of them are boondoggles, but by and large the facilities will contribute to the future economic viability of the state.

The other 18 pages of the bill, however, appropriates about $27 million for projects such as the following:

— $54,600 Anchorage current event society.

— $12,000 Anchorage Child Abuse Board for Advertising.

— $305,000 Anchorage operation of treatment alternative to street crime program.

— $87,000 Tyonek Village documentary film.

— $75,000 Alaska Federation for Community Self-Reliance grant.

— $180,000 Alaska Conservation Foundation.

— $35,000 Anchorage grant to task force on smoking and health.

— $453,000 Anchorage — Alaska Public Advocacy Corporation.

— $75,000 Alaska Public Interest Research Group.

— $48,000 Anchorage — Citizen Participation Project.

— $317,500 Anchorage — Alaska Center for Policy Studies.

These expenditures are the type that are only made when the state has money burning a hole in it's pocket. Many of these appropriations are to accomplish goals that are not proper for a government. Many of the appropriations are made to new organizations set up to employ friend of those in government. Many of them will result in substantial intrusions upon our democratic society.

IN ADDITION we have legislation pending to subsidize the cost of fuel and electricity so that there will be one price anywhere in the state regardless of the quantity used or the remoteness of the area from the product. We will have legislation also to establish one price for transportation of anyone or a commodity north of Seattle. Even if you happen to be in favor of this state subsidization, you must realize the result will be the state control of all those services and commodities. The legislature only pays the cost of a program for so long before it takes it over and establishes the manner of it's operation, the number of employees, the pay, and the profit margin.

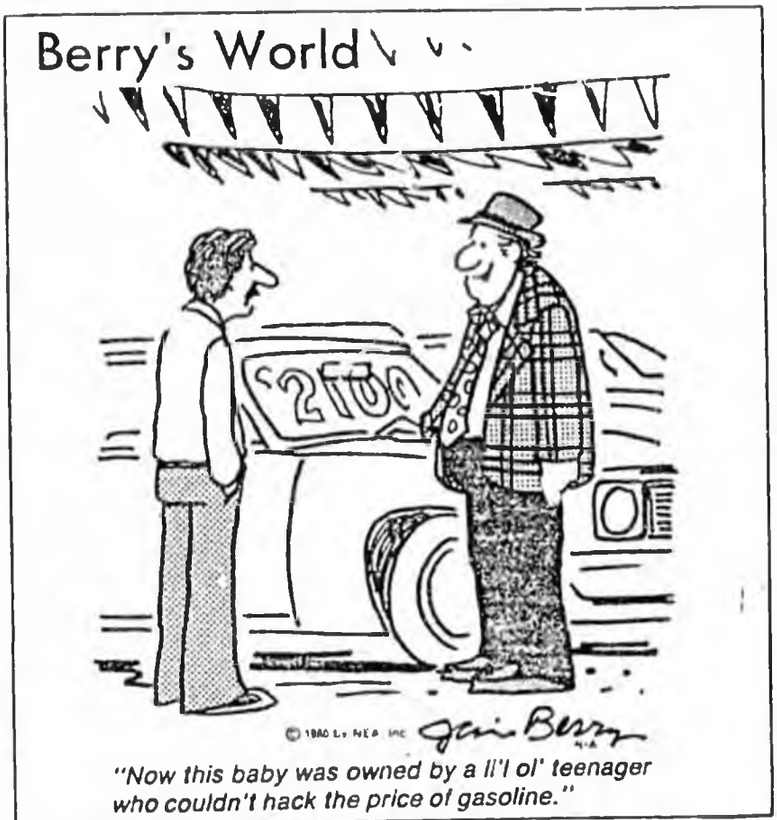
We already, of course, have set up a Renewable Resource Corporation with many millions of dollars and a Fish and Agricultural Bank which recently announced it is opening up six branches in the state. These institutions are totally state owned.

There really are only two answers to stop government expenditures for improper purposes this session. First of all the governor could and should veto by line item such expenditures. However, the probability is the governor will go to the Free Conference Committee and tell them if they add $50 million for his pet projects, he will agree not to veto any part of it.

THE SPEAKER of the House recently in a speech asked the public to quit putting pressure on the legislature to spend more money because they are unable to withstand the pressure. The Speaker knows or should know that this pressure will always exist as long as the government has a surplus. The Speaker is one of the people in the leadership who has to have the fortitude to say "no". It is the problem of which he complains that convinces most of us that we must spend the state's money on debt reduction and capital improvements so that the money isn't there for all these foolish operational programs.

Unless the leadership is going to assume the fortitude to say "no", I suggest the legislature gets about it's business and ends the sessions. Repeal taxes, make money available at reasonable rates for credit within the state, pass the operational budget, and adopt a large capital improvement budget.

The pressure to spend on all sorts of foolish programs will get stronger rather than weaker with every passing day.



"Now this baby was owned by a li'l ol' teenager who couldn't hack the price of gasoline."

generally prevailed.

Yet, always there is the hope of government for all. And so, on April 20, will try again. Five yea three general junta took President Oswaldo Lope was charged with takin bribe from United Brands United Fruit. The junta is tarily relinquishing powe the heady prospect of a open election with a mod curate vote count.

But it is difficult not to Nicaragua, where leftists ists combined to get Anastasio Somoza, now be sliding into Cuban-sty nism. Although the El Sa has ordered the expropr agricultural properties acres the radicals are and shooting continues. ago a cache of bodies ered in a Guatemala ca parent work of right squads.

Why can't Central make democracy work?

First, there is the self, mostly Indian, poli but gyrating between asms and black despair reach out and touch though they were angel dicious cynicism neces ble self-government.

Then, there is the n tral America's agricu coffee fincas may be re client, but sugar and best raised on large t land-owning companie been fair game for but either they or the tem of bickerin, coo necessities. Either wa men wielding machet their own masters.

But in recent ye arisen a more compel social chaos, and that ation of people due t ering of the death rat tries are due to doub tions in the next 18 like the Puerto Rica grate freely to the U the Mexicans who c the fence, these nat cape hatch.

IN 1968, HONDUR with El Salvador t squatters. The Mex thrown back Guatem from the south. With for arable land in t desperate people mo where they form lar increasingly restive

If the population off in this lovely spi two continents pros right, for technology But every advance new tide of babies.

And Marxism, one-time dividend and redistribution, song.

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REPORT OF THE

INTERIM COMMITTEE ON HEALTH CARE,

SOCIAL SERVICES AND

MENTAL HEALTH DELIVERY SYSTEMS

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FEBRUARY 1974

The Health-Care Merry-Go-Round

by George Silver

The health insurance plan offered by Senator Long (left) has the best chance of getting through Congress this session.

FOR ALMOST 60 years now, a political event has unfolded each spring, a ritualized controversy over the value and scope of a national health program. While it is usually billed as "national health insurance," the underlying argument has little to do with health, and only a bit more to do with real insurance.

In the past 20 years, because the Democratic party has adopted national health insurance as a plank in its political platform, the spring ritual has become curiously formalized. The President issues a "health message" around February; White House aides and agency (usually HEW) experts prepare a legislative proposal that goes to the appropriate committee (or committees) in March or April. Then hearings are held, the witnesses for and against heard. The media join the fray with articles, learned discourse on local and national TV, and books. The administration announces the imminence of a legislative health program; Congress denounces the proposal and offers its own alternatives. In fact, a particularly novel aspect of this seasonal rite has been the lush proliferation of congressional counter-proposals, making the health insurance field look more like a war of all against all than an intra-party squabble. The rapid and uncontrollable escalation of the costs of medical care has convinced everyone that some sort of bill should be passed; but the profusion of bills has made consensus even harder to reach. Thus, after a great deal of noise about the need for sweeping reform, one bill cancels out another, and, in the end, only a small, tentative step is taken. And the 1978-80 congressional term looks like a textbook case of the usual formula.

While the ritual has remained more or less the same, the substance of the debate has grown ever more complicated. Seventy years ago national health insurance meant little more than being able to pay a doctor for care. Today we have solved the basic problems of acute and epidemic disease, infant mortality, and the like—except for minority groups and the poor—and we are more concerned with a *program* of care, a guarantee of *systematic* care. We have learned that our piecemeal system doesn't work, doesn't help the people it was presumably targeted for—the needy—and works against the others because it inflates and distorts, and deprives everyone when it doesn't work for the targeted population.

With this new element added, nobody can agree on exactly what national health care means. The variety of proposals is staggering and self-defeating. Once the principal obstacles to national health insurance were such antagonists as physicians, entrepreneurs in pharmacy manufacture or equipment, industry and insurance companies; now there is a plethora of protagonists with such conflicting proposals that the result is the same as if they were antagonists too. There are public and private advocates; professional anti-professionals recommending "health" insurance (as against medical-care insurance) with emphasis on preventive services, lifestyle change, and self-help; syndicalists with a platform of worker-management control; populists with a platform of community control.

The academic world has not been idle either, and there are contrasting economic recipes: tax revenue funding as against employer-employee funding; co-insurance and co-payment advocates as against those who argue for no payment at the time of service; and the anti-insurance cohorts who recommend a heavy personal financial commitment by the patient before *any* government support in order to check the heedless and prodigal use of, and demand for, medical services. Political scientists argue the benefits of a regulatory approach or a public utilities model, while management experts (the new mandarins) propose complex, computerized schemes for controls that would limit costs, adjust distribution, and assure quality.

Congress watchers point to the American Medical Association's multimillion-dollar political contributions and Washington "information office" as the chief villain and architect of the anti-national health program campaign. Certainly political contributions play an important role and have a strong impact on legislators and legislation. But it would be a mistake to give this factor too important a role in frustrating the legislative possibilities over the years. That block has been effective in over 10 administrations. Can the AMA be held solely and totally accountable? On the U.S. political scene representative government requires shifting minority allegiances to [illegible]

position by reciprocal trade-offs: Lesser issues buy votes on larger issues. Health insurance just may not represent a big enough issue for most congressmen to stake out a major position on the agenda.

In any case, it's not the AMA that's responsible for the bewildering variety of health bills now facing Congress; it would rather that none be promoted. Personal experience may shed some light on a more deserving culprit. From 1965 to 1968 I served as the deputy assistant secretary for Health. My boss was the first assistant secretary ever appointed to that job. Another first was the assistant secretary for planning and evaluation, brought over from the Department of Defense to introduce managerial skills and planning expertise into the hodgepodge of the HEW bureaucracy. Planning had one deputy also, for health program evaluation. All in all, there were about a dozen health professionals charged with the responsibility for developing programs agreed upon by the secretary of HEW and proposed by the President. There were also one or two assistants in the White House with such interest. At HEW, we occupied a few rooms on one side of the fifth floor of the old HEW building at Fourth and Constitution.

Congress was similarly endowed: The House and Senate each had one health staff member attached to the relevant committee. Wilbur Mills, then chairman of the House Ways and Means Committee, had a knowledgeable staff man, too, but he liked to keep a strong grip on health financing matters himself.

Today, nearly 250 people are preoccupied with the ramifications of health program development and health planning and evaluation in HEW. There is a huge new building down the street on Independence Avenue to house them. There are over 100 professional staff people in six congressional committees to deal with health legislation. Each congressman on a committee that touches health matters has a specialized staff assistant for health.

In the 1960s the dozen of us managed to get more than 40 health bills through the Congress: powerful instruments like Medicare, Medicaid, and a health manpower development act. Today's hosts have had to postpone even housekeeping measures like salary appropriations from one session to the next because they couldn't muster a majority vote on any health issue.

The problems of bureaucratic overkill and legislative free-for-all are not, of course, confined to health care; most social programs suffer from the same confused welter. The same may be said for the general American resistance to radical reform of any kind. Our taste for "creeping incrementalism" has led to a passion for tinkering and crude adjustment; whether in health care, the tax code, or welfare reform, reconstruction and systematic change have been neglected and delayed, so that social change proceeds at a snail's pace.

THE PRESENT congressional season features an apparent showdown in health-care legislation: Both President Carter and his nemesis, Senator Kennedy, have submitted major health-care bills. But the likelihood is that the prize will elude both. The best we can probably look forward to in this session of the Congress is Senator Russell Long's Catastrophic Health Insurance Protection Bill, possibly to be known as the National Health Insurance Act, even though it will not be, in scope or coverage, what the national health insurance struggle is about.

Kennedy's ambitious health care bill provides free medical care to everyone.

The Kennedy bill provides for everyone in the U.S. to have a credit card entitling him or her to medical care in the home, doctor's office, or hospital without added charge; old people would have their prescribed medicines paid for as well. There is no limit on use (except for psychiatric services) and preventive services are paid for. Funds will come from some employee contributions, larger employer contributions, tax funds for the poor, and contributions from the elderly (who will pay a part themselves as they do today under Medicare). The self-employed will pay, if they choose, a special health insurance premium geared to their income. The monies will go to privately controlled insurance funds, which will dole them out and monitor their use; the program will be planned and supervised by a variety of groups at the local, state, and national levels. There is a special fund set aside to develop and allocate resources (and redistribute them where necessary). And there is a ceiling, unfixed as yet, on expenditures. All this is to become operative in 1983.

The Carter plan is not so ambitious. It puts a ceiling on the total any person would have to spend for health care ("catastrophic" health insurance coverage); prescribes free care for pregnant women and infants under one year of age; recommends fee schedules for private health insurance for which the employer will pay at least three-quarters of the premium; and draws up fee schedules for public medical care to which doctors must adhere. Probably the largest jump in governmental responsibility is in federalizing medical care for the poor. Where now the states set income levels for Medicaid, the new law would set a new federal poverty level and immediately raise by more than 50 percent the number eligible. The Carter plan envisions phasing in of its objectives: After phase one has been implemented, there will be a review of the whole and consideration of what additional steps might be taken next.

Senator Kennedy's proposal, despite its grand intentions, is seriously defective. The surrender to the private insurance industry is curious, for Senator Kennedy has been the principal antagonist of the industry and has criticized it for stoking inflation in collaboration with health-care providers. While a ceiling on expenditures is proposed, and physician income may well be curtailed in this way, *non-physician* income is untouched. Since 60 percent of hospital costs are personnel costs and hospital costs are 40 percent of overall medical-care expenditures, there is a large loophole for sharply rising costs to escape the ceiling. What measures will be taken if institutions exceed budget? Will they file for bankruptcy? More serious is the vast increase in personnel proposed, layered on top of an existing regulatory bureaucracy. By now we must have learned that large bureaucracies cannot provide human services with efficiency.

President Carter's plan has highly visible flaws and no appeal to the articulate constituencies (like labor) that seek national health insurance legislation which will benefit *them*, immediately. It is *targeted* for specific groups, a shibboleth of his economic advisors, and offers little universal benefit. The failures of implementation of existing reform legislation bode ill for that part of the effort. It prescribes a reliance on unsupervised private insurance far greater than does Senator Kennedy's proposal. The whole effort is more pious and prayerful than useful. Costs would continue to mount, most of the poorly served would remain so, specialism would increase, and enrichment of the medical profession would continue to be guaranteed. No ceiling on expenditures means no ceiling on costs or income.

Sadly enough, in extending the Medicaid principle and reinforcing it, the Carter plan continues the "two-tier" sys-

tem of medical care that has been the curse of the present system: poor medical care for poor people, better medical care for the better off.

Senator Long's plan, the leading contender for passage in this Congress, if any bill is to pass, is relatively simple and ineffectual in altering the circumstances that contribute to present dissatisfactions. It will most certainly augment inflation. The plan advocates a catastrophic protection clause: After a family spends $2,000, government insurance would pay the remainder of any medical bills that year. It encourages hospital care and offers incentives to doctors and hospitals to raise fees ("get over that barrier" of $2,000 as quickly as possible to make the family eligible). President Carter's endorsement of this proposal as part of his phase one is equally inflationary.

But if history is our guide, Long's plan has the inside track. First of all, it will change nothing, a considerable advantage. Second, national legislation usually waits for state models to provide guidelines as well as to test the water of public acceptance. The states serve as "laboratories" for national experimentation, to use Brandeis's phrase. We have had state experiments in the health field before passage of other national health legislation; and in the past five years we have had state catastrophic health insurance laws (Rhode Island and Hawaii, for example). But we have never had a state compulsory health insurance law, despite some efforts on occasion in California, New York, Massachusetts, Michigan, and Pennsylvania. The generally successful experience with state catastrophic health insurance laws makes the probability of Long's plan becoming law more likely.

Political wisdom might dictate to Senator Kennedy (or Governor Brown, and other potential presidential candidates practicing in the bullpen) a powerful effort to obtain a model state program of compulsory health care. Who controls the politics of Massachusetts anyway?

TODAY'S PROPOSALS for national health insurance offer little cause for optimism that real change will take place in the system. The one thing that none of the plans promise—neither Carter's nor Kennedy's nor Long's—is equity. A concern with equity makes us ask the question: Do we want the poor and minorities to have the same medical care as the rich and the white? Do we want a health-care system that says that we are all entitled to care, as we need it, when we need it? Or one that says, if we can find it, or get it, an insurance company will pay for it?

It may be that, given the alignment of forces, this is the time to suggest a state health insurance program that undertakes radical reform, but in a smaller arena, say child health care, to test the feasibility, cost, and organizational considerations. We should seek equal access and high-quality cost control in this smaller arena by cooperative effort in which the federal government waives rigid regulations for the use of federal funds and the states incorporate these sums into a statewide health service financial budget. Applying such a program to child health care would naturally include an emphasis on preventive services, which are especially cheap for children: The most comprehensive program, instituted in Holland, costs roughly 9¢ per child per day. Since the Dutch standard of living and wage scale aren't too different from ours, it's likely that such a preventive system will cost no more here.

Carter's plan has visible flaws and is more pious and prayerful than useful.

If such a program worked for children, the lessons ultimately could be applied to adults and to the nation as a whole. There is already fairly widespread acceptance of the rough outline of an effective and economical national system. It will be prepaid; that is, people will pay little or nothing at the time of care to overcome costly and cumbersome bookkeeping, financial barriers to prompt use of services, and the quirky variations in charges that make budgeting impossible. Doctors will be part of a group organization, making all kinds of specialized care readily available to patients. The doctors will be salaried, eliminating the competitive aspects of present practice that encourage overuse of technology and referrals.

Primary care will be a team process, with family doctors and nurse practitioners or medical assistants liberally distributed in small clusters throughout the neighborhoods of the communities for easy access by patients. The teams will be part of groups, which in turn will be part of hospital units serving designated populations. Very complicated, delicate, and expensive hospital procedures will be restricted to a few regional hospitals, and effective transport and emergency vehicles will tie this network of care together.

From an organizational standpoint, regional commissions, possibly elected units like regional school boards, will deal with budgets, distributional problems, and manpower. Local committees, also possibly elected, will serve as channels of communication between the patients and the professionals: Grievances can be mediated this way, and local supervision can provide information on the operation of the groups and teams.

The entire program will be highly localized in order to keep huge bureaucracies from developing and becoming the self-serving megastructures that are the bane of modern life. If the regional commissions actually carry out their supervisory functions, this allocation of funds to local communities to plan imaginative and locally satisfactory approaches to medical care will ensure a useful national health program.

It will follow that while the monies for the service will be in the hands of local boards for disbursement, the source of the funds still will have to be federal and state taxes. The actual way in which the tax structure will have to be changed to accommodate a valid national health-care system remains unclear.

It's easy for someone outside the system to spin out an ideal plan, particularly if that someone won't have to take the responsibility for what happens if it should become operative. Nonetheless, the political possibilities are there and the potential examples abound. Ten million Americans belong to prepaid group practice systems. There are school systems with comprehensive preventive programs for children. Nearly 30 percent of the doctors in the United States are on salary now. Many neighborhood hospitals, like neighborhood schools, serve the local population exclusively. What is missing is a national commitment, national standards, assent to equity.

The agonizing over a national health program is only another example of the struggle Americans have had in this century to come to terms with the contradictions of their political heritage: individual responsibility and freedom to succeed and achieve, and to fail and suffer, on the one hand; on the other, government responsibility for the good and welfare of all. Our political tradition is cautious, too, not wanting to take too big a bite at one time. It makes sense to try the new remedy in a few states before you prescribe it for 215 million people. But you must try it, then, or be reconciled never to have a remedy at all!

Dr. Silver is a professor of public health at the Yale School of Medicine. His most recent book is Child Health: America's Future.

Health Boards

Board or Commission	Appointee	Term

BOARD OF NURSING
AS 08.68 - 7 members; 5 year term; removed only for neglect of duty or for unprofessional or dishonorable conduct after a fair and impartial hearing.

Norma J. Frank, R.N. — March 31, 1979
Box 4229
Mt. Edgecumbe, Alaska 99835
747-8244 (home)
966-8342 (work)

Eileen Montano, R.N. (chairman) — March 31, 1981
SR Box 10033
1.5 Mile Chena Ridge Road
Fairbanks, Alaska 99701
353-4227

Betty Irwin Hodo, R.N. — March 31, 1980
3812 Katmai Circle
Anchorage, Alaska 99503
274-3740 (home)
272-5522 Extention 140 (work)

Kandace Henry (public member/secretary) — March 31, 1980
1222 16th Avenue
Fairbanks, Alaska 99701
452-5310 (home)

Carol Ann Verga — March 31, 1982
Box 5138
Ketchikan, Alaska 99901
225-2620 (home)
225-6688 (work)

Erna Rasmussen (public member) — March 31, 1981
Box 2
Nome, Alaska 99762
443-2919 (home)
443-2798 (work)

Marion E. Bayless, R.N. — March 31, 1983
Chief, Area Nursing Services Branch
Alaska Area Native Health Service
Box 7-741
Anchorage, Alaska 99510
265-3121; 265-3122 work
333-5742

Board or Commission	Appointee	Term
STATE MEDICAL BOARD AS 08.64 - 7 members; 4 year term, serves until new member is appointed and qualified.		
	Jeffrey A. Partnow SR 3, Box 31473 Fairbanks, Alaska 99701 456-4724 (home) 452-4769 (work)	November 6, 1980
	Thomas J. Harrison, M.D. 3500 Lateuche, Suite 250 Anchorage, Alaska 99501 333-~~4513~~ (home) 4563 277-4151 (work)	July 8, 1980
	Thomas Stengl, M.D. Box 1059 Auke Bay, Alaska 99821 586-7466 or 586-6601 (work) 789-0805 (home)	January 12, 1980
	Hilbert J. Henrickson, M.D. (chairman) 3612 North Tongass Avenue Ketchikan, Alaska 99901 225-58[illegible] (home) 225-5146 (work)	April 21, 1982
	Winthrop Fish, M.D. 1249 Bannister Anchorage, Alaska 99504 279-8262 (home) 272-5733 (work)	April 21, 1981
	Janette P. Adasiak 1835 Crescent Drive Anchorage, Alaska 99504 279-4970	August 13, 1980
	Hugh Gellert Box 386 E. SRA Anchorage, Alaska 99507 344-3240 (home) 272-4922 (work)	January 19, 1981

Board or Commission	Appointee	Term

BOARD OF PHARMACY
AS 08.80 - 7 members, 5 year term; serves until the new member is appointed and qualified; Legislative co..firmation.

Eldon Ulmer (chairman) P.O. Box 1420 Anchorage, Alaska 99510 344-1260 (home) 277-2567 (work)	March 31, 1982
James L. Murphy 1114 Galena Street Fairbanks, Alaska 99701 456-4667 (home) 452-2328 (work)	March 31, 1981
Lester E. Elkins P.O. Box 409 Petersburg, Alaska 99833 772-3241 (work)	March 31, 1983
Charles R. Rush Box 3728 Anchorage, Alaska 99501 277-2701 (home) 272-6431 (work)	March 31, 1979
James H. McCorcle Box 450 Juneau, Alaska 99802 586-1025 (work) 586-2493 (home)	March 31, 1980
Fred Savok (public member) 8320 East 10th Anchorage, Alaska 99504 337-4965 (home)	March 31, 1981
Robert K. Snider (public member) P.O. Box 1620 Anchorage, Alaska 99510 277-5306 (home) 279-6471 (work)	March 31, 1980

Board or Commission	Appointee	Term

BOARD OF EXAMINERS IN OPTOMETRY
AS 08.72 - 5 members; 3 year term; serves until new member is appointed.

Timothy B. McLaughlin, O.D. (chairman) — June 15, 1979
P.O. Box 498
Sitka, Alaska 99835
747-6645 (work)
747-8449 (home)

John T. Shank, O.D. — June 15, 1980
P.O. Box 827
Kodiak, Alaska 99615
486-3859 (home)
486-5504 or 5592 (work)

Thomas Kinsella (public member) — June 15, 1981
SR Box 31071
Fairbanks, Alaska 99701
456-2617 (home)
452-1155 (work)

Carolyn J. Black — June 15, 1979
Box 24
Haines, Alaska 99827
766-2583 (home)
766-2576 (work)

Dr. Maynard Falconer — June 15, 1981
P.O. Box 919
Anchorage, Alaska 99501

Board or Commission	Appointee	Term

BOARD OF DISPENSING OPTICIANS
AS 08.71 - 7 members; serve at the pleasure of the Governor, 3 year term

George Tresnak — June 14, 1979
6051 East 22nd Avenue
Anchorage, Alaska 99504
333-9931 (home)
272-5715 (work)

Dick L. Kleinkopf (chairman) — June 14, 1981
P.O. Box 1660
Fairbanks, Alaska 99701
456-5316 (home)
452-5208 (work)

Philip A. Lampert — June 14, 1979
P.O. Box 4-2183
Anchorage, Alaska 99509
274-2273 (home)
274-9210 (work)

Edna M. Lyon — June 14, 1981
P.O. Box 92
Anchorage, Alaska 99510
272-6328 (home)
272-5715 (work)

Robert Sherwood (public member) — June 14, 1980
730 I Street
Anchorage, Alaska 99501
279-0422 (work)
276-4960 (home)

Harry J. Lang (public member) — June 14, 1979
1406 West 47th Avenue
Anchorage, Alaska 99503
279-5741 (work)

Larry E. Harper — June 14, 1980
404 K Street
Anchorage, Alaska 99501
349-4394 (home)
272-8632 (work)

Board or Commission	Appointee	Term

STATE PHYSICAL THERAPY BOARD
AS 08.84 - 5 members; 3 year term; shall serve until successors are appointed; appointed by the Governor.

Edward T. Heuston (secretary) Star Route, Box 6014 Eagle River, Alaska 99577 694-9761 (home) 274-3505 (work)	September 1, 1980
Gary W. McCarthy 1940 Patterson Anchorage, Alaska 99504	September 1, 1980
Donna Klokkevold, RPT (chairman) 3710 East 20th Avenue Anchorage, Alaska 99504 277-2219 (home) 272-0586 (work)	September 1, 1981
J. Michael James, M.D. 3710 East 20th Avenue Anchorage, Alaska 99504 277-1312 (work) 279-6094 (home)	September 1, 1980

Board or Commission	Appointee	Term

BOARD OF NURSING HOME ADMINISTRATORS
AS 08.70 - 5 members; 3 year term; serve at the pleasure of the Governor.

Leona Bowles 318 4th Street, Graehl Fairbanks, Alaska 99701 456-4586 (home) 452-1735 (work)	October 1, 1981
Roberley Reh Potter (administrator) Box 1176 Sitka, Alaska 99835 747-8250 (work)	October 1, 1979
Jane Hanna, R.N. (chairman) Route 3, Box 3738 Juneau, Alaska 99801 586-1529 (home)	October 1, 1980
Donna M. Stephens SR Box 50060 Fairbanks, Alaska 99701 479-4543 (home) 452-1921 (work)	October 1, 1980
Dove M. Kull 326 4th Street Mendenhall Apartments #1010 Juneau, Alaska 99801 586-2670 (home)	October 1, 1980

Board or Commission	Appointee	Term
BOARD OF CHIROPRACTIC EXAMINERS AS 08.20 - 5 members; 3 year term; serve at the pleasure of the Governor.		
	Keith Godfrey (chairman) 3800 Lake Otis Parkway Anchorage, Alaska 99504 272-0123 (work) 279-5838 (home)	July 15, 1979
	Adrian Barber (secretary) Klatt Station Box 10033 Anchorage, Alaska 99501 344-1501 (work) 344-7674 (home)	July 15, 1978
	Lee Q. Burger (vice president) 320 Bawden #306 Ketchikan, Alaska 99901 225-6815 (work) 225-2018 (home)	July 15, 1980
	Locke Jacobs (public member) 3540 Wingate Circle Anchorage, Alaska 99504 277-5682 (home) 277-1587 (work)	July 15, 1979
	Linnea Burmeister (public member) P.O. Box 1103 Nome, Alaska 99762 443-2958	July 15, 1981

Board or Commission	Appointee	Term

BOARD OF DENTAL EXAMINERS
AS 08.36 - 7 members; serves 5 year term, until new member is appointed and qualified

Wayne Putman, D.M.D. — February 1, 1983
Route 5, Box 5107
Juneau, Alaska 99803
789-6983 (work)
789-9045 (home)

Arthur Hansen (chairman) — February 1, 1982
3487 Airport Road
Fairbanks, Alaska 99701
479-2100 (work)
479-2101 (home)

Leonard Yuknis, D.D.S. — February 1, 1979
2601 Boniface Parkway
Anchorage, Alaska 99504
333-9591 (work)
344-5784 (home)

John R. Beard (public member) — February 1, 1981
425 G Street
Anchorage, Alaska 99501
277-3213 (work)

Jana M. Varrati, R.D.H. (dental hygienist) — February 1, 1981
7030 Foothill Drive
Anchorage, Alaska 99504
333-9591 or 272-7232 (work)
279-0268 (home)

Claude G. Rick, D.D.S. — February 1, 1981
3606 Rhone Circle
Anchorage, Alaska 99504
279-6235 (work)
272-0812 (home)

John Kobylarz, D.M.D. (secretary) — February 1, 1980
P.O. Box 830
Soldotna, Alaska 99669
262-4690 (work)
262-4942 (home)

Board or Commission	Appointee	Term

BOARD OF VETERINARY EXAMINERS
AS 08.98 - 3 members; 4 year term; serves at the pleasure of the Governor.

Berton A. Gore, D.V.M. (chairman) — July 31, 1980
P.O. Box 666
Palmer, Alaska 99645
745-3219 (work)
745-3345 (home)

Clifford D. Lobaugh, D.V.M. — January 31, 1981
RR#6 Box 3552
Juneau, Alaska 99803
789-9210 (home)
789-7551 (work)

David Howe, D.V.M.
2639 Boniface Parkway
Anchorage, Alaska 99504
337-1561 (work)
333-7207 (home)

Board or Commission	Appointee	Term

BOARD OF PSYCHOLOGISTS AND PSYCHOLOGICAL ASSOCIATE EXAMINERS
AS 08.86 - 5 members; 3 year terms; serves at the pleasure of the Governor.

Dorothy Whitmore, Ed.D. (chairman) — July 1, 1980
207 E. Northe Lights Blvd.
Suite 202
Anchorage, Alaska 99503
344-2078 (home)
276-2230 (work)

James C. Parsons — July 1, 1979
207 E. Northern Lights Blvd.
Suite 202
Anchorage, Alaska 99503
276-2230 (work)
279-3735 (home)

Robert D. Bowers — July 1, 1981
7744 Boundary Avenue
Anchorage, Alaska 99504
337-6256 (home)
279-9544 (work)

Dick L. Madson — July 1, 1980
Suite D, Nerland Building
543 Third Avenue
Fairbanks, Alaska 99701
456-7219 (home)
452-4215 or 452-4254 (work)

Pam Delys Raglien, Ph.D. — July 1, 1981
Kodiak/Aleutian Mental
Health Center
P.O. Box 712
Kodiak, Alaska 99615
486-5742 (work)

Official Business

Alaska State Legislature

House of Representatives

Committee on

Health, Education & Social Services

Pouch V
State Capitol
Juneau, Alaska 99811

March 28, 1980

To: Members of the House HESS Committee

From: Representative Thelma Buchholdt, Chair
House HESS Committee

Subject: HB977

Coming up for hearing in Committee on Monday, March 31 and Tuesday and Wednesday, April 1 and 2, will be a major bill to extend health coverage in this state. Enclosed is background material on the legislation. Briefly, it includes:

I. Summary of Proposed Health Legislation

This is a detailed explanation of the provisions of the bill. Section one requires employers to sponsor prepaid group health care plans for their employers. Section two requires insurance carriers to form a joint underwriting association and issue coverage for high risk "uninsurable" clients. It also establishes state standards for "qualified" health policies and requires carriers to offer qualified olicies to their clients. The remaining several sections expand s ate medical assistance programs and address provider payment problems.

II. An Analysis of the Extent of Health Care Coverage and Gaps in Coverage

This is an excerpt from Third Party Health Coverage in Alaska published by Legislative Affairs Agency Research Division in April, 1978. The author estimates that between 20 and 25 percent of the non-Native non-military population state-wide currently lack third party health coverage. An addendum h been included estimating that roughly 200 high risk clients uld enroll for the pooled risk coverage.

III. An Analysis of the Social Impact of the Proposed Health Legislation

This section considers the bill's impact on the public, on employers and employees, and on insurance carriers. It is estimated that the legislation would expand health coverage in the state to cover more than 95 percent of the population. Mandatory employer sponsored covera in which the premiums

are shared by the employer and the employee would raise labor costs to the employer and would lower the take-home pay of the employee. The premium cost of the required coverage is estimated at $30 to $50 per month for a single employee and $75 to $110 per month for an employee with dependents. The impact on insurance carriers would depend on how closely the bill's requirements match current practice and how large the volume of health insurance business the carrier has in Alaska.

IV. The Experience in Other States

This section includes two speeches presented at the "Health Care Financing Options for Colorado" conference, September, 1979. The first speech is by George Yuen, Director of Health, State of Hawaii, and describes the operation of Hawaii's Prepaid Health Care Act mandating employer sponsored coverage. The second speech is by Brian Oberg, Administrative Assistant to the Health and Welfare Committee, Minnesota House of Representatives. It describes the operation of Minnesota's Comprehensive Health Insurance Act which sets minimum standards for health insurance policies and establishes a mandatory assocaition of insurance carriers to underwrite health insurance for people who, because of existing health conditions, are unable to buy standard coverage. Both states have been very pleased with the results of their legislation and have experienced very few problems with it.

V. Legal Issues

A law suit has been brought against the Minnesota law challenging its constitutionality. While it is too early to predict the final outcome, the State of Minnesota is confident that the law will survive this test. This section includes a speech by John Igrassia, Supervisor of the Life and Health Section of the Minnesota Division of Insurance, discussing some of the legal issues in the case.

PROJECT HEALTH

The Multnomah County Medical Society supports the concept and goals of "Project Health" in principal, as they act to care for the medically indigent in our community. The Society encourages individual physicians to give consideration to participation in this project.

POSITION: Board of Trustees 2/27/74 - Executive Committee

PROJECT HEALTH I

The Multnomah County Medical Society recommends that, in the interest of quality patient care, physicians participating in the 'Project Health' pilot program should continue to bill their usual fees for professional services. When 'Project Health' funds are exhausted, the Multnomah County Medical Society urges its members to continue to provide care for these patients.

The Society also asks the 'Project Health' staff to provide an accounting of those patients who received care, showing the number of patients receiving care, the amounts billed, and the amounts paid.

POLICY: Board of Trustees 3/27/74 - Executive Committee

LA11 2313 11.28 JA01 0020 11.28 04/03/80

TO REP. BUCHHOLDT AND HER STAFF

BERNEICE BAR, 4220 B ST., SUITE 201, ANCHORAGE, AK 99503 WAS AT THE TELECONFERENCE ON HB 977 THE OTHER DAY, AND DURING THE COURSE OF THE CONFERENCE ASKED WHAT "REHABILITATIVE SERVICES" ON P. 33, LINE 8, ENTAILED. SHE SPOKE WITH SOMEONE FROM REP. BUCHHOLDT'S STAFF (COULDN'T REMEMBER THE NAME) WHO TOLD HER THAT SHE WOULD RESEARCH IT AND SEND HER INFORMATION. MS. BAR WORKS WITH REHABILITATION SERVICES AND THIS IS OF PARTICULAR INTEREST TO HER.

MS. BAR WAS EXPECTING THIS INFO TO BE TELECOPIED TO HER THROUGH OUR OFFICE.

WILL THE INFO BE FORTHCOMING? COULD I TELL HER WHEN TO EXPECT IT? THANKS. EFFIE (ANCHORAGE LEGISLATIVE INFORMATION OFFICE)

Jan 5

LA11 2390 14.02 JA01 0066 14.02 04/10/80

TO: JAN IN REP. BUCHHOLDT'S OFFICE
HOUSE MESS

FROM BERNEICE BAR, 4220 B. ST., SUITE 201, ANCHORAGE 99503
PHONE 279-9431

I HAVE NOT YET RECEIVED THE INFORMATION WHICH I REQUESTED ABOUT THE REHABILITATION SERVICES MENTIONED ON P. 33 LINE 8, OF HB 977. YOU MENTIONED WHEN I INQUIRED LAST WEEK THAT YOU WOULD BE MAILING IT.

Sent 4-11

YOUR PROMPT ATTENTION TO THIS MATTER WOULD REALLY BE APPRECIATED.
THANKS.

LIMITS ON EMPLOYEE SHARE OF PREMIUM COST

Hourly Wage	Gross Monthly Wage (172 hrs.)	Maximum employee share (HB 977) 1.5%	2%	3%
$3.60	$619	$9.29	12.38	18.57
4.00	688	10.32	13.76	20.64
6.00	1032	15.48	20.64	30.96
8.00	1376	20.64	27.52	41.28
10.00	1720	25.80	34.40	51.60
15.00	2580	38.70	51.60	77.40
20.00	3440	51.60	68.80	103.20

ESTIMATED PREMIUM COSTS FOR NUMBER TWO QUALIFIED PLANS[1]

Individual Plans - Employee Only	Minnesota Rate November 1979 (Quarterly)	Area Differential[2]	Est. Rate in Alaska (Quarterly)	Est. Rate in Alaska (Monthly)
low: Blue Cross/Blue Shield, Male age 20-24	$31.47	+12%	$35.25	$11.75
high: State Farm, Male or Female age 60-64	214.40	+ 7%	229.41	76.47
Average of 5 carriers[3], Male age 35-39	55.42	+11%	61.52	20.51
Average of 5 carriers[3], Female age 35-39	87.13	+11%	96.71	32.24
Individual Plans - Employee and Dependents				
low: Blue Cross/Blue Shield, M 20-24 + F 20-24 + children	$128.27	+13%	144.95	$48.32
high: State Farm, M 60-64 + F 60-64 + children	487.68	+ 7%	521.82	$173.94
Average of 5 carriers[3], M 35-39 + F 30-34 + children	185.80	+11%	206.24	$68.75

Group plan premiums are roughly 8% less than individual plan premiums.

1 The Minnesota minimum standards for a number two qualified plan are the same as those specified in HB 977 except that the requirements for coverage for well baby care, physical exams, and multi phasic screening have not yet taken effect in Minnesota, and Minnesota does not cover medically necessary transportation (other than an ambulance) or treatment for alcoholism or chemical dependence.

2 Derived from the area schedule of premiums of the CARE group insurance trust for all Alaska and for Anoka, Dakota, Hennepin, Ramsey, and Washington counties in Minnesota.

3 Blue Cross/Blue Shield, Prudential, State Farm, National Farmers Union, and Massachusetts Mutual. This is a straight average and not a weighted average. Since Blue Cross/Blue Shield has by far the lowest rates and covers 96% of the people covered by these five Minnesota carriers, the straight average used here is substantially higher than the weighted average would be.

A COMPARISON OF BENEFITS UNDER HB 977
AND THREE OTHER COMPREHENSIVE HEALTH PLANS

Benefit	State Employees Blue Cross Plan	Alaska #2 Qualified Plan (HB 977)	Minnesota #2 Qualified Plan	Connecticut Middle Option Plan
deductible	$50/person; $150/family	$500/person; $1500/family	$500/person	$500/person
co-payment	10%	20%	20%	20%
out-of-pocket limit	$2000	$3000	$3000	$1000/person; $2000/family
maximum lifetime benefit	$250,000	$250,000	$250,000	$1,000,000
pre-existing conditions limit	maximum benefit limited during 1st year of plan coverage to $1000 for any pre-existing condition which was treated during the 3 months prior to enrollment in the plan	not specified	not specified	conditions manifested or treated in the 6 months prior to enrollment excluded from coverage for one year
fee basis	usual, customary and reasonable charges	usual and customary charges	usual and customary charges	may not exceed reasonable charges or rates approved by the commission on hospital and health care
COVERED SERVICES:				
hospital services	yes	yes	yes	yes
physician services	care rendered by M.D., osteopath, psychologist, chiropractor, podiatrist or Christian Science practitioner	care rendered by or at the direction of a physician	care rendered by or at the direction of a physician	professional services rendered by an M.D., osteopath, chiropractor, podiatrist, psychologist, or naturopath
private duty nursing	RN services at the direction of a physician	professional services rendered at the direction of a physician	professional services rendered at the direction of a physician	professional services rendered by a registered nurse at the direction of a physician

Benefit	State Employees Blue Cross Plan	Alaska #2 Qualified Plan (HB 977)	Minnesota #2 Qualified Plan	Connecticut Middle Option Plan
Prescription drugs	yes	yes	yes	yes
radiation	yes	yes	yes	yes
x-ray & lab exams	yes	yes	yes	yes
oxygen	yes	yes	yes	yes
anesthetic	yes	yes	yes	yes
prostheses	yes	yes	yes	yes
medical supplies	bandages, crutches, wheel chairs, respirators, blood, hospital type beds, plasma	rental or purchase of durable medical equipment	rental or purchase of durable medical equipment	rental or purchase of durable medical equipment
pregnancy & childbirth	yes	yes	yes	$250 limit except for complications
travel	ambulance or commercial airline to nearest facility	medically necessary transportation	ambulance to nearest facility & mileage rate to kidney dialysis treatment center	ambulance to nearest facility
alcoholism treatment	yes, on inpatient basis, except limited to $1000 maximum if the facility does not have a contract with Blue Cross	yes	yes(required by law of all health insurance policies	yes
mental & nervous disorders	50% coverage up to $2500 maximum per year when rendered by and M.D., D.O., or licensed psychologist	———	———	50% coverage

Benefits	State Employees Blue Cross Plan	Alaska #2 Qualified Plan (HB 977)	Minnesota #2 Qualified Plan	Connecticut Middle Option Plan
Nursing home	___	120 days maximum if begun within 14 days of a hospital stay of at least 3 days	120 days maximum if it would qualify under Medicare	120 days maximum if begun within 14 days of a hospital stay of at least 3 days
home health care	____	up to 180 visits/year	if it would qualify under Medicare	up to 180 visits/year
oral surgery	yes	yes	yes	yes
physical therapist	___	yes	yes	yes
well baby care	___	yes, subject to deductibles, coinsurance and limits	effective July 1, 1980	_____
physical exams	___	yes, subject to applicable deductibles coinsurance and limits	effective July 1, 1982	_____
multiphasic screening & other diagnosis	___	yes, subject to coinsurance, deductibles & limits	effective July 1, 1982	_____
dental care	70 - 100% coverage up to a maximum of $1000 per year	_____	_____	_____
vision & optical	90% coverage for 1 exam and 1 set of lenses/year	_____	_____	_____
audio	80% coverage up to $400 over 3 years	_____	_____	_____
medical social services	_____	_____	_____	$200 limit

Benefit	State Employees Blue Cross Plan	Alaska #2 Qualified Plan (HB 977)	Minnesota #2 Qualified Plan	Connecticut Middle Option Plan
conversion privileges	yes	yes	yes	yes
dependent coverage	spouse, dependent children under 23, disabled children of any age who are financially dependent	spouse, children under 18, children under 25 who are students and financially dependent, disabled children of any age who are financially dependent and dependent household members	spouse, children under 19, children under 25 who are students and financially dependent, children of any age who are disabled and dependent	not specified

Section 18.12.040, on Page 3. This section discusses the commencement of coverage. It will mean a change in the usual probationary periods that have been set up by employers for their employees. The four week phase-in into the health care plan does not jibe with the usual two month, or sometimes three month, probation period for employees joining a company and may create a problem for an employer. We would need, here at Blue Cross, to adjust for our Alaskan employees the standard probationary period of our company. This would create a problem for our company as it would for any other company who has employees both in Alaska and in other states.

Section 18.12.070, Pages 4 and 5. This section of the legislation enables a person who has coverage as a dependent under some other health care plan to waive his coverage through his employer. That will create a complication in administration for employers. Looking at it from the point of view of insurance coverage, it will also create the possibility of selection of coverage, where the person knowing himself/herself to be in poor health will accept coverage under both types of employment and the healthy individual will not. That will result in the utilization being increased and therefore the cost to the employer for premium also will rise.

4B/11
js

Section 21.50.010(d) on Page 13. In this section of the bill an "unqualified policy" is used as terminology. There is no definition in this bill of an unqualified policy. This bill also uses the term "nonqualified plan" and there is confusion between "unqualified policy" and "nonqualified plan."

js
4B/12

Section 21.50.030(1), on Pages 14 and 15. The definition of minimum benefits needs some major corrections. All benefits offered in a state health plan should be determined to be medically necessary. A definition of medically necessary should be included in the definition section of this legislation. The reference throughout this subsection to services by varying health care practitioners never refers to them as licensed health care practitioners which I think should be inserted into the bill. The bill does not require that the service [redacted] be provided by a practitioner [redacted] within the scope of his practice. Tightening up the language will eliminate payment of claims for procedures that were provided by a practitioner whose scope of practice does not include that procedure and would eliminate payment for procedures which are not necessary to the life or health of the patient. In Subsection (D), services of a nursing home are included as a benefit. Nursing homes should be identified either as licensed or Medicare-approved.

Subsection (E) defines services of a home health agency. In the delineation of services by a home health agency I would urge you to list those services which will be covered for a patient served in his home. In other insurance contracts home health services often lists the practitioners whose services will be accepted as well as the paraprofessionals that will be included in this service. This bill, as it is now written, could result in a tremendous increase in home health costs and therefore an increase in premium price over a more restricted benefit.

Subsection (L) of this bill deals with oral surgery. While the root canal and oral surgery definitions are well worded, the wording of the language dealing with periodontal work would be very hard to administer. It would be difficult to explain to a patient that his periodontal services will be paid for if only periodontal work is done, but will not be paid for if, at the same time as having the periodontal surgery, there is some extraction or repair of teeth.

In subsection (N) the provision of payment for transportation must be more succinctly defined. As written,it is very broad and will be very expensive and administration will be difficult.

js
4B/13

Section 21.50.030(2) on Page 15. Subsection 2 deals with the exclusions for services or articles which will not be covered in the insurance. In (b) of that section, the phrase "birth defect" is used. I would suggest that a definition of birth defect be included in the definition section.

I would urge you to add a 5th exclusion to this section for services of custodial care. I would urge you to add a definition of custodial care which might read "Any portion of a service, procedure or supply rendered to manage a patient's illness, disease or injury after he or she has reached a point in recovery where such management, can no longer be expected to improve the condition."

Subsection (3) of this minimum benefit section lists benefits with specialized co-insurance, premium deductibles, and limitations. A definition of "well baby care" is needed. The inclusion of routine physicals and annual physicals should be limited more than the present language. Annual physicals, technically, are not prescribed by a physician. To control overutilization of this benefit, you may want to look at some of the recent changes announced by the American Cancer Society where they are recommending that cancer check-ups for persons between ages 20 and 40 be limited to one every three years. They are talking in terms of mammography for breast cancer detection yearly only for women over 50 and they are reducing the recommended number of chest x-rays as well as the recommended number of Pap smears from one a year to one every three years. This seems to be the trend in the detection of illness area and the language used in this bill should perhaps refer either to limitations of this sort or to dollar limitations in order to control utilization of a procedure that may not be cost effective.

Multiphasic screening should also be limited either by a dollar limitation or by a limitation on the number of procedures per year which will be paid for by the insurance.

All these changes have been suggested to eliminate the probability of excessive use, to eliminate inappropriate utilization, and to control costs to those necessary for the good health of Alaskans.

js
4B/14

Section 21.50.040 on Page 16. This section, which deals with Medicare Supplement Plans, does not seem to recognize that Medicare Supplement is also available to the disabled person under age 65 who is a Medicare recipient. The language of this section needs to take into account the fact that there are persons under 65 who are disabled who do purchase Medicare Supplement policies.

It is our concern that the benefits in this section for the Medicare Supplement Plan are so extensive that the costs will become too high for the average person to purchase a Medicare Supplement policy. The benefits which the State of Alaska would include in a Medicare Supplement Plan (which are not now included in Medicare-approved services) are prescription drugs, prostheses, durable medical equipment, oral surgery, and transportation. Two of the services, those of physical therapists and alcoholism treatment, are now limited by Medicare and an appreciable portion of the costs for services of this sort would then be born by the Supplement Plan. Since there is also a limitation of a $1,000 per person out-of-pocket for these covered services, it is expected that the utilization of these benefits would be extremely heavy and would therefore make the cost of the Medicare Supplement Program extremely high.

At the time that Congress was debating Medicare coverage, prescription drugs, transportation, and custodial care in nursing homes were all subjects which were debated and which were dropped out of Medicare coverage because the Federal Government did not feel that it had sufficient revenues to pay for these coverages. While the addition of these benefits would be of interest to many senior citizens in Alaska, the cost of providing these services may result in pricing the Medicare Supplement contract out of the reach of anyone on a retirement income.

js
4B/15

Section 21.50.080, Subsection 6(c), Page 21. This section specifies a 12-1/2 percent limit for retention costs and agent fees for the writing carrier of the State Plan. I know of no information which would indicate that this is a reasonable percentage. I would suggest that the Division of Insurance determine a reasonable limit and adopt it in regulations after sufficient experience indicates what that limitation should be.

In Section 6(e) the wording should be amended on lines 23 and 25 of Page 21 so that the losses which the members of the association will share will be losses due to administrative as well as claims expenses. I would suggest that on lines 23 and 25 that the words "and administrative" be inserted between the word "claims" and "expenses".

Section 21.50.080(6)(f) concerns the assessment of losses and they are offset either by income tax or premium tax payable in the State of Alaska. This offset will of course result in a loss of state revenue. It is the opinion of those persons at Blue Cross who have studied this legislation that the write-off should be eliminated and instead that rates for the state plan should be adjusted to assure revenue sufficient to refund the assessments paid by members of the association. This would eliminate the loss of revenue to the state and would place all members in an equal status regardless of whether they are accident and health insurers or nonprofit health service plans.

If an offset is included in this legislation then the second sentence of paragraph (f) should be amended in order to assure that the report to the legislature is placed within a workable time frame. It is my understanding that premium tax payments are made on a calendar year basis. They must be reported to the state during February of any year and are payable by March 31 of that year. A report concerning the losses from premium tax which is due before the end of January would not be feasible in my estimation.

js
4B/16

Section 21.50.100, Page 23. This section specifies the method by which the state plan is administered, however, there is no definition of a source of monies from which claims will be paid if those claims are in excess of the premium paid into the plan. There is no money available to continue payment of claims until the assessment against losses is paid as this legislation is now written.

Section 21.50.130, Pages 26 and 27. In this section a "individual coverage qualified plan" is referred to. I can find no definition of what an individual coverage qualified plan is.

Subsection (b) of this section is unclear. Blue Cross assumes that this subsection refers to a widow/widower of a person who has a conversion policy but we are not certain of this interpretation. If this section refers to the right of the widow/widower of a group member, then the language is obtuse and administration of that provision will be difficult.

js
14B/17

Section 21.50.200 on Pages 27 and 28. One of the definitions in this section is the definition of "dependent". You have specified that this includes "A household member who is financially dependent on the primary insured". That addition to the usual "family" dependents which can be identified by a legal action (marriage, divorce or adoption) or by birth will create administrative headaches and excessive additions or deletions on dependent lists. This definition of dependent would be open to abuse. It is conceivable that "dependents" could be changed readily creating administrative problems and claims payment problems and that dependents, in some cases, might be added solely for the ability to provide them with health care coverage through the policy being paid for by the primary insured's employer. That portion of the definition of dependent should be deleted from this bill.

js
4B/18

METHOD USED TO DEVELOP FISCAL NOTE FOR HB 977

House Bill 977 proposes to add new coverage and new eligible categories to the Medicaid and General Relief Medical (GRM) programs administered by the Department of Health & Social Services through the Division of Public Assistance. The bill would add services and eligible beneficiaries not presently covered by a medical assistance program administered by the Department. In order to attempt to gauge the effect of HB 977, it was necessary to do some projections based on the present Alaska Medicaid and GRM programs and the Medicaid programs in other similar states. In developing a fiscal note for SB 320, the Department acquired financial reports from five western states having medically needy programs. The financial reports covered the federal fiscal years 1977 and 1978 for Hawaii, Montana, North Dakota, Utah, and Washington. This information also was used to develop the fiscal note for HB 977.

The fiscal note is divided into four pages to allow for separate considerations of adding new services and eligible groups to Medicaid on the GRM program by the effect that addition to Medicaid, the creation of a medically needy program, and the payment of interest on past due medical claims.

The first page of the fiscal note covers the addition of new eligible groups and service categories under the Medicaid program. The basic Medicaid request for FY 81 minus the 100% federally-funded Indian Health Care Improvement Act coverage ($40,720,600) was used as a base. To that was added 17.1% additional funds for those new service categories that are not presently covered under the Alaska Medicaid program. This brings the total to $47,683,800. The 17.1% figure is derived from the average percentage in the five other states for those categories of service that are not covered under the Alaska Medicaid program that would be added by this bill. This subtotal was then multiplied by 1.5, the factor by which I believe the overall cost of the Medicaid program would increase ($71,525,700). Alaska has a lower percent of the total population participating in the Medicaid program than in other states, particularly in the groups of individuals under 21 and intact families.

To double check these perceptions, and to arrive at a more precise budget projection, the fiscal note was developed by budget components. It was projected that the Medicaid components would be affected in the following ways: hospital increase by 1.33, physicians increase by 1.33, other services increase by 1.33, EPSDT increase by 2.0, nursing homes remain constant, and Indian health increase by 2.0. The effect on the GRM budget, reflected by page two of the fiscal note, would be as follows: hospital reduced by .33, physicians reduced by .33, other services reduced by .50, and nursing homes and catastrophic illness remaining constant. These changes by specific component produced the total used for the fiscal note of $71,487,900 for Medicaid in FY 81.

The high amount of federal funds shown in the fiscal note is the result of a large increase predicted in the Indian health component which is 100% federal funding. This increase would not be a function of people receiving new services but the result of a funding change--the Alaska Area Native Health Service (AANHS) would be able to receive more federal

Medicaid money for services that they are already providing to persons eligible for AANHS, but who are not Medicaid eligible now simply because Alaska's Medicaid program does not provide coverage for intact families.

The third page of the fiscal note covers the effect of adding a medically needy program in Alaska. It is based on the projections done in developing the fiscal note for the Senate HESS Committee for SB 320. For purposes of HB 977, the amount in that fiscal note was doubled to reflect the fact that HB 977 would require medically needy coverage for not only adult cases but also for families and individuals under age 21, and would establish a higher cut-off point for eligibility.

The fourth page provides an analysis of the costs of providing interest payments on past due clean claims submitted to the Department. While HB 977 does not say specifically that the provision would apply only to the Medicaid and GRM programs, that assumption has been made for purposes of the fiscal note. The amount projected is approximately one-half percent of the total Medicaid and GRM budgets, minus the Indian health component since that is merely a transfer of federal funds and not an actual payment for services rendered. The figure is based on the assumption that the Department will be able to continue to make improvements in its claims processing system, eventually obviating the need for any interest payments to be made. Of course, if the claims processing system would revert back to its previous condition, the amount of this fiscal note would be considerably greater.

STATE OF ALASKA

Legislative Affairs Agency

THIRD PARTY HEALTH COVERAGE IN ALASKA

Prepared by

LEGISLATIVE AFFAIRS AGENCY

Research Division

April 1978

Foreword

This study was prepared by Sharman Haley of the Legislative Affairs Agency staff at the request of Representative Thelma Buchholdt. The issue of access to health care in Alaska is a matter of general concern to many other policymakers as well, and we are therefore making the report available, with Ms. Buchholdt's permission, in this more convenient format.

Interested readers are invited to share with us any comments they may have on the report or its subject matter.

Gregg K. Erickson
Director of Research
Legislative Affairs Agency

Juneau, Alaska
April 1978

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SUMMARY

With the costs of health care continuing to rise, third party health coverage is becoming increasingly crucial for the protection of people's health and financial security. A variety of state and federal health programs and private health insurance policies provide piecemeal third party coverage for Alaska's civilian population. It is estimated that 20 to 25 percent of Alaska's non-Native, non-military-dependent civilian population are without third party health coverage of any kind. The comprehensiveness of coverage or level of coverage provided the covered population is not known; in some cases the coverage may be inadequate to protect people from financial hardship or inappropriate levels of medical care. There are a variety of approaches the legislature may consider to improve or extend third party health coverage in Alaska. These options include: state subsidized health insurance, state mandated employer subsidized health insurance, state regulation of health insurance carriers, and expansion of the state's Medicaid program. While plugging these coverage gaps would not cure all the ills of the health care system, it would be a step.

I. INTRODUCTION

With the dramatic increases in health care costs in the last decade or two, routine medical care has become for many an unaffordable luxury. A serious illness or accident for them would be a financial catastrophy. More and more people are relying on health insurance and other kinds of third party health coverage to finance the major part of their unpredictable health expenses. To an ever growing extent people are demanding third party coverage for routine health expenses as well. Third party health coverage has become an integral and crucial part of the health care system.

Because public and private third party payers foot the bill for two-thirds of the nation's personal health care expenditures, their policies profoundly affect the nature and terms of the health care itself. For example, many insurance policies will pay for hospital care, but not nursing care; so patients are hospitalized in many cases where nursing care would be sufficient, and less costly. Similarly, many people will not see a doctor until health conditions become acute, because preventive care is not customarily covered. The policies of third party payers also affect providers in terms of the rates they charge, the quality of care they provide, and the services they can afford to develop.

As third party health financing becomes paramount to ensure financial access to health care, the gaps in third party coverage become more glaring. The following chapters of this report address themselves to

these gaps in third party coverage. Sections II and III describe all the major public programs and private plans which currently provide third party health coverage in Alaska. Section IV analyzes available data on the extent of existing coverage and identifies some of the gaps both in terms of the covered population and services covered. Section V outlines a smorgasbord of legislative remedies to plug some of these gaps. The concluding chapter indicates other areas which may be of concern to the legislature.

II. A DESCRIPTION OF HEALTH COVERAGE FROM PUBLIC SOURCES

As this report is concerned primarily with comprehensive health care, only the public programs which cover a broad range of health services and serve a significant portion of the population are described here. There are a number of programs which cover only specific health services, such as family planning or treatment of occupational injuries, or serve only a narrowly defined segment of the population, such as crippled children, which are not described here.

Alaska Area Native Health Service

The Alaska Area Native Health Service (AANHS) is a regional administrative unit of the Indian Health Service, which is a branch of the U. S. Public Health Service. It serves an estimated 65,000 eligible Alaska Natives, spouses, and dependents.

Primary care is provided in villages by 216 community health aides, each selected by the village council and paid under contract with AANHS. These aides are responsible for giving first aid in emergencies, examining the ill, reporting their symptoms to the physician, carrying out the treatment recommended, instructing the family in giving nursing care, and conducting on-going health education in the villages. Routine primary care is also delivered in the villages by itinerant doctors, nurses, dentists, and other health professionals.

If the injury or illness is serious enough to require inpatient care or more specialized diagnosis and treatment, the patient is referred to the nearest of the seven field hospitals. This secondary level of

care includes routine hospital admissions for common illnesses or injuries, for minor surgical conditions, or for pregnancy. The field hospital staff also provides primary care for their immediate community.

Serious or life-threatening illnesses or injuries are referred to Alaska Native Medical Center in Anchorage for treatment under the immediate direction of a specialist. Major surgery and complex diagnostic procedures are performed at the Medical Center. The Alaska Native Medical Center also provides primary health care for the Anchorage area AANHS eligibles and secondary health care for the Anchorage Service Unit.

In areas where direct health care by AANHS is not available, or for services which AANHS is unable to provide, health care is purchased under contract from private physicians, dentists, optometrists, hospitals, and pharmacies by AANHS on behalf of Native patients. Highly specialized treatments, such as heart surgery or kidney transplants, are referred out-of-state. In areas of the state where private health services exist, contractual care is an important component of the AANHS delivery system.

Despite the comprehensive design, there are gaps in this delivery system. Budgeted funds for contractual services are limited, and frequently become depleted long before the next allocation. If it is not an emergency condition, the patient must wait, or else pay for the treatment himself. If it is an emergency condition, transportation is usually arranged to another delivery point.

U. S. Public Health Service

The Bureau of Medical Services, a division of the U. S. Public Health Service akin to Indian Health Services, provides direct comprehensive health care for the Coast Guard and merchant seamen, and provides occupational health care and safety services for all federal employees. Federal health care responsibility for seamen derives from a 1798 act of Congress providing for the "relief of sick and disabled seamen".

In Alaska this care is delivered by the Alaska Area Native Health Service under contract with the BMS. In addition to an estimated 24,000 Coast Guard personnel and dependents, and bonafide merchant seamen, many fishermen are eligible for Public Health Services. Fishermen and other boaters qualify if they are owners or principal operators of a documented vessel. A documented vessel is a seaworthy power boat registered with the Coast Guard which could be utilized by the Coast Guard in case of a national emergency. There are an estimated 3,750 documented vessels in Alaska, including fishing boats and pleasure boats. There may be more than one principal operator of a boat. Dependents are not covered.

Uniformed Services Health Benefits Program

The military provides comprehensive health care to enlisted personnel through military medical facilities and staff. They also provide comprehensive health care to retirees and military dependents through the Uniformed Services Health Benefits Program (USHBP). USHBP provides health services to military dependents in two ways: through military medical facilities and staff on a space-available basis, and through the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) when necessary medical services are not available through

military facilities. CHAMPUS is a supplementary health insurance plan purchased from a private carrier. CHAMPUS will reimburse 75 - 80 percent of allowable charges for necessary medical care. A $50 deductible is also collected on outpatient services. The CHAMPUS carrier in 1975 estimated that 55,000 dependents and retirees were covered in Alaska.

Medicare

Medicare is a federal health insurance program for people 65 and over, and certain disabled people under 65. It is financed by a combination of employee contributions, employer contributions, monthly premiums and federal funds, and is administered by the Social Security Administration.

Part A of Medicare is hospital insurance which is provided at no premium charge to those who have worked long enough under social security, and provided to others over 65 for a monthly premium of $54. Medicare Part A only helps pay for medically necessary covered services up to a specified number of inpatient days or home health visits. The Medicare patient must pay a deductible and a scheduled percentage of the covered costs, as well as the costs of uncovered services and services beyond the limits of Medicare coverage. The Part A hospital insurance helps pay for inpatient hospital care, inpatient care in a skilled nursing facility when it is medically necessary following a hospital stay, and certain prescribed services from a home health agency following a hospital stay. Medicare does not pay for custodial or long-term care.

Part B of Medicare is medical insurance. Anyone eligible for Part A hospital insurance is eligible for Part B medical insurance at a monthly premium of $7.70. Medicare medical insurance can help pay for doctors' services, outpatient hospital care, outpatient physical therapy

and speech pathology, and many other health services and supplies which are not covered by Part A hospital insurance. The medical insurance enrollee must pay the first $60 worth of covered services each year. After that the medical insurance pays 80 percent of "reasonable charges" for covered services and supplies. "Reasonable charges" are computed each year by Aetna (the Medicare carrier in Alaska) based on billings the previous year. The actual charges by the provider may exceed the "reasonable charges" covered by Medicare, and the patient must pay the difference, as well as paying the uncovered 20 percent of the "reasonable charges". Among the services not covered by Part B medical insurance are: routine physical exams, prescription drugs, eye glasses, hearing aids, dentures, dental care, and chiropractic services.

Though people over 65 must have accumulated sufficient work under the social security system to automatically be eligible for hospital insurance, the 1966 law "grandfathered in" all the social security ineligibles at that time. It is estimated that now 99 percent of the non-Native population in Alaska over 65 are enrolled in Medicare.

Medicaid

Medicaid is a medical assistance program funded jointly by the state and federal governments. In Alaska it is open to public assistance clients and eligibles, and certain other needy people in nursing homes, or inpatient psychiatric hospitals. Medicaid clients receive care from participating private providers, who then bill the Medicaid program. Alaska's Medicaid program covers all the federally mandated services: inpatient and outpatient hospital services, physicians services, x-ray and lab services, skilled nursing home services, home health

services, family planning services, transportation, and early and periodic screening, diagnosis and treatment (EPSDT) for eligible people under the age of 21. In addition, the state program covers a few optional services: inpatient psychiatric care for those over 65 or under 22, intermediate nursing home care, eye glasses, treatment for speech, hearing and language disorders, and approved outpatient mental health care. The state Medicaid program does not cover the following services for which federal match is available: prescription drugs, dental care or dentures for those over 21, prosthetic devices for those over 21, physical therapy, chiropractor's services, or preventive care for those over 21.

In FY 1976, 22,952 Alaskans, or 5 percent of the civilian population, were enrolled in the categorical public assistance programs (Old Age Assistance, Aid to the Blind, Aid to the Disabled, Aid to Families with Dependent Children, and Supplemental Security Income) and eligible for Medicaid.

To be eligible for public assistance, and therefore Medicaid, a person must not only meet income criteria, but categorical criteria of need, such as over 65, blindness, mental or physical disability, under 18 and deprived of the care of one or both parents, or a person related to and caring for eligible dependent children. Many Alaskans, such as low income families with both parents present, meet the income criteria for public assistance but do not meet the categorical criteria, and are therefore not eligible for Medicaid.

Because Natives receive much of their medical care from the U. S. Public Health Service, Native eligibles account for only one-third of Medicaid expenditures even though nearly two-thirds of the Medicaid

eligibles are Native. This may change with the implementation of the Indian Health Care Improvement Act of 1976. This federal law requires that medical care provided to Native Medicaid eligibles by the U. S. Public Health Service be billed to the state Medicaid program, with the state receiving 100 percent reimbursement from the federal government for Medicaid expenditures in behalf of Natives. This new billing procedure has not yet been implemented in Alaska.

General Relief Medical

The state-funded General Relief Medical program covers needy people and services not covered under Medicaid, as funding permits. People who meet the income criteria for Medicaid but do not meet the program criteria and have no prior health resource (such as Indian Health or health insurance) are eligible for all General Relief Medical covered services. Any Medicaid eligible is also eligible for those General Relief Medical services not covered under Medicaid. The GRM program covers the same services as Medicaid (inpatient and outpatient hospital care, physicans services, x-ray and laboratory services, nursing home care, home health care, mental health care, eyeglasses, treatment for speech, hearing, and language disorders, and transportation) plus many more not covered by Medicaid, such as drugs, physical therapy, prosthetic devices, hearing aids, chiropractors, podiatrists, emergency dental care, wheelchairs and other equipment. Nearly all services except hospital and physican care must be pre-authorized by the state program administration, and most services are subject to strict limitations. Medically justified services will be refused when funds are not available. The budget is established by the legislature.

The General Relief Medical program ensures that all Alaskans under the income limits for public assistance have some health care resource. For a single adult paying over $35 rent per month, that income limit is $334 per month; for a couple it is $490. For a family the formula is based on adjusted net income; the first $30 of earned income, one-third of every dollar of earned income after that, and reasonable work-related expenses are deducted from the net income to maintain an incentive for cash assistance recipients to work. Therefore, there is no simple dollar figure for General Relief Medical eligibility for a family. While the estimated 22,950* Alaskans below the federal poverty level might meet the income criteria for General Relief Medical, it should be noted that many of these are Alaska Natives or Medicaid eligibles, and so have a prior health resource. In FY 77, $3.7 million was expended in the GRM program, and $4 million was budgeted for FY 78.

Catastrophic Illness Program

The state Catastrophic Illness Committee administers a program that provides financial aid for persons of all income levels who have suffered a catastrophic illness--an illness that incurs high medical expenses. Total medical bills related to the illness must exceed $1000 in a 12 month period after all sources of third party payment, such as state and federal medical assistance programs, private and military health insurance, and awards in legal actions, have been exhausted. The Committee

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* U. S. Department of Commerce, 1976 Survey of Income and Education Preliminary Results.

meets twice a month to determine the eligibility of applicants and the amount of medical assistance to be awarded, using a formula based on annual income, number of dependents, amount of assets, and the assumption that the applicant's share will be paid to the provider on a payment schedule covering a period of at least three years.

In its second year of operation, the program has granted aid to over 80 persons with the number of applicants steadily increasing as the program becomes better known. The largest portion of applicants are those in lower income brackets who do not qualify for other forms of aid. While applicants would have to be refused aid if funds were depleted, it is anticipated that the $450,000 appropriation for FY 78 will be adequate to meet this year's needs.

III. A DESCRIPTION OF HEALTH COVERAGE FROM PRIVATE SOURCES

Private Health Insurance

Health insurance pays benefits on an indemnity basis. When covered health expenses are incurred, the subscriber submits a claim to the insurance carrier. Benefits are normally paid to the subscriber. Normally, benefits are calculated on the basis of "reasonable charges" for each service or a schedule of maximum fees, rather than actual charges, and the subscriber must pay the difference if actual charges are higher.

Hospital expense coverage is the core of health insurance, because hospital care is the largest single medical expense. Hospital costs have risen faster in the last ten years than any other item in the consumer price index, and they continue to rise. Similarly, surgery has become a highly technological and expensive component of medical care, and the expansion of surgical expense coverage has followed closely the expansion of hospital expense coverage. Regular medical expense coverage is the third component of what is known as "Basic Protection", and covers physicians' services, and other medical services such as x-rays and lab tests. Basic protection policies are designed to cover one or more of these key medical services and the bulk of unpredictable medical expenses. Basic protection policies typically have limits on the number of days, dollars or visits covered, as well as a schedule of maximum benefits for services.

Major medical is the other main category of health insurance, and is designed to protect the subscriber from very large, unpredictable

medical expenses. It covers virtually any kind of health care prescribed by a physician. The maximum benefits under major medical is characteristically high, and the subscriber is typically required to pay a deductible and co-insurance as a disincentive for unnecessary utilization of medical care. Major medical insurance can either be designed to supplement a basic protection policy, or to incorporate basic protection and provide comprehensive coverage.

Blue Cross

Blue Cross is not an insurance company, but a hospital/medical service corporation, along with Fairbanks Physicians' Service and Delta Dental. As well as being non-profit, a hospital/medical service corporation differs from an insurance company in that it contracts with health care providers to deliver services to subscribers. The providers bill the corporation directly for the services provided, according to a fee schedule established in the contract. The subscribers pay a flat monthly premium for the coverage.

Blue Cross is specifically a hospital service corporation and maintains contracts with all the general hospitals in the state (not military or PHS hospitals). Fairbanks Physicians' Service is a medical service corporation and contracts with local physicians for services. Delta Dental is a dental service corporation and contracts with local dentists.

Blue Cross, however, covers more than just hospital expenses. Blue Cross provides major medical coverage, and subscribers are required to pay deductibles and co-payments, just like an insurance policy. Covered

expenditures delivered by providers not under contract with the service corporation are handled like insurance claims, on an indemnity basis. Benefits are based on "reasonable charges" and the subscribers must pay the difference if actual charges exceed "reasonable charges".

Pre-paid hospital/medical service plans are typically less expensive than health insurance through private carriers for several reasons: 1) they are non profit corporations, and any money in excess of their benefit payments and operating expenses usually goes toward equipment purchases for participating providers; 2) through their contracts with providers they are able to exert some cost and quality control pressure on providers, however, the effectiveness of this is mitigated by the extensive use of cost-plus contracts; and 3) though they do advertise, they do not deal through insurance agents and do not pay commissions. The end result is that an estimated 90 percent of subscriber premiums to an established hospital medical service plan are paid out in benefits, while only 50 to 80 percent of subscriber premiums to a private insurance carrier are paid out in benefits.*

Health Maintenance Organizations

Health maintenance organizations (HMOs) provide a full range of health care services to enrollees either directly through plan-owned facilities and plan-employed providers, or by contract with private facilities and providers. Enrollees pay a flat monthly rate for compre-

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* Source: Don Koch, Alaska Department of Commerce and Economic Development, Division of Insurance.

hensive health care, with no deductibles or co-payments. HMOs have proven to be the most cost effective form of comprehensive health care services, because they are the only form of health care delivery which has built-in cost controls and an orientation toward preventive health care. HMOs have demonstrated significantly lower hospital utilization rates than any other kind of health care plan. Hospitalization continues to be the largest and fastest growing component of health care expenses nationwide.

The federal government has taken a great deal of interest in HMOs. There is a federal loan program for planning and establishing qualified HMOs, there is a federal law requiring large employers in HMO service areas to offer HMO coverage as an alternative to health insurance benefits, and DHEW is currently organizing a conference of labor and industry leaders to promote the HMO concept.

Alaska has one HMO in the planning stage, the Greater Anchorage Health Plan.

Teamsters

In most union health plans, employer contributions for health benefits are paid into a trust fund, and the trustees of the fund purchase group insurance for eligible union members. The Alaska Teamster-Employer Welfare Trust is unlike other union health trusts in that it is a self-insurer. In other words, the Teamster trustees do not purchase health coverage from a private health insurance carrier; they are their own carrier, and pay health insurance benefits to qualifying Teamsters directly from their own trust fund. In addition to a health insurance plan, the Alaska Teamster-Employer Welfare Trust offers an alternate

HMO-type plan called the Alaska Health Plan. The Alaska Health Plan is not officially an HMO under federal law because it does not offer open enrollment and does not provide the full range of services required of a qualified HMO. However, its operation is similar to an HMO. The Alaska Health Plan contracts with the Alaska Clinic and the Alaska Hospital and Medical Center to provide preventive, curative, and rehabilitative health services to plan members. The relationship between the Teamsters and the Alaska Hospital is more than just contractual, however, as Teamsters financed the hospital and serve on the board. The Teamster Alaska Dental Plan is also on an HMO model, but it differs from the health plan in that the Alaska Dental Clinic is directly owned and the dentists are directly employed by the Teamsters.

There are an estimated 28,000 Teamsters Local 959 members in Alaska, though they are not all eligible for health benefits. Eligibility is determined by the number of hours worked, and with the high post-pipeline unemployment, some Teamsters have exhausted their health benefits.

IV. AN ANALYSIS OF THE EXTENT OF HEALTH CARE COVERAGE AND GAPS IN COVERAGE

The Covered Population

Nationally, 178 million people - more than 8 out of 10 persons in the civilian non-institutional population - had some form of private health insurance in 1975, according to the Health Insurance Institute. The same survey reported 250 thousand people in Alaska, (two thirds of the civilian population) had private coverage.

The major public programs, U.S. Public Health Service, Medicaid and Medicare, provide health coverage to an estimated 20% of Alaska's civilian population. It is not known to what extent public coverage duplicates private coverage state-wide. However, random sample surveys were conducted in 1974-75 in both Anchorage and Kodiak Island Borough with questions regarding health coverage. The Anchorage survey reported that 79.9% of the sample had third party health coverage of some sort, and 20.1% had none. In Kodiak Island Borough 92.6% of the respondents reported third party health coverage, while only 7.4% reported none. This high percentage of health coverage in Kodiak Island is largely due to the high proportions of Indian Health Service eligibles (over 40%) and military personnel and dependents (over 25%). Those 7.4% without coverage constituted over 20% of the non-Native non-military or military dependent population.

The 20.1% of the Anchorage sample without health coverage constituted over 25% of the non-Native non-military or military dependent population in Anchorage.

If we can assume that a similar percentage (20-25%) of the non-Native non-military population state-wide currently are without third party health coverage from any source, 56 to 71 thousand Alaskans totally lack third party health coverage.

The biggest hole in this coverage patchwork is moderate and low income people who are self-employed or marginally employed, or non-union employees of an employer who doesn't provide health benefits. These people are above the income eligibility standards for Medicaid or General Relief Medical, yet their cash income is not adequate to afford either the expense of private health insurance, nor the expense of many medical services on a fee-for-service basis. This group includes farmers, shop owners, small contractors, temporary and part-time employees, casual laborers, subsistence providers and the unemployed. It also includes a large number of non-union workers, particularly those working for small employers, such as child care workers, waitresses, clerks, clerical workers, delivery truck drivers, gas station attendants and construction workers in home building. And of course the dependents of these bread-winners normally lack coverage as well.

In Alaska there are many seasonally employed people as well who have health coverage only part of the year while they are employed, such as loggers and cannery workers. Most construction workers (outside of home building) are unionized and have "hour banks" for health benefits such that if they work enough hours over the summers their accrued health benefits will last through to the next season. However, when there is not enough work to go around, many people are not able to accumulate enough health coverage to last the winter.

Services Covered

Health plans vary widely in the services covered and the levels of coverage provided. The foregoing analysis distinguished between people who have any sort of third party health coverage, and those who have no coverage at all. We have not yet considered whether those with some coverage have coverage that is adequate to protect them from financial hardship. Some policies, for instance, are specialized and cover only hospital expenses, or only surgical expenses. Many policies do not cover particular services such as prescription drugs, office visits, or nursing care outside of a hospital.

In the Anchorage survey, while 20% of the respondents lacked hospital coverage, 24% of the respondents lacked surgical coverage, 46% lacked coverage for visits to the doctor's office, 60% lacked dental coverage, and 70% lacked mental health coverage.

Many policies have limits on coverage that are exhausted by severe illnesses, or require co-payments which can add up to substantial sums. Many policies limit their payments to "reasonable charges" as defined by the insurance company, regardless of the actual charges, and the consumer must pay the difference.

It is not difficult for a consumer even with some health insurance to incur heavy financial losses due to health care expenditures. The following statistics suggest that insurance companies in fact are not paying the bulk of health care expenses.

While the private health insurance industry claims to serve over 80% of the nation's civilian non-institutionalized population, in 1976 they paid only 26% of personal health care expenditures nationally.

Government programs paid another 40%, and consumers paid 32% directly. The remaining 1% of personal health care expenditures was paid by philanthropic organizations.[1]

1 "National Health Expenditures, fiscal year 1976", Social Security Bulletin, April 1977, page 8.

V. POSSIBLE LEGISLATIVE ACTION TO EXTEND COVERAGE

There are several measures which have been conceived to fill some of the gaps in health care coverage. Maine, Connecticut, Rhode Island, Minnesota, and Alaska have all enacted some form of state assistance for catastrophic illnesses. Connecticut and Minnesota have also made some cautious steps toward more comprehensive coverage with legislation that regulates health insurance carriers, mandating minimum benefit standards, controlling premium rates, and mandating pooled coverage for high risk subscribers. Hawaii has taken the boldest step toward expanding health coverage by mandating that all employers subsidize health coverage for their employees. These states are pioneers. Their state health insurance programs are new, and are being watched with interest by other states.

No state has instituted a universal or a state subsidized comprehensive health insurance program. While universal coverage is the goal for proponents of government sponsored health coverage, no one has been able to develop an acceptable scheme of financing universal coverage, either at the state or national level. If universal coverage is not yet a viable option for states, we are left with a patchwork approach to health coverage, covering only the holes we can reach. The following is an inventory of some of the "patches" available to state legislatures, in order of decreasing cost to the state.

Universal Coverage

Uniform and universal coverage for all residents is the fairest and most expensive approach to state sponsored health insurance. If group coverage comparable to the plan for state employees was purchased by the state for all state residents without federal health coverage, it would cost about 87 million dollars. Such broad coverage is certainly unnecessary because it duplicates and discourages coverage from other sources. It could also cause a substantial migration of people seeking free health coverage into Alaska. No state has tried such a plan.

Coverage for the Uncovered

State sponsored health insurance for all residents without coverage from other sources would avoid the problem of duplicating coverage, but it would still discourage private coverage and cause in-migration. Groups and individuals would drop their private coverage because they know the state would pick them up. In the long run, the program would approach universal coverage. Using estimates of the currently uncovered population, the cost for such state purchased coverage could be anywhere from $27 million to $40 million dollars in 1977. No state has tried such a plan.

Coverage for Non-Wage Earners and the Marginally Employed

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proach state subsidies could be targeted for those who need them most. The main target groups to be considered would be the unemployed, part time, employed, and the low income self-employed--people without access to group coverage, or the financial resources to pay for private insurance. This plan avoids some of the problems of the broader coverage as discussed above, because it is not likely that significant numbers of people would leave their jobs to get state subsidized health insurance, nor is it likely the unemployed people from out-of-state could afford to move to Alaska just to get coverage. This approach would dovetail well with mandatory employer coverage as discussed later.

The cost to the state of subsidizing health care premiums for these groups would be substantial, but it could be contained in at least two dimensions: the eligible population could be limited by definition, and the state's rate of subsidy could be set at any desired level. To discourage in-migration, the state subsidy could vary according to length of residency, with first year residents getting little or no subsidy, and long term residents getting a more substantial subsidy. Or the state subsidies could vary according to the income of the subscriber with a higher subsidy for low income people and a lower subsidy for higher income people.

A sliding scale of premium subsidization would provide a continuum of access to health care insurance up and down the income scale, avoiding the injustices of an arbitrary threshold. However, it would also require an extensive investigation into each subscriber's income to determine which rate they are eligible for, much like the eligibility determination for welfare. Eligibility would constitute the larges. administrative task under this plan.

The total premium costs for group coverage for the unemployed, self-employed and the non-labor force population without coverage from public sources would be an estimated $25 million. If the state opted for less than 100% subsidization, some members of the target groups would not enroll. The resulting savings to the state would not be as large as one might expect, however, because with any voluntary plan in which subscribers bear some costs, the premiums would be higher than with a universal plan. This is due to the fact that subscribers would be self selecting toward higher use of medical care. In other words, people who do not expect to use much medical care would be less likely to purchase the insurance, while people who expect high medical expenses would be very likely to purchase the insurance. Also, many low income people who have immediate needs and expenses are less likely to purchase insurance, because the benefits of medical insurance are deferred and uncertain. Low enrollment on the whole would save the state money, but it would also contradict the purpose of state subsidized health insurance, namely to make health care available to more people. No state has ever instituted a direct health insurance subsidy program.

Income Tax Credit

A state income tax credit for health insurance would be an indirect way for the state to subsidize health insurance, and avoids many of the administrative problems associated with direct subsidy programs. The Alaska tax forms would provide a line for the taxpayer to enter the appropriate credit against their Alaska state taxes. The credit would be equally available to all state residents filing income tax returns,

including employers. Yet at the same time, if it were a fixed dollar amount, it would be a relatively greater benefit to low income people than to higher income people. If a fixed dollar tax credit were offered, the state would probably want to require evidence that the health insurance purchased meets minimum state standards. This would ensure that state dollars would subsidize only health coverage of acceptable quality, and no one could collect the credit for just token coverage costing less than the credited amount.

If the credit were computed as a percentage of the premium cost, with an upper limit provided, no minimum benefit level would need to be established, because the state would be contributing only a token amount to token coverage, and a more substantial amount to more substantial coverage.

This alternative would not reach low income people who do not file tax returns, nor those who cannot afford even a percentage of the premiums for health insurance. It would be extremely difficult to estimate how many people would respond to such an incentive program. A higher credit could predictably get more response. The current state employee health plan has an annual premium well over $800. If an $800 tax credit were offered currently covered taxpayers, the initial costs would be an estimated $68 million, and would rise as more people responded to the incentive. If a $250 credit were offered, the initial cost to the state would be around $21 million.

Medicaid Medically Needy Program

"Medically needy" is an optional Medicaid program with federal matching dollars. Currently Medicaid provides medical care to anyone eligible for public assistance grants under categorical programs: Aid to families with Dependent Children, Old Age Assistance, Aid to the Blind, and Aid to the Disabled. These public assistance programs have program criteria (blindness, age, disability, dependent children) as well as income criteria for eligibility. There are many Alaskans who meet these categorical criteria, but have incomes a few dollars above the income threshold for public assistance eligibility. These Alaskans are able to meet their daily living expenses out of their own incomes, but medical expenses put a severe strain on their budgets, and often deplete their resources to the point that they must again resort to public assistance grants and Medicaid.

Under the medically needy option, people who meet program criteria but have incomes within a limited range above the income threshold for public assistance grants, are also eligible for Medicaid. Twenty nine states, two territories, and the District of Columbia currently participate in the medically needy option. Medically needy includes a "spend down" provision. This means that people categorically eligible but financially ineligible can become eligible for medical assistance if their income above the medically needy threshold is spent on medical bills. The difference between the person's income and the medically needy threshold is essentially an income-related deductible which must be met to be eligible for Medicaid. The medically needy program and the spend down provision soften the line between people eligible for both

public assistance grants and Medicaid, and those ineligible for either due to a few dollars more income. It also serves as an emergency medical resource for low income people with categorical eligibility who cannot afford adequate health insurance.

Originally, the Alaska Medicaid program was limited to the federally mandated target groups and benefits. The primary reason for this was that 65% of Medicaid eligibles have another medical resource--the Alaska Native Health Service--which is 100% federally funded. Medicaid is funded jointly by the state and federal governments. The state has kept its 100% state funded General Relief-Medical program which can pay for medically necessary services not provided by Medicaid, or ANHS, subject to state administrative controls.

Since the Indian Healthcare Improvement Act of 1976, the federal government must reimburse the State for Medicaid expenditures on behalf of Natives. This act has not yet been implemented in Alaska, but when it is implemented, it will significantly reduce the fiscal liability of the State for Medicaid. A program expansion such as Medically needy would then become much more feasible. Some of the medical assistance now provided under the state's General Relief-Medical program could be paid for jointly by the state and federal governments under the Medicaid medically needy program. HEW Region X estimated that, based on Washington State experience, a medically needy program would expand the current Medicaid budget by 10-13%.

Unlike other Medicaid eligibles, for "spend downers" (those who must spend their excess income on medical bills to become eligible for Medicaid under the medically needy option) there is a dual liability for

medical bills - the person is responsible for medical bills until the deductible is met, then Medicaid takes over. This dual liability causes administrative problems. It is difficult to determine exactly when the deductible has been met and when eligibility commenced, which bills the patient is liable for, and which Medicaid is liable for. The only states that have developed an efficient system of administering the spend down program are out of compliance with federal regulations.

Mandatory Employer Coverage

Of the various approaches open to the Legislature for extending health care coverage, the program with the least impact on the state budget for the greatest increase in coverage would be mandating employer sponsored coverage available to all employees. Such legislation would stipulate minimum benefit standards for employee group plans and would set minimum rates for employer contributions to the premium costs. To make such a program more palatable the legislation could also provide that the state subsidize premiums when necessary in small, marginal businesses.

Hawaii for example requires that employers pay at least 50% of the premium. Employers with fewer than eight employees whose share of the premiums would exceed 1.5% of their payroll, are entitled to state subsidies in the amount that the excess over 1.5% of the payroll exceeds 5% of the employers income from the business. Though several employers applied for state subsidies under the Hawaii legislation, none were found to be eligible according to these criteria.

Mandating employer coverage however has potential side effects. Mandatory group health plans would be similar to raising the minimum wage - it would be more expensive for employers to employ people, so fewer people would be hired. Though the resulting unemployment would probably not be significant among skilled and experienced workers, teenage workers would certainly be hit hardest. On the positive side, mandating employer coverage would be most beneficial to women and minorities who often work in the non-union low paid jobs without fringe benefits such as health insurance.

High Risk Reinsurance Pools

Many people are unable to purchase full health insurance coverage because existing health conditions (a weak heart, chronic illness, etc.) make them a bad insurance risk. To fill this gap in health insurance availability, two states, Minnesota and Connecticut, have established mandatory carrier reinsurance pools. All health insurance carriers in each state are mandated to offer a health insurance package to high risk subscribers at a reasonable premium. Such coverage is reinsured by the carriers association, in which membership is mandatory, so that the risk is pooled among all carriers in the state.

Because premiums are limited to affordable levels, the high risk coverage does not necessarily pay for itself. Any deficit must either be absorbed by the insurance carriers, or by the state. Connecticut and Minnesota both have established such reinsurance pools with virtually no administrative or premium expenses for the state.

Minimum Benefits Standards

Legislation establishing minimum standards for health benefits is a form of consumer protection. It is designed to insure that purchasers of state approved plans have the recommended range of coverage to protect them from financial hardship due to large medical expenses. The legislation can either mandate that all plans sold in the state meet minimum standards, or that all carriers offer a state qualified plan. Another variation is mandating that all employment related group health plans meet minimum benefit standards.

Such standard setting legislation would be an extension of existing state regulatory powers. The impact of such regulation on the state's major carriers would probably be minimal, but some small carriers may decide to drop their health insurance business rather than comply with such regulations. The more stringent regulation, setting minimum benefit standards for all health insurance plans, may also make it more difficult for low income people to afford health insurance, because low priced, low benefit insurance would be prohibited.

The Ninth Legislature considered minimum benefit legislation in their second session. House Bill 792 would have required that health insurance policies written in the state cover less costly alternatives to hospitalization, such as nursing care and home health care.

VI. CONCLUSION

The possible legislative approaches outlined in this report are only partial. They are not solutions to the problems of the health care system in this country. The health care system has many other major problems not addressed in this report, such as: cost control, quality control, appropriate levels of care, unnecessary treatment, and access to providers. The remedies discussed in this report don't even resolve the issue that they address: that of financial access to health care. It is not likely that all these problems of the health care system can be resolved on a state by state level.

However, states can take significant steps in each of these areas, and in doing so contribute to the body of knowledge and experience on which a national solution may be built. The intent of this report is to provide the legislature with the information they need to consider whether or not state intervention to improve third party coverage in Alaska is desirable, and what, if any, the next step will be.

There are three general philosophies of state intervention in service delivery. One assumes that the private sector is capable of meeting the demand for services, and that the state need only subsidize the purchase of services to ensure the satisfactory delivery of services to the desired target group. The second assumes that additional state intervention is necessary, in the form of regulation to ensure quality or accountability, or centralized planning to ensure coordination of service delivery, or technical or financial assistance to aid the private provider, to ensure that the private sector will deliver services

to the desired target group to the satisfaction of the state. The third philosophy assumes that it is to the state's and the public's advantage, for whatever reason, to deliver the desired services directly.

The first four remedies discussed in this report, three levels of state sponsored coverage and the income tax credit, would subsidize consumers to purchase health coverage from private providers. They reflect the first philosophy, that the private sector is capable of satisfactorally meeting the expanded demand. The last four approaches, Medicaid medically needy, mandatory employer coverage, high risk pools, and benefits regulation, embody the second philosophy, that intervention on a policy level is required. The Catastrophic Illness Program, already enacted by the state, reflects the third philosophy of direct state service delivery. The state is directly providing a form of catastrophic health insurance to all state residents.

Any of these alternatives that significantly expand health care coverage would increase the demand for health care, and as a result, health care costs would tend to rise. It would therefore be prudent to accompany any legislation substantially expanding coverage with legislation instituting cost controls on the health care industry. Though cost control legislation is not within the scope of the analysis presented here, it also deserves consideration.

The alternatives discussed in this report are not exclusive or exhaustive. Many of the ideas can be re-combined with each other or with other ideas not explored in this report. State intervention in third party coverage is a subject for pioneering.

The carriers which might find compliance with HB 977 most difficult perhaps are those who write only accident or illness indemnity policies with fixed reimbursement rates (for example, $50 per day for every day in the hospital). These companies are not set up to handle claims based on expenses incurred as required of a qualified plan under HB 977. The largest carrier of this type in Alaska has a premium volume of $723,000. It is not known how many other carriers of this type there are, nor what their premium volume might be. While it is perhaps undesirable to adversely affect any Alaska business with this legislation, it is notable that those for whom compliance with HB 977 would be most difficult are precisely those carriers who specialize in limited types of accident and health coverage which afford the least financial and medical protection to consumers.

PROFILE OF ALASKA CARRIERS 1978

Of the more than

300 carriers licensed to write accident and health insurance in Alaska, only

204 carriers reported any group or individual accident and health policy premium volume;

21 carriers reported over $500,000 in accident and health individaul and group premiums;

36 carriers reported $50,000 to $499,000 in accident and health individual and group premiums;

68 carriers reported 5000 to 49,000 in accident and health individual and group premiums; and

79 carriers reported less than $5,000 in accident and health individual and group premiums.

Hospital medical services corporations reported the following premium volumes:

Blue Cross of Washington and Alaska	$31,260,000
Deltal Dental Plan of Alaska	741,000
Physicians Services of Fairbanks	214,000
National Hospital Association	32,000

data from the 1979 Insurance Report by the Department of Commerce and Economic Development

GEORGE R. ARIYOSHI
GOVERNOR

TANY S. HONG
DIRECTOR
BANK EXAMINER
COMMISSIONER OF SECURITIES
INSURANCE COMMISSIONER

DONALD D. H. CHING
DEPUTY DIRECTOR

STATE OF HAWAII
OFFICE OF THE DIRECTOR
DEPARTMENT OF REGULATORY AGENCIES
1010 RICHARDS STREET
P. O. BOX 541
HONOLULU, HAWAII 96809

April 14, 1980

Representative Thelma Buchholdt
State Representative
District 9 (Spenard)
Chair, House HESS Committee
Alaska State Legislature
Pouch V, State Capitol
Juneau, Alaska

Dear Representative Buchholdt:

It's been one full week since I have returned to my desk after my visit to Juneau and the "Lower 48". Our Legislature is in the midst of winding up for a possible adjournment this Friday. Therefore, I have been running from one conference committee meeting to another, especially since my Director is in Denver, Colorado, on official business.

I want to thank you and all of your associates for making my visit to Juneau very enjoyable and interesting. I have already discussed with Mrs. Ching plans to travel up the inland sea on a cruise, if not this summer, possibly next. I do not know whether the cruise will go as far north as Juneau, but I would like to show your capital to her.

I hope my visit was of some help to you and your proposed legislation I commend you for your efforts in trying to make Alaska a better community for Americans to live in. My best wishes to you and your associates in the successful conclusion of your efforts in regards to the Prepaid Health Care Insurance. Please call on me if I can be of any further assistance to you.

My best regards to all of your staff and associates.

Aloha,

Donald Ching

STATE OF MINNESOTA

Commissioner of Banks
(612) 296-2715
Commissioner of Insurance
(612) 296-2488

Commissioner of Securities
(612) 296-6848
Executive Secretary
(612) 296-2283

DEPARTMENT OF COMMERCE
500 Metro Square Building
St. Paul, Minnesota 55101

April 9, 1980

The Honorable Thelma Buchholdt
State Representative
Committee on Health, Education and Social Services
State of Alaska
State Capitol
Juneau, Alaska 99801

Dear Representative Buchholdt:

Thank you for the hospitality you and your staff extended to me during my recent visit to your beautiful state. It was a wonderful experience for me, one that I shall never forget.

I'm enclosing a copy of the statement I presented to the Pennsylvania House Insurance Committee last year. The presentation summarizes our experience and my thoughts on mandatory insurance coverage for treatment of drug and alcohol abuse.

I shall be happy to respond to any questions or to send you additional information on our insurance statutes or on the Minnesota Comprehensive Health Association.

Sincerely,

John T. Ingrassia
Supervisor
Life and Health Section
Insurance Division

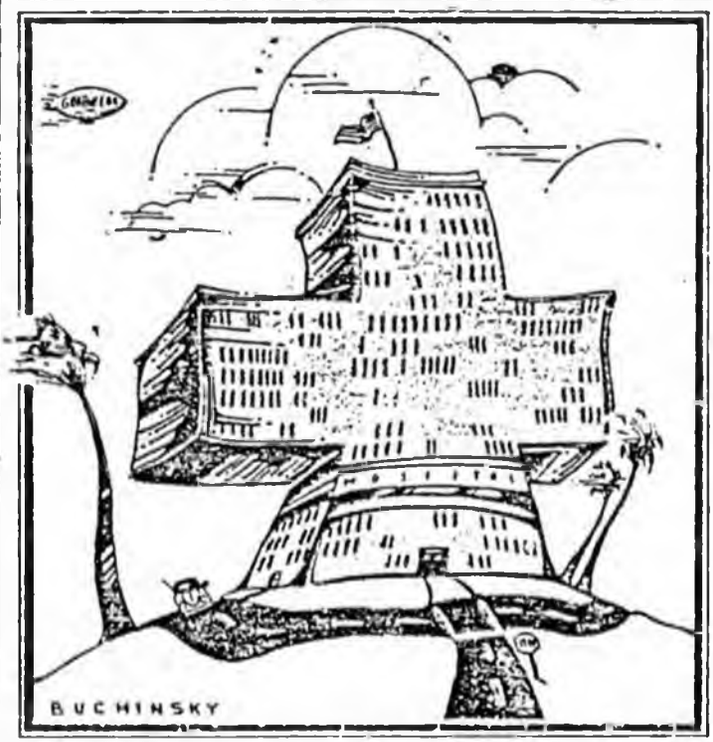
mw
enclosure
0509

AN EQUAL OPPORTUNITY EMPLOYER

Mother's Healer

YOUR HEALTH AT TOO HIGH A PREMIUM

by Hugh Drummond, M.D.



SOME FORM OF national health insurance seems inevitable. It has been an almost sacred tenet of American liberalism since the New Deal. The Great American Center has shifted its hemorrhoidal bottom in this direction, and even organized medicine has begun to calculate the finger-lickin' goodies involved in a $60 billion-plus federal program.

Insurance is, of course, the American way of dealing with life's terror. No institution better describes a population trying to save its ass. It is a vestige of the medieval myth that moats and castle walls could keep out the plague. Insurance buildings are designed to convey immortality; steel and granite, sheathed in glass, they are meant to look like the executives who minister to them—vigorous, phallic, Apollonian. If God should break his contract with Noah, those buildings will endure the flood to pay the claims of a well-covered, if dead, constituency.

So it is inevitable that as we grow more anxious we will develop a form of universal health insurance, propped up by the federal government and its corporate underpinnings. About the only people left who are opposed to it are a few herbalists and that peculiar gaggle of paranoids on the Left and the Right, who cannot believe that anything compassionate or rational can emerge from the heart of this nation.

I have great respect for paranoia. So let me count myself among the crazies this time and suggest that, like the massive public housing projects that were another vision of American liberalism, national health insurance as currently conceived will someday be subjected to euthanasia.

Health insurance is really not health insurance at all, but sickness insurance. The major premise behind it is that we are all terrified by cancer and heart disease, which can be treated by such techniques as transplants, by-pass procedures and radiotherapy. These are enormously expensive technologies that the government will be expected to underwrite.

Overlooked are the pervasive diseases of the young and poor, such as lead poisoning, which affects a quarter of the kids in low-income neighborhoods, and malnutrition, which affects even more. Insurance doesn't touch these problems because their control has to do with social and environmental conditions. You can't fight hunger with pocketa-pocketa machines in medical centers.

In fact, when you get right down to it, you can't stop cancer and heart disease that way either. They are just as much social and environmental diseases as they are medical ones.

Since 1900, the ratio of cancer deaths to all deaths has increased five times; the same is true for heart disease. Together they will kill more than half of us. It is calculated by the American Heart Association and the Department of Health, Education and Welfare (HEW) that in a life of 65 years, we lose 1,300 days for being 25 per cent overweight, 1,800 days for living in a city and 3,300 days for smoking a pack a day. Yet we have virtually no information on the relative impact of bad housing, polluted air and water, Muzak and Twinkies. If we did, we would know we were losing the battle.

To really stop cancer we would need to control all industrial pollutants, such as asbestos, vinyl chloride and sulphur dioxide. The huge numbers of synthetic additives poured into our bodies every day would have to be eliminated. If we wanted to control heart disease we might have to do something about unemployment, which has been documented to increase nor-epinephrine and cholesterol excretion to murderous levels. We might also have to eat less, drink less, smoke less and drive less. If a serious effort were made in this country to prevent cancer, strokes and heart disease, the economy would collapse—a fact not lost on the pilots of the empire, many of them now supporting some form of national health insurance.

There have been amazingly few studies on the actual "outcome" of medical care in this country, but when they have been done the results are invariably depressing. A Johns Hopkins University doctor found that only 27 per cent of emergency room patients at Baltimore City Hospital received effective medical care. When the doctor's superiors insisted that the results would be radically different at a more "prestigious" hospital, namely Johns Hopkins, the doctor checked out the patients there who had gastrointestinal symptoms. He found that only 28 per cent of these Johns Hopkins patients received quality treatment. In other words, more insurance will help more people get lousy care.

With Medicaid and Medicare, the forerunners of national health insurance, the more we spent the less we got. In the first year of the programs, doctors' fees rose two and a half times as fast as the cost of living. In the last two years from September 1974 to September 1976, physicians' fees rose 23.3 per cent, while the Consumer Price Index increased by only 13.7 per cent. According to a report released in February by the Health Research Group, Medicare and Medicaid pay out more than $6 billion yearly in doctors' charges. Hospital costs have climbed even faster—a four-and-a-half-fold increase since the programs started. Where did all the extra money go?

Not to new services; there were hardly any of those. A lot of doctors got richer. There was expensive and "interesting" medical technology to utilize, such as the hyperbaric chamber at Mount Sinai, which is operated on an average of only once or twice a day. The money

it on buying and running it uld finance 20,000 outpatient isits a year, or a huge lead poisoning program in East Harlem. But that's not as much fun. Unfortunately, there is no assurance that similarly wasteful health care programs will not be funded by massive national health insurance.

Upper-level hospital personnel increased their salaries as the federal programs took hold. Hundreds of thousands of dollars were spent in efforts to prevent hospital employees from organizing unions. Much of the extra money went for outrageously expensive drugs and supplies. As long as the government was willing to underwrite the cost, the hospitals and doctors didn't care. Most of them welcomed the bucks the federal bonanza brought, no longer convinced that their salaries would decrease under the "socialized medicine" of Medicare and Medicaid.

And for the people the programs were supposed to serve? More people had access to bad health care. But one-third of Americans living below the poverty level remained untouched by Medicare and Medicaid. There was still no medical care for the poor. Enter national health insurance.

With national insurance, the $140 billion-a-year health industry could *really* rake it in. There would be the kind of guaranteed security the defense industry enjoyed during the height of the Cold War. Just think—no more people skipping out on their bills. The whole country as paying customers, and for each person, another prescription filled out, another piece of hardware needed, another disposable whatnot disposed of.

Under national health insurance, the poor still will not have quality medical attention. The health care system is not radically changed under the program, only subsidized fully. There will be no improved doctor-patient relationships, no health clinics that are community controlled. National health insurance does not mean better hospitals, with staffs responsive to the special problems of poor people. No fundamental change for the rich either. As usual, they will buy their way to priority.

We can also look forward to the government entering into some sort of alliance with private insurance companies, as it has with Medicare and Medicaid. Blue Cross is the leading contender for the job of administering a national health insurance system. That's the same Blue Cross that has allowed runaway hospital fees to multiply in the last ten years, while the average length of hospital stay has *decreased*. You might be interested in knowing that Blue Cross is controlled by the hospitals themselves. The hospitals created it during the Depression to ensure that their bills were paid, and you can be sure that with national insurance, hospital bills—no matter how ridiculously high—will be found "reasonable" by Blue Cross.

> "With national health insurance, the $140-billion-a-year health industry could really rake it in—as the defense industry did during the Cold War."

My real anxiety about national health insurance isn't only economic; it is philosophical. There is something wrong with a social policy that irrevocably consigns to a single profession something so subtle and profound as human health. For all the wonders of Western medical science, it has no understanding of and little interest in the meaning of health. It is possible that when you set out to "conquer disease," no less than when you set out to "conquer space," you can't win. Western medicine tries to throttle its patients into well-being. It relies on the military model of technology, the invention of hammers and the subsequent search for heads to bang with them. It has only given us a new ecology of disease with the smell of progress.

I am not suggesting that we dismantle all the cobalt units, computer assisted tomographs and heart-lung machines. But national health insurance will retard a more pluralistic approach to health, which might include self-help programs, herbal remedies and even faith healing. Is it antiscientific to permit the existence of activities that may have centuries of traditional practice and pure empiricism behind them? They may be conceptualized in less mechanistic terms than we have been trained to believe truthful. However, dying empires have always insisted that their vision of the truth is eternal when their artifacts barely survive.

Do I have the courage of my own convictions? Of course not. If I awake tonight with a right lower quadrant pain, shall I not call one of my surgical confreres rather than a Navajo healer? Would I deny that preference to anyone else? No. But neither would I deny the preference of someone for a Navajo healer. Yet with national health insurance, like all the other medical programs, Navajo healers will not be licensed to accept government money. National health insurance grants access to one kind of health care, and if a bill is passed, the "right" to medical care established will be a right to bad medicine.

Think of China for a moment. It has brought health to 800 million people, who were as mutilated, starved, infected and demoralized as any who have ever lived. And in that nation, where pragmatism is almost religious, where waste is murder, they brought health to the people with as much respect for the ancient and the traditional as for the modern and innovative.

Needless to say, there were other changes.

If you have any medical or psychiatric questions you'd like Dr. Hugh Drummond to address in this column, please write Mother's Healer, c/o Mother Jones, 607 Market Street, San Fran-

MEMO

TO: REP. TERRY GARDINER
FROM: JAMES LOVE
RE: HEALTH CARE
DATE: FEB. 20, 1980

A number of legislators have expressed an interest in health care legislation, but there is currently no program slated for consideration this year. What started out as a priority for 1980 has been pushed back a year, in the minds of several legislators.

While a year's delay is comforting for many reasons, there are equally compelling reasons for action this year. First, the legislature can accomplish a number of important objectives this year which will significantly expand health care services to many low-income and unemployed Abaskans, without attempting to design a comprehensive state insurance plan. The preliminary research on these proposals is in hand now. Specific proposals could be ready for introduction within two weeks, and floor action could be scheduled within four to six weeks.

This is an election year, and political consequences are important. But although some may see health care as a risky proposition, it has always recieved good marks from the public in opinion surveys. A state with a large supplus could do worse than spend some of it on the health of it's citizens.

Senate passage of any good legislation is always problematical, but we may have a few drawing cards. For example, the House and Senate are deadlocked on the State Medical Board, over the provision which requires doctors to treat Medicaid patients. The impact of this is twofold. The doctors are put in the position of arguing that health care for the poor is a government, rather than a private sector, responsibility. The doctors are also going to put pressure on the Senate for continuation of the Medical Board. The House can trade the Medicaid provision for movement on other health care bills.

Moreover, Hackney is pushing a health bill - something called "medic-alert" - which will provide for in-home care for the elderly. (this according to news reports). It may provide a vehicle for tacking on the House health package, which will include the elderly care, plus expanded care for many other Alaskans. This would get us to a vote on the Senate floor, in an election year, where Colletta, Bradley, Hackney, Sumner and others are running for re-election.

Several people are ready for action this year. Thelma is anxious to work on health care bills, willing to introduce a package through her committee, and willing to lend significant staff time to the effort. McKinnon is personally interested, and he chairs the Finance Subcommittee on health. Parker is interested and I imagine a number of other key House members would weigh in. Thelma and Joe, with some help from Parker, could provide the lead. In some ways both have held back, waiting for you to make your move.

AkPIRG will make health care a major priority this year if the pieces can be pulled together. We have one person already working full-time on the problems faced by Medicaid patients, and she could spend time lining up support for a health package.

The key consideration, in my thinking, concerns our ability to get solid back-up research for a legislative package - on a tight time table. Thelma will ask Jan to work on this, and Parker will ask Jim Erickson, but neither individual has prior experiance in the health care field. Duncan Read, who already has requests from Parker and others, has assigned Kreinheder to look at several of the proposals that should go this year, such as the Hawaii mandatory employer coverage. However, while Duncan's staff is certainly competent, they are also sorely overextended, and will not be able to provide the day by day, blow by blow, back-up needed to prepare a bill for passage within the short time frame needed for action this year.

According to Duncan, this could be remedied somewhat if he recieved requests from several legislators to work on health care problems. With enough interest, he could approach his governing council and ask that one staff be assigned full time to the health care area. Of course this would require that the other research topics be assigned a lower priority, and this by itself may not be desired.

The one person who knows more about this area than anyone else is Sharman. Her two memorandums to Thelma in 1977 and 1978 are still the basic research on the issue. She is working as a waitress for the federal cafeteria. She is interested in consulting on health care legislation. I imagine that she would need about two months work to justify quitting her present job. She would be available within five working days.

John Crandall tells me that the House will take up a supplemental this week or next which could provide funding for additional committee staff or consultants. Thelma, I am told, would prefer to have a contract with the Alaska Center for Policy Studies, or AkPIRG, than to expand her committee staff. This woild also solve the timing problem a bit, because either the Center, or AkPIRG could start work immediately on assurances from you or thelma that funding would be forthcomming.

The Alaska Center for Policy Studies, as I may have told you, is a non-profit corporation which undertakes public policy studies. It currently has two contracts with the legislature, including contracts with Rogers' Susitna Alternatives Committee and McKinnon's Leasing Policy Committee. The board of the Center includes Joe Josephson, Chairman, Vic Fischer, Vice-Chairman, and Hugh Fleischer, Sec/Treas. Other board members include Matt Berman, Pat Dobey, and Peter Gruenstein.

Assuming that we can agree to proceed, we could begin work on the following proposals:

1. Mandatory Employer Coverage. Hawaii now requires every employer to provide health insurance. This would expand coverage to many non-union workers, particularly those in low-paying service industries, who now lack coverage. Large employers, or those who have been organized by unions, should not be a source of opposition to this bill. Hawaii provides a special program for small employers which subsidizes the cost of insurance if it exceeds certain criteria.

2. Minimum Benefit Standards. The State would be given the authority to regulate the level of service covered by health insurance policies. Several states already do this, and in addition, the National Association of Insurance Commissioners (NAIC) has developed model state health insurance legislation for setting minimum health benefit standards.

3. Medicaid Medically Needy Program. This is an optional medicaid program which extends medicaid assistance to needy people who are a bit over current income guidlines. Twenty-nine states, two territories, and the District of Columbia participate in this program. Alaska does not.

4. Amend Medicaid Statutes. Provide Oregon option to use medicaid funds to purchase health insurance; provide for funding of interest payment penalties when the state is delinquent on its bills; and add additional services to the medicaid program, such as dental care.

5. Reinsurance Pools. Several states have developed mandatory reinsurance pools to ensure health care coverage availablity to high risk persons at reasonable rates. There will be little cost to the state to implement this.

6. Expand State Direct Service Programs. Additional funding could be made available to health clinics throughout Alaska to provide care to Alaskans on a sliding fee basis, according to income. The federal government already subsidizes physicians in areas like Juneau and Palmer, where the availability of services is a problem. This would also be a big help to communities that have doctors, if there was a problem of access, such as a refusal by doctors to accept medicaid coupons.

While these programs do not close all gaps, or address all health care issues, such as cost containment, they will extend services to many Alaskans, at a reasonable cost. Nothing is particularly novel, and experiance from other states is available. It can be pulled together as a House health package within the time frame detailed below.

Feb. 22 decision to proceed

29 detailed drafting request to LA legal

March 7 bills ready for introduction

17 hearings begin in HESS

31 legislation ready for floor action

With a combination of focus, coordination, and concentration, we can put together an excellent package this session. It would affect people's lives directly and immediately.

STATE OF ALASKA
THE LEGISLATURE
LEGISLATIVE AFFAIRS AGENCY

POUCH Y STATE CAPITOL
JUNEAU, ALASKA 99811
907-465-3600

MEMORANDUM

May 27, 1977

SUBJECT: State Health Insurance (W.O. #4206)

TO: The Honorable Thelma Buchholdt

FROM: Sharman Haley SH
Research Analyst

Carter's National Health Insurance Proposal

The Carter Administration has not developed a comprehensive health insurance proposal. An advisory committee was recently established to evaluate the alternative approaches to national health insurance, and they are currently taking testimony in several cities across the country.

During the campaign, Carter promised national health insurance with the following provisions:

1. universal and mandatory coverage, implemented in stages based on priorities of need and financial feasibility;
2. comprehensive and uniform benefits with emphasis on preventive medicine;
3. financing by payroll taxes and general tax revenues;
4. cost and quality controls, uniform standards and set rates;
5. maximum personal interrelationship between patient and physician consumer choice of provider, and basic concern for the dignity of the person, unrelated to wealth or income;
6. incentives for improved delivery of services, for increased productivity, for redistribution of health personnel, and

resources for the development of alternative delivery systems;

7. consumer representation in development and administration.

Carter estimated the cost of implementing this program at $10 billion of new federal expenditures. It is not clear what his reasoning was to arrive at such a low figure, since he has not proposed a plan that can be costed out. One comprehensive mandatory plan that has been cost estimated is the Health Security Act, and the estimate of new federal expenditures for that pla is $80 billion.

There were 23 different national health insurance proposals before Congress last year, but none are moving now.

State Approaches

Two national organizations have developed model state health insurance legislation. The Conference of Insurance Legislators proposes a comprehensive health care program with universal voluntary coverage, regulated by the state, but administered by private carriers and financed by consumers. The National Association of Insurance Commissioners proposes a catastrophic health care program financed by the state. We have requested copies of these two models.

There are five states that have passed and implemented state health insurance. In Rhode Island, Maine, and Minnesota, the state provides financial assistance for catastrophic health expenses. In Hawaii, Connecticut and Minnesota, again, the state regulates private comprehensive health coverage to insure quality and availability and to control costs. No state directly subsidizes comprehensive health insurance for its residents, because it appears to be prohibitively expensive.

Hawaii: Every employer in Hawaii is required to offer a qualified health care plan to his/her employees and to pay at least half the premium. Qualified plans must meet state minimum standards. Small employers with fewer than eight employees whose share of the premiums would exceed 1.5% of their payroll, when that excess is greater than 5% of the employer's income from the business are entitled to a state subsidy for the remainder of the premium. This statute took effect in 1975, and though several employers applied for state assistance, none were found to be eligible.

Connecticut: The Connecticut comprehensive health care plans statute insures the universal availability of comprehensive health care insurance contracts meeting state minimum standards, at standardized premiums. The Health Reinsurance Association is created with mandatory membership of all carriers in the state to pool risk for the mandated coverage. The premium rates vary by sex and age, and for group contracts by geographical area, as well. Sample quarterly premium rates are in Table I.

Table I - Sample Quarterly Premium Rates for Connecticut Comprehensive Health Care Plans

Individual/ /Group*	30-year old Female	60-year old Male
Deductible		
$200	$114.57/ /$103.11	$243.15/ /$218.82
$500	$ 85.92/ /$ 77.34	$182.37/ /$164.13
$750	$ 74.46/ /$ 67.02	$158.04/ /$142.23

* Rate for Hartford, New Haven and Fairfield region.

Minnesota: The Minnesota statute requires all health insurance carriers to offer health coverage which meets minimum state standards, and requires employee health benefits to meet minimum standards. It also established a state comprehensive health plan available to any resident who is rejected, restricted, or limited in their health coverage from the private sector. This state plan is offered by all carriers and reinsured by an association of carriers, in which membership is mandatory, to pool the profits and losses of high risk coverage.

This comprehensive health insurance statute in Minnesota took effect in January of this year. There are now 12 law suits pending challenging the law. Interstate employers complain that when Minnesota law requires a high standard of health benefits for employees, the employer must offer the same high benefits to its employees in other states. Thus, the law has impact beyond the borders of the state and may be unconstitutional.

Minnesota also has a Catastrophic Health Expense Protection Act under which the state pays 90 percent of a resident's health care expenses after the resident's out-of-pocket expenses exceed (a) 40 percent of his/her household income under $15,000, 50 percent of his/her household income between $15,000 and $25,000, plus 60 percent of his/her household income in excess of $25,000; or (b) $2,500; whichever is greater. This statute does not take effect until July 1 this year, so its fiscal impact is not known. On the basis of very crude estimates, it was budgeted for $18 million over the two year budget period, plus $50,000 for administration.

Rhode Island: Rhode Island's catastrophic health insurance statute has been in effect for three years. For the 85 percent of Rhode Island's residents who have private health coverage which meets minimum standards,

the state will pay costs of health care beyond the limits or coverage of the private insurance and above $500 or 10 percent of the resident's income. For the other 15 percent who do not have private insurance, the state will pay costs over $5,000 or 50 percent of the resident's income. The program is not well known yet. Of the 300 to 400 applications to the state for payment of health bills received each year, only half are found to be eligible. The annual state expenditure for the coverage is running $1,500,000 per year.

A health resources development fund is established not only to pay catastrophic costs but to make grants, loans, or contracts for the improvement of health facilities, services or education.

The statute also authorizes state regulation regarding consumer protection, quality of health coverage, universal availability, and rates.

Maine: The Maine catastrophic illness statute provides that the state will pay all remaining eligible health care expenses when the resident's out-of-pocket expenses reach 20 percent of the resident's net income, plus $1,000. For residents whose net worth exceeds $20,000 and such net worth includes cashable assets, 10 percent of such cashable assets are added to the out-of-pocket expenses threshold.

Considerations for Alaska

Although Alaska has a Catastrophic Illness Committee, it has not been given clear guidelines nor adequate funding.

The state approaches which have been tested elsewhere which you may want to consider for Alaska include:

1. state minimum standards for comprehensive health plans offered by private carriers;
2. mandatory availability of such plans to all state residents regardless of age or physical condition;
3. mandatory membership of all health insurance carriers in a reinsurance association to pool risk;
4. regulation of premium rates and provider reimbursements;
5. comprehensive health benefits mandated for all employees, with at least 50 percent of the premiums paid by employers;

All of the above provisions combined would still leave some people without comprehensive coverage. Self-employed, part-time or non-working people with adequate incomes would have a choice whether or not to purchase coverage, and some would choose not to. Self-employed, part-time, unemployed and non-working people with low incomes, however, could not afford to purchase private health insurance. People in this category might include farmers, homesteaders, miners, independent truckers, fishermen, small family business people, widows, retired people not eligible for Medicare, lots of low paid part-time workers (mostly women) and, of course, all their dependents. In addition, there are large numbers of seasonally employed people in Alaska who would only have coverage part of the year, such as loggers, cannery workers, and tourist industry employees. Public Health Services, Medicaid, and Medicare provide coverage for large sectors of low income Alaskans, plus General Relief-Medical and other state programs provide piecemeal health services for eligibles, but we are still far from comprehensive coverage for all.

The only way for the state to insure universal coverage is to subsidize it to the tune of millions of dollars.

Before we can proceed to draft a state comprehensive health insurance plan for Alaska, some policy decisions must be made:

1. Coverage - is enrollment voluntary or mandatory, and for whom is the coverage targeted?
2. Benefits - which expenses will be covered?
3. Financing - what portion will the state or employers pay? How much in premiums, deductibles, or co-payments must the consumer pay?
4. Cost and Quality Control - how will rates or standards of care be set?
5. Administration - what is the role of private carriers? What is the role of the state?

There will be a seminar on state health insurance plans on Friday, July 29, in Washington, D. C., sponsored by the Georgetown University Health Policy Center. There will be four forums: (1) political planning for enactment of state health insurance; (2) administrative aspects; (3) benefit coverage and eligibility; and (4) the cost of state health insurance, and looking ahead to national health insurance. Reservations or inquiries should be directed to: Jordan Braveman, Director of Policy Analysis, Georgetown University Health Policy Center, 3520 Prospect Street, N.W., Washington, D. C. 20057. He can also be reached by phone at (202) 625-3092.

We will be happy to meet with you at your earliest convenience to discuss these questions.

SH:jm

GEORGE R. ARIYOSHI
GOVERNOR

TANY S. HONG
DIRECTOR
BANK EXAMINER
COMMISSIONER OF SECURITIES
INSURANCE COMMISSIONER

DONALD D. H. CHING
DEPUTY DIRECTOR

STATE OF HAWAII
OFFICE OF THE DIRECTOR
DEPARTMENT OF REGULATORY AGENCIES
1010 RICHARDS STREET
P. O. BOX 541
HONOLULU, HAWAII 96809

March 24, 1980

Representative Thelma Buchholdt
State Representative
District 9 (Spenard)
Chair, House HESS Committee
Alaska State Legislature
Pouch V, State Capitol
Juneau, Alaska 99811

Dear Representative Buchholdt:

This is to acknowledge receipt of your letter of March 18, 1980, inviting me to testify on proposed legislation similar to Hawaii's "Prepaid Health Care Act." Because the subject matter is not related at all with the state department which I am presently serving, I originally could not justify my going to Juneau as official State of Hawaii business. However, my Director and the Governor both feel that if my presence would assist Alaska in enacting progressive health care legislation, I would be given leave to go to Juneau with Hawaii's experience in this field.

I have spoken with Ms. Sorice of your office and am making plans to arrive in Juneau on Sunday, March 30, 1980, and will be available to testify on March 31 and April 1, 1980, if necessary.

I am looking forward to being of any assistance that I can possibly render in your efforts to enact such a bill. I think it has been of much benefit to the people of the State of Hawaii.

May I give you a short biographical sketch so that you may use this in further evaluation of my testimony next week:

1. Member of the Hawaii Legislature from 1959-1978 (8 years-House of Representatives; 12 years-Senate).

2. Attorney-at-Law.

3. Former Vice-President of the Bank of Hawaii (1963-1979).

4. Presently Deputy Director of the Department of Regulatory Agencies, State of Hawaii.

5. Member of the Board of Directors-Hawaii Medical Service Association (Blue Shield and Blue Cross Plan) (1965 to present), presently serving as its President.

I have never been to the great State of Alaska, and I am looking forward to my first visit.

Very truly yours,

Donald Ching

Donald D. H. Ching
Deputy Director

cc: Ms. Jan Sorice

19 March 1980

To: Representatives Buchholdt, McKinnon, Parker, Gardiner

From: Sharman Haley
Alaska Public Interest Research Group

Subject: Policy Options in Proposed Health Legislation

The health bill which is presently being drafted at Representative Buchholdt's request is largely modeled after Hawaii and Minnesota laws. These laws do not necessarily conform in detail to the situation in Alaska nor the interests of the Alaska sponsors. This memo calls to your attention various points in the model legislation which you may wish to consider modifying for Alaska. Certain policy considerations in the proposed Medicaid amendments and medically needy program are also discussed.

Health Insurance Minimum Standards and Risk Pooling

The Comprehensive Health Insurance Act adapted from Minnesota law and published in 1980 Suggested Legislation Vol. 39, by the Council of State Governments, is the model for the minimum benefits and risk pooling portions of the proposed legislation. One section in the model bill requires health insurance carriers to offer certain kinds of conversion privilages. For example, when an individual drops out of a group plan (such as with the termination of employment) the carrier must offer an individual plan to continue coverage without the addition of underwriting restrictions. Also, when the primary insured dies, the carrier must allow other individuals covered under the plan to continue coverage. This issue was not addressed in our drafting request. You may wish to consider including language on conversion privilages in the bill.

The model legislation also contains a provision known as "dual option" which requires major employers of 100 or more employees who offer health benefits to their employees, to offer both insurance or membership in a health maintenance organization where both are available. This in part is a policy to promote HMOs. This provision was not included in the drafting request. Since Anchorage may have an HMO in the near future, you may wish to consider a similar provision in the legislation for Alaska.

The model legislation sets out standards for three types of qualified plans. You should be aware that the legislation does not require that only qualified plans can be sold; it merely requires of all carriers that qualified plans be offered to each eligible customer.

The model legislation sets numerous specific dollar amounts. Presumably these amounts will have to be periodically updated for inflation or changes in standards. You may wish to consider adding the provision that the specified amounts are applicable for the first year and subsequently the commissioner may revise and update all the dollar amounts by regualtion.

The model legislation initially sets premiums for the high risk coverage at the average premium level among the five largest carriers in the state for comparable standard risk coverage, and provides that in subsequent years the premiums are to be set such that the plan pays for itself according to actuarial principles. In Minnesota's experience however, the claims in the first 18 months were so high that they feared premiums would have to be raised 100% to cover the claims. To keep the premiums at an affordable level, the legislature amended the statute to limit the premiums to 125% of the standard risk premiums, and provided that assessments made against the carriers by the carriers association to cover the losses due to claims, could offset any income or premium taxes owed to the state by that carrier. Thus the state was made responsible for the losses incurred by the plan. You may wish to consider these amendments for the Alaska legislation as well.

The model act defines dependent as spouse, unmarried child under the age of 19, dependent child under the age of 25 who is a student and

is financially dependent on the parent, or a dependent child of any age who is disabled. You may wish to consider the addition of any household member who is financially dependent on the head of household, in order to include other relatives or non-relatives who may be members of that family unit.

The model legislation, in its itemization of minimum services covered and not covered, states that transportation costs other than ambulance are not covered. This is not well suited to Alaska, since medically necessary travel is frequent and expensive in most parts of the state.

The model legislation includes well baby care, routine physicals, and multi-phasic screening. It should be understood that since these are routine, predictable expenses, they do not fall within the central prupose of insurance -- that is, to insure against risk. Requiring coverage of basic medical care such as these in a consumer-paid plan does no service whatsoever to the consumer, since he or she will pay the full cost of routine care through higher premiums anyway. Requiring coverage of them in an employer-paid plan does offer an advantage to the consumer, of course, because it shifts the costs of these medical services from the consumer to the employer. Arguably there is a public purpose served in this requirement even for consumer-paid coverage -- namely to promote the utilization of these services in the interests of preventive medicine. Since the services have already been paid for, the consumer may as well utilize them. There are experts who claim, however, that routine physical exams, other than pap smears, blood pressure checks, or other procedures tailored to the health risks of the individual patient, are not cost effective; that overall they do not save more expense through the early detection of disease than they consume.*

Mandatory Employer Sponsored Coverage

The Hawaii Prepaid Health Care Act is the model for the mandatory employer sponsored coverage portions of the proposed legislation. The Hawaii

* One school of thought maintains that a more effective approach to preventive medicine would be promoting health education, self-awareness and self-responsibility for maintaining health among consumers. This would also promote early detection and reporting of symptoms when they do occur.

act excludes seasonal employees, in particular the pineapple pickers. The only explanation for this offered by the Hawaii program administrator was that the plantation owners had the political clout to get their employees exempted. Seasonal employees are a large component of Alaska's labor force, and often lack health coverage. You may wish to consider including seasonal employees in the Alaska legislation, or perhaps some form of hour bank for seasonal and temporary employees similar to the union health plans in the construction trades.

The model legislation mandates coverage of the employee only, and coverage of dependants is optional (unless the plan is of lower standard than the largest plan and is approved by the commissioner). You may wish to consider making coverage of dependents mandatory in employer-sponsored plans.

The Hawaii model sets up a separate fund for premium supplementation for qualifying employers. Several sections of the bill are devoted to defining the fund and how it is to be managed. Since the fund is not going to be self-supporting and will require annual appropriations anyway, there is little apparent advantage in terms of management or oversight in establishing a separate fund. You may wish to consider making premium supplementation part of the general fund.

The Hawaii model appears to make employee participation, including payment fo the employee share of the premium, mandatory. The advantage in this is that more people will have coverage and employers cannot pressure employees to decline such coverage. The disadvantage is that employees may be required to contribute to the premium and have no choice whether or not to participate. You may wish to consider making participation voluntary on the part of the employee.

Linkage Between Hawaii and Minnesota Models

The Hawaii and the Minnesota models take two different approaches toward defining the minimum benefit standards for qualified health coverage plans. The Hawaii law is setting standards for mandatory employer coverage. In addition to meeting the very general benefit guidelines itemized in the

law, a qualified plan must meet one of two alternative benefit standards: (1) the benefits must meet or exceed the benefits of the largest plan in the state (in Alaska this would be either the Alaska State employees plan or possible the Teamsters plan); or (2) the benefits must provide a level of coverage deemed satisfactory by the Commissioner. If these benefit plans are mre limited than the largest plan, the employer must pay half the premium for dependents as well as the primary insured. The bill also establishes a prepaid health care council to advise the Commissioner on benefit levels. The law is administered by the Department of Labor.

The Minnesota law is setting standards for state qualified plans which all carriers are required to offer. The law specifies the scope of required benefits as well as minimum or maximum limits, copayments, and deductibles for three levels of qualified plans. The law is administered by the Division of Insurance.

While there is no direct conflict between these two laws which are proposed for Alaska, there is some duplication. Since the Alaska Department of Labor has no expertise in the arena of health insurance benefits, you may wish to consider centralizing all responsibility for benefit standards under the Division of Insurance, and leave only the employer compliance responsibilities with the Department of Labor. You should be aware that the Alaska Division of Insurance is already seeking authority to regulate minimum standards for insurance of all kinds in HB882 and SB513.

Consideration should also be given to the question of what standards employer coverage should meet and how they should be set. The Minnesota model specifies the standards for three levels of qualified coverage in law, and requires that employers who offer health coverage provide at least a number two qualifie plan. The Hawaii model only provides general guidelines of minimum services to be covered, and leaves the other details up to the Commissioner, or else ties the standard to the benefits provided by the largest plan in the state. The state employees plan and the Teamsters plan are both more comprehensive than the minimum standards for the number two qualified plan, but of course would also be more expensive. The Minnesota approach is much simper than the Hawaii approach and gives the legislature

greater control over the minimum standards. The standard required for employer plans does not necessarily have to be the same standard required for a qualified plan offered to individual consumers, particularly in the area of routine care for the reasons discussed in an earlier section.

Medicaid Medically Needy

Federal financial participation requirements in the Medicaid medically needy program set the maximum income threshold for medically needy program eligibility at 133% of the Aid to Families with Dependent Children income standard for a household of equivalent size. The minimum income threshold is set equal to the Adult Public Assistance standard or the AFDC standard, whichever is higher, for a household of equivilent size. Since in Alaska the AFDC standard is so much lower than the APA standard, $350 for an AFDC family of two compared to $608 for two APA elibibles, the federally mandated minimum medically needy income threshold for a family of two, $608, is higher than the federally mandated maximum income threshold of: $466.55 ($350 x 1.33). These are clearly impossible criteria. The federal policy manual appears to resolve the contradiction in favor of the lower standard. The result is that for adult elibibles the Medically needy income threshold is not much higher, and for a two person household is actually lower, than the income standard for the regular Adult Public Assistnace program. (See attachment) This inconsistency could be left as is, or resolved in one of two ways: (1) the AFDC standard (which is lower than AFDC standards in many other states and a virtually impossible budget for a family in Alaska) could be raised; or (2) the medically needy income threshold could be set higher than 133% of the AFDC standard and the program could by financed entirely by the state.

Medicaid Optional Services

The Medicaid optional services included in the drafting request were the nine uncovered services most often requested by Medicaid clients and most recommended by social workers, as reported in OPTING: A Study of Medicaid Client Need. A copy of Table 2 from this report is attached. A complete listing of Medicaid optional services is attached should you wish to consider other optional services.

HOUSE RESEARCH AGENCY
Pouch Y - State Capitol
Juneau, Alaska 99811
465-3991

MEMORANDUM

March 18, 1980

TO: Representative Bill Parker
Attn: Mr. Jim Erickson

FROM: Jack Kreinheder, Issues Analyst JK

RE: State Health Care Programs
Research Request No. 61

You have asked that we: (1) provide any available studies on Medicaid, state health insurance, and th State's health care program in general; and (2) determine whether the State could provide medical care for low-income groups in medically underserved areas of the state. The enclosed materials represent all the relevant materials we were able to locate, with the exception of past copies of the State Health Plan and the Medicaid Annual Status Report. These reports were not included because of their bulk and uncertain value to you; should you wish to review these documents, please let us know.

Our major findings with regard to direct State delivery of medical services are the following:

1. There appear to be no legal reasons why the State could not hire doctors to treat low-income groups or any other class of people; however, four major practical difficulties with such an approach were raised during the course of our research. The first problem is that everyone we contacted believed the medical community would oppose the competition which direct State participation in the delivery of medical services would represent. Secon., the State would need to purchase malpractice insurance for doctors in its employment, thus incurring substantial costs. Third, if the legislature approved funding for such a program, and later discontinued it, or if State physicians' services were to be provided on a temporary basis, the problem of "medical abandonment" could result in lawsuits against the State unless adequate arrangements were made for the further treatment of patients handled under the program. Fourth, it appears that medical services provided by State physicians would not be eligible for federal Medicaid funds

except on a temporary or special situation basis; therefore, the State would have to bear the full cost of the program unless State-provided services were demonstrated to qualify for a waiver from the usual federal Medicaid requirements.

2. Withdrawal from the Medicaid program is not, however, a prerequisite to the establishment of a State physician program. My understanding of the alternative health care system you are considering is that the State would not necessarily provide all the medical services now administered by private physicians under the Medicaid program, but would instead make State doctors available in areas which are medically under-served either because of the lack of physicians, the lack of specific medical services, or because of the refusal of available physicians to accept Medicaid patients. It is clear that the State could continue to receive federal Medicaid funds for medical services provided by private physicians; and, in addition, it appears that funds could also be received for State-provided services if a federal waiver from certain regulations could be obtained. The State currently receives over $22 million per year in federal Medicaid funds.

3. It may be possible to improve medical care for low-income persons by means other than, or in addition to, direct State health care delivery, and without opting out of the Medicaid program The principal problem with the Medicaid program, from the recipient's point of view, appears to be that many doctors in Alaska refuse to accept Medicaid patients. This reluctance to take Medicaid patients is, in turn, largely attributable to the extensive paper-work requirements and the extremely slow payment process of the current Medicaid system in Alaska. However, these problems are not inherent in the federal Medicaid system, and it appears that more rapid and efficient reimbursement of medical providers could substantially improve low-income access to medical care by encouraging more doctors to participate in the program. Of course, there may be other problems with the Medicaid program which might make withdrawal from the system desirable.

4. The expanded use of fiscal intermediaries may be one option for making more doctors available to low-income persons. Delta Dental Plan of Alaska is currently the only organization of this type in Alaska and handles only dental services, but all parties involved--the Department of Health and Social Services, the participating dentists, and the Medicaid recipients--seem to be very satisfied with the program. About 96 percent of the dentists in Alaska are members of Delta Dental and 95 percent of these participate in Medicaid. The fact that reimbursement to dentists by

Delta Dental for Medicaid cases usually occurs within two weeks, as compared to up to several months for other Medicaid claims handled by the State, is the main reason for the almost universal acceptance of Medicaid cases by Alaska dentists.

In an administrative review of the Alaska Medicaid program completed in 1979, HEW officials recommended that the Division of Public Assistance contract with a fiscal intermediary for Medicaid processing. The Division is planning to solicit within the next six months requests for proposals for the processing of all Medicaid claims by a fiscal intermediary, although H&SS may still elect to process claims in-house. Robert Ogden, Chief of Medical Assistance for the Division, stated that a fiscal intermediary handling all Medicaid claims could probably process claims as rapidly as Delta Dental currently does for dental claims, thus improving the prospects for physicians accepting Medicaid patients. However, the choice between the use of a fiscal intermediary and processing the Medicaid claims in-house will depend on administrative decisions made within the department.

Each of the four points summarized above will now be discussed in more detail.

State Medical Care

According to the sources we contacted, the basic answer to your second question is yes, the State could hire doctors to treat low-income groups. Eligibility could be determined in a number of ways and would not need to parallel the federal Medicaid system. Placement of the State-employed doctors throughout the state could be based on whatever criteria were deemed appropriate by the State.

The State already provides direct delivery of medical services to a limited degree. Nurses employed by the Division of Public Health administer the Early Periodic Screening, Diagnosis, and Treatment Program (EPSDT) for children throughout the state. The program is small in comparison to other medical services, but it does provide a precedent on the State level for direct delivery of services.

Political resistance by the medical community was cited by several persons with whom we spoke as the greatest obstacle to the direct employment of doctors by the State. Our contacts believed that many doctors would view such an action as State competition with the private sector,

and as "socialization" of the medical profession. The apparent acceptance by the medical community of the EPSDT program suggests that opposition to the State physician approach would not be as strong if the approach were used only in a few selected areas or were clearly temporary in nature. For example, if the State adopted a procedure similar to that which was employed by the federal Department of Health, Education, and Welfare (HEW) to identify and designate the low-income population of Anchorage as a Critical Health Manpower Shortage Area (see Attachment A), doctors might be more willing to accept the State delivery approach than if it were part of a comprehensive, state-wide system.

Under the HEW system, which is authorized by section 332 of the Public Health Service Act, an area or population group of an area may be designated as a Health Manpower Shortage Area if the population-to-primary care physician ratio exceeds a certain level. An area is also given a degree-of-shortage classification based on this ratio. The population-to-physician ratio takes account of physician accessibility, rather than simply dividing the population by the number of physicians. For example, in Anchorage, the ratio of Medicaid eligible persons to all primary care practioners is estimated at 161:1, but when HEW adjusted for the fact that most of these physicians do not accept Medicaid patients, the final population-to-primary care physician ratio was determined to be 3,041:1.

This ratio qualified the low-income population of Anchorage as a degree-of-shortage group 4, which makes the area eligible to: (1) apply for placement of National Health Service Corps (NHSC) physicians; (2) be an eligible service area for purposes of repayment of health professions student loans and for the NHSC scholarship program; and (3) apply for grant funds under various sections of the Public Health Act.

A similar approach to improving medical care for medically underserved areas or population groups could be utilized by the State. Designation under the program might qualify an area for the placement of State-hired physicians, for grants to improve health care delivery, or perhaps for a special streamlined medicaid process which would encourage doctors to accept Medicaid patients. The latter option might be effective in a case like Anchorage's, in which the number of practicing physicians in an area is sufficient to meet the medical needs of the population, but the physicians will not accept Medicaid patients because of dissatisfaction with the reimbursement system.

Attachment B, which is a letter to Representative Martin from Commissioner Beirne, suggests other questions which should be considered if the State elects to provide medical care directly and/or withdraw from the Medicaid program. As Duncan Read indicated in his earlier memo, Dr. Frederick McGinnis, Deputy Commissioner of H&SS, has proposed a major study of health care financing options which would address questions relating to

State provision of health care, such as who would be eligible for the program, and what services should be provided. Dr. McGinnis has apparently expanded the scope of the proposed study and is attempting to obtain about $170,000 for the project. If the study is conducted, the results would be submitted to the 1981 legislature.

If the State physician health delivery system is to be pursued, the problems of malpractice insurance and medical abandonment must be considered. Neither of these problems would prevent the State from hiring doctors, but their cost and legal implications may have some bearing on the issue. The State currently carries a small amount of malpractice insurance for doctors employed in administrative capacities, apparently in the event that they are called upon in an emergency situation. To fully insure doctors employed by the State who regularly provided medical services would require a substantial expenditure. The magnitude of the insurance cost would depend on the number of doctors employed the service provided, and the scope of the program, but the cost could be significant.

Medical abandonment appears to be a relatively easy problem to avoid, but it could present legal problems if it is not considered in the design of any State-provided medical care program. Under state and federal law, physicians are responsible for arranging for continued medical care for their patients if, for any reason, they discontinue their treatment. A doctor not fulfilling this responsibility may be sued by a patient. The two ways in which the issue of medical abandonment could arise are: (1) if the legislature suddenly discontinued funding for the program, and (2) if the program were discontinued in an area because it was determined that the private physicians in the area could now adequately serve the population. In both instances, the problem of medical abandonment could be avoided by ensuring that adequate arrangements were made for the continuing treatment of patients after the State ceased providing service directly.

A final point to be considered regarding direct State delivery of medical care is the Medicaid funding question. I contacted officials with the Northwest regional office of the HEW Medicaid Bureau in Seattle to determine if federal Medicaid funding could be provided for medical services delivered by State-employed physicians. A firm answer could not be secured within the time frame of this project, but it appears that a waiver from certain federal regulations pertaining to reimbursement procedures and other matters would be required for federal funding to be given for State-provided services. The necessary conditions for such a waiver are also unclear at this time, but HEW officials indicated that the designation of an area or population group having a severe shortage of medical care might meet the waiver requirements.

You have indicated an interest in the possibility of the State withdrawing entirely from the Medicaid program, and the question of Medicaid support for State-provided services may therefore not be a major concern. However, the State currently receives over $22 million each year in federal Medicaid funds. It may, therefore, be desirable to retain these funds if a State medical care program could meet, or be exempted from, the necessary federal regulations without compromising the program. Please let us know if you would like a more concrete response to the Medicaid funding question. A written request to HEW would be required and their response could take two weeks or more, but we would be glad to pursue this issue if you would like.

Medicaid Issues

Although we were not asked to specifically address the Medicaid program in this memorandum, we obtained information on Medicaid during our research which may be of value to you in considering health care options. The greatest problem with the current Medicaid program in Alaska is that the claims processing system is inefficient, requires excessive paperwork, and results in long delays in provider reimbursement. It is the paperwork and the payment delays which have been the primary cause of Alaska physicians refusing to accept Medicaid patients. Attachments C and D provide a physician's perspective on the problems of the Medicaid system. In many cities, most notably Anchorage, the number of physicians seems to be adequate, but a Medicaid patient cannot see a doctor because the majority of physicians refuse to take Medicaid cases. It therefore appears that a more efficient and rapid claims processing system could do much to alleviate the difficulty of obtaining medical care for low-income Alaskans.

The current program of Medicaid dental services lends strong support to this premise. Medicaid claims for dental care do not go through the State system used for other medical services, but instead are handled by the Delta Dental Plan of Alaska, which acts as a fiscal intermediary between the providers and the State. The pertinent statistics regarding Medicaid participation by dentists were cited in the findings section, but the importance of Delta Dental in this discussion is that the vast majority of the state's dentists accept Medicaid patients. The two-week Medicaid reimbursement time which Delta Dental provides for dentists is the primary reason for the high degree of cooperation by Alaska dentists with the Medicaid program.

The obvious question, then, is if Delta Dental is so efficient, why doesn't the State use Delta or another fiscal intermediary to process all its Medicaid claims. There are a number of reasons why fiscal intermediaries do not represent an easy solution to the Medicaid and low-income health care problems.

The first is that Delta Dental does not appear eager, and may not have the capability to take on the processing of medical claims. Attachment D is a letter from the Pediatricians' Association to Representative Martin suggesting that the State contract with Delta Dental for payment of Medicaid claims for pediatric services. However, I spoke with Denise Knapp, Executive Director of Delta Dental, and she indicated that Delta has not agreed to process pediatric claims and is still only discussing the idea. Robert Ogden, Chief of Medical Assistance for H&SS, stated that while he has been very pleased with Delta's performance, he is not sure if Delta could handle the large volume of Medicaid claims for medical services, and knows of no other in-state firms who could.

A second possible problem with the expanded use of fiscal intermediaries is cost. Each claim processed by Delta Dental costs the State an average of more than $14, while the medical claims processed under the current system cost only about $1.45 each. However, Mr. Ogden was quick to point out that the current system does not meet federal requirements, and meeting these requirements is likely to increase the cost of processing claims whether a fiscal intermediary is used or not. In addition, Delta's cost is much higher than would be that of a fiscal intermediary handling all medical claims, because the fixed costs of the Delta claims processing system are spread over a relatively small number of claims (8,000 per year). A fiscal intermediary handling all Medicaid claims for medical services would process about 144,000 claims per year; cost per claim would therefore be much lower, perhaps in the $2.50 range, according to Mr. Ogden.

HEW has mandated that the Division of Public Assistance implement a new claims processing system by September, 1980. In an administrative review completed a year ago, HEW officials recommended that the Division contract with a fiscal intermediary for the processing of all Medicaid claims. (See Attachment E, Chapter 7, for more detail on this recommendation.) However, it is still uncertain whether this recommendation will be followed. The Division plans to solicit requests for proposals (RFP) for claims processing within the next six months. At least six to eight firms are expected to bid on the contract, but it appears that the decision to use a fiscal intermediary or to process Medicaid claims in-house will be more dependent on administrative decisions within H&SS than on the results of the RFP process.

We hope the information we have provided is useful to you. This memorandum is a brief treatment of a complex subject, so please let us know if you would like additional research, or if we may be of further assistance in any other way.

JK/dp

cc: Representative Terry Martin

Attachments:

A. HEW designation of Anchorage as a Health Manpower Shortage Area, from the Anchorage Neighborhood Health Center.

B. Letter from Commissioner Beirne to Representative Martin on Medicaid/State Health Care issues.

C. Letter from Dr. Lillibridge to HEW discussing Medicaid problems.

D. Letter from Dr. Lillibridge to Representative Martin on Medicaid problems and the Delta Dental program.

E. HEW administrative review of the Alaska Medicaid program.

F. H&SS task force recommendations on the Medicaid program.

G. Information supplied by Delta Dental on their program.

H. Alaska and National Health Insurance--report by Dr. McGinnis of H&SS.

I. Third Party Health Coverage in Alaska--1978 report by the former Legislative Affairs Research Division.

J. Opting-A Study of Medicaid Client Need--1977 report by the former Research Division.

K. H&SS 1977 Medicaid Annual Status Report.

L. January. 1980 State Health Plan.

STATE OF ALASKA

Legislative Affairs Agency

THIRD PARTY HEALTH COVERAGE IN ALASKA

Prepared by

LEGISLATIVE AFFAIRS AGENCY

Research Division

April 1978

IV. AN ANALYSIS OF THE EXTENT OF HEALTH CARE COVERAGE AND GAPS IN COVERAGE

The Covered Population

Nationally, 178 million people - more than 8 out of 10 persons in the civilian non-institutional population - had some form of private health insurance in 1975, according to the Health Insurance Institute. The same survey reported 250 thousand people in Alaska, (two thirds of the civilian population) had private coverage.

The major public programs, U.S. Public Health Service, Medicaid and Medicare, provide health coverage to an estimated 20% of Alaska's civilian population. It is not known to what extent public coverage duplicates private coverage state-wide. However, random sample surveys were conducted in 1974-75 in both Anchorage and Kodiak Island Borough with questions regarding health coverage. The Anchorage survey reported that 79.9% of the sample had third party health coverage of some sort, and 20.1% had none. In Kodiak Island Borough 92.6% of the respondents reported third party health coverage, while only 7.4% reported none. This high percentage of health coverage in Kodiak Island is largely due to the high proportions of Indian Health Service eligibles (over 40%) and military personnel and dependents (over 25%). Those 7.4% without coverage constituted over 20% of the non-Native non-military or military dependent population.

The 20.1% of the Anchorage sample without health coverage constituted over 25% of the non-Native non-military or military dependent population in Anchorage.

If we can assume that a similar percentage (20-25%) of the non-Native non-military population state-wide currently are without third party health coverage from any source, 56 to 71 thousand Alaskans totally lack third party health coverage.

The biggest hole in this coverage patchwork is moderate and low income people who are self-employed or marginally employed, or non-union employees of an employer who doesn't provide health benefits. These people are above the income eligibility standards for Medicaid or General Relief Medical, yet their cash income is not adequate to afford either the expense of private health insurance, nor the expense of many medical services on a fee-for-service basis. This group includes farmers, shop owners, small contractors, temporary and part-time employees, casual laborers, subsistence providers and the unemployed. It also includes a large number of non-union workers, particularly those working for small employers, such as child care workers, waitresses, clerks, clerical workers, delivery truck drivers, gas station attendants and construction workers in home building. And of course the dependents of these bread-winners normally lack coverage as well.

In Alaska there are many seasonally employed people as well who have health coverage only part of the year while they are employed, such as loggers and cannery workers. Most construction workers (outside of home building) are unionized and have "hour banks" for health benefits such that if they work enough hours over the summers their accrued health benefits will last through to the next season. However, when there is not enough work to go around, many people are not able to accumulate enough health coverage to last the winter.

Services Covered

Health plans vary widely in the services covered and the levels of coverage provided. The foregoing analysis distinguished between people who have any sort of third party health coverage, and those who have no coverage at all. We have not yet considered whether those with some coverage have coverage that is adequate to protect them from financial hardship. Some policies, for instance, are specialized and cover only hospital expenses, or only surgical expenses. Many policies do not cover particular services such as prescription drugs, office visits, or nursing care outside of a hospital.

In the Anchorage survey, while 20% of the respondents lacked hospital coverage, 24% of the respondents lacked surgical coverage, 46% lacked coverage for visits to the doctor's office, 60% lacked dental coverage, and 70% lacked mental health coverage.

Many policies have limits on coverage that are exhausted by severe illnesses, or require co-payments which can add up to substantial sums. Many policies limit their payments to "reasonable charges" as defined by the insurance company, regardless of the actual charges, and the consumer must pay the difference.

It is not difficult for a consumer even with some health insurance to incur heavy financial losses due to health care expenditures. The following statistics suggest that insurance companies in fact are not paying the bulk of health care expenses.

While the private health insurance industry claims to serve over 80% of the nation's civilian non-institutionalized population, in 1976 they paid only 26% of personal health care expenditures nationally.

Government programs paid another 40%, and consumers paid 32% directly. The remaining 1% of personal health care expenditures was paid by philanthropic organizations.[1]

1 "National Health Expenditures, fiscal year 1976", Social Security Bulletin, April 1977, page 8.

Alaska State Legislature

House of Representatives

Committee on

Health, Education & Social Services

Official Business

Pouch V
State Capitol
Juneau, Alaska 99811

April 2, 1980

HEALTH INSURANCE BILL TO BE HEARD ON TELECONFERENCE NETWORK

The House Health, Education and Social Services Committee, chaired by Rep. Thelma Buchholdt, will hold three teleconferenced hearings on HB 977, " An Act relating to the health of residents of the state".

The first hearing will be teleconferenced to all sites on Tuesday, April 8th at 1:30 p.m., Juneau time, and will include testimony from all interested persons.

The second hearing, also on the 8th, will be held at 7:00 p.m., Juneau time. The committee will be taking testimony from insurance carriers and will include all teleconferencing sites.

The third hearing will be teleconferenced to all sites on Thursday, April 10th at 7:00 p.m..

Persons interested in testifying or observing at these hearings should contact the local Legislative Information Office in the following communities: Anchorage, Bethel, Fairbanks, Dillingham, Kotzebue, Nome, Kodiak, Soldotna, Ketchikan and Sitka. Further information may be obtained from the Committee Chair (465-3797) or the Teleconference Coordinator (465-4980)

OPTIONAL SERVICES

OPTIONAL SERVICES	ALASKA	IDAHO	OREGON	WASHINGTON
Podiatrist Services	No	Yes	Yes	Yes
Optometric Services	Yes	Yes	Yes	Yes
Chiropractic Services	No	Yes	Yes	Yes
Other Practitioner Services	No	No	Yes	Yes
Private Duty Nursing	No	No	Yes	Yes
Clinic Services	Yes	Yes	Yes	Yes
Physical Therapy	No	Yes	Yes	Yes
Occupational Therapy	No	No	No	No
Services for Speech, Hearing & Language Disorders	Yes	No	No	Yes
Prescribed Drugs	No	Yes	Yes	Yes
Dentures	No	No	Yes	Yes
Prosthetic Devices	No	No	Yes	Yes
Eyeglasses	Yes	No	Yes	Yes
Other Services				
Diagnostic	No	No	Yes	Yes
Screening	No	No	No	Yes
Prevention	No	No	No	Yes
Rehabilitation	No	No	Yes	Yes
Services to Individuals Over 65 in Institutions for T.B.				
Inpatient	No	No	Yes	Yes
Skilled	No	No	Yes	Yes
ICF	No	No	Yes	Yes
Services to Individuals Over 65 in Institutions for Mental Diseases				
Inpatient	Yes	No	Yes	Yes
Skilled	No	No	Yes	Yes
ICF	No	Yes	Yes	Yes
Intermediate Care Facilities	Yes	Yes	Yes	Yes
Inpatient Psychiatric Services for Under 22	Yes	No	Yes	Yes
Transportation	Yes	Yes	Yes	Yes
Services for Christian Science Nurses	No	No	No	No
Services for Christian Science Sanitoria	No	No	Yes	No
SNF for Under 21	Yes	Yes	Yes	Yes
Emergency Hospital Services	Yes	Yes	Yes	Yes
Dental Services	No	No	Yes	Yes
Personal Care Services	No	No	No	No
ICF/MR	Yes	Yes	Yes	Yes

ALASKA PUBLIC INTEREST RESEARCH GROUP
Post Office Box 1093/Anchorage, Alaska 99510/(907) 278-3661

MEMO

To: Those interested in health care coverage
Re: Health care
Date: March 1980
From: Susan Johnson

Below is an outline of the legislation we discussed at the meeting held February 29, 1980 at the Federal Building, for you to review. The legislation is presently being drafted by Thelma Buchholdt's (hESS) Committee. The components are as follows:

1/ Mandatory Reinsurance: Several states have developed mandatory reinsurance pools to ensure health care coverage availability to high risk persons at reasonable rates. Many people are unable to purchase full health insurance coverage because existing health conditions make them a bad insurance risk. This component of the bill would mandate all health insurance carriers in each state to offer a health insurance package to high risk subscribers at a reasonable premium. Such coverage is reinsured by the carriers association, in which membership is mandatory, so the risk is pooled among all carriers in the state.

2/ Minimum Benefits Standards: The state would be given the authority to regulate the level of service covered by health insurance policies. Several states have already implemented this and the National Association of Insurance Commissioners (NAIC) had developed model state health insurance legislation for setting minimum health benefit standards. This would address, for example, persons who are excluded from coverage because of pre-existing conditions.

3/ Amend Medicaid Statutes: This would provide the Oregon option to use Medicaid funds to purchase health insurance; provide for the funding of interest payment penalties when the state is delinquent on its bills, and to add additional services to the Medicaid program, such as prescription drugs, dental care, etc.

4/ Medicaid Medically Needy: This program would extend state medical assistance to those persons whose income exceeds the income standards of current assistance programs, but who have incurred medical expenses which equal or exceed the difference between the person's monthly income and the income standard applicable under the current program. In other words, the state would provide medical assistance to persons who otherwise would not have been eligible because they make too much money. The purpose of the "medically-needy" program is to allow lower-middle income persons who can not afford to shoulder the full cost of medical care the opportunity to receive needed medical assistance. Under such a program, these individuals would "spend down" to the income limits, and the state would pick up the rest.

5/ Mandatory Employer Coverage: Hawaii requires every employer to provide health insurance. This would expand coverage to many non-union workers, especially those in low-paying service industries, who now lack coverage. Hawaii offers this to employees who work a minimum of 20 hours. Small employers may apply for state subsidation, if the cost of insurance exceeds certain criteria.

Finally, AkPIRG supports appropriations for expended direct services by the state and local government and non-profit providers. For example, two GYN's will be added to the Neighborhood Health Center in Anchorage. Any suggestions are welcomed concerning other areas that could use additional funding.

I will contact you again when the bill has a number. Feel free to call should you have any questions.

Again, thank you for attending the meeting.

Sincerely,

To: Billy Berrier, Director
Legal Services Division
Legislative Affiars Agency

From: Representative Thelma Buchholdt
Health, Education and Social Services Committee Chair

Subject: Request for bill drafting

Please have one of your staff prepare for introduction one bill which will include the following elements:

Medicaid Amendments. This bill would add the Medically Needy program and several optional services to the state's participation in the federal Medicaid program. The bill would also allow the use of medicaid funds for the purchase of private health insurance as provided in Oregon law (ORS 414.115). The following Medicaid options would be included: prescription drugs, adult dental care, dentures, adult prosthetic devices, physical therapy and related services, chiropractors' services, podiatrists' services and private duty nursing.

Mandatory Employer-sponsored Health Insurance. This bill would require employers in the state to subsidize group health insurance plans for their employees. The bill would be modeled after the Hawaii Prepaid Health Care Act.

Health Insurance Regulation. This bill would give the state authority to regulate the level of service covered by health insurance policies sold in the state. The bill would also mandate coverage of high-risk clients and pooling of risk among all carriers. The bill would be modeled after relevant portions of the Comprehensive Health Insurance Act in 1980 Suggested State Legislation, Vol. 39, by The Council of State Governments.

TABLE 2

Average Ranking of Selected Medicaid Options by Type of Public Assistance Client

Rank	Recipients of Adult Public Assistance	Recipients of Aid to Families with Dependent Children
1st	Prescribed Drugs	Prescribed Drugs
2nd	Adult Dental Services	Adult Dental Services
3rd	Dentures	Physical Therapy and Related Services
4th	Physical Therapy and Related Services	Dentures
5th	Hearing Aids [1]	Chiropractor's Services
6th	Prosthetic Devices	Hearing Aids [1]
7th	Chiropractor's Services	Prosthetic Devices
8th	Private Duty Nursing	Private Duty Nursing
9th	Podiatrist's Services	Podiatrist's Services
10th	Care for Patients 65 or Over in Tuberculosis Institutions	Care for Patients 65 or Over in Tuberculosis Institutions

[1] *Hearing aids, at the time the survey was conducted, were not included in the coverage program offered to all Medicaid clients. An interpretation of Medicaid law and regulation by federal officials allowed hearing aids to be covered as part of the treatment of speech, hearing, and language disorders option. This policy change was implemented by the Division of Public Assistance in November.*

To: Billy Berrier, Director
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From: Representative Thelma Buchholdt
Health, Education and Social Services Committee Chair

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My assistant Jan Sorice will be in charge of this project and any further direction to the drafters will be provided by her. She may be reached at 465-3797.

This bill is to be introduced by the House Health, Education and Social Services Committee by request of Representative Thelma Buchholdt.

By federal statute, the maximum limit for income eligibility under Medicaid medically needy is 133 1/3% of the state AFDC standard for an equivalent family size (except that for a single person, the two-person family income standard is used). The following chart indicates what the Medicaid medically needy income limit would be for certain family sizes and types (where two income limits are listed, the difference is based on whether or not the adult-only household has rent, mortgage or other payments greater than $35 per month).

Household	AFDC	GRM	APA	MN (133 1/3%)
1 Person	$150	$235/ $300	$335/ $414	$466.55
2 Adults		$335/ $400	$502/ $608	$466.55
1 Adult, 1 Child	$350	$300		$466.55
1 Adult, 3 Children	$450	$400		$600

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Options by Type of Public Assistance Client

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MEDICAID OPTIONAL SERVICES--INCLUDING THOSE NOT CURRENTLY COVERED BY THE ALASKA MEDICAID PROGRAM

The following is a list of all optional services under the Medicaid program. Optional services may be selected by the individual states for inclusion in their Medicaid program if a state decides to make those services available to all categories eligible for the basic Medicaid coverage. A brief description of each option is provided below followed by a comparison of optional services that are offered in Alaska, Idaho, Oregon and Washington, the four states comprising federal Region X. Those services covered in Alaska are indicated.

(1) Podiatrist services. Manipulation of the feet and treatment of corns, bunions, callouses, etc., by a licensed podiatrist.

(2) Optometric services. Covered under Alaska Medicaid.

(3) Chiropractic services. Treatment by a licensed chiropractor limited to manual manipulation of the spine.

(4) Other practitioner services. Naturopaths, homeopaths, herbalists, faith healers.

(5) Private duty nursing. Care by a registered nurse or licensed practical nurse under a physician's supervision in home, hospital or nursing facility when a person requires exceptional individual and continuous care.

(6) Clinic services. Under the Alaska Medicaid program this is currently limited to state-operated and state-funded community mental health clinics. This option could also include such other services as health care clinics, alcoholism treatment centers, ambulatory surgical centers, and rural health care clinics. Rural health clinics are now a mandatory service pursuant to Public Law 95-210.

(7) Physical therapy. Physician-prescribed services provided by a licensed or certified physical therapist (depending upon state licensing procedures).

(8) Occupational therapy. Physician-prescribed services provided by a licensed or certified occupational therapist (depending upon state licensing procedures).

(9) Services for speech, hearing, and language disorders. Included under the Alaska Medicaid program.

(10) Prescribed drugs. Covered by state-only General Relief Medical. Alaska is one of only two states without Medicaid coverage for this option.

(11) Dentures. Replacement of a full or partial set of teeth.

(12) Prosthetic devices. Physician-prescribed replacement, corrective or supportive devices that artificially replace a missing part of the body, to prevent deformity or malfunction, to support a weak or deformed portion of the body.

(13) Eyeglasses. Covered by Alaska Medicaid.

(14) Other diagnostic, screening, preventive and rehabilitative services. Identification of illness, injury or other health deviation; preventive and rehabilitative services to restore patient to functional level.

(15) Services to individuals over 65 years of age in institutions for tuberculosis. Facility providing services could be ICF, SNF or inpatient hospital.

(16) Services to individuals over 65 years of age in institutions for mental diseases. (a) Inpatient psychiatric care for persons over 65 is covered under the Alaska Medicaid program. (b) ICF and SNF care for persons over 65 with mental diseases is not covered in Alaska. Under this provision, it would be possible to provide nursing care for persons with mental disabilities who may not otherwise qualify for nursing care due to a lack of physical health problems requiring nursing home care.

(17) Intermediate care facilities (ICF). Covered under the Alaska Medicaid program.

(18) Inpatient psychiatric services for persons under 22 years of age. Covered by the Alaska Medicaid program.

(19) Transportation. Covered under the Alaska Medicaid program.

(20) Services by Christian Science nurses.

(21) Services by Christian Science Sanatoria.

(22) Skilled nursing facility care (SNF) for persons under 21 years of age. Covered by the Alaska Medicaid program.

(23) Emergency hospital services. Covered under the Alaska Medicaid program.

(24) Dental services. Adult dental services are not covered by Medicaid in Alaska.

(25) Personal care services. Physician-ordered services provided to a person in their home by a non-relative and supervised by a registered nurse.

(26) Intermediate care for the mentally retarded and persons with related conditions (ICF/MR). Covered under the Medicaid program in Alaska.

Alaska Native Health Board

1689 C STREET, SUITE 230, ANCHORAGE, ALASKA 99501 PHONE 276 8989

REGIONAL HEALTH DIRECTORS
Mailing List
Reference #A79-1050

Mike Martin - Acting Health Director
ALEUTIAN-PRIBILOF ISLAND ASSOC., INC.
1689 "C" Street, 2nd Floor
Anchorage, AK 99501
PHONE: 276-2700

Robert Clark
BRISTOL BAY AREA HEALTH CORPORATION
P.O. Box 10235
Dillingham, AK 99576
PHONE: 842-5266

Barbara Lewis - Health Department
COOK INLET NATIVE ASSOCIATION
670 West Fireweed Lane
Anchorage, AK 99503
PHONE: 278-4641

Billie Peters - Health Director
COPPER RIVER HEALTH AUTHORITY
Drawer H
Copper Center, AK 99573
PHONE: 822-3521

Frank Peterson - Executive Director
KODIAK AREA NATIVE ASSOCIATION
P.O. Box 172
Kodiak, AK 99615
PHONE: 486-5726

Howard Monroe
MAUNELUK ASSOCIATION
P.O. Box 256
Kotzebue, AK 99752
PHONE: 442-3311 or 442-3312

Ellen Pagano - Health Director
THE NORTH PACIFIC RIM
903 W. Northern Lights, Suite 203
Anchorage, AK 99503
PHONE: 276-2121

Elise Patkotak - Executive Director
NORTH SLOPE BOROUGH HEALTH CORPORATION
P.O. Box 69
Barrow, AK 99723
PHONE: 852-3999

Bill Dann - Executive Director
NORTON SOUND HEALTH CORPORATION
P.O. Box 966
Nome, AK 99762
PHONE: 443-5411

Neils Cesar - Executive Director
SOUTHEAST ALASKA REGIONAL HEALTH CORP.
P.O. Box 2800
Juneau, AK 99803
PHONE: 789-2131

Paul Sherry - Health Director
TANANA CHIEFS HEALTH AUTHORITY
First & Hall Streets - Doyon Building
Fairbanks, AK 99701
PHONE: 452-8251

Jim Martin - Administrative Director
YUKON-KUSKOKWIM HEALTH CORPORATION
P.O. Box 528
Bethel, AK 99559
PHONE: 543-3321

10/26/79
pbm

ALEUTIAN PRIBILOF ISLAND ASSOC. INC.
BRISTOL BAY AREA HEALTH CORPORATION
COOK INLET NATIVE ASSOCIATION
COPPER RIVER NATIVE ASSOCIATION

KODIAK AREA NATIVE ASSOCIATION
MAUNELUK ASSOCIATION
THE NORTH PACIFIC RIM
NORTH SLOPE BOROUGH HEALTH CORP.

NORTON SOUND HEALTH CORPORATION
SOUTHEAST ALASKA REGIONAL HEALTH CORP.
TANANA CHIEFS CONFERENCE
YUKON-KUSKOKWIM HEALTH CORPORATION

OREGON

...th or tuberculosis not otherwise expressly ... posed or granted by law.
...556 §10]

...090 [1953 c.204 §6; renumbered 414.860 and ... 566.370]

414.095 Exemptions applicable to ... ments. Neither medical assistance nor ... ments payable to vendors out of public ... assistance funds are transferable or assigna... at law or in equity and none of the money ... ed or payable under the provisions of ORS ...435 and this chapter is subject to execu... levy, attachment, garnishment or other ... process.
...556 §11; 1967 c.502 §14]

414.105 Recovery of certain medical ... stances; certain transfers of property ...idable. (1) The Adult and Family Services ...sion may recover from any person the ... ...nts of medical assistance incorrectly paid ... behalf of such person.

(2) Medical assistance pursuant to ORS ...435 and this chapter paid on behalf of an ...idual who was 65 years of age or older ... he received such assistance may be ... ...ered from his estate, or if there be no ... the estate of the surviving spouse, if ..., shall be charged for such aid paid to ... or both; provided, however, that claim ... such medical assistance correctly paid to ... may be established against the estate, but ... shall be no adjustment or recovery ... until after the death of the surviving ..., if any, and only at a time when he has ... surviving child who is under 21 years of ... or is blind or permanently and totally ...bled. Transfers of real or personal prop... by recipients of such aid without ade... consideration are voidable and may be ... aside under subsection (2) of ORS 411.620.

(3) Except where there is a surviving ..., or a surviving child who is under 21 ... of age or is blind or permanently and ...ly disabled, the amount of any medical ... paid under this chapter is a claim ... the estate in any guardianship or ...servatorship proceedings and may be paid ...uant to ORS 126.353.
...556 §12; 1967 c.502 §15; 1969 c.507 §2; 1971 c.334 ... c.334 §1; part renumbered 416.280; 1975 c.386 ...

INSURANCE AND SERVICE CONTRACTS

414.115 Medical assistance by insurance or service contracts. In lieu of providing one or more of the medical and remedial care and services available under medical assistance by direct payments to providers thereof and in lieu of providing such medical and remedial care and services made available pursuant to ORS 414.065, the Adult and Family Services Division shall use available medical assistance funds to purchase and pay premiums on policies of insurance, or enter into and pay the expenses on health care service contracts, or medical or hospital service contracts that provide one or more of the medical and remedial care and services available under medical assistance for the benefit of the categorically needy or the medically needy, or both. The policy of insurance or the contract by its terms, or the insurer or contractor by written acknowledgment to the division must guarantee:

(1) To provide medical and remedial care and services of the type, to the extent and according to standards prescribed under ORS 414.065;

(2) To pay providers of medical and remedial care and services the amount due, based on the number of days of care and the fees, charges and costs established under ORS 414.065, except as to medical or hospital service contracts issued by a hospital association which employs a method of accounting or payment on other than a fee-for-service basis;

(3) To provide medical and remedial care and services under policies of insurance or contracts in compliance with all laws, rules and regulations applicable thereto; and

(4) To provide such statistical data, records and reports relating to the provision, administration and costs of providing medical and remedial care and services to the division as may be required by the division for its records, reports and audits.
[1967 c.502 §9; 1975 c.401 §1]

414.125 Rates on insurance or service contracts; requirements for insurer or contractor. (1) Any payment of available medical assistance funds for policies of insurance or service contracts shall be according to such uniform area-wide rates as the Adult and Family Services Division shall have established and which it may revise from time to time as may be necessary or practical, except that, in the case of a research and demonstra-

tion project entered into under ORS 411.135 special rates may be established.

(2) No premium or other periodic charge on any policy of insurance, health care service contract, or medical or hospital service contract shall be paid from available medical assistance funds unless the insurer or contractor issuing such policy or contract is by law authorized to transact business as an insurance company, health care service contractor or hospital association in this state.
[1967 c.502 §10; 1975 c.509 §6]

414.135 Contracts with direct providers of care and services. The Adult and Family Services Division may enter into nonexclusive contracts under which funds available for medical assistance may be administered and disbursed by the contractor to direct providers of medical and remedial care and services available under medical assistance in consideration of services rendered and supplies furnished by them in accordance with the provisions of this chapter. Payment shall be made according to the rules of the division pursuant to the number of days and the fees, charges and costs established under ORS 414.065. The contractor must guarantee the division by written acknowledgment:

(1) To make all payments under this chapter promptly but not later than 30 days after receipt of the proper evidence establishing the validity of the provider's claim.

(2) To provide such data, records and reports to the division as may be required by the division.
[1967 c.502 §11]

414.145 Implementation of ORS 414.115 to 414.135. The provisions of ORS 414.115, 414.125 or 414.135 shall be implemented [illegible] Department that such implementation will provide comparable benefits at equal or less cost than provision thereof by direct payments by the Adult and Family Services Division to the providers of medical assistance.
[1967 c.502 §11a; 1975 c.401 §3]

MEDICAL ADVISORY COMMITTEE

414.205 Medical advisory committee. (1) A medical advisory committee is established, consisting of not more than 15 members to be appointed by the Governor from among persons in the health professions, providers of medical and remedial care and services and the general public. In making his appointment, the Governor shall consult with appropriate professional and other interested organizations.

(2) Members shall serve at the pleasure of the Governor.

(3) Members of the advisory committee shall receive no compensation for their services, but subject to any applicable state law, shall be allowed actual and necessary travel expenses incurred in the performance of their duties from the Public Welfare Account.
[1967 c.502 §18]

414.210 [1957 c.692 §1; repealed by 1963 c.631 §2]

414.215 Duties of committee. The medical advisory committee shall advise the Adult and Family Services Division on:

(1) Health and medical care and services to be provided pursuant to this chapter.

(2) Matters referred to it for study by the division.
[1967 c.502 §19]

414.220 [1957 c.692 §2; repealed by 1963 c.631 §2]

414.225 Division to consult with and assist committee. (1) The Adult and Family Services Division shall consult with the medical advisory committee concerning the determinations required under ORS 414.065.

(2) The division shall provide secretarial services to the medical advisory committee.
[1967 c.502 §20]

414.230 [1957 c.692 §5; repealed by 1963 c.631 §2]

414.240 [1957 c.692 §3; repealed by 1963 c.631 §2]

414.250 [1957 c.692 §4; repealed by 1963 c.631 §2]

414.260 [1957 c.692 §6; repealed by 1963 c.631 §2]

414.270 [1957 c.692 §7(1); repealed by 1963 c.631 §2]

[illegible]

414.300 [1957 c.692 §5; repealed by 1963 c.631 §2]

MISCELLANEOUS

414.305 Payment of cost of medical care for institutionalized persons. (1) The Adult and Family Services Division is hereby authorized to pay the cost of care for patients within Mental Health Division institutions under the medical assistance program established by this chapter.

(2) All moneys received by the Mental Health Division from the Adult and Family

ALASKA PUBLIC INTEREST RESEARCH GROUP
Post Office Box 1093/Anchorage, Alaska 99510/(907) 278-3661

March 1980 NEWSLETTER Vol. 6, No. 2

New Date for Annual Meeting

The annual meeting will be held on *April 1, 1980* at the Pioneer Schoolhouse at 3rd and Eagle. The time of the meeting is set for 7:00 p.m. The primary business of the meeting will be the election of new members to the Board of Directors. Ballots and numbered envelopes are included in this newsletter; each number coincides with a member's name. Please return your ballot in the designated envelope so we can ensure that each member votes only once. Ballots will be counted the night of the meeting. If you can't attend the meeting to voice your concerns about the direction taken by AkPIRG during the past year, *mail your ballot* anyway. The election of an informed and dynamic Board of Directors is crucial to the well-being of AkPIRG.

Mike Ireton: Volunteer of the Year

Mike Ireton has been selected as Outstanding Volunteer for the year 1979 and will be honored at the University Affiliates Volunteer of the Year Award Presentation on March 21. Mike has put in an incredible number of hours working for AkPIRG and the entire staff and Board of Directors thank him warmly.

Thanks also to *all* AkPIRG volunteers for the generous donation of their time and energies. Volunteers are always needed and appreciated; if anyone is interested in participating as a volunteer, please call 278-3661.

The Alaska Public Interest Research Group newsletter is available to any AkPIRG member. The subscription price is included in the membership dues: $10 for individuals, $25 for institutions or businesses, and $5 for persons on limited incomes. The Alaska Public Interest Research Group is a non-profit citizens group, tax exempt under 501(c)(3) of the Internal Revenue Code.

AkPIRG offices are located at 513 West Seventh Avenue, Anchorage, Alaska. The mailing address is P.O. Box 1093, Anchorage, AK 99510. The phone number is 278-3661.

Comments on the newsletter, or any other aspect of AkPIRG activities are appreciated.

Editor: Laurie H. Otto.

Typography by Visible Inc., Anchorage, AK.

Oil Rig Discrimination

A legislative investigation of charges of discrimination against women in oil rig hiring practices was initiated March 5 by Speaker of the House Terry Gardiner. The need for an investigation was brought to light by OIL WATCH, a recently formed citizens-group which monitors all aspects of oil development in Alaska. The investigation will be conducted by the Commerce Committee, which is chaired by Fred Brown, D-Fairbanks.

In mid-November, Jim Bounds, member of Hotel, Restaurant, and Construction Camp Employees Union Local 878, came to OIL WATCH and told them that he had evidence that Amoco Production Company and Union Oil were responsible for discrimination against women. Bounds said that women in the culinary workers' union who had faithfully paid their union dues were waiting in the hiring halls, but not being dispatched for jobs for which they were qualified. Many of these women were on the union's "A" list, the top list of those waiting for jobs, while men lower on the lists or even outside the union were being dispatched instead, sometimes secretly.

The union is under contract to Universal Services Incorporated International (USI) to supply the labor promised by USI in its own contract with Amoco and Union Oil to do culinary work on their platforms in Cook Inlet. When Bounds asked officials in his union why no women were being dispatched, he was told that the contractor, USI, had warned the union not to send women out on dispatch on penalty of losing the USI contract. USI would apparently go with non-union labor if it had to, just to avoid sending women out to the platforms. The union officials explained that they had been told by USI people that a similar threat was in turn coming down on USI from Amoco and Union Oil. Apparently, the oil companies had told USI not to send women out to their platforms, or else USI would lose *its* contract with the companies. So, to hold onto its contract with Amoco and Union Oil, USI had decided to comply with these companies' requests not to send women out to the platforms in filling culinary jobs.

Mr. Bounds' evidence was primarily a series of taped telephone conversations between himself and officers of Amoco, Union Oil, and the field supervisor of their catering subcontractor, USI. An excerpt from the transcript of one of the tapes is presented below. The excerpt is from a conversation between Jim Bounds and Bob Gurnand, who is a field supervisor in the Kenai area for USI.

Jim Bounds: Here's what it boils down to: in other words, the oil companies come to the catering companies and say, "We don't want no women out there on them jobs," right?

Bob Gurnand: That's—well, more or less.

Jim Bounds: Then the catering companies go to the union and the catering companies tell the unions that, "We absolutely don't want no women out there on them jobs, and if you want

(continued on page 4)

Health Care Survey: Doctors and Medicaid

A survey of 113 Anchorage doctors was conducted in order to determine the percentage of Anchorage physicians presently accepting Medicaid recipients as patients. The surveyors, posing as prospective patients, called each physician's office in an attempt to schedule an appointment. *After* it had been determined if the physician had any openings available, the method of payment was discussed. The conversation ws specifically structured this way, in order to provide an indication of the extent to which the method of payment altered accessibility to health care.

The results of the survey are delineated in the accompanying chart. The percentage break-down is as follows: Pediatrics 40% of the doctors will accept Medicaid coupons, 60% will not; OB/GYN 6% will accept, 94% will not; Family Practice 27% will accept, 73% will not; internal 52% will accept, 48% will not; cardiology 100% will not accept; radiology 100% will accept. The chart clarifies the results, for example, cardiologists are not accepting Medicaid coupons, but they will accept as little as $1.00 per month as payment.

The survey clearly shows the existence of a problem for Medicaid recipients seeking medical care. The brunt of the problem falls on women and children, not only because fewer pediatricians, obstetricians and gynecologists accept Medicaid patients, but also because *most* Medicaid patients *are* women and children. For example, in November 1979, 8,418 adults were eligible for Medicaid in Alaska; 6,193 of the total were women. The total number of Medicaid eligible children was 9,998.

There are *no* existing public facilities in Anchorage which provide prenatal care. There are *no* OB/GYN's in Anchorage who accept new Medicaid recipients needing gynecological care as patients; only one Anchorage OB/GYN will accept new Medicaid patients for obstetrical care. It has been suggested that those women in need of, and without access to, OB and/or GYN care elicit the assistance of a family practitioner. Presently 73% of the family practitioners will not accept coupons as the method of payment.

It has further been suggested that poor people use the emergency room as a recourse to health care. This is a non-solution; the function of an emergency room is crisis-oriented, it is not designed to provide on-going care. At Providence Hospital, business personnel estimate that up to 30% of the patients using the emergency room are Medicaid recipients. Reportedly, the number of recipients using the emergency room has incrementally increased as the number of doctors willing to accept coupons has decreased.

Physicians who have elected to exclude patients from health care base their refusal on claims that they receive unsatisfactory payment for their services from Medicaid and that the reimbursements they do receive are untimely. It is also felt that the state requires an excessive amount of paperwork before reimbursements are approved. Doctors further claim that they owe no ethical obligation to the poor.

Although the state has encountered numerous difficulties in making timely Medicaid payments, the recent implementation of a new computer system has succeeded in processing the vast majority of all pending claims.

Poor people, still waiting in long lines at the welfare office to procure Medicaid coupons, continue to lack accessible health care. As one recipient complained to a staff person at the welfare office, coupons in hand, "What am I supposed to do with these, if no doctors in town will take them?"

Availability of Health Care to Medicaid Recipients: Jan./Feb. 1980 Telephone Survey

I Will accept all forms of payment including medicaid	II Will *not* accept new medicaid patients/info on established caseload n/a	III Will *not* accept *new* medicaid patients; but carries an established medicaid caseload	IV Not accepting any new patients
OB/GYN			
Eastburn, Lydia	Gills, Raymond E. Nist, Richard Ekvall, David L. Ivy, William 1/ Ferucci, Leonard 1/ Newton, Burrit 1/ Orren, Jerry Wallner, Charles Stransky, George Curtis, Richard	Hanson, Hedric Erkman, John Renn, Claire Gibson, Sam	Compton, William
PEDIATRICS			
Keller, R. Tower, John C. Witt, Marian Zartman, Harvey P. Martin, Sarah	Lillibridge, Clinton Nesbitt, James Jr. Roberts, Dion Schriever, Gerry Hatton, Elizabeth Patterson, James Larson, William 1/	Kiehl, Phyllis Wallington, Joanne	

FAMILY PRACTICE

Agnew, Mark
Myers, Robert C.
Sydnam, Nancy E. 2/
Manwiller, Charles
Jones, Warren 3/
Billings, Robert
Feirtag, Mary
Martin, Asa
Lindhal, James
Sutherland, Richard

Arbow, Donald
Jones, Leland
Laufer, Kenneth
Kiessling, Bruce
Taylor, Richard
Cates, Vernon
Romig, Howard C.
Monlux, George
Mosley, Charles
Persons, Jean C.
Jackson, Marcell
Burgess, Joan
Bryan, Harold
Cormack, Allan
Nolan, Patrick
Smith, John
Colyar, A. B. 1/
Morgan, Royce 1/
Olsen, Harry 1/
Lang, Thomas 1/

St. John, Charles
Bosveld, Robert
Foland, Mary Ann
Wieland, Tyron

INTERNAL MEDICINE

Watson, III, James
Webb, Dale 4/
Ames, John
Hemry, David
Fish, Winthrop
Burtis, Buffington
Sonneborn, David
Armstrong, Michael
Ragle, William
Wilkins, Robert
Archer, Gary
Beechman, Sherman
Austin, Stanley
Stewart, George

Behymer, G. W.
Steer, Paul
Hall, Robert
Peach, David
Morris, Ann
Morris, Gerald
Princiville, Thomas
Blankinship, Gilbert 5/

Whaley, Robert

Buchanan, Richard
Schlosstein, Lee
Brownsberger, Keith 6/
Witt, Richard 6/
Wilson, Rodman 6/

RADIOLOGY

Gibbons, John
Hall, Randolph
Hendrics, Zeke
Pister, James
Coyle, Maurice J.
Kottra, John
Sternhagen, Charles

CARDIOLOGY

Baldauf, James 5/
Bustad, Leo 5/

Footnotes:
1/ Cash only
2/ Limited amount
3/ Will not take coupons for O.B. care
4/ For cancer patients only
5/ Will not accept medicaid coupons; will accept minimal monthly cash payments (i.e.: $1.00/mo.)
6/ Does have established medicaid caseload

Oil Rig *(cont. from page 1)*

the contract, you don't send no women out there," right?

Bob Gurnand: Well, that's just what the Union Oil Company man told me. He said if I send a woman out there, he's going to send her right back to us, and we lose the contract. And the union up there knows too, goddamnit.

After reviewing Jim Bounds' tapes, members of OIL WATCH interviewed and took sworn affidavits from other members of Local 878. One individual, Ruth Callan, gave particularly compelling testimony. Ms. Callan has lived in Alaska for thirty-three years and has been an officer of the Hotel, Restaurant and Construction Camp Employees Union, Local 878, since 1955. She served as a member of Local 878's Elective Board for ten years, including one term as President. For the past twenty years she has been a delegate to the Central Labor Council. She currently serves as Vice-President of the State Labor Council.

Ms. Callan has served as both head business agent and Secretary-Treasurer of Local 878. She stated in a sworn affidavit:

> While I was Secretary-Treasurer of Local #878, Bob Ryan, the head of USI in Alaska, told me that USI would lose its contract with the oil companies if women were sent out to the rigs. He said that one reason for this was the lack of "facilities" for women, meaning the lack of separate bunking and bathroom facilities.

It is interesting to note that both Bob Gurnand and Ruth Callan, in her affidavit, mentioned the dispatch of Dorothy Jackson, and the oil company's subsequent refusal to accept a woman dispatch on its rig. Ruth Callan stated:

> In May of 1979, USI called the Local for a bull cook which they needed by 5:00 p.m. I was told that if a woman answered the call that I should tell her that she would have to bunk and sleep with the men and use their same latrine facilities. This was intended to discourage a woman from accepting the dispatch. They didn't figure on Dorothy Jackson though. She said she didn't care, she was broke. I notified USI. Bob Ryan told me not to dispatch her because she was a woman. I replied that I was not going to refuse her a dispatch because she was a female. Bob Ryan told me that he would have to find some way to keep her off the rig. When Dorothy Jackson got to USI she was told that the dispatch was cancelled because the USI employee who had been scheduled to take R&R had changed his mind. Bob Ryan called me and said that I had cost some other union member his job because I had dispatched a woman. He told me that if the union dispatched women, the oil companies would end their USI contract and hire some non-union outfit that hired only men.

Bob Gurnand's version goes as follows:

> **Gurnand:** Well, I'll tell you here a while back I got into a situation with Union Oil Company, and I called Anchorage for a bull cook. So they put it on the open call in the union hall, and a woman took it. So they called me back and told me that a woman had taken the dispatch and I said "...Don't send her down there," I said, "...because they won't let her out there." So this was explained to the gal that took the dispatch, that there wasn't separate facilities and all this stuff for her, you know, and she was going to—she insisted on taking the dispatch and coming. So the Anchorage office called me back and they wanted me to call out there and explain the situation to the Union Oil Company people. I called out there, and you know what they told me?
>
> **Bounds:** No
>
> **Gurnand:** He said, "You send a woman out there, you lose the catering contract, and we'll go to a non-union contractor."

Union Oil Company dismissed Bounds' evidence by saying the whole thing was ridiculous. Union did confirm, however, that only one of the fourteen platforms in Cook Inlet had any women on it working in culinary positions. They asserted that women didn't want jobs on the platforms, since the conditions were "...awfully rough on a gal, and most gals prefer to work elsewhere."

Amoco has not responded to Bounds' charges; however, they also confirmed that only one of fourteen platforms has a woman currently working on it in a culinary position. Amoco asserted that to build separate facilities for women would be to discrimate against men.

The Alaska State Commission on Human Rights was asked to investigate this matter. The Director of the Commission, Neil Thomas, declined to initiate an investigation. Although Mr. Thomas acknowledes that this matter comes under the jurisdiction of the Commission, he has advised OIL WATCH that the Commission's present level of funding and its current caseload prevent him from investigating a matter which, under more favorable conditions, he would undertake.

The National Labor Relations Board was also asked to investigate, but the Board has the authorization to investigate only union matters—not oil companies or their sub-contractors.

The legislative investigation is expected to bring forward witnesses and victims of discrimination who have until now been unsure of where to go. OIL WATCH is continuing its independent investigation and will be aiding the committee in its legislative inquest.

Alaska Legislative Information

The following teleconferences have been scheduled to allow constituents the chance to discuss the issues with their legislators. For more information contact your local Legislative Affairs office. The phone number in Anchorage is 278-3668.

March 10: Anderson, Hohman at 7:00 p.m., Dillingham, 842-5319.

March 11: Interior Delegation at 7:00 p.m., Fairbanks 452-4448.

March 12: District 12 at 7:00 p.m., 1024 6th St. Anchorage.

March 13: District 10 at 7:00 p.m., 1024 6th St. Anchorage.

March 17: Hohman at 2:30 p.m., Bethel, 543-3541.

March 18: Interior Delegation at 7:00 p.m., Fairbanks, 452-4448.

March 19: Carney at 6:00 p.m., Mat-Su Office, 376-3704. Mulcahey, Zharoff at 7:00 p.m., Kodiak, 486-4881.

March 20: District 9 at 7:00 p.m., 1024 6th St. Anchorage.

March 24: District 13 at 7:00 p.m., Kenai, 264-9364.

March 25: Interior Delegation at 7:00 p.m., Fairbanks, 452-4448. District 8 at 8:00 p.m., Mt. View Library.

March 26: District 7 at 5:00 p.m., 1024 6th St. Anchorage. Munson at 7:30 p.m., 1024 6th St., Anchorage.

March 27: District 8 at 7:00 p.m., Eagle River Library.

Individual memberships play an important role in maintaining the vitality of AkPIRG. Membership renewals allow AkPIRG to continue its effective and responsive representation of the interests of Alaska's citizens. During this coming month AkPIRG will attempt to contact those persons whose memberships have lapsed. Please renew! For all members who have moved, please let us know your current address, so we can keep you informed of AkPIRG's ongoing activities.

Thursday March 20, 1980

TO: Reps. Buchholdt, McKinnon, and Parker

FROM: Sharman Haley
Alaska Public Interest Research Group

The proposed health legislation which is being prepared for introduction next week is scheduled for hearing in the House Health, Education and Social Services Committee the first week of April. A major portion of this bill is based on the Minnesota Comprehensive Health Insurance Act of 1976. In this act Minnesota pioneered the creation of a mandatory insurance carriers association to underwrite coverage for high risk "uninsurable" clients, as well as state regulation of minimum standards for health insurance policies. You may wish to bring someone from the State of Minnesota to testify on the proposed Alaska legislation from the perspective of the experience in Minnesota.

In the course of my research on the proposed legislation I have spoken at length with John Igrassia, Supervisor of the Life and Health Section of the Division of Insurance in Minnesota, and would recommend him as a good source of expert testimony on this subject. He has worked in his present capacity since the inception of the Minnesota legislation and is quite familiar with all its provisions, its administrative implementation, it's political fortune, and the legal challenges to it. Mr. Igrassia is proud of Minnesota's innovation in the area of health insurance and has testified in at least two other states who are considering similar legislation. He indicated that he would probably be able to come to Alaska in the time frame we are contemplating.

Travel and per diem expenses to bring Mr. Igrassia to Juneau would amount to less than $800. If you would like to extend an invitation to him to come, he may be reached at (612) 296-6929 in St Paul, Minnesota. I do not have a mailing address for him.

3/31/80
4/2/80

Intelligencer

E OF THE NORTHWEST SINCE 1863 L★ COPYRIGHT 1980, SEATTLE POST-INTELLIGENCER

3/23/80

—P-I PHOTO BY CARY TOLMAN

turned Domingo from college and career bound to house bound.

Doctors vs. Medicaid

Thousands Caught In Crossfire

By Carol Perkins

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Significant numbers of doctors, extremely unhappy with the state Medicaid program, are refusing to treat welfare patients, doctors told The Post-Intelligencer.

Some experts fear that a monumental health-care crisis is imminent because thousands of welfare patients are caught in a crossfire between doctors and the state Department of Social and Health Services over what are reasonable fees and necessary services.

Medicaid is the $350,000 joint federal and state health care program for the poor. Administered by the state, it serves 260,000 persons.

One such patient is Lenore Erdmann, who has a jaw and gum disease that is so excruciating that she goes for days without eating — sipping only a mixture of vinegar and honey to numb the pain.

A $4,000 operation could relieve the 55 - year - old Holly Park woman's agony. But her only income is a $253 monthly public assistance check.

But for nine years, the state has refused to pay for her requested oral surgery. And doctors are not lining up to perform the operation for free.

At the heart of the Medicaid issue is economics and professional dignity, doctors say. Under a new fee schedule, many are receiving less for treating welfare patients than they did last year.

The boycott of patients is scattered — but is growing in momentum. Many community health clinics report they are beginning to feel the crunch as more Medicaid patients are turned down by private physicians.

Some doctors are treating Medic-

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Coeds?

U.S. Looking At

Rights Restored To Kim

By Henry Scott Stokes
The New York Times

SEOUL, South Korea — The government's recent action in restoring civil rights to Kim Dae-jung transformed politics here at a stroke.

The action foreshadows a busy summer and autumn as Kim re-engages himself in a bid for the presidency, taking up where he left off in 1971. That year he took 45 percent of the poll in a contest with President Park Chung-hee.

Inevitably, people ask how the decision to let Kim re- enter the political arena was made when the army, the effective controller of South Korea under martial law, was known to detest the aspiring democrat, accusing him of supposed Marxist associations 30 years ago.

The decision was reached, according to reliable informants, through a long process of consultation led by Lt. Gen. Chon Doo-hwan, head of the Army Security Command, an army unit in Seoul, who along with a group of younger officers around him effectively controls the country.

On Dec. 12 these young officers displaced an older group led by the martial law commander, Chung Seung-hwa, in a midnight raid directed by Chon, who seized his commander and several other top generals and forced nearly 40 senior officers to step down. Chung was stripped of his four stars and has been convicted on charges of aiding Park's assassin, Kim Jae-kyu, former director of the Korean Central Intelligence Agency.

The supremacy of the 49-year-old Chon is therefore clear, and yet there are limits to his authority.

For instance, the economy, which was in dire trouble for a time after Chon's midnight action is run primarily by Deputy Prime Minister Lee Hahn-been. Lee visited the United States in February in an attempt to rebuild overseas bankers' trust in South Korea and its extraordinary economy, which since the early 1960's has been the most rapidly growing of its size in the world.

Above Lee, who is head of the central unit in the bureaucracy, the Economic Planning Board, is Prime Minister Shin Hyon-hwak,

Thousands of Patients Caught in Crossfire

From Page A-1

aid patients for emergencies only, while others are taking no new patients. Other doctors continue to treat Medicaid patients, but don't do the paperwork in hopes of putting economic pressure on the state, which receives matching funds from the federal government for the program.

"Everyone is a loser," says Dr. W. Maurice Lawson, Washington State Medical Association president. Because the state refuses to pay customary fees, the losses have to be absorbed by physicians, private pay patients and insurance companies.

The state medical association's judicial committee ruled that the boycott is not unethical unless doctors refuse to serve an entire class of patients.

However, many doctors feel they have a right to restrict the amount of charity work they do, and consider their Medicaid losses as charity.

Doctors are dissatisfied with Medicaid for many reasons:

- They contend fee schedules are grossly below customary fees, ranging from only 35 to 70 percent of their normal charges.
- Doctors maintain that Medicaid limits on types of service, prevent them from giving welfare patients adequate care. They note that preventive measures aren't usually covered.
- Doctors are angered by bureaucratic red tape. Washington Anesthesiologists' Association says that 14 percent of their patients are on Medicaid, but account for 40 percent of their office paperwork. Medical office managers report that it sometimes takes from two months to two years to be reimbursed for Medicaid claims.
- Doctors resent what they call "harrassment" by the state. They are angered because DSHS demands prior authorization for many medical procedures, and because the state audits their medical records, which they maintain violates their patients' rights to privacy.

Dr. Ted Haley, who is a Tacoma representative, says that a widespread Medicaid boycott by doctors next spring is a distinct possibility.

"We'll talk to DSHS, the legislature, the governor, but if we don't get relief, a boycott of the system — not the patient — may be the only alternative."

However, Sen. William "Big Daddy Day," senate social and health srvices chairman, who also is a Spokane chiropractor, asserts that doctors shold bite the bullet. "Hell, they've beenrecipients of state aid when they were in medical school, they can pay it back now by taking more charity cases."

This kind of response is what makes many doctors squeamish about stomping their feet too loudly in Olympia.

"Politically, doctors are the least able to defend themselves, " says Dr. Peter West, a Seattle family practioner. "They aren't seen as a group that is suffering a lot.

"The public is going to be quick to say, 'Those unfeeling bastards don't care about the poor.'"

"But doctors can't tell their secretaries and suppliers to accept 70 percent of usual wages and costs, but that is exactly what the state is doing to us," West says.

Entire clinics are refusing to accept Medicaid patients, except in emergency situations.

"It costs more for us to do the Medicaid paperwork than we get back from the state," says Roberto Robles, Swedish Hospital anesthesiologist.

All 17 of the anesthesiologists at Swedish Hospital are boycotting Medicaid, except in emergency cases, Robles says.

Bruce Ferguson, DSHS Medicaid director, acknowledges there are inequities in parts of the fee schedule and that the doctors have good reason to be upset. "We're working on the problem, but we've only got so much money, and as it is it looks like we're going to be overspent by $20 to $30 million dollars this bieninium."

He maintains that the extensive paperwork and audits "are necessary because we are spending public money."

Both physicians and patients are scrutinized for fraud violations. Last year ony only seven health care specialists were convicted of violations.

Jim Benz, regional federal Medicaid director, says Washington state does "a good job" policing the program, and says that "to my knowledge there are none of the Medicaid mills or kickbacks that are rampant in some areas of the country."

Dr. Fred Quarnstrom, who says he was one of the largest Medicaid dental providers in the state in 1978, no longer takes new welfare patients.

The Beacon Hill dentist says that he could no longer afford to keep up with the losses he was encountering. People think doctors get rich on Medicaid — I guess if you hired dozens of assistants and did hundreds of dentures a day you could make a living at it."

Dr. Larry Iversen, a Bremerton orthopedic surgeon, says, "If a doctor has a large welfare practice, he is scrutitinized and hassled by the state. If he doesn't take any Medicaid patients, he's accused of not being a humanitarian."

Elise Chayet of Evergreen Legal Services, reports a considerable increase in Medicaid clients who can't find doctors or are appealing state's refusal to put them on Medicaid or pay for certain medical expenses.

Community health care clinics are seeing an increase in Medicaid patients unable to get help from private doctors, and the increase is putting a strain on clinic budgets.

Caroline MacColl, King County Visiting Nurse Service director, says the agency stopped accepting new Medicaid patients for a two - month period in 1978. Even though the state finally raised the service's reimbursemnts, the agency will still lose $30,000 a year because of the "Medicaid gap," she says. Social workers are upset because patients are caught in the middle of the battle.

"It's an inhumane system," says Maria Crocker of Country Doctor clinic. "It's terrible when a sick person has to go through the yellow pages looking for a doctor and getting turned down time after time."

State Sen. James McDermott, a Seattle psychiatrist, says, "There is no final solution. All that can be done is to set a health care system in motion and keep adjusting it until it is humane and equitable."

DSHS chief Ferguson agrees, emphasizing that the issue is "cosmic in proportion."

But while health care experts hashes out the issue, patients like Lenore Erdmann continue to suffer

Erdmann, who has applied to Medicaid four times in the past nine years for oral surgery, says, "I don't understand why I have to wait so long when I'm in so much pain. I just keep praying, they'll take me this time."

Shacks Bare Endurance Of Yugoslav Guerrillas

Alaska State Legislature

House of Representatives

Committee on

Health, Education & Social Services

Official Business

Pouch V
State Capitol
Juneau, Alaska 99811

March 18, 1980

Donald D.H. Ching
Deputy Director
Department of Regulatory Agencies
P.O. Box 541
Honolulu, Hawaii 96809

Dear Mr. Ching:

The Alaska House of Representatives is currently considering legislation similar to Hawaii's "Prepaid Health Care Act." As you are an acknowledged expert on this legislation, your testimony would provide needed insight into the benefits of mandatory employment related health coverage.

I would therefore like to invite you to Alaska on March 31 and April 1 to testify on this bill. The legislation is presently being drafted, we will forward you a copy of the bill as soon as it is available. Please contact Jan Sorice of my office at 907-465-3777 if you need further information.

Sincerely,

Thelma

Thelma Buchholdt
State Representative
District 9 (Spenard);
Chair, House HESS Com[illegible]

Third-Party Health Coverage:

A third-party payer includes any organization, public or private, that pays or insures health or medical expenses on behalf of beneficiaries or recipients (e.g. Blue Cross and Shield, commercial insurance companies, Medicare and Medicaid). The individual generally pays a premium for such coverage in all private and some public programs. The organization then pays bills on his behalf; such payments are called third party payments and are distinguished by the separation between the individual receiving the service (the first party), the individual or institution providing it (the second party) and the organization paying for it (the third party).

It is difficult to identify the extent of third party coverage for Alaskans; to identify those that may not be protected by any program or those that may not have coverage adequate to fulfill their needs. Perhaps the most appropriate method of identifying those Alaskans without coverage or without adequate coverage are: 1) through a survey of individuals regarding health coverage, and/or 2) from a search of hospital and other health care billings that were paid "out of pocket" by the individual.

A random survey prepared in 1974/75 by Comprehensive Health Planning of Anchorage reported that 79.9% of the sample had third party coverage of some sort, and 20.1% had no such coverage. The same survey conducted through the Regional Medical Program among residents of the Kodiak Island Borough resulted in 92.6% of the respondents reporting that they had third party coverage, while 7.4% had none. These figures change significantly when applied to the non-Native, non-military population alone. In this perspective, over 25% of the Anchorage sample and over 20% of the Kodiak Island non-Native, non-military sample responded as having no health coverage. If these percentages (20%-25%) can be applied statewide, it would result in an estimate of 56,000 to 71,000 Alaskans lacking any third party health coverage.

A detailed search of hospital bills and other major medical bills that were paid "out of pocket" by the individual may result in significant information regarding not only those without coverage but also those finding that their coverage was not adequate to fulfill their needs. A general indication of the number of discharges from hospitals that result in payment by the individual can be obtained by information collected in the annual hospital survey. The percent of hospital bills paid by the individual varied considerably from one hospital to another. The Alaska Hospital and South Peninsula Hospital reported the highest percentages; 26% of the discharges making "out of pocket" payments. Further screening of this type of information is necessary.

DISCHARGES BY PRIMARY SOURCE OF PAYMENT

CY 1978

(Percent of all Discharges)

HOSPITAL	Workmen's Compensation	Medicare	Medicaid	CHAMPUS	IHS	Blue Cross	Other Commercial Insurance Co.	Prepaid Group Health Plan	Medical Foundation	Private Pay	No Charge	Other
SOUTHEAST												
Ketchikan General	4	10	6	2	21	13	32	-	-	8	-	6
Petersburg General	- not available -											
Wrangell General	-	13	4	-	-	-	-	-	-	-	-	83**
PHS-ANH Mt. Edgecumbe	- not available											
Sitka Community	7	9	3	-	-	43	22	-	-	9	-	5
Bartlett Memorial**	2	9	3	10	17	27	22	-	-	10	-	-
SOUTHCENTRAL												
Cordova Community	- not available -											
Valdez Community	- not available -											
Seward General	-	49	26	-	24	-	-	-	-	-	-	-
Faith	2	9	5	1	25	12	24	0	0	22	-	-
Central Peninsula	-	4	5	-	-	19	-	-	-	17	-	55***
South Peninsula	3	13	8	-	18	12	19	-	-	26	<1	-
Valley	1	10	13	-	-	13	55	-	-	25	-	4
Alaska Hospital and Medical Center	4	2	8	<1	-	11	25	24	-	26	-	-
Providence***	6	8	7	2	<1	15	39	-	-	7	2	13
PHS-ANH Alaska Native Medical Center	- not available -											
USAF Hospital, Elmendorf	- not available -											
Kodiak Island**	54	6	7	-	20	4	-	-	8	<1	-	1
Naval Regional Medical Center, Bremerton-Adak	- not available -											
PHS-ANH Kanakanak	-	-	-	-	100	-	-	-	-	-	-	-
PHS-ANH Bethel**	- not available -											
Norton Sound Regional **	2	6	11	1	65	11	4	0	0	1	0	0
NORTHERN												
PHS-ANH Kotzebue	- not available -											
PHS-ANH Barrow**	- not available -											
Fairbanks Memorial	1	3	10	1	10	14	29	-	-	25	1	-
PHS-ANH Tanana**	- not available -											
Bassett Army	- not available-											

**Includes all sources of payment except Medicare and Medicaid.

***Includes Workmen's Comp., CHAMPUS, Other Commercial Ins., Prepaid Group Health Plan, Medical Foundation and Other.

*Workmen's Compensation and Other.

**Reporting period is as follows: Bartlett Memorial: FY 1978; Kodiak Island: May 15 - Dec. 31, 1978; PHS-ANH Bethel, Barrow, and Tanana: FY 1977.

***Providence Hospital includes both outpatient and inpatient data.

Source: Office of Information Systems, Alaska Dept. of Health & Social Services, 1979 Annual Hospital Questionnaire.
AANHS, IHS, U.S. DHEW, Leading Health Problems of the Alaska Natives, FY 1977.

If the estimates of Alaskans protected by each type of third party coverage or non-fee services are added together, the total comes to 458,305 or more than the current estimate of the resident population (411,211 in 1977). This highlights the fact that there is considerable double coverage within the state such as individuals and their dependents covered by Blue Cross who are also eligible for the CHAMPUS program, Alaska Natives eligible for services by Alaska Area Native Health Services who are also covered by private health insurance, and families with more than one member subscribing to coverage that protects all dependents.

This is certainly NOT to say that all Alaskans are protected by some type of health coverage. Unfortunately, information regarding the number of persons covered by each program will not produce an estimate of who is without coverage. To accomplish this it would be necessary to identify all those with more than one type of coverage (both subscribers/enrollees and dependents).

ESTIMATED ALASKAN POPULATION
PROTECTED BY SPECIFIC HEALTH COVERAGE PROGRAMS

Private Health Insurance & Blue Cross	263,000
Teamster Employee Welfare Trust/Alaska Health Plan	25,200
Alaska Area Indian Health Services	
Alaska Natives	65,857
CHAMPUS & USHBP	
Active Military	24,984
Military Dependents & Retirees	55,000
Medicare Enrollees	9,818
Medicaid Participants (Not all eligibles)	11,815
General Relief Medical Program Participants	2,631
Catastrophic Relief Health Insurance Program	*
Veterans Administration	**

*Catastrophic Health Insurance Program is available to all Alaskans meeting criteria identified later in this chapter.

**The V.A. pays for health care that is related to prior military service.

Private Health Insurance: The major source of third party coverage is through private health insurance and the Blue Cross Plan. Although Blue Cross is considered a hospital/medical service corporation rather than a health insurance company, it is included in these discussions and in the data from the National Health Insurance Institute.

There is considerable variation in the services covered by different types of health insurance policies. Types of coverage include hospital expense, surgical expense, regular medical expense and major medical expense.

The National Health Insurance Institute estimates that 263,000 Alaskans under 65 years of age were covered by some type of health insurance as of December 31, 1976. The number by type of coverage is indicated below.

Figure V-32

PRIVATE HEALTH INSURANCE AND BLUE CROSS

NUMBER OF PERSONS IN ALASKA UNDER AGE 65 PROTECTED BY HOSPITAL SURGICAL, REGULAR MEDICAL AND MAJOR MEDICAL EXPENSE COVERAGE

December 31, 1976

Hospital Expense	263,000
Surgical Expense	246,000
Regular Medical Expense	248,000
Major Medical Expense	146,000

Note: The data refer to the net total of people protected, i.e. duplication among persons protected by more than one kind of insuring organization or more than one insurance company policy providing the same type of coverage has been eliminated. The estimated distribution by states reflects coverage by residence rather than employment. "Major Medical Expense" data refer to people covered by insurance companies only.

Sources: Health Insurance Association of America, Blue Cross Association, National Association of Blue Shield Plans, and the U.S. Department of Health, Education and Welfare.

The total dollar figure in premiums written for Alaskans was over $84 million during 1977. The amount of premiums written compared to losses incurred are summarized below. The total dollar figures of direct premiums written during 1977 by the twenty leading vendors in Alaska are identified in the following Figure V-34. These figures are accessed through the individual insurance companies' annual reports and aggregated by the Division of Insurance.

Figure V-33

TOTAL ACCIDENT & HEALTH INSURANCE
FINANCIAL DATA FOR ALASKA

1977

	Premiums Written	Losses Incurred
TOTAL	$84,822,000*	$63,158,343
Blue Cross	32,483,000*	29,380,307
Other Group	45,377,811	36,661,724
Credit	1,641,059	651,917
All Other	3,650,859	1,464,395
(Additional Figures)	1,669,000*	

*Some figures were rounded to the nearest thousand due to the information available.

Source: Alaska State Division of Insurance; from Annual Reports by each insurance company (Home Headquarters).

Figure V-34

HEALTH INSURANCE PREMIUMS WRITTEN IN ALASKA
Figures From Individual Company Annual Statements - 1977

TOP 20 VENDORS	PREMIUMS WRITTEN (In Thousands of Dollars)
Blue Cross of Washington & Alaska	$32,483.
Aetna Life Insurance Co.	10,082.
Bankers Life Co.	6,462.
Travelers Insurance Co., Life Dept.	4,782.
United Benefit Life Insurance Co.	4,226.
Continental Assurance Co.	2,638.
Metropolitan Life Insurance Co.	2,242.
Connecticut General Life Insurance Co.	1,903.
Equitable Life Assurance Co.	1,859.
New York Life Insurance Co.	1,488.
Pacific Mutual Life Insurance Co.	1,258.
Prudential Insurance Co. of America	1,038.
Western Life Insurance Co.	941.
Penn Mutual Life Insurance Co.	807.
Occidental Life Insurance Co. of Calif.	785.
First Farwest Life Insurance Co.	725.
Combined Insurance Co. of Americal	658.
Mutual of Omaha Insurance Co.	653.
Mutual Life Insurance Co. of New York	564.
Security Benefit Life Insurance Co.	438.
TOTAL PREMIUMS WRITTEN BY 301 COMPANIES:	$84,822.

Medicare: Medicare is a health insurance program administered by the federal government for the aged (Title 18 of the Social Security Act of 1965). Medicare coverage was extended in 1974 to also include disabled persons and persons with chronic kidney disease. Part A, Medicare coverage provides insurance for hospital care, post-hospital extended care and home health benefits. Part B, available on a voluntary basis with the payment of monthly premiums, provides medical insurance that covers not only care by physicians but also hospital outpatient services, physical therapy, diagnostic x-rays, ambulance services, etc.

By 1972, more than 95% of the U.S. population aged 65 and older was covered by Part A of Medicare. However, because of Medicare's deductibles and co-insurance provisions, and because of gaps in Medicare coverage, more than half of the Americans over 65 are buying private insurance to supplement Medicare. Medicare paid less than 35% of the total health bill to those over 65 during 1975.

Medicare expenditures for Alaska totaled over $7 million in 1976. Total Medicare expenditures rose by 54.9% between 1974 and 1976 for Alaska compared to 46.5% nationally. The Hospital Insurance Component (Part A) rose by 54.7% in Alaska and 45.1% nationally. The Supplementary Medical Insurance component (Part B) rose by a full 55.3% for Alaska compared to 50.1% nationally. During 1976, 9,818 Alaskans were enrolled in the Medicare program; including 8,653 persons age 65 and over, 1,165 disability beneficiaries, and 31 individuals with chronic kidney disease.

Figure V-35

MEDICARE ENROLLMENT (JULY 1) AND REIMBURSEMENT FOR HOSPITAL AND MEDICAL INSURANCE

ALASKA & U.S. CY 1976

	Hospital and/or medical insurance			Hospital insurance			Supplementary medical insurance		
	Number of persons enrolled	Amount reimbursed	Monthly average	Number of persons enrolled	Amount reimbursed	Monthly average	Number of persons enrolled	Amount reimbursed	Monthly average
All persons enrolled									
Alaska	9818	$7,161,870	$ 60.79	9750	$4,915,506	$ 42.01	8185	$2,246,364	$ 22.87
U.S.			$ 58.10			$ 42.79			$ 16.38
Persons age 65+									
Alaska	8653	$5,668,674	$ 54.59	8585	$4,101,190	$ 39.81	7174	$1,567,484	$ 18.21
U.S.			$ 56.80			$ 42.42			$ 15.41
Disability Beneficiaries									
Alaska	1165	$1,493,196	$ 106.81	1165	$ 814,316	$ 58.25	1011	$ 678,880	$ 55.96
U.S.			$ 70.82			$ 46.39			$ 26.44
Chronic Peral Disease									
Alaska	31	$ 651,374	$1,751.01	31	$ 189,239	$508.71	30	$ 462,135	$1,283.71
U.S.			$1,108.33			$305.26			$ 830.96

Medicaid and General Relief Medical: Persons eligible for the cash assistance payments (public assistance) under the categorical assistance programs (Old Age Assistance, Aid to the Blind, Aid to the Disabled, and Aid to Families with Dependent Children) are eligible for Medicaid coverage of health care costs. Additional eligibility criteria for Medicaid exists for persons in nursing facilities and children in foster care or juvenile care situations. Medicaid is a state administered medical assistance program funded by both federal and state sources.

General Relief Medical coverage is available for persons having no prior medical care resources and who meet financial eligibility requirements for the assistance programs listed above but do not meet other qualifications for Medicaid coverage (under 65, both parents in the home are physically able to work, not blind or disabled under federal definition). General Relief Medical (GRM) provides coverage for some medical services and supplies not covered under Medicaid such as prescription drugs, prosthetic devices and medical equipment. GRM is administered by the state and totally state funded.

During fiscal year 1977, 11,815 persons received Medicaid services in Alaska and 2,631 received services under the General Relief Medical program. The total funds expended and the services covered are identified in Figures V-36, V-37 and V-38.

Medicaid expenditures have grown tremendously as a result of population growth, inflation, increased availability of services, rising cost of services and increased utilization of federal revenues for medical programs. The following figures show that Medicaid expenditures have grown by over 300% between 1973 and 1977.

Figure V-36

FISCAL YEAR	MEDICAID EXPENDITURES	GR MED EXPENDITURES	ADMINISTRATION AND SUPPORT
1973	$ 4,447,219	$ 3,675,277	$ 481,890
1974	7,876,759	2,607,112	631,129
1975	9,309,702	2,358,080	722,778
1976	14,328,201	2,881,213	1,085,086
1977	18,608,568	3,743,128	1,253,002
1978 1/	25,915,719	6,213,100	1,346,800
1979 2/	38,611,695	6,769,100	1,423,950

1/ Projected expenditures
2/ Total of budget request including supplemental requests--includes $6,422,300 for Indian Health Care Improvement Act billings by ANHS; this is 100% federal funds.

SOURCE: Medicaid Annual Status Report FY 77, State of Alaska, Dept Health and Social Services, Division f Public Assistance.

Figure V-37

DISTRIBUTION OF MEDICAID PAYMENTS BY TYPE OF SERVICE

BY DATE OF SERVICE

FISCAL YEAR 1977

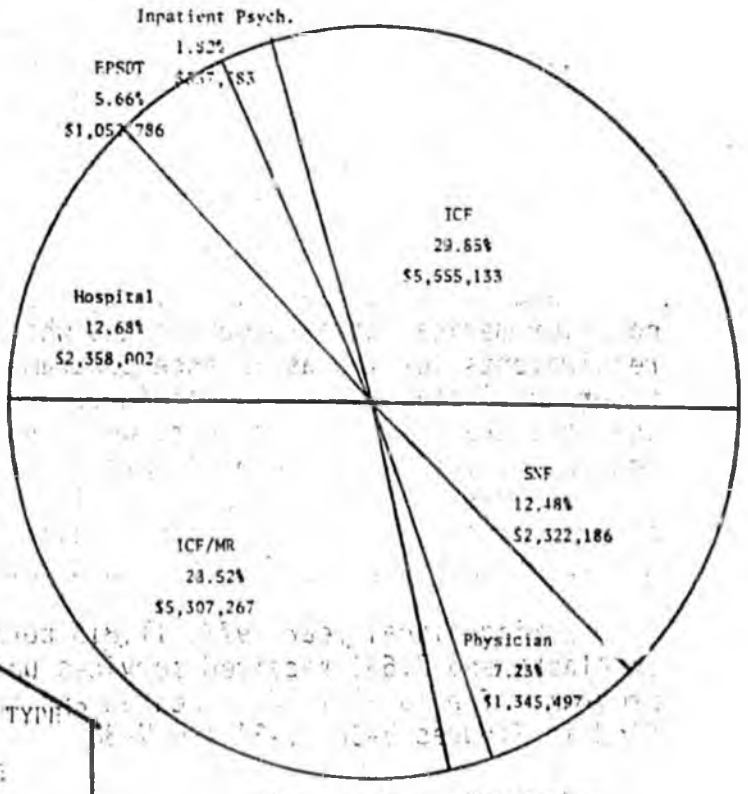
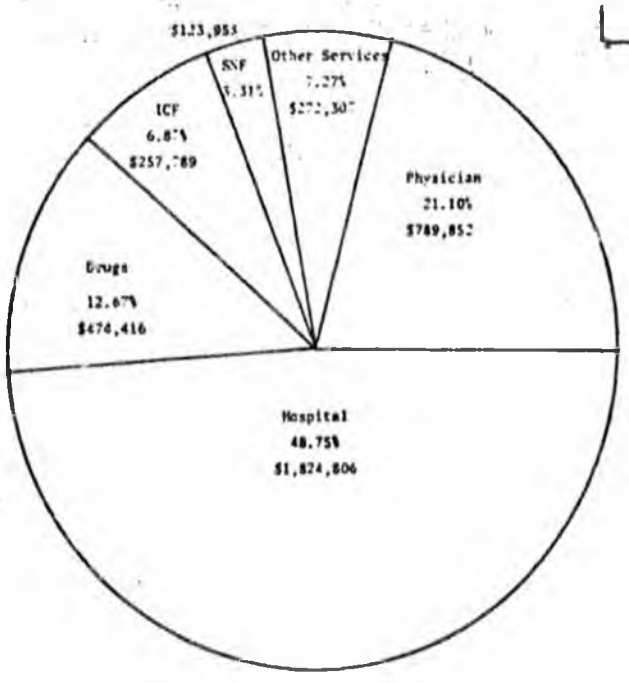


Figure V-38

DISTRIBUTION OF GR MED PAYMENTS BY TYPE OF SERVICE BY DATE OF SERVICE

FISCAL YEAR 1977



SOURCE: Medicaid Annual Status Report FY 77, State of Alaska, Dept Health and Social Services, Division of Public Assistance.

Catastrophic Illness Coverage: The State of Alaska initiated the Catastrophic Illness Program in July 1976 to assist individuals that have suffered an illness that results in high medical expenses. The program applies to medical bills related to catastrophic illnesses of more than $1,000 in a period not to exceed 12 months after all sources of third party payment has been exhausted. An applicant must be a resident of the state of Alaska at the time of the application and must have been a resident at the time of the catastrophic illness.

The Catastrophic Illness Committee, which administers the Program, determines the eligibility of applications and the amount of medical assistance to be awarded. The committee applies a formula for determining the amount of payment based upon family income and assets, and the amount of medical expenses incurred. The total budget for the Catastrophic Illness Program for FY 1979 is $514,000. The number of applications for catastrophic illness coverage which can be approved is therefore restricted by the appropriate budget. The program granted financial aid to over 80 persons during FY 78 and the number of applicants is increasing steadily.

Violent Crime Compensation: "Alaska Statute 18.67, establishing a Violent Crimes Compensation Board, was adopted by the State Legislature in 1972. Its purpose was to alleviate the financial hardships caused by crime related medical expenses or loss of income sustained by innocent victims of violent crimes in Alaska. Additionally, it provides for the payment of pecuniary loss to dependents of deceased victims to mitigate the loss of a loved one." The maximum award allowable per victim per incident is $25,000; except in the case of the death of a victim who has numerous eligible dependents, for which the maximum allowable is $40,000. The growth in the awareness of Violent Crimes Compensation has resulted in an increase in the number of applications received. The following chart documents the applications received and awards granted since 1973.

Figure V-39

APPLICATIONS AND AWARDS

	FY73	FY74	FY75	FY76	FY77	FY78
Applications Received	15	50	71	68	93	100
Applications Heard	-0-	37	51	82	81	99
Total Amount Awards Granted	-0-	36,025.60	125,266.20	272,948.29	120,968.07	285,672.63*
Pending Claims At End Of FY	13	38	41	8	28	33

*The Legislature approved a supplemental appropriation of $75,000.00 for awards for FY78. $94,379.30 of the F /78 award money was spent on prior year claims.

Administrative costs for Violent Crimes Compensation for FY 78 were as follows:

Staff salaries (2 persons) and benefits	$57,315.37
Travel includes board member travel and per diem	5,195.44
Attorney fees, office expenses, equipment, etc	11,372.97
Total Costs	$73,883.78

spouse and such children whose coverage under the policy terminates at the same time, or (ii.) to a child solely with respect to himself upon termination of his coverage by reason of ceasing to be a qualified family member under the group policy, if a conversion privilege is not otherwise provided above with respect to such termination.

(17) If the benefit levels required in paragraphs (10) and (11) exceed the benefit levels provided under the group policy, the conversion policy may offer benefits which are substantially similar to those provided under the group policy in lieu of those required in paragraphs (10) and (11).

(18) The insurer may elect to provide group insurance coverage in lieu of the issuance of a converted individual policy.

(19) A notification of the conversion privilege shall be included in each certificate of coverage.

(20) A converted policy which is delivered outside [state] must be on a form which could be delivered in such other jurisdiction as a converted policy had the group policy been issued in that jurisdiction.

Section 3. [*Severability.*] [Insert severability clause.]

Section 4. [*Repeal.*] [Insert repealer clause.]

Section 5. [*Effective Date.*] [Insert effective date.]

Comprehensive Health Insurance Act

This draft statute requires that employers in the state must include qualified catastrophic health insurance protection and minimum types of benefits for routine care in any policy provided to their employees pursuant to the individual's employment. This includes policies which are paid for partly or fully by the employee as well as those which are completely employer-paid. If only nonqualified plans are offered to employees, the employer may not deduct for tax purposes the cost of the insurance to him. In order to qualify, a plan must meet specified benefit levels and have no more than a maximum allowable deductible. This draft act also includes as Sections 18 and 19 a state catastrophic medical insurance plan under which the state will pay the medical expenses of those persons who incur uninsured medical expenses exceeding specified portions of their income.

This medical insurance plan is implemented by requiring in the statute that all insurers writing health insurance in the state must offer a qualified plan to their customers. A compulsory association of all insurers in the state is also to be formed under the act for the purpose of offering a qualified plan of insurance to those individuals whom the insurers have individually refused to insure. For those individuals who may be leaving employment at which they were enrolled in a qualified plan, the act provides mandatory conversion privileges enabling the individual to continue his insurance.

As the above indicates, this draft act is broad in scope and is directed toward multiple purposes. Among the related but separate purposes of the legislation are ensuring minimum standards for group health plans, creating an association of insurers as a resort for those individuals who could not otherwise obtain effective coverage, and providing catastrophic medical expense protection for all through employers and private insurers where possible and through the state welfare system where necessary.

This draft legislation is based on a 1976 Minnesota statute.

Suggested Legislation

(Title, enacting clause, etc.)

Section 1. [*Short Title.*] This act may be cited as the [state] Comprehensive Health Insurance Act.

Section 2. [*Definitions.*] As used in this act:

(1) "Employer" means any person, partnership, association, trust, estate, or corporation, which employs 10 or more individuals who are residents of this state.

(2) "Health maintenance organization" means a nonprofit corporation licensed and operated as provided in [appropriate state statute].

(3) "Qualified plan" means those health benefit plans which have been certified by the commissioner as providing the minimum benefits required by Section 6 of this act or the actuarial equivalent of those benefits.

(4) "Qualified Medicare supplement plan" means those health benefit plans which have been certified by the commissioner as providing the minimum benefits required by Section 7 of this act or the actuarial equivalent of those benefits.

(5) "Commissioner" means the [commissioner of insurance].

(6) "Dependent" means a spouse or unmarried child under the age of 19 years, a dependent child who is a student under the age of 25 and financially dependent upon the parent, or a dependent child of any age who is disabled.

(7) "Employee" means any [state] resident who has entered into the employment of or works under contract or service or apprenticeship with any employer. "Employee" does not include a person who has been employed for less than [30] days by his present employer, nor one who is employed less than an average of [30] hours per week by his present employer.

(8) "Plan of health coverage" means any plan or combination of plans of coverage, including combinations of self-insurance, individual accident and health insurance policies, group accident and health insurance policies, coverage under a nonprofit health service plan, or coverage under a health maintenance organization subscriber contract.

(9) "Insurer" means those companies operating pursuant to [appropriate state statute] and offering or selling policies or contracts of accident and health insurance. "Insurer" does not include health maintenance organizations.

(10) "Accident and health insurance policy" or "policy" means insurance or nonprofit health service plan contracts providing benefits for hospital, surgical, and medical care. "Policy" does not include coverage which is (i) limited to disability or income protection coverage, (ii) automobile medical payment coverage, (iii) supplemental to liability insurance, (iv) sold by fraternals and provides payments on a per diem, daily indemnity or nonexpense-incurred basis, or (v) credit accident and health insurance issued pursuant to [appropriate state statute].

(11) "Health benefits" means benefits offered to employees on an indemnity or prepaid basis which pay the costs of or provide medical, surgical, or hospital care.

(12) "Eligible person" means an individual who is a resident of [state] and meets the enrollment requirements of Section 14 of this act. For purposes of Sections 18, 19, and 20 only, "eligible person" means any person who while a resident of [state] has been found by the [commissioner of public welfare] to have incurred an obligation to pay qualified expenses for himself and any dependents in any [12] consecutive months exceeding (i) [40] percent of his household income up to $[15,000], plus [50] percent of his household income between $[15,000 and $25,000], plus [60] percent of his household income in excess of $[25,000], or (ii) $[2,500], whichever is greater.

(13) "Comprehensive health association" or "association" means the association created by Section 10 of this act.

(14) "Medicare" means Part A and Part B of the United States Social Security Act, Title XVIII, as amended, 42 U.S.C. Sections 1394, et seq.

(15) "Medicare supplement plan" means any plan of insurance protection which provides benefits for the costs of medical, surgical, or hospital care and which is marketed as providing benefits which complement or supplement the benefits provided by Medicare.

(16) "State plan premium" means the premium determined pursuant to Section 8 of this act.

(17) "Writing carrier" means the insurer or insurers and health maintenance organization or organizations selected by the association and approved by the commissioner to administer the comprehensive health insurance plan.

(18) "Fraternal beneficiary association" or "fraternal" means a corporation, society, order, or voluntary association without capital stock which sells health and accident insurance in accordance with [appropriate state statute].

(19) "Comprehensive health insurance plan" or "state plan" means policies of insurance and contracts of health maintenance organization coverage offered by the association through the writing carrier.

(20) "Self-insurer" means an employer who directly provides a plan of health coverage to his employees and administers the plan of health coverage himself or through an insurer. "Self-insurer" does not include an employer engaged in the business of providing health care services to the public who provide health care services directly to his employees at no charge to them.

(21) "Self-insurance" means a plan of health coverage offered by a self-insurer.

(22) "Qualified expense" means any charge incurred subsequent to [insert date] for a health service which is included in the list of covered services described in Section 6(a), and for which no third party is liable.

(23) "Household income" means the gross income of an eligible person and all his dependents for the calendar year preceding the year in which an application is filed pursuant to Section 18.

(24) "Gross income" means income as defined in [appropriate state tax statute].

(25) "Third party" means any person other than the eligible person or his dependents.

Section 3. [*Duties of Employer.*]

(a) Each employer who provides or makes available to his employees a plan of health coverage shall make available to his employees employed in this state a plan or combination of plans which have been certified by the commissioner as a number two qualified plan. If the plan of health coverage does not meet the requirements of Section 6 for a number two qualified plan, the employer shall make available a supplemental plan of health benefits which, when combined with the existing plan of health benefits, constitutes a number two coverage plan. The plan or combinations of plans may be financed from funds contributed solely by the employer or solely by the employees or any combination thereof. The plans may consist of self-insurance, health maintenance contracts, group policies, or individual policies or any combination thereof.

(b) In the event that an employer fails to make available at least a number two qualified plan health benefits to his employees employed in this state, none of the employer's costs for health benefits shall qualify as an income tax deduction pursuant to [appropriate state tax statute]. In the case of an employer who meets the requirements of [state statute defining tax exempt organizations], if the employer fails to make available at least a number two qualified plan to his employees, the employer shall lose his status as an exempt organization.

Section 4. [*Duties of Insurers.*]

(a) For each type of qualified plan described in Section 6, an insurer or fraternal issuing individual policies of accident and health insurance in this state, other than group conversion policies, shall develop and file with the commissioner an individual policy which meets the minimum standards of that type of qualified plan. An insurer or fraternal issuing individual policies of accident and health insurance in this state shall offer each type of qualified plan to each person who applies and is eligible for accident and health insurance from that insurer or fraternal.

(b) An insurer or fraternal issuing Medicare supplement plans in this state shall develop and file with the commissioner a Medicare supplement policy which meets the minimum standards of a qualified Medicare supplement plan. An insurer or fraternal issuing Medicare supplement plans in this state shall offer a qualified Medicare supplement plan to each person who is eligible for coverage and who applies for a Medicare supplement plan.

(c) For each type of qualified plan described in Section 6, an insurer or fraternal issuing group policies of accident and health insurance in this state shall develop and file with the commissioner a group policy which provides for each member of the group the minimum benefits required by that type of qualified plan. An insurer or fraternal issuing group policies of accident and health insurance in this state shall offer each type of qualified plan to each eligible applicant for group accident and health insurance.

(d) Each insurer and fraternal shall include coverage of major medical costs in every unqualified policy of accident and health insurance, unless the applicant for a new or renewal policy declines the coverage in writing. The coverage shall provide that when a covered individual incurs out-of-pocket expenses of $[5,000] or more within a calendar year for services covered in Section 6(a), benefits shall be payable, subject to any copayment authorized by the commissioner, up to a maximum lifetime limit of $[250,000].

(e) No policy of accident and health insurance may be issued or renewed in this state [180] days after [insert date] by an insurer or a fraternal which has not complied with the requirements of this section.

(f) An insurer or fraternal may fulfill its obligations under this section by issuing the required coverages in their own name and reinsuring the risk and administration of the coverages with the association in accordance with paragraphs (5) and (6) of Section 10(g).

(g) Nothing in this section shall require an insurer or fraternal to offer or issue a policy to any person who does not meet the underwriting or membership requirements of the insurer or fraternal.

Section 5. [*Certification of Qualified Plans.*] Upon application by an insurer, fraternal, or employer for certification of a plan of health coverage as a qualified plan or a qualified Medicare supplement plan for the purposes of Sections 1 to 17, the commissioner shall make a determination within [90] days as to whether the plan is qualified. All plans of health coverage shall be labeled as "qualified" or "nonqualified" on the front of the policy or evidence of insurance. All qualified plans shall indicate whether they are number one, two, or three coverage plans.

Section 6. [*Minimum Benefits of Qualified Plan.*]

(a) A plan of health coverage shall be certified as a number three qualified plan if it otherwise meets the requirements established by [appropriate state statute] and the other laws of this state and whether or not the policy is issued in this state and meets or exceeds the following minimum standards:

(1) The minimum benefits for a covered individual shall, subject to the other provisions of this subsection, be equal to at least [80] percent of the cost of covered services in excess of an annual deductible which does not exceed $[150] per person. The coverage shall include a limitation of $[3,000] per person on total annual out-of-pocket expenses for services covered under this subsection. The coverage may be subject to a maximum lifetime benefit of not less than $[250,000]. Covered expenses shall be the usual and customary charges for the following services and articles when prescribed by a physician:

(i) Hospital services.

(ii) Professional services for the diagnosis or treatment of injuries, illnesses, or conditions, other than outpatient mental or dental, which are rendered by a physician or at his direction.

(iii) Drugs requiring a physician's prescription.

(iv) Services of a nursing home for not more than [120] days in a year if the services commence within [14] days following confinement of at least

[three] days in a hospital for the same condition.

(v) Service of a home health agency up to a maximum of [180] visits per year.

(vi) Use of radium or other radioactive materials.

(vii) Oxygen.

(viii) Anesthetics.

(ix) Prostheses.

(x) Rental or purchase, as appropriate, of durable medical equipment.

(xi) Diagnostic X-rays and laboratory tests.

(xii) Oral surgery for partially or completely unerupted impacted teeth, a tooth root without the extraction of the entire tooth, or the gums and tissues of the mouth when not performed in connection with the extraction or repair of teeth.

(xiii) Services of a physical therapist.

(2) Covered expenses for the services and articles specified in this subsection do not include the following:

(i) Any charge for any care for any injury or disease either arising out of an injury in the course of employment and subject to a worker's compensation or similar law, for which benefits are payable without regard to fault under coverage statutorily required to be contained in any motor vehicle or other liability insurance policy or equivalent self-insurance, or for which benefits are payable under another policy of accident and health insurance or Medicare.

(ii) Any charge for treatment for cosmetic purposes other than surgery for the repair of an injury or birth defect.

(iii) Any charge for travel other than travel by ambulance to the nearest health care institution qualified to treat the illness or injury.

(iv) Any charge for confinement in a private room to the extent it is in excess of the institution's charge for its most common semi-private room, unless a private room is prescribed as medically necessary by a physician.

(v) That part of any charge for services or articles rendered or prescribed by a physician, dentist, or other health care personnel which exceeds the prevailing charge in the locality where the service is provided.

(vi) Any charge for services or articles the provision of which is not within the scope of authorized practice of the institution or individual rendering the services or article.

(3) Effective [insert date], the minimum benefits for a qualified plan shall include, in addition to those benefits specified in subsection (a)(1), benefits for the following services subject to applicable deductibles, coinsurance provisions, and maximum lifetime benefit limitations:

(i) Well baby care.

(ii) Physicians' services for routine checkups and annual physicals when prescribed by a physician.

(iii) Multiphasic screening and other diagnostic testing. The commissioner by rule shall prescribe reasonable limits on the reimbursement required for these services.

(b) A plan of health coverage shall be certified as a number two qualified plan if it meets the requirements established by the laws of this state and provides for payment of [80] percent of the covered expenses required by this section in excess of a deductible which does not exceed $[500] per person.

(c) A plan of health coverage shall be certified as a number one qualified plan if it meets the requirements established by the laws of this state and provides for payment of [80] percent of the covered expenses required by this section in excess of a deductible which does not exceed $[1,000] per person.

(d) A health maintenance organization which provides the services required by [appropriate state statute] shall be deemed to be providing a number three qualified plan.

Section 7. [*Qualified Medicare Supplement Plan.*] Any plan which provides benefits to persons over the age of 65 years may be certified as a qualified Medicare supplement plan if the plan is designed to supplement Medicare and provides coverage of [50] percent of the deductible and copayment required under Medicare and [80] percent of the charges for covered services described in Section 6(a), which charges are not paid by Medicare. The coverage shall include a limitation of $[1,000] per person on total annual out-of-pocket expenses for the covered services. The coverage may be subject to a maximum lifetime benefit of not less than $[100,000].

Section 8. [*State Plan Premium.*]

(a) For the first year of operation of the comprehensive health insurance plan, the association shall establish the following premiums to be charged for membership in the comprehensive health insurance plan:

(1) The premium for the number one qualified plan shall be the average of rates charged by the [five] insurers with the largest number of individuals in a number one individual qualified plan of insurance in force in the state.

(2) The premium for the number two qualified plan shall be the average of rates charged by the [five] insurers with the largest number of individuals in a number two individual qualified plan of insurance in force in the state.

(3) The premium for a qualified Medicare supplement plan shall be the average of rates charged by the [five] insurers with the largest number of individuals enrolled in a qualified Medicare supplement plan.

(4) The charge for health maintenance organization coverage shall be based on generally accepted actuarial principles.

(b) For the second and subsequent years, the schedule of premiums for membership in the comprehensive health insurance plan shall be designed to be self-supporting and based on generally accepted actuarial principles.

Section 9. [*Duties of Commissioner.*] The commissioner may:

(1) Formulate general policies to advance the purposes of Sections 1 to 17; the commissioner may also adopt, promulgate, repeal, and amend rules pursuant to the rulemaking provisions of [state administrative procedure act] to carry out the provisions of Sections 1 to 17.

(2) Supervise the creation of a comprehensive health association within the limits described in Section 10.

(3) Approve the selection of the writing carrier by the association and approve the association's contract with the writing carrier including the state plan coverage and premiums to be charged.

(4) Appoint advisory committees.

(5) Conduct periodic audits to assure the general accuracy of the financial data submitted by the writing carrier and the association.

(6) Contract with the federal government or any other unit of government to ensure coordination of the state plan with other governmnental assistance programs.

(7) Undertake directly or through contracts with other persons studies or demonstration programs to develop awareness of the benefits of Sections 1 to 17, so that the residents of this state may best avail themselves of the health care benefits provided by these sections.

(8) Contract with insurers and others for administrative services.

Section 10. [*Comprehensive Health Association.*]

(a) There is established a comprehensive health association with membership consisting of all insurers, self-insurers, fraternals, and health maintenance organizations licensed or authorized to do business in this state.

(b) The board of directors of the association shall be made up of [seven] individuals selected by participating members, subject to approval by the commissioner. To select the initial board of directors, and to initially organize the association, the commissioner shall give notice to all members of the time and place of the organizational meeting. In determining voting rights at the organizational meeting, each member shall be entitled to vote in person or by proxy. The vote shall be a weighted vote based upon the member's cost of self-insurance, accident and health insurance premium, subscriber contract charges, or health maintenance contract payment derived from or on behalf of residents in the previous calendar year, as determined by the commissioner. If the board of directors is not selected within [60] days after notice of the organizational meeting, the commissioner may appoint the initial board. In approving or selecting members of the board, the commissioner shall consider, among other things, whether all types of members are fairly represented. Members of the board may be reimbursed from the moneys of the association for expenses incurred by them as members, but shall not otherwise be compensated by the association for their services. The costs of conducting meetings of the association and its board of directors shall be borne by members of the association.

(c) All members shall maintain their membership in the association as a condition of doing business in this state. The association shall submit bylaws and operating rules to the commissioner for approval.

(d) All meetings of the association, its board, and any committees of the association shall comply with the provisions of [state open meetings act].

(e) All members shall enter into a contract with the association according to terms specified in Section 11. The contract of reinsurance shall be executed for a period of one year and shall be renewed annually thereafter. A company which ceases to do business within the state shall remain liable under the contract for the reinsurance contracted for during that calendar year.

(f) In the performance of their duties as members of the association, the members shall be exempt from the provisions of [state antitrust statute].

(g) The association may:

(1) Exercise the powers granted to insurers under the laws of this state.

(2) Sue or be sued.

(3) Enter into contracts with insurers, similar associations in other states, or other persons for the performance of administrative functions including the functions provided for in paragraphs (5) and (6) of this subsection.

(4) Establish administrative and accounting procedures for the operation of the association.

(5) Provide for the reinsuring of risks incurred as a result of issuing the coverages required by Sections 4 and 16 by members of the association. Each member which elects to reinsure its required risks shall determine the categories of coverage it elects to reinsure in the association. The categories of coverage are: (i) individual qualified plans, excluding group conversions; (ii) group conversions; (iii) group qualified plans with fewer than [50] employees or members; and (iv) major medical coverage. A separate election may be made for each category of coverage. If a member elects to reinsure the risks of a category of coverage, it must reinsure the risk of the coverage of every life covered under every policy issued in that category. Members electing to administer the risks which are reinsured in the association shall comply with the benefit determination guidelines and accounting procedures established by the association. The fee charged by the association for the reinsurance of risks shall not be less than [110] percent of the total anticipated expenses incurred by the association for the reinsurance.

(6) Provide for the administration by the association of policies which are reinsured pursuant to paragraph 5 of this subsection. Each member electing to reinsure one or more categories of coverage in the association may elect to have the association administer the categories of coverage on the member's behalf. If a member elects to have the association administer the categories of coverage, it must do so for every life covered under every policy issued in that category. The fee for the administration shall not be less than [110] percent of the total anticipated expenses incurred by the association for the administration.

(a) Upon certification as an eligible person in the manner provided by Section 14, an eligible person may enroll in the comprehensive health insurance plan by payment of the state plan premium to the writing carrier.

(b) Any employer which has in its employ one or more eligible persons enrolled in the comprehensive health insurance plan may make all or any portion of the state plan premium payment to the state plan directly to the writing carrier.

(c) Not less than [87½] percent of the state plan premium paid to the writing carrier shall be used to pay claims, and not more than [12½] percent shall be used for the payment of agent referral fees as authorized in Section 15(c) and for payment of the writing carrier's direct and indirect expenses, as specified in Section 13(g).

(d) Any income in excess of the costs incurred by the association in providing reinsurance or administrative services shall be held at interest and used by the association to offset losses due to claims expenses of the state plan or allocated to reduce state plan premiums.

(e) Each member of the association shall share the losses due to claims expenses of the comprehensive health insurance plan pursuant to the terms of the individual reinsurance contracts executed by the association with each member in accordance with Section 10(e). Deviations in the claim experience of the state plan from the premium payments allocated to the payment of benefits shall be the liability of the association members. Association members shall share in the excess costs of the state plan in an amount equal to the ratio of the member's total cost of self-insurance, accident and health insurance premium, subscriber contract charges, or health maintenance organization contract charges received from or on behalf of [state] residents as divided into the total cost of self-insurance, accident and health insurance premium, subscriber contract charges, and health maintenance organization contract charges received by all association members from or on behalf of [state] residents, as determined by the commissioner. The reinsurance contract shall provide for a retroactive determination of each member's liability and payment due within [30] days after each renewal date of the reinsurance contract. Failure by a member to tender to the association the assessed reinsurance payment within [30] days of notification by the association shall be grounds for termination of the member's membership. Net gains, if any, from the operation of the state plan shall be held at interest and used by the association to offset future losses due to claims expenses of the state plan or allocated to reduce state plan premiums.

Section 12. [*Minimum Benefits of Comprehensive Health Insurance Plan.*] The association through its comprehensive health insurance plan shall offer policies which provide the benefits of a number one qualified plan, a number two qualified plan, and a qualified Medicare supplement plan. They shall offer health maintenance organization contracts in those areas of the state where a health maintenance organization has agreed to make the coverage available and has been selected as a writing carrier.

Section 13. [*Administration of Plan.*]

(a) Any member of the association may submit to the commissioner the policies of accident and health insurance or the health maintenance organization contracts which are being proposed to serve in the comprehensive health insurance plan. The time and manner of the submission shall be prescribed by rule of the commissioner.

(b) Upon the commissioner's approval of the policy forms and contracts submitted pursuant to Section 10, the association shall select policies and contracts submitted by a member or members of the association to be the comprehensive health insurance plan. This selection shall be based upon criteria including the member's proven ability to handle large group accident and health insurance cases, efficient claim paying capacity, and the estimate of total charges for administering the plan. The association may select separate writing carriers for the two types of qualified plans, the qualified Medicare supplement plan, and the health maintenance organization contract.

(c) The writing carrier shall perform all administrative and claims payment functions required by this section. The writing carrier shall provide these services for a period of [three] years, unless a request to terminate is approved by the commissioner. The commissioner shall approve or deny a request to terminate within [90] days of its receipt. A failure to make a final decision on a request to terminate within the specified period shall be deemed to be an approval. [Six] months prior to the expiration of each [three]-year period, the association shall invite submissions of policy forms from members of the association, including the writing carrier. The association shall follow the provisions of subsection (b) in selecting a writing carrier for the subsequent three-year period.

(d) The writing carrier shall provide to all eligible persons enrolled in the plan an individual certificate, setting forth a statement as to the insurance protection to which he is entitled, with whom claims are to be filed and to whom benefits are payable. The certificate shall indicate that coverage was obtained through the association.

(e) The writing carrier shall submit to the association and the commissioner on a monthly basis a report on the operation of the state plan. Specific information to be contained in this report shall be determined by the association prior to the effective date of the state plan.

(f) All claims shall be paid by the writing carrier pursuant to the provisions of Sections 1 to 17 and shall indicate that the claim was paid by the state plan. Each claim payment shall include information specifying the procedure to be followed in the event of a dispute over the amount of payment.

(g) The writing carrier shall be reimbursed from the state plan premiums received for its direct and indirect expenses. Direct and indirect expenses

shall include, but need not be limited to, a pro rata reimbursement for that portion of the writing carrier's administrative, printing, claims administration, management and building overhead expenses which are assignable to the maintenance and administration of the state plan. The association shall approve cost accounting methods to substantiate the writing carrier's cost reports consistent with generally accepted accounting principles. Direct and indirect expenses shall not include costs directly related to the original submission of policy forms prior to selection as the writing carrier.

(f) The writing carrier shall at all times when carrying out its duties under Sections 1 to 17 be considered an agent of the association and the commissioner with civil liability subject to the provisions of [appropriate state tort liability statute].

(i) Premiums received by the writing carrier for the comprehensive health insurance plan are specifically exempted from the provisions of Section 15 .

Section 14. [*Enrollment by Eligible Person.*]

(a) The comprehensive health insurance plan shall be open for enrollment by eligible persons. An eligible person may enroll by submission of a certificate of eligibility to the writing carrier. The certificate shall provide the following:

(1) Name, address, age, and length of time at residence of the applicant.

(2) Name, address, and age of spouse and children, if any, if they are to be insured.

(3) Evidence of rejection, or a requirement of restrictive riders, or a preexisting conditions limitation on a qualified plan, the effect of which is to substantially reduce coverage from that received by a person considered a standard risk, by at least [two] association members within [six] months of the date of the certificate.

(4) A designation of the coverage desired.

(b) Within [30] days of receipt of the certificate described in Section 14(a), the writing carrier shall either reject the application for failing to comply with the requirements in Section 14(a) or forward the eligible person a notice of acceptance and billing information. Insurance shall be effective immediately upon receipt of the first month's state plan premium, and shall be retroactive to the date of application, if the applicant otherwise complies with the requirements of Sections 1 to 17. An eligible person may not purchase more than one policy from the state plan.

(c) No person who obtains coverage pursuant to this section shall be covered for any preexisting condition during the first [six] months of coverage under the state plan if the person was diagnosed or treated for that condition during the [90] days immediately preceding the filing of an application.

Section 15. [*Solicitation of Eligible Persons.*]

(a) The association pursuant to a plan approved by the commissioner shall disseminate appropriate information to the residents of this state regarding the existence of the comprehensive health insurance plan and the means of enrollment. Means of communication may include use of the press, radio, and television, as well as publication in appropriate state offices and publications.

(b) The association shall devise and implement means of maintaining public awareness of the provisions of Sections 1 to 17 and shall administer these sections in a manner which facilitates public participation in the state plan.

(c) The writing carrier shall pay an agent's referral fee of $[25] to each insurance agent who refers an applicant to the state plan, if the application is accepted. Selling or marketing of qualified state plans shall not be limited to the writing carrier or its agents. The referral fees shall be paid by the writing carrier from money received as premiums for the state plan.

(d) Every insurer which rejects or applies underwriting restrictions to an applicant for accident and health insurance shall notify the applicant of the existence of the state plan, the requirements for being accepted in it, and the procedure for applying to it.

Section 16. [*Conversion Privileges.*] Every program of self-insurance, policy of group accident and health insurance or contract of coverage by a health maintenance organization written or renewed in this state shall include the right to convert to an individual coverage qualified plan without the addition of underwriting restrictions regardless of the reason for leaving the group. The person leaving the group may exercise his right to conversion within [30] days of leaving the group. Plans of health coverage shall also include a provision which, upon the death of the individual in whose name the contract was issued, permits every other individual then covered under the contract to elect, within the period specified in the contract, to continue his coverage under the same or a different contract without the addition of underwriting restrictions until he would have ceased to have been entitled to coverage had the individual in whose name the contract was issued lived.

Section 17. [*Dual Option.*]

(a) An employer who employs in this state, on the average during a calendar quarter, [100] employees or more, other than employees engaged in seasonal employment, and who offers a health benefits plan to employees, whether purchased from an insurer or a health maintenance organization, or provided on a self-insured basis, shall, upon the next renewal of the health benefits plan contract, offer his employees a dual option to obtain health benefits through either an accident and health insurance policy or a health maintenance organization contract if one is available. An option need not be provided if fewer than [25] employees select that option.

(b) An employer may make the dual offers through an insurer, a health maintenance organization or on a self-insured basis. If an offer is made on a self-insured basis, the accident and health insurance type of coverage or

health maintenance organization type of coverage shall meet the requirements of the laws of this state as to the services covered or benefits provided, but need not otherwise be approved by the commissioner or the board of health.

(c) No insurer shall make acceptance of its offer to provide insurance coverage contingent on acceptance by the employer of health maintenance organization coverage by a particular health maintenance organization. No health maintenance organization shall make acceptance of its offer to provide health maintenance organization coverage contingent on acceptance by the employer of insurance coverage by a particular insurer. No offer to provide the accident and health insurance policy and the health maintenance organization contract shall combine the two in a single price package.

(d) The [board of health], in consultation with the commissioner, shall adopt rules to implement the provisions of this section.

Section 18. [*Application for Assistance.*]

(a) Any person who believes that they are or will become an eligible person may submit an application for state assistance to the [commissioner of public welfare]. The application shall include a listing of expenses incurred prior to the date of the application and shall designate the date on which the [12]-month period for computing expenses began.

(b) If the [commissioner of public welfare] determines that an applicant is an eligible person, he shall pay [90] percent of all qualified expenses of the eligible person and his dependents in excess of: (1) [40] percent of his household income under $[15,000], plus [50] percent of his household income between $[15,000] and $[25,000], plus [60] percent of his household income in excess of $[25,000]; or (2) $[2,500], whichever is greater for the [12]-month period in which the applicant becomes an eligible person. If the [commissioner of public welfare] determines that the charge for a health service is excessive, he may limit his payment to the usual and customary charge for that service. If the [commissioner of public welfare] determines that a health service provided to an eligible person was not medically necessary, he may refuse to pay for the service. To the extent feasible, the [commissioner of public welfare] shall contract with a review organization in making any determinations as to whether or not a charge is excessive. To the extent feasible, the [commissioner of public welfare] shall contract with a review organization in making any determination as to whether or not a service was medically necessary. If the [commissioner of public welfare], in accordance with this section, refuses to pay all or a part of the charge for a health service, the unpaid portion of the charge shall be deemed to be an unconscionable fee, against the public policy of this state, and unenforceable in any action brought for the recovery of moneys owed.

Section 19. [*Duties of Commissioner.*]

(a) The [commissioner of public welfare] shall:

(1) Promulgate reasonable rules to implement Sections 18 to 20.

(2) Establish application forms and procedures for the use of persons seeking to be declared eligible persons.

(3) Investigate applications to determine whether or not the applicant is a qualified person and investigate claims from providers of health services to determine whether or not to pay them.

(b) The [commissioner of public welfare] may:

(1) Enter into contracts with the United States or any state agency, instrumentality or political subdivision for the purpose of coordinating the program established by this act, with other programs which provide or pay for the delivery of health services.

(2) Enter into contracts with third parties to perform some or all of the duties imposed on the [commissioner of public welfare] by Sections 18 and 19.

Section 20. [*Appeals.*] The final decision of the [commissioner of public welfare] in denying an application for status as an eligible person or denying all or part of the charges for a health service may be appealed by any interested party pursuant to [state administrative procedure act].

Section 21. [*Severability.*] [Insert severability clause.]

Section 22. [*Repeal.*] [Insert repealer clause.]

Section 23. [*Effective Date.*] [Insert effective date.]

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STATE OF ALASKA

Legislative Affairs Agency

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A Study of Medicaid Client Need

February 1977

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O P T I N G

A Study of Medicaid Client Need

PREPARED BY

LEGISLATIVE AFFAIRS AGENCY
DIVISION OF RESEARCH

FEBRUARY, 1977

Foreword

In the fall of 1972, Alaska entered the national Medicaid program, providing certain of its citizens thereby a limited spectrum of medical care services.

Since this modest beginning, the legislature has increased Medicaid coverage by the addition of a few services above those which the state is required to cover in order to participate in the federal program. These optional services allowed the state to earn addition "matching" federal funds, some of which were a direct one-for-one offset to medical care expenditures that the state itself had been previously paying for in their entirety. Other program additions resulted in increased state expenditures, but provided a more complete medical coverage package.

In order to maximize the benefits from the additional expenditures, optional service additions must undergo careful scrutiny to insure that the options chosen return the greatest level of benefits in terms of meeting the health needs of the approximately seven percent of Alaska's population served by the Medicaid program. During 1976, a number of legislators indicated their desire to have better information upon which to base their decisions concerning the addition (or deletion) of various possible optional services. In order to meet this need, Miss Deborah Behr of the Research Division staff began, in June of 1976, an extensive effort directed at reviewing public assistance eligibility supervisors' perceptions of client requirements, analyzing written denials of additional client service requests, and obtaining information from various states regarding their experience with selected options. The present study is the result of this effort.

Gregg K. Erickson
Director of Research
Legislative Affairs Agency

Juneau, Alaska
February, 1977

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O P T I N G

A Study of Medicaid Client Need

PART I. OVERVIEW OF THE MEDICAID PROGRAM

INTRODUCTION TO THE PROGRAM

Medicaid is a program funded jointly by the federal and state governments which aids certain needy Alaskans in providing payments for them to receive medical services. It helps assure that medical services are available to those needy eligible persons when they are ill or injured. It also assists in guaranteeing that the highest quality care of the kind required by the patient's condition is available, by mandating certain medical reviews of patient care and treatment. Medicaid also attempts to make services available by utilizing the present system of private practitioners, facilities, and institutions to provide the care required at the lowest possible cost to the taxpayer.

STATE PLAN FOR MEDICAID

The Medicaid program in Alaska is administered by a single state agency, the Department of Health and Social Services, which is required to submit a state plan to the Secretary of the federal Department of Health, Education, and Welfare for his review and approval.

The state plan is essentially a contract between the state department and the federal Department of Health, Education, and Welfare specifying conditions to be met in order to qualify for federal financial participation. Some topics included in it are:

1. eligibility determination
2. recipient eligibility
3. eligibility verification
4. medical services
5. health care
6. quality control
7. fair hearings
8. methods of administration
9. utilization review
10. fraud

Many of these items are required be included in the plan (mandatory), but others the state may decide whether or not to include (optional). The optional portions allow the state to shape a medical assistance program to the needs and financial resources of its citizens.

DIFFERENCES BETWEEN MEDICAID AND MEDICARE

Medicaid is often confused with the Medicare program in the state. Medicaid is a medical assistance program for certain needy low-income people. In Alaska, Medicaid is administered by the Division of Public Assistance, an agency of the Alaska Department of Health and Social Services. It is authorized under Title XIX of the federal Social Security Act and AS 47.07.010-.080 of the Alaska statutes. States can design their own programs within set federal guidelines to meet the needs and resources of its citizens. Medicaid programs can and do vary from state to state.

In comparison, Medicare is a medical insurance program for those people, rich or poor, covered by Social Security. It is administered by the Social Security Administration of the federal government. The program is the same in all fifty states. Almost everyone over 65 and some younger persons who have been receiving Social Security disability payments for at least two years qualify for the program.

BRIEF HISTORY OF MEDICAID PROGRAM IN ALASKA

On July 6, 1972, Alaska became the 49th state to provide the Medicaid program for its residents. The state had, since the mid-60's, provided for such services under the General Relief - Medical program. Costs had risen from $1.8 million to $8.7 million in FY 72. This dramatic increase was due to many factors, the major ones being:

1. The number of eligibles had increased, but the rate of expenditure was increasing at even a faster pace.

2. The scope of the program had been liberalized and expanded with a related increase in utilization of services.

3. Medical care costs were rising at a rate disproportionate to that of other costs of living.

In light of this situation, the administration and the legislature came to basic conclusions that the General Relief - Medical program, which was supported 100% with state monies, had need of administrative controls to review services and, hopefully, reduce health care expenditures. There was a general consensus that either the General Relief - Medical program had to be upgraded or research should be done to investigate the possibility of the implementation of the Medicaid program. In April, 1972, the Department of Health and Social Services contracted with Touche Ross and Company, a public accounting firm, to develop a cost benefit study of the Medicaid program. Budgets were developed and testimony was made to the legislature that session. On June 17, 1972, the enabling bill for the Medicaid program passed the legislature and was later signed into law with an effective date of July 6, 1972. (The history of the program can be traced on Table 1: Medicaid History Timeline.)

TABLE 1

State of Alaska
Medicaid History Timeline

Date	Occurrence
April 10, 19 2	Touche Ross & Company begin Medicaid System Design
April 18-June 9, 1972	Departmental Presentation to Legislature
May 10, 1972	Department of Health and Social Services' Steering Committee Established
June 17, 1972	Enabling Bill Passes Legislature
July 6, 1972	Medicaid Becomes Law
September 1, 1972	Medicaid Implemented
September 28, 1972	State Plan Submitted to Federal Department of Health, Education and Welfare
April 4, 1973	Effective date of Intermediate Nursing Home Care Option
May 16, 1974	Effective date of Inpatient Psychiatric Hospital Option for Eligible Persons 65 or Over and Under 22
May 16, 1974	Effective Date of Miscellaneous Minor Eligibility Groups (Primarily needy children under 21 in foster care under supervision by Department of Health and Social Services)
July 13, 1974	Effective date of 60 day limit on filing Medicaid claims
April 15, 1975	New Division of Public Assistance Formed
September 2, 1975	Effective date of Intermediate Nursing Home Care for Mentally Retarded Under 21 who Meet AFDC Need Standards Option
March 12, 1976	Effective date of Eye Glasses and Optometrist Service Options
June 21, 1976	Effective Date of New Nursing Home Group of Eligibles
July 1, 1976	Effective Date of Limited Clinic Services Option (Primarily Community Mental Health Centers and State Operated Mental Centers)
July 1, 1976	Effective date of Treatment of Speech, Hearing, and Language Disorders Option

The Department of Health and Social Services worked during the interim period to provide the necessary procedures and organization to make Medicaid an administrative reality in Alaska. A new Division of Medical Assistance in the Department of Health and Social Services was formed to administer the new program, as well as the remnants of the General Relief - Medical program. On September 1, 1972, the Medicaid program was actually implemented. (The Division continued to administer the program until April, 1975, when the new Division of Public Assistance was formed. This new division combined the eligibility determination, income maintenance, and medical assistance functions into one organizational grouping in the state.) Later that month, the official state plan was submitted to the federal Department of Health, Education and Welfare for its approval.

With the approval of the state plan, Alaska realized the benefits due to implementation of the Medicaid program:

1. Federal matching funds for medical expenditures became 50%, thereby allowing the continuation of the level of medical services without further increase in state general fund expenditure.

2. Federal match for categorical assistance programs under the Social Security Act increased from 30% to 50%.

3. Administrative controls, seen as necessary, were implemented to fulfill Medicaid requirements in order to receive federal financial participation.

When the legislature approved the Medicaid program, it included a restriction in statute mandating that all new services or eligibility group additions must receive its approval. At time of passage, the enabling legislation included those services and eligibility groups mandated by the federal government in order to receive federal financial participation. Since that time, the legislature has added few additional services or eligible groups.

The legislature added the first additional service option in 1973. At that time, intermediate nursing home care was selected. This option permitted the coverage of a lower and less expensive level of nursing home care. This addition allowed many Medicaid recipients in skilled nursing, who did not require that level of treatment, to be properly placed in intermediate nursing care thus "saving" state general fund dollars.

In 1974, the inpatient psychiatric hospital services option was added for eligible persons 65 years of age or over and 21 or under. This allowed the state to claim federal reimbursement for some persons at Alaska Psychiatric Institute, who were eligible for Medicaid coverage and were at that time receiving their care 100% from state monies. Also, other small groups of new eligibles were added at that time. Primarily they consisted of certain needy foster care children under 21 supervised by the Department of Health and Social Services. Prior to

that time these children had, in most cases, received coverage for their health care through the General Relief-Medical program. Also, legislation was passed requiring that medical assistance claims be submitted promptly, no later than six months after date of service or third party payment was received. This permitted more administrative control of expenditures and allowed for greater accuracy in budget projections.

The option to include a new group of needy eligibles under 21 who were in intermediate nursing homes for the mentally retarded became effective in 1975. This permitted a group of children at Harborview Memorial Hospital, Alaska Psychiatric Institute, and Hope Park to receive Medicaid coverage and, hence, additional federal dollars could be earned for their care.

In 1976 the legislature chose to add four new items to the program. A new group of needy persons became eligible for Medicaid coverage for their nursing home care due to an addition of an option. Also, that session, prescription eyeglasses and optometrist's services were added to the program. The legislature also approved the addition of limited clinic services which allowed state operated mental health centers and state approved community outpatient mental health centers receiving grants under A.S. 47.30.520 - 47.30.620 to be covered. This permitted federal funds to be earned in these state general fund supported projects. Also, at that time, the coverage of treatment of speech, hearing, and language disorders was added to the Medicaid program.

The legislature has shown interest in examining and evaluating the available Medicaid options, as seen by the recent history of the program in the state. Many of these options, especially in the case of coverage of nursing home care for certain needy eligible persons, actually "saved" state money. By adding them to the Medicaid program, federal funds could be realized for some of those services, which were being paid at that time 100% from state general funds. Also, by increasing the scope of the service package, a more consistent medical treatment program could be offered to these needy persons. For example, prior to the 1976 addition, eyeglasses were not generally available to all Medicaid eligibles who needed them. Only Medicaid eligible children who had been seen in early screening programs and referred for eyeglasses could be reasonably assured of coverage under the program for their lenses. Needy adults, such as those in nursing homes, had no such guarantee.

Alaska was one of the last states to join the Medicaid program and has been cautious in increasing the scope of the program in the state. In comparison with many other states in the program, Alaska's program is limited, with few service and eligibility group options beyond those basic services and groups required to maintain compliance with the program. This paper will later examine the current scope of the program and the options available under it that the legislature may be called upon to evaluate in 1977 and thereafter.

PART II. CURRENT STATUS OF MEDICAID PROGRAM IN ALASKA

ELIGIBILITY OF CLIENTS

The Alaska Medicaid program provides coverage for certain needy persons receiving or eligible to receive public assistance under:

Federal Supplemental Security Income (SSI),

Alaska Old Age Assistance (OAA),

Alaska Aid to the Blind (AB),

Alaska Aid to the Disabled for Persons who Meet Federal Criteria for Disability (AD), or

Aid to Families with Dependent Children (AFDC),

and certain others (mostly children)

Alaska does not cover the medically needy under its Medicaid program.

In general to be eligible for Medicaid in Alaska, an individual must:

(1) Be physically present in Alaska at time of application and citizen of U.S. or lawfully admitted alien;

(2) Not be in a public institution such as a jail (a person may however be in chronic disease facility such as a nursing home);

(3) Not have more than $1,500 in non-exempt personal property; this excludes a home (there is no lien requirement), personal belongings, in certain cases, a necessary automobile and some types of income producing property;.

(4) Not have transferred property to qualify for assistance;

(5) Meet program requirements such as blind, disabled, aged over 65, or dependent child

The Division of Public Assistance examines the financial and living situation to determine if a person is eligible. As a basic rule, if a family of four meets general program requirements, has monthly net income of no more than $400 earned (excluding reasonable work related expenses) and unearned income, the family would qualify for assistance under Aid to Families With Dependent Children program. There is no geographical differential on the total amounts allowed. The amounts vary for the adult programs (OAA, AB, AD) but generally, if household expenses (excluding fuel) are over $35 a month and the net income is no more than $334 a month of earned (excluding reasonable work-related expenses) and unearned income, a single person family would qualify if other program requirements are met. The $334 figure can vary annually

in accordance with cost of living adjustments required in AS 47.25.640; 47.25.430; 47.25.810. Eligibility for categorical assistance programs automatically makes one eligible for Medicaid.

SERVICES COVERED UNDER MEDICAID

The State of Alaska covers basically two types of services: mandatory, which the states are required to provide, and optional, which the state may provide and receive federal reimbursement. Alaska provides all mandatory services, but optional services are limited.

Mandatory Services

Alaska must provide the following services: 1) inpatient hospital services; 2) outpatient hospital services; 3) physician's services; 4) x-ray and laboratory services; 5) skilled nursing home services; 6) home health services; 7) early and periodic screening, diagnosis, and treatment of children under 21; and 8) family planning services. Alaska also is required to cover transportation necessary to receive medical service, if unavailable from any other source, but it is not listed as a federal requirement.

Optional Services

In addition to the mandatory services, Alaska provides and receives federal reimbursement for the following services:

(1) Inpatient psychiatric hospital services for individuals age 65 or older or under age 22
(2) Intermediate care facility services
(3) Skilled nursing for those persons under 21 years of age
(4) Emergency hospital services
(5) Eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist
(6) Services for individuals with speech, hearing, and language disorders
(7) Services through state approved out-patient community mental health clinics which receive grants under AS 47.30.520-47.30.620 and state-operated mental health clinics
(8) Optometrist's services and limited dental and prosthetic devices as required under EPSDT regulations

Other services that the state could choose to provide for certain of its needy individuals, but which has not yet opted for, include:

(1) Prescribed drugs
(2) Dental Services (for persons over 21 not covered under the early screening program)
(3) Dentures
(4) Prosthetic devices (for persons over 21 not covered under the early screening program)

(5) Private duty nursing
(6) Physical therapy and related services
(7) Chiropractor's services and other practitioners
(8) Podiatrist's services
(9) Care for patients aged 65 or older in Institutions for Tuberculosis
(10) Other diagnostic services, screening, preventive services, rehabilitative services

Parts III through V of this report deal later with these optional services in more depth, examining the need and aspects to consider in the evaluation of these alternatives to the program.

FINANCIAL PARTICIPATION BY FEDERAL GOVERNMENT

The federal government financially participates in the Medicaid program by means of matching state dollars for allowable administrative and medical expenditures. Services to eligible clients receive 50% reimbursement, except for family planning supplies and services which are matched at 90% level. Administrative costs are generally matched at 50%. Professional medical review staff are reimbursed at 75% level. (Certain other administrative services receive special match rates, such as 100% for certification and survey of nursing homes. These special rates are itemized in federal law and regulation.)

At the present time there is no "ceiling" or set limit for Alaska on the amount of federal funds available for reimbursement. There has, in recent years, been much discussion on the federal level to restrict such reimbursement, as was indicated in President Ford's budget address in January, 1976. At that time, he mentioned the possibility of placing the Medicaid program in a block grant package with other federally assisted health care programs. By this method, a dollar limit would have been set on the available federal funds for those purposes. Generally, though, the prospects for major funding modifications in the Medicaid program appear slim, although tighter management and administrative mechanisms to control fraud and quality of services seems to be a continued interest.

NEW DEVELOPMENTS IN MEDICAID

In the fall of 1976 the federal government placed additional responsibilities on the Medicaid program, through the passage of Public Law 94-437. That bill, known as the Indian Health Care Improvement Act, mandated closer coordination of Medicaid and Indian health services and required that all services for Medicaid eligible Alaska Natives in Indian health facilities be billed to Medicaid. The federal government would then reimburse the state's Medicaid program at 100% for such services. Additional administrative functions would receive normal federal reimbursement rates. The services eligible for reimbursement under Public Law 94-437 are only those included in the approved Medicaid state plan and provided to Medicaid eligible Alaskan Natives.

Total ramifications of the bill are yet unknown. Federal officials report though that Alaska is far ahead of other affected states in implementing the new law. For example, seven of Alaska's nine Indian Health Service hospitals currently meet statutory requirements for participation in Medicaid without further action. State officials note though that unless there is a major shift in procedures for handling people covered under Indian Health Improvement Act, field office work will increase greatly (e.g., issuing medical coupons, arranging necessary transportation, answering client and provider questions). These state officials voiced concern that estimates of the number of new Alaska Native clients attracted to apply for Medicaid coverage are unknown. The attachment of a dollar figure to the cost of medical services for these persons would be just a rough estimation.

PART III. GENERAL INFORMATION REGARDING OPTIONAL SERVICES

CONTROLS THAT STATES MAY IMPOSE ON MEDICAID OPTIONAL SERVICES

Since the addition of optional services is at the discretion of the state, the federal government allows great flexibility for states to determine the scope of the option that they wish to provide for their Medicaid clients. Generally, federal law and regulation define the basic objectives and requirements of the options, all of which must be met in order to obtain federal financial participation. Some of the requirements address equal offering of services to all eligibles, the qualifications of persons providing the services, and degree of supervision required for paraprofessionals. Within those broad parameters states can shape optional services to fit their unique needs and resources.

Alaska can limit optional services by (1) qualifying coverage, (2) requiring prior authorization, (3) limiting usage frequency, (4) requiring clients to share in cost of services, or (5) limiting the amount of provider reimbursement:

(1) *Qualifying Coverage*

Medicaid law and regulation permit the limiting of coverage of optional services. For example, dentures can be selected as a separate service without having to cover other prosthetic devices such as hearing aids, crutches, etc, or without having to cover other dental services. The Medicaid program does require that the option limitations be applied equally to all eligible clients. (There are certain exceptions to this policy. Some options are defined in federal law to include only specific age groups such as persons under 21 or over 65.) The state, for example, cannot as a general rule limit eligibility for optional service to only those persons receiving aid under a particular program such as Old Age Assistance. If a state chooses an optional service, it must be covered for all groups (except as noted in federal law or regulation) or federal reimbursement will be jeopardized.

(2) *Requiring Prior Authorization*

States can control inappropriate overutilization of optional services by requiring the client to receive approval from the Medicaid agency prior to obtaining certain medical care. Preauthorization is usually based on medical need for services and appropriateness of the care requested to the condition being treated. The Division of Public Assistance has, since the beginning of Medicaid, required preauthorization of all nursing home placements. This mechanism serves to reduce unnecessary placements, place clients at appropriate levels of care, and suggest alternative, and usually cheaper, methods of treatment.

(3) *Limiting Usage Frequency*

Optional services can also be limited by restricting client use. This is generally done by limiting the number of treatments or services paid by Medicaid in a specific time period. For example, Maryland limits adults to one eye examination and one pair of eyeglasses every two years. Arkansas limits Medicaid clients to three prescriptions per month. These restrictions must be applied though uniformly to all clients receiving assistance. Limitations of the amount of services should take into account unusual emergency situations. States cannot impose barriers to needed minimum levels of health care, or risk federal sanction.

(4) *Requiring Clients to Share in Cost of Services*

Some states require Medicaid clients to participate in sharing the costs of certain optional services. Federal regulation sets certain maximum allowable limits on the amount of payment that clients can be required to cover. Those regulations also specify the mechanisms that states can use to allow clients to share in the cost of certain services. Fees are generally limited to small amounts such as $.50 per prescription drug and $2.00 per pair of eyeglasses. Originally, this procedure was instituted to control overutilization of services and not to generate funds. California, along with some other states which elected this option, has found that the cost of administration of this mechanism generally did not offset the revenues gained. The charges did not significantly affect client use of services, and the states found that the collecting and controlling of such small fees were bothersome to both client and provider.

(5) *Limiting the Amount of Provider Reimbursement*

Costs of optional services can also be reduced by limiting the amount of provider reimbursement. Often this comes in the form of reducing reimbursement by a set percentage or by "freezing" payment levels at the current standards. (Medicaid pays "reasonable" rates to its providers. The costs allowable under its definitions often differ greatly from those accepted by Blue Cross and other insurance companies. Fees paid under Medicaid are often lower than fees paid by the general public for the same services.) The state of Michigan, for example, recently implemented an 11% reduction in normal fees paid to practitioners, dentists, laboratories, and other providers. Often such changes receive strong provider reaction and sometimes jeopardize the continued participation of those providers in the program. Federal officials also note the potential use of low bid health providers. For example, the state could solicit bids for a contract to supply Medicaid clients with specific services, such as eyeglasses. The state could select the most advantageous bid and award the contract without jeopardizing federal reimbursement.

OTHER ISSUES TO CONSIDER IN EVALUATING MEDICAID OPTIONAL SERVICES

Although this study focuses primarily on client need, there are other factors that must be considered in evaluating the merits of any given Medicaid option. Three of these major considerations are: availability of funds, costs versus benefits of options, and ease of administration.

The availability of funds plays a major role in the scope of services that a state believes it can provide for its citizens. The high cost of medical care demands an in-depth analysis of cost before any new service is added. Although this study does not discuss this financial issue, it is a major part of any decision to modify the program. Legislators who have a well defined proposal for additional option(s) may request the Research Division of the Legislative Affairs Agency to prepare an analysis of its costs, both direct and administrative.

The costs versus benefits of an option can be an important consideration in deciding whether or not the state should participate in it. For example, certain Medicaid options sometimes "save" state money, if that service is currently paid entirely from state funds or if it allows a client to receive less specialized and less expensive type of service that are more appropriate to this medical condition or problem. In 1976, the Alaska State Legislature added coverage of new limited group of needy eligibles who currently reside in nursing homes. The care for those persons at that time was paid for 100% from state general funds through the General Relief-Medical program. By adding that option, the state was able to claim 50% federal reimbursement for their care. Also, in 1973, the state added the intermediate nursing home care option. By covering this lower and less expensive level of nursing home care, many Medicaid recipients in skilled nursing, who did not require that level of treatment, could be placed in intermediate nursing care. The cost per day for each patient was reduced considerably.

The ease of administration is important also in evaluating the merits of certain options. The drug option, for example, requires that strict payment procedures regarding maximum allowable charges be in place. These are spelled out in some detail in the federal regulations, and the state must meet those requirements or risk loss of federal participation. Federal officials note that many of these cost containment mechanisms would normally be in place in any efficiently administered pharmaceuticals program, regardless of source of funding for it. The transfer of a program from state-only funding to federal assistance should cause minimal additional administrative expenses if adequate cost containment measures are in place in the existing program.

IV. MEDICAID CLIENT NEEDS

QUESTIONNAIRE OF PUBLIC ASSISTANCE SUPERVISORS

In Fall, 1976, a questionnaire was prepared to poll public assistance supervisors (eligibility work supervisors) on their estimation of client need for certain services based on their actual experience in the field. The questionnaire, prior to mailing, was reviewed by both the Division of Public Assistance and Department of Health and Social Services Commissioner's Office. The questionnaires were mailed to nineteen supervisors, many of whom had worked with public assistance clients for a significant period of time. (That sample of supervisors was chosen under the guidance of the Division of Public Assistance's Chief of Field Operations.) Approximately one month after mailing, a follow-up questionnaire was sent.

Fourteen, or 75%, of the supervisors polled responded to the questionnaire. All areas of the State were represented, including Anchorage, Fairbanks, Fort Yukon, Juneau, Kenai, Ketchikan, Nome, and Sitka. Each supervisor was asked specific questions concerning his or her evaluations of client need for Medicaid options not yet selected by the State.

QUESTION #1: In your experience, what optional services currently not covered under Medicaid do you feel your Medicaid eligible clients need most?

Table 2 shows the rank order obtained from the supervisor's responses to question #1. Interestingly, the top four items for each category (Adult Public Assistance and Aid to Families with Dependent Children program recipients) were the same. The ranking for dentures option differed slightly, being seen more necessary for older persons receiving Adult Public Assistance than the younger Aid to Families with Dependent Children recipients.

Since the Medicaid program requires that services included in the State Plan be offered equally to all eligible persons (except for certain specialized programs such as early childhood screening) the similar ranking of need options for both Adult Public Assistance and Aid to Families with Dependent Children Program is particularly meaningful. If it were called upon to evaluate new options, the legislature could be reasonably sure that any of the top four options (prescribed drugs, adult dental services, dentures, and physical therapy and related services) would be "needed" by both categories of clients.

QUESTION #2: On the average, how many Medicaid clients a month ask you if they can receive certain services?

Table 3 shows the responses by the supervisors concerning the requests of Medicaid eligibles for additional services. The responses to question #2 did not match the pattern formed from the supervisor's responses

TABLE 2

Average Ranking of Selected Medicaid
Options by Type of Public Assistance Client

Rank	Recipients of Adult Public Assistance	Recipients of Aid to Families with Dependent Children
1st	Prescribed Drugs	Prescribed Drugs
2nd	Adult Dental Services	Adult Dental Services
3rd	Dentures	Physical Therapy and Related Services
4th	Physical Therapy and Related Services	Dentures
5th	Hearing Aids [1]	Chiropractor's Services
6th	Prosthetic Devices	Hearing Aids [1]
7th	Chiropractor's Services	Prosthetic Devices
8th	Private Duty Nursing	Private Duty Nursing
9th	Podiatrist's Services	Podiatrist's Services
10th	Care for Patients 65 or Over in Tuberculosis Institutions	Care for Patients 65 or Over in Tuberculosis Institutions

[1] *Hearing aids, at the time the survey was conducted, were not included in the coverage program offered to all Medicaid clients. An interpretation of Medicaid law and regulation by federal officials allowed hearing aids to be covered as part of the treatment of speech, hearing, and language disorders option. This policy change was implemented by the Division of Public Assistance in November.*

to question #1. For example, the Medicaid prescribed drug option which was ranked as needed first for both program categories, received less than 50% of the requests made for adult dental services, which was ranked as needed second by the supervisors. This could be anticipated for Medicaid clients who do not have prior health resources equal or better in coverage to General Relief-Medical automatically receive their drugs through GRM. One Juneau public assistance supervisor noted that for these persons, eligibility for prescription drugs under GRM is automatically determined at the time that Medicaid eligibility is confirmed. Therefore, few Medicaid clients would ask for prescription drugs, since coverage is established at the time they enter the Medicaid program.

Aid to Families with Dependent Children recipients requested fewer services than did the Adult Public Assistance recipients. This was expected, for the recipients of AFDC tend to be young and thus often have less need for diverse health services. Also, many AFDC recipients are eligible for a wider range of treatment service through the Early Periodic, Diagnosis and Treatment Program (EPSDT), a child check-up program. For example, dental care is available to public assistance recipients under 21 as a referral through EPSDT, but currently persons over 21 who are mostly on Adult Public Assistance programs cannot routinely receive preventative dental care under any of the state medical assistance programs.

Many of the Medicaid options available under the federal program do not match with Alaska's availability of services. In rural Alaska, it would be difficult to obtain chiropractor's or podiatrist's services close to home. Also, the option of care for patients 65 or over in tuberculosis institutions is not really relevant to Alaska, since there are no tuberculosis sanatoriums in the State. Care for such conditions would have to be provided in nursing homes, hospitals, and physicians' offices, all of which are currently covered under Medicaid.

The low number of requests in all categories may be due to lack of client awareness that these additional services sometimes can be covered under the state funded medical assistance program, General Relief-Medical. Because of limited funds under that program, the Division of Public Assistance has not actively conducted an outreach program to inform clients of eligibility requirements and services covered. Also, many clients may be reluctant to ask for services, which they feel they stand a likelihood of being rejected. Dentures are a good example of this. Because of funding limitations, dentures can only be covered in extreme hardship situations. Clients often are informed of this policy from their dentists, public health nurses, or social workers, before a formal request is made to the Division of Public Assistance.

SURVEY OF "DENIALS" OF SERVICE RECORDS

The needs of clients were also analyzed through a survey of all denials of requests for additional services for Medicaid clients. Medicaid clients sometimes require services that are not included in the Medicaid

TABLE 3

Total Average Number of Medicaid-Eligibles Requesting Optional Services Monthly by Program Category

Option	Recipients of Adult Public Assistance	Recipients of Aid to Families with Dependent Children	Total
Adult Dental Services	81.5	88.0	169.5
Dentures	60.5	21.0	81.5
Prescribed Drugs	38.0	39.0	77.0
Physical Therapy and Related Services	20.5	23.0	43.5
Hearing Aids [1]	27.0	16.0	43.0
Prosthetic Devices	25.5	12.0	37.5
Chiropractor's Services	15.5	15.0	30.5
Private Duty Nursing	13.5	5.5	19.0
Podiatrist's Services	4.0	1 5	5.5
Care for Patients 65 or Over in Tuberculosis Institutions	1.0	0.0	1.0
Total	287.0	221.0	508.0

[1] *Hearing aids, at the time of the survey, were not included in the coverage program offered to all Medicaid clients. An interpretation by federal officials of the treatment of speech, hearing, and language disorders options allowed hearing aids to be covered as part of a treament plan. This policy change was implemented in November.*

TABLE 4

Denials of Optional Services for Medicaid-Eligibles
(September 1, 1972 to July 31, 1976) [1]

1.	Dental Services	140 [2]
2.	Therapy	63
3.	Dentures	44 [2]
4.	Prosthetic Devices	37
5.	Prescription Drugs	28
6.	Hearing Aids	15 [3]
7.	Chiropractor's Services	3
8.	Podiatrist's Services	2
9.	Private Duty Nursing	1
10.	Tuberculosis Institution for 65 or Over	0

[1] *The figure includes only denials of requests submitted in writing to the Division of Public Assistance, Central Office. That Division also handles numbers of informal telephone requests, which are not included in these figures.*

[2] *The figure excludes Delta Dental Corporation denials. Delta Dental Corporation currently reviews and evaluates all public assistance clients requests for care. These records were not readily available in Juneau for the study period. In FY76, Delta Dental denied 454 Medicaid adults for dental services and 20 Medicaid adults for dentures.*

[3] *Hearing aids were added to the Medicaid program as of November, 1976. An interpretation by federal officials of the treatment of speech, hearing, and language disorders option added last session allowed hearing aids to be covered as part of the treatment plan.*

program. If the client has no other prior health care resource equal or better in coverage to that of General Relief-Medical (GRM) Program, that client may be able to receive those services through GRM. Since GRM is funded entirely by state general funds, monies are strictly controlled and extremely limited. In order to insure the equitable use of the funds, many services require pre-authorization by the Central Office of the Division of Public Assistance before they can be provided and paid for by the General Relief-Medical Program.

Requests for service can come in two forms: letters and phone calls. The Division of Public Assistance maintains files of only written requests for service. During the month of July, 1976, a tabulation of those records was performed. Table 4 shows the number of denials of optional services which were requested by Medicaid clients during the period September 1, 1972 to July 31, 1976.

Note that the top four options that eligibility work supervisors felt their clients needed appeared within the top five items requested for those clients. Thus, the public assistance supervisors confirm the client perceived need for dental services, therapy, dentures, and prescription drugs. The survey also revealed a client perceived need for prosthetic devices (such as artificial limbs, crutches, canes, etc.).

These tabulations of requests for service represent only written requests. Because of the "emergency" nature of some services and the ease of telephoning for approval, many denials of services are not represented in the written files. Also, many clients will not request a service which they know is unavailable or which they stand a likelihood of being denied. Clearly, then, these figures substantially under-represent client need.

RESULTS OF STUDY

1. Basically State of Alaska eligibility work supervisors feel that their Medicaid-eligible clients most need:

1. Prescription Drugs
2. Adult Dental Services
3. Dentures*
4. Physical Therapy and Related Services*

* *The rank order of these services varies by program which client is receiving aid. The adult public assistance clients are seen to need dentures much more frequently than do clients of Aid to Families with Dependent Children.*

2. The top four services that eligibility work supervisors feel that their Medicaid-eligible clients ask for most frequently are:

1. Adult Dental Services
2. Dentures
3. Prescription Drugs
4. Physical Therapy and Related Services

3. Records of "denials" of requests for services to be provided from the General Relief-Medical Program to Medicaid recipients indicate that the following services are requested and denied most frequently:

1. Dental Services
2. Therapy
3. Dentures
4. Prosthetic Devices

4. The records for the number of client requests generally underestimate client need because only written records are available and because many public assistance clients will not request a service which they know is unavailable or which they stand a likelihood of being denied.

PART V. ANALYSIS OF OTHER STATES' EXPERIENCE WITH SELECTED OPTIONS

OVERVIEW OF STATES PARTICIPATING IN SELECTED OPTIONS

The survey of denials of requests for services and tabulation of the responses to the questionnaire sent to the public assistance supervisors point to four service options which clients are perceived as needing most. These are: prescription drugs, adult dental services, dentures, and physical therapy and related services.

These optional services have been elected by many other states. For example--

- 96% of all states and United States protectorates have Prescription Drug Option *
- 64% of all states and United States protectorates have Dental Services Option *
- 60% of all states and United States protectorates have Physical Therapy and Related Services Option *

**Only states participating in Medicaid program are included in total figures. Data are as of June 1, 1976 and were obtained from United States Department of Health, Education and Welfare. (Data are unavailable on the number of states offering denture service to their eligibles.)*

Many states added these services in the mid-1960's when Medicaid first began. However, it was found that some states eliminated or restricted some of these options during the period January 1, 1975 to July 1, 1976. With the skyrocketing cost of medical care and the increasing demand upon state dollars, we decided to review the options that were selected as needed by public assistance supervisors and contact those states that had recently modified them.

QUESTIONNAIRE OF STATES MODIFYING SERVICES

In early December, the Research Division of the Legislative Affairs Agency prepared a questionnaire to ask the views of state Medicaid program administrators regarding the options they had recently restricted. Fourteen states that had recently modified optional services included in this survey were contacted. Eleven states (or 79%) responded to the questionnaire. Since existing federal reports do not pinpoint the number of states modifying their denture coverage, that option was not included in the discussion.

State Experience With Prescription Drug Option

Of the 51 states providing prescription drugs, 11 states (or 22%) reduced their coverage during the period of January 1, 1975 - July 1, 1976. Seven of those states responded to the questionnaire. The majority of those states reduced coverage of drugs in order to reduce expenditure of state dollars. They noted that it created a hardship, but most clients felt coverage of only certain drugs was better than no coverage at all of them. Basically, controls were maintained by limiting the number of monthly prescriptions any one client could obtain and by limiting the types of drugs covered.

It is interesting to note that one state, Oklahoma, added the drug option during this period. In responding to the questionnaire, the director of the Oklahoma program stated that the option was added at the direction of their legislature. Certain administrative restrictions were imposed when the option was added. Prescriptions were limited to three per client per month and the different categories of drugs were also restricted. The director noted that public reaction to the addition of services has been generally favorable.

State Experience With Dental Services Option

13% of the states which chose the dental services option eliminated it during the period January 1, 1975 to July 1, 1976. (Recently two states, Massachusetts and New Jersey, have reinstated coverage of this option). Five of the seven states eliminating this option responded to the survey.

Generally, these five states found that the adult dental services option was needed by clients and was easy to administer. Restrictions on the option were basically due to lack of state funds. In one instance, New Hampshire, the legislature set a priority list of services that were to be provided. Since adult dental services received a low priority and funds were limited, the option was dropped. The dropping of the option generated considerable negative client reaction, as evidenced primarily by an increased number of client administrative appeals on this issue.

State Experience With Physical Therapy and Related Services Option

Michigan was the only one of 32 states which included physical therapy and related services in their programs and chose to modify that option during the period January 1, 1975 to July 1, 1976. The Michigan Medicaid program responded to the questionnaire and noted its experience with the option. The respondent found that the option was needed by clients; however, the cut, an elimination of physical therapy in long term care institutions, was made in response to lack of sufficient funding. To date, this change in the program has not been rescinded.

RESULTS

1. At least 60% of all states participating in the Medicaid program also cover some form of prescription drugs, dental services, and physical therapy and related services options for their clients. These services were among the top four requested by Alaska public assistance clients and seen as needed most for them according to a survey of Alaska public assistance supervisors. (Nationwide data on the numbers of states covering dentures in their programs are not available.)

2. Two of the top four services seen as needed for public assistance clients, prescription drugs and dental services, were also the top two services restricted or eliminated by other states during the period January 1, 1975 - July 1, 1976. (See Part IV for survey results.)

3. Most states modified the options to reduce expenditure of state funds. They did not drop or restrict them because of lack of client need or complexities in administration.

4. Restrictions of service options were generally done in four ways: limiting coverage of service, limiting client access, reducing provider fee payments, and charging clients small fees.

5. Reduction of fees generally brought strong reaction by the provider sector.

6. The states believe that limiting coverage to certain number of services allowable per month and restricting coverage of type of service allowable under the option was generally more acceptable than totally eliminating it.

7. In most cases, states modifying these options chose to restrict prescription drug coverage but they chose to eliminate dental services (except as was required under the early screening program).

8. In some cases states reinstated changes in options a short time after they were made. This was generally due to the strong reaction received from the groups affected.

PART VI. CONCLUSIONS TO THE STUDY

From the responses to the questionnaire sent to public assistance supervisors concerning client need, the survey of denial records of requests for additional services, and the responses from other states regarding their experience with the program, the following conclusions can be drawn:

1. Of Medicaid optional services available that Alaska does not currently provide under its program, public assistance clients appear to need most(in descending order of need):

   (1) Prescription Drugs
   (2) Dental Services
   (3) Dentures*
   (4) Physical Therapy and Related Services*

   * *The rank order of these services varies by program under which client is receiving aid. The adult public assistance clients are seen to need dentures as a higher priority than do clients of Aid to Families with Dependent Children.*

2. Three of the optional services listed in Item #1 are included by over 60% of the states participating in Medicaid. Prescription drugs, for example, are included in 95% of all state programs. (Data on coverage of dentures are generally unavailable on nationwide basis.)

3. Two of the options that clients "need" most--prescription drugs and dental services--topped the list of options that states reduced or eliminated during the period January 1, 1975 - July 1, 1976. These modifications were done as cost containment measures and not as a response to lack of client need or to complexities of administering the options.

4. Alaska could be reasonably assured that services listed in Item #1 would be needed and used by clients. The choice to include them appears to be a decision based primarily on the state's availability of state funds. The state could choose to cover an option, but restrict that option in many ways to meet funding limitations.

GLOSSARY OF TERMS

AB - See Aid to the Blind.

AD - See Aid to Disabled.

ADC - See Aid to Families with Dependent Children.

AFDC - See Aid to Families with Dependent Children.

APA - See Adult Public Assistance.

APD - See Aid to Disabled. Stands for Aid to Permanently Disabled.

Adult Public Assistance - A cash supplemental program administered by the state in cooperation with the U.S. Department of Health, Education, and Welfare. Designed to provide a state-legislated level of cash assistance to aged, blind, and disabled persons who meet certain income and resource requirements, and who are predominately eligible for Supplemental Security Income (SSI) payments. State administrative costs as well as actual cost payments are 100% state only costs.

Aid to the Blind - A cash supplemental program administered by the state in cooperation with the U.S. Department of Health, Education, and Welfare. Designed to provide a state legislated level of cash assistance to those eligible blind persons who meet certain income and resource requirements, and who are predominately eligible for SSI payments. It is considered an "Adult Public Assistance" program.

Aid to Disabled - A cash supplemental program administered by the state in cooperation with the U.S. Department of Health, Education and Welfare. Designed to provide a state legislated level of cash assistance to those eligible disabled persons who meet certain income and resource requirements and who are predominately eligible for SSI payments. It is considered an "Adult Public Assistance" program.

Aid to Families with Dependent Children - A federal program administered by the state through an approved state plan filed with the U.S. Department of Health, Education, and Welfare. Designed to provide a state-legislated level of cash assistance to dependent children who have been deprived of one or both parents, and who meet certain income and resource requirements. Both administration costs and the actual cash payments provided to recipients are shared equally (50%) by the state and federal government.

Categorical Assistance - Aid, in form of income maintenance, to certain needy persons who receive assistance under Old Age Assistance, Aid to the Blind, Aid to the Disabled, Supplemental Security Income, and Aid to Families of Dependent Children programs.

Compliance - In a federal program, the act of performing certain set program functions in accordance with those requirements outlined in the state plan, federal law, and regulation. Generally, meeting all federal program requirements is necessary to receive federal financial participation in the program.

DHSS - See Department of Health and Social Services.

Department of Health and Social Services - A department of the executive branch designated to be single state agency to administer the Medicaid program for the state of Alaska.

EPSDT - See Early and Periodic Screening, Diagnosis and Treatment.

Early and Periodic Screening, Diagnosis and Treatment - A mandatory service under Medicaid which provides for special check-ups at set intervals for certain needy children, in order to find and treat health problems before they become serious. Coverage includes only those Medicaid eligibles under 21 years of age.

Eligible - A person qualified to receive assistance funded under particular program. Eligibility criteria can vary, so that eligibility must be established on program by program basis.

FFP - See Federal Financial Participation.

Federal Financial Participation - The means by which the federal government asssists in supporting certain specific program. The federal government generally provides aid by two methods: 1) matching dollars by set percentage or 2) formula money grants.

GRM - See General Relief-Medical.

General Relief-Medical - A state emergency medical program designed to respond to immediate medical needs of Alaskan families in time of extreme financial crisis. All assistance rendered under this program is in the form of vendor payments to medical providers. State administrative costs as well as actual cash payments to vendors are 100% state-only costs.

Intermediate Nursing Care - An optional service available to be provided under Medicaid program. Denotes a less intensive and less expensive level of around-the-clock nursing care, in comparison to skilled nursing.

Mandatory Coverage - A portion of the Medicaid program that is required to be covered by each and every state in the program, in order for the state to be entitled to federal financial participation. Mandatory coverage items concern persons eligible to receive services and the services provided to those persons. States can still administratively "control" mandatory services and not jeopardize federal financial participation by controlling the amount of service available to client, amount of financial participation (deductible required to be paid by client) in order for the client to receive such services, and other mechanisms.

Medicaid - A federal assistance program established by Title XIX of the Social Security Act and administered by the state through an approved state plan filed with U.S. Department of Health, Education, and Welfare. Designed to provide medical coverage for recipients of Aid to Families With Dependent Children; Supplemental Security Income, elderly and blind recipients of Adult Public Assistance and those disabled persons who meet federal definitions of disability; and certain other groups. State administrative costs are shared equally (50%) by the state and federal governments, except for professional medical support personnel who are funded at 75% federal reimbursement. Actual medical vendor payments are shared equally (50%) by the state and federal government, except for family planning which is funded at 90% federal reimbursement.

Medically Needy - An optional group of eligibles for whom federal reimbursement for necessary medical care may be covered under the Medicaid program. Generally includes individuals who have insufficient income and resources to meet the costs of necessary medical or remedial care and services. Presently Alaska does not include the medically needy under its Medicaid program.

Medicare - An insurance program administered solely by the federal government to provide payments for necessary medical care for those people, rich or poor, who receive Social Security payments.

OAA - See Old Age Assistance.

Old Age Assistance - A cash supplemental program administered by the state in cooperation with the U.S. Department of Health, Education, and Welfare. Designed to provide a state legislated level of cash assistance to those eligible persons 65 and over who meet certain income and resource requirements and who are predominately eligible for Supplemental Security Income payments. It is considered an "Adult Public Assistance" program.

Option - A portion of the Medicaid program that is discretionary on the part of the state. Options generally deal with persons eligible for coverage or medical services available for those eligible persons. Options are set out in federal law and regulations and are generally eligible for federal financial participation. Since the choice of options is up to each state, options can generally be designed to fit the state's unique needs and available resources, but each option chosen must meet certain broad federal program requirements.

Public Assistance - A division of Department of Health and Social Services, responsible for administration of the Medicaid, General Relief-Medical, and Income Maintenance programs. This division determines the eligibility of state's residents for such services by carefully reviewing the person's income, resources, and other factors according to state and federal standards.

Quality Control - An office of the Department of Health and Social Services which is assigned the responsibility to verify that

randomly selected cases are eligible to receive services in month that service was rendered. The verification consists of check of files, client contact, and collateral sources.

Recipient - A person receiving income maintenance or assistance services funded under a particular program.

SSA - See Social Security Administration.

SSI - See Supplemental Security Income.

Skilled Nursing Care - A mandatory service required to be provided under the Medicaid program. Denotes highly professional round-the-clock nursing care and monitoring. Generally more expensive and more specialized care than intermediate care.

Social Security Administration - An agency of the federal Department of Health, Education and Welfare assigned the responsibility to administer Social Security, Medicare, and Supplemental Security Income programs.

State Plan - A contract between the single state agency to administer the Medicaid program and the federal Department of Health, Education and Welfare, specifying conditions to be met in order to be eligible for federal financial participation.

Supplemental Security Income - An assistance program funded and administered by federal government which provides payments to certain needy persons who are aged, blind, or disabled and meet program and financial requirements. Payments are uniform nationwide and are based on need.

Title XIX - A portion of the federal Social Security Act which outlines the Medicaid program.

Title XVIII - A portion of federal Social Security Act which outlines the Medicare program.

Utilization Review - Random records check of sample institutional Medicaid billing to insure that services rendered match with those billed to the program. Verifies that institutional records are complete, accurate, and up-to-date. Examines for overuse or misuse of treatment and professional resources and the patient's duration of stay relating to those resources.

Georgetown University Health Policy Center
Seminar on State Health Insurance Plans
Mayflower Hotel, Washington, D.C.

September, 1977

THE POLITICAL PLANNING OF A STATE HEALTH INSURANCE PROGRAM

By Senator Donald D. H. Ching
Majority Leader
Hawaii State Senate

The concept of prepaid health care based on mandatory employment-related coverage was a brand new idea when first introduced in the Hawaii Legislature in 1971. It became law three years later as Act 210 of the 1974 legislative session.

Enactment of our Prepaid Health Care Law climaxed several years of lively discussion in the Legislature, and for many of us who supported it, Act 210 marked yet another milestone in the growing body of progressive legislation placed in our statutes since our Islands became a sovereign state in 1959.

Measured against the national background, the law represented a significant achievement in terms of social progress. Yet, while there was much discussion between introduction and enactment, the proposal was not widely viewed as politically controversial by the public at large. As a matter of fact, in my nearly 20 years of experience in our Legislature, I have seen a lot more heat generated over issues of considerably lesser public import.

To be sure, there was resistance and opposition from the traditional opponents of so-called "social legislation." But there was not the hue and cry that one might expect, considering the novelty of the concept.

This is not to say that the spectrum of political thought in Hawaii does not cover any ground to the right of center. Let me assure you we do have traditional conservative views held by many in our State, and I, for one, believe this is a healthy condition. But to the credit of those who did not adhere to the concept, their opposition was not based on the emotionalism that too often attends and distorts vital public issues of the day.

I believe the law was generally accepted by the public because of the kind of political climate we have in Hawaii and because the law was viewed as a logical extension of the kinds of programs that were already in effect at the time.

Let me briefly describe our Prepaid Health Care Law, then attempt to present an account of its chronological place in the context of Hawaii's legislative history.

The Act requires virtually every employer in the State to provide regular employees a health insurance program and to contribute at least one-half the premium cost for the employees' coverage. The major categories of employees excluded are insurance and real estate salesmen paid entirely by commissions and individuals under 21 working under a parental relationship.

The employee's contribution is limited to no more than 1.5 per cent of his monthly salary. A "regular" employee is defined as one who works at least 20 hours a week, excepting seasonal hires in Hawaii's pineapple industry.

Health plans negotiated under collective bargaining agreements are exempt because such negotiated benefits are, for the most part, more liberal in coverage or employer contributions than required under the Act.

An employer can elect to provide a plan which obligates the insurer to either reimburse the expenses of health care or to directly furnish the required health care benefits. The level of benefits provided must be equal to or medically reasonably substitutable for those benefits provided by prepaid health care plans of each type -- direct or reimbursed -- which has the largest number of subscribers in the State. In Hawaii, the standards are thus based on the Kaiser Health Foundation's Plan I, in the case of direct services, and the Hawaii Medical Service Association's (Blue Shield) Plan IV, in the case of reimbursed expenses. Both the Kaiser and HMSA plans are basic, comprehensive medical plans emphasizing ambulatory care.

Plans offered by other insurers may be provided, upon review and approval of a seven-member advisory council comprised of consumer, employer, medical profession, and health plan representatives.

What kind of coverage is required by our law? Every qualifying plan must include the following:

-- 120 days of hospital benefits, plus outpatient services.

-- surgical benefits, including anesthesiologist services.

-- medical services, including home, office, hospital visits, and intensive medical care.

-- laboratory, x-ray, and radio-therapeutic services necessary for diagnosis and treatment.

-- maternity benefits, provided an employee has been covered for nine months prior to childbirth.

-- and, under an amendment added last year, substance abuse benefits for alcoholism and drug addiction, including outpatient services and detoxification and acute care benefits.

The foregoing summarizes the basic provisions of our law.

How, then, did we come to enact what some may view as an extremely liberal mandatory health insurance program?

First, it should be noted that we have a substantial body of progressive and advanced social legislation in Hawaii. This is true of our labor laws, our educational system, our public welfare program, and in our judicial system. For instance, our minimum wage law, wage and hour law, workers' compensation, temporary disability insurance, and unemployment insurance programs all have standards comparable to the highest in the Nation. In addition, we also have a public defender program and a criminal injuries compensation law. We also have a no-fault insurance law and a medical malpractice law, the latter amended this year to remove the mandatory feature and to permit doctors the option of forming cooperative indemnity plans to protect themselves against liability judgments.

Our public assistance program is so liberal it is causing us severe financial strains -- but that's another story, and I won't digress into it, except to note that we eagerly look forward to federal reform initiatives promised by the Carter Administration.

The political foundation for eventual enactment of our prepaid health care law was further set during the mid-sixties in a program popularly labeled "The New Hawaii," adopted jointly by the legislative majorities and the Administration.

During this period, dramatic changes were advanced in terms of Hawaii's social, economic, and political conditions. Basically, the stated objective was to enact laws and programs to insure equal treatment and equal opportunities for all citizens. If this sounds simplistic, it should be borne in mind that Hawaii was pretty much the political domain of the sugar and pineapple plantation interests up until the end of World War II and that when, for the first time in our history, we elected a Democratic Governor and Democratic majorities in both houses of the State Legislature in 1962, there were not a few who thought the revolution was at hand.

But the changes we sought were achieved in orderly, not revolutionary, fashion. And there was early ferment for novel and innovative legislation to extend equal opportunity in basic human concerns to all segments of our society.

It appeared logical to move toward some form of mandatory prepaid health care law. The question then was how best to extend coverage to the uninsured working men and women

of Hawaii and thereby provide them "equal treatment" as a matter of social equity. Moreover, how could this be best achieved without any substantial added costs to the State, bearing in mind that our centralized system imposes unusually heavy financial burdens on the State?

To determine cost factors and the numbers and classes of employees in the uncovered "gap group. a study was commissioned through the Legislative Reference Bureau, the Legislature's principal research arm. Dr. Stefan A. Riesenfeld, former University of California law professor and a widely recognized authority on social legislation, now counsel to the U.S. State Department, was selected to do the research. Professor Riesenfeld had prepared an earlier report for the Legislature on temporary disability insurance, which study was extremely valuable to us in enacting our TDI law in 1969.

The Riesenfeld report, published in 1971, was a thorough and comprehensive study. Acknowledging the difficulty of precisely quantifying need, the report generally concluded that, among the State's employed, 11.7 per cent did not have hospital coverage, 13.5 per cent lacked surgical coverage, and 17.2 per cent did not have regular medical insurance.

The existence of a significant number of otherwise uncovered potential beneficiaries of the proposed legislation formed the primary policy consideration of the program. Other factors considered included the rising costs of health care and the need to assue the most practical method of ensuring the financial availability of health care for Hawaii's working men and women. Thus, the overall health of our population was the over-riding concern; without ensuring the

ready accessibility of health care, how could optimum health care be maintained?

Data compiled and analyzed in the report were very thorough. Sources outside the State included the Health Insurance Association of America, the Health Insurance Institute, the Bureau of Labor Statistics, the Social Security Administration Bureau of the Census. Information from State agencies included data from the State Statistician and the Departments of Taxation, Planning and Economic Development, Social Services and Housing, and Labor and Industrial Relations. Data was also gathered from labor unions, the Hawaii Employers Council, the HMSA, Kaiser Foundation, and through questionnaires mailed to all employers covered by the Hawaii Employment Security Law.

Data used included statistics relative to the following:

-- Population by age levels, civilian and military. The latter distinction was important because of the sizeable permanent military presence in Hawaii.

-- Labor force, public and private.

-- Population entited to Medicare.

-- Extent of prepaid health plan coverage for hospital, surgical, and medical benefits, both for subscribers and dependents.

-- Size and type of business of private employers.

-- Medical assistance recipients and expenditures.

As indicated by the sources of data, the full range of interest groups became involved in the process, whether employer or employee oriented.

During our legislative committee hearings, testimony was presented by representatives of the insurance industry, the health professions, the University of Hawaii Schools of Public Health and Social Work, the Comprehensive Health Planning Council, and a wide range of individual citizens.

There was very little question as to whether the plan proposed would be comprehensive or catastrophic in its approach. The Riesenfeld report recommended the comprehensive coverage plan and specifically recommended the adoption of prevailing coverages in the State, which then became the legal minimum. This reflected the health care habits and patterns of the State and set a floor without unduly disrupting the existing schedules of coverage.

The decision to make coverage mandatory was central to the legislation proposed. Before enactment of Act 210, voluntary participation was, in effect, the public policy of the State.

As to the question of affordability, the only new cost factors imposed upon the State weere founded upon the administrative requirements of the law and anticipated premium supplementation.

Administration of the new program proved to be quite easy, as it was smoothly meshed in as a responsibility of the Disability Compensation Division of the State's Department of Labor and Industrial Relations. Thus, three important employee benefits programs were placed under one umbrella: the well-established Worker's Compensation Law; the TDI law passed in 1969; and the 1974 Prepaid Health Care Act. (Incidentally,

you may have noticed that what used to be known as Workmen's Compensation is now referred to as Workers' Compensation in our State, reflecting the many similar amendments we have adopted consonant to our accepted policy on equal rights.)

Much to our pleasant surprise, the administrative expenses of Act 210 have been comparatively low. Initially, we authorized 11 new positions in the Disability Compensation Division, with an appropriation of $250,000 in General Funds to cover salaries and other expenses. Much to the division's credit, Act 210 was implemented with substantially the existing staff. The first appropriation thus lapsed, and it was renewed this year at the same annual level on the expectation that additional personnel will be recruited during the next biennium.

A feature of Act 210 is a provision for premium supplementation financed by the State to cover employer premium requirements caused by limits imposed on employee contributions. This feature subsidizing employer contributions was included to provide a cost protection for marginal small businesses. Initially, $375,000 was set aside in a trust fund for premium supplementation. Again, to our pleasant surprise, there has been little need to supplement premiums. It's estimated that, to date, only some $20,000 to $30,000 has been tapped from the trust fund in subsidies. Meanwhile, the fund is held in an interest-earning status.

What are the numbers that actually surfaced as a consequence of Act 210? The division reports that about 18,500 employers have thus far been registered. However, the extent

of newly covered workers has been difficult to establish because many of the registered employers had voluntary programs in effect before Act 210. Dr. Riesenfeld has estimated some 40,000 employees were not covered at the time he conducted his study. The Disability Compensation Division is of the opinion that actually more than 40,000 received new benefits because of the requirement that employers cover at least half of the premium costs.

Of the 18,500 employers, all but some 1,000 have elected plans offered by the State's two major insurers -- HMSA and Kaiser. The approximately 1,000 employers who have opted for plans offered by other insurers are the major source of additional workload upon the division. Each submittal in this category must be reviewed by the advisory council.

The advisory council provision serves another purpose. During the course of legislative hearings on the act, public health advocates had expressed concern that the required benefits might be too rigid and unresponsive to changes in health care over the years. The Prepaid Health Care Advisory Council provisions were thus added to establish an appropriate agent to review medical equivalency of benefits.

To conclude, in light of Hawaii's experience, I believe any national health insurance plan should take into consideration the course that we have opted for. I am confident the standards we have set would meet any that a federal law would impose. As a means of encouraging other states to follow suit, or to adopt a true state plan such as Rhode Island's,

I suggest federal legislation provide support grants to at least cover administrative costs and any necessary premium supplementation expenses.

Finally, let me summarize the conditions that led to the successful adoption and implementation of Hawaii's Prepaid Health Care Act:

1 -- A political climate sympathetic to social needs.

2 -- Timeliness in terms of progressive improvements to the general body of social legislation already on the books.

3 -- A comprehensive study of a state's needs, to arm proponents with the information necessary to justify the proposed legislation.

4 -- Open discussion involving all interested elements within the public.

5 -- The last may be an element not very common to other jurisdictions, but I believe it was an important consideration in our own deliberations. This is the fact, well established in our study, that the majority of employees insured under voluntary plans or through government-employee programs were covered under plans offered by two major insurers in the State. Having a clear pattern to follow in prevailing benefits, it was easier to overcome resistance against extending similar benefits to all the State's working men and women.

I hope our experience and the foregoing thoughts presented for your discussion prove helpful to you in your own endeavors to develop plans for extending health care benefits to all others who need such coverage in our Nation.

Mahalo.

# # #

STATE HEALTH INSURE. #4

SECTION BY SECTION COMPARISON OF HB 977 AND SIMILAR LEGISLATION FROM OTHER JURISDICTIONS

SECTION 1	
18.12.010: requires employers to provide qualified coverage for regular employees and their dependents.	Based on Hawaii law except that minimum standard of coverage is based on prevailing coverage and dependents are not covered.
18.12.020: allows employers to select type of plan and contractor.	Based on Hawaii law.
large employers must provide employees with a "dual option" or choice of plan type to enroll in.	Based on Minnesota law.
18.12.030 - 18.12.130: details of employer coverage.	Same as Hawaii law.
18.12.140: premium supplementation.	Based on Hawaii law except that Hawaii sets up a separate fund.
18.12.150 - 18.12.200: existing plans, termination of chapter, and definitions.	Same as Hawaii law.
SECTION 2	
21.50.010: duties of insurers.	Same as Minnesota law.
21.50.020: certification of qualified plans.	Same as Minnesota law.
21.50.030: minimum benefits of qualified plan.	Based on Minnesota law except that Alaska law covers medically necessary transportation and alcoholism treatment, and Minnesota law delays the effective date of coverage for preventative care services.
21.50.040 - 21.50.150: details of state plan and administration.	Same as Minnesota law.
SECTION 3	
47.05.070 - 47.05.100: medical assistance by insurance or service contracts.	Same as Oregon law.

47.05.110: cash advances.	No model.
47.05.120: interest on late payments.	No model.
SECTION 4	
Extends Medicaid to all optional eligible groups.	No model.
SECTION 5	
Expands Medicaid coverage to optional services.	No model.
SECTION 6	
General Relief-Medically Needy program.	No model.
SECTION 7	
Expands AFDC and Medicaid coverage to unborn children.	No model.
SECTION 8	
Repeals AS 47.07.020(d).	Companion to SECTION 4.
SECTION 9	
Adjustment of Employer sponsored plans.	Same as Hawaii law.

GEORGE R. ARIYOSHI
GOVERNOR

TANY S. HONG
DIRECTOR
BANK EXAMINER
COMMISSIONER OF SECURITIES
INSURANCE COMMISSIONER

DONALD D. H. CHING
DEPUTY DIRECTOR

STATE OF HAWAII
OFFICE OF THE DIRECTOR
DEPARTMENT OF REGULATORY AGENCIES
1010 RICHARDS STREET
P. O. BOX 541
HONOLULU, HAWAII 96809

March 24, 1980

Representative Thelma Buchholdt
State Representative
District 9 (Spenard)
Chair, House HFSS Committee
Alaska State Legislature
Pouch V, State Capitol
Juneau, Alaska 99811

Dear Representative Buchholdt:

This is to acknowledge receipt of your letter of March 18, 1980, inviting me to testify on proposed legislation similar to Hawaii's "Prepaid Health Care Act." Because the subject matter is not related at all with the state department which I am presently serving, I originally could not justify my going to Juneau as official State of Hawaii business. However, my Director and the Governor both feel that if my presence would assist Alaska in enacting progressive health care legislation, I would be given leave to go to Juneau with Hawaii's experience in this field.

I have spoken with Ms. Sorice of your office and am making plans to arrive in Juneau on Sunday, March 30, 1980, and will be available to testify on March 31 and April 1, 1980, if necessary.

I am looking forward to being of any assistance that I can possibly render in your efforts to enact such a bill. I think it has been of much benefit to the people of the State of Hawaii.

May I give you a short biographical sketch so that you may use this in further evaluation of my testimony next week:

1. Member of the Hawaii Legislature from 1959-1978 (8 years-House of Representatives; 12 years-Senate).

2. Attorney-at-Law.

3. Former Vice-President of the Bank of Hawaii (1963-1979).

4. Presently Deputy Director of the Department of Regulatory Agencies, State of Hawaii.

5. Member of the Board of Directors-Hawaii Medical Service Association (Blue Shield and Blue Cross Plan) (1965 to present), presently serving as its President.

I have never been to the great State of Alaska, and I am looking forward to my first visit.

Very truly yours,

Donald Ching

Donald D. H. Ching
Deputy Director

cc: Ms. Jan Sorice

STATE OF MINNESOTA

Commissioner of Banks
(612) 296-2715
Commissioner of Insurance
(612) 296-2488

Commissioner of Securities
(612) 296-6848
Executive Secretary
(612) 296-2283

DEPARTMENT OF COMMERCE
500 Metro Square Building
St. Paul, Minnesota 55101

March 24, 1980

Ms. Jan Sorice
Health, Education & Social Services
State of Alaska
Room 108 State Capitol
Juneau, Alaska 99801

Dear Ms. Sorice:

This will confirm our telephone conversation today. You advised you are sending a copy of the proposed health legislation for my review prior to presenting testimony relative to Minnesota's experience with similar legislation known as the Minnesota Comprehensive Health Act of 1976.

My testimony will be heard between 1:30 p.m. and 3:30 p.m. on Monday, March 31. I shall report to your office at 10 a.m. for a final briefing prior to my testimony.

Enclosed is a copy of travel plans from Minneapolis to Juneau. You have graciously arranged for lodging March 29 through March 31 at the Baranof Hotel.

I look forward to meeting you, the interested members of your legislature, and visiting your capital city.

Sincerely,

John T. Ingrassia

John T. Ingrassia
Supervisor
Life and Health Section
Insurance Division

mw
enclosure

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FOR: Mr. John T. Ingrassia

REMARKS:

DEPART AND ARRIVE	CARRIER	FLIGHT	DATE	TIME DEPART	TIME ARRIVE	STATUS
FROM MPLS/St.Paul						
TO Seattle	Northwest	125	March 29	2:40PM	5:06PM	ok
TO Juneau	Alaska	69	March 29	7:05PM	9:20PM	ok
TO Seattle	Alaska	60	April 1	7:00AM	9:55AM	ok
TO MPLS/St.Paul	Northwest	50	April 1	11:30AM	4:22PM	ok
TO						
TO						
TO						
TO						
TO						

TR 5936 (9/77)

March 26, 1980

Honorable Thelma Bucholdt
Alaska State House of Representatives
Pouch V
Juneau, AK 99811

Dear Thelma:

I have enclosed a copy of Women for Political Action's position on health issues before your committee.

We furnished a statement to Susan Johnson at AKPIRG for use as a teleconference hearing on April 1, 1980 in Anchorage.

Very truly yours,

Linda O'Bannon

Linda O'Bannon
Chair, WPA Legislative
Committee
3281 Montpelier Ct.
Anchorage, AK 99503

LO/vlm

March 26, 1980

Women for Political Action, an Anchorage based organization, affiliated with the National Women's Political Caucus recognizes the difficulty that many low income persons in Alaska have in locating and procuring adequate medical care and services. Many of the Alaskans who are not receiving adequate medical care are women and children, who traditionally in our society have been without political power and who are often at the lower end of the economic scale.

Women for Political Action endorses the efforts of those legislators who are attempting to find the solution to the problem of inadequate medical care for low income Alaskans. In a State fortunate enough to be able to consider repeal of state income taxes and payments to its citizens from the permanent fund, it seems reasonable for that state to establish aid and support programs designed to promote adequate medical care of all of its citizens.

AMENDMENTS

p.5 line 3:(2) protected by health insurance or a prepaid health care plan established under a law of the United States other than as a beneficiary of a residual health care plan:

This amendment is mainly for clarification for the Native groups of the state; it ensures that they are eligible for the benefits of the legislation and that they are not excluded because of Indian Health Services.

p. 15, line 11: (O) substance abuse

This includes drug and alcohol abuse

p. 34 line 12: Sec. 8. AS 47.07.020 (d) is repealed

p. 30, line 7: Sec. 47.05.070. MEDICAL ASSISTANCE BY INSURANCE OR SERVICE CONTRACTS. (a) A person eligible for medical assistance may elect to obtain policies of insurance or health care service contracts in lieu of receiving medical assistance by direct payments to providers and upon such election, the commissioner shall use available medical assistance funds to purchase and pay premiums on policies of insurance or pay the expenses on health care service contracts or medical or hospital service contracts that provide one or more of the medical and remedial care and services available under state medical assistance programs.

This amendment lets the client choose between a health insurance policy or health care service contract and medical assistance by direct payments.

GEORGE R. ARIYOSHI
GOVERNOR

STATE OF HAWAII
OFFICE OF THE DIRECTOR
DEPARTMENT OF REGULATORY AGENCIES
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I have never been to the great State of Alaska, and I am looking forward to my first visit.

Very truly yours,

Donald D. H. Ching
Deputy Director

cc: Ms. Jan Sorice

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September 24-25, 1979

HAWAII'S PREPAID HEALTH CARE ACT

George Yuen

Director of Health, State of Hawaii

HAWAII'S PREPAID HEALTH CARE ACT

George Yuen

Director of Health, State of Hawaii

September 24, 1979

First of all, let me say that I am very happy to be in the backyard of the Denver Broncos and the Nuggets. As you know, Hawaii does not have a professional football team and neither do we have a professional basketball team so that, as a matter of practice, we adopt certain professional teams on the mainland and consider them as our "home team," so to speak. So I can say that we have alot of Bronco and Nugget fans in Hawaii. By the way, most of the games are televised live in Hawaii so we are in pretty close touch with what is going on.

Secondly, whenever I speak away from home, I really can't resist the urge to extend greetings to you from Hawaii, the youngest and healthiest state in the country. I say "healthiest" because, according to the latest U.S. census, the average citizen in Hawaii lives three years longer than the average resident on the mainland. Also we show the lowest incidence of killer diseases such as heart disease, cancer and stroke, and also the lowest rate per unit population of death due to accidents. Environmentally, we take pride in having the cleanest air and the cleanest water in the country, although some of you from the other states may dispute that, especially those of you from Colorado.

Coming back to the Hawaii plan--five years ago, Hawaii became the first state in the country to mandate employers to provide comprehensive health insurance for every full-time employee. Although our law is not perfect, we in Hawaii are very proud of this innovative legislation which is being reviewed by a number of states and by the federal government as possible model legislation. We view this law as yet another milestone in a very impressive record of progressive legislation enacted since Hawaii become a state in 1959. In this respect Hawaii is, in reality, a very unique laboratory for the nation.

Normally, in a presentation of this kind, one begins with a historical review and gradually leads up to the description of the plan itself. What I am going to do today is to give you a description of the plan first, followed by a little history, a discussion of our experience, and a listing of our recommendations after we have observed the plan in operation for five years. The plan became effective January 1, 1975.

I. WHAT ARE SOME OF THE BASIC PRINCIPLES OF HAWAII'S PREPAID HEALTH CARE ACT OF 1974?

1. Every regular full-time employee in private employment is protected by a prepaid plan providing for hospital, surgical, and medical coverage. Coverage for dependents of employees is not mandatory under the law. However, most employers in Hawaii do provide full or partial coverage for dependents. Normally, the employer chooses the health plan, unless collective bargaining is involved. We have found that benefits established under collective bargaining are usually equal to or superior to those specified in the Act.

2. The level of benefits provided must be equal to those of the most prevalent plan in Hawaii and must include certain benefits specified in the Act. Therefore, coverage of outpatient care as well as surgery and hospitalization

plus catastrophic coverage provided by the most prevalent plan is required of all carriers.

As a result, at least the following benefits are mandated:

a. hospitalization (full service, 120 days per year);

b. surgery and anesthesia;

c. medical services (home, office, and hospital);

d. diagnostic laboratory and X-ray services and radiotherapy;

e. maternity services; and

f. substance abuse services (including outpatient and inpatient services), mandated by a 1976 amendment to the Act.

In summary, a basic benefit package covering outpatient care as well as surgery and hospitalization plus catastrophic coverage ($50,000 - $250,000) is now required of all insurance carriers. In addition, I am proud and happy to point out that, entirely on a voluntary basis, and this is not required in the law, most of the carriers in Hawaii now provide for abortions and some coverage for mental health conditions.

3. Costs are shared by the employer and the employee. The employer pays at least half the cost of the coverage. The employee's share, in any event, is limited to 1.5% of his wages; we have calculated for employees receiving a minimum wage, this represents about $7 a month. The employee's share, in any event, is limited to 1.5% of his wages. We have found that many employers pay the entire cost of the premium as a fringe benefit.

4. Coverage can be arranged with any existing carrier who offers an approved plan. This includes Kaiser Health Maintenance Organization, Hawaii

Medical Services Association (HMSA), a nonprofit association offering both fee-for-service and health maintenance programs, and also commercial insurance companies like Aetna and Travelers and so forth, that may also participate in this plan.

5. Generally, the free choice of a physician by the employee is protected. At the same time the employer or often the employee can choose a health maintenance plan which will probably mean less out-of-pocket expenses for the employee.

6. Finally, an employer who fails to provide the required health coverage is liable for any costs incurred by his employees during the period when he failed to provide coverage and, in addition to that, fines are also assessed for noncompliance.

II. HOW IS THE ACT ADMINISTERED?

The Hawaii Prepaid Health Care Act is administered by the Disability Compensation Division of the Hawaii Department of Labor and Industrial Relations, with the assistance and support of an appointed citizen group. The name of this group is the Prepaid Health Care Advisory Council. The function of this council is to review all plans submitted by carriers for medical equivalency of benefits. All plans meeting the standards of our Act are approved.

Because this division already monitors temporary disability insurance, worker's compensation and unemployment compensation, only about a dozen employees were needed to monitor compliance with the new Act. The major carriers remain the primary fiscal agents.

III. HOW HAS THE LAW WORKED OVER THE FIRST FIVE YEARS?

A recent federally funded study of the impact of the law concluded that:

1. The law has not resulted in any identifiable strains on the health care system.
2. It has not caused recogn zable economic problems for employers.
3. It has not resulted in major dislocations among employers.
4. It has expanded health insurance coverage both in terms of the number of persons covered and the type of benefits received.
5. It has guaranteed an open competitive environment between the traditional fee-for-service system and prepaid health maintenance plan or the HMO.
6. It has made it possible for about 98% of the people to receive insurance coverage.

Good as it is, Hawaii's Prepaid Health Care Plan is not without shortcomings. I will go into that later, but I would first like to discuss the major factors which enabled Hawaii to pass and successfully implement the first mandatory comprehensive health insurance plan in the nation.

IV. WHY WAS HAWAII ABLE TO PASS THIS INNOVATIVE LEGISLATION?

1. Historically, plantation medicine played a major role in defining employer responsibility. At the same time, it supported the development of group or individual practice. Subsequently, large multi-specialty clinics were established stressing ambulatory care over hospitalization. About one-third of physicians in Hawaii are associated with these multi-specialty clinics. By comparison, about 12% of the physicians in the other states throughout the country are so associated. So that's a comparison of 33% to 12%.

2. Since attaining statehood in 1959, Hawaii has consistently shown a willingness to enact relatively liberal social legislation -- e.g. minimum wages, wage and hour requirements, worker's compensation, unemployment insurance, and temporary disability income. All of these were generously defined in terms of coverage, benefits, or requirements to protect workers.

3. In addition, the first years of Hawaii's statehood coincided with a period of economic growth and prosperity. As a result, costs of social benefits had not been of primary or overriding concern.

4. When the idea of a Prepaid Health Care Law was aggressively proposed, the Hawaii legislature in 1968 requested that its legislative reference bureau research the subject and prepare a comprehensive report on the subject. The report, prepared between 1969-1971, reviewed the various current approaches to compulsory or universal health insurance and noted the extent and scope of existing prepaid health care coverage. The study found that, of the total resident population, 88% of the people of Hawaii had hospital insurance, 12% did not, and 83% had medical insurance either under an insurance plan or a government-sponsored program, or 17% did not.

5. Perhaps most important, however, to the passage of the Act was the fact that the Prepaid Health Care Act only required what most employers--and virtually all of the major employers--were already doing. With close to 90% of the population covered, no major interest-group saw the proposed legislation as a significant threat.

Support for the proposal came from various health-related organizations such as the Hawaii Tuberculosis and Respiratory Disease Association, the State Advisory Council for Comprehensive Health Planning, and the Regional Medical Program. No labor unions opposed it and, in fact, one labor union, the ILWU, actually supported it.

The strongest objections, mentioned many times in opposing testimony during the period of legislative debate in 1971-74, was the idea that it would be inappropriate or unnecessary for Hawaii to enact such a plan because federal action on the subject of national health insurance was imminent. Events have since shown that fear to have been unfounded.

The Hawaii Medical Association recommended that "any action on the Hawaii Prepayment Act be deferred until such time as this national program comes into being." That's a medical profession. This objection was met by adding a provision in the Hawaii law mandating its termination on "the effective date of federal legislation that provides for mandatory prepaid health care for the people of Hawaii." So we have that proviso in the law.

The Health Insurance Association of America also opposed the bill, feeling that it was not necessary and that it would impose a financial burden on the people.

In general, opposition was regarded as being more a matter of preference, a matter of philosophy, or approach, than a matter of vital interest.

Other factors which, to account for the successful implementation of the Act, include:

1. The statutory requirements were based on a well developed existing administrative structure. The law is administered by the State Department of Labor and Industrial Relations in tandem with Worker's Compensation and Temporary Disability Insurance requirements. In turn, the benefit requirements are met through health insurance carriers.

2. Premium supplements from the state are available to employers who can show economic hardship as a result of the requirements for health insurance coverage. In other words, if an employer can show that his costs of coverage exceed 1.5% of his employees' salaries and that it exceeds 5% of his own income, he may apply for supplemental assistance from a fund which was appropriated by the legislature. I might say at this time that our data has shown that the number of applications for supplemental assistance has been very, very low. The legislature appropriated over $300,000 for that purpose and, during the first year of the application of the law, we spent less than $25,000 out of that amount for supplemental assistance. So the need for employers for help has been practically nil.

3. Hawaii's health care delivery financing systems have effective incentives and controls limiting hospitalization. This, in turn, helps keep costs down. Hawaii's hospital-use rate, adjusted for population differences, is about 45% of the rate throughout continental U.S. This does not appear to be due to significant differences in disease patterns (except possibly for terminal diseases among the elderly) but more to what doctors do in treating disease. Because of the high incidence of group practice, doctors in Hawaii tend to restrict hospital use to just serious illnesses. They tend to avoid hospitalization for conditions which can otherwise be handled on an ambulatory basis. Many of these doctors who participated in group practice have established very

well-equipped clinics. By group practice we mean 6 or more doctors being associated and practicing in a clinic. We have many of these well-equipped clinics and they have the benefit of peer consultation and so forth. This practice is further supported by reimbursement by all health insurance carriers for out-of-hospital treatment as well as inhospital care.

The net result is comparatively comprehensive and economical care for the residents of our state.

As I mentioned previously, Hawaii's Prepaid Health Care Act is not perfect.

V. WHAT ARE SOME OF ITS SHORTCOMINGS?

1. Coverage is not truly universal. In 1977, only 72% of the civilian population was covered by employer-subsidized premiums. A liberal Medicaid policy covers another 11%, about 7% are covered by Medicare and 8% by CHAMPUS. In short, an estimated 2% of the state's civilian population, or about 15,000 individuals, do not have adequate health insurance coverage. Among these are unpaid family workers (people who work in a family business), seasonal or part-time employees (these are employees who work less than 20 hours a week), temporarily unemployed persons, new employees (the law provides that you must be on the job for at least 4 weeks before you can qualify for coverage--some of these new employees are not covered), some immigrants are not covered, persons with marginal incomes but with assets too great to qualify for Medicaid, and some dependents of some employees are not covered. Naturally we are concerned about this so-called "gap group."

2. There are some gaps in coverage, especially dental care and mental health services which are not mandated, although limited mental health coverage became part of the package for certain of the large carriers.

3. The law lacks an implicit requirement for coverage of workers' dependents.

4. The uniform cost of the premium for all employees results in a regressive burden of costs, as the percentage of wages paid to health care decreases as wages increase. The co-payment aspect (about 20% of cost) of the fee-for-service often becomes burdensome for the working poor.

A major problem Hawaii faces is not with the implementation of the law itself, but rather a threat at the national level.

Through District Court action, Standard Oil Company of California successfully challenged the right of Hawaii to enact and enforce such a law, contending that through the Employee Retirement Security Act of 1974, Congress had pre-empted all state initiatives regarding employee benefits. Hawaii contends that this was not the intention of Congress, and that such legislation will deny states the right to try novel social and economic experiments without risk to the rest of the country. As the plantiff's contention was confirmed by a Supreme Court ruling rendered in November 1977, Hawaii is seeking remedial legislation through Congress.

This year marks the 10th anniversary of Hawaii's first steps toward a mandatory Prepaid Health Care Act, and the fifth year of its actual operation. We have found that this law, which formalized a health care delivery and financing system characterized by effective incentives and controls limiting hospitalization, works to provide about 98% of Hawaii's residents with comprehensive health care coverage. Hawaii has a health insurance system that is affordable, comprehensive, and virtually universal.

The relatively simple and cost-effective administration of the law by the Department of Labor, and the full cooperation of the insurance carriers to keep costs to a minimum, further contribute to its successful implementation.

Our present concerns are to extend this coverage to 100% of our residents and to assure that the high quality of health care in our state is not lowered or pre-empted by national legislation.

Looking into the future, we would like to see coverage extended to dental health, possibly the provision of hearing and visual aids and prosthetics, and definitely to a broad spectrum of mental health care. Cost of these services, together with catastrophic coverage and coverage for "gap" groups (especially immigrants), should be borne by the federal government within the framework of a national health insurance plan.

It is my belief that Hawaii's Prepaid Health Care Plan can serve as a model for a national health insurance plan, as we have testified in Washington several times, and we feel that it is also applicable to individual state plans. Today, mandatory health care is an integral part of life in Hawaii. It has been accomplished with a minimum of effort and cost to the taxpayers. It is our hope that we can convey to you a balanced accounting so that Hawaii's Prepaid Health Care Act and its operation can be readily understood and realistically assessed.

In closing, I would like to quote from a recent study on the matter:

> "Whether the experience of Hawaii should inspire emulation -- by other states of the United States -- is a policy matter. It is not our intention

> or appropriate function to advocate one form of legislation or another. But, we believe, it is clear that wider recognition of Hawaii's achievements in health care organization and financing is appropriate. Hawaii's experience gives some dimension as to what can be done."

It has been a pleasure for me to be here today to share our experience with you. I hope I have given you some idea as to what we are doing in Hawaii. Most importantly, I hope the State of Colorado will move forward vigorously and with vision to adopt a plan which will provide high quality health care for all the people, a plan that would entail minimum cost, and a plan which would be accepted by all. And in your move to achieve this, I hope we can be of some help to you. Thank you.

MINNESOTA HEALTH INSURANCE ACT

Brian Osberg

Administrative Assistant to the Minnesota House and Welfare Committee

September 24, 1979

Good afternoon. I have been asked to brief you on the workings of the 1976 Minnesota Law which has improved the availability and quality of health insurance coverage that has established a financial assistance program for families who incur high medical expenses. Respective articles of this law are referred to as the Comprehensive Health Insurance Act and the Catastrophic Health Defense Protection Act.

It is my understanding that the State of Colorado is currently evaluating alternative methods of financing medical expenses incurred by its indigent population. As I describe the Minnesota program, I will note its viability in terms of being a suitable alternative. It must be kept in mind, however, that the Minnesota Law was not enacted with the intent of providing medical assistance to the poor. Minnesota has a very extensive medical care system for the indigent. The State's Medicaid program covers the medical care system for the indigent. The State's Medicaid program covers the medically needy as well as categorical program recipients. Plus, we have a medical care program for the indigents who are not otherwise eligible for medical assitance. It is what we call the General Systems Medical Care Program, financed by the State and local counties. What the Minnesota Legislature recognized and sought to correct was the poor standard of existing health insurance policies, the unavailability of coverage for the high risk population and the exhaustion of resources of families who were unfortunate enough to incur high medical expenses. Our programs are primarily geared to middle class and working populations; however, I believe that they could be adapted to serve the poor and the near-poor.

The 1976 law consists of three articles:

- Article I establishes minimal standards for health insurance policies and creates an insurance pool for persons unable to buy coverage, because of an existing health condition.
- Article III provides for financial relief to households which incur high medical expenses; i.e. our catastrophic program.

Concerning Article I, I plan to concentrate my remarks on the insurance pool; however, I do want to briefly review the changes in our health insurance laws, as well. The objective of this article is to:

1. upgrade health insurance policies, and
2. increase the availability of insurance coverage.

Concerning the first objective, we established minimal insurance standards and in establishing those standards, the article outlines the duties of the insurors and the employers. All health insurance companies doing business in the State of Minnesota are required to offer what the law defines as a qualified health insurance plan. The qualified plan must pay at least 80% of the cost of covered services in excess of an annual deductible. These covered services, or minimal benefits as it is sometimes called, are itemized in the statute. This does not prohibit insurors from developing and selling an unqualified plan; however, they must offer a qualified plan so that the enrollee has the opportunity to purchase a comprehensive policy. Employers who make available to their employees the health insurance plan, must offer a qualified plan to those employees. This does not necessarily mean they have to finance the plan, however; it can be financed from funds contributed solely by the employer or solely by the employees, or a combination thereof.
Again, I do not want to dwell on that portion of the law. If you have any questions conerning the health insurance statute, I will be glad to answer them.

The second aspect of Article I is the creation of a Comprehensive Health Association, for purposes of operating a Health Insurance Plan, or what we call a State Pool, to those who are uninsurable. This association, which is made up of all health insurors doing business in our State, is responsible for selecting a writing carrier to administer this Plan. The writing carrier is Northwestern National Life at the present time. In accordance to administrative rules, any person who has been turned down by two private insurors, or who has a presumptive condition, such as kidney disease, is elegible for enrollment in the Plan.

The Insurance Plan was intended to be self-supporting. The premium for the first 18 months of the Plan's operation was set equal to the average premium charged for equivalent policies offered by the five largest insurors in each planned category. In other words, for a group plan, we took the five largest insurors in Minnesota doing group plans and averaged their premium. This average then became the charge for the premium during the first 18 months of the operation of the pool. After that time, it was to be based on actuarial experience, to be self-supporting, but that did not work out as well as planned. The rate of claim expense was so high that the Association feared an increase of 100% in the premium rate would be necessary. With the possibility of a forbidding premium increase staring the Legislature in the face, they placed a cap of 125% on the average premiums charged in order to make the plan affordable. We replaced that cap in a rider in an appropriations bill. We have now put it in statute; however, this has caused some problems, which I will explain later. With that, in 1978 the Legislature appropriated $200,000 to the Association to pay for any claims over the premiums generated. In other words, we are going to subsidize them to a point, realizing that if we are going to put a cap on, we certainly could not allow the Association to bear all the losses of the plan. However, a long-term solution on the financial stability of the Plan was necessary. During the last Legislative

session, the Legislature decided that the State should assume the financial responsibility of the Plan. The 125% cap on those premiums remained intact, and any losses incurred due to the operation of the plan would now be assumed by the State.

At the present time, we have only 1,500 policies in force in this uninsurable pool, a figure much lower than what we projected. It is either a problem of marketing or we simply overestimated the number of people who needed such protection. I think we overestimated the number of uninsurable or high-risk people in need of this kind of protection. We also have trouble marketing the plan but I don't believe that is the major problem at this point.

The question at hand, however, is whether or not the State should expand the population of this pool to include low-income individuals. This would probably involve a premium subsidy program, based on the ability to pay. The advantages would be twofold:

1. We could improve the experience of the plan due to the inclusion of a healthier population. This would especially be true if we included other poor-risk groups, such as small contracts, self-employers, and others who have difficulty in getting access to health insurance coverage.

2. We would provide protection to a population that has fallen through the assistance crack. I am referring to families who make between $5,000 and $10,000 a year, for example; too rich to receive public assistance in our State, too poor to afford health insurance coverage.

In our incremental approach to protect Minnesotoans from high medical costs, the low-income or working poor as we call them, will be the next group to receive consideration. Thus, I believe that medical expense protection

can be provided to the near-poor through an insurance pool with an appropriate premium subsidy program. I do not believe that it is the answer for the indigent who are categorized as medically needy, though it may be feasible. It would depend on the nature of the subsidy program and the extent of the use of deductibles and co-payments of the Plan. I will be happy to share my thoughts on the effectiveness of the creating of a health insurance plan for uninsurables, or the working poor. For a closer look at this section of the law I would refer you to a publication by John Stone, entitled appropriately, THE MINNESOTA COMPREHENSIVE HEALTH INSURANCE ACT OF 1976.

Some final thoughts on the first Article of this Law. We received some resistance from the insurance industry, as expected, though most of the Minnesota-based companies are now in support, or at least not in opposition. There has been litigation initiated by some foreign insurors, challenging certain portions of the Act. I expect that the State will win that lawsuit; however, a separate challenge involving self-insurors seeking preemption from ORISA does not look as hopeful. That lawsuit should be decided soon. It will be very interesting, not only for the State of Minnesota, but across the country, in terms of establishing such plans.

If the State of Colorado decides to develop an insurance plan to increase access to coverage, it should include all poor-risk population groups; the near-poor, high-risk, self-employed and possibly small contract groups. You should not do what we did in terms of financial responsibility; i.e., do not make insurance companies—in other words, the members of the Association or whatever group you establish--responsible for losses of the pool; the State should take on that burden. The reasons for this approach are:

1. to keep the premium rate affordable,
2. the State can change or adapt that program to meet other population groups,

3. to avoid constitutional questions which have been raised in Minnesota.

I want to touch briefly on Article II of the law which is called the Hospital Rate Review Program. When you talk about increasing the access to insurance protection and mandating certain benefits, you have to talk about cost, which is the purpose of this Article. Article II establishes a system of reviewing hospital acute care rates, by a non-profit rate review organization, with direction and supervision given by the State Health Department. We have been quite encouraged by the results of this process. If the hospitals comply to their approved budgets, acute care rates will rise only 9 to 10%, compared to 14% a few years ago. I understand that the State of Colorado has considered abandoning their rate review or rate setting system. I'm not advocating rate setting, but I do want to press the need for some kind of cost containment efforts, particularly when you talk about increasing your programs to include the medically indigent.

Cost containment is essential as a State begins to commit its natural resources to the payment of medical services for the poor. We have begun to look at ways of instituting market forces into the health care system as a way of creating competition on a price basis. For example, the development and promotion of HMOs and other alternative health care plans have begun. Many believe that this is preferable to governmental regulation when addressing the cost problem. Minnesota has Interstudy which has been supporting HMOs, and other market forces in the health system in lieu of governmental regulation. We are looking at these options very seriously this year.

Moving on to Article III, or the Catastrophic Program. As I indicated earlier, this Act provides financial relief to individuals who incur catastrophic medical expenses. Under the program as initially enacted, in 1976, the State pays 90% of qualified expenses for which no third-party is liable

in excess of a threshold figure, which is calculated by an income-related formula. These qualified expenses are those minimal benefits listed in Article I, of our law. Let me give you an example of how this works. If the household income of a particular family is $20,000, the State will pay 90% of out-of-pocket medical expenses exceeding $8,500 (that $8,500 is calculated in our income-related formula). If the family has incurred out-of-pocket expenses of $100,000, the State will pay $82,350, with the remainder being the responsibility of the family. That is how the program worked when the law was passed in 1976. The income-related formula, for purposes of calculating the threshhold figure, was as small as 40% of the first $15,000 of household income, 50% of the next $10,000, and 60% of any income over $25,000, with a minimum of $2,500; in other words, a family had to incur, not necessarily pay, but incur $2,500 before the State comes in. Due to the low rate of the utilization of the program, those percentage figures have been reduced, and the $2,500 minimum has been removed.

What is important to note and remember here is that our program has two criteria:

1. the household income of the family, and

2. the amount of out-of-pocket medical expenses incurred by the family.

This income formula can be adjusted depending on the level of financial commitment that the State is going to make. Unlike other states' catastrophic programs, specifically Rhode Island, we do not include the amount of health insurance carried by the family, as a criterion. We considered this, however, it appeared to us to be discriminatory.

The catastrophic program has unlimited success, to say the least. The Legislature appropriated $8,000,000 for fiscal year 1978, of which only $252,000 was expended. In my opinion, there are four reasons for the low utilization.

- First, the threshold figures in the formula were simply too high. As I said, they are being adjusted down; for example, instead of 40% of the first $15,000, next year they will be 30% of the first $15,000 of income, and the year after, it will be 20%. This was put into one of our riders in the appropriations bill, but it was not codified, so in another two years, we could revert back, but I doubt that. I expect that in the next two years, we will codify those percentage reductions.
- Second, we have mandated a limitation of $3,000 on out-of-pocket expenses for qualified health insurance policies issued in Minnesota, thus, diminishing the need for catastrophic coverage. We do not even allow for an actuarial equivalency to our catastrophic coverage that we require in our health insurance policies provided in Minnesota. Thus, it is very important; if nobody has to pay more than $3,000 out-of-pocket during a one-year period, they are not going to reach the threshold figure in our catastrophic program. So, the people who have access to qualified health plans, which is a great majority in Minnesota, will simply not benefit from the catastrophic program, due to the high-threshold figures, and due to the structure of the formula itself.
- Third, the program is administered by a county welfare agency which is probably not the preferable office, since the people seeking assistance are not on welfare, and a stigma seems to exist that catastrophic insurance is then a welfare program.
- Fourth, the Minnesota Department of Public Welfare restrictively interpreted the array of services covered in the catastrophic program. This has not been resolved, but I expect some alterations to the State Department rule on the services covered.

In spite of the changes in threshold figures and services covered, I

do not expect a major increase in the program's expenditures. Though the Legislature appropriated $6,000,000 for the current fiscal year, again I do not think we are going to spend that much money. We are closely watching Rhode Island's program and watching our experience and maybe in our third and fourth year we may indeed see the kinds of increases that Rhode Island has had in their program.

In an analysis prepared by our Department of Public Welfare, it was found that during the first 14 months of the program, there were only 149 eligible cases. Two-thirds of those cases were between the ages of 45 and 65, and one-half of the patients were suffering from either cancer or heart disease. We also found that almost one-half of the patients had no health insurance coverage of any type. It was feared that this program would be relied upon as an alternative to health insurance. We see no evidence at all of that occurring; that is, we do not see people abandoning their insurance policy in order to take the risk and then rely on catastrophic as a last resort. It is also interesting to note that 75% of the cases involved families of household incomes of less than $10,000. In other words, this program, without our intention necessarily, is being utilized primarily by the working poor or near-poor. This is explained by the fact that most of the cases were chronic in nature and these people may be limited in generating the high income.

Before I get into some final comments in this program, as a viable approach to providing medical assistance to the poor, I want to review another section of the Catastrophic Law which I suggest you do not consider. This section is the payment of nursing-home expenses for persons under the age of 65, who have resided in a nursing home for more than 24 months. This was a provision tailored for a very, very persistent lobbyist or citizen in the State Legislature. Initally, it was for anybody under the age of 65 who has been in a nursing home for more than three years, then the program would come in. This program is known as CHEP II, and is a separate

program from our other Catastrophic Program. It covers all nursing-home expenses in excess of 20% of household income, for a person who has resided in a nursing home for more than two years. The inclusion of nursing-home care under the regular Catastrophic Program was heavily debated; senior citizen groups lobbied hard for this provision; however, the cost of such inclusion was prohibitive. I would strongly urge any State considering the Catastrophic Program, to have only one system. It should be up to the State to determine whether or not they have the resources and priority to include long-term care in a Catastrophic Program. Avoid the separate system.

Let me conclude my remarks by commenting on the Catastrophic Program as a viable alternative. I would highly suggest that if the State of Colorado chooses to go this route, that you determine in advance the population group you want to assist and then develop the income formula, accordingly. We did not necessarily do that. The advantage of this system is that it can be adapted to serve the population you want to serve.

The nature of a Catastrophic Program suggests that it is a plan of last resort. It does not apply until all other insurance coverage is exhausted and, further, it requires the payment of a deductible. For that reason, a Catastrophic Health Expense Program would fall short of meeting the medical needs of the indigent. This type of program is designed to prevent a family from spending down to welfare or from going bankrupt due to high medical expenses. One of the disadvantages of instituting such a system for the medically indigent is the fact that it is 100% State-financed. There is no federal participation, such as we have in the Medical Assistance Program. However, I would encourage you to negotiate at the federal level, with the possibility of receiving some medical assistance monies since it can be argued that a Catastrophic Program assists the family before they spend down their assets to become eligible for MA (Medical Assistance) thus

saving federal funds. We made that argument and had a very good reception from the Federal Government. Our Department of Public Welfare did not follow up on that and at the present time I do not know the status of trying to ascertain some federal monies, due to keeping some people off the medical assistance role.

In our Catastrophic Program we have put in some requirements allowing the Commission of the Department of Public Welfare to question the necessity of some medical services. It is also to question the reason for the charge being made, or a reasononable charge of the provider. We gave the Department the option to have a contract with the PSRO to determine medical necessity if they so wish, and I believe they are doing that. I believe that is important in the Catastrophic Program, since it assures some safeguards, similar to our medical assistance program, of making sure that the charges are reasonable and that services are indeed necessary.

In conclusion, I would submit that the need for a Catastrophic Program is dependent in large part on two factors:

1. The prevalence of catastrophic coverage in available health insurance policies and
2. The comprehensiveness of government medical assistance programs.

I offer the assistance of my office to the State of Colorado, if they so choose, to develop a similar program. I will be happy to answer any questions.

Thank you.

"AN OVERVIEW OF

THE MINNESOTA COMPREHENSIVE HEALTH ACT OF 1976, AS AMENDED"

Presentation Prepared

for

North Dakota Legislative Council

Health Care Committee

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John T. Ingrassia
Supervisor
Life and Health Section
Insurance Division
State of Minnesota

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February 20, 1980 - 11:00 a.m.

Bismarck, North Dakota

"AN OVERVIEW OF

THE MINNESOTA COMPREHENSIVE HEALTH ACT OF 1976, AS AMENDED"

It has been my privilege to be deeply involved in a health and welfare plan which has demonstrated that a state has the foresight and ability to provide benefits from such a plan to the residents within its jurisdiction.

It is further a privilege for me to represent the State of Minnesota and its Commissioner of Insurance, Michael D. Markman, as your guest at this meeting.

I am pleased that the Health Care Committee has shown an interest in the Minnesota experience and state honestly that it is flattering to our legislature and to the hundreds of people both from State Government and industry who have cooperated to bring the purposes of the Act to fruition.

As a result of the mandate, the Minnesota Comprehensive Health Association was established, the primary purpose for which was to make comprehensive health coverage available to those Minnesota residents who cannot obtain such coverage from the private health insurance market at standard rates. Such persons who do not have access to comprehensive health coverage face the possible harms of:

1) forgoing necessary medical attention in order to meet everyday living expenses;

2) losing opportunities for gainful employment because of an inability to pay for necessary medical care; and

3) living with the anxiety of lacking means to pay for medical care in the event of serious illness or accident.

The Minnesota Legislature was made aware of these problems and reacted accordingly. The health coverage made available by the Association is known as the State Plan. It is comprehensive major medical coverage with a choice of deductibles $500 or $1,000, 80% co-insurance feature and a $3,000 annual out-of-pocket limitation.

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State plan eligibility standards require that an applicant demonstrate Minnesota residency and a denial of coverage or coverage subject to a restrictive rider from two insurers within the previous six months. An experiment to provide coverage to individuals suffering from one or more conditions included in a list of "presumptive conditions" was supported by the industry generally and proved popular with agents in particular because of convenience. The conditions are of such a serious nature that, without doubt, an applicant with such a condition would be rejected for coverage. Unfortunately, the mandatory eligibility requirements were reestablished by amendment pending promulgation of rules pertaining to eligibility.

The Association is managed by a Board of seven directors, representative of the membership. The current Board is composed of five representatives of commercial insurance companies, one representative of a non-profit health service plan corporation, and one representative of a health maintenance organization. The directors are elected by the members of the Association based on a weighted vote, in proportion to their volume of accident and health insurance business, HMO business, or self-insurance business in the State of Minnesota.

The day-to-day administration of the State Plan is performed by Northwestern National Life Insurance Company as the writing carrier acting as agent of the Association and the Commissioner. The Association operates under close supervision of the Commissioner, pursuant to the Act and Rules promulgated by the Commissioner.

Claims expenses exceeding premiums collected, operating and administrative expenses of the Association were until May 31, 1979, shared by members of the Association in an amount equal to the ratio of each member's total accident and health insurance premiums (or subscriber contract charges or plan costs) received from Minnesota residents divided by the total accident and health insurance premium received by all insurers, HMO's and self-insurers from Minnesota residents. Assessments are levied by the Board of Directors of the Association subject to approval by the Commissioner.

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Currently only "contributing members" are responsible for Association assessments attributable to losses on and after May 31, 1979. A contributing member is one which pays premium tax. Such members may offset any assessments against all premium and income taxes payable to the State of Minnesota. This most recent example of our legislature providing public funding for the Association was preceded by an appropriation for the biennium ended June 30, 1979, in the amount of $200,000.00 for reimbursement to the Association for claims expenses incurred after June 30, 1978 in excess of State Plan premium collected.

The present public funding is subject to a "sunset" provision which ends July 1, 1981. During this time, the effect of the offset is to be reported to several committees of the legislature. Considering the past support demonstrated by the legislature, including a large state subsidy to reduce losses in 1978 and 1979, proponents of the State Plan predict that the offset provision will be renewed or another form of public funding will be enacted.

It has been recommended by the magistrate who presided at the trial in U. S. District Court, Insurers' Action Council Et Al Vs. Berton W. Heaton Et Al, that the Court enter judgment and adjudicating and declaring the Minnesota Comprehensive Health Act unconstitutional. The magistrate found that the assessments violate the Equal Protection Clause of the Fourteenth Amendment to the U. S. Constitution.

The Association not only denies that classification of "contributing members" constitutes invidious discrimination but maintains the classification is rationally related to a legitimate state interest.

The magistrate found that the eligibility requirements of the Act, including the discretion granted the Commissioner to determine additional, consistent requirements for coverage unde the State Plan, constitute an unlawful delegation of legislative authority and are vague.

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The Association has requested the Court to reject the magistrate's recommendations and find that the Act is not in violation of the Equal Protection Clause nor in violation of proscriptions against vagueness or unlawful delegation of legislative authority on the basis of the record and the law. The magistrate is charged with committing innumerable errors of fact and law as well as many irrelevant and immaterial references. It is the conclusion of the Association that the magistrate has failed completely to understand the basic issues of the lawsuit.

United Cerebral Palsy, Minnesota Epilepsey League and Minnesota Association of Retarded Citizens intervened as defendants in support of the Act. Appearing as amici curiae are Minnesota Public Interest Research Group; the Minnesota Catholic Conference; Senior Citizens Coalition of Greater St. Paul, Inc.; Metropolitan Senior Federation, Inc.; and Senior Citizens Legislative Council of St. Paul.

The Health Insurance Association of America participated as amicus curiae in opposition to the Act.

In addition to the creation of the Minnesota Comprehensive Health Association, the Act provided for establishment and administration of certin plans of health insurance to make minimum benefits available to all persons in Minnesota. The objective is to improve health care by making comprehensive accident and health insurance easily available to all persons in Minnesota willing to pay the premium. The Act mandated that every company offering or providing hospital, surgical, and medical care coverage in Minnesota must offer a plan that contains certain minimum levels of coverage and to discourage sale of coverages which are so limited as to be of little value to most consumers.

The Act requires that all insurers and fraternals who sell broad coverage individual hospital, surgical, and medical care policies in Minnesota, in addition to other policies, offer their customers a so-called "qualified" plan containing the list of

comprehensive hospital, surgical and medical care benefits set forth in the Act or the actuarial equivalent of those benefits. To be eligible to purchase a qualified plan, a person must meet the insurer's underwriting requirements and, of course, pay the premium established by the insurer for such a plan. Insurers selling group plans must offer "qualified" group plans.

Insurers are not prohibited in any way from selling or even recommending unqualified policies. However, it is required that persons applying for or renewing an unqualified plan be offered a major medical rider or policy at a premium established by the insurer. Again, underwriting standards may apply.

The Act further requires that insurers which sell Medicare Supplement policies to persons over age 65 offer, as an alternative to unqualified Medicare Supplement policies, a qualified Medicare Supplement Plan.

The Act further requires that every group health care policy issued to employers include the right of an individual leaving the group, or the dependents of a deceased group member, to convert to an individual qualified plan without the imposition of meeting insurability requirements. However, the premium is payable by the insured and not by the group policyholder.

These requirements are, in the opinion of the magistrate, unconstitutional. The magistrate believes that the mandatory offer provisions violate due process, that the major medical offer provision violates the Contract Clause, and that the extra-territorial application to conversion requirement violates the Commerce Clause.

Changed to 4/25/80

Oral arguments are to be heard by Judge Edward Devitt on February 29. It is anticipated that the decision will be appealed by the aggrieved party.

The Association is still breathing and appears to be serving its intended purpose. As of December 31, 1979, 1,608 policies were in force. Approximately 60 applica-

tions are processed montly. For each dollar of premium received the plan is paying two dollars in benefits. This steady but unspectacular growth contrasts sharply with the testimony of the plaintiffs who projected that the State Plan enrollees would number 4,000 by the end of its first year of operation. The State Plan opened for business on January 2, 1977. Opening day was the culmination of a cooperative effort among members of the legislature, its staff, the unselfish participation by dozens of industry people, consumers and State personnel.

In May of 1976 call was made for volunteers to serve on proposed advisory committees which would review and study the Act in order to recommend positive programs for consideration by the Commissioner as to implementation and administration of the requirements contained in the Act. The response to the call for help resulted in the formation of five advisory committees in the area of legal, forms, administration, actuarial and public information.

Prototype forms were developed which could be immediately certified by the Commissionner as qualified plans. Included in the prototypes are group, individual, major medical and Medicare Supplement. The plans were available to any interested company for use as their own with the company's own rate structure.

The actuarial committee developed rate schedules for the State Plan and developed an actuaial equivalence table which was subsequently incorporated into the rules.

The public information committe prepared and distributed informational brochures and conducted seminars throught the state to advise the public and the industry agency force of the State Plan.

To the volunteers who staffed the committees and who continue to serve unselfishly to sustain the Association and the State Plan, the people of Minnesota are grateful. All of us in Minnesota benefit from the operation of the Act. The fruits of the

program vary but certainly they contribute meaningfully to the way we live in Minnesota and to the concern we have for each other.

I shall be happy to respond to any question or to comment further on the implementation of the Act.

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III. An Analysis of the Social Impact of the Proposed Legislation

With hospital care averaging $369 per patient day for acute impatient care, plus an array of high priced medical technology and drugs for out patient care, and physicians fees on top of that, any accident or illness requiring more than nominal medical attention can mean serious financial hardship or catastrophe for the average family. As the cost of medical care continues to rise faster than any component of the consumer price index, some form of health insurance, pre-paid health care, or other third-party health coverage becomes more and more essential to people's health, welfare, and economic security.

The 56 to 71 thousand Alaskans who currently lack health coverage are likely to be unemployed, marginally employed, self-employed, or those employed by a small business, plus their dependents. The proposed legislation would automatically extend coverage to all those in regular employment and their dependents. The expansion of Medicaid coverage and the General Relief - medically needy program in the bill would fill another coverage gap.

The income threshhold for the medically needy program is set at 150% of the poverty guidelines for Alaska. For 1979, the poverty guidelines were as follows:

Non-farm poverty income guidelines

Family size	Annual	Monthly	150%
1	$4,270	356	534
2	5,640	470	705
3	7,010	584	876
4	8,380	698	1047
5	9,750	813	1219
6	11,120	927	1390

A person or family which is over income becomes eligible for medical assistance under this program if their income in excess of the threshhold is spent on medical bills. Essentially, this provides a form of catastophic coverage for all families, as well as a form of basic coverage for low-income families. The program would probably cover a large proportion of Alaska's unemployed and marginally employed people who lack health coverage from other sources.

The bill also would make coverage available to approximately 200 people who are presently denied private insurance due to high-risk health conditions. Thus, the most significant group of people who would still lack health coverage are likely to be middle-income self-employed people who do not choose to purchase health insurance, new employees who are not covered for their first month, and some seasonal employees who do not qualify for the medically needy program during their off-season because their assets (other than income) exceed the assets limits set in regulation. These groups are not likely to be large, however. Under the

proposed legislation, probably fewer than five percent of the population would be without coverage.

Impact of the Mandatory Health Benefits on Employers and Employees

Most large employers provide health insurance for their employees anyway, so the largest impact will probably be on small employers and low-budget non-profit organizations. Mandating employer-sponsored health benefits would have essentially the same economic impact as raising the minimum wage -- it would make it more expensive for employers to hire people, so fewer people would be hired. Though the resulting unemployment would not be significant among skilled and experienced workers, unskilled and teenage workers would be hardest hit. On the other hand, teenagers will often be covered as dependents under their parent's policy and therefore exempt from coverage by their own employer. Similarly, spouses, welfare recipients, and moonlighters may have coverage from another source and therefore be exempt. The fact that employers are not required to provide coverage to people such as these who have coverage from another source may offer a small financial incentive to the employer to hire them. If the employee group is enrolled in a plan which charges a higher premium rate for employees with dependents than for single employees, the employer may have some financial incentive to discriminate against people with dependents.

A number two qualified plan would cost about $30 to $50 per month for a single employee, and $75 to $110 per month for

an employee with dependents. The bill requires that the employer pay at least half the premium cost. A small employer whose liability would exceed 1.5 percent of their total payroll plus five percent of the employer's gross income from the business would be entitled to premium supplementation from the State. The employee's share is also limited to 1.5%* of his or her wages, or about $8.85 per month for a minimum wage employee; the employer is liable for the difference.

From the employees' point of view, the share they must pay toward the premium cost of the mandatory coverage, however small, will lower their take-home pay. Although it would insure them against financial catastophe due to medical expenses, in most cases it would provide no tangible benefits. With a deductible as high as $500 per person, most people won't incur any claims.

Impact on Insurance Carriers

The impact on carriers of the minimum benefits regulation will depend on two factors: how closely the bill tracks with current practice, and how large the volume of business is that the carrier conducts in Alaska. Smaller carriers may find that the required changes in their policies and practices would

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* This limit may not be appropriate for Alaska. It is taken from Hawaii where health insurance costs are about two-thirds of what they are in Alaska.

be more trouble and expense than they are worth for the small volume of busniess the carrier does in Alaska, and they may choose to stop writing health and accident insurance in Alaska rather than comply with the law.

Addendum Concerning High Risk "Uninsurables"

A number of insurances carriers in Minnesota who were opposed to the joint underwriting of high risk coverage in that state testified to a projection of 4,000 enrollees in the State Plan, which provides health coverage for "uninsurable" individuals, within the first year of operation. This incidence would be one per thousand population. In fact, actual enrollment over the first three years of operation has been less than half of that projection, though it is still growing.

Alaska has a young, healthy population compared to most other states, and therefore might expect a lower incidence of high-risk health conditions than Minnesota. Therefore, one high-risk "uninsurable" individual per two thousand population, or 200 people statewide, is a high estimate of what State Plan enrollment in Alaska might be.

In Minnesota, the ratio of claims to premiums under the State Plan has been running two to one, with an estimated loss of $800,000 for 1979. As Alaska has approximately one-tenth the population of Minnesota, a rough estimate of the loss Alaska might incur from the State Plan would be $80,000 per year.

Amended MINNESOTA statute

Subd. 7. The commissioner may rescind approval of a demonstration project if the commissioner makes any of the findings listed in section 62D.15, subdivision 1, with respect to the project for which it has not been granted a specific exemption, or if the commissioner finds that the project's operation is contrary to the information contained in the approved application.

[*1979 c 268 s 1*]

CHAPTER 62E. HEALTH CARE

Sec.		Sec.	
62E.02	Definitions	62E.10	Comprehensive health association
62E.035	Self insurer identification and reporting	62E.11	Operation of comprehensive plan
62E.04	Duties of insurers	62E.13	Administration of plan
62E.06	Minimum benefits of qualified plan	62E.14	Enrollment by an eligible person
62E.08	State plan premium		

62E.02 Definitions.

[*For text of subds 1 to 9, see M.S.1978*]

Subd. 10. "Insurer" means those companies operating pursuant to chapters 62A or 62C and offering, selling, issuing, or renewing policies or contracts of accident and health insurance. "Insurer" does not include health maintenance organizations.

[*For text of subds 11 to 22, see M.S.1978*]

Subd. 23. "Contributing member" means those companies operating pursuant to chapter 62A, paying premium taxes pursuant to section 60A.15, and offering, selling, issuing, or renewing policies or contracts of accident and health insurance.

[*1979 c 272 s 1,2*]

62E.035 Self insurer identification and reporting.

The commissioner shall require self insurers to report annually that they are engaged in self insurance business. These reports shall be for the previous calendar year and shall include the self insurer's total cost of self insurance and other information the commissioner may by rule require relating to the self insurer's plan of health coverage. Upon request of the commissioner, the commissioner of revenue shall cooperate with the commissioner in the identification of self insurers, and shall modify forms and promulgate rules as may be necessary to identify self insurers. In adopting the forms and rules promulgated pursuant to this section the commissioner of revenue shall consult with the commissioner.

[*1979 c 272 s 3*]

62E.04 Duties of insurers.

[*For text of subds 1 to 3, see M.S.1978*]

Subd. 4. **Major medical coverage.** Each insurer and fraternal shall affirmatively offer coverage of major medical expenses to every applicant who applies to the insurer or fraternal for a new unqualified policy at the time of application and annually to every holder of an unqualified policy of accident and health insurance renewed by the insurer or fraternal. The coverage shall provide that when a covered individual incurs out-of-pocket expenses of $5,000 or more within a calendar year for services covered in section 62E.06, subdivision 1, benefits shall be payable, subject to any copayment authorized by the commissioner, up to a maximum lifetime limit of $250,000. The offer of coverage of major medical expenses may consist of the offer of a rider on an existing unqualified policy or a new policy which is a qualified plan.

[For text of subds 5 to 7, see M.S.1978]

Subd. 8. **Reduction of benefits because of other services.** No policy of accident and health insurance shall contain any provision denying or reducing benefits because services are rendered to an insured or dependent who is eligible for or receiving benefits pursuant to chapters 256B and 256D, or sections 62E.51 to 62E.55 or 252.27; 260.251, subdivision 1a; 261.27; 393.07, subdivision 1 or 2.

[1979 c 174 s 3; 1979 c 272 s 4]

62E.06 Minimum benefits of qualified plan.

Subdivision 1. **Number three plan.** A plan of health coverage shall be certified as a number three qualified plan if it otherwise meets the requirements established by chapters 62A and 62C, and the other laws of this state, whether or not the policy is issued in Minnesota, and meets or exceeds the following minimum standards:

(a) The minimum benefits for a covered individual shall, subject to the other provisions of this subdivision, be equal to at least 80 percent of the cost of covered services in excess of an annual deductible which does not exceed $150 per person. The coverage shall include a limitation of $3,000 per person on total annual out-of-pocket expenses for services covered under this subdivision. The coverage shall be subject to a maximum lifetime benefit of not less than $250,000.

The $3,000 limitation on total annual out-of-pocket expenses and the $250,000 maximum lifetime benefit shall not be subject to change or substitution by use of an actuarily equivalent benefit.

(b) Covered expenses shall be the usual and customary charges for the following services and articles when prescribed by a physician:

(1) Hospital services;

(2) Professional services for the diagnosis or treatment of injuries, illnesses, or conditions, other than outpatient mental or dental, which are rendered by a physician or at his direction;

(3) Drugs requiring a physician's prescription;

(4) Services of a nursing home for not more than 120 days in a year if the services would qualify as reimbursable services under medicare;

(5) Services of a home health agency if the services would qualify as reimbursable services under medicare;

(6) Use of radium or other radioactive materials;

(7) Oxygen;

(8) Anesthetics;

(9) Prostheses other than dental;

(10) Rental or purchase, as appropriate, of durable medical equipment other than eyeglasses and hearing aids;

(11) Diagnostic X-rays and laboratory tests;

(12) Oral surgery for partially or completely unerupted impacted teeth, a tooth root without the extraction of the entire tooth, or the gums and tissues of the mouth when not performed in connection with the extraction or repair of teeth;

(13) Services of a physical therapist; and

(14) Transportation provided by licensed ambulance service to the nearest facility qualified to treat the condition; or a reasonable mileage rate for transportation to a kidney dialysis center for treatment.

(c) Covered expenses for the services and articles specified in this subdivision do not include the following:

(1) Any charge for care for injury or disease either (i) arising out of an injury in the course of employment and subject to a workers' compensation or similar law, (ii) for which benefits are payable without regard to fault under coverage statutorily required to be contained in any motor vehicle, or other liability insurance policy or equivalent self-

insurance, or (iii) for which benefits are payable under another policy of accident and health insurance, medicare or any other governmental program except as otherwise provided by law;

(2) Any charge for treatment for cosmetic purposes other than surgery for the repair of an injury or birth defect;

(3) Care which is primarily for custodial or domiciliary purposes which would not qualify as eligible services under medicare;

(4) Any charge for confinement in a private room to the extent it is in excess of the institution's charge for its most common semi-private room, unless a private room is prescribed as medically necessary by a physician, provided, however, that if the institution does not have semi-private rooms, its most common semi-private room charge shall be considered to be 90 percent of its lowest private room charge;

(5) That part of any charge for services or articles rendered or prescribed by a physician, dentist, or other health care personnel which exceeds the prevailing charge in the locality where the service is provided; and

(6) Any charge for services or articles the provision of which is not within the scope of authorized practice of the institution or individual rendering the services or articles.

(d) The minimum benefits for a qualified plan shall include, in addition to those benefits specified in clauses (a) and (e), benefits for the following services subject to applicable deductibles, coinsurance provisions, and maximum lifetime benefit limitations:

(1) Well baby care, effective July 1, 1980;

(2) Physicians' services for routine check-ups and annual physicals when prescribed by a physician, effective July 1, 1982;

(3) Multiphasic screening and other diagnostic testing, effective July 1, 1982. The commissioner by rule shall prescribe reasonable limits on the reimbursement required for services listed in this clause.

(e) Effective July 1, 1979, the minimum benefits of a qualified plan shall include, in addition to those benefits specified in clause (a), a second opinion from a physician on all surgical procedures expected to cost a total of $500 or more in physician, laboratory and hospital fees, provided that the coverage need not include the repetition of any diagnostic tests.

[*For text of subds 2 to 4, see M.S.1978*]

[*1979 c 272 s 5*]

62E.08 State plan premium.

Subdivision 1. The association shall establish the following maximum premiums to be charged for membership in the comprehensive health insurance plan:

(a) The premium for the number one qualified plan shall be up to a maximum of 125 percent of the average of rates charged by the five insurers with the largest number of individuals in a number one individual qualified plan of insurance in force in Minnesota;

(b) The premium for the number two qualified plan shall be up to a maximum of 125 percent of the average of rates charged by the five insurers with the largest number of individuals in a number two individual qualified plan of insurance in force in Minnesota;

(c) The premium for a qualified medicare supplement plan shall be up to a maximum of 125 percent of the average of rates charged by the five insurers with the largest number of individuals enrolled in a qualified medicare supplement plan; and

(d) The charge for health maintenance organization coverage shall be based on generally accepted actuarial principles.

The five insurers whose rates are used to establish the premium for each type of coverage offered by the association shall be determined by the commissioner on the ba-

sis of information provided by all insurers annually at the commissioner's request, concerning the number of individual qualified plans and qualified medicare supplement plans or actuarially equivalent plans offered by the insurer and rates charged by the insurer for each type of plan offered by the insurer. In determining the insurers whose rates shall be used in establishing the premium, the commissioner shall utilize generally accepted actuarial principles and structurally compatible rates. Subject to this subdivision, the commissioner shall include any insurer operating pursuant to chapter 62C in establishing the premium. In establishing premiums pursuant to this section, the association shall utilize generally accepted actuarial principles.

Subd. 2. Subject to subdivision 1, the schedule of premiums for coverage under the comprehensive health insurance plan shall be designed to be self-supporting and based on generally accepted actuarial principles.

[*1979 c 272 s 6*]

62E.10 Comprehensive health association.

Subdivision 1. **Creation; tax exemption.** There is established a comprehensive health association to promote the public health and welfare of the state of Minnesota with membership consisting of all insurers, self insurers, fraternals and health maintenance organizations licensed or authorized to do business in this state. The comprehensive health association shall be exempt from taxation under the laws of this state and all property owned by the association shall be exempt from taxation.

Subd. 2. **Board of directors; organization.** The board of directors of the association shall be made up of seven individuals selected by participating members, subject to approval by the commissioner. In determining voting rights at members' meetings, each member shall be entitled to vote in person or proxy. The vote shall be a weighted vote based upon the member's cost of self insurance, accident and health insurance premium, subscriber contract charges, or health maintenance contract payment derived from or on behalf of Minnesota residents in the previous calendar year, as determined by the commissioner. In approving members of the board, the commissioner shall consider, among other things, whether all types of members are fairly represented. Members of the board may be reimbursed from the moneys of the association for expenses incurred by them as members, but shall not otherwise be compensated by the association for their services. The costs of conducting meetings of the association and its board of directors shall be borne by members of the association.

Subd. 3. **Mandatory membership.** All members shall maintain their membership in the association as a condition of doing accident and health insurance, self-insurance, or health maintenance organization business in this state. The association shall submit its articles, bylaws and operating rules to the commissioner for approval; provided that the adoption and amendment of articles, bylaws and operating rules by the association and the approval by the commissioner thereof shall be exempt from the provisions of sections 15.041 to 15.052.

Subd. 4. **Open meetings.** All meetings of the association, its board, and any committees of the association shall comply with the provisions of section 471.705.

Subd. 5. [Repealed, 1979 c 272 s 11]

Subd. 6. **Antitrust exemption.** In the performance of their duties as members of the association, the members shall be exempt from the provisions of sections 325.8011 to 325.8028.

Subd. 7. **General powers.** The association may:

(a) Exercise the powers granted to insurers under the laws of this state;

(b) Sue or be sued;

(c) Enter into contracts with insurers, similar associations in other states or with other persons for the performance of administrative functions including the functions provided for in clauses (e) and (f);

(d) Establish administrative and accounting procedures for the operation of the association;

(e) Provide for the reinsuring of risks incurred as a result of issuing the coverages required by sections 62E.04 and 62E.16 by members of the association. Each member which elects to reinsure its required risks shall determine the categories of coverage it elects to reinsure in the association. The categories of coverage are:

(1) Individual qualified plans, excluding group conversions;

(2) Group conversions;

(3) Group qualified plans with fewer than 50 employees or members; and

(4) Major medical coverage.

A separate election may be made for each category of coverage. If a member elects to reinsure the risks of a category of coverage, it must reinsure the risk of the coverage of every life covered under every policy issued in that category. A member electing to reinsure risks of a category of coverage shall enter into a contract with the association establishing a reinsurance plan for the risks. This contract may include provision for the pooling of members' risks reinsured through the association and it may provide for assessment of each member reinsuring risks for losses and operating and administrative expenses incurred, or estimated to be incurred in the operation of the reinsurance plan. This reinsurance plan shall be approved by the commissioner before it is effective. Members electing to administer the risks which are reinsured in the association shall comply with the benefit determination guidelines and accounting procedures established by the association. The fee charged by the association for the reinsurance of risks shall not be less than 110 percent of the total anticipated expenses incurred by the association for the reinsurance; and

(f) Provide for the administration by the association of policies which are reinsured pursuant to clause (e). Each member electing to reinsure one or more categories of coverage in the association may elect to have the association administer the categories of coverage on the member's behalf. If a member elects to have the association administer the categories of coverage, it must do so for every life covered under every policy issued in that category. The fee for the administration shall not be less than 110 percent of the total anticipated expenses incurred by the association for the administration.

Subd. 8. **Department of state exemption.** The association shall be exempt from the provisions of chapter 15.

[*1979 c 272 s 7*]

62E.11 Operation of comprehensive plan.

Subdivision 1. Upon certification as an eligible person in the manner provided by section 62E.14, an eligible person may enroll in the comprehensive health insurance plan by payment of the state plan premium to the writing carrier.

Subd. 2. Any employer which has in its employ one or more eligible persons enrolled in the comprehensive health insurance plan may make all or any portion of the state plan premium payment to the state plan directly to the writing carrier.

Subd. 3. Not less than 87-1/2 percent of the state plan premium paid to the writing carrier shall be used to pay claims, and not more than 12-1/2 percent shall be used for the payment of agent referral fees as authorized in section 62E.15, subdivision 3 and for payment of the writing carrier's direct and indirect expenses, as specified in section 62E.13, subdivision 7.

Subd. 4. Any income in excess of the costs incurred by the association in providing reinsurance or administrative services pursuant to section 62E.07, clauses (e) and (f) shall be held at interest and used by the association to offset losses due to claims expenses of the state plan or allocated to reduce state plan premiums.

Subd. 5. Each contributing member of the association shall share the losses due to claims expenses of the comprehensive health insurance plan for plans issued or approved for issuance by the association, and shall share in the operating and administrative expenses incurred or estimated to be incurred by the association incident to the conduct of its affairs. Claims expenses of the state plan which exceed the premium payments allocated to the payment of benefits shall be the liability of the contributing members. Contributing members shall share in the claims expense of the state plan and operating and administrative expenses of the association in an amount equal to the ratio of the contrib-

uting member's total accident and health insurance premium, received from or on behalf of Minnesota residents as divided by the total accident and health insurance premium, received by all contributing members from or on behalf of Minnesota residents, as determined by the commissioner.

Subd. 6. The association shall make an annual determination of each contributing member's liability, if any, and may make an annual fiscal year end assessment if necessary. The association may also, subject to the approval of the commissioner, provide for interim assessments against the contributing members as may be necessary to assure the financial capability of the association in meeting the incurred or estimated claims expenses of the state plan and operating and administrative expenses of the association until the association's next annual fiscal year end assessment. Payment of an assessment shall be due within 30 days of receipt by a contributing member of a written notice of a fiscal year end or interim assessment. Failure by a contributing member to tender to the association the assessment within 30 days shall be grounds for termination of the contributing member's membership. A contributing member which ceases to do accident and health insurance business within the state shall remain liable for assessments through the calendar year during which accident and health insurance business ceased. The association may decline to levy an assessment against a contributing member if the assessment, as determined herein, would not exceed ten dollars.

Subd. 7. Net gains, if any, from the operation of the state plan shall be held at interest and used by the association to offset future losses due to claims expenses of the state plan or allocated to reduce state plan premiums.

Subd. 8. Any annual fiscal year end or interim assessment levied against a contributing member may be offset, in an amount equal to the assessment paid to the association, against the income tax or the premium tax payable by that contributing member pursuant to section 60A.15 for the year in which the annual fiscal year end or interim assessment is levied. The commissioner of revenue shall annually, on or before January 15, report to the chairmen of the senate finance, house appropriations, senate commerce and house financial institutions and insurance committees as to the total amount of income tax or premium tax offset claimed by contributing members during the preceding calendar year.

[*1979 c 272 s 8*]

NOTE: The provisions of subdivision 8 shall expire July 1, 1981. See Laws 1979, Chapter 272, Section 12.

62E.13 Administration of plan.

[*For text of subd 1, see M.S.1978*]

Subd. 2. The association may select policies and contracts, or parts thereof, submitted by a member or members of the association, or by the association or others, to develop specifications for bids from any members which wish to be selected as a writing carrier to administer the state plan. The selection of the writing carrier shall be based upon criteria including the member's proven ability to handle large group accident and health insurance cases, efficient claim paying capacity, and the estimate of total charges for administering the plan. The association may select separate writing carriers for the two types of qualified plans, the qualified medicare supplement plan, and the health maintenance organization contract.

[*For text of subds 3 to 9, see M.S.1978*]

[*1979 c 272 s 9*]

62E.14 Enrollment by an eligible person.

Subdivision 1. **Certificate, contents.** The comprehensive health insurance plan shall be open for enrollment by eligible persons. An eligible person shall enroll by submission of a certificate of eligibility to the writing carrier. The certificate shall provide the following:

(a) Name, address, age, and length of time at residence of the applicant;

(b) Name, address, and age of spouse and children if any, if they are to be insured;

(c) Evidence of rejection, a requirement of restrictive riders, a rate up, or a pre-existing conditions limitation on a qualified plan, the effect of which is to substantially reduce coverage from that received by a person considered a standard risk, by at least two association members within six months of the date of the certificate, or other eligibility requirements adopted by rule by the commissioner which are not inconsistent with this chapter and which evidence that a person is unable to obtain coverage substantially similar to that which may be obtained by a person who is considered a standard risk; and

(d) A designation of the coverage desired.

An eligible person may not purchase more than one policy from the state plan. Upon ceasing to be a resident of Minnesota a person is no longer eligible to purchase or renew coverage under the state plan.

[*For text of subds 2 and 3, see M.S.1978*]

[*1979 c 272 s 10*]

CHAPTER 64A. FRATERNAL BENEFICIARY ASSOCIATIONS

Sec
64A.221 Payment to welfare recipients

64A.221 Payment to welfare recipients.

No association authorized to do business in this state which provides or pays for any health care benefits shall issue any certificate which contains any provision denying or reducing benefits because services are rendered to a certificate holder or beneficiary who is eligible for or receiving medical assistance pursuant to chapter 256B or services pursuant to sections 252.27; 260.251, subdivision 1a; 261.27; or 393.07, subdivision 1 or 2.

[*1979 c 174 s 4*]

CHAPTER 65A. FIRE AND RELATED INSURANCE

Sec
65A.01 Minnesota standard fire insurance policy
65A.08 Special provisions
65A.27 Definitions
65A.28 Disclosure and filing requirements
Sec
65A.29 Cancellation, nonrenewal, refusal to write
65A.35 Fair plan business; distribution and placement

65A.01 Minnesota standard fire insurance policy.

[*For text of subds 1 and 2, see M.S.1978*]

Subd. 2a. **Facsimile signatures authorized.** On any policy of insurance regulated under this chapter, the signature of an officer or agent of the insurer may be a facsimile signature.

[*For text of subds 3 to 6, see M.S.1978*]

[*1979 c 115 s 2*]

65A.08 Special provisions.

Subdivision 1. [Repealed, 1979 c 175 s 1]

[*For text of subds 2 to 6, see M.S.1978*]

1979 Amendments to MINNESOTA

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

Section 1. Minnesota Statutes 1978, Section 176.521, Subdivision 2, is amended to read:

Subd. 2. **APPROVAL.** Settlements shall be approved only where the terms conform with this chapter.

The division and the workers' compensation court of appeals shall exercise discretion in approving or disapproving a proposed settlement.

The parties to the agreement of settlement have the burden of proving that the settlement is reasonable, fair, and in conformity with this chapter. A settlement agreement where both the employee or his dependent and the employer or insurer and intervenors in the matter are represented by an attorney shall be presumed to be reasonable, fair, and in conformity with chapter 176.

Sec. 2. Minnesota Statutes 1978, Section 79.21, is amended to read:

79.21 **RATES TO BE UNIFORM; EXCEPTIONS.** No insurer shall write insurance at a rate other than that made and put into force by the bureau and approved as adequate and reasonable by the commissioner. The bureau may reduce or increase a rate by the application to individual risks of the system of merit or experience rating which has been approved by the commissioner. This reduction or increase shall be set forth in the policy or by indorsement thereon. Upon written request an insurer shall furnish a written explanation to the insured of how and why the individual rate was adjusted by application of a system of merit or experience rating. This explanation shall be mailed to the insured within 30 days of the request.

Approved May 30, 1979

CHAPTER 272—S.F.No.1191

An act relating to insurance; providing for changes in the operation and funding of the comprehensive health association, requiring identification of certain insurers, setting premium standards, changing the effective dates of certain mandated benefits, amending Minnesota Statutes 1978, Sections 62E.02, Subdivision 10, and by adding a subdivision; 62E.06, Subdivision 4; 62E.06, Subdivision 1; 62E.08; 62E.10; 62E.11; 62E.13, Subdivision 2; 62E.14, Subdivision 1, and Chapter 62E, by adding a section; repealing Minnesota Statutes 1978, Section 62E.10, Subdivision 5.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA

Section 1. Minnesota Statutes 1978, Section 62E.02, Subdivision 10, is amended to read:

Changes or additions indicated by underline deletions by strikeout

Subd. 10. "Insurer" means those companies operating pursuant to chapters 62A or 62C and offering or , selling, issuing, or renewing policies or contracts of accident and health insurance. "Insurer" does not include health maintenance organizations.

Sec. 2. Minnesota Statutes 1978, Section 62E.02, is amended by adding a subdivision to read:

Subd. 23. "Contributing member" means those companies operating pursuant to chapter 62A, paying premium taxes pursuant to section 60A.15, and offering, selling, issuing, or renewing policies or contracts of accident and health insurance.

Sec. 3. Minnesota Statutes 1978, Chapter 62E, is amended by adding a section to read:

[62E.035] **SELF INSURER IDENTIFICATION AND REPORTING.** The commissioner shall require self insurers to report annually that they are engaged in self insurance business. These reports shall be for the previous calendar year and shall include the self insurer's total cost of self insurance and other information the commissioner may by rule require relating to the self insurer's plan of health coverage. Upon request of the commissioner, the commissioner of revenue shall cooperate with the commissioner in the identification of self insurers and shall modify forms and promulgate rules as may be necessary to identify self insurers. In adopting the forms and rules promulgated pursuant to this section the commissioner of revenue shall consult with the commissioner.

Sec. 4. Minnesota Statutes 1978, Section 62E.04, Subdivision 4, is amended to read:

Subd. 4. **MAJOR MEDICAL COVERAGE.** Each insurer and fraternal shall affirmatively offer coverage of major medical expenses to every applicant who applies to the insurer or fraternal for a new unqualified policy at the time of application and annually to every holder of an unqualified policy of accident and health insurance issued by the insurer or fraternal. The coverage shall provide that when a covered individual incurs out-of-pocket expenses of $5,000 or more within a calendar year for services covered in section 62E.06, subdivision 1, benefits shall be payable, subject to any copayment authorized by the commissioner, up to a maximum lifetime limit of $250,000. The offer of coverage of major medical expenses may consist of the offer of a rider on an existing unqualified policy or a new policy which is a qualified plan.

Sec. 5. Minnesota Statutes 1978, Section 62E.06, Subdivision 1, is amended to read:

62E.06 **MINIMUM BENEFITS OF QUALIFIED PLAN.** Subdivision 1. **NUMBER THREE PLAN.** A plan of health coverage shall be certified as a number three qualified plan if it otherwise meets the requirements established by chapters 62A and 62C, and the other laws of this state, whether or not the policy is issued in Minnesota, and meets or exceeds the following minimum standards:

(a) The minimum benefits for a covered individual shall, subject to the other provisions of this subdivision, be equal to at least 80 percent of the cost of covered services in excess of an annual deductible which does not exceed $150 per person. The

coverage shall include a limitation of $3,000 per person on total annual out-of-pocket expenses for services covered under this subdivision. The coverage shall be subject to a maximum lifetime benefit of not less than $250,000.

The $3,000 limitation on total annual out-of-pocket expenses and the $250,000 maximum lifetime benefit shall not be subject to change or substitution by use of an actuarily equivalent benefit.

(b) Covered expenses shall be the usual and customary charges for the following services and articles when prescribed by a physician:

(1) Hospital services;

(2) Professional services for the diagnosis or treatment of injuries, illnesses, or conditions, other than outpatient mental or dental, which are rendered by a physician or at his direction;

(3) Drugs requiring a physician's prescription;

(4) Services of a nursing home for not more than 120 days in a year if the services would qualify as reimbursable services under medicare;

(5) Services of a home health agency if the services would qualify as reimbursable services under medicare;

(6) Use of radium or other radioactive materials;

(7) Oxygen;

(8) Anesthetics;

(9) Prostheses other than dental;

(10) Rental or purchase, as appropriate, of durable medical equipment other than eyeglasses and hearing aids;

(11) Diagnostic X-rays and laboratory tests;

(12) Oral surgery for partially or completely unerupted impacted teeth, a tooth root without the extraction of the entire tooth, or the gums and tissues of the mouth when not performed in connection with the extraction or repair of teeth;

(13) Services of a physical therapist; and

(14) Transportation provided by licensed ambulance service to the nearest facility qualified to treat the condition; or a reasonable mileage rate for transportation to a kidney dialysis center for treatment.

Changes or additions indicated by underline deletions by strikeout

(c) Covered expenses for the services and articles specified in this subdivision do not include the following:

(1) Any charge for care for injury or disease either (i) arising out of an injury in the course of employment and subject to a workers' compensation or similar law, (ii) for which benefits are payable without regard to fault under coverage statutorily required to be contained in any motor vehicle, or other liability insurance policy or equivalent self-insurance, or (iii) for which benefits are payable under another policy of accident and health insurance, medicare or any other governmental program except as otherwise provided by law;

(2) Any charge for treatment for cosmetic purposes other than surgery for the repair of an injury or birth defect;

(3) Care which is primarily for custodial or domiciliary purposes which would not qualify as eligible services under medicare;

(4) Any charge for confinement in a private room to the extent it is in excess of the institution's charge for its most common semi-private room, unless a private room is prescribed as medically necessary by a physician, provided, however, that if the institution does not have semi-private rooms, its most common semi-private room charge shall be considered to be 90 percent of its lowest private room charge;

(5) That part of any charge for services or articles rendered or prescribed by a physician, dentist, or other health care personnel which exceeds the prevailing charge in the locality where the service is provided; and

(6) Any charge for services or articles the provision of which is not within the scope of authorized practice of the institution or individual rendering the services or articles.

(d) ~~Effective July 1, 1980,~~ The minimum benefits for a qualified plan shall include, in addition to those benefits specified in clauses (a) and (c), benefits for the following services subject to applicable deductibles, coinsurance provisions, and maximum lifetime benefit limitations:

(1) Well baby care, effective July 1, 1980;

(2) Physicians' services for routine check-ups and annual physicals when prescribed by a physician, effective July 1, 1982;

(3) Multiphasic screening and other diagnostic testing, effective July 1, 1982. The commissioner by rule shall prescribe reasonable limits on the reimbursement required for services listed in this clause.

(e) Effective July 1, 1979, the minimum benefits of a qualified plan shall include, in addition to those benefits specified in clause (a), a second opinion from a physician on all surgical procedures expected to cost a total of $500 or more in physician, laboratory and hospital fees, provided that the coverage need not include the repetition of any diagnostic

tests.

Sec. 6. Minnesota Statutes 1978, Section 62E.08, is amended to read:

62E.08 **STATE PLAN PREMIUM.** Subdivision 1. ~~For the first eighteen months of operation of the comprehensive health insurance plan~~ The association shall establish the following maximum premiums to be charged for membership in the comprehensive health insurance plan:

(a) The premium for the number one qualified plan shall be up to a maximum of 125 percent of the average of rates charged by the five insurers with the largest number of individuals in a number one individual qualified plan of insurance in force in Minnesota;

(b) The premium for the number two qualified plan shall be up to a maximum of 125 percent of the average of rates charged by the five insurers with the largest number of individuals in a number two individual qualified plan of insurance in force in Minnesota;

(c) The premium for a qualified medicare supplement plan shall be up to a maximum of 125 percent of the average of rates charged by the five insurers with the largest number of individuals enrolled in a qualified medicare supplement plan; and

(d) The charge for health maintenance organization coverage shall be based on generally accepted actuarial principles.

The five insurers whose rates are used to establish the premium for each type of coverage offered by the association shall be determined by the commissioner on the basis of information provided by all insurers annually at the commissioner's request, concerning the number of individual qualified plans and qualified medicare supplement plans or actuarially equivalent plans offered by the insurer and rates charged by the insurer for each type of plan offered by the insurer. In determining the insurers whose rates shall be used in establishing the premium, the commissioner shall utilize generally accepted actuarial principles and structurally compatible rates. Subject to this subdivision, the commissioner shall include any insurer operating pursuant to chapter 67C in establishing the premium. In establishing premiums pursuant to this section, the association shall utilize generally accepted actuarial principles.

Subd. 2. ~~For subsequent enrollees or renewals of membership~~ Subject to subdivision 1 of this section, the schedule of premiums for membership in coverage under the comprehensive health insurance plan shall be designed to be self-supporting and based on generally accepted actuarial principles.

Sec. 7. Minnesota Statutes 1978, Section 62E.10, is amended to read:

62E.10 **COMPREHENSIVE HEALTH ASSOCIATION.** Subdivision 1. **CREATION; TAX EXEMPTION.** There is established a comprehensive health association to promote the public health and welfare of the state of Minnesota with membership consisting of all insurers, self insurers, fraternals and health maintenance organizations licensed or authorized to do business in this state. The comprehensive

health association shall be exempt from taxation under the laws of this state and all property owned by the association shall be exempt from taxation.

Subd. 2. **BOARD OF DIRECTORS; ORGANIZATION.** The board of directors of the association shall be made up of seven individuals selected by participating members, subject to approval by the commissioner. ~~To select the initial board of directors, and to initially organize the association, the commissioner shall give notice to all members of the time and place of the organizational meeting.~~ In determining voting rights at ~~the organizational meeting~~ members' meetings, each member shall be entitled to vote in person or proxy. The vote shall be a weighted vote based upon the member's cost of self insurance, accident and health insurance premium, subscriber contract charges, or health maintenance contract payment derived from or on behalf of Minnesota residents in the previous calendar year, as determined by the commissioner. ~~If the board of directors is not selected within 60 days after notice of the organizational meeting, the commissioner may appoint the initial board.~~ In approving ~~or selecting~~ members of the board, the commissioner shall consider, among other things, whether all types of members are fairly represented. Members of the board may be reimbursed from the moneys of the association for expenses incurred by them as members, but shall not otherwise be compensated by the association for their services. The costs of conducting meetings of the association and its board of directors shall be borne by members of the association.

Subd. 3. **MANDATORY MEMBERSHIP.** All members shall maintain their membership in the association as a condition of doing accident and health insurance, self-insurance, or health maintenance organization business in this state. The association shall submit its articles, bylaws and operating rules to the commissioner for approval; provided that the adoption and amendment of articles, bylaws and operating rules by the association and the approval by the commissioner thereof shall be exempt from the provisions of sections 15.041 to 15.052.

Subd. 4. **OPEN MEETINGS.** All meetings of the association, its board, and any committees of the association shall comply with the provisions of section 471.705.

Subd. 5. All members shall enter into a contract with the association according to terms specified in section 11. The contract of reinsurance shall be executed on or before January 1, 1977, for a period of one year and shall be renewed annually thereafter. A company which ceases to do business within the state shall remain liable under the contract for the reinsurance contracted for during that calendar year.

Subd. 6. **ANTITRUST EXEMPTION.** In the performance of their duties as members of the association, the members shall be exempt from the provisions of sections 325.8011 to 325.8028.

Subd. 7. **GENERAL POWERS.** The association may:

(a) Exercise the powers granted to insurers under the laws of this state;

(b) Sue or be sued;

(c) Enter into contracts with insurers, similar associations in other states or with other persons for the performance of administrative functions including the functions provided for in clauses (e) and (f);

(d) Establish administrative and accounting procedures for the operation of the association;

(e) Provide for the reinsuring of risks incurred as a result of issuing the coverages required by sections 62E.04 and 62E.16 by members of the association. Each member which elects to reinsure its required risks shall determine the categories of coverage it elects to reinsure in the association. The categories of coverage are:

(1) Individual qualified plans, excluding group conversions;

(2) Group conversions;

(3) Group qualified plans with fewer than 50 employees or members; and

(4) Major medical coverage.

A separate election may be made for each category of coverage. If a member elects to reinsure the risks of a category of coverage, it must reinsure the risk of the coverage of every life covered under every policy issued in that category. A member electing to reinsure risks of a category of coverage shall enter into a contract with the association establishing a reinsurance plan for the risks. This contract may include provision for the pooling of members' risks reinsured through the association and it may provide for assessment of each member reinsuring risks for losses and operating and administrative expenses incurred, or estimated to be incurred in the operation of the reinsurance plan. This reinsurance plan shall be approved by the commissioner before it is effective. Members electing to administer the risks which are reinsured in the association shall comply with the benefit determination guidelines and accounting procedures established by the association. The fee charged by the association for the reinsurance of risks shall not be less than 110 percent of the total anticipated expenses incurred by the association for the reinsurance; and

(f) Provide for the administration by the association of policies which are reinsured pursuant to clause (e). Each member electing to reinsure one or more categories of coverage in the association may elect to have the association administer the categories of coverage on the member's behalf. If a member elects to have the association administer the categories of coverage, it must do so for every life covered under every policy issued in that category. The fee for the administration shall not be less than 110 percent of the total anticipated expenses incurred by the association for the administration.

Subd. 8. **DEPARTMENT OF STATE EXEMPTION.** The association shall be exempt from the provisions of chapter 15.

Sec. 8. Minnesota Statutes 1978, Section 62E.11, is amended to read:

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Subd. 2. A
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Subd. 3. No
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Subd. 6. The re
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62E.11 **OPERATION OF COMPREHENSIVE PLAN.** Subdivision 1. Upon certification as an eligible person in the manner provided by section 62E.14, an eligible person may enroll in the comprehensive health insurance plan by payment of the state plan premium to the writing carrier.

Subd. 2. Any employer which has in its employ one or more eligible persons enrolled in the comprehensive health insurance plan may make all or any portion of the state plan premium payment to the state plan directly to the writing carrier.

Subd. 3. Not less than 87-1/2 percent of the state plan premium paid to the writing carrier shall be used to pay claims, and not more than 12-1/2 percent shall be used for the payment of agent referral fees as authorized in section 62E.15, subdivision 3 and for payment of the writing carrier's direct and indirect expenses, as specified in section 62E.13, subdivision 7.

Subd. 4. Any income in excess of the costs incurred by the association in providing reinsurance or administrative services pursuant to section 62E.07, clauses (e) and (f) shall be held at interest and used by the association to offset losses due to claims expenses of the state plan or allocated to reduce state plan premiums.

Subd. 5. Each contributing member of the association shall share the losses due to claims expenses of the comprehensive health insurance plan health insurance plan for plans issued or approved for issuance by the association, and shall share in the operating and administrative expenses incurred or estimated to be incurred by the association incident to the conduct of its affairs, pursuant to the terms of the individual reinsurance contracts executed by the association with each member in accordance with section 62E.10, subdivision 5. Deviations in the claim experience of the state plan from Claims expenses of the state plan which exceed the premium payments allocated to the payment of benefits shall be the liability of the association contributing members. Association Contributing members shall share in the claims expense of the state plan and operating and administrative expenses of the association in an amount equal to the ratio of the contributing member's total cost of self insurance, accident and health insurance premiums, subscriber contract charges, or health maintenance organization contract charges received from or on behalf of Minnesota residents as divided into by the total cost of self insurance, accident and health insurance premium, subscriber contract charges, or health maintenance organization contract charges received by all association contributing members from or on behalf of Minnesota residents, as determined by the commissioner.

Subd. 6. The reinsurance contract shall provide for The association shall make an annual determination and assessment of each contributing member's liability, if any, and may make an annual fiscal year end assessment if necessary. Payment of the assessment shall be due within 30 days after the end of the association's fiscal year. The association may also, subject to the approval of the commissioner, the reinsurance contract may provide for interim assessments against the contributing members as may be necessary to assure the financial capability of the association in meeting the incurred or estimated claims expenses of the state plan and operating and administrative expenses of the association until the association's next annual fiscal year end assessment. Payment of an

assessment shall be due within 30 days of receipt by a contributing member of a written notice of a fiscal year end or interim assessment. Failure by a contributing member to tender to the association the ~~assessed reinsurance payment~~ assessment within 30 days ~~of notification by the association~~ shall be grounds for termination of the contributing member's membership. A contributing member which ceases to do accident and health insurance business within the state shall remain liable for assessments through the calendar year during which accident and health insurance business ceased. The association may decline to levy an assessment against a contributing member if the assessment, as determined herein, would not exceed ten dollars.

Subd. 7. Net gains, if any, from the operation of the state plan shall be held at interest and used by the association to offset future losses due to claims expenses of the state plan or allocated to reduce state plan premiums.

Subd. 8. Any annual fiscal year end or interim assessment levied against a contributing member may be offset, in an amount equal to the assessment paid to the association, against the income tax or the premium tax payable by that contributing member pursuant to section 60A.15 for the year in which the annual fiscal year end or interim assessment is levied. The commissioner of revenue shall annually, on or before January 15, report to the chairmen of the senate finance, house appropriations, senate commerce and house financial institutions and insurance committees as to the total amount of income tax or premium tax offset claimed by contributing members during the preceding calendar year.

Sec. 9. Minnesota Statutes 1978, Section 62E.13, Subdivision 2, is amended to read:

Subd. 2. ~~Upon the commissioner's approval of the policy forms and contracts submitted pursuant to chapter 62A,~~ The association may select policies and contracts, or parts thereof, submitted by a member or members of the association ~~to be the comprehensive health insurance plan~~ , or by the association or others, to develop specifications for bids from any members which wish to be selected as a writing carrier to administer the state plan. ~~This~~ The selection of the writing carrier shall be based upon criteria including the member's proven ability to handle large group accident and health insurance cases, efficient claim paying capacity, and the estimate of total charges for administering the plan. The association may select separate writing carriers for the two types of qualified plans, the qualified medicare supplement plan, and the health maintenance organization contract.

Sec. 10. Minnesota Statutes 1978, Section 62E.14, Subdivision 1, is amended to read:

62E.14 **ENROLLMENT BY AN ELIGIBLE PERSON.** Subdivision 1. **CERTIFICATE, CONTENTS.** The comprehensive health insurance plan shall be open for enrollment by eligible persons. An eligible person ~~may~~ shall enroll by submission of a certificate of eligibility to the writing carrier. The certificate ~~may~~ shall provide the following:

(a) Name, address, age, and length of time at residence of the applicant;

(b) Name, address, and age of spouse and children if any, if they are to be insured;

(c) Evidence of rejection, ~~or~~ a requirement of restrictive riders, a rate up, or a pre-existing conditions limitation on a qualified plan, the effect of which is to substantially reduce coverage from that received by a person considered a standard risk, by at least two association members within six months of the date of the certificate , or other eligibility requirements adopted by rule by the commissioner which are not inconsistent with this chapter and which evidence that a person is unable to obtain coverage substantially similar to that which may be obtained by a person who is considered a standard risk ; and

(d) A designation of the coverage desired.

An eligible person may not purchase more than one policy from the state plan. Upon ceasing to be a resident of Minnesota a person is no longer eligible to purchase or renew coverage under the state plan.

Sec. 11. **REPEALER.** Minnesota Statutes 1978, Section 62E.10, Subdivision 5, is repealed.

Sec. 12. **EFFECTIVE DATE.** This act is effective the day following its final enactment. The provisions of section 62E.11, subdivision 8, shall expire on July 1, 1981.

Approved May 30, 1979.

CHAPTER 273—S.F.No.1218

An act relating to Polk and Norman Counties; permitting the imposition of a tax on removing gravel; providing for its administration; providing a penalty.

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

Section 1. Every person engaged in the business of removing gravel from gravel pits or deposits of gravel in Polk or Norman County shall pay to the county an occupation tax in an amount the board of county commissioners determines necessary for the purposes set forth in section 5, but not more than ten cents on each cubic yard of gravel removed.

Sec. 2. Every person engaged in the removal of gravel shall at the times herein provided, file with the county auditor, under oath, a correct report in the form and containing the information he requires, covering each year. A report shall be filed on December 1, 1979, covering the period between the effective date of the act and December 1, 1979 and thereafter on December 1 of each year, covering the preceding year's operation. The operator shall compute the amount of the tax due on the basis of the information contained in the report. The tax computed in the report shall be due and payable to the county treasurer prior to the last business day of December.

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62A.041 MATERNITY BENEFITS; UNMARRIED WOMEN. Each group policy of accident and health insurance issued or renewed after June 4, 1971, shall provide the same coverage for maternity benefits to unmarried women and minor female dependents that it provides to married women including the wives of employees choosing dependent family coverage. If an insured is a parent or an acknowledged or adjudicated parent of a dependent illegitimate child each group policy issued or renewed after July 1, 1976, shall provide the same coverage for that child as that provided for the child of an employee choosing dependent family coverage if the insured elects dependent family coverage.

Each individual policy of accident and health insurance shall provide the same coverage for maternity benefits to unmarried women and minor female dependents as that provided for married women. If the insured is a parent or an acknowledged or adjudicated parent of a dependent illegitimate child, each individual policy issued or renewed after July 1, 1976, shall also provide the same coverage for that child as that provided for the child of an insured choosing dependent family coverage if the insured elects dependent family coverage.

For the purposes of this section, the term "maternity benefits" shall not include elective, induced abortion whether performed in a hospital, other abortion facility, or the office of a physician.

[*1971 c 680 s 1; 1973 c 651 s 1; 1976 c 121 s 3*]

62A.042 FAMILY COVERAGE; COVERAGE OF NEWBORN INFANTS. Subdivision 1. **Individual family policies; renewals.** No policy of individual accident and sickness insurance which provides for insurance for more than one person under section 62A.03, subdivision 1, clause (3), shall be renewed to insure any person in this state or be delivered or issued for delivery to any person in this state unless such policy includes as insured members of the family any newborn infants immediately from the moment of birth and thereafter which insurance shall provide coverage for illness, injury, congenital malformation or premature birth.

Subd. 2. **Group policies; renewals.** No group accident and sickness insurance policy which provides for coverage of family members or other dependents of an employee or other member of the covered group shall be renewed to cover members of a group located in this state or delivered or issued for delivery in this state unless such policy includes as insured family members or dependents any newborn infants immediately from the moment of birth and thereafter which insurance shall provide coverage for illness, injury, congenital malformation or premature birth.

[*1973 c 303 s 1*]

62A.043 DENTAL PROCEDURES. Subdivision 1. The provisions of this section shall apply to all individual or group policies or subscriber contracts providing payment for care in this state, which policies or contracts are issued or renewed after August 1, 1976 by an accident and health insurance company regulated under this chapter, or a nonprofit health service plan corporation regulated under chapter 62C.

Subd. 2. Any policy or contract referred to in subdivision 1 which provides coverage for services which can be lawfully performed within the scope of the license of a duly licensed dentist or podiatrist, shall provide benefits for such services whether performed by a duly licensed physician, dentist or podiatrist.

[*1973 c 430 s 1; 1976 c 207 s 1*]

62A.044 PAYMENTS TO GOVERNMENTAL INSTITUTIONS. No group or individual policy of accident and sickness insurance issued or renewed after May 22, 1973 pursuant to this chapter, and no group or individual service plan or subscriber contract issued or renewed after May 22, 1973 pursuant to chapter 62C, shall contain any provision denying or prohibiting payments for services rendered by a hospital or medical institution owned or operated by the federal, state, or local government or practitioners therein in any instance wherein charges for such services are imposed against the policy holder or subscriber. The unit of government operating the institution may maintain an action for recovery of such charges.

[*1973 c 471 s 1*]

62A.045 PAYMENTS TO WELFARE RECIPIENTS. No policy of accident and sickness insurance issued or renewed after August 1, 1975, shall contain any provision denying or reducing benefits because services are rendered to an insured or dependent

who is eligible for or receiving medical assistance pursuant to chapter 256B.

[*1975 c 247 s 1*]

62A.05 CONSTRUCTION OF PROVISIONS. Subdivision 1. No policy provision which is not subject to section 62A.04 shall make a policy, or any portion thereof, less favorable in any respect to the insured or the beneficiary than the provisions thereof which are subject to sections 62A.01 to 62A.09 hereof.

Subd. 2. A policy delivered or issued for delivery to any person in this state in violation of sections 62A.01 to 62A.09 hereof, shall be held valid but shall be construed as provided in sections 62A.01 to 62A.09 hereof. When any provision in a policy subject to sections 62A.01 to 62A.09 hereof, is in conflict with any provision of sections 62A.01 to 62A.09 hereof, the rights, duties and obligations of the insurer, the insured and the beneficiary shall be governed by the provisions of sections 62A.01 to 62A.09 hereof.

[*1967 c 395 art 3 s 5*]

62A.06 STATEMENTS IN APPLICATION. Subdivision 1. **Inclusion in policy.** The insured shall not be bound by any statement made in an application for a policy unless a copy of such application is attached to or endorsed on the policy when issued as a part thereof. If any such policy delivered or issued for delivery to any person in this state shall be reinstated or renewed, and the insured or the beneficiary or assignee of such policy shall make written request to the insurer for a copy of the application, if any, for such reinstatement or renewal, the insurer shall within 15 days after the receipt of such request at its home office or any branch office of the insurer, deliver or mail to the person making such request, a copy of such application. If such copy shall not be so delivered or mailed, the insurer shall be precluded from introducing such application as evidence in any action or proceeding based upon or involving such policy or its reinstatement or renewal.

Subd. 2. **Alterations.** No alteration of any written application for any such policy shall be made by any person other than the applicant without his written consent, except that insertions may be made by the insurer, for administrative purposes only, in such manner as to indicate clearly that such insertions are not to be ascribed to the applicant.

Subd. 3. **Effect of applicant's statement.** The falsity of any statement in the application for any policy covered by sections 62A.01 to 62A.09 hereof, may not bar the right to recovery thereunder unless such false statement materially affected either the acceptance of the risk or the hazard assumed by the insurer.

[*1967 c 395 art 3 s 6*]

62A.07 RIGHTS OF INSURER, WHEN NOT WAIVED. The acknowledgment by an insurer of the receipt of notice given under any policy covered by sections 62A.01 to 62A.09 hereof, or the furnishing of forms for filing proofs of loss, or the acceptance of such proofs, or the investigation of any claim thereunder shall not operate as a waiver of any of the rights of the insurer in defense of any claim arising under such policy.

[*1967 c 395 art 3 s 7*]

62A.08 COVERAGE OF POLICY, CONTINUANCE IN FORCE. If any such policy contains a provision establishing, as an age limit or otherwise, a date after which the coverage provided by the policy will not be effective, and if such date falls within a period for which premium is accepted by the insurer or if the insurer accepts a premium after such date, the coverage provided by the policy will continue in force subject to any right of cancellation until the end of the period for which premium has been accepted. In the event the age of the insured has been misstated and if, according to the correct age of the insured, the coverage provided by the policy would not have become effective, or would have ceased prior to the acceptance of such premium or premiums, then the liability of the insurer shall be limited to the refund, upon request, of all premiums paid for the period not covered by the policy.

[*1967 c 395 art 3 s 8*]

62A.081 PAYMENTS TO FACILITIES OPERATED BY STATE OR LOCAL GOVERNMENT. Every group or individual policy of accident and sickness insurance issued or renewed after July 1, 1973 regulated by this chapter, and every group or in-

dividual service plan or subscriber contract issued or renewed after July 1, 1973 regulated by chapter 62C, providing care or payment for care in this state, shall provide payments for services rendered by a hospital or medical facility owned or operated by, or on behalf of, the state or any unit of local government, or practitioners therein, on the same basis as are made for like care in other facilities. The unit of government concerned may maintain an action for recovery of such payments.

[*1973 c 765 s 24*]

62A.09 LIMITATION. Nothing in sections 62A.01 to 62A.08 shall apply to or affect:

(1) any policy of workers' compensation insurance or any policy of casualty or fire and allied lines insurance with or without supplementary coverage therein; or

(2) any policy or contract of reinsurance; or

(3) any blanket or group policy of insurance; or

(4) life insurance, endowment or annuity contracts, or contracts supplemental thereto which contain only such provisions relating to accident and sickness insurance as (a) provide additional benefits in case of death or dismemberment or loss of sight by accident, or as (b) operate to safeguard such contracts against lapse or to give a special surrender value or special benefit or an annuity in the event that the insured or annuitant shall become totally and permanently disabled, as defined by the contract or supplemental contract.

[*1967 c 395 art 3 s 9; 1975 c 359 s 23*]

62A.10 GROUP INSURANCE. Subdivision 1. **Requirements.** Group accident and health insurance is hereby declared to be that form of accident and health insurance covering not less than two employees nor less than ten members, and which may include the employee's or member's dependents, consisting of husband, wife, children, and actual dependents residing in the household, written under a master policy issued to any governmental corporation, unit, agency, or department thereof, or to any corporation, copartnership, individual, employer, or to any association having a constitution or bylaws and formed in good faith for purposes other than that of obtaining insurance under the provisions of this chapter, where officers, members, employees, or classes or divisions thereof, may be insured for their individual benefit.

Any insurer authorized to write accident and health insurance in this state shall have power to issue group accident and health policies.

Subd. 2. **Policy forms.** No policy of group accident and health insurance may be issued or delivered in this state unless the same has been approved by the commissioner in accordance with section 62A.02, subdivisions 1 to 6. These forms shall contain the standard provisions relating and applicable to health and accident insurance and shall conform with the other requirements of law relating to the contents and terms of policies of accident and sickness insurance in so far as they may be applicable to group accident and health insurance, and also the following provisions:

(1) **Entire contract.** A provision that the policy and the application of the employer, or executive officer or trustee of any association, and the individual applications, if any, of the employees or members insured, shall constitute the entire contract between the parties, and that all statements made by the employer or any executive officer or trustee in behalf of the group to be insured, shall, in the absence of fraud, be deemed representations and not warranties, and that no such statement shall be used in defense to a claim under the policy, unless it is contained in the written application;

(2) **Master policy-certificates.** A provision that the insurer will issue a master policy to the employer, or to the executive officer or trustee of the association; and the insurer shall also issue to the employer or to the executive officer or trustee of the association, for delivery to the employee or member who is insured under the policy, an individual certificate setting forth a statement as to the insurance protection to which he is entitled and to whom payable, together with a statement as to when and where the master policy, or a copy thereof, may be seen for inspection by the individual insured; this individual certificate may contain the names of, and insure the dependents of, the employee or member, as provided for herein;

(3) **New insureds.** A provision that to the group or class thereof originally insured may be added, from time to time, all new employees of the employer or

members of the association eligible to and applying for insurance in that group or class and covered or to be covered by the master policy.

[*1967 c 395 art 3 s 10; 1973 c 303 s 2*]

62A.11 BLANKET ACCIDENT AND SICKNESS INSURANCE. Subdivision 1. **Requirements.** Blanket accident and sickness insurance is hereby declared to be that form of accident and sickness insurance covering special groups of persons as enumerated in one of the following paragraphs:

(1) Under a policy issued to any common carrier, which shall be deemed the policyholder, covering a group defined as all or any class of persons who may become passengers on such common carrier.

(2) Under a policy issued to an employer, who shall be deemed the policyholder, covering all employees or any group of employees defined by reference to exceptional hazards incident to such employment.

(3) Under a policy issued to a college, school, or other institution of learning or to the head or principal thereof, who or which shall be deemed the policyholder, covering students or teachers.

(4) Under a policy issued in the name of any volunteer fire department, first aid, or other such volunteer group, which shall be deemed the policyholder, covering all of the members of such department or group.

(5) Under a policy issued to a sports team or to a camp, which team or camp or sponsor thereof shall be deemed the policyholder, covering members or campers.

(6) Under a policy issued to any other substantially similar group which, in the discretion of the commissioner, may be subject to the issuance of a blanket accident and sickness policy.

Subd. 2. **Authority.** Any insurer authorized to write accident and sickness insurance in this state shall have the power to issue blanket accident and sickness policies.

Subd. 3. **Policy forms.** No policy of blanket accident and sickness insurance may be issued or delivered in this state unless a copy of the form thereof has been approved by the commissioner and it contains in substance such of the provisions required for individual policies as may be applicable to blanket accident and sickness insurance and the following provisions:

(1) A provision that the policy and the application of the policyholder shall constitute the entire contract between the parties, and that, in the absence of fraud, all statements made by the policyholder shall be deemed representations and not warranties, and that no statement made for the purpose of affecting insurance shall avoid such insurance or reduce benefits unless contained in a written instrument signed by the policyholder, a copy of which has been furnished to such policyholder.

(2) A provision that to the group or class originally insured shall be added from time to time all new persons eligible for coverage.

Subd. 4. **Application; certificate.** An individual application shall not be required from a person covered under a blanket accident and sickness policy, nor shall it be necessary for the insurer to furnish each person a certificate.

Subd. 5. **Benefits.** All benefits under any blanket accident and sickness policy shall be payable to the person insured, or to his designated beneficiary, or beneficiaries, or to his estate, except that if the person insured be a minor, such benefits may be made payable to his parent, guardian, or other person actually supporting him. Provided further, however, that the policy may provide that all or any portion of any indemnities provided by any such policy on account of hospital, nursing, medical or surgical services may, at the insurer's option, be paid directly to the hospital or person rendering such services; but the policy may not require that the services be rendered by a particular hospital or person. Payment so made shall discharge the insurer's obligation with respect to the amount of insurance so paid.

Subd. 6. **Legal liability.** Nothing contained in this section shall be deemed to affect the legal liability of policyholders for the death of, or injury to, any such member of such group.

[*1967 c 395 art 3 s 11*]

62A.12 TRANSITION PROVISION AS TO INDIVIDUAL POLICIES, RIDERS OR ENDORSEMENTS. A policy, rider or endorsement, which could have been lawfully used or delivered or issued for delivery to any person in this state immediately before April 18, 1957, may be used or delivered or issued for delivery to any such person until January 1, 1959, without being subject to the provisions of sections 62A.03, 62A.04, or 62A.05.

[*1967 c 395 art 3 s 12*]

62A.13 COMMERCIAL TRAVELER INSURANCE COMPANIES. Any domestic assessment, health or accident association now licensed to do business in this state, which confines its membership to commercial travelers, professional men, and others whose occupation is of such character as to be ordinarily classified as no more hazardous than commercial travelers, and which does not pay any other commissions or compensations, other than prizes to members of nominal value in proportion to the membership fees charged for securing new members, may issue certificates of membership, which, with the application of the member and the bylaws of the association, shall constitute the contract between the association and the member. A printed copy of the bylaws and a copy of the application shall be attached to the membership certificate when issued, and a copy of any amendment to the bylaws shall be mailed to the members following their adoption. Certified copies of certificate, bylaws and amendments shall be filed with the commissioner of insurance and subject to his approval. The bylaws shall conform to the requirements of this chapter, so far as applicable, and wherever the word "policy" appears in this chapter, it shall, for the purpose of this section, be construed to mean the contract as herein defined.

[*1967 c 395 art 3 s 13*]

62A.14 HANDICAPPED CHILDREN. Subdivision 1. **Individual family policies.** An individual hospital or medical expense insurance policy delivered or issued for delivery in this state more than 120 days after May 16, 1969, which provides that coverage of a dependent child shall terminate upon attainment of the limiting age for dependent children specified in the policy shall also provide in substance that attainment of such limiting age shall not operate to terminate the coverage of such child while the child is and continues to be both (a) incapable of self-sustaining employment by reason of mental retardation or physical handicap and (b) chiefly dependent upon the policyholder for support and maintenance, provided proof of such incapacity and dependency is furnished to the insurer by the policyholder within 31 days of the child's attainment of the limiting age and subsequently as may be required by the insurer but not more frequently than annually after the two year period following the child's attainment of the limiting age.

Subd. 2. **Group policies.** A group hospital or medical expense insurance policy delivered or issued for delivery in this state more than 120 days after May 16, 1969, which provides that coverage of a dependent child of an employee or other member of the covered group shall terminate upon attainment of the limiting age for dependent children specified in the policy shall also provide in substance that attainment of such limiting age shall not operate to terminate the coverage of such child while the child is and continues to be both (a) incapable of self-sustaining employment by reason of mental retardation or physical handicap and (b) chiefly dependent upon the employee or member for support and maintenance, provided proof of such incapacity and dependency is furnished to the insurer by the employee or member within 31 days of the child's attainment of the limiting age and subsequently as may be required by the insurer but not more frequently than annually after the two year period following the child's attainment of the limiting age.

[*1969 c 436 s 1*]

62A.145 SURVIVORS OF DECEASED EMPLOYEE; DEFINITIONS. Subdivision 1. For the purposes of this section and section 62A.146, the terms defined in this section shall have the meanings here given them.

Subd. 2. "Covered employee" means any person who, at the time of his death, was employed by any employer providing, offering or contributing to group insurance coverage for that employee who was so enrolled for the coverage.

Subd. 3. Group insurance" means any policy or contract of accident and health protection, regardless of by whom underwritten, paid for in full or in part by an employer, which provides benefits, including cash payments for reimbursement of expen-

ses and the provision of usual and needed health care and medical services as the result of any injury, sickness, disability or disease suffered by a group of employees, or any one of them, and the dependents of such employees.

Subd. 4. "Employer" means any natural person, company, corporation, partnership, association or firm which employs any employee.

Subd. 5. "Survivor" means any person who would be entitled to and be dependent upon economic support by an employee if that employee were alive; including any spouse and/or child or children as defined by the group insurance policy.

[*1973 c 339 s 1*]

62A.146 GROUP INSURANCE; CONTINUATION OF BENEFITS TO SURVIVORS. Every employer providing a policy or plan of accident and health protection and benefits for his employees, or any of them, and the dependents of such employees shall not, except upon the written consent of the survivor or survivors of any deceased covered employee, terminate, suspend or otherwise restrict the participation in or the receipt of benefits otherwise payable under such policy or plan of group insurance to such survivor or survivors within one year of the covered employee's death. Provided, however, that any survivor or survivors, in order to have the coverage and benefits extended for such one year period, as herein provided, may be required to pay the entire cost of such protection. Failure of the survivor to make premium payments in advance to the employer shall be a basis in itself for the termination of the coverage without the written consent heretofore required for such termination, but in event of termination by reason of the survivor's failure to make required premium payments, if any, written notice of such cancellation must be sent by the policyholder by mail to said survivor's last known address at least 15 days prior to such cancellation.

[*1973 c 339 s 2*]

62A.147 DISABLED EMPLOYEES' BENEFITS; DEFINITIONS. Subdivision 1. For the purposes of this section and section 62A.148, the terms defined in this section shall have the meanings here given them.

Subd. 2. "Covered employee" means any person who, at the time he suffered an injury resulting in total disability or became totally disabled by reason of illness, was employed by and receiving a salary, commission, hourly wage, or other remuneration for his services by any employer providing, offering or contributing to group insurance coverage for that employee who was so enrolled for the coverage.

Subd. 3. "Total disability" means (a) the inability of an injured or ill employee to engage in or perform the duties of his regular occupation or employment within the first two years of such disability and (b) after the first two years of such disability, the inability of the employee to engage in any paid employment or work for which he may, by his education and training, including rehabilitative training, be or reasonably become qualified.

Subd. 4. "Group insurance" means any policy or contract of accident and health protection, regardless of by whom underwritten, which provides benefits, including cash payments for reimbursement of expenses or the provision of usual needed health care and medical services as the result of any injury, sickness, disability or disease suffered by a group of employees, or any one of them, and which protection is paid for or otherwise provided in full or in part by an employer.

Subd. 5. "Employer" means any natural person, company, corporation, partnership, association, firm, or franchise which employs any employee.

Subd. 6. "Insurer" means any person, company, corporation including a nonprofit corporation, partnership, association, firm or franchise which underwrites or is by contract or other agreement obligated to provide accident and health protection benefits to any group of employees of any employer.

[*1973 c 340 s 1*]

62A.148 GROUP INSURANCE; PROVISION OF BENEFITS FOR DISABLED EMPLOYEES. No employer or insurer of that employer shall terminate, suspend or otherwise restrict the participation in or the receipt of benefits otherwise payable under any program or policy of group insurance to any covered employee who becomes totally disabled while employed by the employer solely on account of absence caused by such total disability. If the employee is required to pay all or any part of the pre-

mium for the extension of coverage, payment shall be made to the employer, by the employee.

[*1973 c 340 s 2*]

62A.149 BENEFITS FOR ALCOHOLICS AND DRUG DEPENDENTS. Subdivision 1. The provisions of this section shall apply to all group policies of accident and health insurance and group subscriber contracts offered by nonprofit health service plan corporations regulated under chapter 62C, and to a plan or policy that is individually underwritten or provided for a specific individual and the members of his family as a nongroup policy unless the individual elects in writing to refuse benefits under this subdivision in exchange for an appropriate reduction in premiums or subscriber charges under the policy or plan, when the policies or subscriber contracts are issued or delivered in Minnesota or provide benefits to Minnesota residents enrolled thereunder.

Every insurance policy or subscriber contract included within the provisions of this subdivision, upon issuance or renewal, shall provide for payment of benefits for the treatment of alcoholism, chemical dependency or drug addiction to any Minnesota resident entitled to coverage thereunder on the same basis as coverage for other benefits when treatment is rendered in

(1) a licensed hospital,

(2) a residential treatment program as licensed by the state of Minnesota pursuant to diagnosis or recommendation by a doctor of medicine,

(3) a non-residential treatment program approved or licensed by the state of Minnesota.

Subd. 2. Coverage under subdivision 1, clauses (1) and (2) shall be for at least 20 percent of the total patient days allowed by the policy and in no event shall coverage be for less than 28 days in each 12 month benefit year. Coverage under subdivision 1, clause (3), shall be for at least 130 hours of treatment in a 12 month benefit year.

[*1973 c 585 s 1,2; 1976 c 262 s 1; 1978 c 793 s 60*]

62A.15 CHIROPRATIC SERVICES IN ACCIDENT AND HEALTH AND NONPROFIT HEALTH SERVICE POLICIES. Subdivision 1. **Applicability.** The provisions of this section shall apply to all group policies or subscriber contracts providing payment for care in this state, which are issued or renewed after August 1, 1973, and after August 1, 1976, for optometric services, by accident and health insurance companies regulated under this chapter, and nonprofit health service plan corporations regulated under chapter 62C.

Subd. 2. **Chiropractic services.** All benefits provided by any policy or contract referred to in subdivision 1, relating to expenses incurred for medical treatment or services of a physician shall also include chiropractic treatment and services of a chiropractor to the extent that the chiropractic services and treatment are within the scope of chiropractic licensure.

Subd. 3. **Optometric services.** All benefits provided by any policy or contract referred to in subdivision 1, relating to expenses incurred for medical treatment or services of a physician shall also include optometric treatment and services of an optometrist to the extent that the optometric services and treatment are within the scope of optometric licensure. This subdivision is intended to provide equal payment of benefits for optometric treatment and services and is not intended to change or add to the benefits provided for in such policies or contracts.

Subd. 4. **Denial of benefits.** No carrier referred to in subdivision 1 shall, in the payment of claims to employees in this state, deny benefits payable for services covered by the policy or contract if the services are lawfully performed by a duly licensed chiropractor.

[*1973 c 252 s 1; 1976 c 192 s 1,2; 1976 c 242 s 1*]

62A.151 HEALTH INSURANCE BENEFITS FOR EMOTIONALLY HANDICAPPED CHILDREN. No policy or plan of health, medical, hospitalization, or accident and sickness insurance regulated under this chapter, or nonprofit health service plan corporation regulated under chapter 62C, or health maintenance organization regulated under chapter 62D which provides coverage of or reimbursement for inpatient hospital and medical expenses shall be delivered, issued, executed or renewed in this state, or approved for issuance or renewal in this state by the commissioner of insur-

ance, after July 1, 1975 unless the policy or plan includes and provides health service benefits to any subscriber or other person covered thereunder, on the same basis as other benefits, for the treatment of emotionally handicapped children in a residential treatment facility licensed by the commissioner of public welfare. For purposes of this section "emotionally handicapped child" shall have the meaning set forth by the commissioner of public welfare in the rules and regulations relating to residential treatment facilities. The restrictions and requirements of this section shall not apply to any plan or policy which is individually underwritten or provided for a specific individual and the members of his family as a nongroup policy. The mandatory coverage under this section shall be on the same basis as inpatient hospital medical coverage provided under the policy or plan.

[*1975 c 40 s 1*]

62A.152 BENEFITS FOR AMBULATORY MENTAL HEALTH SERVICES. Subdivision 1. The provisions of this section shall apply to all group policies or subscriber contracts which are issued or renewed within this state after August 1, 1975 by accident and health insurance companies regulated under this chapter, and nonprofit health service plan corporations regulated under chapter 62C.

Subd. 2. All group policies and all group subscriber contracts providing benefits for mental or nervous disorder treatments in a hospital shall also provide coverage, to at least the extent of 90 percent of the first $600 of the cost of the usual and customary charges incurred over a 12-month period, for mental or nervous disorder consultation, diagnosis and treatment services delivered while the insured person is not a bed patient in a hospital, if such services are furnished by (1) a licensed or accredited hospital, (2) a community mental health center or mental health clinic approved or licensed by the commissioner of public welfare or other authorized state agency, or (3) by a consulting psychologist licensed under the provisions of sections 148.87 to 148.99, or by a psychiatrist licensed under chapter 147.

[*1975 c 89 s 1*]

62A.153 FREE STANDING AMBULATORY SURGICAL CENTERS. No policy or plan of health, medical, hospitalization, or accident and sickness insurance regulated under this chapter, or subscriber contract provided by a nonprofit health service plan corporation regulated under chapter 62C shall be issued, renewed, continued, delivered, issued for delivery or executed in this state, or approved for issuance or renewal in this state by the commissioner of insurance unless the policy, plan or contract specifically provides coverage for a health care treatment or service rendered by a free standing ambulatory surgical center or facilities offering ambulatory medical service 24 hours a day seven days a week, which are not part of a hospital, but have been reviewed and approved by the state commissioner of health to provide the treatment or service, on the same basis as coverage provided for the same health care treatment or service rendered by a hospital.

[*1976 c 45 s 1; 1977 c 305 s 45*]

62A.16 GROUP HOSPITAL AND MEDICAL COVERAGE AND HEALTH CARE PLANS, APPLICABILITY. The provisions of sections 62A.16 and 62A.17 shall apply to all group insurance policies or group subscriber contracts providing coverage for hospital or medical expenses incurred by a Minnesota resident employed within this state. Sections 62A.16 and 62A.17 shall also apply to health care plans established by employers in this state through health maintenance organizations certified under chapter 62D.

[*1974 c 101 s 1; 1976 c 142 s 1*]

62A.17 TERMINATION OF EMPLOYMENT. Subdivision 1. **Continuation of coverage.** Every group insurance policy, group subscriber contract and health care plan included within the provisions of section 62A.16, except policies, contracts or health care plans covering employees of an agency of the federal government, shall contain a provision which permits every eligible employee whose employment is terminated, if the policy, contract or health care plan remains in force for active employees of the employer, to elect to continue the coverage for himself and his dependents.

Subd. 2. **Responsibility of employee.** Every eligible employee electing to continue coverage shall pay his former employer, on a monthly basis, the cost of the continued coverage. If the policy, contract or health care plan is administered by a trust every eligible employee electing to continue coverage shall pay the trust the cost

of continued coverage according to the eligibility rules established by the trust. The employee shall be eligible to continue the coverage until he becomes re-employed and eligible for health care coverage under a group policy, contract or plan sponsored by the same or another employer, or for a period of six months after the termination of employment, whichever is shorter.

Subd. 3. **Eligibility for continued coverage.** An employee shall be eligible to make the election for himself and his dependents provided for in subdivision 1 if:

(a) In the period preceding the termination of his employment, he and his dependents were covered through his employment by a group insurance policy, subscriber's contract or health care plan included within the provisions of section 62A.16;

(b) The termination of employment was for reasons other than the discontinuance of the business, bankruptcy, the employee's disability or retirement.

Subd. 4. **Responsibility of employer.** After timely receipt of the monthly payment from an eligible employee, if the employer, or the trustee if the policy, contract or health care plan is administered by a trust, fails to make the payment to the insurer, the nonprofit health service plan corporation or the health maintenance organization, with the result that the employee's coverage is terminated, the employer or the trust shall become liable for the employee's coverage to the same extent as the insurer, the nonprofit health service plan corporation or the health maintenance organization, would be if the coverage were still in effect.

Subd. 5. **Notice of options.** Upon the termination of employment of an eligible employee, the employer shall inform the employee within ten days after termination of:

(a) his right to elect to continue the coverage;

(b) the amount he must pay monthly to the employer to retain the coverage;

(c) the manner in which and the office of the employer to which the payment to the employer must be made; and

(d) the time by which the payments to the employer must be made to retain coverage.

If the policy, contract or health care plan is administered by a trust, the terminating employer is relieved of the obligation imposed by clauses (a) to (d). The trust shall inform the employee of the information required by clauses (a) to (d).

Notice may be in writing and sent by first class mail to the employee's last known address which the employee has provided the employer or trust. If the employer or trust fails to so notify the employee who is properly enrolled in the program, the employee shall have the option to retain coverage provided he makes this election within 60 days of the date his employment is terminated by making the proper payment to the employer or trust to provide continuous coverage.

A notice in substantially the following form shall be sufficient. As a terminated employee the law authorizes you to maintain your group medical insurance for a period of up to six months. To do so you must notify your former employer within ten days of this notice that you intend to retain such coverage and must make a monthly payment of $..... to ..... at ..... by the .... of each month.

Subd. 6. **Conversion to individual policy.** A group insurance policy that provides post termination coverage as required by this section shall also include a provision allowing a covered employee or surviving spouse or dependent at the expiration of the post termination coverage provided by subdivision 2 to obtain from the insurer offering the group policy or group subscriber contract, at the employee's, spouse's or dependent's option and expense, without further evidence of insurability and without interruption of coverage, an individual policy of insurance or an individual subscriber contract providing at least the minimum benefits of a qualified plan as prescribed by section 62E.0 d the option of a number three qualified plan, a number two qualified plan, and mber one qualified plan as provided by section 62E.06, subdivisions 1 to 3. A policy providing reduced benefits at a reduced premium rate may be accepted by the employee, the spouse or a dependent in lieu of the optional coverage otherwise required by this subdivision.

The individual policy shall be renewable at the option of the individual as long as the individual is not covered under another qualified plan as defined in section 62E.02, subdivision 4, up to age 65 or to the day before the date of eligibility for coverage under Title XVIII of the Social Security Act, as amended. Any revisions in the table of

rate for the individual policy shall apply to the covered person's original age at entry, and shall apply equally to all similar policies issued by the insurer.

[*1974 c 101 s 2; 1975 c 100 s 1-3; 1976 c 142 s 2,3; 1977 c 409 s 2*]

62A.18 PROHIBITION AGAINST DISABILITY OFFSETS. No individual or group policy of accident and health insurance issued, amended, renewed, or delivered in this state on or after January 1, 1976 shall contain any provision offsetting, or in any other manner reducing, any benefit under the policy by the amount of, or in proportion to, any increase in disability benefits received or receivable under the federal Social Security Act, the Railroad Retirement Act, any Veteran's Disability Compensation and Survivor Benefits Act, Workers' Compensation, or any similar federal or state law, as amended subsequent to the date of commencement of such benefit.

[*1975 c 323 s 1*]

62A.21 CONVERSION PRIVILEGES FOR INSURED FORMER SPOUSES. Subdivision 1. No policy of accident and health insurance providing coverage of hospital or medical expense on either an expense incurred basis or other than an expense incurred basis, which in addition to covering the insured also provides coverage to the spouse of the insured shall contain a provision for termination of coverage for a spouse covered under the policy solely as a result of a break in the marital relationship except by reason of an entry of a valid decree of dissolution of marriage.

Subd. 2. Every policy described in subdivision 1 which contains a provision for termination of coverage of the spouse upon dissolution of marriage shall contain a provision to the effect that upon the entry of a valid decree of dissolution of marriage between the insured parties the spouse shall be entitled to have issued to him or her, without evidence of insurability, upon application made to the company within 31 days following the entry of the decree, and upon the payment of the appropriate premium, an individual policy of accident and health insurance. The policy shall provide the coverage then being issued by the insurer which is most nearly similar to, but not greater than, the terminated coverages. Any and all probationary or waiting periods set forth in the policy shall be considered as being met to the extent coverage was in force under the prior policy.

Subd. 3. This section applies to every policy of accident and health insurance which is delivered, issued for delivery, renewed or amended on or after the effective date of this section.

[*1977 c 186 s 1*]

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Subd. 6. Each health maintenance organization for which a demonstration project is approved shall annually file a report with the commissioner summarizing the project's experience at the same time it files its annual report required by section 62D.08. The report shall be on a form developed by the commissioner and shall be separate from the annual report required by section 62D.08.

Subd. 7. The commissioner may rescind approval of a demonstration project if the commissioner makes any of the findings listed in section 62D.15, subdivision 1, with respect to the project for which it has not been granted a specific exemption, or if the commissioner finds that the project's operation is contrary to the information contained in the approved application.

Added by Laws 1979, c. 268, § 1, eff. May 31, 1979.

[1] 42 U.S.C.A. § 1395 et seq.

Library References
Physicians and Surgeons ⇨4.
C.J.S. Physicians and Surgeons § 12.

CHAPTER 62E. HEALTH CARE [NEW]

COMPREHENSIVE HEALTH INSURANCE

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62E.01 Citation.
62E.02 Definitions.
62E.03 Duties of the employer.
62E.035 Self insurer identification and reporting [New].
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62E.05 Certification of qualified plans.
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COMPREHENSIVE HEALTH INSURANCE

62E.01 Citation

Sections 62E.01 to 62E.17 may be cited as the Minnesota comprehensive health insurance act of 1976.

Laws 1976, c. 296, art. 1, § 1, eff. July 1, 1976.

Title of Act:

An Act relating to health care; providing for establishment and administration of certain plans of health insurance to make minimum health care benefits available to all persons in the state; creating a comprehensive health care association; requiring review of hosp[illegible] and insurance premium rates; providing protection against catastrophic health care expenses; regulating coverage of dental services by health maintenance organizations; appropriating money; amending Minnesota Statutes 1971, Sections 62A.02, Subdivisions 1 and 3; 62C.15, Subdivision 2; and 62D.12, by adding a subdivision. Laws 1976, c. 296

Index to Notes

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Validity 1

1. Validity

This act does not deny due process by being unreasonable or arbitrary exercise of state's power to regulate business of insurance, nor is it unconstitutionally vague. Insurers' Action Council, Inc. v. Heaton, D.C.1976, 423 F.Supp. 921.

This act does not impair contractual obligations insofar as it was applicable to existing guaranteed renewable policies. Id.

[illegible]

2. In general

Provisions of § 62E.03 relating to employer's obligation to offer specified forms of group insurance to his employees were not preempted by Employee Retirement Income Security Act of 1974. Insurers' Action Council, Inc. v. Heaton, D.C.1976, 423 F.Supp. 921.

Law Review Commentaries

[illegible]

Medical benefit plans in Minnesota. Robert D. Strauss. 34 Bench and Bar No. 6, p. 19 (Nov.1977).

Minnesota Comprehensive Health Insurance Act of 1977. By John F. Stone and Margo S. Struthers. 34 Bench and Bar No. 7, p. 27 (Jan.1978).

Library References
Insurance ⇨4.2.
C.J.S. Insurance § 67.

62E.02 Definitions

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Subd. 15. "Medicare" mea
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62E.02 Definitions

Subdivision 1. For the purposes of sections 62E.01 to 62E.17, the terms and phrases defined in this section have the meanings given them.

Subd. 2. "Employer" means any person, partnership, association, trust, estate or corporation, including the state of Minnesota or any agency, instrumentality or governmental subdivision thereof, which employs ten or more individuals who are residents of this state.

Subd. 3. "Health maintenance organization" means a nonprofit corporation licensed and operated as provided in chapter 62D.

Subd. 4. "Qualified plan" means those health benefit plans which have been certified by the commissioner as providing the minimum benefits required by section 62E.06 or the actuarial equivalent of those benefits.

Subd. 5. "Qualified medicare supplement plan" means those health benefit plans which have been certified by the commissioner as providing the minimum benefits required by section 62E.07 or the actuarial equivalent of those benefits.

Subd. 6. "Commissioner" means the commissioner of insurance.

Subd. 7. "Dependent" means a spouse or unmarried child under the age of 19 years, a dependent child who is a student under the age of 25 and financially dependent upon the parent, or a dependent child of any age who is disabled.

Subd. 8. "Employee" means any Minnesota resident who has entered into the employment of or works under contract or service or apprenticeship with any employer. "Employee" does not include a person who has been employed for less than 30 days by his present employer, nor one who is employed less than 30 hours per week by his present employer, nor an independent contractor.

Subd. 9. "Plan of health coverage" means any plan or combination of plans of coverage, including combinations of self insurance, individual accident and health insurance policies, group accident and health insurance policies, coverage under a nonprofit health service plan, or coverage under a health maintenance organization subscriber contract.

Subd. 10. "Insurer" means those companies operating pursuant to chapters 62A or 62C and offering or, selling, issuing, or renewing policies or contracts of accident and health insurance. "Insurer" does not include health maintenance organizations.

Subd. 11. "Accident and health insurance policy" or "policy" means insurance or nonprofit health service plan contracts providing benefits for hospital, surgical and medical care. "Policy" does not include coverage which is (1) limited to disability or income protection coverage, (2) automobile medical payment coverage, (3) supplemental to liability insurance, (4) designed solely to provide payments on a per diem, fixed indemnity or non-expense incurred basis, (5) credit accident and health insurance issued pursuant to chapter 62B, (6) designed solely to provide dental or vision care, (7) blanket accident and sickness insurance as defined in section 62A.11, or (8) accident only coverage issued by licensed and tested insurance agents or solicitors which provides reasonable benefits in relation to the cost of covered services. The provisions of clause (4) shall not apply to hospital indemnity coverage which is sold by an insurer to an applicant who is not then currently covered by a qualified plan.

Subd. 12. "Health benefits" means benefits offered to employees on an indemnity or prepaid basis which pay the costs of or provide medical, surgical or hospital care.

Subd. 13. "Eligible person" means an individual who is a resident of Minnesota and meets the enrollment requirements of section 62E.14.

Subd. 14. "Minnesota comprehensive health association" or "association" means the association created by section 62E.10.

Subd. 15. "Medicare" means part A and part B of the United States Social Security Act, Title XVIII, as amended, 42 U.S.C. Sections 1394, et seq.

Subd. 16. "Medicare supplement plan" means any plan of insurance protection which provides benefits for the costs of medical, surgical or hospital care and which is marketed as providing benefits which complement or supplement the benefits provided by medicare.

Subd. 17. "State plan premium" means the premium determined pursuant to section 62E.08.

Subd. 18. "Writing carrier" means the insurer or insurers and health maintenance organization or organizations selected by the association and approved by the commissioner to administer the comprehensive health insurance plan.

Subd. 19. "Fraternal beneficiary association" or "fraternal" means a corporation, society, order, or voluntary association without capital stock which sells health and accident insurance in accordance with chapter 64A.

Subd. 20. "Comprehensive health insurance plan" or "state plan" means policies of insurance and contracts of health maintenance organization coverage offered by the association through the writing carrier.

Subd. 21. "Self insurer" means an employer or an employee welfare benefit fund or plan which directly or indirectly provides a plan of health coverage to its employees and administers the plan of health coverage itself or through an insurer, trust or agent except to the extent of accident and health insurance premium, subscriber contract charges or health maintenance organization contract charges. "Self insurer" does not include an employer engaged in the business of providing health care services to the public which provides health care services directly to its employees at no charge to them.

Subd. 22. "Self insurance" means a plan of health coverage offered by a self insurer.

Subd. 23. "Contributing member" means those companies operating pursuant to chapter 62A, paying premium taxes pursuant to section 60A.15, and offering, selling, issuing, or renewing policies or contracts of accident and health insurance.

Laws 1976, c. 296, art. 1, § 2, eff. July 1, 1976. Amended by Laws 1977, c. 409, §§ 4 to 7, eff. June 3, 1977; Laws 1979, c. 272, §§ 1, 2, eff. May 31, 1979.

1977 Amendment. Added "including the state of Minnesota or any agency, instrumentality or governmental subdivision thereof" to subd. 2. Deleted "on average of" as descriptive of 30 hours as it appears in subd. 8, and added "nor an independent contractor" at the end of that subdivision.

Revised subds. 11 and 21 which formerly read:

"Subd. 11. 'Accident and health insurance policy' or 'policy' means insurance or nonprofit health service plan contracts providing benefits for hospital, surgical and medical care. 'Policy' does not include coverage which is (1) limited to disability or income protection coverage, (2) automobile medical payment coverage, (3) supplemental to liability insurance, (4) sold by fraternals and provides payments on a per diem, daily indemnity or non-expense incurred basis, or (5) credit accident and health insurance issued pursuant to Minnesota Statutes, Chapter 62H.

"Subd. 21. 'Self insurer' means an employer who directly provides a plan of health coverage to his employees and administers the plan of health coverage himself or through an insurer. 'Self insurer' does not include an employer engaged in the business of providing health care services to the public who provides health care services directly to his employees at no charge to them."

1979 Amendment. Added "issuing or renewing" to subd. 10. Added subd. 23.

62E.03 Duties of the employer

Subdivision 1. Each employer who provides or makes available to his employees a plan of health coverage shall make available to his employees employed in this state a plan or combination of plans which have been certified by the commissioner as a number two qualified plan. If the plan of health coverage does not meet the requirements of section 62E.06 for a number two qualified plan, the employer shall make available a supplemental plan of health benefits which, when combined with the existing plan of health benefits, constitutes a number two coverage plan. The plan or combinations of plans may be financed from funds contributed solely by the employer or solely by the employees or any combination thereof. The plans may consist of self insurance, health maintenance contracts, group policies or individual policies or any combination thereof.

Subd. 2. In the event
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Laws 1976, c. 296, art. 1, §
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Law Review Commentaries
Medical benefit plans in
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No. 5, p. 19 (Nov.1977).
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62E.035 Self insurer identif

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Added by Laws 1979, c. 272, §

Library References
Insurance ⇐9.
C.J.S. Insurance § 73.

62E.04 Duties of insurers

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Subd. 2. In the event that an employer fails to comply with subdivision 1, none of the employer's costs for health benefits shall qualify as an income tax deduction pursuant to section 290.09, subdivision 2, clause (a)(1). In the case of an employer who meets the requirements of section 297A.25, subdivision 1, clause (j) or clause (p) if the employer fails to make available at least a number two qualified plan to his employees, the employer shall lose his status as an exempt organization under section 297A.25, subdivision 1, clause (j) or clause (p), as appropriate.

Laws 1976, c. 296, art. 1, § 3, eff. Jan. 1, 1977. Amended by Laws 1977, c. 409, § 8, eff. June 3, 1977.

1977 Amendment. Substituted "comply with subdivision 1" for "make available at least a number two qualified plan of health benefits to his employees employed in this state" at the beginning of subd. 2 and included the subsequent references to clause (j).

Law Review Commentaries

Medical benefit plans in Minnesota. Robert F. Strauss. 34 Bench and Bar No. 5, p. 19 (Nov.1977).

Minnesota Comprehensive Health Insurance Act of 1977. By John F. Stone and Margo S. Struthers. 34 Bench and Bar No. 1, p. 27 (Jan.1978).

Library References

Master and Servant ⇐10.
C.J.S. Master and Servant § 14.

1. In general

Provisions of this section relating to employer's obligation to offer specified forms of group insurance to his employees were not preempted by Employee Retirement Income Security Act of 1974. Insurers' Action Council, Inc. v. Heaton, D.C.1978, 423 F.Supp. 921.

62E.035 Self insurer identification and reporting

The commissioner shall require self insurers to report annually that they are engaged in self insurance business. These reports shall be for the previous calendar year and shall include the self insurer's total cost of self insurance and other information the commissioner may by rule require relating to the self insurer's plan of health coverage. Upon request of the commissioner, the commissioner of revenue shall cooperate with the commissioner in the identification of self insurers, and shall modify forms and promulgate rules as may be necessary to identify self insurers. In adopting the forms and rules promulgated pursuant to this section the commissioner of revenue shall consult with the commissioner.

Added by Laws 1979, c. 272, § 3, eff. May 31, 1979.

Library References

Insurance ⇐9.
C.J.S. Insurance § 73.

62E.04 Duties of insurers

Subdivision 1. Individual policies. For each type of qualified plan described in section 62E.06, an insurer or fraternal issuing individual policies of accident and health insurance in this state, other than group conversion policies, shall develop and file with the commissioner an individual policy which meets the minimum standards of that type of qualified plan. An insurer or fraternal issuing individual policies of accident and health insurance in this state shall offer each type of qualified plan to each person who applies and is eligible for accident and health insurance from that insurer or fraternal.

Subd. 2. Medicare supplement plan. An insurer or fraternal issuing medicare supplement plans in this state shall develop and file with the commissioner a medicare supplement policy which meets the minimum standards of a qualified medicare supplement plan. An insurer or fraternal issuing medicare supplement plans in this state shall offer a qualified medicare supplement plan to each person who is eligible for coverage and who applies for a medicare supplement plan.

Subd. 3. Group policies. For each [illegible] section 62A.21, an insurer or fraternal issuing group policies of accident and health insurance in this state shall develop and file with the commissioner a group policy which provides for each member of the group the minimum benefits required by that type of qualified plan. An insurer or fraternal issuing group policies of accident and health insurance in this state shall offer each type of qualified plan to each eligible applicant for group accident and health insurance.

Subd. 4. Major medical coverage. Each insurer and fraternal shall affirmatively offer coverage of major medical expenses to every applicant who applies to the insurer or fraternal for a new unqualified policy at the time of application and annually to every holder of an unqualified policy of accident and health insurance renewed by the insurer or fraternal. The coverage shall provide that when a covered individual in rs out-of-pocket expenses of $5,000 or more within a calendar year for services covered in section 62E.06, subdivision 1, benefits shall be payable, subject to any copayment authorized by the commissioner, up to a maximum lifetime limit of $250,000. The offer of coverage of major medical expenses may consist of the offer of a rider on an existing unqualified policy or a new policy which is a qualified plan.

Subd. 5. Effect of non-compliance. No policy of accident and health insurance may be issued or renewed in this state 180 days after July 1, 1976, by an insurer or a fraternal which has not complied with the requirements of this section.

Subd. 6. Reinsurance allowed. An insurer or fraternal may fulfill its obligations under this section by issuing the required coverages in their own name and reinsuring the risk and administration of the coverages with the association in accordance with section 62E.10, subdivision 7, clauses (e) and (f).

Subd. 7. Underwriting standards may apply. Nothing in this section shall require an insurer or fraternal to offer or issue a policy to any person who does not meet the underwriting or membership requirements of the insurer or fraternal.

Subd. 8. Reduction of benefits because of other services. No policy of accident and health insurance shall contain any provision denying or reducing benefits because services are rendered to an insured or dependent who is eligible for or receiving benefits pursuant to chapters 256B and 256D, or sections 62E.51 to 62E.55 or 252.27; 260.251, subdivision 1a; 261.27; 393.07, subdivision 1 or 2.

Laws 1976, c. 296, art 1, § 4, eff. July 1, 1976. Amended by Laws 1977, c. 409, §§ 9, 10, eff. June 3, 1977; Laws 1979, c. 174, § 3, eff. May 23, 1979; Laws 1979, c. 272, § 4, eff. May 31, 1979.

1977 Amendment. Revised Subd. 4 which formerly read:

"Each insurer and fraternal shall include coverage of major medical costs in every unqualified policy of accident and health insurance, unless the applicant for a new or renewal policy declines the coverage in writing. The coverage shall provide that when a covered individual incurs out-of-pocket expenses of $5,000 or more within a calendar year for services covered in section 62E.06, subdivision 1, benefits shall be payable, subject to any copayment authorized by the commissioner, up to a maximum lifetime limit of $250,000."

Added subd. 8.

1979 Amendments. Laws 1979, c. 174, deleted "issued or renewed after August 1, 1977" following "insurance" and added the alternative cites at the end of subd. 8.

Laws 1979, c. 174, § 6, provides:

"This act is effective the day following its final enactment [eff. May 23, 1979] and applies to any policy or plan of private health care coverage issued or renewed on or after that date."

Laws 1979, c. 272, added "who applies to the issurer or fraternal" and "renewed by the insurer or fraternal" to the first sentence of subd. 4, and the last sentence of that subdivision.

Library References

Insurance ⇐133(1.2), 531.1.
C.J.S. Insurance §§ 263, 897, 950.

62E.05 Certification of qualified plans

Upon application by an insurer, fraternal, or employer for certification of a plan of health coverage as a qualified plan or a qualified medicare supplement plan for the purposes of sections 62E.01 to 62E.17, the commissioner shall make a determination within 60 days as to whether the plan is qualified. All plans of health coverage shall be labelled as "qualified" or "nonqualified". All plans of health coverage shall be labelled as "qualified" or "nonqualified" on the front of the policy or evidence of insurance. All qualified plans shall indicate whether they are number one, two, or three coverage plans.

Laws 1976, c. 296, art. 1, § 5, eff. July 1, 1976.

62E.06 Minimum benefit

Subdivision 1. Number

fied as a number three q
established by chapters 6.
er or not the policy is issu
minimum standards:

(a) The minimum benefit
provisions of this subdivis
covered services in excess c
per person. The coverage
total annual out-of-pocket e
The coverage shall be subje
$250,000.

The $3,000 limitation on tc
maximum lifetime benefit st
of an actuarily equivalent be.

(b) Covered expenses shall
lowing services and articles w

(1) Hospital services;

(2) Professional services fo
or conditions, other than outp
physician or at his direction;

(3) Drugs requiring a physi

(4) Services of a nursing ho
services would qualify as reh

(5) Services of a home hea
imbursable services under med

(6) Use of radium or other

(7) Oxygen;

(8) Anesthetics;

(9) Prostheses other than de

(10) Rental or purchase, as
other than eyeglasses and hearin

(11) Diagnostic X-rays and la

(12) Oral surgery for partiall
tooth root without the extractio
of the mouth when not performe
of teeth;

(13) Services of a physical the

(14) Transportation provided t
facility qualified to treat the c
transportation to a kidney dialy

(c) Covered expenses for the
division do not include the follow

(1) Any charge for care for in
injury in the course of employm
or similar law, (ii) for which benef
coverage statutorily required to
liability insurance policy o. eq
benefits are payable under anothe
medicare or any other governmen
by law;

(2) Any charge for treatment
for the repair of an injury or birt

(3) Cure which is primarily for
would not qualify as eligible servic

62E.06 Minimum benefits of qualified plan

Subdivision 1. Number three plan. A plan of health coverage shall be certified as a number three qualified plan if it otherwise meets the requirements established by chapters 62A and 62C, and the other laws of this state, whether or not the policy is issued in Minnesota, and meets or exceeds the following minimum standards:

(a) The minimum benefits for a covered individual shall, subject to the other provisions of this subdivision, be equal to at least 80 percent of the cost of covered services in excess of an annual deductible which does not exceed $150 per person. The coverage shall include a limitation of $3,000 per person on total annual out-of-pocket expenses for services covered under this subdivision. The coverage shall be subject to a maximum lifetime benefit of not less than $250,000.

The $3,000 limitation on total annual out-of-pocket expenses and the $250,000 maximum lifetime benefit shall not be subject to change of substitution by use of an actuarily equivalent benefit.

(b) Covered expenses shall be the usual and customary charges for the following services and articles when prescribed by a physician:

(1) Hospital services;

(2) Professional services for the diagnosis or treatment of injuries, illnesses, or conditions, other than outpatient mental or dental, which are rendered by a physician or at his direction;

(3) Drugs requiring a physician's prescription;

(4) Services of a nursing home for not more than 120 days in a year if the services would qualify as reimbursable services under medicare;

(5) Services of a home health agency if the services would qualify as reimbursable services under medicare;

(6) Use of radium or other radioactive materials;

(7) Oxygen;

(8) Anesthetics;

(9) Prostheses other than dental;

(10) Rental or purchase, as appropriate, of durable medical equipment other than eyeglasses and hearing aids;

(11) Diagnostic X-rays and laboratory tests;

(12) Oral surgery for partially or completely unerupted impacted teeth, a tooth root without the extraction of the entire tooth, or the gums and tissues of the mouth when not performed in connection with the extraction or repair of teeth;

(13) Services of a physical therapist; and

(14) Transportation provided by licensed ambulance service to the nearest facility qualified to treat the condition; or a reasonable mileage rate for transportation to a kidney dialysis center for treatment.

(c) Covered expenses for the services and articles specified in this subdivision do not include the following:

(1) Any charge for care for injury or disease either (i) arising out of or [illegible] coverage currently required to be contained in any motor vehicle, or other liability insurance policy or equivalent self-insurance, or (ii) for which benefits are payable under another policy of accident and health insurance, medicare or any other governmental program except as otherwise provided by law;

(2) any charge for treatment for cosmetic purposes other than surgery for the repair of an injury or birth defect;

(3) Care which is primarily for custodial or domiciliary purposes which would not qualify as eligible services under medicare;

(4) Any charge for confinement in a private room to the extent it is in excess of the institution's charge for its most common semi-private room, unless a private room is prescribed as medically necessary by a physician, provided, however, that if the institution does not have semi-private rooms, its most common semi-private room charge shall be considered to be 90 percent of its lowest private room charge;

(5) That part of any charge for services or articles rendered or prescribed by a physician, dentist, or other health care personnal which exceeds the prevailing charge in the locality where the service is provided; and

(6) Any charge for services or articles the provision of which is not within the scope of authorized practice of the institution or individual rendering the services or articles.

(d) The minimum benefits for a qualified plan shall include, in addition to those benefits specified in clauses (a) and (c), benefits for the following services subject to applicable deductibles, coinsurance provisions, and maximum lifetime benefit limitations:

(1) Well baby care, effective July 1, 1980;

(2) Physicians' services for routine check-ups and annual physicals when prescribed by a physician, effective July 1, 1982;

(3) Multiphasic screening and other diagnostic testing, effective July 1, 1982. The commissioner by rule shall prescribe reasonable limits on the reimbursement required for services listed in this clause.

(e) Effective July 1, 1979, the minimum benefits of a qualified plan shall include, in addition to those benefits specified in clause (a), a second opinion from a physician on all surgical procedures expected to cost a total of $500 or more in physician, laboratory and hospital fees, provided that the coverage need not include the repetition of any diagnostic tests.

Subd. 2. Number two plan. A plan of health coverage shall be certified as a number two qualified plan if it meets the requirements established by subdivision 1 except that the deductible shall not exceed $500 per person.

Subd. 3. Number one plan. A plan of health coverage shall be certified as a number one qualified plan if it meets the requirements established by subdivision 1 except that the deductible shall not exceed $1,000 per person.

Subd. 4. Health maintenance plans. A health maintenance organization which provides the services required by chapter 621 shall be deemed to be providing a number three qualified plan.

Laws 1975, c. 359, § 23; Laws 1976, c. 206, art. 1, § 6, eff. July 1, 1976; Laws 1977, c. 409, § 11, eff. June 3, 1977; Laws 1979, c. 272, § 5, eff. May 31, 1979.

1977 Amendment. Revised this section which formerly provided:

"Subdivision 1. A plan of health coverage shall be certified as a number three qualified plan if it otherwise meets the requirements established by Minnesota Statutes, Chapter 62A and Chapter 62C, and the other laws of this state, whether or not the policy is issued in Minnesota, and meets or exceeds the following minimum standards:

"(a) The minimum benefits for a covered individual shall, subject to the other provisions of this subdivision, be equal to at least 80 percent of the cost of covered services in excess of an annual deductible which does not exceed $100 per person. The coverage shall be subject to a maximum lifetime benefit of not less than $250,000. Covered expenses shall be the usual and customary charges for the following services and articles when prescribed by a physician:

"(1) Hospital services;

"(2) Professional services for the diagnosis or treatment of injuries, illnesses, or conditions, other than outpatient mental or dental, which are rendered by a physician or at his direction;

"(3) Drugs requiring a physician's prescription;

"(4) Services of a nursing home for not more than 120 days in a year if the services commence within 14 days following confinement of at least three days in a hospital for the same condition;

"(5) Service of a home health agency up to a maximum of 180 visits per year;

"(6) Use of radium or other radioactive materials;

"(7) Oxygen;

"(8) [illegible]

"(9) [illegible]

"(10) [illegible]

"(11) [illegible] ry costs;

"(12) Oral surgery for partially or completely [illegible] a tooth root without the extraction of the entire tooth, or the gums and tissues of the mouth when not performed in connection with the extraction or repair of teeth; and

"(13) Services of a physical therapist.

"(b) Covered expenses for [illegible] ices and articles specified in t[illegible] vision do not include the follow[illegible]

"(1) Any charge for any ca[illegible] injury or disease either (i) a [illegible] of an injury in the course o[illegible] ment and subject to a workm[illegible] pensation or similar law, (ii) [illegible] benefits are payable without [illegible] fault under coverage statut[illegible] quired to be contained in a[illegible] vehicle, or other liability [illegible] policy or equivalent self-insur[illegible] (iii) for which benefits are pa[illegible] der another policy of accid[illegible] health insurance or medicare;

"(2) Any charge for treatm[illegible] cosmetic purposes other than [illegible] for the repair of an injury or b[illegible] fect;

"(3) Any charge for travel ot[illegible] travel by ambulance to the [illegible] health care institution qualified [illegible] the illness or injury;

"(4) Any charge for confinem[illegible] private room to the extent it i[illegible] cess of the institution's charge [illegible] most common semi-private room[illegible] a private room is prescribed as m[illegible] ly necessary by a physician;

"(5) That part of any char[illegible] services or articles rendered [illegible] scribed by a physician, dentist, o[illegible] health care personnel which exce[illegible] prevailing charge in the locality [illegible] the service is provided; and

"(6) Any charge for services or[illegible] cles the provision of which is not [illegible] the scope of authorized practice [illegible] institution or individual renderin[illegible] services or articles.

"(c) Effective January 1, 1980 [illegible] minimum benefits for a qualified [illegible] shall include, in addition to those [illegible] fit specified in clause (a), benefi[illegible] the following services subject to [illegible] cable deductibles, coinsurance p[illegible] sions, and maximum lifetime be[illegible] limitations;

"(1) Well baby care;

62E.07 Qualified medicare supple[illegible]

Any plan which provides benef[illegible] be certified as a qualified medica[illegible] to supplement medicare and provi[illegible] and copayment required under m[illegible] covered services described in sect[illegible] not paid by medicare. The cover[illegible] person on total annual out-of-pock[illegible] coverage may be subject to a m[illegible] $100,000.

L[illegible]s 1976, c. 206, art. 1, § 7, eff. Jul[illegible]

62E.08 State plan premium

Subdivision 1. The association [illegible] premiums to be charged for memb[illegible] nance plan:

(a) [illegible] insurance in force in Minnesota;

(b) The premium for the number [illegible] equal to 125 percent of the average o[illegible] the largest number of individuals in [illegible] of insurance in force in Minnesota;

(c) The premium for a qualified m[illegible] maximum of 125 percent of the avera[illegible]

"(b) Covered expenses for the services and articles specified in this subdivision do not include the following:

"(1) Any charge for any care for any injury or disease either (i) arising out of an injury in the course of employment and subject to a workmen's compensation or similar law, (ii) for which benefits are payable without regard to fault under coverage statutorily required to be contained in any motor vehicle, or other liability insurance policy or equivalent self-insurance, or (iii) for which benefits are payable under another policy of accident and health insurance or medicare;

"(2) Any charge for treatment for cosmetic purposes other than surgery for the repair of an injury or birth defect;

"(3) Any charge for travel other than travel by ambulance to the nearest health care institution qualified to treat the illness or injury;

"(4) Any charge for confinement in a private room to the extent it is in excess of the institution's charge for its most common semi-private room, unless a private room is prescribed as medically necessary by a physician;

"(5) That part of any charge for services or articles rendered or prescribed by a physician, dentist, or other health care personnel which exceeds the prevailing charge in the locality where the service is provided; and

"(6) Any charge for services or articles the provision of which is not within the scope of authorized practice of the institution or individual rendering the services or articles.

"(c) Effective January 1, 1980, the minimum benefits for a qualified plan shall include, in addition to those benefits specified in clause (a), benefits for the following services subject to applicable deductibles, coinsurance provisions, and maximum lifetime benefit limitations;

"(1) Well baby care;

"(2) Physicians' services for routine check-ups and annual physicals when prescribed by a physician; and

"(3) Multiphasic screening and other diagnostic testing. The commissioner by rule shall prescribe reasonable limits on the reimbursement required for services listed in this clause.

"Subd. 2. A plan of health coverage shall be certified as a number two qualified plan if it meets the requirements established by the laws of this state and provides for payment of 80 percent of the covered expenses required by this section in excess of a deductible which does not exceed $500 per person.

"Subd. 3. A plan of health coverage shall be certified as a number one qualified plan if it meets the requirements established by the laws of this state and provides for payment of 80 percent of the covered expenses required by this section in excess of a deductible which does not exceed $1,000 per person.

"Subd. 4. A health maintenance organization which provides the services required by Minnesota Statutes, Chapter 62B shall be deemed to be providing a number three qualified plan."

1979 Amendment Added to subd. 1(b)(14): "or a reasonable mileage rate for transportation to a kidney dialysis center for treatment". Deleted as the beginning words in subd. 1(d); effective July 1, 1980. Inserted the following effective dates in subd. 1(d): in clause (d)(1), July 1, 1980; in clause (d)(2), July 1, 1982; in clause (d)(3), July 1, 1982.

Law Review Commentaries

Medical benefit plans in Minnesota. Robert F. Strauss. 31 Bench and Bar No. 5, p. 19 (Nov.1977).

Minnesota Comprehensive Health Insurance Act of 1977. By John F. Stone and Margo S. Struthers. 34 Bench and Bar No. 7, p. 27 (Jun.1978).

Library References

Insurance ⇐531.1.
C.J.S. Insurance §§ 897, 980

62E.07 Qualified medicare supplement plan

Any plan which provides benefits to persons over the age of 65 years may be certified as a qualified medicare supplement plan if the plan is designed to supplement medicare and provides coverage of 50 percent of the deductible and copayment required under medicare and 80 percent of the charges for covered services described in section 62E.06, subdivision 1, which charges are not paid by medicare. The coverage shall include a limitation of $1,000 per person on total annual out-of-pocket expenses for the covered services. The coverage may be subject to a maximum lifetime benefit of not less than $100,000.

Laws 1976, c. 206, art. 1, § 7, eff. July 1, 1976.

62E.08 State plan premium

Subdivision 1. The association shall establish the following maximum premiums to be charged for membership in the comprehensive health insurance plan:

(a) The premium for the number one qualified plan shall be up to a maximum of 150 percent of the average of rates charged by the five insurers with the largest number of individuals in a number one individual qualified plan of insurance in force in Minnesota;

(b) The premium for the number two qualified plan shall be up to a maximum of 125 percent of the average of rates charged by the five insurers with the largest number of individuals in a number two individual qualified plan of insurance in force in Minnesota;

(c) The premium for a qualified medicare supplement plan shall be up to a maximum of 125 percent of the average of rates charged by the five insurers

with the largest number of individuals enrolled in a qualified medicare supplement plan; and

(d) The charge for health maintenance organization coverage shall be based on generally accepted actuarial principles.

The five insurers whose rates are used to establish the premium for each type of coverage offered by the association shall be determined by the commissioner on the basis of information provided by all insurers annually at the commissioner's request, concerning the number of individual qualified plans and qualified medicare supplement plans or actuarially equivalent plans offered by the insurer and rates charged by the insurer for each type of plan offered by the insurer. In determining the insurers whose rates shall be used in establishing the premium, the commissioner shall utilize generally accepted actuarial principles and structurally compatible rates. Subject to this subdivision, the commissioner shall include any insurer operating pursuant to chapter 62C in establishing the premium. In establishing premiums pursuant to this section, the association shall utilize generally accepted actuarial principles.

Subd. 2. Subject to subdivision 1 of this section, the schedule of premiums for coverage under the comprehensive health insurance plan shall be designed to be self-supporting and based on generally accepted actuarial principles.

Laws 1976, c. 206, art. 1, § 8, eff. July 1, 1976. Amended by Laws 1977, c. 469, § 12, eff. June 3, 1977; Laws 1979, c. 272, § 6, eff. May 31, 1979.

1977 Amendment. Substituted 18 months for a year at the beginning of the section, modified subd. 2 accordingly.

1979 Amendment. Revised this section which formerly read:

"Subdivision 1. For the first eighteen months of operation of the comprehensive health insurance plan the association shall establish the following premiums to be charged for membership in the comprehensive health insurance plan:

"(a) The premium for the number one qualified plan shall be the average of rates charged by the five insurers with the largest number of individuals in a number one individual qualified plan of insurance in force in Minnesota;

"(b) The premium for the number two qualified plan shall be the average of rates charged by the five insurers with the largest number of individuals in a number two individual qualified plan of insurance in force in Minnesota;

"(c) The premium for a qualified medicare supplement plan shall be the average of rates charged by the five insurers with the largest number of individuals enrolled in a qualified medicare supplement plan; and

"(d) The charge for health maintenance organization coverage shall be based on generally accepted actuarial principles.

"Subd. 2. For subsequent enrollees or renewals of membership, the schedule of premiums for membership in the comprehensive health insurance plan shall be designed to be self-supporting and based on generally accepted actuarial principles."

Library References
Insurance ⇨11.2.
C.J.S. Insurance § 60 et seq.

62E.09 Duties of commissioner

The commissioner may:

(a) Formulate general policies to advance the purposes of sections 62E.01 to 62E.17;

(b) Supervise the creation of the Minnesota comprehensive health association within the limits described in section 62E.10;

(c) Approve the selection of the writing carrier by the association and approve the association's contract with the writing carrier including the state plan coverage and premiums to be charged;

(d) Appoint advisory committees;

(e) Conduct periodic audits to assure the general accuracy of the financial data submitted by the writing carrier and the association;

(f) Contract with the federal government or any other unit of governmental to ensure coordination of the state plan with other governmental assistance programs;

(g) Undertake directly or through contracts with other persons studies or demonstration programs to develop awareness of the benefits of sections 62E.01 to 62E.17, so that the residents of this state may best avail themselves of the health care benefits provided by these sections;

(h) Contract with in

(i) Adopt, amend, su carry out and make eff to 62E.17. The commis rules.

Laws 1976, c. 206, art. 1, § 13, eff. June 3, 1977.

1977 Amendment. Delete ing from the end of clause ed clause (i): "the comm also adopt, promulgate,

62E.10 Comprehensive he

Subdivision 1. Creatior hensive health associatior state of Minnesota with n fraternals and health mai business in this state. Th from taxation under the l association shall be exempt

Subd. 2. Board of direc association shall be made members, subject to appro rights at members' meetings or proxy. The vote shall be self insurance, accident and charges, or health maintenar Minnesota residents in the p missioner. In approving me sider, among other things, wi ed. Members of the board sociation for expenses incurr be compensated by the associ meetings of the association members of the association.

Subd. 3. Mandatory membe bership in the association as nance, self-insurance, or healt state. The association shall su the commissioner for approval of articles, bylaws and operati the commissioner thereof shal 15.041 to 15.052.

Subd. 4. Open meetings. All committees of the association 471.705.

Subd. 5. Repealed by Laws 1

Subd. 6. Antitrust exemption. bers of the association, the men sections 325.8011 to 325.8028.

Subd. 7. General powers. The

(a) Exercise the powers grant the Secretary of State;

(c) Enter into contracts with in with other persons for the perfor the functions provided for in clause

(d) Establish administrative and of the association;

(e) Provide for the reinsuring o coverages required by sections 62E

(h) Contract with insurers and others for administrative services; and

(i) Adopt, amend, suspend and repeal rules as reasonably necessary to carry out and make effective the provisions and purposes of sections 62E.01 to 62E.17. The commissioner may until December 31, 1978 adopt emergency rules.

Laws 1976, c. 296, art. 1, § 9, eff. July 1, 1976. Amended by Laws 1977, c. 409, § 13, eff. June 3, 1977.

1977 Amendment. Deleted the following from the end of clause (a) and added clause (i): "the commissioner may also adopt, promulgate, repeal, and amend rules pursuant to the rule making provisions of Minnesota Statutes, Chapter 15, to carry out the provisions of sections 62E.01 to 62E.17;"

62E.10 Comprehensive health association

Subdivision 1. Creation; tax exemption. There is established a comprehensive health association to promote the public health and welfare of the state of Minnesota with membership consisting of all insurers, self insurers, fraternals and health maintenance organizations licensed or authorized to do business in this state. The comprehensive health association shall be exempt from taxation under the laws of this state and all property owned by the association shall be exempt from taxation.

Subd. 2. Board of directors; organization. The board of directors of the association shall be made up of seven individuals selected by participating members, subject to approval by the commissioner. In determining voting rights at members' meetings, each member shall be entitled to vote in person or proxy. The vote shall be a weighted vote based upon the member's cost of self insurance, accident and health insurance premium, subscriber contract charges, or health maintenance contract payment derived from or on behalf of Minnesota residents in the previous calendar year, as determined by the commissioner. In approving members of the board, the commissioner shall consider, among other things, whether all types of members are fairly represented. Members of the board may be reimbursed from the moneys of the association for expenses incurred by them as members, but shall not otherwise be compensated by the association for their services. The costs of conducting meetings of the association and its board of directors shall be borne by members of the association.

Subd. 3. Mandatory membership. All members shall maintain their membership in the association as a condition of doing accident and health insurance, self-insurance, or health maintenance organization business in this state. The association shall submit its articles, bylaws and operating rules to the commissioner for approval; provided that the adoption and amendment of articles, bylaws and operating rules by the association and the approval by the commissioner thereof shall be exempt from the provisions of sections 15.041 to 15.052.

Subd. 4. Open meeting. All meetings of the association, its board, and any committees of the association shall comply with the provisions of section 471.705.

Subd. 5. Repealed by Laws 1979, c. 272, § 11, eff. May 31, 1979.

Subd. 6. Antitrust exemption. In the performance of their duties as members of the association, the members shall be exempt from the provisions of sections 325.8011 to 325.8028.

Subd. 7. General powers. The association may:

(a) Exercise the powers granted to insurers under the laws of this state;

(b) Sue or be sued;

(c) Enter into contracts with insurers, medical associations or other persons for the performance of medical review and for performing the functions provided for in clauses (e) and (f);

(d) Establish administrative and accounting procedures for the operation of the association;

(e) Provide for the reinsuring of risks incurred as a result of issuing the coverages required by sections 62E.04 and 62E.16 by members of the associa-

tion. Each member which elects to reinsure its required risks shall determine the categories of coverage it elects to reinsure in the association. The categories of coverage are:

(1) Individual qualified plans, excluding group conversions;

(2) Group conversions;

(3) Group qualified plans with fewer than 50 employees or members; and

(4) Major medical coverage.

A separate election may be made for each category of coverage. If a member elects to reinsure the risks of a category of coverage, it must reinsure the risk of the coverage of every life covered under every policy issued in that category. A member electing to reinsure risks of a category of coverage shall enter into a contract with the association establishing a reinsurance plan for the risks. This contract may include provision for the pooling of members' risks reinsured through the association and it may provide for assessment of each member reinsuring risks for losses and operating and administrative expenses incurred, or estimated to be incurred in the operation of the reinsurance plan. This reinsurance plan shall be approved by the commissioner before it is effective. Members electing to administer the risks which are reinsured in the association shall comply with the benefit determination guidelines and accounting procedures established by the association. The fee charged by the association for the reinsurance of risks shall not be less than 110 percent of the total anticipated expenses incurred by the association for the reinsurance; and

(f) Provide for the administration by the association of policies which are reinsured pursuant to clause (e). Each member electing to reinsure one or more categories of coverage in the association may elect to have the association administer the categories of coverage on the member's behalf. If a member elects to have the association administer the categories of coverage, it must do so for every life covered under every policy issued in that category. The fee for the administration shall not be less than 110 percent of the total anticipated expenses incurred by the association for the administration.

Subd. 8. Department of state exemption. The association shall be exempt from the provisions of chapter 15.

Laws 1976, c. 296, art. 1, § 10, eff. July 1, 1976. Amended by Laws 1977, c. 409, §§ 14 to 16, eff. June 3, 1977; Laws 1979, c. 272, § 7, eff. May 31, 1979.

1977 Amendment. Added "to promote the public health and welfare of the state of Minnesota" to the first sentence of subd. 1 as well as the last sentence of that subdivision. Added "accident and health insurance, self-insurance, or health maintenance organization" to subd. 3. Added the sentences to subd. 10(e)(4) relating to the reinsurance contracts.

1979 Amendment. Revised the terms of subds. 2 and 3 and added subd. 8. Revised subds. 2 and 3 and repealed subd. 5 read as follows:

"Subd. 2. The board of directors of the association shall be made up of seven individuals selected by participating members, subject to approval by the commissioner. To select the initial board of directors, and to initially organize the association, the commissioner shall give notice to all members of the time and place of the organizational meeting. In determining voting rights at the organizational meeting each member shall be entitled to vote in person or by proxy. The vote shall be a weighted vote based upon the member's cost of self insurance, accident and health insurance premium, subscriber contract charges, or health maintenance contract payment derived from or on behalf of Minnesota residents in the previous calendar year, as determined by the commissioner. If the board of directors is not selected within 60 days after notice of the organizational meeting, the commissioner may appoint the initial board. In approving or selecting members of the board, the commissioner shall consider, among other things, whether all types of members are fairly represented. Members of the board may be reimbursed from the moneys of the association for expenses incurred by them as members, but shall not otherwise be compensated by the association for their services. The costs of conducting meetings of the association and its board of directors shall be borne by members of the association.

"Subd. 3. All members shall maintain their membership in the association as a condition of doing accident and health insurance, self-insurance, or health maintenance organization business in this state. The association shall submit bylaws and operating rules to the commissioner for approval.

"Subd. 5. All members shall enter into a contract with the association according to terms specified in section [illegible]. The contract of reinsurance shall be executed on or before January 1, 1977, for a period of one year and shall be renewed annually thereafter. A company which ceases to do business within the state shall remain liable under the contract for the reinsurance contracted for during that calendar year."

Library References

Insurance ⇐31.1.
C.J.S. Insurance § 91 et seq.

62E.11 Operation of cer

Subdivision 1. Upon
vided by section 62E.14,
health insurance plan b
carrier.

Subd. 2. Any employe
enrolled in the compreh
portion of the state plan
writing carrier.

Subd. 3. Not less than
writing carrier shall be
shall be used for the pay
62E.15, subdivision 3 and
direct expenses, as specifi

Subd. 4. Any income fr
providing reinsurance or
clauses (e) and (f) shall be
set losses due to claims ex
plan premiums.

Subd. 5. Each contribut
due to claims expenses of
issued or approved for iss
operating and administrati
by the association incident
of the state plan which exce
of benefits shall be the lia
members shall share in the
administrative expenses of
the contributing member's
ceived from or on behalf of
dent and health insurance pr
or on behalf of Minnesota

Subd. 6. The association
tributing member's liability,
assessment if necessary. The
the commissioner, provide fo
members as may be necessary
tion in meeting the incurred
and operating and administrat
tion's next annual fiscal year
be due within 30 days of recei
of a fiscal year end or in eri
ber to tender to the associatio
for termination of the cont
member which ceases to do
the state shall remain liable fo
which accident and health ins
decline to levy an assessment
[illegible], as determined herein

Subd. 7. Net gains, if any,
held at interest and used by
claims expenses of the state pl

Subd. 8. Any annual fiscal y
contributing member may be off
to the association, against the
that contributing member pursu
annual fiscal year end or interi
revenue shall annually, on or be
the senate finance, house appropr

62E.11 Operation of comprehensive plan

Subdivision 1. Upon certification as an eligible person in the manner provided by section 62E.14, an eligible person may enroll in the comprehensive health insurance plan by payment of the state plan premium to the writing carrier.

Subd. 2. Any employer which has in its employ one or more eligible persons enrolled in the comprehensive health insurance plan may make all or any portion of the state plan premium payment to the state plan directly to the writing carrier.

Subd. 3. Not less than 87½ percent of the state plan premium paid to the writing carrier shall be used to pay claims, and not more than 12½ percent shall be used for the payment of agent referral fees as authorized in section 62E.15, subdivision 3 and for payment of the writing carrier's direct and indirect expenses, as specified in section 62E.13, subdivision 7.

Subd. 4. Any income in excess of the costs incurred by the association in providing reinsurance or administrative services pursuant to section 62E.07, clauses (e) and (f) shall be held at interest and used by the association to offset losses due to claims expenses of the state plan or allocated to reduce state plan premiums.

Subd. 5. Each contributing member of the association shall share the losses due to claims expenses of the comprehensive health insurance plan for plans issued or approved for issuance by the association, and shall share in the operating and administrative expenses incurred or estimated to be incurred by the association incident to the conduct of its affairs. Claims expenses of the state plan which exceed the premium payments allocated to the payment of benefits shall be the liability of the contributing members. Contributing members shall share in the claims expense of the state plan and operating and administrative expenses of the association in an amount equal to the ratio of the contributing member's total accident and health insurance premium, received from or on behalf of Minnesota residents as divided by the total accident and health insurance premium, received by all contributing members from or on behalf of Minnesota residents, as determined by the commissioner.

Subd. 6. The association shall make an annual determination of each contributing member's liability, if any, and may make an annual fiscal year end assessment if necessary. The association may also, subject to the approval of the commissioner, provide for interim assessments against the contributing members as may be necessary to assure the financial capability of the association in meeting the incurred or estimated claims expenses of the state plan and operating and administrative expenses of the association until the association's next annual fiscal year end assessment. Payment of an assessment shall be due within 30 days of receipt by a contributing member of a written notice of a fiscal year end or interim assessment. Failure by a contributing member to tender to the association the assessment within 30 days shall be grounds for termination of the contributing member's membership. A contributing member which ceases to do accident and health insurance business within the state shall remain liable for assessments through the calendar year during which accident and health insurance business ceased. The association may decline to levy an assessment against a contributing member if the assessment, as determined herein, would not exceed ten dollars.

Subd. 7. Net gains, if any, from the operation of the state plan shall be held at interest and used by the association to offset future losses due to claims expenses of the state plan or allocated to reduce state plan premiums.

Subd. 8. Any annual fiscal year end or interim assessment levied against a contributing member may be offset, in an amount equal to the assessment paid to the association, against the income tax or the premium tax payable by that contributing member pursuant to section 60A.15 for the year in which the annual fiscal year end or interim assessment is levied. The commissioner of revenue shall annually, on or before January 15, report to the chairmen of the senate finance, house appropriations, senate commerce and house financial

institutions and insurance committees as to the total amount of income tax or premium tax offset claimed by contributing members during the preceding calendar year.

Laws 1976, c. 296, art. 1, § 11, eff. Jan 1, 1977. Amended by Laws 1977, c. 409, § 17, eff. June 3, 1977; Laws 1979, c. 272, § 8, eff. May 31, 1979.

1977 Amendment. Revised subd. 5 which formerly read:

"Each member of the association shall share the losses due to claims expenses of the comprehensive health insurance plan pursuant to the terms of the individual reinsurance contracts executed by the association with each member in accordance with section 62E.10, subdivision 5. Deviations in the claim experience of the state plan from the premium payments allocated to the payment of benefits shall be the liability of the association members. Association members shall share in the excess costs of the state plan in an amount equal to the ratio of the member's total cost of self insurance, accident and health insurance premium, subscriber contract charges, or health maintenance organization contract charges received from or on behalf of Minnesota residents as divided into the total cost of self insurance, accident and health insurance premium, subscriber contract charges, and health maintenance organization contract charges received by all association members from or on behalf of Minnesota residents, as determined by the commissioner. The reinsurance contract shall provide for a retroactive determination of each member's liability and payment due within 30 days after each renewal date of the reinsurance contract. Failure by a member to tender to the association the assessed reinsurance payment within 30 days of notification by the association shall be grounds for termination of the member's membership.

"Net gains, if any, from the operation of the state plan shall be held at interest and used by the association to offset future losses due to claims expenses of the state plan or allocated to reduce state plan premiums."

1979 Amendment. Revised subd. 5 to appear as subds. 5 to 7 and added the provisions of subd. 8. Subd. 5 formerly read:

"Each member of the association shall share the losses due to claims expenses of the comprehensive health insurance plan for plans issued or approved for issuance by the association, and shall share in the operating and administrative expenses incurred or estimated to be incurred by the association incident to the conduct of its affairs, pursuant to the terms of the individual reinsurance contracts executed by the association with each member in accordance with section 62E.10, subdivision 5. Deviations in the claim experience of the state plan from the premium payments allocated to the payment of benefits shall be the liability of the association members. Association members shall share in the claims expense of the state plan and operating and administrative expenses of the association in an amount equal to the ratio of the member's total cost of self insurance, accident and health insurance premium, subscriber contract charges, or health maintenance organization contract charges received from or on behalf of Minnesota residents as divided into the total cost of self insurance, accident and health insurance premium, subscriber contract charges, and health maintenance organization contract charges received by all association members from or on behalf of Minnesota residents, as determined by the commissioner. The reinsurance contract shall provide for an annual determination and assessment of each member's liability, if any. Payment of the assessment shall be due within 30 days after the end of the association's fiscal year. Subject to the approval of the commissioner, the reinsurance contract may provide for interim assessments as may be necessary to assure the financial capability of the association in meeting the incurred or estimated claims expenses of the state plan and operating and administrative expenses of the association until the association's next annual fiscal year end assessment. Failure by a member to tender to the association the assessed reinsurance payment within 30 days of notification by the association shall be grounds for termination of the member's membership.

"Net gains, if any, from the operation of the state plan shall be held at interest and used by the association to offset future losses due to claims expenses of the state plan or allocated to reduce state plan premiums."

Laws 1979, c. 272, § 12, provided in part that the provisions of section 62E.11, subd. 8, shall expire on July 1, 1981.

Law Review Commentaries

Medical benefit plans in Minnesota. Robert F. Strauss. 34 Bench and Bar No. 5, p. 19 (Nov.1977).

Minnesota Comprehensive Health Insurance Act of 1977. By John F. Stone and Margo S. Struthers. 34 Bench and Bar No. 7, p. 27 (Jan.1978).

Library References

Justices of the Peace ⇨34(1).
C.J.S. Justices of the Peace § 27.

62E.12 Minimum benefits of comprehensive health insurance plan

The association through its comprehensive health insurance plan shall offer policies which provide the benefits of a number one qualified plan, a number two qualified plan and a qualified medicare supplement plan. They shall offer health maintenance organization contracts in those areas of the state where a health maintenance organization has agreed to make the coverage available and has been selected as a writing carrier.

Laws 1976, c. 296, art. 1, § 12, eff. Jan. 1, 1977.

62E.13 Administration of plan

Subdivision 1. Any member of the association may submit to the commissioner the policies of accident and health insurance or the health maintenance organization contracts which are being proposed to serve in the comprehensive health insurance
shall be prescribed by rule of

Subd. 2. The association
submitted by a member or n
or others, to develop specific
be selected as a writing carr
of the writing carrier shall
proven ability to handle large
cient claim paying capacity,
ing the plan. The associatio
two types of qualified plans,
health maintenance organizatio

Subd. 3. The writing carri
payment functions required b
vide these services for a perio
is approved by the commissio
a request to terminate within
final decision on a request to
deemed to be an approval. Si
year period, the association s
members of the association, in
shall follow the provisions of s
the subsequent three year period.

Subd. 4. The writing carrier
in the plan an individual policy
the insurance protection to whic
filed and to whom benefits are
cate that coverage was obtained

Subd. 5. The writing carrier
missioner on a monthly basis
Specific information to be cont
the association prior to the effec

Subd. 6. All claims shall be
provisions of sections 62E.01 to 6
paid by the state plan. Each cl
fying the procedure to be followe
of payment.

Subd. 7. The writing carrier
premiums received for its direct
expenses shall include, but need
for that portion of the writing
administration, management and
signable to the maintenance and o
ation shall approve cost accountin
rier's cost reports consistent wit
Direct and indirect expenses shal
original submission of policy form

Subd. 8. The writing carrier sh
under sections 62E.01 to 62E.17 be
the commissioner may elect to

Subd. 9. Premiums received by
health insurance plan are specifie
tion 60A.15.

Laws 1976, c. 296, art. 1, § 13, eff. J
§§ 18, 19, eff. June 3, 1977; Laws

1977 Amendment. Substituted t
reference to "Chapter 62A" for the re
erence to "Section 62A.10" at the begi
ning of subd. 2, as well as "may" fo

prehensive health insurance plan. The time and manner of the submission shall be prescribed by rule of the commissioner.

Subd. 2. The association may select policies and contracts, or parts thereof, submitted by a member or members of the association, or by the association or others, to develop specifications for bids from any members which wish to be selected as a writing carrier to administer the state plan. The selection of the writing carrier shall be based upon criteria including the member's proven ability to handle large group accident and health insurance cases, efficient claim paying capacity, and the estimate of total charges for administering the plan. The association may select separate writing carriers for the two types of qualified plans, the qualified medicare supplement plan, and the health maintenance organization contract.

Subd. 3. The writing carrier shall perform all administrative and claims payment functions required by this section. The writing carrier shall provide these services for a period of three years, unless a request to terminate is approved by the commissioner. The commissioner shall approve or deny a request to terminate within 90 days of its receipt. A failure to make a final decision on a request to terminate within the specified period shall be deemed to be an approval. Six months prior to the expiration of each three year period, the association shall invite submissions of policy forms from members of the association, including the writing carrier. The association shall follow the provisions of subdivision 2 in selecting a writing carrier for the subsequent three year period.

Subd. 4. The writing carrier shall provide to all eligible persons enrolled in the plan an individual policy or certificate, setting forth a statement as to the insurance protection to which he is entitled, with whom claims are to be filed and to whom benefits are payable. The policy or certificate shall indicate that coverage was obtained through the association.

Subd. 5. The writing carrier shall submit to the association and the commissioner on a monthly basis a report on the operation of the state plan. Specific information to be contained in this report shall be determined by the association prior to the effective date of the state plan.

Subd. 6. All claims shall be paid by the writing carrier pursuant to the provisions of sections 62E.01 to 62E.17, and shall indicate that the claim was paid by the state plan. Each claim payment shall include information specifying the procedure to be followed in the event of a dispute over the amount of payment.

Subd. 7. The writing carrier shall be reimbursed from the state plan premiums received for its direct and indirect expenses. Direct and indirect expenses shall include, but need not be limited to, a pro rata reimbursement for that portion of the writing carrier's administrative, printing, claims administration, management and building overhead expenses which are assignable to the maintenance and administration of the state plan. The association shall approve cost accounting methods to substantiate the writing carrier's cost reports consistent with generally accepted accounting principles. Direct and indirect expenses shall not include costs directly related to the original submission of policy forms prior to selection as the writing carrier.

Subd. 8. The writing carrier shall at all times when carrying out its duties under sections 62E.01 to 62E.17 be considered an agent of the association and the commissioner with civil liability subject to the provisions of section 3.751.

Subd. 9. [illegible]

Laws 1976, c. 338, art. 1, § 3, eff. July 1, 1976. Amended by Laws 1977, c. 109, §§ 18, 19, eff. June 3, 1977; Laws 1979, c. 272, § 9, eff. May 31, 1979.

1977 Amendment. Substituted the reference to "Chapter 62A" for the reference to "Section 62A.10" at the beginning of subd. 2, as well as "may" for "shall" following the citation. Inserted "policy" as used in conjunction with "certificate" in subd. 4.

1979 Amendment. Revised subd. 2 which formerly read:

"Upon the commissioner's approval of the policy forms and contracts submitted pursuant to chapter 62A, the association may select policies and contracts submitted by a member or members of the association to be the comprehensive health insurance plan. This selection shall be based upon criteria including the member's proven ability to handle large group accident and health insurance cases, efficient claim paying capacity, and the estimate of total charges for administering the plan. The association may select separate writing carriers for the two types of qualified plans, the qualified medicare supplement plan, and the health maintenance organization contract."

Library References

Insurance ⇐31.1.
C.J.S. Insurance § 91 et seq.

62E.14 Enrollment by an eligible person

Subdivision 1. Certificate, contents. The comprehensive health insurance plan shall be open for enrollment by eligible persons. An eligible person shall enroll by submission of a certificate of eligibility to the writing carrier. The certificate shall provide the following:

(a) Name, address, age, and length of time at residence of the applicant;

(b) Name, address, and age of spouse and children if any, if they are to be insured;

(c) Evidence of rejection, a requirement of restrictive riders, a rate up, or a pre-existing conditions limitation on a qualified plan, the effect of which is to substantially reduce coverage from that received by a person considered a standard risk, by at least two association members within six months of the date of the certificate, or other eligibility requirements adopted by rule by the commissioner which are not inconsistent with this chapter and which evidence that a person is unable to obtain coverage substantially similar to that which may be obtained by a person who is considered a standard risk; and

(d) A designation of the coverage desired.

An eligible person may not purchase more than one policy from the state plan. Upon ceasing to be a resident of Minnesota a person is no longer eligible to purchase or renew coverage under the state plan.

Subd. 2. Writing carrier's response. Within 30 days of receipt of the certificate described in subdivision 1, the writing carrier shall either reject the application for failing to comply with the requirements in subdivision 1 or forward the eligible person a notice of acceptance and billing information. Insurance shall be effective immediately upon receipt of the first month's state plan premium, and shall be retroactive to the date of the application, if the applicant otherwise complies with the requirements of sections 62E.01 to 62E.17.

Subd. 3. Pre-existing conditions. No person who obtains coverage pursuant to this section shall be covered for any pre-existing condition during the first six months of coverage under the state plan if the person was diagnosed or treated for that condition during the 90 days immediately preceding the filing of an application.

Laws 1976, c. 296, art. 1, § 14, eff. Jan. 1, 1977. Amended by Laws 1977, c. 409, § 20, eff. June 3, 1977; Laws 1979, c. 272, § 10, eff. May 31, 1979.

1977 Amendment. Substituted "may" for "shall" with regard to the content of the certificate.

1979 Amendment. Revised subd. 1 which formerly read:

"The comprehensive health insurance plan shall be open for enrollment by eligible persons. An eligible person may enroll by submission of a certificate of eligibility to the writing carrier. The certificate may provide the following:

"(a) Name, address, age, and length of time at residence of the applicant;

"(b) Name, address, and age of spouse and children if any, if they are to be insured;

"(c) Evidence of rejection, or a requirement of restrictive riders, or a pre-existing conditions limitation on a qualified plan, the effect of which is to substantially reduce coverage from that received by a person considered a standard risk, by at least two association members within six months of the date of the certificate; and

"(d) A designation of the coverage desired.

"An eligible person may not purchase more than one policy from the state plan."

Law Review Commentaries

Stopping benefit plans in Minnesota. Robert P. Strauss. 34 Bench and Bar No. 5, p. 19 (Nov.1977).

Minnesota Comprehensive Health Insurance Act of 1977. By John F. Stone and Margo B. Strathern. 34 Bench and Bar No. 7, p. 27 (Jan.1978).

Library References

Insurance ⇐130.
C.J.S. Insurance § 232.

62E.15 Solicitation of eligible

Subdivision 1. The associat
sioner shall disseminate appro
regarding the existence of th
means of enrollment. Means
radio and television, as well
publications.

Subd. 2. The association s
ing public awareness of the p
administer these sections in a
in the state plan.

Subd. 3. The writing carri
each insurance agent who ref
cation is accepted. Selling or
limited to the writing carrier
by the writing carrier from n

Subd. 4. Every insurer wh
to an applicant for accident a
of the existence of the state
it, and the procedure for appl
Laws 1976, c. 296, art. 1, § 15, ef

62E.16 Conversion privileges

Every program of self insura
ance or contract of coverage
or renewed in this state, shall
by section 62A.17, the right to c
without the addition of under
leaves the group regardless of
cellation or termination of the
rupted and continuous group
The person may exercise his rig
group or within 30 days follow
termination of coverage of the
the date of termination or canc
nation of coverage for a group
erage in the group by the insure
tion cancelling or terminating
indicates that uninterrupted ne
vided to the group. Every em
health insurance, group subscrib
nance organization shall, upon
nance organization a list of th
Plans of health coverage shall
of the individual in whose name
individual then covered under
fied in the contract, to continu
contract without the addition of
ceased to have been entitled to
the contract was issued [lived
health maintenance organization
enforced contract for the purpos
Laws 1976, c. 296, art. 1, § 16, eff
§ 1.

1977 Amendment. Inserted, in first sentence, following "restrictio the words "if the individual leave group" and added the alternative exception at the end of the first tence; and rewrote the second sent which previously read: "The pe

62E.15 Solicitation of eligible persons

Subdivision 1. The association pursuant to a plan approved by the commissioner shall disseminate appropriate information to the residents of this state regarding the existence of the comprehensive health insurance plan and the means of enrollment. Means of communication may include use of the press, radio and television, as well as publication in appropriate state offices and publications.

Subd. 2. The association shall devise and implement means of maintaining public awareness of the provisions of sections 62E.01 to 62E.17 and shall administer these sections in a manner which facilitates public participation in the state plan.

Subd. 3. The writing carrier shall pay an agent's referral fee of $25 to each insurance agent who refers an applicant to the state plan, if the application is accepted. Selling or marketing of qualified state plans shall not be limited to the writing carrier or its agents. The referral fees shall be paid by the writing carrier from money received as premiums for the state plan.

Subd. 4. Every insurer which rejects or applies underwriting restrictions to an applicant for accident and health insurance shall notify the applicant of the existence of the state plan, the requirements for being accepted in it, and the procedure for applying to it.

Laws 1976, c. 296, art. 1, § 15, eff. July 1, 1976.

62E.16 Conversion privileges

Every program of self insurance, policy of group accident and health insurance or contract of coverage by a health maintenance organization written or renewed in this state, shall include, in addition to the provisions required by section 62A.17, the right to convert to an individual coverage qualified plan without the addition of underwriting restrictions if the individual insured leaves the group regardless of the reason for leaving the group, or upon cancellation or termination of the coverage for the group except where uninterrupted and continuous group coverage is otherwise provided to the group. The person may exercise his right to conversion within 30 days of leaving the group or within 30 days following his receipt of due notice of cancellation or termination of coverage of the group and upon payment of premiums from the date of termination or cancellation. Due notice of cancellation or termination of coverage for a group shall be provided to each employee having coverage in the group by the insurer, self insurer or health maintenance organization cancelling or terminating the coverage except where reasonable evidence indicates that uninterrupted and continuous group coverage is otherwise provided to the group. Every employer having a policy of group accident and health insurance, group subscriber or contract of coverage by a health maintenance organization shall, upon request, provide the insurer or health maintenance organization a list of the names and addresses of covered employees. Plans of health coverage shall also include a provision which, upon the death of the individual in whose name the contract was issued, permits every other individual then covered under the contract to elect, within the period specified in the contract, to continue his coverage under the same or a different contract without the addition of underwriting restrictions until he would have ceased to have been entitled to coverage had the individual in whose name the contract was issued lived. An individual conversion contract issued by a health maintenance organization shall not be deemed to be an individual enrollment contract for the purposes of section 62D.10.

Laws 1976, c. 296, art. 1, § 16, eff. Jan. 1, 1977. Amended by Laws 1977, c. 305, § 1.

1977 Amendment. Inserted, in the first sentence, following "restrictions", the words "if the individual leaves the group" and added the alternative and exception at the end of the first sentence; and rewrote the second sentence which previously read: "The person leaving the group may exercise his right to conversion within 30 days of leaving the group."

Library References

Insurance ⇐178.3(4).
C.J.S. Insurance § 329 et seq.

62E.17 Dual option

Subdivision 1. An employer who employs in this state, on the average during a calendar quarter, 100 employees or more, other than employees engaged in seasonal employment as defined in section 268.07, subdivision 5, and who offers a health benefits plan to employees, whether (i) purchased from an insurer or a health maintenance organization, or (ii) provided on a self insured basis, shall, upon the next renewal of the health benefits plan contract, offer his employees a dual option to obtain health benefits through either an accident and health insurance policy or a health maintenance organization contract if one is available. An option need not be provided if less than 25 employees select that option.

Subd. 2. An employer may make the dual offers through an insurer, a health maintenance organization or on a self insured basis. If an offer is made on a self insured basis, the accident and health insurance type of coverage or health maintenance organization type of coverage shall meet the requirements of the laws of this state as to the services covered or benefits provided, but need not otherwise be approved by the commissioner or the commissioner of health.

Subd. 3. No insurer shall make acceptance of its offer to provide insurance coverage contingent on acceptance by the employer of health maintenance organization coverage by a particular health maintenance organization. No health maintenance organization shall make acceptance of its offer to provide health maintenance organization coverage contingent on acceptance by the employer of insurance coverage by a particular insurer. No offer to provide the accident and health insurance policy and the health maintenance organization contract shall combine the two in a single price package.

Subd. 4. The commissioner of health, in consultation with the commissioner, shall adopt rules to implement the provisions of this section.
Laws 1976, c. 296, art. 1 § 17, eff. Jan. 1, 1977. Amended by Laws 1977, c. 305, § 45, eff. May 28, 1977.

1977 Amendment. Laws 1977, c. 305, § 45, directed that changes in names with relation to officials involved in state health functions be made generally throughout the statutes.

Library References
Insurance ⇐130.
C.J.S. Insurance § 232.

CATASTROPHIC HEALTH EXPENSE PROTECTION

62E.51 Citation

Sections 62E.51 to 62E.55 may be cited as the Minnesota catastrophic health expense protection act of 1976.
Laws 1976, c. 296, art. 3, § 1, eff. July 1, 1977.

Law Review Commentaries
Comprehensive Health Insurance Act of 1976: An experiment in health coverage. John F. Stone and Margo S. Struthers. 34 Bench and Bar No. 10 p. 31 (April 1978).

Library References
Mental Health ⇐241.
C.J.S. Insane Persons § 69.

62E.52 Definitions

Subdivision 1. For the purposes of sections 62E.51 to 62E.55, the terms defined in this section have the meanings given them.

Subd. 2. "Eligible person" means any person who is a resident of Minnesota [illegible] who has been issued by the commissioner a certificate of eligibility for [illegible]

(1) qualified expenses for himself and any dependents in any 12 consecutive months exceeding:

(a) 40 percent of his household income up to $15,000, plus 50 percent of his household income between $15,000 and $25,000, plus 60 percent of his household income in excess of $25,000; or

(b) $2,500, whichever is greater; or

(2) qualified nursing ho
any 12 consecutive months

Subd. 3. "Qualified exp
July 1, 1977 for a health s
vices described in 62E.06,
liable.

Subd. 3a. "Qualified nu
red for nursing home serv
to a person 64 years of age o

Subd. 4. "Dependent" m
19 years, a child who is a
pendent upon the parent, or
upon the parent.

Subd. 5. "Household inc
son and all his dependents
preceding the year in which

Subd. 6. "Gross income"
division 3.

Subd. 7. "Commissioner"

Subd. 8. "Third party" m
his dependents.
Laws 1976, c. 296, art. 3, § 2, §§ 1 to 3.

1977 Amendment. Laws 197
added subd. 2(3) and subd. 3a

62E.53 Application for assi

Subdivision 1. Any per
an eligible person may subm
missioner. The application s
to the date of the applicatio
month period for computing e

Subd. 2. If the commissio
person, he shall pay

(1) 90 percent of all quali
pendents in excess of:

(a) 40 percent of his house
household income between $1
hold income in excess of $25,0

(b) $2,500;

whichever is greater for t
comes an eligible person and

(2) all qualified nursing h
dependents in excess of 20
however, that the payment o
made until the end of the fis
of qualified nursing home ex
ing home expenses, the comm
eligible persons in proportion
nursing home expenses of all

Subd. [illegible] Unless otherwise provided [illegible] by the same provi
under the provisions of chapt
the charge for a health servic
reasonable charge for that se
health service provided to an
may refuse to pay for the serv
view organization as defined i

(2) qualified nursing home expenses for himself and any dependents in any 12 consecutive months exceeding 20 percent of his household income.

Subd. 3. "Qualified expense" means any charge incurred subsequent to July 1, 1977 for a health service which is included in the list of covered services described in 62F.06, subdivision 1, and for which no third party is liable.

Subd. 3a. "Qualified nursing home expense" includes any charge incurred for nursing home services after 36 months of continuous care provided to a person 64 years of age or younger in long-term care facilities.

Subd. 4. "Dependent" means a spouse or unmarried child under the age of 19 years, a child who is a student under the age of 25 and financially dependent upon the parent, or a child of any age who is disabled and dependent upon the parent.

Subd. 5. "Household income" means the gross income of an eligible person and all his dependents 23 years of age or older for the calendar year preceding the year in which an application is filed pursuant to section 62E.53.

Subd. 6. "Gross income" means income as defined in section 290A.03, subdivision 3.

Subd. 7. "Commissioner" means the commissioner of public welfare.

Subd. 8. "Third party" means any person other than the eligible person or his dependents.

Laws 1976, c. 296, art. 3, § 2, eff. July 1, 1977. Amended by Laws 1977, c. 448, §§ 1 to 3.

1977 Amendment. Laws 1977, c. 448, added subd. 2(2) and subd. 3a, and inserted "23 years of age or older" in subd. 5.

62E.53 Application for assistance

Subdivision 1. Any person who believes that he is or will become an eligible person may submit an application for state assistance to the commissioner. The application shall include a listing of expenses incurred prior to the date of the application and shall designate the date on which the 12 month period for computing expenses began.

Subd. 2. If the commissioner determines that an applicant is an eligible person, he shall pay

(1) 90 percent of all qualified expenses of the eligible person and his dependents in excess of:

(a) 40 percent of his household income under $15,000, plus 50 percent of his household income between $15,000 and $25,000, plus 60 percent of his household income in excess of $25,000; or

(b) $2,500;

whichever is greater for the 12 month period in which the applicant becomes an eligible person and

(2) all qualified nursing home expenses of the eligible person and his dependents in excess of 20 percent of his household income. Provided, however, that the payment of qualified nursing home expenses shall not be made until the end of the fiscal year. If the appropriation for the payment of qualified nursing home expenses is inadequate to pay all qualified nursing home expenses, the commissioner shall prorate the payments among all eligible persons in proportion to their share of the total of the qualified nursing home expenses of all eligible persons.

Subd. 3. The commissioner shall by rule establish procedures for determining whether and to what extent qualified expenses are reasonable charges. Unless otherwise provided for by rule, charges shall be reviewed for reasonableness by the same procedures used to review and limit reimbursement under the provisions of chapter 256B. If the commissioner determines that the charge for a health service is excessive, he may limit his payment to the reasonable charge for that service. If the commissioner determines that a health service provided to an eligible person was not medically necessary, he may refuse to pay for the service. The commissioner may contract with a review organization as defined in section 145.61, in making any determinations

as to whether or not a charge is excessive and in making any determination as to whether or not a service was medically necessary. If the commissioner in accordance with this section refuses to pay all or a part of the charge for a health service, the unpaid portion of the charge shall be deemed to be an unconscionable fee, against the public policy of this state, and unenforceable in any action brought for the recovery of moneys owed.

Laws 1976, c. 296, art. 3, § 3, eff. July 1, 1977. Amended by Laws 1977, c. 409, § 21, eff. June 3, 1977; Laws 1977, c. 448, § 4.

1977 Amendments. Laws 1977, c. 409 revised subd. 2 which now appears as subds. 2 and 3. Subd. 2 formerly read:

"If the commissioner determines that an applicant is an eligible person, he shall pay 50 percent of all qualified expenses of the eligible person and his dependents in excess of:

(a) 40 percent of his household income under $15,000, plus 50 percent of his household income between $15,000 and $25,000, plus 60 percent of his household income in excess of $25,000; or

"(b) $2,500;

whichever is greater for the 12 month period in which the applicant becomes an eligible person. If the commissioner determines that the charge for a health service is excessive, he may limit his payment to the usual and customary charge for that service. If the commissioner determines that a health service provided to an eligible person was not medically necessary, he may refuse to pay for the service. To the extent feasible, the commissioner shall contract with a review organization as defined in Minnesota Statutes, Section 145.61, in making any determinations as to whether or not a charge is excessive. To the extent feasible, the commissioner shall contract with a review organization as defined in Minnesota Statutes, Section 145.61, in making any determination as to whether or not a service was medically necessary. If the commissioner in accordance with this section refuses to pay all or a part of the charge for a health service, the unpaid portion of the charge shall be deemed to be an unconscionable fee, against the public policy of this state, and unenforceable in any action brought for the recovery of moneys owed."

Laws 1977, c. 448, added subd. 2(2).

62E.531 Third party liability

Subdivision 1. When the commissioner pays for or becomes liable for payments for health services under the provisions of sections 62E.51 to 62E.55, the department of public welfare shall have a lien for payments and liabilities for the services upon any and all causes of action which accrue to the person to whom the services were furnished, or to his legal representatives, as a result of injuries which directly or indirectly led to the incurring of qualified expenses.

The department may perfect and enforce its lien by following the procedures set forth in sections 514.69, 514.70, and 514.71, except that it shall have one year from the date when the last item of health service was furnished in which to file its verified lien statement. The statement shall be filed with the appropriate clerk of court in the county in which the recipient of the services resides or in the county in which the action was filed.

Subd. 2. Where a third party may be liable in whole or in part for payment for health services, the commissioner may consider the charges for the health services to be qualified expenses if the eligible person assigns any rights accruing by virtue of any third party liability to the commissioner to the extent necessary to reimburse the state for any payments made under the provisions of this section.

Subd. 3. Upon furnishing assistance under the provisions of sections 62E.51 to 62E.55, the department of public welfare shall be subrogated, to the extent of its payments for health services, to any rights the eligible person or his dependents may have under the terms of any plan of health coverage as the result of injury, sickness or death for which assistance was provided. The right of subrogation shall not be asserted against the proceeds of the recovery of subscription charges or premiums of the plan of health coverage.

The attorney general, or the appropriate county attorney, acting upon direction from the attorney general, may institute or join a civil action against the issuer of the plan of health coverage to recover under this subdivision.

Added by Laws 1977, c. 409, § 22, eff. June 3, 1977.

Library References
Insurance ⇐602.2(4).
C.J.S. Insurance § 1406 et seq.

62E.54 Duties of commissioner

Subdivision 1. The commissioner shall:

(a) Promulgate reasonable rules, including emergency rules, to implement sections 62E.51 to 62E.55.

(b) Establish application forms and procedures for the use of persons seeking to be declared an eligible person; and

(c) Investigate applications to determine whether or not the applicant is a qualified person and investigate claims from providers of health services to determine whether or not to pay them.

Subd. 2. The commissioner may:

(a) Enter into contracts with the United States or any state agency, instrumentality or political subdivision for the purpose of coordinating the program established by sections 62E.51 to 62E.55, with other programs which provide or pay for the delivery of health services;

(b) Enter into contracts with third parties to perform some or all of the duties imposed on the commissioner by sections 62E.53 and 62E.54.

Laws 1976, c. 296, art. 3, § 4, eff. July 1, 1977. Amended by Laws 1977, c. 409, § 23, eff. June 3, 1977.

1977 Amendment. Added "including emergency rules" to subd. 1(a).

62E.55 Appeals

The final decision of the commissioner denying an application for status as an eligible person or denying all or part of the charges for a health service may be appealed by any interested party pursuant to chapter 15.

Laws 1976, c. 296, art. 3, § 5, eff. July 1, 1977.

CHAPTER 62F. MEDICAL PRACTICE INSURANCE [NEW]

Sec.
62F.01 Citation; expiration date.
62F.02 Joint underwriting association.
62F.03 Definitions.
62F.04 Authorization to issue insurance.
62F.05 Plan of operation.
62F.06 Policy forms and rates.
62F.07 Participation.
62F.08 Procedures.
62F.09 Stabilization reserve fund.
62F.10 Investigation.
62F.11 Privileged communications.
62F.12 Appeals; judicial review.
62F.13 Public officers or employees.
62F.14 Annual statements.

62F.01 Citation; expiration date

Subdivision 1. Sections 62F.01 to 62F.14 may be cited as the "Temporary Joint Underwriting Association Act."

Subd. 2. Sections 62F.01 to 62F.14 expire September 1, 1980.

Laws 1976, c. 242, § 2, eff. April 14, 1976. Amended by Laws 1978, c. 571, § 1, eff. March 24, 1978.

1978 Amendment. Laws 1978, c. 571, § 1, added subd. 3 to this section fixing the expiration date of Sept. 1, 1980. Laws 1978, c. 571, § 2, repealed Laws 1976, c. 242, § 16, which had provided an expiration date for sections 62F.01 to 62F.14 of two years after its effective date extending date was April 14, 1978.

Law Review Commentaries

Defense of joint tortfeasors: Pierringer release in Minnesota. John E. Simonett. 1977, 3 Wm. Mitchell L.Rev. 1.

62F.02 Joint underwriting association

Subdivision 1. Creation. There is created a temporary joint underwriting association to provide medical malpractice insurance coverage to any licensed health care provider unable to obtain this insurance through ordinary methods. Every insurer authorized to write and writing personal injury liability insurance in this state shall be a member of the association as a condition to obtaining and retaining a license to write insurance in this state.

Subd. 2. Directors. The association shall have a board of directors composed of 11 persons chosen annually as follows: five persons elected by members of the association at a meeting called by the commissioners; three mem-

OREGON

...th or tuberculosis not otherwise expressly ... posed or granted by law.
...556 §10]

...090 [1953 c.204 §6; renumbered 414.860 and ... 556.360]

414.095 Exemptions applicable to ...ments. Neither medical assistance nor ...ments payable to vendors out of public ...stance funds are transferable or assigna... law or in equity and none of the money ...d or payable under the provisions of ORS ...435 and this chapter i... subject to execu... levy, attachment, garnishment or other ... process.
...556 §11; 1967 c.502 §14]

414.105 Recovery of certain medical ...tance; certain transfers of property ...idable. (1) The Adult and Family Services ...ision may recover from any person the ...nts of medical assistance incorrectly paid ...behalf of such person.

(2) Medical assistance pursuant to ORS ...435 and this chapter paid on behalf of an ...idual who was 65 years of age or older ...n he received such assistance may be ...vered from his estate, or if there be no ... the estate of the surviving spouse, if ..., shall be charged for such aid paid to ...r or both; provided, however, that claim ... such medical assistance correctly paid to ...may be established against the estate, but ...e shall be no adjustment or recovery ...eof until after the death of the surviving ...se, if any, and only at a time when he has ... surviving child who is under 21 years of ... or is blind or permanently and totally ...bled. Transfers of real or personal prop... by recipients of such aid without adeq... consideration are voidable and may be ...ered under subsection (2) of ORS 111.620.

(3) Except where there ... surviving ...se, or a surviving child who is under 21 ...rs of age or is blind or permanently and ...ally disabled, the amount of any medical ...tance paid under this chapter is a claim ...st the estate in any guardianship or ...servatorship proceedings and may be paid ...suant to ORS 126.353.
...556 §12; 1967 c.502 §15; 1969 c.507 §2; 1971 c.334 ... 973 c.334 §1; part renumbered 416.280; 1975 c.388 ...

INSURANCE AND SERVICE CONTRACTS

414.115 Medical assistance by insurance or service contracts. In lieu of providing one or more of the medical and remedial care and services available under medical assistance by direct payments to providers thereof and in lieu of providing such medical and remedial care and services made available pursuant to ORS 414.065, the Adult and Family Services Division shall use available medical assistance funds to purchase and pay premiums on policies of insurance, or enter into and pay the expenses on health care service contracts, or medical or hospital service contracts that provide one or more of the medical and remedial care and services available under medical assistance for the benefit of the categorically needy or the medically needy, or both. The policy of insurance or the contract by its terms, or the insurer or contractor by written acknowledgment to the division must guarantee:

(1) To provide medical and remedial care and services of the type, to the extent and according to standards prescribed under ORS 414.065;

(2) To pay providers of medical and remedial care and services the amount due, based on the number of days of care and the fees, charges and costs established under ORS 414.065, except as to medical or hospital service contracts issued by a hospital association which employs a method of accounting or payment on other than a fee-for-service basis;

(3) To provide medical and remedial care and services under policies of insurance or contracts in compliance with all laws, rules and regulations applicable thereto; and

(4) To provide such statistical data, records and reports relating to the provision, administration and costs of providing medical and remedial care and services to the division as may be required by the division for its records, reports and audits.
[1967 c.502 §9; 1975 c.401 §1]

414.125 Rates on insurance or service contracts; requirements for insurer or contractor. (1) Any payment of available medical assistance funds for policies of insurance or service contracts shall be according to such uniform area-wide rates as the Adult and Family Services Division shall have established and which it may revise from time to time as may be necessary or practical, except that, in the case of a research and demonstra-

tion project entered into under ORS 411.135 special rates may be established.

(2) No premium or other periodic charge on any policy of insurance, health care service contract, or medical or hospital service contract shall be paid from available medical assistance funds unless the insurer or contractor issuing such policy or contract is by law authorized to transact business as an insurance company, health care service contractor or hospital association in this state.
[1967 c.502 §10; 1975 c.509 §6]

414.135 Contracts with direct providers of care and services. The Adult and Family Services Division may enter into nonexclusive contracts under which funds available for medical assistance may be administered and disbursed by the contractor to direct providers of medical and remedial care and services available under medical assistance in consideration of services rendered and supplies furnished by them in accordance with the provisions of this chapter. Payment shall be made according to the rules of the division pursuant to the number of days and the fees, charges and costs established under ORS 414.065. The contractor must guarantee the division by written acknowledgment:

(1) To make all payments under this chapter promptly but not later than 30 days after receipt of the proper evidence establishing the validity of the provider's claim.

(2) To provide such data, records and reports to the division as may be required by the division.
[1967 c.502 §11]

414.145 Implementation of ORS 414.115 to 414.135. The provisions of ORS 414.115, 414.125 or 414.135 shall be implemented whenever it appears to the Executive Department that such implementation will provide comparable benefits at equal or less cost than provision thereof by direct payments by the Adult and Family Services Division to the providers of medical assistance.
[1967 c.502 §11a; 1975 c.401 §3]

MEDICAL ADVISORY COMMITTEE

414.205 Medical advisory committee. (1) A medical advisory committee is established, consisting of not more than 15 members to be appointed by the Governor from among persons in the health professions, providers of medical and remedial care and services and the general public. In making his appointment, the Governor shall consult with appropriate professional and other interested organizations.

(2) Members shall serve at the pleasure of the Governor.

(3) Members of the advisory committee shall receive no compensation for their services, but subject to any applicable state law, shall be allowed actual and necessary travel expenses incurred in the performance of their duties from the Public Welfare Account.
[1967 c.502 §18]

414.210 [1957 c.692 §1; repealed by 1963 c.631 §2]

414.215 Duties of committee. The medical advisory committee shall advise the Adult and Family Services Division on:

(1) Health and medical care and services to be provided pursuant to this chapter.

(2) Matters referred to it for study by the division.
[1967 c.502 §19]

414.220 [1957 c.692 §2; repealed by 1963 c.631 §2]

414.225 Division to consult with and assist committee. (1) The Adult and Family Services Division shall consult with the medical advisory committee concerning the determinations required under ORS 414.065.

(2) The division shall provide secretarial services to the medical advisory committee.
[1967 c.502 §20]

414.230 [1957 c.692 §5; repealed by 1963 c.631 §2]

414.240 [1957 c.692 §3; repealed by 1963 c.631 §2]

414.250 [1957 c.692 §4; repealed by 1963 c.631 §2]

414.260 [1957 c.692 §6; repealed by 1963 c.631 §2]

414.270 [1957 c.692 §7(1); repealed by 1963 c.631 §2]

[illegible]

414.300 [1957 c.692 §8; repealed by 1963 c.631 §2]

MISCELLANEOUS

414.305 Payment of cost of medical care for institutionalized persons. (1) The Adult and Family Services Division is hereby authorized to pay the cost of care for patients within Mental Health Division institutions under the medical assistance program established by this chapter.

(2) All moneys received by the Mental Health Division from the Adult and Family

spouse and such children whose coverage under the policy terminates at the same time, or (iii) to a child solely with respect to himself upon termination of his coverage by reason of ceasing to be a qualified family member under the group policy, if a conversion privilege is not otherwise provided above with respect to such termination.

(17) If the benefit levels required in paragraphs (10) and (11) exceed the benefit levels provided under the group policy, the conversion policy may offer benefits which are substantially similar to those provided under the group policy in lieu of those required in paragraphs (10) and (11).

(18) The insurer may elect to provide group insurance coverage in lieu of the issuance of a converted individual policy.

(19) A notification of the conversion privilege shall be included in each certificate of coverage.

(20) A converted policy which is delivered outside [state] must be on a form which could be delivered in such other jurisdiction as a converted policy had the group policy been issued in that jurisdiction.

Section 3. [*Severability.*] [Insert severability clause.]

Section 4. [*Repeal.*] [Insert repealer clause.]

Section 5. [*Effective Date.*] [Insert effective date.]

1980 Suggested State Legislation
Vol. 39, The Council of State Governments

Comprehensive Health Insurance Act

This draft statute requires that employers in the state must include qualified catastrophic health insurance protection and minimum types of benefits for routine care in any policy provided to their employees pursuant to the individual's employment. This includes policies which are paid for partly or fully by the employee as well as those which are completely employer-paid. If only nonqualified plans are offered to employees, the employer may not deduct for tax purposes the cost of the insurance to him. In order to qualify, a plan must meet specified benefit levels and have no more than a maximum allowable deductible. This draft act also includes as Sections 18 and 19 a state catastrophic medical insurance plan under which the state will pay the medical expenses of those persons who incur uninsured medical expenses exceeding specified portions of their income.

This medical insurance plan is implemented by requiring in the statute that all insurers writing health insurance in the state must offer a qualified plan to their customers. A compulsory association of all insurers in the state is also to be formed under the act for the purpose of offering a qualified plan of insurance to those individuals whom the insurers have individually refused to insure. For those individuals who may be leaving employment at which they were enrolled in a qualified plan, the act provides mandatory conversion privileges enabling the individual to continue his insurance.

As the above indicates, this draft act is broad in scope and is directed toward multiple purposes. Among the related but separate purposes of the legislation are ensuring minimum standards for group health plans, creating an association of insurers as a resort for those individuals who could not otherwise obtain effective coverage, and providing catastrophic medical expense protection for all through employers and private insurers where possible and through the state welfare system where necessary.

This draft legislation is based on a 1976 Minnesota statute.

Suggested Legislation

(Title, enacting clause, etc.)

Section 1. *Short Title.*] This act may be cited as the [state] Comprehensive Health Insurance Act.

Section 2. [*Definitions.*] As used in this act:

(1) "Employer" means any person, partnership, association, trust, estate, or corporation, which employs 10 or more individuals who are residents of this state.

(2) "Health maintenance organization" means a nonprofit corporation licensed and operated as provided in [appropriate state statute].

(3) "Qualified plan" means those health benefit plans which have been certified by the commissioner as providing the minimum benefits required by Section 6 of this act or the actuarial equivalent of those benefits.

(4) "Qualified Medicare supplement plan" means those health benefit plans which have been certified by the commissioner as providing the minimum benefits required by Section 7 of this act or the actuarial equivalent of those benefits.

(5) "Commissioner" means the [commissioner of insurance].

(6) "Dependent" means a spouse or unmarried child under the age of 19 years, a dependent child who is a student under the age of 25 and financially dependent upon the parent, or a dependent child of any age who is disabled. or a household member who is financially dependent

(7) "Employee" means any [state] resident who has entered into the employment of or works under contract or service or apprenticeship with any employer. "Employee" does not include a person who has been employed for less than [30] days by his present employer, nor one who is employed less than an average of [30] hours per week by his present employer.

(8) 'Plan of health coverage" means any plan or combination of plans of coverage, including combinations of self-insurance, individual accident and health insurance policies, group accident and health insurance policies, coverage under a nonprofit health service plan, or coverage under a health maintenance organization subscriber contract.

(9) "Insurer" means those companies operating pursuant to [appropriate state statute] and offering or selling policies or contracts of accident and health insurance. "Insurer" does not include health maintenance organizations.

(10) "Accident and health insurance policy" or "policy" means insurance or nonprofit health service plan contracts providing benefits for hospital, surgical, and medical care. "Policy" does not include coverage which is (i) limited to disability or income protection coverage, (ii) automobile medical payment coverage, (iii) supplemental to liability insurance, (iv) sold by fraternals and provides payments on a per diem, daily indemnity or nonexpense-incurred basis, or (v) credit accident and health insurance issued pursuant to [appropriate state statute].

(11) "Health benefits" means benefits offered to employees on an indemnity or prepaid basis which pay the costs of or provide medical, surgical, or hospital care.

(12) "Eligible person" means an individual who is a resident of [state] and meets the enrollment requirements of Section 14 of this act. For purposes of Sections 18, 19, and 20 only, "eligible person" means any person who while a resident of [state] has been found by the [commissioner of public welfare] to have incurred an obligation to pay qualified expenses for himself and any dependents in any [12] consecutive months exceeding: (i) [40] percent of his household income up to $[15,000], plus [50] percent of his household income between $[15,000 and $25,000], plus [60] percent of his household income in excess of $[25,000], or (ii) $[2,500], whichever is greater.

(13) "Comprehensive health association" or "association" means the association created by Section 10 of this act.

(14) "Medicare" means Part A and Part B of the United States Social Security Act, Title XVIII, as amended, 42 U.S.C. Sections 1394, et seq.

(15) "Medicare supplement plan" means any plan of insurance protection which provides benefits for the costs of medical, surgical, or hospital care and which is marketed as providing benefits which complement or supplement the benefits provided by Medicare.

(16) "State plan premium" means the premium determined pursuant to Section 8 of this act.

(17) "Writing carrier" means the insurer or insurers and health maintenance organization or organizations selected by the association and approved by the commissioner to administer the comprehensive health insurance plan.

(18) "Fraternal beneficiary association" or "fraternal" means a corporation, society, order, or voluntary association without capital stock which sells health and accident insurance in accordance with [appropriate state statute].

(19) "Comprehensive health insurance plan" or "state plan" means policies of insurance and contracts of health maintenance organization coverage offered by the association through the writing carrier.

(20) "Self-insurer" means an employer who directly provides a plan of health coverage to his employees and administers the plan of health coverage himself or through an insurer. "Self-insurer" does not include an employer engaged in the business of providing health care services to the public who provides health care services directly to his employees at no charge to them.

(21) "Self-insurance" means a plan of health coverage offered by a self-insurer.

(22) "Qualified expense" means any charge incurred subsequent to [insert date] for a health service which is included in the list of covered services described in Section 6(a), and for which no third party is liable.

(23) "Household income" means the gross income of an eligible person and all his dependents for the calendar year preceding the year in which an application is filed pursuant to Section 18.

(24) "Gross income" means income as defined in [appropriate state tax statute].

(25) "Third party" means any person other than the eligible person or his dependents.

Section 3. [*Duties of Employer.*]

(a) Each employer who provides or makes available to his employees a plan of health coverage shall make available to his employees employed in this state a plan or combination of plans which have been certified by the commissioner as a number two qualified plan. If the plan of health coverage does not meet the requirements of Section 6 for a number two qualified plan, the employer shall make available a supplemental plan of health benefits which, when combined with the existing plan of health benefits, constitutes a number two coverage plan. The plan or combinations of plans may be financed from funds contributed solely by the employer or solely by the employees or any combination thereof. The plans may consist of self-insurance, health maintenance contracts, group policies, or individual policies or any combination thereof.

(b) In the event that an employer fails to make available at least a number two qualified plan of health benefits to his employees employed in this state, none of the employer's costs for health benefits shall qualify as an income tax deduction pursuant to [appropriate state tax statute]. In the case of an employer who meets the requirements of [state statute defining tax exempt organizations], if the employer fails to make available at least a number two qualified plan to his employees, the employer shall lose his status as an exempt organization.

Section 4. [*Duties of Insurers.*]

(a) For each type of qualified plan described in Section 6, an insurer or fraternal issuing individual policies of accident and health insurance in this state, other than group conversion policies, shall develop and file with the commissioner an individual policy which meets the minimum standards of that type of qualified plan. An insurer or fraternal issuing individual policies of accident and health insurance in this state shall offer each type of qualified plan to each person who applies and is eligible for accident and health insurance from that insurer or fraternal.

(b) An insurer or fraternal issuing Medicare supplement plans in this state shall develop and file with the commissioner a Medicare supplement policy which meets the minimum standards of a qualified Medicare supplement plan. An insurer or fraternal issuing Medicare supplement plans in this state shall offer a qualified Medicare supplement plan to each person who is eligible for coverage and who applies for a Medicare supplement plan.

(c) For each type of qualified plan described in Section 6, an insurer or fraternal issuing group policies of accident and health insurance in this state shall develop and file with the commissioner a group policy which provides for each member of the group the minimum benefits required by that type of qualified plan. An insurer or fraternal issuing group policies of accident and health insurance in this state shall offer each type of qualified plan to each eligible applicant for group accident and health insurance.

(d) Each insurer and fraternal shall include coverage of major medical costs in every unqualified policy of accident and health insurance, unless the applicant for a new or renewal policy declines the coverage in writing. The coverage shall provide that when a covered individual incurs out-of-pocket expenses of $[5,000] or more within a calendar year for services covered in Section 6(a), benefits shall be payable, subject to any copayment authorized by the commissioner, up to a maximum lifetime limit of $[250,000].

(e) No policy of accident and health insurance may be issued or renewed in this state [180] days after [insert date] by an insurer or a fraternal which has not complied with the requirements of this section.

(f) An insurer or fraternal may fulfill its obligations under this section by issuing the required coverages in their own name and reinsuring the risk and administration of the coverages with the association in accordance with paragraphs (5) and (6) of Section 10(g).

(g) Nothing in this section shall require an insurer or fraternal to offer or issue a policy to any person who does not meet the underwriting or membership requirements of the insurer or fraternal.

Section 5. [*Certification of Qualified Plans.*] Upon application by an insurer, fraternal, or employer for certification of a plan of health coverage as a qualified plan or a qualified Medicare supplement plan for the purposes of Sections 1 to 17, the commissioner shall make a determination within [90] days as to whether the plan is qualified. All plans of health coverage shall be labeled as "qualified" or "nonqualified" on the front of the policy or evidence of insurance. All qualified plans shall indicate whether they are number one, two, or three coverage plans.

Section 6. [*Minimum Benefits of Qualified Plan.*]

(a) A plan of health coverage shall be certified as a number three qualified plan if it otherwise meets the requirements established by [appropriate state statute] and the other laws of this state and whether or not the policy is issued in this state and meets or exceeds the following minimum standards:

(1) The minimum benefits for a covered individual shall, subject to the other provisions of this subsection, be equal to at least [80] percent of the cost of covered services in excess of an annual deductible which does not exceed $[150] per person. The coverage shall include a limitation of $[3,000] per person on total annual out-of-pocket expenses for services covered under this subsection. The coverage may be subject to a maximum lifetime benefit of not less than $[250,000]. Covered expenses shall be the usual and customary charges for the following services and articles when prescribed by a physician:

(i) Hospital services.

(ii) Professional services for the diagnosis or treatment of injuries, illnesses, or conditions, other than outpatient mental or dental, which are rendered by a physician or at his direction.

(iii) Drugs requiring a physician's prescription.

(iv) Services of a nursing home for not more than [120] days in a year if the services commence within [14] days following confinement of at least

[three] days in a hospital for the same condition.

(v) Service of a home health agency up to a maximum of [180] visits per year.

(vi) Use of radium or other radioactive materials.

(vii) Oxygen.

(viii) Anesthetics.

(ix) Prostheses.

(x) Rental or purchase, as appropriate, of durable medical equipment.

(xi) Diagnostic X-rays and laboratory tests.

(xii) Oral surgery for partially or completely unerupted impacted teeth, a tooth root without the extraction of the entire tooth, or the gums and tissues of the mouth when not performed in connection with the extraction or repair of teeth.

(xiii) Services of a physical therapist.

(2) Covered expenses for the services and articles specified in this subsection do not include the following:

(i) Any charge for any care for any injury or disease either arising out of an injury in the course of employment and subject to a worker's compensation or similar law, for which benefits are payable without regard to fault under coverage statutorily required to be contained in any motor vehicle or other liability insurance policy or equivalent self-insurance, or for which benefits are payable under another policy of accident and health insurance or Medicare.

(ii) Any charge for treatment for cosmetic purposes other than surgery for the repair of an injury or birth defect.

(iii) Any charge for travel other than travel by ambulance to the nearest health care institution qualified to treat the illness or injury.

(iv) Any charge for confinement in a private room to the extent it is in excess of the institution's charge for its most common semi-private room, unless a private room is prescribed as medically necessary by a physician.

(v) That part of any charge for services or articles rendered or prescribed by a physician, dentist, or other health care personnel which exceeds the prevailing charge in the locality where the service is provided.

(vi) Any charge for services or articles the provision of which is not within the scope of authorized practice of the institution or individual rendering the services or articles.

(3) Effective [insert date], the minimum benefits for a qualified plan shall include, in addition to those benefits specified in subsection (a)(1), benefits for the following services subject to applicable deductibles, coinsurance provisions, and maximum lifetime benefit limitations:

(i) Well baby care.

(ii) Physicians' services for routine checkups and annual physicals when prescribed by a physician.

(iii) Multiphasic screening and other diagnostic testing. The commissioner by rule shall prescribe reasonable limits on the reimbursement required for these services.

(b) A plan of health coverage shall be certified as a number two qualified plan if it meets the requirements established by the laws of this state and provides for payment of [80] percent of the covered expenses required by this section in excess of a deductible which does not exceed $[500] per person.

(c) A plan of health coverage shall be certified as a number one qualified plan if it meets the requirements established by the laws of this state and provides for payment of [80] percent of the covered expenses required by this section in excess of a deductible which does not exceed $[1,000] per person.

(d) A health maintenance organization which provides the services required by [appropriate state statute] shall be deemed to be providing a number three qualified plan.

Section 7. [*Qualified Medicare Supplement Plan.*] Any plan which provides benefits to persons over the age of 65 years may be certified as a qualified Medicare supplement plan if the plan is designed to supplement Medicare and provides coverage of [50] percent of the deductible and copayment required under Medicare and [80] percent of the charges for covered services described in Section 6(a), which charges are not paid by Medicare. The coverage shall include a limitation of $[1,000] per person on total annual out-of-pocket expenses for the covered services. The coverage may be subject to a maximum lifetime benefit of not less than $[100,000].

Section 8. [*State Plan Premium.*]

(a) For the first year of operation of the comprehensive health insurance plan, the association shall establish the following premiums to be charged for membership in the comprehensive health insurance plan:

(1) The premium for the number one qualified plan shall be the average of rates charged by the [five] insurers with the largest number of individuals in a number one individual qualified plan of insurance in force in the state.

(2) The premium for the number two qualified plan shall be the average of rates charged by the [five] insurers with the largest number of individuals in a number two individual qualified plan of insurance in force in the state.

(3) The premium for a qualified Medicare supplement plan shall be the average of rates charged by the [five] insurers with the largest number of individuals enrolled in a qualified Medicare supplement plan.

(4) The charge for health maintenance organization coverage shall be based on generally accepted actuarial principles.

(b) For the second and subsequent years, the schedule of premiums for membership in the comprehensive health insurance plan shall be designed to be self-supporting and based on generally accepted actuarial principles.

Section 9. [*Duties of Commissioner.*] The commissioner may:

(1) Formulate general policies to advance the purposes of Sections 1 to 17; the commissioner may also adopt, promulgate, repeal, and amend rules pursuant to the rulemaking provisions of [state administrative procedure act] to carry out the provisions of Sections 1 to 17.

(2) Supervise the creation of a comprehensive health association within the limits described in Section 10.

(3) Approve the selection of the writing carrier by the association and approve the association's contract with the writing carrier including the state plan coverage and premiums to be charged.

(4) Appoint advisory committees.

(5) Conduct periodic audits to assure the general accuracy of the financial data submitted by the writing carrier and the association.

(6) Contract with the federal government or any other unit of government to ensure coordination of the state plan with other governmental assistance programs.

(7) Undertake directly or through contracts with other persons studies or demonstration programs to develop awareness of the benefits of Sections 1 to 17, so that the residents of this state may best avail themselves of the health care benefits provided by these sections.

(8) Contract with insurers and others for administrative services.

Section 10. [*Comprehensive Health Association.*]

(a) There is established a comprehensive health association with membership consisting of all insurers, self-insurers, fraternals, and health maintenance organizations licensed or authorized to do business in this state.

(b) The board of directors of the association shall be made up of [seven] individuals selected by participating members, subject to approval by the commissioner. To select the initial board of directors, and to initially organize the association, the commissioner shall give notice to all members of the time and place of the organizational meeting. In determining voting rights at the organizational meeting, each member shall be entitled to vote in person or by proxy. The vote shall be a weighted vote based upon the member's cost of self-insurance, accident and health insurance premium, subscriber contract charges, or health maintenance contract payment derived from or on behalf of residents in the previous calendar year, as determined by the commissioner. If the board of directors is not selected within [60] days after notice of the organizational meeting, the commissioner may appoint the initial board. In approving or selecting members of the board, the commissioner shall consider, among other things, whether all types of members are fairly represented. Members of the board may be reimbursed from the moneys of the association for expenses incurred by them as members, but shall not otherwise be compensated by the association for their services. The costs of conducting meetings of the association and its board of directors shall be borne by members of the association.

(c) All members shall maintain their membership in the association as a condition of doing business in this state. The association shall submit bylaws and operating rules to the commissioner for approval.

(d) All meetings of the association, its board, and any committees of the association shall comply with the provisions of [state open meetings act].

(e) All members shall enter into a contract with the association according to terms specified in Section 11. The contract of reinsurance shall be executed for a period of one year and shall be renewed annually thereafter. A company which ceases to do business within the state shall remain liable under the contract for the reinsurance contracted for during that calendar year.

(f) In the performance of their duties as members of the association, the members shall be exempt from the provisions of [state antitrust statute].

(g) The association may:

(1) Exercise the powers granted to insurers under the laws of this state.

(2) Sue or be sued.

(3) Enter into contracts with insurers, similar associations in other states, or other persons for the performance of administrative functions including the functions provided for in paragraphs (5) and (6) of this subsection.

(4) Establish administrative and accounting procedures for the operation of the association.

(5) Provide for the reinsuring of risks incurred as a result of issuing the coverages required by Sections 4 and 16 by members of the association. Each member which elects to reinsure its required risks shall determine the categories of coverage it elects to reinsure in the association. The categories of coverage are: (i) individual qualified plans, excluding group conversions; (ii) group conversions; (iii) group qualified plans with fewer than [50] employees or members; and (iv) major medical coverage. A separate election may be made for each category of coverage. If a member elects to reinsure the risks of a category of coverage, it must reinsure the risk of the coverage of every life covered under every policy issued in that category. Members electing to administer the risks which are reinsured in the association shall comply with the benefit determination guidelines and accounting procedures established by the association. The fee charged by the association for the reinsurance of risks shall not be less than [110] percent of the total anticipated expenses incurred by the association for the reinsurance.

(6) Provide for the administration by the association of policies which are reinsured pursuant to paragraph 5 of this subsection. Each member electing to reinsure one or more categories of coverage in the association may elect to have the association administer the categories of coverage on the member's behalf. If a member elects to have the association administer the categories of coverage, it must do so for every life covered under every policy issued in that category. The fee for the administration shall not be less than [110] percent of the total anticipated expenses incurred by the association for the administration.

(a) Upon certification as an eligible person in the manner provided by Section 14, an eligible person may enroll in the comprehensive health insurance plan by payment of the state plan premium to the writing carrier.

(b) Any employer which has in its employ one or more eligible persons enrolled in the comprehensive health insurance plan may make all or any portion of the state plan premium payment to the state plan directly to the writing carrier.

(c) Not less than [87½] percent of the state plan premium paid to the writing carrier shall be used to pay claims, and not more than [12½] percent shall be used for the payment of agent referral fees as authorized in Section 15(c) and for payment of the writing carrier's direct and indirect expenses, as specified in Section 13(g).

(d) Any income in excess of the costs incurred by the association in providing reinsurance or administrative services shall be held at interest and used by the association to offset losses due to claims expenses of the state plan or allocated to reduce state plan premiums

(e) Each member of the association shall share the losses due to claims expenses of the comprehensive health insurance plan pursuant to the terms of the individual reinsurance contracts executed by the association with each member in accordance with Section 10(e). Deviations in the claim experience of the state plan from the premium payments allocated to the payment of benefits shall be the liability of the association members. Association members shall share in the excess costs of the state plan in an amount equal to the ratio of the member's total cost of self-insurance, accident and health insurance premium, subscriber contract charges, or health maintenance organization contract charges received from or on behalf of [state] residents as divided into the total cost of self-insurance, accident and health insurance premium, subscriber contract charges, and health maintenance organization contract charges received by all association members from or on behalf of [state] residents, as determined by the commissioner. The reinsurance contract shall provide for a retroactive determination of each member's liability and payment due within [30] days after each renewal date of the reinsurance contract. Failure by a member to tender to the association the assessed reinsurance payment within [30] days of notification by the association shall be grounds for termination of the member's membership. Net gains, if any, from the operation of the state plan shall be held at interest and used by the association to offset future losses due to claims expenses of the state plan or allocated to reduce state plan premiums.

Section 12. [*Minimum Benefits of Comprehensive Health Insurance Plan.*] The association through its comprehensive health insurance plan shall offer policies which provide the benefits of a number one qualified plan, a number two qualified plan, and a qualified Medicare supplement plan. They shall offer health maintenance organization contracts in those areas of the state where a health maintenance organization has agreed to make the coverage available and has been selected as a writing carrier.

Section 13. [*Administration of Plan.*]

(a) Any member of the association may submit to the commissioner the policies of accident and health insurance or the health maintenance organization contracts which are being proposed to serve in the comprehensive health insurance plan. The time and manner of the submission shall be prescribed by rule of the commissioner.

(b) Upon the commissioner's approval of the policy forms and contracts submitted pursuant to Section 10, the association shall select policies and contracts submitted by a member or members of the association to be the comprehensive health insurance plan. This selection shall be based upon criteria including the member's proven ability to handle large group accident and health insurance cases, efficient claim paying capacity, and the estimate of total charges for administering the plan. The association may select separate writing carriers for the two types of qualified plans, the qualified Medicare supplement plan, and the health maintenance organization contract.

(c) The writing carrier shall perform all administrative and claims payment functions required by this section. The writing carrier shall provide these services for a period of [three] years, unless a request to terminate is approved by the commissioner. The commissioner shall approve or deny a request to terminate within [90] days of its receipt. A failure to make a final decision on a request to terminate within the specified period shall be deemed to be an approval. [Six] months prior to the expiration of each [three]-year period, the association shall invite submissions of policy forms from members of the association, including the writing carrier. The association shall follow the provisions of subsection (b) in selecting a writing carrier for the subsequent three-year period.

(d) The writing carrier shall provide to all eligible persons enrolled in the plan an individual certificate, setting forth a statement as to the insurance protection to which he is entitled, with whom claims are to be filed and to whom benefits are payable. The certificate shall indicate that coverage was obtained through the association.

(e) The writing carrier shall submit to the association and the commissioner on a monthly basis a report on the operation of the state plan. Specific information to be contained in this report shall be determined by the association prior to the effective date of the state plan.

(f) All claims shall be paid by the writing carrier pursuant to the provisions of Sections 1 to 17 and shall indicate that the claim was paid by the state plan. Each claim payment shall include information specifying the procedure to be followed in the event of a dispute over the amount of payment.

(g) The writing carrier shall be reimbursed from the state plan premiums received for its direct and indirect expenses. Direct and indirect expenses

hall include, but need not be limited to, a pro rata reimbursement for that portion of the writing carrier's administrative, printing, claims administration, management and building overhead expenses which are assignable to the maintenance and administration of the state plan. The association shall approve cost accounting methods to substantiate the writing carrier's cost reports consistent with generally accepted accounting principles. Direct and indirect expenses shall not include costs directly related to the original submission of policy forms prior to selection as the writing carrier.

(h) The writing carrier shall at all times when carrying out its duties under Sections 1 to 17 be considered an agent of the association and the commissioner with civil liability subject to the provisions of [appropriate state tort liability statute].

(i) Premiums received by the writing carrier for the comprehensive health insurance plan are specifically exempted from the provisions of Section 15 .

Section 14. [*Enrollment by Eligible Person.*]

(a) The comprehensive health insurance plan shall be open for enrollment by eligible persons. An eligible person may enroll by submission of a certificate of eligibility to the writing carrier. The certificate shall provide the following:

(1) Name, address, age, and length of time at residence of the applicant.

(2) Name, address, and age of spouse and children, if any, if they are to be insured.

(3) Evidence of rejection, or a requirement of restrictive riders, or a preexisting conditions limitation on a qualified plan, the effect of which is to substantially reduce coverage from that received by a person considered a standard risk, by at least [two] association members within [six] months of the date of the certificate.

(4) A designation of the coverage desired.

(b) Within [30] days of receipt of the certificate described in Section 14(a), the writing carrier shall either reject the application for failing to comply with the requirements in Section 14(a) or forward the eligible person a notice of acceptance and billing information. Insurance shall be effective immediately upon receipt of the first month's state plan premium, and shall be retroactive to the date of application, if the applicant otherwise complies with the requirements of Sections 1 to 17. An eligible person may not purchase more than one policy from the state plan.

(c) No person who obtains coverage pursuant to this section shall be covered for any preexisting condition during the first [six] months of coverage under the state plan if the person was diagnosed or treated for that condition during the [90] days immediately preceding the filing of an application.

Section 15. [*Solicitation of Eligible Persons.*]

(a) The association pursuant to a plan approved by the commissioner shall disseminate appropriate information to the residents of this state regarding the existence of the comprehensive health insurance plan and the means of enrollment. Means of communication may include use of the press, radio, and television, as well as publication in appropriate state offices and publications.

(b) The association shall devise and implement means of maintaining public awareness of the provisions of Sections 1 to 17 and shall administer these sections in a manner which facilitates public participation in the state plan.

(c) The writing carrier shall pay an agent's referral fee of $[25] to each insurance agent who refers an applicant to the state plan, if the application is accepted. Selling or marketing of qualified state plans shall not be limited to the writing carrier or its agents. The referral fees shall be paid by the writing carrier from money received as premiums for the state plan.

(d) Every insurer which rejects or applies underwriting restrictions to an applicant for accident and health insurance shall notify the applicant of the existence of the state plan, the requirements for being accepted in it, and the procedure for applying to it.

Section 16. [*Conversion Privileges.*] Every program of self-insurance, policy of group accident and health insurance or contract of coverage by a health maintenance organization written or renewed in this state shall include the right to convert to an individual coverage qualified plan without the addition of underwriting restrictions regardless of the reason for leaving the group. The person leaving the group may exercise his right to conversion within [30] days of leaving the group. Plans of health coverage shall also include a provision which, upon the death of the individual in whose name the contract was issued, permits every other individual then covered under the contract to elect, within the period specified in the contract, to continue his coverage under the same or a different contract without the addition of underwriting restrictions until he would have ceased to have been entitled to coverage had the individual in whose name the contract was issued lived.

Section 17. [*Dual Option.*]

(a) An employer who employs in this state, on the average during a calendar quarter, [100] employees or more, other than employees engaged in seasonal employment, and who offers a health benefits plan to employees, whether purchased from an insurer or a health maintenance organization, or provided on a self-insured basis, shall, upon the next renewal of the health benefits plan contract, offer his employees a dual option to obtain health benefits through either an accident and health insurance policy or a health maintenance organization contract if one is available. An option need not be provided if fewer than [25] employees select that option.

(b) An employer may make the dual offers through an insurer, a health maintenance organization or on a self-insured basis. If an offer is made on a self-insured basis, the accident and health insurance type of coverage or

health maintenance organization type of coverage shall meet the requirements of the laws of this state as to the services covered or benefits provided, but need not otherwise be approved by the commissioner or the board of health.

(c) No insurer shall make acceptance of its offer to provide insurance coverage contingent on acceptance by the employer of health maintenance organization coverage by a particular health maintenance organization. No health maintenance organization shall make acceptance of its offer to provide health maintenance organization coverage contingent on acceptance by the employer of insurance coverage by a particular insurer. No offer to provide the accident and health insurance policy and the health maintenance organization contract shall combine the two in a single price package.

(d) The [board of health], in consultation with the commissioner, shall adopt rules to implement the provisions of this section.

Section 18. [*Application for Assistance.*]

(a) Any person who believes that they are or will become an eligible person may submit an application for state assistance to the [commissioner of public welfare]. The application shall include a listing of expenses incurred prior to the date of the application and shall designate the date on which the [12]-month period for computing expenses began.

(b) If the [commissioner of public welfare] determines that an applicant is an eligible person, he shall pay [90] percent of all qualified expenses of the eligible person and his dependents in excess of: (1) [40] percent of his household income under $[15,000], plus [50] percent of his household income between $[15,000] and $[25,000], plus [60] percent of his household income in excess of $[25,000]; or (2) $[2,500], whichever is greater for the [12]-month period in which the applicant becomes an eligible person. If the [commissioner of public welfare] determines that the charge for a health service is excessive, he may limit his payment to the usual and customary charge for that service. If the [commissioner of public welfare] determines that a health service provided to an eligible person was not medically necessary, he may refuse to pay for the service. To the extent feasible, the [commissioner of public welfare] shall contract with a review organization in making any determinations as to whether or not a charge is excessive. To the extent feasible, the [commissioner of public welfare] shall contract with a review organization in making any determination as to whether or not a service was medically necessary. If the [commissioner of public welfare], in accordance with this section, refuses to pay all or a part of the charge for a health service, the unpaid portion of the charge shall be deemed to be an unconscionable fee, against the public policy of this state, and unenforceable in any action brought for the recovery of moneys owed.

Section 19. [*Duties of Commissioner.*]

(a) The [commissioner of public welfare] shall:

(1) Promulgate reasonable rules to implement Sections 18 to 20.

(2) Establish application forms and procedures for the use of persons seeking to be declared eligible persons.

(3) Investigate applications to determine whether or not the applicant is a qualified person and investigate claims from providers of health services to determine whether or not to pay them.

(b) The [commissioner of public welfare] may:

(1) Enter into contracts with the United States or any state agency, instrumentality or political subdivision for the purpose of coordinating the program established by this act, with other programs which provide or pay for the delivery of health services.

(2) Enter into contracts with third parties to perform some or all of the duties imposed on the [commissioner of public welfare] by Sections 18 and 19.

Section 20. [*Appeals.*] The final decision of the [commissioner of public welfare] in denying an application for status as an eligible person or denying all or part of the charges for a health service may be appealed by any interested party pursuant to [state administrative procedure act].

Section 21. [*Severability.*] [Insert severability clause.]

Section 22. [*Repeal.*] [Insert repealer clause.]

Section 23. [*Effective Date.*] [Insert effective date.]

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PART VI. ENFORCEMENT

[§392-91] **Enforcement by the director.** The director shall enforce the provisions of this chapter. The director may appoint such assistants and such clerical, stenographic and other help as may be necessary for the proper enforcement of this chapter subject to any civil service act relating to state employees. The salaries of all the foregoing appointees and employees shall be as fixed by law.

The director may adopt, amend, or repeal such rules and regulations as he deems necessary or suitable for the proper enforcement of this chapter. [L 1969, c 148, pt of §1]

PART VII. MISCELLANEOUS PROVISIONS

[§392-101] **Limitation of fees.** Any individual claiming benefits in any proceeding before the department or the referee may be represented by counsel or other duly authorized agent; but no such counsel or agent shall either charge or receive for such services more than an amount approved by the department or referee, and such amount shall in no case exceed ten per cent of the total amount of benefits received as a result of such proceeding. Any person who violates this section shall, for each such offense, be fined not less than $50 nor more than $500 or imprisoned not more than six months, or both. [L 1971, c 109, §1(m)]

[CHAPTER 393]
PREPAID HEALTH CARE ACT

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[393-51 TERMINATION OF CHAPTER]

PART I. SHORT TITLE; PURPOSE; DEFINITIONS

[§393-1] Short title. This chapter shall be known as the Hawaii Prepaid Health Care Act. [L 1974, c 210, pt of §1]

[§393-2] Findings and purpose. The cost of medical care in case of sudden need may consume all or an excessive part of a person's resources. Prepaid health care plans offer a certain measure of protection against such emergencies. It is the purpose of this chapter in view of the spiraling cost of comprehensive medical care to provide this type of protection for the employees in this State. Although a large segment of the labor force in the State already enjoys coverage of this type either by virtue of collective bargaining agreements, employer-sponsored plans, or individual initiative, there is a need to extend that protection to workers who at present do not possess any or possess only inadequate prepayment coverage.

This chapter shall not be construed to interfere with or diminish any protection already provided pursuant to collective bargaining agreements or employer-sponsored plans that is more favorable to the employees benefited thereby than the protection provided by this chapter or at least equivalent thereto. [L 1974, c 210, pt of §1]

[§393-3] Definitions generally. As used in this chapter, unless the context clearly requires otherwise:

(1) "Department" means the department of labor and industrial relations.

(2) "Director" means the director of labor and industrial relations.

(3) "Employer" means any individual or type of organization, including any partnership, association, trust, estate, joint stock company, insurance company, or corporation, whether domestic or foreign, a debtor in possession or receiver or trustee in bankruptcy, or the legal representative of a deceased person, who has one or more regular employees in his employment. "Employer" does not include:

(A) The State, any of its political subdivisions, or any instrumentality of the State or its political subdivisions;

(B) The United States government or any instrumentality of the United States;

(C) Any other state or political subdivision thereof or instrumentality of such state or political subdivision;

(D) Any foreign government or instrumentality wholly owned by a foreign government, if (i) the service performed in its employ is of a character similar to that performed in foreign countries by employees of the United States government or of an instrumentality thereof, and (ii) the United States Secretary of State has certified or certifies to the United States Secretary of the Treasury that the foreign government, with respect to whose instrumentality exemption is claimed, grants an equivalent exemption with respect to similar service performed in the foreign country by employees of the United States government and of instrumentalities thereof.

(4) "Employment" means service, including service in interstate commerce, performed for wages under any contract of hire, written or oral, expressed or implied, with an employer, except as otherwise provided in sections 393-4 and 393-5.

(5) "Premium" means the amount payable to a prepaid health care plan contractor as consideration for his obligations under a prepaid health care plan.

(6) "Prepaid health care plan" means any agreement by which any prepaid health care plan contractor undertakes in consideration of a stipulated premium:

(A) Either to furnish health care, including hospitalization, surgery, medical or nursing care, drugs or other restorative appliances, subject to, if at all, only a nominal per service charge; or

(B) To defray or reimburse, in whole or in part, the expenses of health care.

(7) "Prepaid health care plan contractor" means:

(A) Any medical group or organization which undertakes under a prepaid health care plan to provide health care; or

(B) Any nonprofit organization which undertakes under a prepaid health care plan to defray or reimburse in whole or in part the expenses of health care; or

(C) Any insurer who undertakes under a prepaid health care plan to defray or reimburse in whole or in part the expenses of health care.

(8) "Regular employee" means a person employed in the employment of any one employer for at least twenty hours per week but does not include a person employed in seasonal employment. "Seasonal employment" for the purposes of this paragraph means employment in a seasonal pursuit as defined in section 387-1 by a seasonal employer during a seasonal period or seasonal periods for the employee in the seasonal pursuit or employment by an employer engaged in the cultivating, harvesting, processing, canning, and warehousing of pineapple during its seasonal periods. The director by rule and regulation may determine the kind of employment that constitutes

seasonal employment.

(9) "Wages" means all cash remuneration for services from whatever source, including commissions, bonuses, and tips and gratuities paid directly to any individual by a customer of his employer.

If the employee does not account to his employer for the tips and gratuities received and is engaged in an occupation in which he customarily and regularly receives more than $20 a month in tips, the combined amount received by him from his employer and from tips shall be deemed to be at least equal to the wage required by chapter 387 or a greater sum as determined by regulation of the director.

"Wages" does not include the amount of any payment specified in section 383-11 or 392-22 or chapter 386. [L 1974, c 210, pt of §1]

[§393-4] Place of performance. "Employment" includes an individual's entire service, performed within or both within and without this State if:

(1) The service is localized in this State; or

(2) The service is not localized in any state but some of the service is performed in this State and

(A) The individual's base of operation, or, if there is no base of operation, the place from which such service is directed or controlled, is in the State; or

(B) The individual's base of operation or place from which the service is directed or controlled is not in any state in which some part of the service is performed but the individual's residence is in this State. [L 1974, c 210, pt of §1]

[§393-5] Excluded services. "Employment" as defined in section 393-3 does not include the following services:

(1) Service performed by an individual in the employ of an employer who, by the laws of the United States, is responsible for care and cost in connection with such service.

(2) Service performed by an individual in the employ of his spouse, son, or daughter, and service performed by an individual under the age of twenty-one in the employ of his father or mother.

(3) Service performed in the employ of a voluntary employee's beneficiary association providing for the payment of life, sick, accident, or other benefits to the members of the association or their dependents or their designated beneficiaries, if

(A) Admission to membership in the association is limited to individuals who are officers or employees of the United States government, and

(B) No part of the net earnings of the association inures (other than through such payments) to the benefits of any private shareholder or individual.

(4) Service performed by an individual for an employer as an insurance agent or as an insurance solicitor, if all such service

performed by the individual for the employer is performed for remuneration solely by way of commission.

(5) Service performed by an individual for an employer as a real estate salesman or as a real estate broker, if all such service performed by the individual for the employer is performed for remuneration solely by way of commission.

(6) Service performed by an individual who, pursuant to the Federal Economic Opportunity Act of 1964, is not subject to the provisions of law relating to federal employment, including unemployment compensation. [L 1974, c 210, pt of §1]

[§393-6] Principal and secondary employer defined; coercion, interference, etc. prohibited. If an individual is concurrently a regular employee of two or more employers as defined in this chapter, the principal employer shall be the employer who pays him the most wages; provided that if one of the employers, who does not pay the most wages, employs the regular employee for at least thirty-five hours per week, the employee shall determine which of the employers shall be his principal employer. His other employers are secondary employers. An employer so designated as the principal employer shall remain as such principal employer for one year or until change of employment, whichever is earlier.

If an individual is concurrently a regular employee of a public entity which is not an employer as defined in section 393-3 and of an employer as defined in section 393-3 the latter shall be deemed to be a secondary employer.

An employer who, directly or indirectly, interferes with or coerces or attempts to coerce an employee in making a determination under this section shall be subject to the penalty provided under subsection 393-33(b). [L 1974, c 210, pt of § 1; am L 1975, c 51, §1]

[§393-7] Required health care benefits. (a) A prepaid health care plan shall qualify as a plan providing the mandatory health care benefits required under this chapter if it provides for health care benefits equal to, or medically reasonably substitutable for, the benefits provided by prepaid health plans of the same type, as specified in section 393-12(a)(1) or (2), which have the largest numbers of subscribers in the State. This applies to the types and quantity of benefits as well as to limitations on reimbursability, including deductibles, and to required amounts of co-insurance.

The director, after advice by the prepaid health care advisory council, shall determine whether benefits provided in a plan, other than the plan of the respective type having the largest numbers of subscribers in the State, comply with the standards specified in this subsection.

(b) A prepaid group health care plan shall also qualify for the mandatory health care benefits required under this chapter if it is demonstrated by the health care plan contractor offering such coverage to the satisfaction of the director after advice by the prepaid health care advisory council that the plan provides for sound basic hospital,

surgical, medical, and other health care benefits at a premium commensurate with the benefits included taking proper account of the limitations, co-insurance features, and deductibles specified in such plan. Coverage under a plan which provides aggregate benefits that are more limited than those provided by plans qualifying under subsection (a) shall be in compliance with section 393-11 only if the employer contributes at least half of the cost of the coverage of dependents under such plan.

(c) Subject to the provisions of subsections (a) and (b) without limiting the development of medically more desirable combinations and the inclusion of new types of benefits, a prepaid health care plan qualifying under this chapter shall include at least the following benefit types:

(1) Hospital benefits:

(A) In-patient care for a period of at least one hundred twenty days of confinement in each calendar year covering:

(i) Room accommodations;

(ii) Regular and special diets;

(iii) General nursing services;

(iv) Use of operating room, surgical supplies, anesthesia services, and supplies;

(v) Drugs, dressings, oxygen, antibiotics, and blood transfusion services.

(B) Out-patient care:

(i) Covering use of out-patient hospital;

(ii) Facilities for surgical procedures or medical care of an emergency and urgent nature.

(2) Surgical benefits:

(A) Surgical services performed by a licensed physician, as determined by plans meeting the standards of subsections (a) and (b);

(B) After-care visits for a reasonable period;

(C) Anesthesiologist services.

(3) Medical benefits:

(A) Necessary home, office, and hospital visits by a licensed physician;

(B) Intensive medical care while hospitalized;

(C) Medical or surgical consultations while confined.

(4) Diagnostic laboratory services, x-ray films, and radio-therapeutic services, necessary for diagnosis or treatment of injuries or diseases.

(5) Maternity benefits, at least if the employee has been covered by the prepaid health care plan for nine consecutive months prior to the delivery.

(d) The prepaid health care advisory council shall be appointed by the director and shall include representatives of the medical and public health professions, representatives of consumer interests, and persons experienced in prepaid health care protection. The membership of the council shall not exceed seven individuals. [L 1974, c 210, pt of §1]

[§393-11] Coverage of regular e
health care plan. Every emplo
ployee monthly wages in an amount
mum hourly wage, specified in chapte
ion of the director, shall provide c
prepaid group health care plan quali
prepaid health care plan contractor i
of this chapter. [L 1974, c 210, pt of

[§393-12] Choice of plan type
ployer required to provide coverage
group health care plan under this cha
shall be provided by:

(1) A plan which obligates the pr
to furnish the required healt

(2) A plan which obligates the pr
to defray or reimburse the expenses c
His election is binding for one year.

(b) Whether the employer elects
tion (a)(1) or in subsection (a)(2), the
contractor but the employee shall
greater amount to the premium than
the employer elected coverage with
vailing coverage of the respective typ

Subject to the provision of sectio
vide coverage with the prepaid hea
pursuant to this subsection for all h
this type of coverage who are covere
except for employees covered by the
cable collective bargaining agreemen
first sentence. [L 1974, c 210, pt of §1

[§393-13] Liability for paymer
less an applicable collective bargain
every employer shall contribute at
the coverage required by this chapte
ute the balance; provided that in no
more than 1.5 per cent of his wages
of the employee's contribution is le
the employer shall be liable for th
premium.

The employer shall withhold th
with respect to pay periods as specif
pt of §1]

[§393-14] Commencement of
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PART II. MANDATORY COVERAGE

[§393-11] Coverage of regular employees by group prepaid health care plan. Every employer who pays to a regular employee monthly wages in an amount of at least 86.67 times the minimum hourly wage, specified in chapter 387, as rounded off by regulation of the director, shall provide coverage of such employee by a prepaid group health care plan qualifying under section 393-7 with a prepaid health care plan contractor in accordance with the provisions of this chapter. [L 1974, c 210, pt of §1]

[§393-12] Choice of plan type and of contractor. (a) Every employer required to provide coverage for his employees by a prepaid group health care plan under this chapter shall elect whether coverage shall be provided by:

(1) A plan which obligates the prepaid health care plan contractor to furnish the required health care benefits; or

(2) A plan which obligates the prepaid health care plan contractor to defray or reimburse the expenses of health care.

His election is binding for one year.

(b) Whether the employer elects a plan type described in subsection (a)(1) or in subsection (a)(2), the employer may elect the particular contractor but the employee shall not be obligated to contribute a greater amount to the premium than he would have to contribute had the employer elected coverage with the contractor providing the prevailing coverage of the respective type in the State.

Subject to the provision of section 393-20, the employer shall provide coverage with the prepaid health care plan contractor selected pursuant to this subsection for all his employees in the State electing this type of coverage who are covered by the provisions of this chapter, except for employees covered by the health care provisions of an applicable collective bargaining agreement as provided in section 393-19(b) first sentence. [L 1974, c 210, pt of §1]

[§393-13] Liability for payment of premium; withholding. Unless an applicable collective bargaining agreement specifies differently every employer shall contribute at least one-half of the premium for the coverage required by this chapter and the employee shall contribute the balance; provided that in no case shall the employee contribute more than 1.5 per cent of his wages; and provided that if the amount of the employee's contribution is less than one-half of the premium, the employer shall be liable for the whole remaining portion of the premium.

The employer shall withhold the employee's share from his wages with respect to pay periods as specified by the director. [L 1974, c 210, pt of §1]

[§393-14] Commencement of coverage. The employer shall provide the coverage required by this chapter for any regular employee, who has been in his employ for four consecutive weeks, at the earliest time thereafter at which coverage may be provided with the prepaid

health care plan contractor selected pursuant to this chapter. [L 1974, c 210, pt of §1]

[§393-15] **Continuation of coverage in case of inability to earn wages.** If an employee is hospitalized or otherwise prevented by sickness from working, the employer shall enable the employee to continue his coverage by contributing to the premium the amounts paid by the employer toward such premium prior to the employee's sickness for the period that such employee is hospitalized or prevented by sickness from working. This obligation shall not exceed a period of three months following the month during which the employee became hospitalized or disabled from working, or the period for which the employer has undertaken the payment of his regular wages in such case, whichever is longer. [L 1974, c 210, pt of §1]

[§393-16] **Liability of secondary employer.** An employer who has been notified by an employee, in the form prescribed by the director, that he is not the principal employer as defined in section 393-6 shall be relieved of the duty of providing the coverage required by this chapter until he is notified by the employee pursuant to section 393-18 that he has become the principal employer. He shall notify the director, in the form prescribed by the director, that he is relieved from the duty of providing coverage or of any change in that status. [L 1974, c 210, pt of §1]

[§393-17] **Exemption of certain employees.** (a) In addition to the exemption specified in section 393-16, an employer shall be relieved of his duty under section 393-11 with respect to any employee who has notified him, in the form specified by the director, that the employee is:

(1) Protected by health insurance or any prepaid health care plan established under any law of the United States;

(2) Covered as a dependent under a prepaid health care plan, entitling him to the health benefits required by this chapter;

(3) A recipient of public assistance or covered by a prepaid health care plan established under the laws of the State governing medical assistance.

(b) Employers receiving notice of a claim of exemption under this section shall notify the director of such claim in the form prescribed by the director. [L 1974, c 210, pt of §1]

[§393-18] **Termination of exemption.** (a) If an exemption which has been claimed by an employee pursuant to section 393-17 terminates because of any change in the circumstances entitling the employee to claim such exemption, the employee shall promptly notify the principal employer of the termination of the exemption and the employer thereupon shall provide coverage as required by this chapter.

(b) If because of a change in the employment situation of an employee or a redetermination by an employee as provided in section 393-6, a principal employer becomes a secondary employer or a secondary employer becomes the principal employer, the employee shall promptly notify the employers affected of such change and the new

principal employer shall provide coverage as required by this chapter. [L 1974, c 210, pt of §1]

[§393-19] **Freedom of collective bargaining.** (a) In addition to the policy stated in section 393-2, nothing in this chapter shall be construed to limit the freedom of employees to bargain collectively for different prepaid health care plan coverage or for a different allocation of the costs thereof. A collective bargaining agreement may provide that the employer himself undertakes to provide the health care specified in the agreement.

(b) If the employees rendering particular types of services are not covered by the health care provisions of the applicable collective bargaining agreements to which their employer is a party, the provisions of this chapter shall be applicable with respect to them. An employer or group of employers shall be deemed to have complied with the provisions of this chapter if they undertake to provide health care services pursuant to a collective bargaining agreement and the services are available to all other employees not covered by such agreement. [L 1974, c 210, pt of §1]

[§393-20] **Adjustment of employer-sponsored plans.** Where employees subject to the coverage of this chapter are included in the coverage provisions of an employer-sponsored prepaid health care plan covering similar employees employed outside the State and the majority of such employees are not subject to this chapter, the benefits applicable to the employees covered by this chapter shall be adjusted within one year after the effective date of this chapter so as to meet the requirements of this chapter. [L 1974, c 210, pt of §1]

[§393-21] **Individual waivers prohibited; additional withholding for dependents.** An employee may not waive individually all or part of the required health care benefits or agree to pay a greater share of the premium for such benefits than is required by this chapter.

Subject to section 393-7(b), an employee may consent to pay a greater share of his wages and to a withholding of such share by the employer for the purpose of providing prepaid health care benefits of his dependents under the plan providing such benefits for himself. [L 1974, c 210, pt of §1]

[§393-22] **Exemption of followers of certain teachings or beliefs.** This chapter shall not apply to any individual who pursuant to the teachings, faith, or belief of any group, depends for healing upon prayer or other spiritual means. [L 1974, c 210, pt of §1]

[§393-23] **Joint provision of coverage.** Employers may form associations for the purpose of jointly providing prepaid health care protection under this chapter for their employees with the contractors authorized to provide such coverage in the State. [L 1974, c 210, pt of §1]

PART III. ADMINISTRATION AND ENFORCEMENT

[§393-31] **Enforcement by the director.** Except as otherwise provided in section 393-7 the director shall administer and enforce this chapter. The director may appoint such assistants and such clerical, stenographic, and other help as may be necessary for the proper administration and enforcement of this chapter subject to any civil service act relating to state employees. [L 1974, c 210, pt of §1]

[§393-32] **Rule making and other powers of the director.** The director may adopt, amend, or repeal, pursuant to chapter 91, such rules and regulations as he deems necessary or suitable for the proper administration and enforcement of this chapter.

The director may round off the amounts specified in this chapter for the purpose of eliminating payments from the premium supplementation fund in other than even dollar amounts or other purposes.

The director may prescribe the filing of reports by prepaid health care plan contractors and prescribe the form and content of requests by employers for premium supplementation and the period for the payment thereof. [L 1974, c 210, pt of §1]

[§393-33] **Penalties.** (a) If an employer fails to comply with section 393-11, 393-12, 393-13, or 393-15 he shall pay a penalty of not less than $25 or of $1 for each employee for every day during which such failure continues, whichever sum is greater. The penalty shall be assessed under rules and regulations promulgated pursuant to chapter 91 and shall be collected by the director and paid into the special fund for premium supplementation established by section 393-41. The director may, for good cause shown, remit all or any part of the penalty.

(b) Any employer employee, or prepaid health care plan contractor who wilfully fails to comply with any other provision of this chapter or any rule or regulation thereunder may be fined not more than $200 for each such violation. [L 1974, c 210, pt of §1]

PART IV. PREMIUM SUPPLEMENTATION

[§393-41] **Establishment of special premium supplementation fund.** There is established in the treasury of the State, separate and apart from all public moneys or funds of the State, a special fund for premium supplementation which shall be administered exclusively for the purposes of this chapter. All premium supplementations payable under this part shall be paid from the fund. The fund shall consist of (1) all money appropriated by the State for the purposes of premium supplementation under this part and (2) all fines and penalties collected pursuant to this chapter. [L 1974, c 210, pt of §1]

[§393-42] **Management of the fund.** The director of finance shall be the treasurer and custodian of the premium supplementation fund and shall administer the fund in accordance with the directions of the director of labor and industrial relations. All moneys in the fund shall be held in trust for the purposes of this part only and shall not be expended, released, or appropriated or otherwise disposed of for any other purpose. Moneys in the fund may be deposited in any depositary bank in which general funds of the State may be deposited but such moneys shall not be commingled with other state funds and shall be maintained in separate accounts on the books of the depositary bank. Such moneys shall be secured by the depositary bank to the same extent and in the same manner as required by the general depositary law of the State; and collateral pledged for this purpose shall be kept separate and distinct from any other collateral pledged to secure other funds of the State. The director of finance shall be liable for the performance of his duties under this section as provided in chapter 37. [L 1974, c 210, pt of §1]

[§393-43] **Disbursements from the fund.** Expenditures of moneys in the premium supplementation fund shall not be subject to any provisions of law requiring specific appropriations or other formal release by the state officers of money in their custody. All payments from the fund shall be made upon warrants drawn upon the director of finance by the comptroller of the State supported by vouchers approved by the director. [L 1974, c 210, pt of §1]

[§393-44] **Investment of moneys.** With the approval of the department the director of finance may, from time to time, invest such moneys in the premium supplementation fund as are in excess of the amount deemed necessary for the payment of benefits for a reasonable future period. Such moneys may be invested in bonds of any political or municipal corporation or subdivision of the State, or any of the outstanding bonds of the State, or invested in bonds or interest-bearing notes or obligations of the State (including state director of finance's warrant notes issued pursuant to chapter 40), or of the United States, or those for which the faith and credit of the United States are pledged for the payment of principal and interest, or in federal land bank bonds or joint stock farm loan bonds. The investments shall at all times be so made that all the assets of the fund shall always be readily convertible into cash when needed for the payment of benefits. The director of finance shall dispose of securities or other properties belonging to the fund only under the direction of the director of labor and industrial relations. [L 1974, c 210, pt of §1]

[§393-45] **Entitlement to premium supplementation.** (a) An employer who employs less than eight employees entitled to coverage under this chapter and who provides coverage to such employees pursuant to section 393-7(a) shall be entitled to premium supplementation from the fund if the employer's share of the cost of providing such

coverage as determined by sections 393-13 and 393-15 exceeds 1.5 per cent of the total wages payable to such employees and if the amount of such excess is greater than five per cent of the employer's income before taxes directly attributable to the business in which such employees are employed.

(b) The amount of the supplementation shall be that part of the employer's share of the premium cost which exceeds the limits specified in subsection (a). [L 1974, c 210, pt of §1]

[§393-46] Income directly attributable to the business. (a) "Income directly attributable to the business" means gross profits from the business minus deductions for:

(1) Compensation of officers;
(2) Salaries and wages, except wages paid by an individual proprietor to himself;
(3) Repairs;
(4) Taxes on business and business property;
(5) Business advertising;
(6) Amounts contributed to employee benefit plans;
(7) Interest on business indebtedness;
(8) Rent on business property; and
(9) Other expenses necessary for the current conduct of business.

(b) Deductions shall not include:

(1) Bad debts;
(2) Contributions or gifts, other than those listed under subsection (a)(6);
(3) Amortization and depreciation; or
(4) Losses by fire, storm, casualty, or theft.

(c) The director may promulgate rules and regulations necessary to define income directly attributable to business for the purpose of section 393-45. [L 1974, c 210, pt of §1]

[§393-47] Claim of premium supplementation. An employer entitled to premium supplementation shall file a claim therefor in the manner provided by regulation of the director. The employer shall have the burden of proof of establishing his entitlement. [L 1974, c 210, pt of §1]

[PART V. TERMINATION OF CHAPTER]

[§393-51 Termination of chapter.] This chapter shall terminate upon the effective date of federal legislation that provides for voluntary prepaid health care for the people of Hawaii in manner at least as favorable as the health care provided by this chapter, or upon the effective date of federal legislation that provides for mandatory prepaid health care for the people of Hawaii. [L 1974, c 210, pt of §2]

§ 38-370b. Notice of cancellation of professional liability policy

Any insurance company doing business in this state shall provide a ninety-day notice to the insured of cancellation of or refusal to renew any professional liability policy.

(1976, P.A. 76-117, eff. April 29, 1976.)

Library References

Insurance ⇐229.

C.J.S. Insurance §§ 450, 473(6) et seq.

§ 38-370c. Mandatory provisions for professional liability insurance policies issued on a claims-made basis

Every professional liability insurance policy issued on a claims-made basis delivered, issued for delivery or renewed in this state on or after October 1, 1978 shall contain (1) a provision for the purchase of prior acts coverage and (2) a contractual right of the insured to purchase at any time during the policy period or not later than thirty days after termination of such policy period coverage for all claims occurring during an insured policy period when made.

(1978, P.A. 78-91.)

CHAPTER 692

COMPREHENSIVE HEALTH CARE PLANS [NEW]

Sec.

38-371. Definitions.
38-372. Applicability of chapter. Individual and group comprehensive health care plans.
38-373. Minimum standard benefits of comprehensive health care plans. Optional and excludible benefits. Carrier subrogation rights.
38-374. Additional requirements and eligibility under group comprehensive health care plans. Insurance commissioner's authority to coordinate benefits.
38-375. Additional requirements for individual comprehensive health care plans. Carrier obligations concerning termination of coverage.
38-376. Health Reinsurance Association. Classes of risk. Audits. Insurance commissioner's powers.
38-377. Hospital and medical service corporations. Residual market mechanism. Insurance commissioner's powers concerning such mechanisms.
38-378. Insurance commissioners' powers concerning comprehensive health care plans. Notification to purchasers of policy or contract terms.
38-379. Application to new or renewed group health policies and contracts. Other regulations.
38-380. Commission on hospitals and health care.
38-381. Commissioner of social services. Contract authority concerning medicaid programs.

§ 38-371. Definitions

For purposes of this chapter, the following terms shall have the following meanings:

(a) "Health insurance" means hospital and medical expenses incurred policies written on a direct basis, nonprofit service plan contracts and self-insured or self-funded employee health benefit plans. The term "health insurance" for purposes of this chapter shall not include accident only policies, disability income policies or coverages which are subject to regulation under chapters 682a and 690.

(b) "Carrier" means an insurer, hospital service corporation or medical service corporation or fraternal benefit society.

(c) "Insurer" means an insurance company licensed to transact accident and health insurance business in this state.

(d) "Self-insurer" means an employer or an employee welfare benefit fund or plan which provides payment for or reimbursement of the whole or any part of the cost of covered hospital or medical expenses for covered individuals. For purposes of this chapter, "self-insurer" shall not include any such employee welfare benefit fund or plan established prior to April 1, 1976, by any organization which is exempt from federal income taxes under the provisions of Section 501 of the United States Internal Revenue Code and amendments thereto and legal interpretations thereof, except any such organization described in Subsection (c)(15) of said Section 501.

(e) "Commissioner" means the insurance commissioner within the department of business regulation of the state of Connecticut.

(f) "Physician" means a doctor of medicine, osteopathy, chiropractic, naturopathy, podiatry, a qualified psychologist and, for purposes of oral surgery only, a doctor of dental surgery or a doctor of medical dentistry, and subject to the provisions of section 20-138d, optometrists duly licensed under the provisions of chapter 380.

(g) "Qualified psychologist" means a person who is duly licensed or certified as a clinical psychologist and has a doctoral degree in and at least two years of supervised experience in clinical psychology in a licensed hospital or mental health center.

(h) "Skilled nursing facility" shall have the same meaning as "skilled nursing facility" as defined in Section 1395x, Chapter 7 of Title 42, United States Code.

(i) "Hospital" shall have the same meaning as "hospital" as defined in Section 1395x, Chapter 7 of Title 42, United States Code.

(j) "Home health agency" shall have the same meaning as "home health agency" as defined in Section 1395x, Chapter 7 of Title 42, United States Code.

(k) "Copayment" means the portion of a charge that is covered by a plan and not payable by the plan and which is thus the obligation of the covered individual to pay.

(l) "Resident employer" means any person, partnership, association, trust, estate, corporation, whether foreign or domestic, or the legal representative, trustee in bankruptcy or receiver or trustee, thereof, or the legal representative of a deceased person, including the state of Connecticut and each municipality thereof, which has in its employ one or more individuals during any calendar year, commencing January 1, 1976. For purposes of this chapter, the term "resident employer" shall refer only to an employer with a majority of employees employed within the state of Connecticut.

(m) "Eligible employee" means, with respect to any employer, an employee who either is considered a fulltime employee, or who is expected to work at least twenty hours a week for at least twenty-six weeks during the next twelve months or who has actually worked at least twenty hours a week for at least twenty-six weeks in any continuous twelve month period.

(n) "Alcoholism treatment facility" shall have the same meaning as in section 38-262b.

(o) "Totally disabled" means with respect to an employee, the inability of the employee because of an injury or disease to perform the duties of any occupation for which he is suited by reason of education, training or experience, and, with respect to a dependent, the inability of the dependent because of an injury or disease to engage in substantially all of the normal activities of persons of like age and sex in good health.

(p) "Deductible" means the amount of covered expenses which must be accumulated during each calendar year before benefits become payable as additional covered expenses incurred.

(q) For purposes of this chapter, "disease or injury" shall include pregnancy and resulting childbirth or miscarriage.

(r) "Complications of pregnancy" means (1) conditions requiring hospital stays, when the pregnancy is not terminated, whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion and similar medical and surgical conditions of comparable severity, and shall not include false labor, occasional spotting, physician-prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, pre-eclampsia and similar conditions associated with management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy; and (2) non-elective cesarean section, ectopic pregnancy which is terminated, and spontaneous termination of pregnancy, which occurs during a period of gestation in which a viable birth is not possible.
(1975, P.A. 75-616, § 1, eff. April 1, 1976; 1976, P.A. 76-399, § 2, eff. June 9, 1976; 1977, P.A. 77-614, § 163, eff. Jan. 1, 1979.)

1976 Amendment

Introductory paragraph: 1976, P.A. 76-399, § 2, substituted "sections 38-371 to 38-381" for "this act".

Subsection (a): 1976, P.A. 76-399, § 2, substituted, in the second sentence, "sections 38-371 to 38-381" for "this act".

Subsection (d): 1976, P.A. 76-399, § 2, amended the second sentence by substituting "sections 38-371 to 38-381" for "this act"; and by substituting "June 9, 1976" for "the effective date of this act".

Subsection (f): 1976, P.A. 76-399, § 2, substituted, in the second sentence, "sections 38-371 to 38-381" for "this act".

Subsections (o) to (r): Added by 1976, P.A. 76-399, § 2.

1977 Amendment

1977, P.A. 77-614, § 163, eff. Jan. 1, 1979, provides for insertion of the words "within the department of business regulation" following "insurance commissioner".

Library References

Words and Phrases (Perm.Ed.)

§ 38-372. Applicability of chapter. Individual and group comprehensive health care plans

(a)(1) Every carrier offering individual health insurance in this state shall, as a condition of transacting such health insurance, make an individual comprehensive health care plan, described in section 38-375, available to every resident of this state who is not eligible for Medicare. An individual shall have a choice of the low option or middle option or high option deductible described in subsection (b) of section 38-373. Individual comprehensive health care plans may be made available through participation in the Health Reinsurance Association in accordance with section 38-376, or a residual market association, in accordance with section 38-377. The premium charged for such a plan which is not insured by or through the Health Reinsurance Association or any other residual market association may not exceed the premium which would be applicable through participation in such associations. The premium charged for such a plan insured by or through the Health Reinsurance Association shall be precisely the premium established for that particular classification under the Health Reinsurance Association.

(2) Every self-insurer whose plan covers three or more employees shall make an individual comprehensive health care plan, described in section 38-375, available under a conversion privilege to every person covered by the plan who is a resident of this state, who is not eligible for Medicare and whose coverage under the self-insured plan ceases as a result of layoff, death or termination of employment. An individual shall have the choice of the low option or middle option or high option deductible described in subsection

(b) of section 38-373. The individual comprehensive health care plans may be provided through a carrier or through participation in the Health Reinsurance Association in accordance with section 38-376. The premium charged for such a plan which is not insured by or through the Health Reinsurance Association may not exceed the premium established for that particular classification under the Health Reinsurance Association. The premium charged for such a plan which is insured by or through the Health Reinsurance Association shall be precisely the premium established for that particular classification under the Health Reinsurance Association.

(b) Every carrier offering group health insurance in this state shall, as a condition of transacting such health insurance, make a group comprehensive health care plan, as described in section 38-374, available to every resident employer of three or more eligible employees. An employer shall have the choice of the low option or middle option or high option deductible described in subsection (b) of section 38-373. Group comprehensive health care plans may be made available to resident employers of between three and twenty-five eligible employees through participation in the Health Reinsurance Association, in accordance with section 38-376 or the residual market association, in accordance with section 38-377. The premium charged for such a plan on groups of between three and twenty-five eligible employees which is not insured by or through the Health Reinsurance Association or a residual market association may not exceed the premium which would be applicable through participation in such associations. The premium charged for such a plan which is insured by or through the Health Reinsurance Association must be precisely the premium established for that particular classification under the Health Reinsurance Association.

(c) Except as provided in subdivision (c) of section 38-378, nothing in sections 38-371 to 38-381 shall preclude the right of carriers to transact other kinds of insurance for which they are authorized, nor preclude the right of carriers to transact any other lawful kind of health insurance.

(d) Nothing in sections 38-371 to 38-381 shall require a carrier to make available coverage under a group or individual comprehensive health care plan to any person or group who is already covered under such a plan.
(1975, P.A. 75-616, § 2, eff. April 1, 1976.)

Library References

Insurance ⇨467.3, 467.4, 467.5.
C.J.S. Insurance §§ 753 et seq., 893, 896.

§ 38-373. Minimum standard benefits of comprehensive health care plans. Optional and excludible benefits. Carrier subrogation rights

All individual and all group comprehensive health care plans shall include minimum standard benefits as described in this section.

(a) Except as provided in subsections (b) and (c), minimum standard benefits shall be benefits, including coverage for catastrophic illness, with a lifetime maximum of one million dollars per individual, for reasonable charges or, when applicable, the allowance agreed upon between a provider and a carrier for charges actually incurred, for the following health care services, rendered to an individual covered by such plan for the diagnosis or treatment of nonoccupational disease or injury: (1) Hospital services; (2) professional services which are rendered by a physician or, at his direction, by a registered nurse, other than services for mental or dental conditions; (3) the diagnosis or treatment of mental conditions, as defined by the commissioner, rendered during the year by one or more physicians on other than an inpatient basis or, at their direction, by their staffs of registered nurses, up to a yearly maximum benefit of one thousand dollars; (4) legend drugs requiring a physician's prescription; (5) services of a skilled nursing fa-

cility for not more than one hundred twenty days in a calendar year, provided such services commence within fourteen days following a confinement of at least three consecutive days in a hospital for the same condition; (6) home health agency services, as defined by the commissioner, up to a maximum of one hundred eighty visits in a calendar year, provided such services commence within seven days following confinement in a hospital or skilled nursing facility of at least three consecutive days for the same condition, provided further, in the case of an individual diagnosed by a physician as terminally ill with a prognosis of six months or less to live, such home health agency services may commence irrespective of whether such covered person was so confined or, if such covered person was so confined, irrespective of such seven-day period, and the yearly benefit for medical social services, as hereinafter defined, shall not exceed two hundred dollars. "Medical social services" means services rendered, under the direction of a physician by a qualified social worker holding a master's degree from an accredited school of social work, including but not limited to (a) assessment of the social, psychological and family problems related to or arising out of such covered person's illness and treatment; (b) appropriate action and utilization of community resources to assist in resolving such problems; (c) participation in the development of treatment for such covered person; (7) use of radium or other radioactive materials; (8) oxygen; (9) anesthetics; (10) non-dental prosthesis; (11) rental of durable medical equipment which has no personal use in the absence of the condition for which prescribed; (12) diagnostic x-rays and laboratory tests as defined by the commissioner; (13) oral surgery for: (A) Excision of partially or completely unerupted impacted teeth, or (B) excision of a tooth root without the extraction of the entire tooth; (14) services of a licensed physical therapist, rendered under the direction of a physician; (15) transportation by a local professional ambulance to the nearest health care institution qualified to treat the illness or injury; (16) certain other services which are medically necessary in the treatment or diagnosis of an illness or injury as may be designated or approved by the insurance commissioner within the department of business regulation; (17) confinement in a facility established primarily for the treatment of alcoholism and licensed for such care by the state, or in a part of a hospital used primarily for such treatment, shall be a covered expense for a period of at least forty-five days within any calendar year.

(b) Minimum standard benefits may include one or more of the following provisions: (1) Subject to the provisions of subdivision (3) such plan may require deductibles. The "low option deductible" shall be two hundred dollars per person, the "middle option deductible" shall be five hundred dollars per person, and the "high option deductible" shall be seven hundred fifty dollars per person. The amount of the deductible may not be greater when a service is rendered on an outpatient basis than when that service is offered on an inpatient basis. Expenses incurred during the last three months of a calendar year and actually applied to an individual's deductible for that year shall be applied to that individual's deductible in the following calendar year. The two hundred dollar maximum, the five hundred dollar maximum and the seven hundred fifty dollar maximum may be adjusted yearly to correspond with the change in the medical care component of the consumer price index, as adjusted by the commissioner. The base year for such computation shall be the first full year of operation of such plan. (2) Subject to the provisions of subdivision (3), such plan shall require a maximum copayment of twenty per cent for charges for all types of health care in excess of the deductible and fifty per cent for services listed in subdivision (3) of subsection (a) in excess of the deductible. (3) The sum of the deductible and copayments required in any calendar year under any option may not exceed a maximum limit of one thousand dollars per covered individual, or two thousand dollars per covered family; provided, covered expenses incurred after the applicable maximum limit has been

reached shall be paid at the rate of one hundred per cent, except that expenses incurred for treatment of mental and nervous conditions may be paid at the rate of fifty per cent as specified in subdivision (3) of subsection (a). The one thousand dollar and two thousand dollar maximums shall be adjusted yearly to correspond with the change in the medical care component of the consumer price index as adjusted by the commissioner. (4) The plan shall limit benefits with respect to each pregnancy, other than a pregnancy involving complications of pregnancy, to a maximum of two hundred fifty dollars. (5) The plan may limit lifetime benefits to a maximum of not less than one million dollars per covered individual. (6) No pre-existing condition exclusion shall exclude coverage of any pre-existing condition unless: (A) The condition first manifested itself within the period of six months immediately prior to the effective date of coverage in such a manner as would cause a reasonably prudent person to seek diagnosis, care or treatment; (B) medical advice or treatment was recommended or received within the period of six months immediately prior to the effective date of coverage, or (C) the condition is pregnancy existing on the effective date of coverage. No policy shall exclude coverage for a loss due to pre-existing conditions for a period greater than twelve months following the effective date of coverage. Any individual comprehensive health care plan issued as a result of conversion from group health insurance or from a self insured group shall credit the time covered under such group health insurance toward any such exclusion.

(c) Plans providing minimum standard benefits need not provide benefits for the following: (1) Any charge for any care for any injury or disease either (A) arising out of and in the course of an employment subject to a workmen's compensation or similar law or (B) to the extent benefits are payable without regard to fault under a coverage statutorily required to be contained in any motor vehicle or other liability insurance policy or equivalent self-insurance; (2) any charge for treatment for cosmetic purposes other than surgery for the prompt repair of an accidental injury sustained while covered; (3) any charge for travel, other than transportation by local professional ambulance to the nearest health care institution qualified to treat the illness or injury; (4) any charge for private room accommodations to the extent it is in excess of the institution's most common charge for a semiprivate room; (5) any charge by health care institutions to the extent that it is determined by the carrier that the charge exceeds the rates approved by the commission on hospital and health care; (6) any charge for services or articles to the extent that it exceeds the reasonable charge in the locality for the service; (7) any charge for services or articles which are determined not to be medically necessary; (8) any charge for services or articles the provisions of which is not within the scope of the license or certificate of the institution or individual rendering such services or articles; (9) any charge for services or articles furnished, paid for or reimbursed directly by or under any law of a government, except as otherwise provided herein; (10) any charge for services or articles for custodial care or designed primarily to assist an individual in meeting his activities of daily living; (11) any charge for services which would not have been made if no insurance existed or for which the covered individual is not legally obligated to pay; (12) any charge for eyeglasses, contact lenses or hearing aids or the fitting thereof; (13) any charge for dental care not specifically covered by this chapter; and (14) any charge for services of a registered nurse who ordinarily resides in the covered individual's home, or who is a member of the covered individual's family or the family of the covered individual's spouse.

(d) Whenever a covered individual who receives benefits for an injury has a right of recovery against any person or organization, a carrier that has paid such benefits to or for the insured person shall be subrogated to all such rights of recovery to the extent of its payments.

(e) The minimum standard benefits of any individual or group comprehensive health care plan may be satisfied by catastrophic coverage offered in conjunction with basic hospital or medical-surgical plans on an expense incurred or service basis as approved by the commissioner as providing at least equivalent benefits.

(1975, P.A. 75-610, § 3, eff. April 1, 1976; 1976, P.A. 76-399, § 3, eff. June 9, 1976; 1977, P.A. 77-614, § 163, eff. Jan. 1, 1979; 1978, P.A. 78-76, § 4.)

1976 Amendment

Subsection (a): 1976, P.A. 76-399, § 3, added subd. (17).

Subsection (b): 1976, P.A. 76-399, § 3, redesignated former subds. (4) and (5) as subds. (5) and (6); inserted subd. (4); and added to subd. (6), par. (C).

Subsection (c): 1976, P.A. 76-399, § 3, substituted, in subd. (13), "sections 38-371 to 38-381" for "this act" following "not specifically covered by".

1977 Amendment

1977, P.A. 77-614, § 163, eff. Jan. 1, 1979, provides for insertion of the words "within the department of business regulation" following "insurance commissioner".

1978 Amendment

1978, P.A. 78-76, § 4, amended subsec. (a)(6) by adding the proviso following "days for the same condition", and by adding a second sentence defining "Medical social services".

Library References

Insurance ⇐467.5.

C.J.S. Insurance § 893 et seq.

§ 38-374. Additional requirements and eligibility under group comprehensive health care plans. Insurance commissioner's authority to coordinate benefits

A group comprehensive health care plan shall contain the minimum standard benefits prescribed in section 38-373, including the choice of the low option, middle option or high option deductible, and shall also conform in substance to the requirements of this section.

(a) The plan shall be one under which the individuals eligible to be covered include: (1) Each eligible employee; (2) the spouse of each eligible employee; and (3) dependent unmarried children, who are under the age of nineteen or are full-time students under the age of twenty-three at an accredited institution of higher learning.

(b) The plan shall provide the option to continue coverage under each of the following circumstances until eligible for other group insurance: (1) Upon layoff or leave of absence, or termination of employment, other than as a result of death of the employee, continuation of coverage for such employee and his covered dependents to the end of the thirty-ninth week following the day on which the employee lost eligibility to participate in the group; (2) upon the death of the employee, continuation of coverage for the covered dependents of such employee to the end of the thirty-ninth week following the day on which the employee lost eligibility to participate in the group; (3) during an employee's absence due to illness or injury, continuation of coverage for such employee and his covered dependents during continuance of such illness or injury or for up to twelve months from the beginning of such absence; (4) upon termination of the group plan, coverage for covered individuals who were totally disabled on the date of termination, shall be continued without premium payment during the continuance of such disability for a period of twelve calendar months following the calendar month in which the plan was terminated, provided claim is submitted therefor within one year of the termination of the plan; (5) the coverage of any covered individual shall terminate: (A) As to a child, at the end of the month following the month in which the child marries, ceases to be dependent on the employee or attains the age of nineteen, whichever occurs first, except that if the child is a fulltime student at an accredited institution, the coverage may be continued while the child remains unmarried and a fulltime student, but not beyond the month following the month in which the child attains the age of twenty-three. If on the date

specified for termination of coverage on a dependent child, the child is unmarried and incapable of self-sustaining employment by reason of mental retardation or physical handicap and chiefly dependent upon the employee for support and maintenance, the coverage on such child shall continue while the plan remains in force and the child remains in such condition, provided proof of such handicap is received by the carrier within thirty-one days of the date on which the child's coverage would have terminated in the absence of such incapacity. The carrier may require subsequent proof of the child's continued incapacity and dependency but not more often than once a year thereafter; (B) as to the employee's spouse, at the end of the month following the month in which a divorce, annulment or legal separation is obtained; and (C) as to the employee or dependent as of midnight of the day preceding such person's eligibility for benefits under Title XVIII of the Social Security Act; (6) any continuation of coverage required by this section except subdivision (4) of subsection (b) may be subject to the requirement, on the part of the individual whose coverage is to be continued, that such individual contribute that portion of the premium he would have been required to contribute had the employee remained an active covered employee, except that the individual may be required to pay the entire premium at the group rate if coverage is continued in accordance with subdivision (1) of subsection (b) above, provided the employer shall not be legally obligated by this act to pay such premium if not paid timely by the employee.

(c) The commissioner shall promulgate regulations concerning coordination of benefits between the plan and other health insurance plans.

(d) The plan shall make available to Connecticut residents, in addition to any other conversion privilege available, a conversion privilege under which coverage shall be available immediately upon termination of coverage under the group plan. The terms and benefits offered under the conversion benefits shall be at least equal to the terms and benefits of an individual comprehensive health care plan.

(1975, P.A. 75-610, § 4, eff. April 1, 1976; 1976, P.A. 76-399, § 1, eff. June 9, 1976.)

1976 Amendment

Introductory paragraph: 1976, P.A. 76-399, § 1, substituted "section 38-373" for "section 3 of this act".

Subsection (b): 1976, P.A. 76-399, § 1, substituted "thirty-ninth week following the day on which the employee lost eligibility to participate in the group" for "ninetieth day following the day on which such layoff, leave of absence or termination commenced" in subd. (1) and for "ninetieth day following the day on which death occurred" in subd. (2).

Library References

Insurance ⇐467.5.

C.J.S. Insurance § 893 et seq.

§ 38-375. Additional requirements for individual comprehensive health care plans. Carrier obligations concerning termination of coverage

An individual comprehensive health care plan shall contain the minimum standard benefits prescribed in section 38-373, including the choice of the low option, middle option or high option deductible, and shall also conform in substance to the requirements of this section. Each individual comprehensive health care plan shall contain provisions:

(1) Which obligate the carrier to continue the contract until the earlier of

(A) the date on which the individual in whose name the contract was issued first becomes eligible for coverage under Title XVIII of the Social Security Act or under a group comprehensive health care plan or,

(B) the plan anniversary date at least sixty days prior to which the carrier has mailed to the individual at his last address shown on the carrier's records written notice of its decision not to continue coverage on a class basis only.

The carrier may reserve the right to adjust premiums by classes in accordance with its experience for policies or contracts not written by or through the Health Reinsurance Association, provided such premium may not exceed the premium established for that particular class by the Health Reinsurance Association;

(2) which, upon the death of the individual in whose name the contract was issued, permits every other individual then covered under the contract to elect, within such period as shall be specified in the contract, to continue the same coverage until such time as he would have ceased to be entitled to coverage had the individual in whose name the contract was issued lived; and

(3) under which the benefits payable shall be excess to all other sources of health insurance benefits, including benefits provided pursuant to any state or federal law other than Medicaid.

(1975, P.A. 75-616, § 5, eff. April 1, 1976.)

Library References

Insurance ⇐467.4.

C.J.S. Insurance §§ 893, 896.

§ 38-376. Health Reinsurance Association. Classes of risk. Audits. Insurance commissioner's powers

There is hereby created a nonprofit legal entity to be known as the Health Reinsurance Association. All insurers and self insurers doing business in the state, as a condition to their authority to transact the applicable kinds of health insurance defined in section 38-371, shall be members of the association. The association shall perform its functions under a plan of operation established and approved under subdivision (a), and shall exercise its powers through a board of directors established under this section.

(a)(1) The board of directors of the association shall be made up of seven individuals selected by participating members, subject to approval by the commissioner. To select the initial board of directors, and to initially organize the association, the commissioner shall give notice to all members of the time and place of the organizational meeting. In determining voting rights at the organizational meeting each member shall be entitled to vote in person or proxy. The vote shall be a weighted vote based upon the net health insurance premium derived from this state in the previous calendar year. If the board of directors is not selected within sixty days after notice of the organizational meeting, the commissioner may appoint the initial board. In approving or selecting members of the board, the commissioner may consider, among other things, whether all members are fairly represented. Members of the board may be reimbursed from the monies of the association for expenses incurred by them as members, but shall not otherwise be compensated by the association for their services.

(2) The board shall submit to the commissioner, a plan of operation for the association necessary or suitable to assure the fair, reasonable and equitable administration of the association. The plan of operation shall become effective upon approval in writing by the commissioner consistent with the date on which the coverage under this act must be made available. The commissioner shall, after notice and hearing, approve the plan of operation provided such plan is determined to be suitable to assure the fair, reasonable and equitable administration of the association, and provides for the sharing of association gains or losses on an equitable proportionate basis. If the board fails to submit a suitable plan of operation within one hundred eighty days after its appointment, or if at any time thereafter the board fails to submit suitable amendments to the plan, the commissioner shall, after notice and hearing, adopt and promulgate such reasonable rules as are necessary or advisable to effectuate the provisions of this section. Such rules shall continue in force until modified by the commissioner or superseded by a plan submitted by the board and approved by the commissioner. The plan of operation shall, in addition to requirements enumerated in sections 38-371 to 38-381:

(A) Establish procedures for the handling and accounting of assets and monies of the association;

(B) establish regular times and places for meetings of the board of directors;

(C) establish procedures for records to be kept of all financial transactions, and for the annual fiscal reporting to the commissioner;

(D) establish procedures whereby selections for the board of directors shall be made and submitted to the commissioner;

(E) establish procedures to amend, subject to the approval of the commissioner, the plan of operations;

(F) establish procedures for the selection of an administering carrier and set forth the powers and duties of the administering carrier;

(G) contain additional provisions necessary or proper for the execution of the powers and duties of the association; and

(H) establish procedures for the advertisement on behalf of all participating carriers of the general availability of the comprehensive coverage under sections 38-371 to 38-381.

(b) The association shall have the general powers and authority granted under the laws of this state to carriers to transact the kinds of insurance defined under section 38-371, and in addition thereto, the specific authority to:

(1) Enter into contracts necessary or proper to carry out the provisions and purposes of sections 38-371 to 38-381;

(2) sue or be sued, including taking any legal actions necessary or proper for recovery of any assessments for, on behalf of, or against participating members;

(3) take such legal action necessary to avoid the payment of improper claims against the association or the coverage provided by or through the association;

(4) establish, with respect to health insurance provided by or on behalf of the association, appropriate rates, scales of rates, rate classifications and rating adjustments, such rates not to be unreasonable in relation to the coverage provided and the operational expenses of the association;

(5) Administer any type of reinsurance program, for or on behalf of participating members;

(6) Pool risks among participating members;

(7) Issue policies of insurance on an indemnity or provision of service basis providing the coverage required by sections 38-371 to 38-381 in its own name or on behalf of participating members;

(8) Administer separate pools, separate accounts or other plans as deemed appropriate for separate members or groups of members;

(9) Operate and administer any combination of plans, pools, reinsurance arrangements or other mechanisms as deemed appropriate to best accomplish the fair and equitable operation of the association;

(10) Set limits on the amounts of reinsurance which may be ceded to the association by its members; and

(11) Appoint from among participating members appropriate legal, actuarial and other committees as necessary to provide technical assistance in the operation of the association, policy and other contract design, and any other function within the authority of the association.

(c) Every member shall participate in the association in accordance with the provisions of this subdivision.

(1) A participating member shall determine the particular risks it elects to have written by or through the association. A member shall designate which of the following classes of risks it shall underwrite in the state, from which classes of risk it may elect to reinsure selected risks:

(A) Individual, excluding group conversion;

(B) Individual, including group conversion; and

(C) groups of between three and twenty-five employees or members.

(2) No member or employer shall be permitted to select out individual lives from an employer group to be insured by or through the association. Members electing to administer risks which are insured by or through the association shall comply with the benefit determination guidelines and the accounting procedures established by the association. A risk insured by or through the association cannot be withdrawn by the participating member except in accordance with the rules established by the association.

(3) Rates for coverage issued by or through the association shall not be excessive, inadequate or unfairly discriminatory. Separate scales of premium rates based on age shall apply for individual risks and group risks. Group rates may be adjusted for area variations in provider costs but individual rates shall not be adjusted for area variations in provider costs. Premium rates shall take into consideration the substantial extra morbidity and administrative expenses for association risks, reimbursement or reasonable expenses incurred for the writing of association risks and the level of rates charged by insurers for groups of such lives. In no event shall the rate for a given classification or group be less than one hundred twenty-five per cent nor more than one hundred fifty per cent of the average group rate charged for that classification or group with similar characteristics under a policy covering ten lives. All rates shall be promulgated by the association through an actuarial committee consisting of five persons who are members of the American Academy of Actuaries, and shall be filed with the commissioner and may be disapproved within sixty days from the filing thereof if excessive, inadequate, or unfairly discriminatory.

(d)(1) Following the close of each fiscal year, the administering carrier shall determine the net premiums, reinsurance premiums less administrative expense allowance, the expense of administration pertaining to the reinsurance operations of the association and the incurred losses for the year. Any net loss shall be assessed to all participating members in proportion to their respective shares of the total health insurance premiums earned in this state during the calendar year or with paid losses in the year, coinciding with or ending during the fiscal year of the association or on any other equitable basis as may be provided in the plan of operations. For self insured members of the association, health insurance premiums earned shall be established by dividing the amount of paid health losses for the applicable period by eighty-five per cent. Net gains, if any, shall be held at interest to offset future losses or allocated to reduce future premiums.

(2) Any net loss to the association represented by the excess of its actual expenses of administering policies issued by the association over the applicable expense allowance shall be separately assessed to those participating members who do not elect to administer their plans. All assessments shall be on an equitable formula established by the board.

(3) The association shall conduct periodic audits to assure the general accuracy of the financial data submitted to the association and the association shall have an annual audit of its operations by an independent certified public accountant. The annual audit shall be filed with the commissioner for his review and the association shall be subject to the provisions of section 38-7.

(e) All policy forms issued by or through the association shall conform in substances to prototype forms developed by the association, shall in all

other respects conform to the requirements of this act, and shall be approved by the commissioner. The commissioner may disapprove any such form if it contains a provision or provisions which are unfair or deceptive or which encourage misrepresentation of the policy.

(f) The association shall not issue nor reissue comprehensive health care plan coverage with respect to any person who is already covered under an individual or group comprehensive health care plan, or who is eligible for Medicare or who is not a resident of this state.

(g) Benefits payable under a comprehensive health care plan insured by or reinsured through the association shall be paid net of all other health insurance benefits paid or payable through any other source, and net of all health insurance coverages provided by or pursuant to any other state or federal law including Title XVIII of the Social Security Act, Medicare, but excluding Medicaid.

(h) There shall be no liability on the part of and no cause of action of any nature shall arise against any carrier or its agents or its employees, the Health Reinsurance Association or its agents or its employees or the residual market mechanism established under the provisions of section 38-377 or its agents or its employees, or the commissioner or his representatives for any action taken by them in the performance of their duties under sections 38-371 to 38-381. This provision shall not apply to the obligations of a carrier, a self-insurer, the Health Reinsurance Association or the residual market mechanism for payment of benefits provided under a comprehensive health care plan.

(1975, P.A. 75-616, § 6, eff. April 1, 1976.)

Library References

Insurance ⇐467.4.

C.J.S. Insurance §§ 893, 896.

§ 38-377. Hospital and medical service corporations. Residual market mechanism. Insurance commissioner's powers concerning such mechanisms

(a) Hospital and medical service corporations may elect to meet the obligations of section 38-372 by participating in the Health Reinsurance Association established in section 38-376, as a full member thereof, or by making comprehensive health care plans available directly through a subscriber contract or combination of contracts or by forming a separate residual market mechanism substantially similar to the association established in section 38-376.

(b) In the event that hospital and medical service corporations choose to form a separate residual market mechanism, the commissioner shall have the same regulatory powers over that residual market mechanism as he has over the Health Reinsurance Association, and such residual market mechanism shall have the same powers and duties as the association. Rating classifications under a residual market mechanism established under this section need not be the same as classifications established under the association, but any rates established by the residual market mechanism shall be approved by the commissioner. The commissioner shall promulgate regulations to carry out the requirements of this section.

(c) If the hospital and medical service corporations do not elect to participate in the Health Reinsurance Association, such hospital and medical service corporations shall be required to make an individual comprehensive health care plan available to every resident of this state who is not eligible for Medicare and whose coverage under a group or individual contract issued by such hospital or medical service corporation has terminated. Such coverage may be made available through a separate residual market mechanism established under this section.

(1975, P.A. 75-616, § 7, eff. April 1, 1976; 1976, P.A. 76-435, § 23, eff. June 9, 1976.)

1976 Amendment
Subsection (c): 1976, P.A. 76-435, § 28. substituted, in the first sentence, "or individual" for "on" following "whose coverage under a group".

§ 38-378. Insurance commissioner's powers concerning comprehensive health care plans. Notification to purchasers of policy or contract terms

In order to provide reasonable standardization of terms and coverages of individual accident and sickness insurance policies and contracts, to facilitate public understanding and comparison, to eliminate provisions which may be misleading or unreasonably confusing in connection with either the purchase of such coverage or with the settlement of claims and to provide for full disclosure in the sale of such coverages:

(a) The commissioner shall issue regulations to establish specific standards for policy provisions used in individual health insurance policies or contracts, but not including group conversion policies or contracts, which shall be in addition to and in accordance with chapter 681 and other applicable laws of this state which may cover the terms of renewability, initial and subsequent conditions of eligibility, nonduplication of coverage provisions, coverage of dependents, termination of insurance, probationary periods, limitations, exceptions, reductions, elimination periods, requirements for replacements, recurrent conditions, pre-existing conditions, and the definition of the terms hospital, accident, sickness, injury, physician, accidental means, total disability, permanent disability, partial disability, nervous disorders, guaranteed renewable, and noncancellable.

(b) The commissioner shall adopt regulations, in accordance with chapter 54, that specify prohibited policy provisions not otherwise specifically authorized by statute which in the opinion of the commissioner are unjust, unfair or unfairly discriminatory to the policyholder, any person insured under the policy, or any beneficiary.

(c) The commissioner shall adopt regulations, in accordance with chapter 54, to establish minimum standards for benefits under each of the following categories of coverage in individual policies, other than conversion policies issued pursuant to a contractual conversion privilege under a group policy: Basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income protection coverage, accident only coverage and specified accident coverage. Specified disease policies, riders and benefits shall be prohibited whether issued on a group or individual basis.

(d) Nothing in this section shall prevent the issuance of any policy which combines two or more of the categories of coverage enumerated in subsection (c), except that specified accident coverage shall not be combined with any other category of coverage. The commissioner shall prescribe the method of identification of policies based upon coverage provided.

(e) No policy shall be delivered or issued for delivery in this state which does not meet the prescribed minimum standards for the categories of coverage listed in subsection (c), provided nothing in this section shall preclude the issuance or delivery of any policy which does not meet such prescribed minimum standards of coverage so long as such policy is clearly identified as not meeting such prescribed standards.

(f) No such policy or contract shall be delivered in this state unless: (1) An outline of coverage described herein accompanies the policy or (2) the outline of coverage described in this section is delivered to the applicant at the time application is made and acknowledgement of receipt of certificate of delivery of such outline is provided the carrier with the application. In the event the policy or contract is issued on a basis other than that applied for, the outline of coverage properly describing the policy shall accompany the policy when it is delivered. The outline of coverage shall include:

(A) A statement identifying the applicable category or categories of coverage provided by the policy in accordance with this section; (B) a description of the principal benefits and coverage provided in the policy; (C) a statement of the exceptions, reductions and limitations contained in the policy or contract; (D) a statement of the renewal provisions including any reservation by the carrier of a right to change premiums; and (E) a statement that the outline is a summary of the policy issued or applied for and that the policy should be consulted to determine governing contractual provisions.

(g) Notwithstanding the provisions of chapter 681, if a carrier elects to use a simplified application form, with or without any questions as to the applicant's health at the time of application, but without any questions concerning the insured's health history or medical treatment history, the policy shall cover loss developing after twelve months from any pre-existing condition not specifically excluded from coverage by the terms of the policy and, except as so provided, the policy shall not include wording that would permit a defense based upon pre-existing conditions.

(h) Regulations promulgated pursuant to this section shall specify an effective date applicable to policy and benefit riders delivered or issued for delivery in this state on and after such effective date which shall not be less than one hundred eighty days after the date of adoption or promulgation. (1975, P.A. 75-616, § 8, eff. April 1, 1976; 1976, P.A. 76-309, § 4, eff. June 9, 1976.)

1976 Amendment
Subsection (c): 1976, P.A. 76-309, § 4, amended the second sentence by inserting ", riders and benefits" following "Specified disease policies", and by adding "whether issued on a group or individual basis" at the end.

§ 38-379. Application to new or renewed group health policies and contracts. Other regulations

(a) In order to assure reasonable continuation of coverage and extension of benefits to the citizens of this state, all group health policies or contracts delivered or issued for delivery or renewal in this state on or after April 1, 1976 shall, subject to the provisions of subsection (c), contain those provisions described in subsections (b) and (d) of section 38-374.

(b) The commissioner shall, within one hundred eighty days after April 1, 1976, adopt regulations in accordance with the provisions of chapter 54, covering group coverage discontinuance and replacement.

(c) Nothing in this section shall alter or impair existing group policies or contracts which have been established pursuant to an agreement which resulted from collective bargaining, and the provisions required by this section shall become effective upon the next regular renewal and completion of such collective bargaining agreement.
(1975, P.A. 75-616, § 9, eff. April 1, 1976.)

§ 38-380. Commission on hospitals and health care

In addition to the powers and duties already granted to it by law, the commission on hospitals and health care shall, within one year of April 1, 1976, adopt regulations designed to allow state professional standard review organizations established under U.S. Public Law 92-603 to extend their review of certain inpatient services to services received by all patients. Such regulations shall be adopted in accordance with the provisions of chapter 54.[1]
(1975, P.A. 75-616, § 10, eff. April 1, 1976; 1977, P.A. 77-118.)

[1] Section 4-166 et seq.

1977 Amendment
1977, P.A. 77-118 substituted "allow" for "require" following "adopt regulations designed to", and substituted the reference to U.S. Public Law "92-603" for "92-408".

§ 38-381. Commissioner of income maintenance. Contract authority concerning medicaid programs

The commissioner of income maintenance may enter into contractual agreements with any carrier or with the Health Reinsurance Association or a residual market mechanism to obtain appropriate administrative services, insurance benefits or any other insurance related services in connection with the state's medicaid program. All terms and provisions of any such contracts shall be mutually acceptable to the parties involved.

(1975, P.A. 75-616, § 11, eff. April 1, 1976; 1977, P.A. 77-614, §§ 521, 608, eff. Jan. 1, 1979; 1977, P.A. 77-614, § 587, eff. June 2, 1977; 1978, P.A. 78-303, § 85, eff. June 6, 1978.)

1977 Amendments

1977, P.A. 77-614, § 608, eff. Jan. 1, 1979, provided for change of term from "welfare commissioner" to "commissioner of income maintenance".

1977, P.A. 77-614, § 587, eff. June 2, 1977 as amended by 1978, P.A. 78-303, § 85, eff. June 6, 1978, authorized technical, grammatical, and punctuation changes with reference to 1977, P.A. 77-614 and the public acts of 1977 and 1978. For text of these provisions, see notes under § 2-56.

INDEX

CONSULT GENERAL INDEX POCKET PART

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STATE
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#5

HB 977

SB 227

FISCAL NOTES

	POSITION TITLE			RANGE/STEP	BARG. UNIT.	LOCATION		APPROV.	DISAPP
1	Assistant Director			21A	Sup.	Juneau	GOV		
	TYPE OF POSITION	STAFF MONTHS	RP No.	PCN No.	PRIORITY	FORM 12 PAGE/LINE			
2	PFT	12					LEG.		

	TYPE OF EXPENDITURE		AMOUNT
	1	2	3
	PERSONAL SERVICES:		
4	SALARY 3.113/mo.	37,356	
5	BENEFITS .1542	5,760	
6	FICA .0665	2,484	
7	HEALTH INS. $127/mo.	1,524	
8	TOTAL PERSONAL SERVICES		47,124
9	TRAVEL		3,144
10	CONTRACTUAL		9,000
11	COMMODITIES		600
12	EQUIPMENT		3,646
13	OTHER		
14	TOTAL COST		63,514

	CODE	FUNDING SOURCE	
15		FED RCPTS	
16		GF MATCH	
17		GEN FUND	63,514
18		I-A RCPTS	
19		PGM RCPTS	
20		OTHER	
21	CONTINUATION		
22	ADDITION	XXX	

FOR S&M USE ONLY

1A KEY NUMBER _____ COLUMN NO. _____

JUSTIFICATION:

Pers. Services: Salary Schedule eff. 3/16/80.

Travel: Fairbanks, Anchorage, Hawaii, Seattle.

Contractual Svcs: Based on cost per position for Juneau. (See attachment for detailed breakdown).

Commodities: Supplies based on cost per position.

Equipment: Desk, Chair, Bookcase, Dictation Equipment, Guest Chair, Panelling.

Justification: This position will be responsible for developing the administrative, fiscal, management and program policies governing the investigative, auditing and mediation functions of the Section, assuming the legislative intent of the Act.

This position will coordinate activities with other departments and agencies, issue periodic reports as required and provide advice and counseling on controversial issues to staff, employees, employers, insurance representatives and the medical profession.

AGENCY Labor PROGRAM AREA Worker Protection

BRU Health Administration

COMPONENT Health Care Act.

13 REQUEST FOR NEW POSITION

FY 81

REVISED DATE _____

	POSITION TITLE			RANGE/STEP	BARG. UNIT.	LOCATION		APPROV.	DISAPP
1	Administrative Assistant III			16A	GGU	Juneau	GOV.		
	TYPE OF POSITION	STAFF MONTHS	RP No.	PCN No.	PRIORITY	FORM 12 PAGE/LINE			
2	PFT	12					LEG.		

	TYPE OF EXPENDITURE			AMOUNT
	1		2	3
3	PERSONAL SERVICES:			
4	SALARY	2,132/mo.	25,584	
5	BENEFITS	.1542	3,945	
6	FICA	.0665	1,701	
7	HEALTH INS.	$127	1,524	
8	TOTAL PERSONAL SERVICES			32,754
9	TRAVEL			1,490
10	CONTRACTUAL			9,000
11	COMMODITIES			550
12	EQUIPMENT			3,452
13	OTHER			
14	TOTAL COST			47,246

	CODE	FUNDING SOURCE	
15		FED RCPTS	
16		GF MATCH.	
17		GEN. FUND	47,246
18		I-A RCPTS	
19		PGM RCPTS	
20		OTHER	
21	CONTINUATION		
22	ADDITION	XXX	

FOR B&M USE ONLY

4A KEY NUMBER _____ COLUMN NO. ____

JUSTIFICATION:

Pers. Services: Salary Schedule eff. 3/16/80

Travel: Anchorage 2 x @ 2 days
Fairbanks 2 x @ 2 days

Contractual Svcs: Based on cost per position for Juneau (See attachment for detailed breakdown)

Commodities: Supplies cost per position.

Equipment: Desk, Chair, Bookcase, Dictation Equip. Guest Chair, Panelling.

Justification: The Administrative Assistant position is needed to implement and operate a management information system, designed to provide immediate access to employer/insurance carrier file data and current claim status to the field offices.

The position is an integral part of an effective management plan, providing for supervision of the administrative process required to support the audit, investigative and hearing functions of the investigators. Supervision of Clerk Typist III.

AGENCY Labor PROGRAM AREA Worker Protection

BRU Health Administration

COMPONENT Health Care Act

13 REQUEST FOR NEW POSITION.

REVISED DATE _____

FY 81

	POSITION TITLE			RANGE/STEP	BARG. UNIT.	LOCATION		APPROV.	DISAPP.
1	Investigator			18A	GGU	Juneau	GOV.		
	TYPE OF POSITION	STAFF MONTHS	RP No.	PCN No.	PRIORITY	FORM 12 PAGE/LINE			
2	PFT	12					LEG.		

3	TYPE OF EXPENDITURE			AMOUNT
	1		2	3
	PERSONAL SERVICES:			
4	SALARY	2,465/mo.	29,580	
5	BENEFITS	.1542	4,561	
6	FICA	.0665	1,967	
7	HEALTH INS.	$127/mo.	1,524	
8	TOTAL PERSONAL SERVICES			37,632
9	TRAVEL			11,000
10	CONTRACTUAL			9,000
11	COMMODITIES			550
12	EQUIPMENT			4,786
13	OTHER			
14	TOTAL COST			62,968

	CODE	FUNDING SOURCE	
15		FED RCPTS.	
16		GF MATCH.	
17		GEN. FUND	62,968
18		I-A RCPTS	
19		PGM RCPTS	
20		OTHER	
21	CONTINUATION		
22	ADDITION	XXX	

FOR B&M USE ONLY

4A KEY NUMBER _____ COLUMN NO. ____

JUSTIFICATION:

Pers. Services: Salary Schedule effective 3/16/80.

Travel: All Southeast Communities
1 trip per week @ 2 days

Contractual Svcs: Based on cost per position for Juneau. (See attachment for detailed breakdown).

Commodities: Cost per position for supplies.

Equipment: Desk, Chair, Bookcase, Dictation Equipment Calculator, Tape Recorder, Guest Chair, Panelling.

Justification: The Investigator position will provide advisory service to employees, employers, insurance companies and medical facilities as to procedures and all party's rights and obligations under the Act.

This position will be responsible for investigating claims or complaints, auditing employer and insurance carrier records to ensure compliance with the Act, conducting hearings on disputed claims and cases of employer non-compliance and perfecting the case file for prosecution by the Attorney General's office.

AGENCY Labor PROGRAM AREA Worker Protectoin

BRU Health Administration

COMPONENT Health Care Act

13 REQUEST FOR NEW POSITION

REVISED DATE _____

FY 81

	POSITION TITLE				RANGE/STEP	BARG. UNIT.	LOCATION		APPROV	DISAPP.
1	Investigator				18A	GGU	Anchorage	GOV.		
2	TYPE OF POSITION: PFT	STAFF MONTHS: 12	RP No.	PCN No.	PRIORITY		FORM 12 PAGE/LINE	LEG.		

3	TYPE OF EXPENDITURE		AMOUNT
	1	2	3
4	PERSONAL SERVICES: SALARY 2.465/mo.	29,580	
5	BENEFITS .1542	4,562	
6	FICA .0665	1,967	
7	HEALTH INS. $127/mo.	1,524	
8	TOTAL PERSONAL SERVICES		37,632
9	TRAVEL		11,370
10	CONTRACTUAL		10,715
11	COMMODITIES		550
12	EQUIPMENT		4,786
13	OTHER		
14	TOTAL COST		65,053

	CODE	FUNDING SOURCE	
15		FED RCPTS	
16		GF MATCH	
17		GEN. FUND	65,053
18		I--A RCPTS	
19		PGM RCPTS	
20		OTHER	
21	CONTINUATION		
22	ADDITION	XXX	

FOR O&M USE ONLY

AA KEY NUMBER _____ COLUMN NO. _____

JUSTIFICATION:

Pers. Services: Salary Schedule effective 3/16/80.

Travel: All Central Region Communities
1 trip per week @ 2 days

Contractual Svcs: Based on cost per position for Anchorage. (See attachment for detailed breakdown).

Commodities: Cost per position for supplies.

Equipment: Desk, Chair, Bookcase, Dictation Equipment Calculator, Tape Recorder, Guest Chair, Panelling.

Justification: The Investigator position will provide advisory service to employees, employers, insurance companies and medical facilities as to procedures and all party's rights and obligations under the Act.

This position will be responsible for investigating claims or complaints, auditing employer and insurance carrier records to ensure compliance with the Act, conducting hearings on disputed claims and cases of employer non-compliance and perfecting the case file for prosecution by the Attorney General's office.

AGENCY Labor PROGRAM AREA Worker Protectoin

BRU Health Administration

COMPONENT Health Care Act

13 REQUEST FOR NEW POSITION

FY 81

REVISED DATE _____

	POSITION TITLE			RANGE/STEP	BARG. UNIT.	LOCATION		APPROV.	DISAPP
1	Investigator			18A	GGU	Fairbanks	GOV.		
2	TYPE OF POSITION: PFT	STAFF MONTHS: 12	RP No.	PRIORITY		FORM 12 PAGE/LINE	LEG.		

	TYPE OF EXPENDITURE	1	2	AMOUNT 3
4	PERSONAL SERVICES: SALARY	2,746/mo.	32,952	
5	BENEFITS	.1542	5,081	
6	FICA	.0665	2,191	
7	HEALTH INS.	$127/mo.	1,524	
8	TOTAL PERSONAL SERVICES			41,748
9	TRAVEL			17,420
10	CONTRACTUAL			10,890
11	COMMODITIES			550
12	EQUIPMENT			4,786
13	OTHER			
14	TOTAL COST			75,394

	CODE	FUNDING SOURCE	
15		FED RCPTS.	
16		GF MATCH.	
17		GEN. FUND	75,394
18		I-A RCPTS.	
19		PGM RCPTS.	
20		OTHER	
21	CONTINUATION		
22	ADDITION	XXX	

FOR OMB USE ONLY

44 KEY NUMBER _____ COLUMN NO. _____

JUSTIFICATION:

Pers. Services: Salary Schedule effective 3/16/80.

Travel: All Northern Region Communities
1 trip per week @ 2 days

Contractual Svcs: Based on cost per position for Fairbanks. (See attachment for detailed breakdown).

Commodities: Cost per position for supplies.

Equipment: Desk, Chair, Bookcase, Dictation Equipment Calculator, Tape Recorder, Guest Chair, Panelling.

Justification: The Investigator position will provide advisory service to employees, employers, insurance companies and medical facilities as to procedures and all party's rights and obligations under the Act.

This position will be responsible for investigating claims or complaints, auditing employer and insurance carrier records to ensure compliance with the Act, conducting hearings on disputed claims and cases of employer non-compliance and perfecting the case file for prosecution by the Attorney General's office.

AGENCY Labor PROGRAM AREA Worker Protectoin

BRU Health Administration

COMPONENT Health Care Act

13 REQUEST FOR NEW POSITION

FY 81

REVISED DATE _____

	POSITION TITLE				RANGE/STEP	BARG UNIT	LOCATION		APPROV.	DISAPP
1	Data Control Clerk				11A	GGU	Juneau	GOV.		
2	TYPE OF POSITION: PFT	STAFF MONTHS: 12	RP No.	PCN No.	PRIORITY		FORM 12 PAGE/LINE	LEG.		

	TYPE OF EXPENDITURE	1	2	AMOUNT 3
3	PERSONAL SERVICES:			
4	SALARY	1,533/mo.	18,396	
5	BENEFITS	.1542	2,837	
6	FICA	.0665	1,223	
7	HEALTH INS.	$127/mo.	1,524	
8	TOTAL PERSONAL SERVICES			23,980
9	TRAVEL			-
10	CONTRACTUAL			9,000
11	COMMODITIES			550
12	EQUIPMENT			1,390
13	OTHER			
14	TOTAL COST			34,920

	CODE	FUNDING SOURCE	
15		FED RCPTS.	
16		GF MATCH.	
17		GEN. FUND	34,920
18		I-A RCPTS.	
19		PGM RCPTS	
20		OTHER	
21	CONTINUATION		
22	ADDITION	XXX	

FOR B&M USE ONLY

4A KEY NUMBER _____ COLUMN NO. _____

JUSTIFICATION:

Pers. Services: Salary Schedule eff. 3/16/80

Contractual Svcs: Cost per position for Juneau (See attachment for detailed breakdown).

Commodities: Cost per position for supplies.

Equipment: Desk, Chair, Calculator, Credenza, Guest Chair.

Justification: The Data Control Clerk position will prepare input data and maintain file reference records schedule and coordinate data processing operations, develop and maintain control procedures, code, classify and catalog data inforamtion, design forms and assist staff and other agencis is use of forms and procedures, review and correct data errors.

Establishing and maintaining complete and accurate records is necessary to enable proper and timely service to those party's covered under the provisions of the Act.

AGENCY Labor PROGRAM AREA Worker Protection

BRU Health Adminstration

COMPONENT Health Care Act

13 REQUEST FOR NEW POSITION.

REVISED DATE _____

FY 81

	POSITION TITLE			RANGE/STEP	BARG. UNIT	LOCATION		APPROV	DISAPP
1	Clerk Typist III			8A	GGU	Juneau	GOV		
	TYPE OF POSITION	STAFF MONTHS	RP No.	PCN No.	PRIORITY	FORM 12 PAGE/LINE			
2	PFT	12					LEG		

	TYPE OF EXPENDITURE	1	2	AMOUNT 3
4	PERSONAL SERVICES: SALARY	1,277/mo.	15,324	
5	BENEFITS	.1542	2,363	
6	FICA	.0665	1,019	
7	HEALTH INS.	$127/mo.	1,524	
8	TOTAL PERSONAL SERVICES			20,230
9	TRAVEL			-0-
10	CONTRACTUAL			9,000
11	COMMODITIES			550
12	EQUIPMENT			950
13	OTHER			
14	TOTAL COST			30,730

	CODE	FUNDING SOURCE	
15		FED RCPTS.	
16		GF MATCH	
17		GEN. FUND	30,730
18		I-A RCPTS.	
19		PGM RCPTS	
20		OTHER	
21	CONTINUATION		
22	ADDITION	XXX	

FOR B&M USE ONLY

AA KEY NUMBER _____ COLUMN NO. _____

JUSTIFICATION:

Pers. Services: Salary Schedule effective 3/16/80.

Contractual Svcs: Cost per position for Juneau (See attachment for detailed breakdown).

Commodities: Cost per position for supplies.

Equipment: Desk, Chair, File Cabinet.

Justification: The Clerk Typist position will provide clerical assistance to maintain case files, current correspondence, transcription and legal typing services and will assist the investigator in scheduling cases for audit and hearing.

This position will also provide assistance to employees in filing claims or complaints and will advise employees, employers and insurance carriers as to procedures and all party's rights and obligations under the Act. Functions as the receptionist, adminstrative support person, etc.

AGENCY Labor PROGRAM AREA Worker Protection

BRU Health Administration

COMPONENT Health Care Act

13 REQUEST FOR NEW POSITION

FY 81

REVISED DATE _____

	POSITION TITLE			RANGE/STEP	BARG. UNIT.	LOCATION		APPROV.	DISAPP
1	Clerk Typist III			8A	GGU	Anchorage	GOV.		
	TYPE OF POSITION	STAFF MONTHS	RP No. / PCN No.	PRIORITY		FORM 12 PAGE/LINE			
2	PFT	12					LEG.		

3	TYPE OF EXPENDITURE	1	2	AMOUNT 3
	PERSONAL SERVICES:			
4	SALARY	1,277/mo.	15,324	
5	BENEFITS	.1542	2,363	
6	FICA	.0665	1,019	
7	HEALTH INS.	$127/mo.	1,524	
8	TOTAL PERSONAL SERVICES			20,230
9	TRAVEL			-0-
10	CONTRACTUAL			10,715
11	COMMODITIES			550
12	EQUIPMENT			950
13	OTHER			
14	TOTAL COST			32,445

	CODE	FUNDING SOURCE	
15		FED RCPTS	
16		GF MATCH	
17		GEN FUND	32,445
18		I-A RCPTS	
19		PGM RCPTS	
20		OTHER	
21	CONTINUATION		
22	ADDITION	XXX	

FOR OMB USE ONLY

AGENCY NUMBER _____ COLUMN NO. _____

JUSTIFICATION:

Pers. Services: Salary Schedule effective 3/16/80.

Contractual Svcs: Cost per position for Anchorage. (See attachment for detailed breakdown).

Commodities: Cost per position for supplies.

Equipment: Desk, Chair, File Cabinet.

Justification: The Clerk Typist position will provide clerical assistance to maintain case files, current correspondence, transcription and legal typing services and will assist the investigator in scheduling cases for audit and hearing.

This position will also provide assistance to employees in filing claims or complaints and will advise employees, employers and insurance carriers as to procedures and all party's rights and obligations under the Act. Functions as the receptionist, adminstrative support person, etc.

AGENCY Labor PROGRAM AREA Worker Protection

BRU Health Administration

COMPONENT Health Care Act

FY 81

13 REQUEST FOR NEW POSITION.

REVISED DATE _____

	POSITION TITLE			RANGE/STEP	BARG. UNIT.	LOCATION		APPROV.	DISAPP
1	Clerk Typist III			8A	GGU	Fairbanks	GOV.		
2	TYPE OF POSITION: PFT	STAFF MONTHS: 12	RF No.	PRIORITY		FORM 12 PAGE/LINE	LEG.		

	TYPE OF EXPENDITURE	1	2	AMOUNT 3
4	PERSONAL SERVICES: SALARY	1,440/mo.	17,280	
5	BENEFITS	.1542	2,665	
6	FICA	.0665	1,149	
7	HEALTH INS.	$127/mo.	1,524	
8	TOTAL PERSONAL SERVICES			22,618
9	TRAVEL			-
10	CONTRACTUAL			10,890
11	COMMODITIES			550
12	EQUIPMENT			950
13	OTHER			
14	TOTAL COST			35,008

	CODE	FUNDING SOURCE	
15		FED RCPTS.	
16		GF MATCH	
17		GEN. FUND	35,008
18		I-A RCPTS.	
19		PGM RCPTS	
20		OTHER	
21	CONTINUATION		
22	ADDITION	XXX	

FOR B&M USE ONLY

4A KEY NUMBER _____ COLUMN NO. _____

JUSTIFICATION:

Pers. Services: Salary Schedule effective 3/16/80.

Contractual Svcs: Cost per position for Fairbanks. (See attachment for detailed breakdown).

Commodities: Cost per position for supplies.

Equipment: Desk, Chair, File Cabinet.

Justification: The Clerk Typist position will provide clerical assistance to maintain case files, current correspondence, transcription and legal typing services and will assist the investigator in scheduling cases for audit and hearing.

This position will also provide assistance to employees in filing claims or complaints and will advise employees, employers and insurance carriers as to procedures and all party's rights and obligations under the Act. Functions as the receptionist, administrative support person, etc.

AGENCY Labor PROGRAM AREA Worker Protection

BRU Health Administration

COMPONENT Health Care Act

13 REQUEST FOR NEW POSITION

FY 81

REVISED DATE _____

HB 977

FISCAL NOTE

ATTACHMENT FOR CONTRACTUAL SERVICES

	No. Staff	5	2	2	9
	Location	Juneau	Anchorage	Fairbanks	Total
330	Rent				
	5 pos. x 150 sq. x $1.70	15,300			15,300
	2 pos. x 150 sq. x $1.25		4,500		4,500
	2 pos. x 150 sq. x $1.25			4,500	4,500
310	Telephone				
	Installation	200	80	80	360
	Local/Centrex	1,500	250	600	2,350
	*Long Distance $1,500/pos.	7,500	3,000	3,000	13,500
	Postage	3,000	1,000	1,000	5,000
320	Printing				
	Forms, Envelopes etc.	6,000	2,000	2,000	10,000
320	Advertising				
	TV, Radio, Newspaper	6,000	2,000	2,000	10,000
320	Subscriptions	400	300	300	1,000
360	Equipment Rent				
364	Word Processing	3,600	3,600	3,600	10,800
368	Highway Working Cap.		3,600	3,600	7,200
340	Repairs & Maintenance		500	500	1,000
390	Other	1,500	600	600	2,700
		45,000	21,430	21,780	88,210
	Cost per position	9,000	10,715	10,890	9,800

*1 - Based on actual exp. FY '79 for Wage & Hour Budget (Similar work).

Official Business

Alaska State Legislature

House of Representatives

Committee on

Health, Education & Social Services

Pouch V
State Capitol
Juneau, Alaska 99811

To: J. Hogan, House Finance

From: Thelma Buchholdt
House HESS

Re: HCS CS SSSB227

Please prepare a fiscal note for HCS CS SS SB227.

I would appreciate this information as soon as possible, as I would like to bring the bill up in Committee next week.

Thank you.

THE LEGISLATURE OF THE STATE OF ALASKA
ELEVENTH LEGISLATURE

FISCAL NOTE

I. REQUEST
Bill/Resolution No. HCS CSSSSB 227 (HESS)
Title "An act relating to the health of residents of the state"
Requested by Health, Education & Social Services Committee Date

II. FISCAL DETAIL
Agency Affected Division of Insurance
Program Category Affected Public Protection
BRU, Program, or Subprogram(s) Affected Division of Insurance
(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 80	FY 81	FY 82	FY 83	FY 84	FY 85
100 PERSONAL SERVICES		49.2				
200 TRAVEL		5.0				
300 CONTRACTUAL		24.9				
400 COMMODITIES		.8				
500 EQUIPMENT		4.0				
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC.						
Reduction of Unrestricted Tax Reciept	#019	90.0				
TOTAL		173.8				

FUNDING (Thousands of Dollars)

GENERAL FUND		83.8				
FEDERAL FUNDS						
OTHER (Specify Fund Source)						
Reduction of Unrestricted Tax Reciept	#019	90.0				

POSITIONS

FULL TIME Market Analyst III		1				
PART TIME Clerk Typist III		1				
TEMPORARY						

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

IV. DATE May 14, 1980 PREPARED BY HESS Staff
AGENCY
PHONE

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)

FISCAL NOTE

PERSONAL SERVICES

The law in Connecticut on which this bill is based was implemented with no additional staff. Most of the substantive work was performed by the industry. One new position with clerical support may be justified, however, for drafting the regulations, reviewing the organization of the Health Reinsurance Association and approving the rates and policy forms developed by the carriers for the comprehensive health plan.

Market Analyst III Range 18A 12 months	$29,580
Clerk Typist III Range 8A half-time, 12 months	8,162
	$37,742
benefits (.188)	7,095
FICA (.0613 x 8162 + 1588)	2,088
health insurance (127 x 1.5 x 12)	2,286
	$49,211

TRAVEL

Travel to Connecticut and Minnesota and to Health Reinsurance Association board meetings	$5,000

CONTRACTUAL

Rent 2 positions x 150 sq. ft. x $1.70 x 12 mo.	$6,120
Phone (80 install + 600 local + 3,000 long distance)	3,680
Postage	1,000
Printing	1,000
Equipment Rental (typewriter)	2,500
Consulting	10,000
Other	600
	$24,900

COMMODITIES (1.5 x 500) $750

EQUIPMENT

desks, chairs, bookcase, filing cabinet, caculator, etc.	$ 4,000

PREMIUM TAX OFFSET

Estimate #1:

Loss experience under Minnesota Comprehensive Health Plan for 1979: $800,000

Alaska population/Minnesota population = 400,000/4,000,000 = .1
Alaska rates/Minnesota rates ≈ 1.12

$800,000 x .1 x 1.12 = $89,600

Estimate #2:

Total comprehensive Health Plan Premiums in Connecticut for 1979: $2,785,367
Total HRA Assessment since April 1, 1976: $80,000

Alaska population/Connecticut population = 400,000/3,000,000 = .133
Alaska rates/ Connecticut rates ≈ 1.12
Loss factor 1: (135% - 125%)/135% = .074
Loss factor 2: (150% - 125%)/150% = .166

(a) $2,785,367 x .133 x 1.12 x .074 + ($80,000/4) = $50,703

(b) $2,785,367 x .133 x 1.12 x .166 + ($80,000/4) = $88,875

While estimate 2(a) is the best estimate from available information, rounding the higher estimates up to $90,000 is the safest estimate.

THE LEGISLATURE OF THE STATE OF ALASKA
ELEVENTH LEGISLATURE

FISCAL NOTE

I. REQUEST
Bill/Resolution No. CS CSSS SB 227
Title
Requested by Date

II. FISCAL DETAIL
Agency Affected
Program Category Affected
BRU, Program, or Subprogram(s) Affected
(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 80	FY 81	FY 82	FY 83	FY 84	FY 85
100 PERSONAL SERVICES		48.3	53.2	58.2		
200 TRAVEL		5.0	3.0	3.3		
300 CONTRACTUAL		40.9	26.8	29.4		
400 COMMODITIES		.8	.8	.9		
500 EQUIPMENT		4.0	—	—		
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC.						
Reduction of Unrestricted Tax Receipt #019		—	45.0 *	99.0 *		
TOTAL						
Assumes 10% inflation		99.0	128.8	190.8		

FUNDING (Thousands of Dollars)

GENERAL FUND		99.0	83.8			
FEDERAL FUNDS						
OTHER (Specify Fund Source)						
Reduction of Unrestricted Tax Receipt #019			45.0	99.0		

POSITIONS

FULL TIME Market Analyst III		1	1	1		
PART TIME Clerk Typist III		1	1	1		
TEMPORARY						

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

* overestimates costs for numerous reasons:

1. assumes full scale operation (only attained in Connecticut after 4 years) in first year
2. includes $20,000 per year of assessments as losses which were primarily administrative costs and therefore could not be passed on to the state under the Alaska bill
3. generous estimates and margins used throughout.

IV. DATE 5/16/80 PREPARED BY
AGENCY
PHONE

Original: Legislative Finance

THE LEGISLATURE OF THE STATE OF ALASKA
ELEVENTH LEGISLATURE

FISCAL NOTE

I. REQUEST
Bill/Resolution No. HCS CSSSB 227 (HESS)
Title An act relating to health insurance for employees in the state
Requested by House Health, Education & Social Service Committee Date

II. FISCAL DETAIL
Agency Affected Division of Insurance
Program Category Affected Public Protection
BRU, Program, or Subprogram(s) Affected Division of Insurance
(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

		FY 80	FY 81	FY 82	FY 83	FY 84	FY 85
100	PERSONAL SERVICES		537.4	609.1	670.1	737.5	811.5
200	TRAVEL		8.0	9.0	13.0	14.0	15.0
300	CONTRACTUAL		170.0	95.0	100.0	105.0	110.0
400	COMMODITIES		2.5	2.5	2.5	2.5	2.5
500	EQUIPMENT		18.5	1.0	1.0	1.0	1.0
600	LAND & STRUCTURES						
700	GRANTS, CLAIMS, ETC.		-	39,305.0	43,236.0	47,560.0	52,316.0
Reduction of unrestricted tax receipt		#019	-	3,344.0	3,678.0	4,046.0	4,451.0
	TOTAL		736.4	43,365.6	47,700.6	52,466.0	57,707.0

FUNDING (Thousands of Dollars)

GENERAL FUND		736.4	40,021.6	44,022.6	48,420.0	53,256.0
FEDERAL FUNDS						
OTHER (Specify Fund Source)						
Reduction of unrestricted tax receipt	#019	-	3,344.0	3,678.0	4,046.0	4,451.0

POSITIONS

FULL TIME		20	20	20	20	20
PART TIME						
TEMPORARY						

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

100 Personal Services

1. There will be a substantial increase in the filing of health insurance made in Alaska and in the kind of review given. A review of rates being charged by the carriers is necessary, not only upon initial use, but also for renewal. Heretofore, the division's role has been to approve or disapprove filings, in addition, we will now be required to determine that plans of health coverage written by the combination of catastrophic with basic hospital and medical-surgical plans provide at least equivalent benefits as outlined in Section 21.50.020. Also, Section 1 of the Act calls for a substantial number of regulations to be promulgated with some regulations needing to be repromulgated on a yearly basis.

IV. DATE 5-9-80 PREPARED BY James J. Jordan
AGENCY Division of Insurance
PHONE 274-3546

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)

33-001 (Rev. 12/79)

THE LEGISLATURE OF THE STATE OF ALASKA
ELEVENTH LEGISLATURE

FISCAL NOTE

I. REQUEST
Bill/Resolution No. HB 977
Title An Act relating to the health of residents of the state
Requested by Health, Education & Social Services Committee Date 4/17/80

II. FISCAL DETAIL
Agency Affected Labor
Program Category Affected Worker Protection
BRU, Program, or Subprogram(s) Affected Health Administration
(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

		FY 80	FY 81	FY 82	FY 83	FY 84	FY 85
100	PERSONAL SERVICES		283.9	283.9	283.9	283.9	283.9
200	TRAVEL		44.4	48.8	53.7	59.1	65.0
300	CONTRACTUAL		88.2	97.0	106.7	117.4	129.1
400	COMMODITIES		5.0	3.3	3.6	4.0	4.4
500	EQUIPMENT		25.7	-	-	-	-
600	LAND & STRUCTURES						
700	GRANTS, CLAIMS, ETC.	?	?	?	?	?	?
	TOTAL See Note 3	?	?	?	?	?	?

FUNDING (Thousands of Dollars)

GENERAL FUND		x	x	x	x	x
FEDERAL FUNDS						
OTHER (Specify Fund Source)						

POSITIONS

FULL TIME		9	9	9	9	9
PART TIME						
TEMPORARY						

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

1. Assumes annual inflation rate of 10%. Personal Services based on Hawaii Program.

2. Commodities for FY '81 are 5.0 for inital set up of forms etc. Afterward, it will drop to 3.0 plus inflation.

3. Annual operating cost,excluding grants and claims are:

FY '81	FY '82	FY '83	FY '84	FY '85
447.2	433.0	447.9	464.4	482.4

Grants and claims are impossible to estimate. This bill provides for a premium supplementation fund. Currently, ALASKA has 10,424 employers; 72% or 7,463 of these employers would be eligible based on number employed. Without cost containment for coverage, premium costs cannot be estimated.

IV. DATE 4/14/80 PREPARED BY James Souby
AGENCY Labor
PHONE 465-2720

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)

33-001 (Rev. 12/79)

Positions required would be: one - Market Analyst III, two - Market Analyst II, and one - Clerk/Typist III. In addition, the availability of qualified personnel in Alaska is limited. These persons would be in the Market Surveillance Section.

2. Section 21.50.090 of this Act calls for the Division of Insurance to administer a premium supplementation program for employers having ten or less regular employees who meet certain criteria as outlined. The administration of a program of this nature is quite foreign to the Division of Insurance. In function, it is more indigenous to the operation of the Department of Revenue. Primarily, the division will have to develop a quasi-tax return to determine the amount of supplementation and also to provide reasonable audit control. The Department of Revenue has assisted us in analyzing this portion of the fiscal note.

   Department of Revenue has indicated that the most expedient way to administer this program is by use of the Federal Tax Return and utilizing primarily "desk audits." If the Federal Tax Return cannot be utilized for legal reasons, the Division of Insurance would, in effect, be required to adopt regulations which would define all items of income and deductible expense in order to effectuate the premium supplementation guidelines. The audit functions would then move from a "desk audit" approach to almost entirely a "field audit" approach requiring definitive audit of the employer's books. If this were to be the case, the following number of positions would need to be doubled. Positions required would be: one - Revenue Auditor III, four - Revenue Auditor II, ten - Tax Examiners, and one - Clerk/Typist III. Anchorage will be the location for these positions. These persons will be in the Financial Examination Section. The availability of qualified personnel to fill these positions is limited.

200 Travel

1. The establishment of the Health Reinsurance Association will require travel and, to a large degree, outside in order to participate in the periodic meetings of the board. The travel outside is due to the fact that the carriers forming the membership are located there.

   The implementation phase for this Act will require outside travel to both Connecticut and Minnesota in order to expedite the formation of the Health Reinsurance Association, and to aid in the development of actuarial equivalence standards.

   Travel will also be required to perform audits of carriers to verify compliance with the rate standards established by this Act.

2. Travel for the audit of the premium supplementation program will be necessary. The travel will be limited and primarily in-state. The travel item associated is the best possible scenario with the assumption of the primary use of "desk audits." This item would have to increase significantly in the case of the worst scenario of "field audits."

300 Contractual

1. It is anticipated that a substantial amount of contract services will be required in order for the division to develop actuarial equivalence standards, basis for approval or disapproval of rates for coverage written by or thorugh the Health Reinsurance Association, and perhaps to assist in the development of the proto-type forms the association will be utilizing.

2. The premium supplementation program will require the rental of office space in Anchorage, allowance for telephone charges, and a substantial printing allowance for the application forms.

   In addition, due to the foreign nature of such a function to the division, contractual services, provided perhaps by the Department of Revenue, will be necessary to establish the parameters and methods of operation for this group of employees.

400 Commodities

Sufficient commodities will be required for the 20 new positions.

500 Equipment

Sufficient office equipment will be required for the 20 new positions. In addition to what normal equipment is necessary, additional storage equipment will be necessary plus equipment that will assure a reasonable level of security in view of the documents to be on hand (e.g., Federal Tax Return).

700 Grants, Claims, Etc.

The fiscal item in this category is comprised entirely of the expected expenditures for the amounts paid to employers pursuant to the premium supplementation program as called for in Section 21.50.090.

A number of assumptions had to be made in arriving at the numbers displayed due to the lack of proper data in a number of areas. The assumptions were chosen, for the most part, to establish the worst possible scenario in order to set the upper bounds of anticipated cost. The assumptions made follow:

1. Employers income, as defined in Section 21.50.200(10), is -0-. This assumption will tend to overstate the result.

2. All effected employers will have coverage and will apply for the premium supplementation. This assumption will tend to overstate the result.

3. All employees have covered dependents. This assumption will tend to overstate the result.

4. All employers contribute 100% of the premium for the health plan. This assumption will tend to overstate the result.

5. The Department of Labor statistics relating to nongovernmental employer units, employees, and wages do not include employers with exactly ten employees. Therefore, the analysis only included employers with nine or less employees. This assumption will tend to understate the result.

6. The employer demographics will not change in the future. The result of the assumption is not determinable as it relates to the complexity of the Alaskan economic situation.

7. The premium rates utilized were 125% of the State of Alaska's rates. This results in an assumtion of a rate of $150/month/employee (125% times $120). The development was accomplished by using employer size breakdowns of 0-3, 4-6, and 7-9 employees separately. In all breakdowns, the $150 rate will be less than that for which the coverage will be able to be purchased. This assumption will tend to understate the result.

There will not be a fiscal impact until FY 82 because the Act would not be effective until January 1, 1981 and employers would file for supplementation of premium paid during calendar year 1981 in the first half of 1982.

Reduction of Unrestricted Tax Receipt #019

Section 21.50.050(m) allows a carrier to offset any assessments paid to the Health Reinsurance Association against its income tax under AS 43.20 or its Alaska state premium tax. In addition, it calls for the Commissioner of Revenue to directly reimburse the carrier for assessments paid in excess of the taxes. This item only includes the loss in the premium taxes.

The assumptions made in developing these numbers will produce the worst result. It was assumed that all premium taxes would be offset by the assessments paid. The basis for the amounts were the premium taxes actually paid by carriers for calendar year 1979.

There will not be a fiscal impact unitl FY '82 because effective the date of this Act is January 1, 1981 and the carriers would not be able to apply the offset for calendar year 1981 premium taxes until 1982.

Offset - Premium Tax

THE LEGISLATURE OF THE STATE OF ALASKA
ELEVENTH LEGISLATURE

FISCAL NOTE

I. REQUEST

Bill/Resolution No. _____

Title _____

Requested by _____ Date _____

II. FISCAL DETAIL

Agency Affected _____

Program Category Affected _____

BRU, Program, or Subprogram(s) Affected _____

(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 80	FY 81	FY 82	FY 83	FY 84	FY 85
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL						
400 COMMODITIES						
500 EQUIPMENT						
600 LAND & STRUCTURES			3344	3678	4046	4451
700 GRANTS, CLAIMS, ETC.		[illegible] -	3040	3040	3040	3040
TOTAL		[illegible] -	3040	3040	3040	3040

FUNDING (Thousands of Dollars)

GENERAL FUND						
FEDERAL FUNDS						
OTHER (Specify Fund Source)						

POSITIONS

FULL TIME						
PART TIME						
TEMPORARY						

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

IV. DATE _____ PREPARED BY _____

AGENCY _____

Original: Legislative Finance PHONE _____

cc: Budget and Management

Prime Sponsor (First Legislator Named)

33–001 (Rev. 12/79)

3 mill. premium tax collected
from carriers + B+
assessing

Can't estimate losses
only can est. assessment expenses
prem. tax

Tom [illegible]
Call me please when opening
Case

III. Premium Taxes Act 1979

Commercial	calyr 1979	$ 2,932,789.72
	LICA	6,419.00
		$ 2,939,219
Hosp. Serv.	Blue X	97,296.44
		$ 3,036,515

FY 81 only 1/2 year taxes involved
worst scenario - ~~all~~ assessments equal premium tax paid.
Premium tax will be dependent in future FY based
on writings of co. in Alaska - Problems
with estimating - so much depend on how
co's view Alaska & the economy. - Use 10%
to extrapolate

FYE2	3,040 x 1.10 =	3,344
FY3		3,678
FY4		4,046
FY5		4,451

shown in note as "reduction in unrestricted tax
receipt #019"

THE LEGISLATURE OF THE STATE OF ALASKA
ELEVENTH LEGISLATURE

FISCAL NOTE

I. REQUEST
Bill/Resolution No. HCS CSSSSSB 227 (HESS)
Title An act relating to the health of residents of the State
Requested by _____ Date _____

II. FISCAL DETAIL
Agency Affected Division of Insurance
Program Category Affected Public Protection
BRU, Program, or Subprogram(s) Affected Division of Insurance
(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 80	FY 81	FY 82	FY 83	FY 84	FY 85
100 PERSONAL SERVICES		127.4	140.1	154.1	169.5	186.5
200 TRAVEL		5.0	6.0	10.0	11.0	12.0
300 CONTRACTUAL		100.0	50.0	55.0	60.0	65.0
400 COMMODITIES		.5	.5	.5	.5	.5
500 EQUIPMENT		2.5	--	--	--	--
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC.						
Reduct. of Unrestricted Tax Rcpt. #019	--	--	3,344.0	3,678.0	4,046.0	4,451.0
TOTAL		235.4	3,540.6	3,897.6	4,287.0	4,715.0

FUNDING (Thousands of Dollars)

GENERAL FUND		235.4	196.6	219.6	241.0	264.0
FEDERAL FUNDS						
OTHER (Specify Fund Source)						
Reduction of Unrestric. Tax Rcpt. #019	--	--	3,344.0	3,678.0	4,046.0	4,451.0

POSITIONS

FULL TIME		4	4	4	4	4
PART TIME						
TEMPORARY						

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

IV. DATE May 21, 1980 PREPARED BY Donald P. Koch
AGENCY Division of Insurance
PHONE 465-2577

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)

33-001 (Rev. 12/79)

100 Personal Services

There will be a substantial increase in the filing of health insurance contracts and forms made in Alaska as new contracts are generated to comply with the requirement to offer such. In addition, the division will newly be required to conduct rate review on a heretofore uncontrolled line of business. This review will have to be made annually in view of the requirement to upgrade minimum benefit standards as appropriate due to inflation or changes in the prevailing standards in the industry.

The conduct of audits is a time consuming function which is appropriate but necessitate adequate staffing. The section calls for regulations with the need to be repromulgated on a yearly basis. Positions required would be: one - Market Analyst III, two - Market Analyst II, and one - Clerk Typist III. These persons would be in the Market Surveillance Sector.

200 Travel

The establishment of the Health Reinsurance Association will require travel and, to a large degree, outside in order to participate in the periodic meetings of the Board. The travel outside is due to the fact that the carriers forming the membership are located there.

The implementation phase for this Act will require outside travel in order to expedite the formation of the Health Reinsurance Association, and to aid in the development of the prototype.

Travel will also be required to perform audits of carriers to verify compliance with the rate standards established by this Act.

300 Contractual

It is anticipated that a substantial amount of contract services will be required in order for the division to develop basis for approval or disapproval of rates for coverage written by or through the Health Reinsurance Association, and perhaps to assist in the development of the proto-type forms the association will be utilizing.

400 Commodities

Sufficient commodities will be required for the 4 new positions.

500 Equipment

Sufficient office equipment will be required for the 4 new positions.

Reduction of Unrestricted Tax Receipt #019

Section 21.50.040(d) allows a carrier to offset any assessments paid to the Health Reinsurance Association against its income tax under AS 43.20 or its Alaska state premium tax. In addition, it calls for the Commissioner of Revenue to directly reimburse the carrier for assessments paid in excess of the taxes. This item only includes the loss in the premium taxes.

The assumptions made in developing these numbers represent a worst possible scenario. It was assumed that all premium taxes would be offset by the assessments paid. The basis for the amounts were the premium taxes actually paid by carriers for calendar year 1979.

FISCAL NOTE

I. REQUEST
Bill/Resolution No. HB 977
Title An Act relating to the health of residents of the state
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(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

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400	COMMODITIES		5.0	3.3	3.6	4.0	4.4
500	EQUIPMENT		25.7	-	-	-	-
600	LAND & STRUCTURES						
700	GRANTS, CLAIMS, ETC.	?	?	?	?	?	?
	TOTAL See Note 3	?	?	?	?	?	?

FUNDING (Thousands of Dollars)

GENERAL FUND		x	x	x	x	x
FEDERAL FUNDS						
OTHER (Specify Fund Source)						

POSITIONS

FULL TIME		9	9	9	9	9
PART TIME						
TEMPORARY						

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1. Assumes annual inflation rate of 10%. Personal Services based on Hawaii Program.

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3. Annual operating cost,excluding grants and claims are:

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Grants and claims are impossible to estimate. This bill provides for a premium supplementation fund. Currently, ALASKA has 10,424 employers; 72% or 7,463 of these employers would be eligible based on number employed. Without cost containment for coverage, premium costs cannot be estimated.

IV. DATE 4/14/80 PREPARED BY James Souby
AGENCY Labor
PHONE 465-2720

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)

33-001 (Rev. 12/79)

LEGISLATIVE AFFAIRS AGENCY

MEMORANDUM

2/1/80

To: Representative Buchholdt

From: Kay Shelton, Legislative Reference Librarian

The enclosed folder was part of the information sent to us to place in our information files. I would appreciate your reviewing the information and indicating (on the release form) how you wish such material handled.

Thank you for your attention to this matter.

LAA 15

CHILDRENS
CODES
SB106
HB204
1977-78

You should check on Chancy's Resolution on the Ch.'s Code from last year - or 1977.

Rudge Klevikoff - 272-5522 ext 345
hm 279-4824

Betsy McGuire
Childs Booklet

CHILDREN'S CODE

BETSY MCQUIRE: Former Director of the Office of Child Advocacy. Ms. McGuire informed us that a task force was appointed in 1975 as a result of two conferences. Had support of the Governor's office. Task force was funded by the Legislative Council. Introduced in 1976, passed in 1977. A change was made in the language, instead of Dependent children, they are "children in need of aid."

MILES: Asked if we had a Children's Code now.

MCGUIRE: Said we have a change in the law, but the Legislative Affairs agency has not followed up. They would like to see the childrens' code under a separate chapter. One title.

CHAT: Asked if it was under the same title?

MCGUIRE: No.

ELIZABETH MUKTARIAN: Division of Social Services.

Spoke on implementing the Children's Code. Stressed the need of solid justification before removal of children from the home.

RICK ROBERTSON: Mentioned that Title 9, which deals with divorce and Title 20, which deals with adoption should be under the same title as the children's code. He stated that the change in the law was very fundamental. He went on to give us examples of how the law works: 1. Adudicary - demonstrates court's power - to prove that the child is in need of aid. 2. Disposition - Court. Showing best interests of the child.

O Reference Library -
Children's Codes - of Other States.

KF 479 A75
1C. 38

KFH 20 .H3 1973

Children's Code

Invitation –

Betsy McGuire – Former Director Office of Child Advocacy. Support from Gov. Office. Task Force. Appointed 1975 (Results) 2 Conferences
1st Introduced 1976. Funded by Legis. Council. Passed 1977. Children's Code.
Formerly Dependent Children. "Children in need of aid."
Sept/Oct

Mike Do we have C C Now

Betsy Changes in laws – Under Separate Chapters Legis. Affairs not followed up. 1 title.

Chet: Same title?

Betsy No

Elizabeth Mactaren – Div S.S. implementing C.C.
Analysis of C.C. Solid justification for removal from home.

Chet: Adm. introduce proposal to accomplish this?

Barnes:

Rick Robertson – AG's

Title 9 — Divorce
" 20 — Adoption
RS. 47.10 - modern day statutory embodiment
Change was fundamental
1977 - parental Conduct. Vague.
Prof Stanford
① adjudicary - demonstrate Courts powers - showing child is in need of aid
② disposition - Court. Best interest of child.

Chat: Guardianship?

Robertson: Minors? Social workers usually one of concern.

Munson: Is there a way to get a guardian ad litem

Robertson - yes. Usually lawyers. Represent best interests.

SB-34
Parent orientated statute.
Clear & convincing evidence.

Mike Bad Environment?

Robertson - abused. physically, emotionally etc.

Hurlbert: True on poverty level?

Robertson if contested case, obviously parent care. To provide for certain needs.

Jurisdictional evidence:

Thelma parents rights hard to terminate.

Robertson when parents recognize the problem, it's a lot easier.

Most cases alcohol related.

Prior to 1977 – if went into court – have to provide actual notice to parent.

Statute says let them know – often hard to find parent.

Chair Guardianship proceedings?

Robertson File Petition, Incompatitated.

AS. 13.26

Munson – Is it necessary for consolidation

Robertson – not very high priority. Supreme Ct hasn't had chance to interpret. Worthy of further study

Mills Codification better for Children?

Robertson – I don't change language of Statute. Easier to read.
Specific change in language of Statutes.

McGuire Revision in Adoption did not get out of Committee.

Chair Committee project.

Barbara McPherson – Criminal Children's Rules

Children's Codes:

Oklahoma Statutes

HB-1089 - Juveniles - Records destruction
SB-8 - Children - Confinement - Release

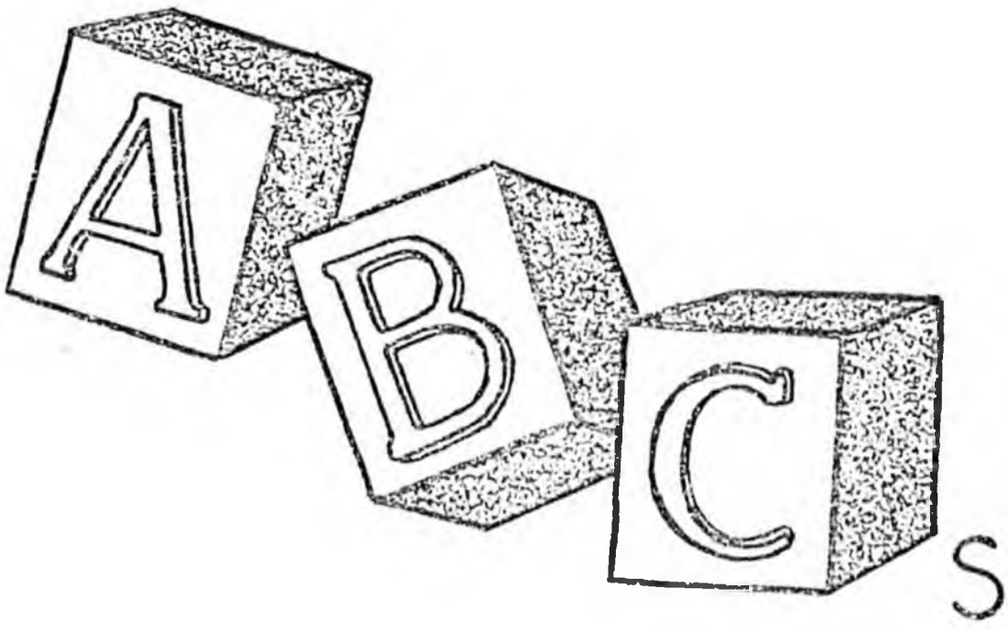
☆ ALASKA LAW - CS HB-304 Judiciary Comm.
SB-186

AS 47.10.290(7)
① Dependent minor ② Child in need of supervision ③ Delinquent ~~child~~ minor

Children's Code:
① Handling Children in need of supervision
② Protection of neglected & abused & battered
③ Delinquent Children.

Name	Organization	address		Bill No.
Thomas H. Robertson	Attney General's Office	Gpt 1		—
Betsey W. M. Guire	Former - Exec. Dir. Office of Ch. Advocacy			
Barbara J. McPherson	Criminal Justice Planning Agency	Pouch AJ		
ELIZABETH MUKTARIAN	DIVISION OF SOCIAL SERVICES	POUCH H05		
Ron L. Sobleff	Rural Alaska Community Action Prog	C/O 165 S. Franklin St. Juneau		

THE



S

OF THE COLORADO CHILDRENS CODE

FOREWORD

This booklet is de nswer some of the more common questions about the Childr s Code. The answers are not legal opinions and should not be relied on as such. Rather, they are the most usual interpretations given to the sections of the Code they cover. Some variation may be found in different judicial districts. Where a legal opinion is needed, an attorney should be consulted.

* * * * * * *

Prepared and released as a public service by:

Colorado Juvenile Court Judges Association

With the cooperation and support of:

Colorado Parent-Teacher Association
League of Women Voters
Colorado Juvenile Council
Metropolitan Council for Community Service
Family Law Committee of the Colorado Bar Association

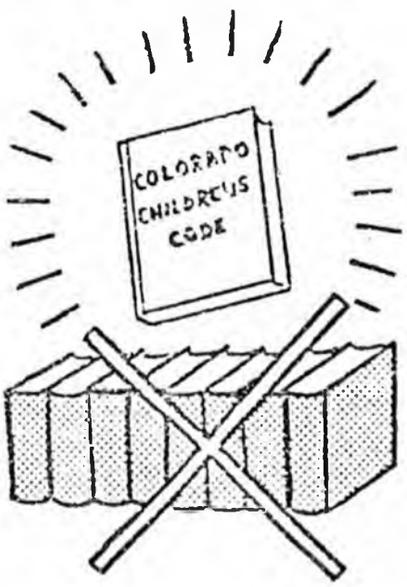
Illustrations: Frank J. Jacobucci

THE A B C's OF THE
COLORADO CHILDREN'S CODE

* * * *

Q. What is the Colorado Children's Code?

A. It is a single chapter of the Colorado Revised Statutes which includes all Colorado laws relating to children.



Q. Is the Children's Code a completely new law?

A. Not really. Parts of it are new but much is a regrouping in a single chapter laws formerly found in many of the 155 chapters of the Colorado Revised Statutes. For example, before the Children's Code, parts of children's laws were found in Chapter 3, Administrative Code, Chapter 4, Adoptions, Chapter 22, Children, Chapter 37, Courts, Chapter 39, Criminal Procedure, Chapter 40, Crimes, Chapter 105, Penal and Correctional Institutions, and Chapter 119, Public Welfare. Many of these laws remain unchanged but have been brought together in one place under the title Colorado Children's Code.

Q. Why was the Children's Code adopted?

A. To up-date Colorado's juvenile laws and to set up standard court procedures, something not covered by the old law.

Q. How does the present Children's Code differ from the former laws?

A. Here are some comparisons:

Definition	Old Law	New Law
Delinquency:	Child 10 to 18 who has: violated state or federal law or municipal ordinance, who is habitually truant from school or who is beyond control of parent. Exceptions: One over 16 charged with a capital offense shall be treated as an adult offender.	Child 10 to 18 who has violated a state or federal law, or municipal ordinance if penalty is a jail sentence. Exceptions: One over 14 charged with capital offense shall be treated as an adult offender.
Child in Need of Supervision:	No provision.	Child under 18 who indulges in anti-social although non-criminal conduct; i.e., who is truant, runaway, or beyond parental control.
Dependent or Neglected Child:	Child under 18 who is abandoned, homeless, neglected, who fails to receive proper parental care or who is dependent on charity for support.	Child under 18 whose parents abuse or neglect him. Note: New law eliminates poverty or dependence on welfare as a ground for declaring a child dependent or neglected.
Procedures		
Petition:	No provision as to contents.	Must state the specific offense.
Hearing:	No provision.	Allegations of petition must be proved beyond reasonable doubt. Child entitled to counsel and hearing must be recorded. Child has right to appeal from Court's judgment.
Disposition:	If child is found delinquent, may be left with parents under probation or may be placed in foster home, training school, or state reformatory.	Same disposition but child may not be committed to state reformatory.
Transfer Hearing:	No provision.	If child is over 14 and accused of serious offense (felony), court may transfer to adult criminal court.
Records:	No limitations on use.	Police must keep record of child in separate file. No release to public; may not be sent to FBI.

Q. Was a change in the law necessary?

A. Yes. Many recent U. S. Supreme Court decisions, especially those relating to the 5th and 14th Amendments, have radically changed court procedures for both adults and juveniles. Recently, the Colorado Supreme Court, in response to such changes, adopted a whole new "Code of Criminal Procedure." The Children's Code is, in a more limited way, an up-to-date code of juvenile procedures.

Q. Is the Colorado Children's Code radically different from Children's laws in other states?

A. Colorado has always been a leader in Children's laws. Denver, with Chicago, pioneered the juvenile court movement. Hence, children's laws of many states have followed Colorado.

Where changed, the Children's Code follows closely the Standard Juvenile Court Act developed by the National Council on Crime and Delinquency, the U. S. Children's Bureau, and the National Council of Juvenile Court Judges. This model law served as a basis for new juvenile codes for such states as New York, Illinois, Maryland, Oregon, and Utah. South Dakota has since adopted a Children's Code almost identical to Colorado's. Oklahoma also updated its children's laws along the same lines.

Q. How does the present Children's Code differ from the former laws?

A. Here are some comparisons:

Definition	Old Law	New Law
Delinquency:	Child 10 to 18 who has: violated state or federal law or municipal ordinance, who is habitually truant from school or who is beyond control of parent. Exceptions: One over 16 charged with a capital offense shall be treated as an adult offender.	Child 10 to 18 who has violated a state or federal law, or municipal ordinance if penalty is a jail sentence. Exceptions: One over 14 charged with capital offense shall be treated as an adult offender.
Child in Need of Supervision:	No provision.	Child under 18 who indulges in anti-social although non-criminal conduct; i.e., who is truant, runaway, or beyond parental control.
Dependent or Neglected Child:	Child under 18 who is abandoned, homeless, neglected, who fails to receive proper parental care or who is dependent on charity for support.	Child under 18 whose parents abuse or neglect him. Note: New law eliminates poverty or dependence on welfare as a ground for declaring a child dependent or neglected.
Procedures		
Petition:	No provision as to contents.	Must state the specific offense.
Hearing:	No provision.	Allegations of petition must be proved beyond reasonable doubt. Child entitled to counsel and hearing must be recorded. Child has right to appeal from Court's judgment.
Disposition:	If child is found delinquent, may be left with parents under probation or may be placed in foster home, training school, or state reformatory.	Same disposition but child may not be committed to state reformatory.
Transfer Hearing:	No provision.	If child is over 14 and accused of serious offense (felony), court may transfer to adult criminal court.
Records:	No limitations on use.	Police must keep record of child in separate file. No release to public; may not be sent to FBI.

	Old Law	New Law
Expungement:	No provision.	If adjudicated delinquent, two years after closing of case, if there has been no further misconduct, child may apply for and the court may expunge the juvenile record.
Publicity:	Name and picture of youth accused of delinquency may not be published without leave of court.	Same provision.

Q. May the police arrest a child accused of a delinquent act?

A. Any form of police detention is called "custody." A child may be taken into custody without court order:

For any violation of law committed in presence of the police, or where there is good reason to think the child committed such offense.

When he is lost, abandoned; when he is a runaway or when he is a danger to himself or others.

Q. When is a child considered to be "in custody"?

A. Only when suspicion focuses on him as an offender and he is questioned, not about an offense in general, but about his involvement and he is no longer free to leave. A runaway child or one who endangers himself or others may likewise be detained "in custody".

Q. May the police take a child into a police car or to headquarters to question him?

A. Yes. In most cases it is needlessly embarrassing to a child to be questioned in a public place. It may be necessary to consult the police files to determine whether the juvenile court has issued a "Request to take into Custody." Finally, since parents should be notified of the

police contact with their child and may be asked to take him home, the police department, a sub-station, or a juvenile detention center, if there is such, are appropriate places to hold the child until the parents arrive.

Q. May the police question a child without his parents being present?

A. Certainly. As a practical matter, if the police did not question a child thought to have committed some unlawful act, or who is on the street at late or unusual hours, or is behaving in a way which might be dangerous to himself or others, they could never learn his name, his address, or who his parents are, receive an explanation of his conduct, or otherwise determine whether there is cause to take the child into custody, make an official report, or refer the matter to a juvenile court.

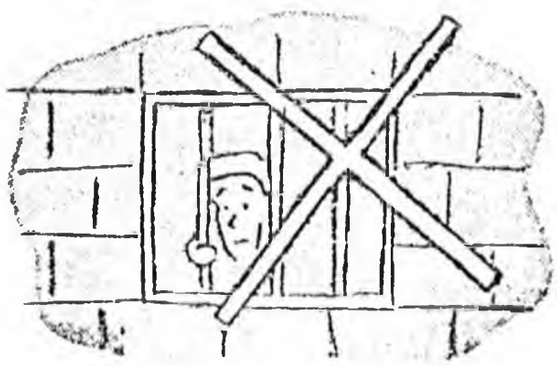
No statement of a child may be used in evidence against him unless a parent or guardian was present and the child and parent were advised of their right to remain silent, that any statement made might be used against the child, and of the right to legal counsel.

Q. What if the child refuses to give the police officer any information?

A. In most communities, ordinances require a person, including a juvenile, to give information to a police officer. Refusal to do so would be a violation of an ordinance, committed in the presence of an officer, warranting taking the child into custody. He is not obliged, however, to make self-incriminating statements.

Q. If a child is taken into custody, what happens then?

A. The Children's Code provides that the child's parents must be notified as soon as possible, and he should be released to them unless his safety, or that of others, indicates he should be detained. A child under 14 may not be placed in jail. If over 14, he may be kept in a juvenile detention center or in a jail, if separated from adult inmates.



Q. If a child is taken into custody, must he post a bail bond for his release?

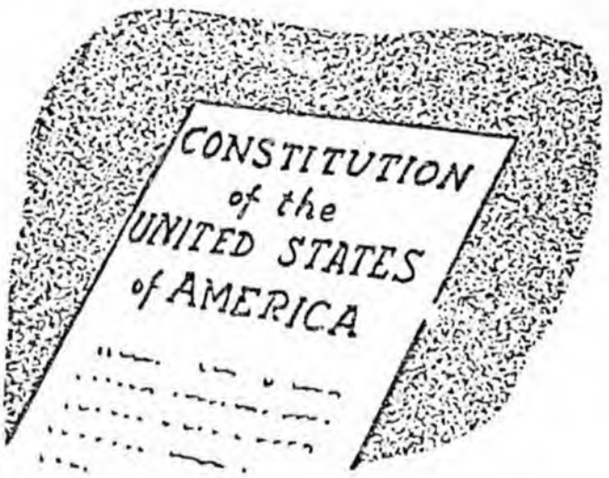
A. Usually, no. The Code provides a child should be released to his parents if they give a written promise to appear in court with the child if and when notified to do so. Such a promise subjects parents to court action if they fail to appear when notified.

Q. Do the limits on arrest and questioning of a juvenile hampter the police in their work?

A. Yes; any restrictions of this kind probably make police work more difficult.

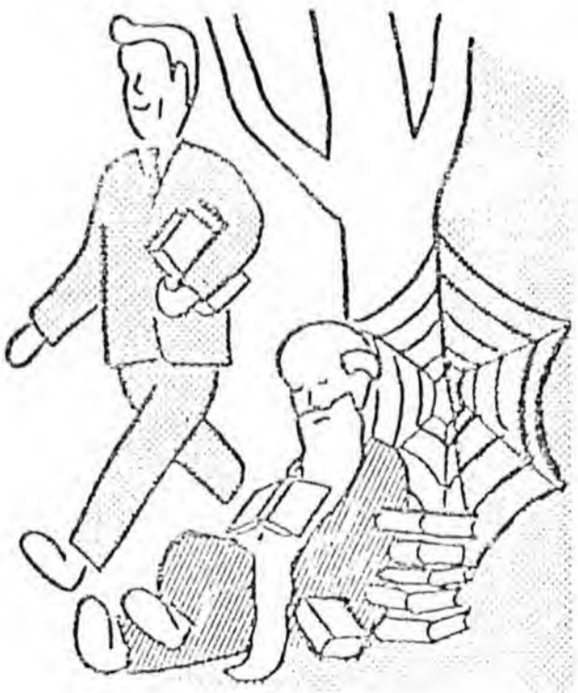
Q. Why should the Children's Code limit the police?

A. It is the United States and Colorado Constitutions which impose these limits, which provide for privilege against self-incrimination, right to counsel, and to release on reasonable bail, presumption of innocence, require proof beyond reasonable doubt, and similar protections guaranteed alike to adults and juveniles. The Children's Code merely sets up procedures which apply these principles and insure that these rights are protected.



Q. Why has the Children's Code been criticized by some?

A. The Children's Code, like many new laws, is not always well or fully understood by all. Yet it imposes limits on the police, the district attorneys and the courts in the handling of juvenile cases, especially in the areas of greater personal safeguards for children. Hence, it has been subject to criticism by many who would rather not change a previously



traditional procedure. Further, such safeguards for the rights and liberties of children and their parents does make more work for the police, prosecution and court, but are essential if we are to maintain constitutional government.

Q. Is the Children's Code concerned only with delinquency?

A. By no means. In addition to delinquency, the Code provides for handling children in need of supervision, protection for those neglected and abused, and for the battered child, i.e., the infant who receives severe, non-accidental injuries not adequately accounted for by parents; for termination of parental rights where appropriate; for hospitalization and treatment of the mentally ill child; for paternity proceedings; for orders to compel payment of support; for court orders to protect a child from mistreatment or other improper conduct by others; for the relinquishment of children where the parent wishes to give up the child; for the adoptive placement of relinquished or other children available for adoption; and for the prosecution and punishment of those who abuse or mistreat children or contribute to their delinquency.

Q. Early complaints by law enforcement stated the Children's Code was not workable. Have changes been made in the law?

A. Yes. In 1968 the legislature changed from 16 to 14 the age at which a child, accused of a capital offense (murder or other offense punishable by death or life imprisonment) may be charged as an adult criminal.

Another change lowered the age at which a child, accused of a [illegible] crime (felony) may be transferred to the adult criminal court.

Still another change now permits a police officer to take a child into custody if there is probable cause to believe he committed a delinquent act.

In 1969 the legislature made other significant changes:

Child abuse cases may be proved by a preponderance of evidence rather than beyond reasonable doubt.

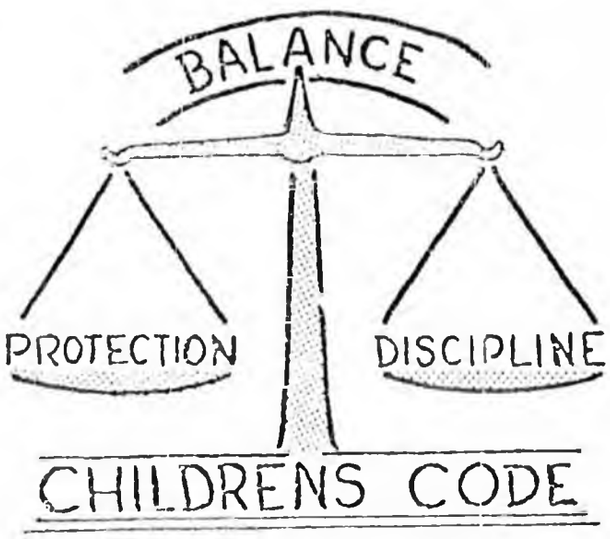
If an infant or small child receives unexplained injuries, it is not necessary to prove these were the result of abuse or neglect by the parent or guardian. Such neglect or abuse is presumed from the injury, although the parent may rebut this presumption by showing otherwise.

Adoptive procedure was simplified.

A separate juvenile section was created at Colorado State Reformatory for boys over 16 who run away from or otherwise cannot be handled adequately at Lookout Mountain School for Boys.

Q. Why a special set of laws for children?

A. Without the Children's Code children who broke a public law would be held to the same degree of responsibility as adults. It affords children protection against abuse and neglect and makes the compulsory school law enforceable. It provides adoption procedures, and empowers the court to enter pro[illegible]orders for children, to det[illegible]aternity, and institute actio[illegible]or support of children. In short, the law recognizes that children have their own special



basic rights which the Children's Code defines and safeguards. The law also holds the child accountable for his own conduct according to his age, maturity and the kind of home in which he lives.

Q. If I know of a case of child abuse or neglect, should I report it and, if so, where?

A. Such a case should be reported immediately to the police or sheriff's office, depending upon where you live, since such conduct may be both a civil and criminal matter. You may also report the incident to your local Welfare Department or to the Juvenile Court. If you request, your name will not be used unless you should be needed as a witness.

Q. Where may one apply to adopt a child?

A. Adoptive placements are made to a licensed child placement agency. These include your local Department of Welfare and, among private agencies, Catholic Charities, Family and Children's Service, Jewish Family and Children's Service and Lutheran Service Society.

Q. May a step parent adopt his step child?

A. Yes, with consent of the spouse and the other natural parent. Such adoptive petitions are filed with the Juvenile Court.

Q. How does the Children's Code affect the Department of Welfare and private social work agencies?

A. The Code gives such agencies the responsibility for most non-institutional placements for children and casework services to families. They also establish and supervise family and group foster homes, provide protective services to children, investigate child abuse complaints, counsel with parents who wish to relinquish children, make adoptive studies and

adoptive placements and furnish the multitude of social services today's complex society demands.

Q. How can we prevent or reduce juvenile crime and child abuse?

A. By good example; by observing all laws and encouraging others to do so.

By supporting, with respect, better pay and full cooperation, your local police and law enforcement officers; when in referring to a police officer, by eliminating such names as "cop" and "fuzz".

By setting firm limits of conduct for your children; requiring regular school attendance and reasonable effort and by knowing your children's companions and whereabouts.

By insisting that schools devise courses for those students who do not fit into the regular school program and by substantial reduction in the dropout rate.

By assisting the communities in securing better treatment facilities for delinquent children.

SECOND REGULAR SESSION

SENATE BILL NO. 511

77TH GENERAL ASSEMBLY

INTRODUCED BY SENATOR SCHNEIDER.

Pre-filed December 20, 1973, and 1,000 copies ordered printed.

VINITA E. RAMSEY, Secretary.

AN ACT

To provide for the State of Missouri to enter into an Interstate Compact on the Placement of Children with other states and setting forth in full the terms of such Compact.

Be it enacted by the General Assembly of the State of Missouri, as follows:

Section 1. The Interstate Compact on the Placement of Children is hereby enacted into law and entered into with all other jurisdictions legally joining therein, in form substantially as follows:

ARTICLE I.

It is the purpose and policy of the party states to cooperate with each other in the interstate placement of children to the end that:

(a) Each child requiring placement shall receive the maximum opportunity to be placed in a suitable environment and with persons or institutions having appropriate qualifi-

cations and facilities to provide a necessary and desirable degree and type of care.

(b) The appropriate authorities in a state where a child is to be placed may have full opportunity to ascertain the circumstances of the proposed placement, thereby promoting full compliance with applicable requirements for the protection of the child.

(c) The proper authorities of the state from which the placement is made may obtain the most complete information on the basis of which to evaluate a projected placement before it is made.

(d) Appropriate jurisdictional arrangements for the care of children will be promoted.

ARTICLE II.

As used in this compact:

(a) "Child" means a person who, by reason of minority, is legally subject to parental, guardianship or similar control.

(b) "Sending agency" means a party state, officer or employee thereof; a subdivision of a party state, or officer or employee thereof; a court of a party state; a person, corporation, association, charitable agency or other entity which sends, brings, or causes to be sent or brought any child to another party state.

(c) "Receiving state" means the state to which a child is sent, brought, or caused to be sent or brought, whether by public authorities or private persons or agencies, and whether for placement with state or local public authorities or for placement with private agencies or persons.

(d) "Placement" means the arrangement for the care of a child in a family free or boarding home or in a child-caring agency or institution but does not include any institution caring for the mentally ill, mentally defective or epileptic

or any institution primarily educational in character, and any hospital or other medical facility.

ARTICLE III.

(a) No sending agency shall send, bring, or cause to be sent or brought into any other party state any child for placement in foster care or as a preliminary to a possible adoption unless the sending agency shall comply with each and every requirement set forth in this article and with the applicable laws of the receiving state governing the placement of children therein.

(b) Prior to sending, bringing or causing any child to be sent or brought into a receiving state for placement in foster care or as a preliminary to a possible adoption, the sending agency shall furnish the appropriate public authorities in the receiving state written notice of the intention to send, bring, or place the child in the receiving state. The notice shall contain:

1. The name, date and place of birth of the child.

2. The identity and address or addresses of the parents or legal guardian.

3. The name and address of the person, agency or institution to or with which the sending agency proposes to send, bring, or place the child.

4. A full statement of the reasons for such proposed action and evidence of the authority pursuant to which the placement is proposed to be made.

(c) Any public officer or agency in a receiving state which is in receipt of a notice pursuant to paragraph (b) of this article may request of the sending agency, or any other appropriate officer or agency of or in the sending agency's state, and shall be entitled to receive therefrom, such supporting or additional information as it may deem necessary under the circumstances to carry out the purpose and policy of this compact.

(d) The child shall not be sent, brought, or caused to be sent or brought into the receiving state until the appropriate public authorities in the receiving state shall notify the sending agency, in writing, to the effect that the proposed placement does not appear to be contrary to the interests of the child.

ARTICLE IV.

The sending, bringing, or causing to be sent or brought into any receiving state of a child in violation of the terms of this compact shall constitute a violation of the laws respecting the placement of children of both the state in which the sending agency is located or from which it sends or brings the child and of the receiving state. Such violation may be punished or subjected to penalty in either jurisdiction in accordance with its laws. In addition to liability for any such punishment or penalty, any such violation shall constitute full and sufficient grounds for the suspension or revocation of any license, permit, or other legal authorization held by the sending agency which empowers or allows it to place, or care for children.

ARTICLE V.

(a) The sending agency shall retain jurisdiction over the child sufficient to determine all matters in relation to the custody, supervision, care, treatment and disposition of the child which it would have had if the child had remained in the sending agency's state, until the child is adopted, reaches majority, becomes self-supporting or is discharged with the concurrence of the appropriate authority in the receiving state. Such jurisdiction shall also include the power to effect or cause the return of the child or its transfer to another location and custody pursuant to law. The sending agency shall continue to have financial responsibility for support and maintenance of the child during the period of the place-

ment. Nothing contained herein shall defeat a claim of jurisdiction by a receiving state sufficient to deal with an act of delinquency or crime committed th ~ein.

(b) When the sending agency is a public agency, it may enter into an agreement with an authorized public or private agency in the receiving state providing for the performance of one or more services in respect of such case by the latter as agent for the sending agency.

(c) Nothing in this compact shall be construed to prevent a private charitable agency authorized to place children in the receiving state from performing services or acting as agent in that state for a private charitable agency of the sending state; nor to prevent the agency in the receiving state from discharging financial responsibility for the support and maintenance of a child who has been placed on behalf of the sending agency without relieving the responsibility set forth in paragraph (a) hereof.

ARTICLE VI.

A chi' ' adjudicated delinquent may 'e placed in an institution in another party jurisdiction pursuant to this compact but no such placement shall be made unless the child is given a court hearing on notice to the parent or guardian with opportunity to be heard, prior to his being sent to such other party jurisdiction for institutional care and the court finds that:

1. Equivalent facilities for the child are not available in the sending agency's jurisdiction; and

2. Institutional care in the other jurisdiction is in ~e best interest of the child and will not produce undue hard' ship.

ARTICLE VII.

The executive head of each jurisdiction party to this compact shall designate an officer who shall be general co-

ordinator of activities under this compact in his jurisdiction and who, acting jointly with like officers of other party jurisdictions, shall have powers to promulgate rules and regulations to carry out more effectively the terms and provisions of this compact.

ARTICLE VIII.

This compact shall not apply to:

(a) The sending or bringing of a child into a receiving state by his parent, step-parent, grandparent, adult brother or sister, adult uncle or aunt, or his gua lian and leaving the child with any such relative or non-agency guardian in the receiving state.

(b) Any placement, sending or bringing of a child into a receiving state pursuant to any other interstate compact to which both the state from which the child is sent or brought and the receiving state are party, or to any other agreement between said states which has the force of law.

ARTICLE IX.

This compact shall be open to joinder by any state, territory or possession of the United States, the District of Columbia, the Commonwealth of Puerto Rico, and with the consent of Congress, the Government of Canada or any province thereof. It shall become effective with respect to any such jurisdiction when such jurisdiction has enacted the same into law. Withdrawal from this compact shall be by the enactment of a statute repealing the same, but shall not take effect until two years after the effective date of such statute and until written notice of the withdrawal has bee. given by the withdrawing state to the Governor of each other arty jurisdiction. Withdrawal of a party state shall not affect the rights, duties and obligations under this compact of any sending agency therein with respect to a placement made prior to the effective date of withdrawal.

ARTICLE X.

The provisions of this compact shall be liberally construed to effectuate the purposes thereof. The provisions of this compact shall be severable and if any phrase, clause, sentence or provision of this compact is declared to be contrary to the constitution of any party state or of the United States or the applicability thereof to any government, agency, person or circumstance is held invalid, the validity of the remainder of this compact and the applicability thereof to any government, agency, person or circumstance shall not be affected thereby. If this compact shall be held contrary to the constitution of any state party thereto, the compact shall remain in full force and effect as to the remaining states and in full force and effect as to the state affected as to all severable matters.

Section 2. The financial responsibility for any child placed pursuant to the Provisions of the Interstate Compact on the Placement of Children shall be determined in accordance with the provisions of Article V thereof, in the first instance. However, in the event of partial or complete default of performance thereunder, the provisions of state laws fixing responsibility for the support of children also may be invoked.

Section 3. The "appropriate public authorities" as used in Article III of the Interstate Compact on the Placement of Children shall, with reference to this state, mean Division of Welfare, and said Division of Welfare shall receive and act with reference to notices required by said Article III.

Section 4. As used in paragraph (a) of Article V "appropriate authority in the receiving state" shall mean the Division of Welfare.

Section 5. Any court having jurisdiction to place delinquent children may place such a child in an institution of

or in another state pursuant to Article VI of the Interstate Compact on the Placement of Children and shall retain jurisdiction as provided in Article V thereof.

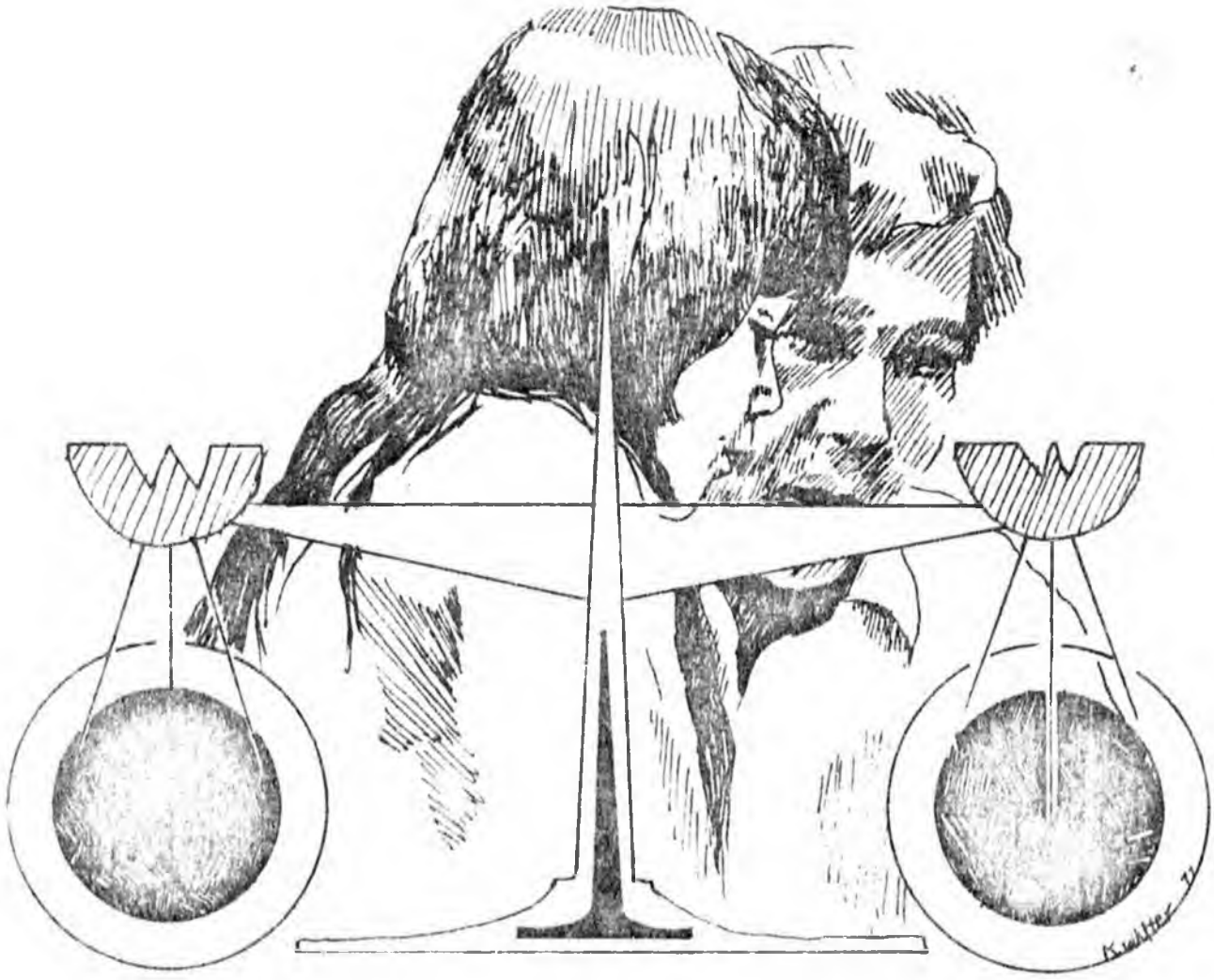
Section 6. As used in Article VII of the Interstate Compact on the Placement of Children the term "executive head" means the Governor. The Governor is hereby authorized to appoint a compact administrator in accordance with the terms of said Article VII.

Section 7. No placement made into this state from a jurisdiction not party to the Interstate Compact on the Placement of Children shall be lawful unless the person or agency making the placement complies with and follows the procedures and requirements of Article III of that compact as though the state or jurisdiction from which the child is sent or brought were party thereto. This section shall not apply to any placement which would not be subject to the terms of the Interstate Compact on the Placement of Children if both this state and the other state or jurisdiction from which the child is sent or brought were parties thereto.

BELKNE

STATE OF ALASKA 3/1/79

Department of Health and Social Services



ANALYSIS of 1977 CHILDRENS CODE

K. McRobertson AG

DIVISION OF SOCIAL SERVICES

CHILDREN'S CODE ANALYSIS

AUGUST, 1977

THIS REPORT WAS PREPARED BY

NINA KINNEY AND ELIZABETH MUKTARIAN

INTRODUCTION

This report has been prepared by the Division of Social Services to assist you in understanding the changes in Alaskan statutes relating to children which are effective on August 26, 1977.

This report has been organized in the following manner. On the right hand pages are the new statutes. Deletions in the previous statutes are included in parentheses in the appropriate sections on the right hand side. Likewise, additions to the statutes are underlined in the new statutes.

On the left hand page, you will find two types of notations. First, whenever a section of the old statute has been repealed and re-enacted, opposite that new section you will find the section which has been repealed.

The significant changes in the new statute are outlined in black boxes on the left hand page.

It must be recognized that the Children's Code, as any set of statutes, will require a period of adjustment after implementation. However, after you have worked under these new statutes you may find areas you consider to be problematic. We suggest that Division of Social Services staff communicate such areas to their Regional Manager who will forward their concerns to the Director's Office. Some areas may require policy decisions within the Division. For other areas it may be necessary to consult the Attorney General's Office for further interpretation.

We hope that this report, by contrasting old and new sections, will help to clarify the significant areas of change in Alaska's Children's Code. We wish to thank Elizabeth Arnold, Assistant Attorney General for her assistance in reviewing the draft of this report, and to acknowledge the Legislative Affairs Agency for their preparation of the typescript of the statute.

Sec. 1. AS 09.55.205 Enumerates criteria to be utilized by a court in determining the "best interests of the child" in awarding custody of children; in addition it specifies what is in the best interests of the child.

Sec. 09.55.205. Judgments for custody. In an action for divorce or for legal separation the court may, during the pendency of the action, or at the final hearing or at any time thereafter during the minority of any child of the marriage, make an order for the custody of or visitation with the minor child which may seem necessary or proper and may at any time modify or vacate the order. Appointment of a guardian ad litem or attorney for the child shall be made under the terms of AS 09.65.130. In awarding custody the court is to be guided by the following considerations:

(1) by what appears to be for the best interests of the child and if the child is of a sufficient age and intelligence to form a preference, the court may consider that preference in determining the question;

(2) as between parents adversely claiming the custody neither parent is entitled to it as of right. (§ 1 ch 160 SLA 1968; am § 1 ch 167 SLA 1975)

"An Act relating to children's laws and related judicial proceedings; changing the court's responsibilities and authority under Children's Rules 11(a), 12(a) and (b), 14, 15, 21 and 28, and Rule of Civil Procedure 17(b)."

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

* Section 1. AS 09.55.205 is repealed and re-enacted to read:

Sec. 09.55.205. JUDGMENTS FOR CUSTODY. In an action for divorce or for legal separation the court may, if it has jurisdiction under AS 25.30.020, and is an appropriate forum under AS 25.30.050 and 25.30.060, during the pendency of the action, or at the final hearing or at any time thereafter during the minority of any child of the marriage, make an order for the custody of or visitation with the minor child which may seem necessary or proper and may at any time modify or vacate the order. Any appointment of a guardian ad litem for a child shall be made under the terms of AS 09.65.130. The court shall determine custody in accordance with the best interests of the child. Neither parent is entitled to preference as a matter of right in awarding custody of the child. In determining the best interests of the child the court shall consider all relevant factors including:

(1) the physical, emotional, mental, religious and social needs of the child;

(2) the capability and desire of each parent to meet these needs;

Sec. 2. AS 09.65.130 deals with representation of a child. The changes clarify the responsibilities of a guardian ad litem and attorney for a child, and provides for the appointment of both and procedures for both.

The new subsection (c) clarifies that the guardian ad litem is to represent the best interests of the child, not his preferences. It also delineates the limits of the guardian ad litem's authority.

(3) the child's preference;

(4) the love and affection existing between the child and each parent;

(5) the length of time the child has lived in a stable, satisfactory environment and the desirability of maintaining continuity;

(6) the desire and ability of each parent to allow an open and loving frequent relationship between the child and his other parent.

* Sec. 2. AS 09.65.130(a) is amended to read:

(a) The court may, upon the motion of either party or upon its own motion, appoint an attorney [OR GUARDIAN AD LITEM] to represent the [INTERESTS OF A] minor [OR DEPENDENT CHILD] with respect to his custody, support, and visitation or in any other legal proceeding involving his welfare. When custody, support, or visitation are at issue in a divorce, it is the responsibility of the parties or their counsel to notify the court that those matters are at issue. Upon notification, the court shall determine whether the child should have legal <u>representation</u> [ASSISTANCE] or other services and shall make a finding on the record before trial. The court shall enter an order for costs, fees, and disbursements in favor of the child's attorney [OR GUARDIAN AD LITEM] and may further order that other services be provided for the protection of the child.

* Sec. 3. AS 09.65.130 is amended by adding a new subsection to read:

(c) Instead of, or in addition to, appointment of an attorney under (a) of this section, the court may, upon the motion of either party or upon its own motion, appoint an attorney or other person to serve as guardian ad litem to represent the best interests of a minor in any legal proceedings involving his welfare. The court shall appoint a guardian ad litem when, in the opinion of the court, representation of the child's best interests, to be distinguished from his preferences,

The guardian ad litem should, when reasonable, be appointed from among persons in the community where the child's parents or the person having legal custody or guardianship of the child's person reside.

Sec 4. AS 30.15.050 deals with consent to adoption. This does not change the requirement; it was added for clarification.

Sec. 5. AS 25.20.010 changes the age of majority from 19 to 18 years. Those statutes which specifically provide an age requirement of 19, such as drinking, jury duty, and selling/serving liquor remain unchanged.

would serve the welfare of the child. The person appointed under (a) of this section may also be appointed as guardian ad litem under this subsection. The court in its order appointing a guardian ad litem shall limit the duration of the appointment of the guardian ad litem to the pendency of the legal proceedings affecting the child's interests, and shall outline the guardian ad litem's responsibilities and limit his authority to those matters related to his effective representation of the child's best interests in the pending legal proceeding. The court shall make every reasonable effort to appoint a guardian ad litem from among persons in the community where the child's parents or the person having legal custody or guardianship of the child's person reside. When custody, support, or visitation are at issue in a divorce, it is the responsibility of the parties or their counsel to notify the court that these matters are at issue. Upon notification, the court shall determine if the child's best interests need representation or if the child needs other services and shall make a finding on the record before trial. The court shall enter an order for costs, fees, and disbursements in favor of the child's guardian ad litem and may further order that other services be provided for the protection of the child.

* Sec. 4. AS 20.15.050(a)(1) and (5) are amended to read:

(1) <u>for purposes of this section,</u> a parent who has abandoned a child <u>for not less than six months</u> [WITHOUT AFFORDING MEANS OF IDENTIFICATION, OR WHO HAS ABANDONED A CHILD AS DETERMINED UNDER AS 47.10.080(c)(3)(B)];

(5) a parent whose parental rights have been terminated by order of the court under <u>AS 47.10.080(c)(3)</u> [SEC. 180 OF THIS CHAPTER];

* Sec. 5. AS 25.20.010 is amended to read:

Sec. 25.20.010. AGE OF MAJORITY. A person is considered to have arrived at majority at the age of <u>18</u> [19] years, and thereafter has

Sec. 6. AS 25.20.060 provides for resolution of a child custody controversy between claimants not parties to an action for divorce or legal separation. The significance of this amendment is that it clarifies that it applies to persons who are not married or to custodians who are not related.

Sec. 47.10.010. Jurisdiction. (a) Proceedings relating to a minor under 18 years of age residing or found in the state are governed by this chapter, except as otherwise provided in this chapter, when the minor

(1) violates a law of the state, or an ordinance or regulation of a political subdivision of the state;

(2) by reason of being wayward or habitually disobedient is uncontrolled by his parent, guardian or custodian;

(3) is habitually truant from school or home, or habitually so conducts himself as to injure or endanger the morals or health of himself or others;

(4) is abandoned by his parent, guardian or custodian;

(5) lacks proper parental care by reason of the faults, habit or neglect of his parent, guardian or custodian;

(6) associates with vagrant, vicious or immoral people, or engages in an occupation or is in a situation dangerous to life or limb or injurious to the health, morals, or welfare of himself or others;

(7) is an orphan who has no relatives willing and able to assume custody and care;

(8) has been released by his parent or parents, or guardian, to the department for adoptive purposes; or

(9) is in need of special care or training not otherwise provided.

Sec. 7. AS 47.10.010(a) is a crucial section for Division of Social Services' staff. It includes major statutory changes. The whole concept of status offenders is removed except for runaway children. In addition, it eliminates the categories "child in need of supervision" (CHINS) and "dependent child" and in substitution grants the court jurisdiction over a child to be a "child in need of aid" (CINA), and significantly changes the types of situations which could result in such a finding. The criteria is much more specific and focuses on actual or imminent harm to the child rather than on conduct of the parent or guardian unless it endangers the child. Note that "caring" (Sec. 7., (2), (A)), means more than physical care. See Sec. 28, (9).

control of his own actions and business and has all the rights and is subject to all the liabilities of citizens of full age, except as otherwise provided by statute.

* Sec. 6. AS 25.20 is amended by adding a new section to read:

Sec. 25.20.060. CUSTODY OF THE CHILD. If there is a dispute over child custody, either parent may petition the superior court for resolution of the matter under this section unless an action between the parents is pending under AS 09.55. The court shall award custody on the basis of the best interests of the child. In determining the best interests of the child, the court shall consider all relevant factors including those factors enumerated in AS 09.55.205. Neither parent, regardless of the question of the child's legitimacy, is entitled to preference in the awarding of custody.

* Sec. 7. AS 47.10.010(a) is repealed and re-enacted to read:

(a) Proceedings relating to a minor under 18 years of age residing or found in the state are governed by this chapter, except as otherwise provided in this chapter, when the court finds the minor

(1) to be a delinquent minor as a result of violating a criminal law of the state or of a municipality of the state; or

(2) to be a child in need of aid as a result of

(A) the child being habitually absent from his home or refusing to accept available care, or having no parent, guardian, custodian or relative caring or willing to care for him, including physical abandonment by

(i) both parents,

(ii) the surviving parent, or

(iii) one parent if the other parent's rights and responsibilities have been terminated under sec. 80 of this chapter or voluntarily relinquished;

Sec. 8. AS 47.10.010(b) deals with jurisdiction. This amendment provides that a child shall be prosecuted as an adult for misdemeanor fish and game and parks and recreational facilities violations.

(B) the child being in need of medical treatment to cure, alleviate, or prevent his suffering substantial physical harm, or mental harm as evidenced by failure to thrive, severe anxiety, depression, withdrawal, or untoward aggressive behavior or hostility toward others, and his parents are unwilling to provide the medical treatment;

(C) the child having suffered substantial physical harm or if there is an imminent and substantial risk that the child will suffer such harm as a result of the actions done by or conditions created by his parent, guardian or custodian or the failure of his parent, guardian or custodian adequately to supervise him;

(D) the child having been sexually abused either by his parent, guardian or custodian, or as a result of conditions created by his parent, guardian or custodian, or by the failure of his parent, guardian or custodian adequately to supervise him;

(E) the child committing delinquent acts as a result of pressure, guidance, or approval from his parents, guardian or custodian.

* Sec. 8. AS 47.10.010(b) is amended to read:

(b) When a minor is accused of violating a traffic statute or regulation, [OR] a traffic ordinance or regulation of an incorporated municipality, a fish and game statute or regulation under AS.16 or a parks and recreational facilities statute or regulation under AS 41.20, excepting a statute the violation of which is a felony, the procedure prescribed in secs. 20 - 90 of this chapter may not be followed, except that a parent, guardian or legal custodian shall be present at all proceedings. The minor accused of a traffic offense, a fish and game statute or regulation under AS 16 or parks and recreational facilities violation under AS 41.20 shall be charged, prosecuted, and sentenced in

Sec. 9. AS 47.01.030(b) requires notice to be given to each parent in any children's proceeding. It requires efforts to notify absent parents regardless of the length of absence. Proof of notice must be filed before the petition is heard. If proof of notice cannot be given, you ust give proof that you tried to give notice.

Sec. 9. AS 47.10.030(b) If the person summoned is not the parent or guardian of the minor, the court shall also give the parent or guardian notice of the place an' time of the hearing. The court may also subpoena the parent of the minor, or any other person whose testimony may be necessary at the hearing. A summons, subpoena or other process may be served by a person authorized by law to make the service. Where personal service cannot be made, th court may direct that service of process be made by registered mail.

Sec. 10. AS 47.10.040 The significant change is that the arbitrary 14 year age requirement is removed.

the district court in the same manner as an adult.

* Sec. 9. AS 47.10.030(b) is repealed and re-enacted to read:

(b) In all cases under this chapter the minor, each parent of the minor and the guardian of the minor shall be given notice adequate to give actual notice of the proceedings and the possibility of termination of parental rights and responsibilities, taking into account education and language differences which are known or reasonably ascertainable by the petitioner or the department. The notice of the hearing shall contain all names by which the minor has been identified. Notice shall be given in the manner appropriate under rules of civil procedure for the service of process in a civil action under Alaska law or in any manner the court by order directs. Proof of the giving of the notice shall be filed with the court before the petition is heard. The court may also subpoena the parent of the minor, or any other person whose testimony may be necessary at the hearing. A subpoena or other process may be served by a person authorized by law to make the service, and where personal service cannot be made, the court may direct that service of process be in a manner appropriate under rules of civil procedure for the service of process in a civil action under Alaska law or in any manner the court directs.

* Sec. 10. AS 47.10.040 is amended to read:

Sec. 47.10.040. RELEASE OF MINOR. A minor who is taken into custody may, in the discretion of the court and upon the written promise of the parent, guardian or custodian to bring the minor before the court at a time specified by the court, be released to the care and custody of the parent, guardian or custodian. The minor, if not released, shall be detained as provided by sec. 140 of this chapter. The court may determine whether the father or mother or another person shall have the custody and control of the minor for the duration of the proceedings. If

Sec. 11 & 12. AS 47.10.050 This section asserts very positively a minor's right to counsel. While a minor can waive counsel voluntarily and knowingly, he/she must consult an attorney prior to the waiver of counsel in all cases which would be felonies if committed by an adult. The intention of this section is to assure that juveniles are not intimidated by the legal proceedings and to ensure their rights are not violated.

Sec. 13. AS 47.10.060(d) The only change is in age from 21 to 20.

the minor is of sufficient age and intelligence to state his desires, the court shall give consideration to his desires [OVER 14 YEARS OF AGE, HIS DESIRES IN THE MATTER SHALL BE GIVEN CONSIDERATION BY THE COURT].

* Sec. 11. AS 47.10.050 is amended to read:

Sec. 47.10.050. APPOINTMENT OF GUARDIAN AD LITEM OR ATTORNEY. (a) Whenever in the course of proceedings instituted under this chapter it appears to the court that the welfare of a minor will be promoted by the appointment of an attorney to represent the minor or an attorney or other person to serve as guardian ad litem [A GUARDIAN AD LITEM OR ATTORNEY], the court may make the appointment. Appointment of a guardian ad litem or attorney shall be made under the terms of AS 09.65.130.

* Sec. 12. AS 47.10.050 is amended by adding a new subsection to read:

(b) In all proceedings initiated under a petition for delinquency, a minor shall have the right to be represented by counsel and if indigent have counsel appointed for him by the court. The court shall appoint counsel in such cases unless it makes a finding on the record that the minor has made a voluntary, knowing, and intelligent waiver of the right to counsel and a parent or guardian with whom the child resides or resided before the filing of the petition concurs with the waiver. In cases where it has been alleged that the minor has committed an act which would be a felony if he were an adult, waiver of counsel shall not be accepted unless the court is satisfied that the minor has consulted with an attorney before his waiver of counsel.

* Sec. 13. AS 47.10.060(d) and (e) are amended to read:

(d) A minor is unamenable to treatment under this chapter if he probably cannot be rehabilitated by treatment under this chapter before he reaches 20 [21] years of age. In determining whether a minor is unamenable to treatment, the court may consider the seriousness of the

Sec. 13 AS 47.10.060(e) The change was to make this section consistent with another section.

Sec. 14. AS 47.10.080(b) deals with limits of custody for delinquents. It eliminates indeterminate custody; custody is limited to two years. The provisions are similar to those for CINA which are explained opposite Sec. 47.10.060(c).

Sec. 14.

Sec. 47.10.080

(b) If the court finds that the minor is delinquent, it shall

(1) order the minor committed to the Department of Health and Social Services for an indeterminate period of time not to extend past a specified date or in any event past the day the minor becomes 19, except that the department may petition the court for continued supervision for an additional one-year period for minors who have not responded to treatment; the department shall place the minor in the juvenile facility which the department considers appropriate and which may include a juvenile correctional school, detention home, or detention facility; the minor may be released from placement or detention and placed on probation on order of the court and may also be released by the department, in its discretion, under § 200 of this chapter; or

(2) order the minor placed on probation, to be supervised by the department, and release him to his parents, guardian, or a suitable person; if the court orders the minor placed on probation, it may specify the terms and conditions of probation; the probation may be for an indeterminate period of time, not to extend past a specified date and in no event past the day the minor becomes 19, except that the department may petition the court for continued supervision for an additional one-year period for minors who have not responded to treatment.

offense the minor is alleged to have committed, the minor's history of delinquency, the probable cause of the minor's delinquent behavior, and the facilities available to the division of youth and adult authority for treating the minor.

(e) If a person who has been tried as an adult under this section has completed his sentence and five years have elapsed, he may petition (or the Department of Health and Social Services may petition for him) the superior court to seal the records of all criminal proceedings against him and all punishments assessed against him, except for traffic offenses, while he was a minor. If the superior court finds that the punishment assessed against the person has had its intended rehabilitative effect, the superior court shall order the record of proceedings and the record of punishments sealed. Sealing the records restores civil rights removed because of a conviction. No person may [EVER] use records so sealed for any purpose except that the court may order their use for good cause shown or may order their use by an officer of the court in making a presentencing report for the court.

* Sec. 14. AS 47.10.080(a) is amended to read:

(a) The court, at the conclusion of the hearing, or thereafter as the circumstances of the case may require, shall find and enter a judgment that the minor is or is not a delinquent [,] or a child in need of aid [SUPERVISION, OR DEPENDENT MINOR].

* Sec. 15. AS 47.10.080(b) is repealed and re-enacted to read:

(b) If the court finds that the minor is delinquent, it shall

(1) order the minor committed to the Department of Health and Social Services for a period of time not to exceed two years or in any event extend past the day the minor becomes 19, except that the department may petition for and the court may grant in a hearing (A) two-year extensions of commitment which do not extend beyond the child's 19th

birthday if the extension is in the best interests of the minor and the public; and (B) an additional one-year period of supervision past age 19 if continued supervision is in the best interests of the person and the person consents to it; the department shall place the minor in the juvenile facility which the department considers appropriate and which may include a juvenile correctional school, detention home, or detention facility; the minor may be released from placement or detention and placed on probation on order of the court and may also be released by the department, in its discretion, under sec. 200 of this chapter;

(2) order the minor placed on probation, to be supervised by the department, and release him to his parents, guardian, or a suitable person; if the court orders the minor placed on probation, it may specify the terms and conditions of probation; the probation may be for a period of time, not to exceed two years and in no event extend past the day the minor becomes 19, except that the department may petition for and the court may grant in a hearing:

(A) two-year extensions of supervision which do not extend beyond the child's 19th birthday if the extension is in the best interests of the minor and the public; and

(B) an additional one-year period of supervision past age 19 if the continued supervision is in the best interests of the person and the person consents to it;

(3) order the minor committed to the department and placed on probation, to be supervised by the department, and release him to his parents, guardian, other suitable person, or suitable nondetention setting such as a family home, group care facility, or child care facility, whichever the department considers appropriate to implement the treatment plan of the predisposition report; if the court orders the minor placed on probation, it may specify the terms and conditions of

Sec. 16. AS 47.10.080(c) eliminates indeterminate custody and limits an order of custody to two years. Provisions are made for two year extensions of custody to be decided by the court in a hearing if the extension is in the best interests of the minor and the public up to the child's 19th birthday. It also makes provisions for one year supervision past age 19 with the consent of the child. The Department must give the child, parents, or guardian and attorneys reasonable notice of transfer of placement.

Sec. 16
AS 47.10.080

(c) If the court finds that the minor is dependent, it shall

(1) order the minor committed to the department for an indeterminate period of time not to exceed the date the minor becomes 19 years of age, except that the department may petition the court for continued supervision for an additional one-year period for minors who have not responded to treatment;

(2) order the minor released to his parents, guardian, or some other suitable person, and, in appropriate cases, order the parents, guardian, or other person to provide medical or other care and treatment; if the court releases the minor it shall direct the department to supervise the care and treatment given to the minor; the department's supervision may not extend past the date the minor reaches majority, except that the department may petition the court for continued supervision for an additional one-year period for minors who have not responded to treatment; or

(3) by order, terminate parental rights and responsibilities of one or both parents and commit the child to the department or to a legally appointed guardian of the person of the child, if one of the following conditions exists:

(A) Each parent, or the surviving parent, or one parent if the other has been deprived of custody and visitation rights wishes to relinquish the child to the department or to a legally appointed guardian of the person of the child for adoptive purposes, and the relinquishment is in writing, signed and acknowledged before the court or duly authorized representative of the department and filed with the court;

(B) the child has been abandoned for a period of not less than six months by

(i) both parents, or

(ii) the surviving parent, or

(iii) one parent if the other has been deprived of custody and visitation rights;

(C) each parent, the surviving parent, or one parent if the other has been deprived of custody and visitation rights has been judicially determined to be of unsound mind and the disability has not been removed and the parent has been hospitalized for reasons of mental illness diagnosed as permanent or of long duration; or

(D) each parent, or the surviving parent, or one parent if the other has been judicially deprived of custody and visitation rights, has demonstrated by his conduct, proven by clear and convincing proof amounting to more than a preponderance of the evidence that he is unfit to continue to exercise his parental rights and responsibilities.

probation; the department may transfer the minor, in his best interests, from one of the probationary placement settings listed in this paragraph to another, and the minor, his parents or guardian and attorney are entitled to reasonable notice of the transfer; the probation may be for a period of time, not to exceed two years and in no event extend past the day the minor becomes 19, except that the department may petition for and the court may grant in a hearing:

(A) two-year extensions of commitment which do not extend beyond the child's 19th birthday if the extension is in the best interests of the minor and the public; and

(B) an additional one-year period of supervision past age 19 if the continued supervision is in the best interests of the person and the person consents to it; or

(4) order the minor to make suitable restitution in lieu of or in addition to the court's order under (1), (2) or (3) of this subsection.

* Sec. 16. AS 47.10.080(c) is repealed and re-enacted to read:

(c) If the court finds that the minor is a child in need of aid, it shall

(1) order the minor committed to the department for placement in an appropriate setting for a period of time not to exceed two years or in any event past the date the minor becomes 19 years of age, except that the department may petition for and the court may grant in a hearing (A) two-year extensions of commitment which do not extend beyond the child's 19th birthday if the extension is in the best interests of the minor and the public; and (B) an additional one-year period of supervision past age 19 if the continued supervision is in the best interests of the person and the person consents to it; the department may transfer the minor, in his best interests, from one placement

A fourth option is added. The court may dispense with the Department's supervision and return the child to his/her family.

(3) In cases where parental rights have been terminated, the Department or guardian must report annually to the court on efforts being made to find a permanent placement for the child. In addition, for parental rights to be terminated a child has to have been adjudicated CINA and parental fault must be clear and convincing that the child is a CINA. It must be shown that the parental conduct is going to continue. This is directly tied to 10 (a) (2).

setting to another, and the minor, his parents or guardian and attorney are entitled to reasonable notice of the transfer;

(2) order the minor released to his parents, guardian, or some other suitable person, and, in appropriate cases, order the parents guardian, or other person to provide medical or other care and treatment; if the court releases the minor, it shall direct the department to supervise the care and treatment given to the minor, but the court may dispense with the department's supervision if the court finds that the adult to whom the minor is released will adequately care for the minor without supervision; the department's supervision may not exceed two years or in any event extend past the date the minor reaches age 19, except that the department may petition for and the court may grant in a hearing:

(A) two-year extensions of supervision which do not extend beyond the child's 19th birthday if the extension is in the best interests of the minor and the public; and

(B) an additional one-year period of supervision past age 19 if the continued supervision is in the best interests of the person and the person consents to it; or

(3) by order, upon a showing in the adjudication by clear and convincing evidence that there is a child in need of aid under sec. 10(a)(2) of this chapter as a result of parental conduct and upon a showing in the disposition by clear and convincing evidence that the parental conduct is likely to continue to exist if there is no termination of parental rights, terminate parental rights and responsibilities of one or both parents and commit the child to the department or to a legally appointed guardian of the person of the child, and the department or guardian shall report annually to the court on efforts being made to find a permanent placement for the child.

Sec. 18. AS 47.10.080(f) adds the provision that the minor and the custodian are entitled to request a review and that reasonable notice in advance of the review will be granted to all parties.

* Sec. 17. AS 47.10.080(e) is amended to read:

(e) If the court finds that the minor is not delinquent or [,] a child in need of aid [SUPERVISION, OR DEPENDENT], it shall immediately order his release from the department's [ITS] custody and his return to his parents, guardian, or custodian, and dismiss [CLOSE] the case.

* Sec. 18. AS 47.10.080(f) is amended to read:

(f) A minor found to be delinquent or [,] a child in need of aid [SUPERVISION, OR DEPENDENT] is a ward of the state as long as he is committed to the department or the department has the power to supervise his actions. The court shall review an order made under (b) or (c)(1) or (2) [OR (j)] of this section annually, and may review the order more frequently to determine if continued placement, probation, or supervision, as it is being provided, is in the best interest of the minor and the public [, AND TO DETERMINE IF THE MINOR IS BEING TREATED FAIRLY]. The department, the minor, [OR] the minor's parents, [OR] guardian, or custodian are [IS] entitled, when good cause is shown, to a review on application. If the application is granted, the court shall afford these parties and their counsel reasonable notice in advance of the review and hold a hearing where these parties and their counsel shall be afforded an opportunity to be heard. The minor shall be afforded the opportunity to be present at the review.

* Sec 19. AS 47.10.085 is amended to read:

Sec. 47.10.085. CHILD IN NEED OF AID [DEPENDENT MINOR]; RELIGIOUS TREATMENT. In a case in which the minor's status as a child in need of aid [DEPENDENT MINOR] is sought to be based on his need for medical care, the court may, upon consideration of the health of the minor and the fact, if it is a fact, that the minor is being provided treatment by spiritual means through prayer in accordance with the tenets and practices of a recognized church or religious denomination by an accredited

See explanation of Sec. 14. AS 47.10.080 on limits of custody.

practitioner of the church or denomination, dismiss the proceedings and thereby close the matter. This may be done, in the interests of justice and religious freedom, on the court's own motion or upon the application of a party to the proceedings, at any stage of the proceedings after information is given to the court under sec. 20(a) of this chapter.

* Sec. 20. AS 47.10.090(b) is amended to read:

(b) The name or picture of a minor under the jurisdiction of the court may not be made public in connection with the minor's status as a delinquent [OR DEPENDENT] child or a child in need of aid unless authorized by order of the court, except that the name of a minor who is found for the second time to have violated a law, which if committed by an adult would be a felony, shall be made public unless the court, for good cause, in certain individual cases, enters an order prohibiting the disclosure.

* Sec. 21. AS 47.10.100(a) and (c) are amended to read:

(a) The court retains jurisdiction over the case and may at any time stay execution, modify, set aside, revoke, or enlarge a judgment or order, or grant a new hearing, in the exercise of its power of protection over the minor and for his best interest, for a period of time not to exceed two years or in any event extend past the day the minor becomes 19 [UNTIL HE BECOMES 19 YEARS OF AGE], unless sooner discharged by the court, except that the department may apply for and the court may grant an additional one-year period of supervision past age 19 if continued supervision is in the best interests of the person and the person consents to it [PETITION THE COURT FOR CONTINUED SUPERVISION FOR AN ADDITIONAL ONE-YEAR PERIOD FOR MINORS WHO HAVE NOT RESPONDED TO TREATMENT]. An application for any of these purposes may be made by the parent, guardian, or custodian acting in behalf of the minor, or the court may, on its own motion, and after reasonable notice to interested

Refer to Sec. 10. AS 47.10.040.

parties and the appropriate department, take action which it considers appropriate.

(c) If a minor is adjudicated a delinquent or [,] a child in need of aid [SUPERVISION, OR A DEPENDENT] before his 18th birthday, the court may retain jurisdiction over him after his 18th birthday for the purpose of supervising his rehabilitation, but the court's jurisdiction over him under this chapter never extends beyond his 19th birthday, except that the department may apply for and the court may grant an additional one-year period of supervision past age 19 if continued supervision is in the best interests of the person and the person consents to it [PETITION THE COURT FOR CONTINUED SUPERVISION FOR AN ADDITIONAL ONE-YEAR PERIOD FOR MINORS WHO HAVE NOT RESPONDED TO TREATMENT]. The department may retain jurisdiction over a child between his 18th and 19th birthdays for the purpose of supervising his rehabilitation, if he has been placed under the supervision [IS COMMITTED TO THE CUSTODY] of the department before his 18th birthday, except that the department may apply for and the court may grant an additional one-year period of supervision past age 19 if continued supervision is in the best interests of the person and the person consents to it [PETITION THE COURT FOR CONTINUED SUPERVISION FOR AN ADDITIONAL ONE-YEAR PERIOD FOR MINORS WHO HAVE NOT RESPONDED TO TREATMENT].

* Sec. 22. AS 47.10.110 is amended to read:

Sec. 47.10.110. APPOINTMENT OF GUARDIAN OR CUSTODIAN. When, in the course of a proceeding under this chapter, it appears to the court that the welfare of a minor will be promoted by the appointment of a guardian or custodian of his person, the court may make the appointment. The court shall have a summons issued and served upon the parents of the minor, if they can be found, in a manner and within a time before the hearing which the court considers reasonable. The court may determine

whether the father, mother, or the Department of Health and Social Services shall have the custody and control of the minor. If the minor is of sufficient age and intelligence to state his desires, the court shall consider his desires [OVER 14 YEARS OF AGE, HIS DESIRES IN THE MATTER SHALL BE GIVEN CONSIDERATION BY THE COURT].

* Sec. 23. AS 47.10.120(a) is amended to read:

(a) When a child in need of aid [DEPENDENT MINOR] is committed under this chapter the court may, after giving the parent a reasonable opportunity to be heard, adjudge that the parent shall pay in a manner which the court directs a sum which will cover in full or in part the support of the child in need of aid [DEPENDENT MINOR]. When a delinquent minor is committed under this chapter the court shall order that the parent of the minor pay in a manner which the court directs a sum which will cover in full or in part the support of the delinquent minor.

* Sec. 24. AS 47.10.142(c) and (d) are amended to read:

(c) When a child is taken into custody under (a) or (b) of this section, the department shall immediately, and in no event more than 12 hours later unless prevented by lack of communication facilities, notify the parents or the person or persons having custody of the child and the court of the action and file with the court a petition alleging that the child is a child in need of aid [DEPENDENCY]

(d) The court shall immediately, and in no event more than 48 hours after being notified unless prevented by lack of transportation, hold a hearing at which the minor, if his health permits, and his parents or guardian, if they can be found, shall be permitted to be present. The court shall determine whether probable cause exists for believing the minor to be a child in need of aid [DEPENDENT MINOR], as defined in sec. 290(8) [290(3)] of this chapter. The court shall inform the minor, and his parents or guardian if they can be found, of the

Sec. 26. AS 47.10.081(b) requires the department to submit a predisposition report to the court prior to the disposition hearing and specifies what shall be included in the report.

Sec. 26. AS 47.10.081(c) The predisposition report will be made available by the court to the child, his parents, the attorneys representing the parties and the guardian ad litem not less than 10 days before the disposition hearing. Because of this 10 day requirement the adjudication and disposition hearings will always be separate proceedings.

reasons given as constituting probable cause and the reasons given as authorizing his temporary placement.

* Sec. 25. AS 47.10.150(1) is amended to read:

(1) purchase, lease or construct buildings or other facilities for the care, detention, rehabilitation and education of <u>children in need of aid</u> [DEPENDENT] or delinquent minors;

* Sec. 26. AS 47.10 is amended by adding new sections to read:

Sec. 47.10.081. PREDISPOSITION HEARING REPORTS. (a) Before the disposition hearing of a delinquent minor the department shall submit a predisposition report with a recommended plan of treatment to aid the court in its selection of a disposition, and any further information which the court may request.

(b) Before the disposition hearing of a child in need of aid the department shall submit a predisposition report to aid the court in its selection of a disposition. This report shall include, but is not limited to, the following:

(1) a statement of changes in the child's or parent's behavior, which will aid the court in determining that supervision of the family or placement is no longer necessary;

(2) if removal from the home is recommended, a description of the reasons the child cannot be protected or rehabilitated adequately in the home, including a description of any previous efforts to work with the parents and the child in the home and the parents' attitude toward placement of the child;

(3) a description of the potential harm to the child which may result from removal from the home and any efforts which can be made to minimize such harm; and

(4) any further information which the court may request.

(c) The court shall inform the child, his parents and the attor-

Sec. 26. AS 47.10.082 requires that dispositions be made in the best interests of the child and the public. The court also must consider the state's ability to take custody. The state must show that it has the ability to do more than warehouse the child.

Sec. 26. AS 47.10.083 This is a significant change. It requires the court at the annual review hearing to order return of the child to the home unless the court finds by a preponderance of the evidence that the reason for original removal from the home continues to exist; specifies the information to be provided in the review hearing. The burden is on the state to show why it should retain custody.

Sec. 26. AS 47.10.084 attempts to define the responsibilities of legal custodians and parents. (a) and (c) need to be read together, and (b) if a guardian is ever involved. These are terms which have been used and never clearly defined.

neys representing the parties and the guardian ad litem that the pre-disposition report will be available to them not less than 10 days before the disposition hearing.

(d) For purposes of this section "parents" means the natural or adoptive parents, and any legal guardian, relative, or other adult person with whom the minor has resided and who has acted as a parent in providing for the minor for a continuous period of time before this action.

Sec. 47.10.082. BEST INTERESTS OF THE CHILD. In making its dispositional order under sec. 80(b) of this chapter the court shall consider the best interests of the child and the public, and in making its dispositional order under sec. 80(c) of this chapter the court shall consider the best interests of the child; in either case the court shall consider also the ability of the state to take custody and to care for the child to protect his best interests under secs. 10 - 142 of this chapter.

Sec. 47.10.083. REVIEW HEARING INFORMATION. In the case of a child in need of aid, the child shall be returned home at the review hearing under sec. 80(f) of this chapter unless the court finds by a preponderance of the evidence that the basis upon which the child was adjudicated under sec. 10(a)(2) of this chapter continues to exist. If the child is not returned home, the court shall establish on the record:

(1) why the child was removed from the home;

(2) what services have been provided to or offered to the parents to facilitate reunion;

(3) what services were utilized by the parents to facilitate reunion;

(4) the visitation history between the parents and the child;

(5) whether additional services are needed to facilitate the

return of the child to his parents;

(6) when return of the child can be expected.

Sec. 47.10.084. LEGAL CUSTODY, GUARDIANSHIP, AND RESIDUAL PARENTAL RIGHTS AND RESPONSIBILITIES. (a) When a child is committed under sec. 80(b)(1) or (c)(1) of this chapter to the department or released under sec. 80(b)(2) or (3) or (c)(2) of this chapter to his parents, guardian, or other suitable person, a relationship of legal custody exists. This relationship imposes on the department and its authorized agents or the parents, guardian, or other suitable person the responsibility of physical care and control of the child, the determination of where and with whom the child shall live, the right and duty to protect, train and discipline the child, and the duty of providing the child with food, shelter, education, and medical care. These obligations are subject to any residual parental rights and responsibilities and rights and responsibilities of a guardian if one has been appointed. When parental rights have been terminated, or there are no living parents and no guardian has been appointed, the responsibilities of legal custody include those in (b) and (c) of this section. The department or person having legal custody of the child may delegate any of the responsibilities under this section, except authority to consent to marriage, adoption, and military enlistment may not be delegated. For purposes of this chapter a person in charge of a placement setting is an agent of the department.

(b) When a guardian is appointed for the child, the court shall specify in its order the rights and responsibilities of the guardian. The guardian shall be removed only by court order. The rights and responsibilities may include, but are not limited to, having the right and responsibility of reasonable visitation, consenting to marriage, consenting to military enlistment, consenting to major medical treat-

Sec. 27
AS 47.10.290 (2)

(2) "delinquent minor" is a minor whom the court determines is within the provisions of § 10 (a) (1) of this chapter;

This makes caring a broader more significant term than just meeting physical needs.

Sec. 28
AS 47.10.290.

(3) "dependent minor" is a minor whom the court determines is within the provisions of § 10 (a) (4), (5), (6), (7), (8), or (9) of this chapter;

(7) "child in need of supervision" is a minor whom the court determines is within the provisions of § 10 (a) (2), (3) or (6). (§ 1 art I ch 145 SLA 1957; am § 5 ch 110 SLA 1967; am §§ 5, 6 ch 27 SLA 1970)

Sec. 29
AS. 47.10.080.

(j) If the court finds the minor is a child in need of supervision it shall make any of the following orders of disposition for his supervision, care and rehabilitation:

(1) any order which is authorized under (c) of this section; or

(2) order the minor placed on probation under those conditions and limitations that the court may prescribe.

ment, obtaining representation for the child in legal actions, and making decisions of legal or financial significance concerning the child.

(c) When there has been transfer of legal custody or appointment of a guardian and parental rights have not been terminated by court decree, the parents shall have residual rights and responsibilities. These residual rights and responsibilities of the parent include, but are not limited to, the right and responsibility of reasonable visitation, consent to adoption, consent to marriage, consent to military enlistment, consent to major medical treatment except in cases of emergency or cases falling under AS 09.65.100, and the responsibility for support, except if by court order any residual right and responsibility has been delegated to a guardian under (b) of this section.

* Sec. 27. AS 47.10.290(2) is repealed and re-enacted to read:

(2) "delinquent minor" means a minor found to be within the jurisdiction of the court under sec. 10(a)(1) of this chapter;

* Sec. 28. AS 47.10.290 is amended by adding new paragraphs to read:

(8) "child in need of aid" means a minor found to be within the jurisdiction of the court under sec. 10(a)(2) of this chapter;

(9) "caring" under sec. 10(a)(2)(A) means to provide for the physical, emotional, mental, and social needs of the child.

* Sec. 29. AS 47.10.080(j) and 47.10.290(3) and (7) are repealed.

* Sec. 30. Section 3 of this Act has the effect of limiting the discretionary authority of the court to appoint a guardian ad litem under Rule 17(b), Alaska Rules of Civil Procedure, and Rules 11(a) and 15, Alaska Rules of Children's Procedure, by requiring as a condition of appointment that the court find that the best interests of the child need articulation. Further, this Act requires limitation of the duration of the appointment, limits the scope of the guardian ad litem's authority, and establishes the geographical

Sec. 34 explains how to deal with custody and the effective date of this act.

area from which the guardian ad litem may be selected.

* Sec. 31. Section 18 of this Act has the effect of adding to the court's responsibilities when holding a review under Rule 28, Alaska Rules of Children's Procedure, by requiring the court to hold a hearing upon a showing of good cause, give notice, and afford an opportunity to be heard.

* Sec. 32. Section 7 of this Act has the effect of changing Children's Rule 12 by deleting any references to "truant from school", "endanger(ing) the morals or health", "being wayward or habitually disobedient", or "uncontrolled", and has the effect of substituting the words "child in need of aid" for the terms "child in need of supervision" and "dependent" where those two terms appear in the Rules of Children's Procedure.

* Sec. 33. Section 12 of this Act has the effect of adding to the court's responsibilities under Rules 14 and 15, Alaska Rules of Children's Procedure, by requiring the court to appoint counsel for an indigent minor unless the minor has made a voluntary, knowing and intelligent waiver, and in certain cases of delinquency where there has been waiver of counsel to appoint counsel for the minor unless the court is satisfied that the minor consulted with an attorney before his waiver of counsel.

* Sec. 34. The portions of AS 47.10.080(b) and (c) in secs. 15 and 16 of this Act which specify the length of commitment to the department or probation or supervision by the department are applicable to those minors affected under former AS 47.10.080(b), (c) and (j) before the effective date of this Act so that the commitment, probation or supervision of minors by the department before the effective date of this Act shall continue, but may not exceed two years from the effective date of this Act unless two-year extensions have been granted by the court under this Act. The commitment, probation or supervision of minors with pending judicial actions under AS 47.10.010(a) on the effective date of this Act may not exceed two years unless two-year extensions have been granted by the court under this Act.

#

SIGNIFICANT ADDITIONAL

STATUTORY AMENDMENTS AFFECTING CHILDREN

It is the intent of these amendments to provide for placement of children in surroundings which are socially and culturally desirable and with persons who are able to meet their special needs. Placement of children with blood relatives will work to prevent loss of identity and self-esteem, and provide for increased family and cultural stability, security and solidarity.

(a) Subject to (e) and (f) of this section, the [THE] Department of Health and Social Services shall arrange for the care of every child committed to its custody by placing him in a foster home or in the care of an agency or institution providing care for children inside or outside the state. The department may place a child in a suitable family home, with or without compensation, and may place a child released to it, in writing verified by the parent, or guardian or other person having legal custody, for adoptive purposes, in a home for adoption in accordance with existing law.

"AS 47.10.230 is amended by adding new subsections to read:

(e) A child may not be placed in a foster home or in the care of an agency or institution providing care for children if a blood relative exists who requests custody of the child. However, the department may retain custody of the child and provide for its placement in the same manner as for other children if it makes a determination, supported by clear and convincing evidence, that the custody of the child by the blood relative will result in physical or emotional damage. In making that determination, poverty, including inadequate or crowded housing, on the part of the blood relative is not considered prima facie evidence that physical or emotional damage to the child will occur. This determination may be appealed to the superior court to hear the matter de novo.

(f) If a blood relative of the child specified under (e) of this section exists and agrees that the child should be placed elsewhere, before placement elsewhere the department shall fully communicate the nature of the placement proceedings to the relative. Communication under this section shall be made in the relative's native language, if necessary. Nothing in this section or in (e) of this section applies to child placement for adoptive purposes.

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JAY S. HAMMOND

FRANCIS S. L. WILLIAMSON, COMMISSIONER

SAM J. GRANATO, DIRECTOR

STATE OF ALASKA
THE LEGISLATURE
LEGISLATIVE AFFAIRS AGENCY

POUCH Y - STATE CAPITOL
JUNEAU, ALASKA 99811
907-465 3800

MEMEORANDUM April 12, 1977

SUBJECT: Committee Substitute for HB 204 - Changes in Original Bill
TO: Representative Terry Gardiner, Chairman House Judiciary Committee
FROM: Andrew Brown

1. Sections 4 & 5 of HB 204 were deleted pursuant to Committee direction, because they relate to criminal laws on excusable homicide and delinquency which will be dealt with in the criminal law revision.

2. Subsection (4) in Section 6 of the bill and sections 7 - 15 have been deleted from HB 204 and introduced in a new separate bill HB 419. These sections deal with adoption, adoption assistance and voluntary relinquishment of parental rights. There is now a sponser substitute for HB 419 which allows for voluntary termination of parental rights either through the court or a representative of the Department of Health and Social Services or a licensed placement agency. This is the only change in HB 419.

3. The placement of the words "the child" in Section 20 of the original bill in line 13 pg 10 has been moved over to the beginning of each phrase in paragraphs (A) - (E). This should make reading of AS 47.10.010(a)(2) easier.

4. Section 20 of the original HB 204 is further changed by defining "mental harm" in line 24 pg 10. The new language reads in (a)(2)(B) "... prevent his suffering substantial physcial harm, or mental harm as evidenced by failure to thrive, severe anxiety, depression, withdrawal, or untoward aggressive behavior or hositility toward others, and his parents are unwilling to provide the medical treatemnt." This new language should remove any vagu ness problems with the use of the term "mental harm".

5. Another change in Section 20 of the original bill is the addition of the word "either" in line 2 pg 11 after the word "abused". This is to make clear that the sexual abuse covered in (D) can be the result of three different situations.

6. In line 19 pg 22 of the original bill the three days has been changed to 10 days.

These were the only changes requested by the Judiciary Committee in its March 26th hearing at which I testified on HB 204.

File
Ch Laws -
Other
States

CHILDREN IN MASSACHUSETTS --- AT THE TOP OF THE LIST

THE GOVERNOR'S RECOMMENDATIONS FOR THE

1974 - 75 CHILDREN'S BUDGET

FACT SHEET

A Major Commitment to Children

The 1974-75 Children's Budget will be submitted by Governor Sargent on January 23rd. The budget includes:

1. a recommendation that 20.4 million new dollars be committed to programs and services to children;

2. the funding of thirty-nine area citizen Councils for Children in the amount of $150,000 for each Council to develop or continue new community-based services for special needs children and to provide each Council with some staff support.

These funding recommendations place children as the single highest priority for service expansion in the 1974-75 budget. It also represents the highest single increase in the appropriation for new programs in human services in recent years.

A Major Accomplishment for Children's Advocacy Groups

The funds and programs recommended in this budget stem from documented reports and studies from a number of citizen commissions and task forces including the Governor's Advisory Committee on Child Development, the Governor's Commission on Child Abuse, and the Governor's Commission on Adoption and Foster Care. It also represents the culmination of untiring efforts of literally dozens of child advocacy groups over the past years. Finally, the budget reflects the effectiveness of the Office for Children as a coordinating agency and as a voice for children within the governmental process.

A Major Commitment to Local Decision-Making --- The Children's Councils

The Office for Children's most important legislative mandate is to assure parents a decisive role in the planning, operation, and evaluation of programs which aid families in the care of children. In its first year, the Office has helped organize the thirty-nine area Councils for Children to enable the Office to develop and coordinate children's services according to priorities set at the local level. Council for Children members -- parent-consumers and providers representing every children's age group and service need -- have played a significant role in:

1. determining how interdepartmental Project for Children monies are spent in their area;

2. developing, with the Office, area information, referral and advocacy programs for individual children in need of services;

3. setting priorities for the 1975-76 Children's Budget by systematically feeding their local priorities into central Office for Children.

BUDGET DETAILS

The 1974-75 Children's Budget is a $20.4 million package of items representing new and improved services for children. These items are part of the state budget which the Governor is submitting to the Legislature for the upcoming fiscal year. They represent services provided by the Office for Children and the Departments of Mental Health, Public Health, Public Welfare and Youth Services.

New Area Programs -- $4,231,750 increase over 74

Office for Children - $3.131.750

The Office for Children budget includes thirty-nine area allocations which total $5.85 million and will allow the Office for Children, upon the recommendation of Councils for Children, to continue programs begun this year and to develop new community based programs for special needs children. The new monies requested will also provide staff support for these volunteer citizen's Councils.

Department of Mental Health - $1,100,000

For the first time, the Department of Mental Health budget commits $1.1 million for developing local services for children recommended by Mental Health and Retardation Area Boards.

New and Expanded Day Care Services -- $5,334,540 increase over 74

Department of Public Welfare - $1,750,000

New funds have been earmarked to increase by about 600 across the state the number of children served in day care programs funded through the Department of Public Welfare. Since this money would be matched by federal funds under Title IV-A of the Social Security Act, children eligible for these services would be those of families on public assistance.

Department of Public Welfare - $1,984,790

Expansion in state funds available for day care under the donated funds program would provide day care for an additional 600 children.

Department of Public Welfare - $1,000,000

A new pilot program, funded through the Welfare Department, would for the first time provide day care to children of working families on a sliding fee scale basis.

Office for Children - $100,000

A small number of staff would be added to the Office for Children licensing unit in order to license and provide technical assistance to the growing number of day care centers and family day care programs.

Department of Public Health - $371,000

Three new day care centers for physically handicapped children would be created in parts of the state like Western Massachusetts and the Fall River/New Bedford area, where such programs presently do not exist. With the creation of these programs, a total of 200 physically handicapped pre-schoolers would be served in six centers across the sta .

Department of Public Health - $74,960

The Baylies Nursery Program in Canton, one of the three existing centers for physically handicapped pre-school children, is unique in that it also includes non-handicapped children. Begun as a pilot program, this nursery would gain permanent status in the new budget as part of the Massachusetts Hospital School.

Department of Mental Health - $53,790

By upgrading the salary status of aides in clinical nurseries for retarded children, the budget would guarantee each of the 112 programs across the state two trained staff persons for every twelve children, many of whom are multiply-handicapped.

Community-Based Care - $8,367,965 increase over 74

Department of Public Welfare - $2,200,000

Proposed new rates for foster care are significantly higher than the current rate of $22 - $25 per week, or $35 - $50 for the care of children with special needs.

New Proposed Rates

For children age 0 - 5	$22 per week
For children age 6 - 10	$32 per week
For children age 11+	$42 per week
With special needs	$60 per week

Department of Public Welfare - $452,000

Increased funds would cover a number of new foster care services, including liability insurance for foster families. The funds would also create a pilot specialized foster care program, providing foster homes for the first time for 56 children across the state.

Department of Public Welfare - $18,825

The Massachusetts Adoption Resource Exchange, which has had considerable success in finding homes for "hard-to-place" children, would gain staff who would publicize the need for adoptive homes.

Office for Children - $58,159

A new Family Resource Exchange, modeled after the Massachusetts Adoption Resource Exchange and administered by the Office for Children, would pool state and private agency publicity and recruitment efforts, and would increase the number of available foster homes.

Department of Public Welfare - $100,000

A new specialized foster home coordination unit would be created to train foster parents in caring for children with special needs, including retarded, physically handicapped, and emotionally disturbed children.

Department of Mental Health - $243,316

A 1973 agreement between the Departments of Mental Health and Public Welfare and the Office for Children paved the way for providing community care for 125 mentally retarded children now in state institutions. Funds in the new budget would provide these children with developmental day services in the community, where they will live in foster homes or small group residences.

Department of Public Welfare - $500,000

The Division of Family and Children's Services would for the first time provide families above IV-A income limits with counseling and homemaker services to help prevent the need for placing children in foster care. The Governor's Commission on Adoption and Foster Care strongly recommended the increased availability of these supportive services as a means of preventing the breakup of families.

Department of Public Welfare - $1,115,505

Protective services for abused and neglected children would be expanded by an increase in the donated funds program.

Department of Public Welfare - $84,601

Funds in the new budget would provide additional child welfare workers needed to cover anticipated new foster care cases.

Department of Public Welfare - $660,000

Increases in the donated funds program would allow additional children to benefit from community-based drug rehabilitation services and developmental services for the retarded.

Department of Mental Health - $245,559

A new program aimed at providing early screening and supportive services for retarded infants up to age 3 would be created in the Department of Mental Health. Teams consisting of a variety of specialists headed by a social worker would provide services and training to children and parents in their homes.

Department of Youth Services - $1,920,000
Increase in purchase of service account will cover cost increases and provide selective expansion of programs in the Department of Youth Services.

Department of Youth Services - $125,000
Funds to staff a new fiscal control system planned by the Department of Youth Services are aimed at putting the agency on a firm financial footing.

Department of Mental Health - $500,000
The 20-acre campus of the former Northampton School for Girls is the site of a planned interdepartmental children's center serving Western Massachusetts. This new center would provide a wide variety of day and short-term residential services for children with special needs. The Office for Children and the Department of Mental Health would jointly coordinate the development of these privately-run programs according to recommendations made by a broadly-based task force made up of both parents and professionals in the area.

Department of Public Health - $15,000
Recent legislation authorized the creation of a state-wide screening program to detect deafness in children thought to be at risk. The fiscal year 1975 budget would allocate additional funds to carry out this program in the Department of Public Health, beginning in 1974.

Office for Children - $130,000
The Office for Children would purchase inter-regional programs of state-wide significance for children with special needs not being served by state agency programs.

Residential Programs -- $2,468,000 increase over 74

Department of Public Welfare - $500,000
Funds in the new budget would cover rate increases in group homes and institutional programs for children separated from their families.

Department of Public Welfare - $288,000
Additional money is earmarked in the budget to provide foster parents with an increased allowance for clothing and hospital care to keep up with today's costs.

Department of Public Health - $265,000

The new Canton Nursery Program for multiply-handicapped children up to age 5 would become a permanent Public Health Department program in the upcoming fiscal year. Begun this spring with funding from the Office for Children, the program includes a month's stay for child and parent at the Massachusetts Hospital School, an evaluation of the child's immediate and long-term rehabilitative needs, training of parents to fulfill these needs at home, and follow-up services after the child leaves. The goal of the Canton program, which serves up to 100 children per year from all over the state, is to enable multiply-handicapped children to avoid institutionalization.

Department of Public Health - $395,000

Increases in the Massachusetts Hospital School budget would increase from 175 to 200 the number of children served at any one time, would supply new equipment for the brace shop, and expand other services. The School provides an extensive variety of medical, therapeutic, and educational services for physically handicapped Massachusetts children of all ages.

Department of Mental Health - $1, 020,000

Funds totalling $3 million are being requested by the Governor for needed improvements in the state's schools. Slightly over $1 million of this amount will go toward additional direct services and improved living conditions for children in the state schools.

TOTAL CHILDREN'S BUDGET - $20,402,255*

*The total of $20,402,255 requested is exclusive of additional funds provided to implement Chapter 766, the Special Education Act, which takes effect on September 1, 1974.

CRITERIA FOR EVALUATING NATIONAL CHILD DEVELOPMENT LEGISLATION

prepared by the

National Association of State Directors of Child Development

I. Type of Service. We believe that national child development legislation, if it is to be most effective, should provide for the following direct and support services for children. In some instances, services for the child are delivered to the parent or parents.

A. Direct services

1. Child care
2. Health care
3. Nutrition
4. Education
5. Legal services and child advocacy
6. Social services
7. Mental Health services

B. Support services

1. Transportation
2. Training
3. Facilities
4. Research and Development
5. Planning, Coordination and Technical Assistance
6. Monitoring and Evaluation

II. Eligibility. We believe that eligibility guidelines written into child development legislation should:

A. focus primarily on the prenatal through five year old period

B. provide programs for children above five years of age with special need; not now being met

C. provide for the unmet needs of all children regardless of economic level, race or creed

III. Administration and Funding. The following conditions should, in our opinion, be written into national child development legislation.

A. Funds should flow to the States

B. States should provide a comprehensive state plan for child development which would:

1. contain an assessment of needs and resources
2. address federal priorities if state assessment indicates that federal priorities are not being met
3. address the question of interagency coordination
4. include a process for the involvement of local private and public agencies and parents.

C. In the absence of state action, local governmental units may submit plans

D. All state agency plans for receipt of funds for child development services must tie into the state comprehensive plan for child development.

JBHSr/de
12-12-73

COUNCILS FOR CHILDREN

State Government and Community Decision-Making

OFFICE FOR CHILDREN
120 Boylston Street
Boston, Mass. 02116

January, 1974

Of all the components that make up the Office for Children, the key ingredient to its uniqueness, and ultimately its effectiveness, is its community base. The formation of 39 Councils for Children, each representing a cross-section of children's interests in every area in the state, has been the Office's first priority. With roughly two dozen community organizers, drawn from the various "children's constituencies" the Office hopes to attract, the effort to bring together coalitions of parents, teenagers, and children's service professionals began in early 1973. These staff community representatives began by contacting every identifiable group related to children and drawing them together as an organizing committee. A publicity campaign, complete with leaflets, mailings, newspaper and radio announcements, and posters, summoned to a public organizing meeting a diverse range of people whose common denominator is their active concern for children and their determination to have a say in the state's policies affecting kids.

The general recruitment meeting, at which Office for Children director David Liederman explained the goals of the Office for Children and the possibilities open to a vocal Council for Children, is followed in each area by an election of the Council's first executive board. Aside from the Office's stipulation that at least half of the board be consumers (persons with no financial interest in providing children's services) and that the board be a representative group elected in an open process, Council members are free to design a board structure in whatever way they believe is most representative of children's interests --- geographically and in terms of children's ages, special needs, types of services required, and sometimes ethnic background. The elections themselves are frequently colorful events. Parents, teachers, social workers, welfare mothers, day care advocates, nurses, foster parents, teenagers, local government officials, and other people representing children's concerns converge to mark their ballots for candidates for their Council's decision-making board.

The Councils for Children are now in various stages of formation. Some held board elections as early as last spring. In other parts of the state, community representatives have just begun the process of informing their cities and towns and neighborhoods about the Office for Children and the prospects of forming a Council. The Councils already organized vary widely: some are already sophisticated, vocal and energetic, others are feeling their way along. Some have experienced the growing pains that come when factions that have traditionally competed for limited social service resources fall into competing for control of an organization; others have felt the excitement of building a unique coalition of diverse members feeling their own strength and working for a common goal.

There is such a thing as the politics of children's services; this has existed since the first orphanages and child welfare organizations. The creation of an Office for Children was really an acknowledgement of the political realities involved in making children's services high among the state's priorities. Together, the Office for Children and the Councils are working as children's advocates both within and outside government. How successfully they will each function still remains to be seen.

For the Office for Children, the development of the Councils is both exciting and bewildering. Thousands of parents and professionals mobilized around children's issues could form an army -- or a monster (depending on where you are coming from!). And existing state government institutions -- the large service-providing agencies with whom the Office for Children works regularly on a whole array of issues -- have never felt comfortable with either an army or a monster. Whatever from the Councils finally take, however, there are already some early signs that they are putting behind children's issues some new weight that an Office for Children, operating within the constraints of the bureaucracy, could never muster on its own.

THE MAKING OF A TYPICAL COUNCIL FOR CHILDREN -- HIGHLIGHTS

The Organizing Process

The Greater Springfield Council for Children, serving Springfield and the outlying communities of Agawam, Hampden, East Longmeadow, Longmeadow, West Springfield and Wilbraham, formed during the spring of 1973. The recruitment process was led by an Office for Children community representative, a young black woman who had been the former assistant director of the community Head-start program. The area's Community Coordinated Child Care (4-C) Committee, advocates of early childhood education, served as the nucleus of an organizing committee that began to reach out and include parents and professionals concerned with physically handicapped, emotionally disturbed, mentally retarded, learning disabled, and perceptually handicapped children of all ages, needs, and abilities. The group grew to include a total of almost 300 men, women, and young people interested in developing the delivery of social, medical, educational, developmental, health, and mental health services benefiting children and teenagers in the Springfield area.

The election of the board, in which 96 candidates competed for 35 seats, was held on June 27. No sooner had the winners been announced in the next morning's newspaper, than the Council experienced its first controversy -- a losing candidate challenged the election, claiming that the rules had not been adequately explained. The challenger failed to convince either the Council's organizing committee or the Office for Children that the election had proceeded improperly, however, and the elections results stood.

Since the summer, the Council has taken up several specific projects, some required by the legislation that created the Office for Children, others stemming from issues of concern to Springfield area residents.

Proposal Review

Every Council for Children is responsible for designing its own procedures for reviewing and approving the program proposals for funding through the Office for Children. The proposal review committee of the Greater Springfield Council carefully reviews the written proposals submitted to the Council by area agencies applying for Office for Children funding. If the proposed program is consistent with the Council's priorities for expanded services for children with special

needs, the program is then submitted to the Council board for approval.

The Springfield proposal review committee has already established a reputation for its tough review procedures and for examining potential programs with a fine toothed comb. The committee has upheld the Council's belief that its purpose is not to simply fund every good program that comes along, but to stretch the Council's slim resources -- $85,000 this fiscal year -- by coordinating as much as possible existing funding in the community. For example, the YWCA submitted to the Council a request for funds to buy equipment for the youth program. The Council arranged between the agency and a nearby community center talks which led to the sharing not only of equipment but also program personnel, and thus serving more children. Thus the Council for Children was able to satisfy the agency's need for supplies not through the expenditure of funds but by helping groups talk to one another -- and the Council views this role as coordinator as important as any other.

The Council has reserved for funding only those programs which provide unique services which could not be funded by any other agency and which are community priorities. One such program deals with infant care, and is operated by an agency already experienced in providing day care for preschoolers. Such a service was determined to be a priority because of an almost total lack of facilities for caring for infants, and because of the relatively high cost of providing such care with a high child/staff ratio. Funds to begin the project had already been committed by the state Department of Public Welfare, by the Junior League, and by a private agency that provides services for pregnant teenagers. The Council saw an opportunity for the Office to participate in a joint community effort to provide a badly needed service, and agreed to become a sponsor of the program. The center now provides care for up to 16 infants, children of low-income parents who would not otherwise be able to properly care for them while working during the day.

A second program which the Council approved for funding through the Office for Children is a community center whose existence had been threatened by cutbacks in the Model Cities program. The center, located in the city's Hill Area which is a priority in terms of service needs for children, has been offering a variety of day and after-school programs for children from pre-school age all the way through their teens. The Model Cities cutbacks had particularly affected those children who are bussed to schools in distant neighborhoods. The center had been providing these children with transportation from school to the center, but the cutbacks discontinued this service along with some other programs the center offered. Council for Children approval of only $1600, supplementing funds from other sources, insures the survival of the community center.

Monitoring and Evaluation

This Council committee, although its task seems perfunctory, has already been responsible for upgrading the quality of service delivery to children in the Springfield area. The committee works closely with the proposal review committee and examines programs approved for funding by the Council. In a couple of cases the committee had found weaknesses which made the program inconsistent with the Office for Children or Council requirements, and its evaluation brought about constructive changes -- such as increased involvement of parents, for instance -- in the program. The committee has now set up a liaison person in contact with each program funded by the Council, and is establishing a system for monitoring all day care programs funded by the Department of Public Welfare.

Child Abuse

The Council established a committee to tackle the very difficult problem of child abuse and neglect in the Springfield area. Composed of both parents and protective service agency representatives, the committee has had an active role finding speedy placement of children at risk in services suited to their special needs and those of their families. A program for abused and neglected children is funded by the Council and serves up to 12 infants with the most urgent service needs. Because the demand for services surpassed the capacity of this program, the committee worked to establish a day program to serve additional children. The committee's most challenging but potentially most far-reaching project is a joint effort with the Office for Children aimed at pooling the efforts, resources, and information of agencies capable of responding to child abuse. These agencies, the Council for Children, and the Office for Children's information and referral staff have made initial plans for a system in which doctors, hospitals, agencies, and others who know of abused or neglected children would report cases to a single telephone number where trained personnel would quickly and reliably assign responsibility to the appropriate agency for efficient response. A cross-reference system would immediately identify children who have been served previously by different medical or social service agencies, and would alert a responding agency to any history of child abuse in the family.

Lead Paint Poisoning

A Council for Children committee, headed by a concerned parent, has been formed to try to break the "vicious bureaucratic circle" the Council feels has stifled the action needed to prevent lead paint poisoning in Springfield, particularly in public housing. Armed with statistics collected by a pediatrician who sits on the Council, the committee is working with representatives of state and city agencies to collectively establish roles and responsibilities with regard to public information and preventive testing.

Chapter 766

A new state Special Education Law requiring local school systems to provide special education for all children who need it will be implemented next September. This controversial but progressive and potentially far-reaching legislation poses many challenges for schools, service providers, and children's advocates. A Council for Children committee, including a number of parents of children with learning disabilities, has formed to work out the role the Council will play in the next year with regard to Chapter 766. Chaired by a parent of a child in a residential school, the committee is studying the regulations for the law's implementation in an effort to plan Council strategy for insuring that adequate programs are developed and that all Springfield special needs children will benefit from the services to which they are entitled.

Other Council Committees:

A legislation committee is concerned with bills pending state legislation related to children.

A publicity and public relations committee is responsible for informing members about Council activities and children's issues through a newsletter, and informing the Springfield community through the media.

A foster care and adoption committee is concerned with recruitment of parents and reforming the foster care and adoption system.

A standards and regulations committee plan to act as a liaison between the Office for Children licensing staff and the community, and will work to interpret new regulations to service providers and parents.

In the Matter of E. M. D., a Minor Child.
No. 1524.

Supreme Court of Alaska.
Nov. 15, 1971.

The Superior Court, Third Judicial District, Harold J. Butcher, J., found minor to be a child in need of supervision and ordered institutionalization of minor, and appeal was taken. The Supreme Court, Rabinowitz, J., held that Superior Court exceeded its authority in ordering the institutionalization of minor who was found to be a child in need of supervision and since child was not found to be a delinquent minor no legal basis existed for her incarceration.

Dispositive provisions of Superior Court's judgment set aside and matter remanded.

1. Infants ⇐16.2, 16.3
A child can be declared a dependent minor, a child in need of supervision, or a delinquent minor. AS 47.10.080(b) (1), 47.10.290(2, 7).

2. Infants ⇐16.12
Superior Court exceeded its authority in ordering the institutionalization of minor who was found to be a child in need of supervision and since child was not found to be a delinquent minor no legal basis existed for her incarceration. AS 47.10.080(b) (1), 47.10.290(2, 7).

3. Infants ⇐16.12
Only instance authorizing institutionalization or incarceration of minor is when child has violated laws of state or any of its political subdivisions and in turn has been adjudged a delinquent minor. AS 47.10.080 (b) (1).

4. Infants ⇐16.4
Notions of benevolent protective policies for children cannot be used to validate departures from positive law relating to adjudicative and dispositive phases of children's proceedings. AS 47.10.010(a) (2, 3, 6), 47.10.080(b) (1), (c) (1), (j), 47.10.290 (2, 7); Rules of Children's Procedure, rule 12(b).

5. Infants ⇐16.12
Department of Health and Welfare does not possess authority to institutionalize any minor, including one who has been declared a child in need of supervision and who has been committed to its custody, and statute prescribes conditions of confinement after a court has lawfully determined that a child should be confined in an institution. AS 22.20.022, 47.10.080(c) (1), (j), 47.10.190.

6. Infants ⇐16.14
Right of appeal existed from dispositive order that minor, who had been adjudged a child in need of supervision, should be institutionalized. AS 22.05.010, 47.10.080(i), 47.10.290(7); Supreme Court Rules, rules 6, 23.

Herbert D. Soll, Public Defender, Bruce A. Bookman, Asst. Public Defender, Anchorage, for the minor child.

John E. Havelock, Atty. Gen., Juneau, Seaborn J. Buckalew, Jr., Dist. Atty., Robert L. Eastaugh, Asst. Dist. Atty., Anchorage, for State of Alaska.

Before BONEY, C. J., and DIMOND, RABINOWITZ, CONNOR, and ERWIN, JJ.

OPINION

RABINOWITZ, Justice.

In this appeal we are called upon to decide whether a minor who has been adjudged a child in need of supervision can be institutionalized under our children's code.

[1] Both Alaska's statutes relating to children's proceedings and the rules of procedure governing such proceedings establish three distinct categories of children. Thus, a child can be declared a dependent minor, a child in need of supervision, or a delinquent minor. AS 47.10.290(7) defines a "child in need of supervision" as a minor whom the court determines is within the provisions of AS 47.10.010(a) (2), (3),

... Those provisions include a minor

... by reason of being wayward or ... ally disobedient is uncontrolled by ... parent, guardian, or custodian;

... is habitually truant from school or ... me, or habitually so conducts himself ... to injure or endanger the morals or health of himself or others;

• • •

... associates with vagrant, vicious or immoral people, or engages in an occupation or is in a situation dangerous to life or limb or injurious to the health, morals, or welfare of himself or others.[1]

Regarding the dispositive phase of children's proceedings, Alaska's children's code provides that if the court determines the minor is a child in need of supervision, it shall make any of the following orders of disposition regarding the minor's supervision, care, and rehabilitation:

(1) any order which is authorized under (c) of this section; or

(2) order the minor placed on probation under those conditions and limitations that the court may prescribe.[2]

Under section (c) of AS 47.10.080, the court is empowered to order the minor committed to the Department of Health and Welfare or order the minor released to his parents, guardian, or some other suitable person.[3]

In the case at bar, the superior court found that E. M. D., a 14-year-old runaway girl, was a child in need of supervision. The court's findings were made after several hearings before a master and the superior court, and were based largely upon the master's findings of fact and recommendations. In the dispositive portion of the trial court's judgment, it was ordered that E. M. D. be

> committed to the custody of the Department of Health and Welfare for an indeterminate period * * *.

The court further ordered that E. M. D. be placed by the Department in a correctional or detention facility as defined in AS 47.10.080(b) (1), to be held in that facility until released therefrom upon a showing by an officer of the Division of Corrections that the minor has completed a program of rehabilitation and has been amenable thereto, and that the Court has been advised in writing that such release is contemplated.

[2] In this appeal it is argued that the superior court exceeded its authority in ordering the institutionalization of E. M. D. who was found to be a child in need of supervision. We are in agreement with the minor's contentions. As mentioned at the outset, Alaska's pertinent statutory provisions and procedural rules distinguish between categories of children for purposes of administering our children's laws. Of controlling significance here is that each class or category man... distinct differences regarding the p... sible content of any dispositional o... e trial court can enter.

[3] Study of our children's laws leads to the conclusion that the legislature has authorized institutionalization only where the child is found to be a delinquent minor. The term "delinquent minor" is defined as a

1 *Compare* R. 12(b), Rules of Children's Procedure.

2 AS 47.10.080(j).

3 AS 47.10.080(c) reads in part as follows:

> (1) order the minor committed to the department for an indeterminate period of time not to exceed the date the minor becomes 19 years of age, except that the department may petition the court for continued supervision for an additional one-year period for minors who have not responded to treatment;
>
> (2) order the minor released to his parents, guardian, or some other suitable person; if the court releases the minor, it shall direct the department to supervise the care and treatment given to the minor; the department's supervision may not extend past the date the minor becomes 19 years of age, except that the department may petition the court for continued supervision for an additional one-year period for minors who have not responded to treatment. • • •

491 Digest

child who has violated a law of the state, or an ordinance or regulation of a political subdivision of the state.[4] As to the appropriate disposition once the child has been determined to be a delinquent minor, the legislature has in part provided that the court shall order the minor committed to the Department of Health and Welfare for an indeterminate period and

> may direct the minor's placement in a juvenile correctional school, detention home, or detention facility designated by the department. * * *[5]

Thus the only instance under our children's laws authorizing institutionalization or incarceration is when the child has violated the laws of the state, or any of its political subdivisions, and in turn has been adjudged a delinquent minor. Since the runaway child in the case at bar was found to be a child in need of supervision, not a delinquent minor, no legal basis existed for her incarceration.[6]

[4] In reaching this conclusion, we have rejected the state's contention that the trial court's order of incarceration is sustainable in light of the legislature's broad policy declaration to the effect that protection of children is the paramount purpose governing its enactment of laws pertaining to children's courts and institutions.[7] In another context we recently held that the benevolent social theory supposedly underlying children's court acts does not furnish justification for dispensing with constitutional safeguards.[8] As to the case at bar, it is equally appropriate to note that notions of benevolent protective policies cannot be used to validate departures from positive law relating to the adjudicative and dispositive phases of children's proceedings.

[5] We also reject the suggestion that the Department of Health and Welfare possesses the authority to institutionalize any minor, including one who has been declared a child in need of supervision, who has been committed to its custody. We find it unreasonable to construe our children's statutes in a manner which would result in the grant to the Department of Health and Welfare of broader powers of commitment than possessed by the trial court.[9] In our view the statute relied upon by the state for this construction prescribes conditions of confinement after the court has lawfully determined that a child should be confined in an institution.[10]

4. AS 47.10.290(2).

5. AS 47.10.080(b) (1).

6. Cf. Fish v. Horn, 14 N.Y.2d 905, 252 N.Y.S.2d 313, 200 N.E.2e 857 (1964).

7. AS 47.10.280 provides:

> The purpose of this chapter is to secure for each minor the care and guidance which is as nearly as possible equivalent to that which should be given him by his parents. The principle is recognized that minors under the jurisdiction of the court are wards of the state, subject to its discipline and entitled to its protection and that the state may act to safeguard them from neglect or injury and to enforce the legal obligation due to them and from them.

8. RLR v. State, 487 P.2d 27, 30-31 (Alaska 1971).

9. The state argues that even if the trial court lacks power to institutionalize a child in need of supervision, it can order the child committed to the Department of Health and Welfare which in turn can place the child in a detention facility. The argument is that under AS 47.10.080(c) (1) a minor can be committed to the Department of Health and Welfare. The state argues that AS 47.10.190 permits the department to institutionalize any minor committed to them. AS 47.10.190 reads as follows:

> When the court commits a minor to the custody of the department, the department shall arrange to place the juvenile in a detention home, facility another suitable place which the department designates for that purpose. A juvenile detained in a jail or similar institution at the request of the department shall be held in custody in a room or other place apart and separate from adults.

10. We note with approval the state's candor in briefing the issues in this case. The state, in its brief, initially conceded that if this court looks only to the express language of AS 47.10.080(j) and 47.10.080 (c), a strong argument can be made that the judgment entered below exceeded the

[6] One additional aspect of this appeal should be discussed for we think it appropriate that an explanation be given as to why this matter has been treated as an appeal rather than coming before us for review. Counsel for the minor sought to invoke our discretionary review jurisdiction in the belief that appeal was unavailable for two reasons. First, he cites In re White, 445 P.2d 813, 815 (Alaska 1968) (Rabinowitz, J., concurring). There this court interpreted AS 22.20.022, which allows peremptory disqualification of a superior court judge in a civil or criminal action. A majority of the court in *White* said:

> While juvenile proceedings have some of the characteristics of both civil and criminal actions, we hold that they are basically different from both, and that the words 'civil or criminal' as used in AS 22.20.022 must be strictly construed. The trial judge was correct in holding that peremptory challenge procedure applied only to civil and criminal actions and not to juvenile proceedings.

Counsel for the minor reads *White* as requiring the filing of a petition for review because the final judgment rule embodied in Supreme Court Rule 6 applies only to civil or criminal actions.[11] Such an expansive reading of *White*, assuming without deciding its continued validity in light of several of our recent decisions which vindicated certain constitutional and procedural rights of children in children's proceedings,[12] would result in precluding any review of children's decisions. For the rules which delineate this court's review jurisdiction limit such jurisdiction to "any order or decision of the superior court, not otherwise appealable under Rule 6, in any action or proceeding, civil or criminal. * * *"[13] Adoption of counsel's interpretation of *White* would also conflict with AS 22.05.010 which places final appellate jurisdiction in all cases in the supreme court.[14] We think *White* should be limited to its interpretation of the peremptory disqualification statute. On the other hand, we hold that the right to appeal from the type of disposition order which was entered in this children's proceeding has been clearly established by the legislature. In this regard, AS 47.10.080(i) provides:

> A minor, his parents or guardian acting on his behalf, or the department may appeal a judgment or order, or the stay, modification, setting aside, revocation, or enlargement of a judgment or order issued by the court under this chapter.

The dispositive provisions of the superior court's judgment are set aside and the matter is remanded for such further disposition proceedings as are necessary and the entry of an appropriate disposition order.

court's disposition jurisdiction. The final portion of the state's brief concludes on the following note:

> Nevertheless, it is the belief of the Department of Law that the judgment ordering petitioner detained exceeded the authority of the court below. This belief is founded on the State's concern that courts should comply with their granted powers even where, as here, the factual circumstances cry out for a disposition beyond the fingertips of the lower court.

11. In regard to what may be appealed, Supreme Ct.R. 6 states:

> An appeal may be taken to this court from a final judgment entered by the superior court or a judge thereof in any action or proceeding, civil or criminal, except that the state shall have a right to appeal in criminal cases only to test the sufficiency of the indictment or information.

12. Doe v. State, 487 P.2d 47 (Alaska 1971); R.L.R. v. State, 487 P.2d 27 (Alaska 1971).

13. Supreme Ct.R. 23.

14. For a discussion of another facet of this court's final appellate jurisdiction *see* State v. Browder, 486 P.2d 925, 929–933 (Alaska 1971).

POSITION PAPER/Department of Health and Social Services

Position Paper

on

Senate Bill No. 106

"An Act relating to children's laws and related judicial proceedings; changing the court's responsibilities and authority under Children's Rules 11(a), 12(a) and (b), 14, 15, 21, and 28, and Rule of Civil Procedure 17(b)."

This Bill constitutes recommendations of the Children's Code Revision Task Force made as the result of meetings held between August 1975 and December 1976. A section by section analysis prepared by the Attorney for the Task Force, is attached.

The changes proposed in the Bill are, in our judgement, appropriate both in the interest of children and their families and in the interest of clarifying intent, roles and responsibilities.

The Department supports the Bill.

Recommended by: _____ Date: 2/9/77
Director of Social Services

_____ Date: 3/1/77
Director of Corrections

Approved by: _____ Date: 2/15/76
for Commissioner
Department of Health & Social Services

Comments by Governor's Office:

By: _____ Date: _____

I. REQUEST

Bill/Resolution No. Senate Bill No. 106

Title An Act relating to children's laws and related judicial prodeedings

Requested by _____ Date 2/8/77

II. FISCAL DETAIL

Agency Affected Department of Health & Social Services

Program Category Affected Division of Social Services

Budget Request Unit(s) Affected Program Services

EXPENDITURES (Thousands of Dollars)

	FY 77	FY 78	FY 79	FY 80	FY 81	FY 82
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL	1.2	1.2	1.3	1.4	1.5	1.6
400 COMMODITIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC.						
TOTAL	1.2	1.2	1.3	1.4	1.5	1.6

FUNDING (Thousands of Dollars)

GENERAL FUND	1.2	1.2	1.3	1.4	1.5	1.6
FEDERAL FUNDS						
OTHER (Specify)						

POSITIONS

FULL TIME						
PART TIME						
TEMPORARY						

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

Section 13 of the Bill, requiring the Department to disseminate information throughout the State about the availability of adoptable children and financial assistance to eligible adopting famlies, constitutes the most significant new cost item in the Bill. Funds will be required for printed material, radio and TV announcements and newspaper ads.

IV. DATE 2/8/77 PREPARED BY Sam J. Granato, Director

AGENCY Division of Social Services

PHONE 465-3170

Original: Legislative Finance

cc: Budget and Management

Prime Sponsor (First Legislator Named)

33-001 (Rev. 10/76)

But such provision involves only persons whose presence is not desired by child.—The area of discretion in the rule, where the court may refuse to open the hearing, involves persons whose presence is not desired by the child. RLR v. State, Sup. Ct. Op. No. 706 (File No. 1156), 487 P.2d 27 (1971).

It is an abuse of discretion for the court to refuse admittance to individuals whose presence is favored by the child, except in special circumstances such as the unavailability of a courtroom sufficiently large to hold all the individuals whose presence is sought. RLR v. State, Sup. Ct. Op. No. 706 (File No. 1156), 487 P.2d 27 (1971).

If the child or his guardian ad litem wants the press, friends, or others to be free to attend, then the hearing must be open to them. RLR v. State, Sup. Ct. Op. No. 706 (File No. 1156), 487 P.2d 27 (1971).

As children are guaranteed the right to a public trial by the Alaska Constitution. RLR v. State, Sup. Ct. Op. No. 706 (File No. 1156), 487 P.2d 27 (1971).

Due process requires that children have the right to a public trial by jury where they are charged with acts which would be a crime if committed by an adult. John Doe v. State, Sup. Ct. Op. No. 707 (File No. 1240), 487 P.2d 47 (1971).

The fundamental constitutional right of public trial by jury must be afforded children in delinquency adjudication proceedings, in spite of the possible interference with the benevolent motives of the children's court system which have, in the past, justified denial of those rights. John Doe v. State, Sup. Ct. Op. No. 707 (File No. 1240), 487 P.2d 47 (1971).

The reasons for the constitutional guarantees of public trial apply as much to juvenile delinquency proceedings as to adult criminal proceedings. RLR v. State, Sup. Ct. Op. No. 706 (File No. 1156), 487 P.2d 27 (1971).

Delinquency must be proved beyond a reasonable doubt under the due process clause of the 14th amendment. RLR v. State, Sup. Ct. Op. No. 706 (File No. 1156), 487 P.2d 27 (1971).

Sec. 47.10.080. Judgments and orders.

(b) If the court finds that the minor is delinquent, it shall

(1) order the minor committed to the Department of Health and Social Services for an indeterminate period of time not to extend past a specified date or in any event past the day the minor becomes 19, except that the department may petition the court for continued supervision for an additional one-year period for minors who have not responded to treatment; the department shall place the minor in the juvenile facility which the department considers appropriate and which may include a juvenile correctional school, detention home, or detention facility; the minor may be released from placement or detention and placed on probation on order of the court and may also be released by the department, in its discretion, under § 200 of this chapter; or

(2) order the minor placed on probation, to be supervised by the department, and release him to his parents, guardian, or a suitable person; if the court orders the minor placed on probation, it may specify the terms and conditions of probation; the probation may be for an indeterminate period of time, not to extend past a specified date and in no event past the day the minor becomes 19, except that the department may petition the court for continued supervision for an additional one-year period for minors who have not responded to treatment.

(c) If the court finds that the minor is dependent, it shall

(1) order the minor committed to the department for an indeterminate period of time not to exceed the date the minor becomes 19 years of age, except that the department may petition the court for continued supervision for an additional one-year period for minors who have not responded to treatment;

(2) order the minor released to his parents, guardian, or some other suitable person, and, in appropriate cases, order the parents, guardian, or other person to provide medical or other care and treatment; if the court releases the minor, it shall direct the department to supervise the care and treatment given to the minor; the department's supervision may not extend past the date the minor reaches majority, except that the department may petition the court for continued supervision for an additional one-year period for minors who have not responded to treatment; or

(3) by order, terminate parental rights and responsibilities of one or both parents and commit the child to the department or to a legally appointed guardian of the person of the child, if one of the following conditions exists:

(A) Each parent, or the surviving parent, or one parent if the other has been deprived of custody and visitation rights wishes to relinquish the child to the department or to a legally appointed guardian of the person of the child for adoptive purposes, and the relinquishment is in writing, signed and acknowledged before the court or duly authorized representative of the department and filed with the court;

(B) the child has been abandoned for a period of not less than six months by

(i) both parents, or

(ii) the surviving parent, or

(iii) one parent if the other has been deprived of custody and visitation rights;

(C) each parent, the surviving parent, or one parent if the other has been deprived of custody and visitation rights has been judicially determined to be of unsound mind and the disability has not been removed and the parent has been hospitalized for reasons of mental illness diagnosed as permanent or of long duration; or

(D) each parent, or the surviving parent, or one parent if the other has been judicially deprived of custody and visitation rights, has demonstrated by his conduct, proven by clear and convincing proof amounting to more than a preponderance of the evidence that he is unfit to continue to exercise his parental rights and responsibilities.

(f) A minor found to be delinquent, a child in need of super-

vision, or dependent is a ward of the state as long as he is committed to the department or the department has the power to supervise his actions. The court shall review an order made under (b) or (c)(1) or (2) or (j) of this section annually, and may review the order more frequently to determine if continued placement, probation, or supervision is in the best interest of the minor and the public, and to determine if the minor is being treated fairly. The department or the minor's parents or guardian is entitled to a review on application. The minor shall be afforded the opportunity to be present at the review.

(k) In making its order under (c) of this section, the court shall consider the fact, if it is a fact, that the minor was being provided treatment by spiritual means through prayer in accordance with the tenets and practices of a recognized church or religious denomination by an accredited practitioner of the church or denomination. (am §§ 6, 7 ch 1 SLA 1972; am §§ 1, 2 ch 125 SLA 1974)

Effect of amendments.

The 1972 amendment, in subsection (c)(2), inserted "and, in appropriate cases, order the parents, guardian, or other person to provide medical or other care and treatment," and substituted "reaches majority" for "becomes 19 years of age." The amendment also added subsection (k).

The 1974 amendment, in paragraph (1) of subsection (b), substituted "the department shall place the minor in the juvenile facility which the department considers appropriate and which may include" for "and may direct the minor's placement in," deleted "designated by the department" following "detention facility," and added "and may also be released by the department, in its discretion, pursuant to § 200 of this chapter." The amendment also, in subsection (f), substituted "state" for "court" in the first sentence and rewrote the fourth sentence.

As the rest of the section was not affected by the amendments, it is not set out.

Notions of benevolent protective policies cannot be used to validate departures from positive law relating to the adjudicative and dispositive phases of children's proceedings. In re A Minor Child, Sup. Ct. Op. No. 737 (File No. 1524), 490 P.2d 658 (1971).

Nor to justify dispensing with constitutional safeguards. — The benevolent social theory supposedly underlying children's court acts does not furnish justification for dispensing with constitutional safeguards. In re A Minor Child, Sup. Ct. Op. No. 737 (File No. 1524), 490 P.2d 658 (1971).

The right of confrontation is paramount to the state's policy of protecting a juvenile offender. Davis v. State, U.S. , 94 S. Ct. 1105, 39 L. Ed. 2d 347 (1974).

But state's interest in secrecy of juvenile adjudications need not always fall before confrontation right. —See Gonzale v. State, Sup. Ct. Op. No. 1030 (File No. 2002), 521 P.2d 512 (1974).

Prosecution witness impeachable by cross-examination for bias from probationary status as juvenile delinquent. — The confrontation clause requires that a defendant in a criminal case be allowed to impeach the credibility of a prosecution witness by cross-examination directed at possible bias deriving from the witness' probationary status as juvenile delinquent although such an impeachment would conflict with a state's asserted interest in preserving the confidentiality of juvenile adjudications of delinquency. Davis v. State, U.S. , 94 S. Ct. 1105, 39 L. Ed. 2d 347 (1974).

Whatever temporary embarrassment might result to a prosecution witness or his family by disclosure of his juvenile record — if the prosecution insisted on using him to make its case — is outweighed by petitioner's right to probe into the influence of possible bias on the testimony of a crucial identification witness. Davis

v. State, U.S. , 94 S. Ct. 1105, 39 L. Ed. 2d 347 (1974).

The state cannot, consistent with right of confrontation, require the defendant to bear the full burden of vindicating the state's interest in the secrecy of juvenile criminal records. Davis v. State, U.S. , 94 S. Ct. 1105, 39 L. Ed. 2d 347 (1974).

The United States supreme court has held that the constitutional right of confrontation required that defense counsel be allowed to investigate the potential bias of a crucial prosecution witness, even where that potential bias arose out of a juvenile adjudication and its resultant probationary status. Gonzales v. State, Sup. Ct. Op. No. 1030 (File No. 2002), 521 P.2d 512 (1974).

The United States supreme court concluded that Alaska's interest in protecting the anonymity of the juvenile offender was outweighed by the more critical need to afford a criminal defendant reasonable inquiry into the motives of prosecution witnesses. Gonzales v. State, Sup. Ct. Op. No. 1030 (File No. 2002), 521 P.2d 512 (1974).

Conflict between section and decision in Davis v. State is superficial. — The conflict between this section and the supreme court's decision in Davis v. State, U.S. , 94 S. Ct. 1105, 39 L. Ed. 2d 347 (1974), is only superficial. Gonzales v. State, Sup. Ct. Op. No. 1030 (File No. 2002), 521 P.2d 512 (1974).

Since disclosure required because of probationary status, not juvenile adjudication.—The constitutional requirement of disclosure in the facts in Davis v. State, U.S. , 94 S. Ct. 1105, 39 L. Ed. 2d 347 (1974), is created not by the juvenile adjudication itself but by the probationary status of the juvenile at the time of Davis' trial, with its potential for motivating false testimony. Gonzales v. State, Sup. Ct. Op. No. 1030 (File No. 2002), 521 P.2d 512 (1974).

Where the witness was not on juvenile probation, it cannot be seriously argued that the fact of previous juvenile convictions, standing alone, provided any inference of potential bias. Gonzales v. State, Sup. Ct. Op. No. 1030 (File No. 2002), 521 P.2d 512 (1974).

State adjudications directed solely at credibility do not conflict with confrontation right.—Juvenile adjudications which are stale by Alaska's standards and directed solely at general credibility rather than bias are generally not sufficiently probative to create a genui conflict with the defendant's right of confrontation. Gonzales v. State, Sup. Ct. Op. No. 1030 (File No. 2002), 521 P.2d 512 (1974).

Where the attempted impeachment was of general credibility by proof of prior "convictions," the probative value of this type of evidence is considerably less than that which suggests false or distorted testimony because of bias, and the need to confront a witness with such evidence is correspondingly less. Gonzales v. State, Sup. Ct. Op. No. 1030 (File No. 2002), 521 P.2d 512 (1974).

As a general rule, the trial courts could properly refuse evidence of stale convictions or juvenile adjudications where these were offered for the purpose of discrediting the witness generally rather than to show some specific potential for bias or prejudice toward the defendant. Thomas v. State, Sup. Ct. Op. No. 1040 (File Nos. 1888, 1854), 522 P.2d 528 (1974).

Subsection (g) provides in part that a juvenile offender may not be considered a criminal by reason of the adjudication, nor may the adjudication be afterward deemed a conviction. Gonzales v. State, Sup. Ct. Op. No. 1030 (File No. 2002), 521 P.2d 512 (1974).

Three distinct categories of children established. — Alaska's statutes relating to children's proceedings and the rules of procedure governing such proceedings establish three distinct categories of children. Thus, a child can be declared a dependent minor, a child in need of supervision, or a delinquent minor. In re A Minor Child, Sup. Ct. Op. No. 737 (File No. 1524), 490 P.2d 658 (1971).

And each category mandates differences regarding content of dispositional orders. — Alaska's pertinent statutory provisions and procedural rules distinguish between categories of children for purposes of administering Alaska children's laws. Of controlling significance is that each class or category mandates distinct differences regarding the permissible content of any dispositional order the trial court

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The age limitation of 19 years in subsection (b)(1) as to the length of time the juvenile court can order commitment to the Department of Health and Social Services reflects a 1970 legislative decision intended to reduce the age of majority in a great number of matters concerning minors and is considered controlling over AS 47.10.060(d) which was not similarly changed apparently through oversight. In re P.H., Sup. Ct. Op. No. 857 (File No. 1538), 504 P.2d 837 (1972).

Section is maximum sentencing statute.—Statutes requiring release upon a specified birthday are, in effect, maximum sentencing statutes. Davenport v. McGinnis, Sup. Ct. Op. No. 1049 (File No. 1942), 522 P.2d 1140 (1974).

Sentence reduction to 19 years of age not retroactive.—There is nothing in the amendatory legislation to this section that indicates an intention that the sentence reduction should operate retrospectively. Davenport v. McGinnis, Sup. Ct. Op. No. 1049 (File No. 1942), 522 P.2d 1140 (1974).

The word "or" between subsections (b)(1) and (b)(2) implies that the court must choose between commitment to the Department of Health and Social Services and probation, and may not delegate the choice to the Department of Health and Social Services. This is a correct textual analysis, especially in light of the provision in subsection (b)(1) for subsequent court order for probation following placement or detention. The legislature has clearly indicated its intent to place this choice in the hands of the court. R.L.R. v. State, Sup. Ct. Op. No. 706 (File No. 1156), 487 P.2d 27 (1971).

Abandonment defined. — Abandonment consists of conduct on the part of the parent which implies a conscious disregard of the obligations owed by a parent to the child, leading to the destruction of the parent-child relationship. D.M. v. State, Sup. Ct. Op. No. 962 (File No. 1843), 515 P.2d 1234 (1973).

Abandonment to be determined objectively.—Whether or not there has been an abandonment within the meaning of this section is to be determined objectively, taking into account not only the verbal expressions of the natural parents, but their conduct as parents as well. D.M. v. State, Sup. Ct. Op. No. 962 (File No. 1843), 515 P.2d 1234 (1973).

The subjective intent standard often focuses too much attention on the parent's wishful thoughts and hopes for the child and too little on the more important element of how well the parents have discharged their parental responsibility. D.M. v. State, Sup. Ct. Op. No. 962 (File No. 1843), 515 P.2d 1234 (1973).

The child's best interests are properly a consideration in determining whether a parent has abandoned the child. D.M. v. State, Sup. Ct. Op. No. 962 (File No. 1843), 515 P.2d 1234 (1973).

A minor who has been adjudged a child in need of supervision cannot be institutionalized under the Children's Code. In re A Minor Child, Sup. Ct. Op. No. 737 (File No. 1524), 490 P.2d 658 (1971).

Where a runaway child found to be a child in need of supervision, not a delinquent minor, no legal basis exists for his incarceration. In re A Minor Child, Sup. Ct. Op. No. 737 (File No. 1524), 490 P.2d 658 (1971).

The only instance under Alaska children's laws authorizing institutionalization or incarceration is when the child has violated the laws of the state, or any of its political subdivisions, and in turn has been adjudged a delinquent minor. In re A Minor Child, Sup. Ct. Op. No. 737 (File No. 1524), 490 P.2d 658 (1971).

The legislature has authorized institutionalization only where the child is found to be a delinquent minor. In re A Minor Child, Sup. Ct. Op. No. 737 (File No. 1524), 490 P.2d 658 (1971).

Power of court under subsection (c). — Under subsection (c) of this section, the court is empowered to order the minor committed to the Department of Health and Social Services or order the minor released to his parents, guardian, or some other suitable person. In re A Minor Child, Sup. Ct. Op. No. 737 (File No. 1524), 490 P.2d 658 (1971).

The Department of Health and Social Services does not possess the authority to institutionalize any minor, including one who has been de-

cared a child in need of supervision, who has been committed to its custody. It is unreasonable to construe Alaska children's statutes in a manner which would result in the grant to the Department of Health and Social Services of broader powers of commitment than possessed by the trial court. In re A Minor Child, Sup. Ct. Op. No. 737 (File No. 1524), 490 P.2d 658 (1971).

Peremptory challenge procedure inapplicable to juvenile proceedings.— While juvenile proceedings have some of the characteristics of both civil and criminal actions, they are basically different from both, and the words "civil or criminal" as used in AS 22.20.022 must be strictly construed. The trial judge was correct in holding that peremptory challenge procedure applied only to civil and criminal actions and not to juvenile proceedings. In Re A Minor Child, Sup. Ct. Op. No. 737 (File No. 1524), 490 P.2d 658 (1971).

A child adjudicated delinquent for selling LSD may be incarcerated, possibly even in a city jail, until age 19, which may be many years. RLR v. State, Sup. Ct. Op. No. 706 (File No. 1156), 487 P.2d 27 (1971).

When sentence determined. — The sentence which may be imposed upon a convicted adult is determined as of the time of the final judgment of conviction, or as of the time of commission of the offense. These rules have been applied to juvenile sentencing. Davenport v. McGinnis, Sup. Ct. Op. No. 1049 (File No. 1942), 522 P.2d 1140 (1974).

Appellate jurisdiction.—AS 22.05.010 places final appellate jurisdiction in all cases in the supreme court. In re A Minor Child, Sup. Ct. Op. No. 737 (File No. 1524), 490 P.2d 658 (1971).

Quoted in Davis v. State, Sup. Ct. Op. No. 816 (File Nos. 1428, 1436), 499 P.2d 1025 (1972).

Stated in In re G.K., Sup. Ct. Op. No. 796 (File Nos. 1627, 1654, 1674), 497 P.2d 914 (1972).

Cited in Elliason v. State, Sup. Ct. Op. No. 898 (File No. 1750), 511 P.2d 1066 (1973).

Sec. 47.10.085. Dependent minor; religious treatment. In a case in which the minor's status as a dependent minor is sought to be based on his need for medical care, the court may, upon consideration of the health of the minor and the fact, if it is a fact, that the minor is being provided treatment by spiritual means through prayer in accordance with the tenets and practices of a recognized church or religious denomination by an accredited practitioner of the church or denomination, dismiss the proceedings and thereby close the matter. This may be done, in the interests of justice and religious freedom, on the court's own motion or upon the application of a party to the proceedings, at any stage of the proceedings after information is given to the court under § 20(a) of this chapter. (§ 8 ch 1 SLA 1972)

Sec. 47.10.090. Records. (a) The court shall make and keep records of all cases brought before it. The court's official records may be inspected only with the court's permission and only by persons having a legitimate interest in them. All information and social records pertaining to a minor and prepared in the discharge of his official duty by an employee of the court or by a federal, state or city agency are privileged and may not be disclosed directly or indirectly to anyone without the court's permission. However, a state or city law-enforcement agency shall disclose information regarding a case which is needed by the person or agency charged with

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(b) The name or picture of a minor under the jurisdiction of the court may not be made public by a newspaper, radio, or television station in connection with the minor's status as a delinquent or dependent child, except as authorized by order of the court.

(c) A person who violates a provision of this section is guilty of a misdemeanor, and upon conviction is punishable by a fine of not more than $500 or by imprisonment for not more than one year, or by both. (§ 10(3)(4) art I ch 145 SLA 1957; am § 1 ch 124 SLA 1972)

Effect of amendment. — The 1972 amendment substituted "may not be disclosed" for "shall not be disclosed" in the third sentence of subsection (a), substituted "a case" for "the case" in the fourth sentence of that subdivision, added the fifth and sixth sentences therein, and designated the last sentence of subsection (b) as subsection (c). In subsection (c), the amendment substituted "a provision of this section" for "this provision."

Waiver of provisions of section. — In the case of use of restraints more severe than placement in adjustment rooms (solitary confinement), the approval of the director of McLaughlin Youth Center must be obtained and a report made to the child's attorney and the family court. The provisions of this section are waived for this purpose. T.M. v. Director of McLaughlin Youth Center, Superior Court, No. 72-449 (1973).

Stated in RLR v. State, Sup. Ct. Op. No 706 (File No. 1156), 487 P.2d 27 (1971).

Sec. 47.10.095. Arrest of a minor. The arrest of a minor other than for a traffic offense is not considered an arrest for any purpose except for the purpose of the disposition of a proceeding arising out of that arrest. (§ 2 ch 124 SLA 1972)

Sec. 47.10.100. Retention of jurisdiction over minor.

(c) If a minor is adjudicated a delinquent, a child in need of supervision, or a dependent before his 18th birthday, the court may retain jurisdiction over him after his 18th birthday for the purpose of supervising his rehabilitation, but the court's jurisdiction over him under this chapter never extends beyond his 19th birthday, except that the department may petition the court for continued supervision for an additional one-year period for minors who have not responded to treatment. The department may retain ju-

August 28, 1975

M E M O R A N D U M

TO : Legislative Council

FROM : Children's Code Revision Task Force

BY : Anne D. Carpeneti, Legislative Counsel

SUBJECT: Monthly Report

Please see attached report.

Alaska State Legislature

LEGISLATIVE AFFAIRS AGENCY

POUCH Y, STATE CAPITOL
JUNEAU, ALASKA 99811
(907) 465-3800

August 28, 1975

WORK PLAN

Legislative Council Task Force

Children's Law Revision

I. PURPOSE

The purpose of the Task Force is to study the Alaska Statutes dealing with children and to propose revision of the statutes which the Task Force finds in need of change. This study and revision is viewed by the Task Force as the first step in developing a children's code for Alaska.

II. GOALS AND OBJECTIVES

During the period before the legislature reconvenes, the Task Force plans to determine the areas of Alaska law dealing with children which are most in need of review, look critically at Alaska's approach to the treatment of children in these areas, comparing Alaska's approach to that of other states, and to submit legislation to the Council revising the statutes which the Task Force determines to be in need of revision.

III. ASSUMPTIONS

A. Responsibilities. The Legislative Council will provide an attorney who will spend approximately one-third of his/her time on the work of the Task Force, travel expenses and per diem for the attorney, office space for the attorney and researcher, and clerical support for the project. The Office of Child Advocacy is funding a full time research person for the interim period, and travel expenses and per diem for the researcher. The Office of the Governor is providing funds for travel expenses and per diem for the members of the Task Force.

B. Task Force Structure. The Task Force will meet five times during the interim period. The meetings are scheduled for August 14, September 17, October 15, November 19 and December 17. At the September meeting the Task Force will break

down into smaller groups. Each group will deal with one of the priority areas which the Task Force has decided to address. The small groups will study the problem areas in depth and report their findings to the Task Force. The Task Force will then decide whether to adopt the reports of the small groups and to recommend legislation to the Legislative Council.

IV. TASKS

At the August 14, 1975 meeting the Task Force decided to look into the following areas during the interim period:

(1) update the draft of the Child Law Compilation prepared by the Legislative Affairs Agency in October 1974;

(2) role of the guardian ad litem in the Alaska Court System;

(3) the treatment of children classified as dependent, neglected, delinquent and in need of supervision in the Alaska Statutes;

(4) the treatment of emotionally disturbed children;

(5) the protection of the property rights of orphaned children in the state, particularly the rights of children under the Alaska Native Claims Settlement Act;

(6) the scope of the term "care of the child" under AS 47.10.230;

(7) the adequacy of the statutes dealing with child abuse in the state;

(8) the treatment of status offenders.

Staff research for the first three areas is scheduled for completion by the September meeting of the Task Force. The remaining research is scheduled for completion by the October meeting. After each meeting a report on the work progress will be prepared for submission to the Legislative Council.

Betsey McGuire, Chairperson
Task Force on the Children's
Law Revision

ADC:hg

STATE OF ALASKA
THE LEGISLATURE
LEGISLATIVE AFFAIRS AGENCY

POUCH Y - STATE CAPITOL
JUNEAU, ALASKA 99801

(907) 465-3800

September 30, 1975

CHILDREN'S CODE REVISION TASK FORCE SUMMARY
OF MEETING SEPTEMBER 17, 1975

Andy Brown, research staff for the task force, reviewed his progress in researching issues dealing with the guardian ad litem in Alaska. The task force then discussed various problems with the present system of providing guardians ad litem for children. The problems discussed included:

1/ attorneys appointed are often not interested or knowledgeable in issues involving children;

2/ the length of time a guardian ad litem is responsible for the child after disposition of the case;

3/ the availability of persons in the bush areas to act as guardians ad litem; and

4/ the duties and powers of guardians ad litem are vague.

Later a working group of the task force formulated the following proposals regarding the guardian ad litem for consideration by the whole task force:

1/ that the present discretionary appointment by the court of guardians ad litem continue to remain in effect;

2/ that the scope of the guardian ad litem's duties be clearly delineated and include

a/ investigation of the legal and factual issues of a particular child's case and report these to the court;

b/ the power as guardian ad litem exist no longer than the particular matter is before the court, in other words from the time of the filing of a petition, which will involve a child's present or future care, custody or control, until the court's disposition of that matter; and

c/ the power of a guardian ad litem is to be distinguished from a guardian of a person in that the former involves only the representation of a child's best interests before a court, while the latter involves the right and power to make decisions concerning a child's physical and emotional welfare, such as food, clothing, housing, schooling, recreation, health, and finances;

3/ AS 09.65.130, AS 20.15.100(j), and AS 47.10.05 be amended to read "guardian ad litem who may also be an attorney" rather than "guardian ad litem or attorney"; and

4/ the term "law guardian" be used instead of the Latin terminology "guardian ad litem".

The staff then reviewed its research into the matters of dependent children, delinquent children and children in need of supervision. The following issues were discussed by the task force:

1/ the mandatory termination at certain intervals of state intervention unless the state can make a positive showing that state involvement is still necessary;

2/ mandatory annual review of a child's disposition;

3/ long range foster care so that foster families can get medical care and state aid;

4/ removing status offenders from the court system entirely;

5/ the problem of getting psychiatric care for children without institutionalizing them; and

6/ the lack of diagnostic services for children and their families.

A working group of the task force met in the afternoon and agreed that the following be researched and submitted to the whole task force:

1/ eliminate the category of children in need of supervision;

2/ remove the "fault" approach from consideration of dependent children;

3/ devising a way that children and their parents may be ordered by the court to receive diagnostic treatment and services;

4/ define "intake services" with greater specificity; and

5/ define "juvenile detention home," "institution," and "juvenile correctional school" with more specificity.

AC:cb

STATE OF ALASKA
THE LEGISLATURE
LEGISLATIVE AFFAIRS AGENCY

POUCH Y · STATE CAPITOL
JUNEAU, ALASKA 99811
907-465-3800

M E M O R A N D U M March 24, 1977

SUBJECT: Response to Issues Brought Up at Joint Senate HESS and House Judiciary Committee Meeting on SB 106 - HB 204

TO: Members of Senate HESS and House Judiciary Committees

FROM: Andrew M. Brown
Attorney for Children's Code Revision
Task Force

Following are comments touching upon the various issues raised by witnesses testifying on SB 106 - HB 204. I hope these comments clarify any uncertainties concerning this legislation.

1. Issue - Statement by Sam Granato, Director of Social Services, concerning the little possibility of state intervention into home life based upon only unsanitary home environment.

Response - Section 20 of the bill redrafts AS 47.10.010(a) because the present law does allow the very distinct possibility of unwarranted intervention in family affairs. Precisely because of the present .010(a)(1) - (9)'s vague standards, the task force has tightened and clarified the scope of the children's court jurisdiction. Under the present "lacks proper parental care by reason of the faults, habit, or neglect of his parent, guardian, or custodian" in .010(a)(5) the Department of Health and Social Services could interfere in family affairs without any showing of actual or imminent harm to the child.

2. Issue - Comments by Rudy Johnson on amending Section 1.

Response - His first amendment concerns deleting "as a matter of right" in lines 21 - 22, page 1. This phrase insures that neither parent has greater rights over the other at the outset of a custody hearing, and the phrase should be kept. Mr. Johnson's second suggestion concerned a sixth standard for the court's consideration of child custody. He desires that the court look at the attitudes of the parents toward each other and how that might affect the relationship between the child and the parent who does not

have custody. Since divorce concerns parental separation based usually on incompatibility, there will often be rancor between the parents and it is inevitable that this rancor may affect the child/non-custodial parent relationship. Whether this added factor will help the court in deciding the child's best interests, I cannot say.

3. Issue - Comment by Sister Mary Clare on her not liking the necessity of the mother relinquishing her parental rights before a judge under Section 18 of this bill.

Response - Under present law in AS 20.15.180 a parent can relinquish his or her rights to a child either in the presence of an agency representative or in court. However, the present law does not set out any standard to insure that the relinquishing parent will be told the full consequences of his or her act. While Sister Mary Clare's agency may do an adequate job explaining the meaning of relinquishment, there is no guarantee that other private or governmental agency personnel will sufficiently explain relinquishment. Since relinquishment is a major irreversible step (excepting the 10 day period after the court's order under 25.20.035(f) in Section 18 of the bill) the task force feels it is imperative that a neutral judge explain the meaning and be sure it is understood. This protects both the relinquishing parent and the child. It should also be noted that the present relinquishment law has a loophole which Section 18 of the bill closes. Under present law, no provision is made as to who is to have custody of the child upon relinquishment; however, Section 18 clearly states the three alternatives the court has in placing the child.

3. Issue - Sister Mary Clare's comment on the court should not interfere with private placements.

Response - There is confusion between the issues of placement of the child and relinquishment. Since relinquishment is a major decision, it is necessary that a disinterested forum insure that the proper decision is made. Once that is done and relinquishment takes place, a placement of the child can be done. If the court gives custody of the child to a licensed private placement agency, then it can place the child. The privacy of the placement will be maintained, but with insurance through court oversight, if necessary, that there will not be placement based on financial reward.

4. Issue - Comment by Sister Mary Clare opposing notice by publication of adoptions.

Response - Again, there is confusion over this issue. Notice by publication would not be mandatory in any case.

It would be discretionary upon the court to decide if it is warranted. Section 9 of the bill retains the present law on notice being given under the rules of civil procedure. Under Rule of Civil Procedure 4(e), the court can direct the manner of notice if personal service is not effective. In most instances publication is a last resort only after personal service and certified mail to the last known address do not work. The present Children's Rule 10(g) mandates notice by publication only after it is shown by an "affidavit of due and diligent inquiry that personal service ... cannot be effected." Since the present law in AS 20.15.100(b) on no notice by publication is ineffective due to the 1974 adoption bill, under which .100(b) was enacted, did not state its effect on court rules as required by Legislative Rule 40(e), and since recent federal and state court decisions uphold the rights of one being adequately notified of court hearings concerning his interests, the discretionary power by the court to order publication when it believes it necessary is a reasonable last resort alternative. The cases which point out the importance of notice are: Stanley v. Illinois, 405 U.S.645 (1972), a child custody case; Mullane v. Central Hanover Bank and Trust Company, 339 U.S. 306 (1950), a case clearly enunciating the importance of notice in any court case; and Aguchak v. Montgomery Ward, 520 P.2d. 1352 (1974), an Alaskan case spelling out the importance of notice.

5. Issue - Comment by Ms. Susan Burke of the Court System on the possible costs of appointment of guardian ad litems under Sections 3, 10, and 24 of this bill.

Response - It is extremely difficult to gauge the fiscal impact of the court's appointment of guardian ad litems, because it is a discretionary power of the court and it is hard to predict when either party may request such an appointment or when a particular judge will on his own make such an appointment. Also, the amount of work the guardian ad litem does and his or her status as an attorney, child specialist, or layperson will affect the bill he or she submits to the court.

6. Issue - Query by Senator Hackney on the effect the jurisdictional statute in Section 20 will have on a child treated pursuant to a parent's religious convictions.

Response - Present law in AS 47.10.085 adequately provides for cases wherein the child may need medical care and he is being treated by spiritual means. This law is not being changed, except the reference to "dependent minor" is changed to "child in need of aid."

7. Issue - Comment by Assistant Attorney General Arnold that Section 22 of the bill on notice of the hearing will require notice to absent parents where no termination of parental rights is contemplated and that this will unduly delay the proceeding.

Response - Children's Court Rule 10 requires notice to the child, parents or guardian, custodian, and guardian ad litem, if one is appointed, upon filing of a petition for adjudication. Section 22 only brings the present law in AS 47.10.030(b) into conformity with this rule, and clarifies that each parent is to receive the notice of the proceeding. When the results of attempting either personal service or service by certified mail are not known within a couple days, a formal children's proceeding can be delayed without harmful results, because under AS 47.10.142 on emergency custody the court must hold an emergency custody hearing within 48 hours to determine if probable cause exists for believing the child is a child in need of aid. This probable cause hearing would allow temporary placement of the child until a full hearing on the allegations is held. In the meantime there can be reasonable attempts to deliver notice to each parent and still allow the Department of Health and Social Services to have temporary protective custody of the child.

8. Issue - Comment by Assistant Attorney General Arnold on having the section on involuntary termination of parental rights under AS 25.20, rather than in AS 47.10.080(c)(3).

Response - Since involuntary termination of parental rights is tied to the jurisdictional basis of the Children's Court in AS 47.10.010(a)(2), (Section 20 of this bill), it would be confusing to take what is now in Section 29 of the bill under .080(c)(3), and move it to another area. The Children's Court can terminate the parent-child relationship in a child in need of aid case only upon grounds proven under the jurisdictional section. All the procedural and substantive protections for both the child and parents come under AS 47.10, and moving the most drastic type of sanction to an unrelated chapter does not make sense.

AMB:hjd

JAY S. HAMMOND
GOVERNOR

STATE OF ALASKA
OFFICE OF THE GOVERNOR
JUNEAU

March 22, 1977

The Honorable Glenn Hackney
Senator
Pouch V
Juneau, Alaska 99811

Dear Senator Hackney:

My staff and representatives of various state agencies have reviewed the final draft of the legislation developed by the Children's Code Revision Task Force, jointly supported by the Legislative Council and the Office of the Governor. This product is now before the Legislature as SB 106 and HB 204. Although I had hoped that a joint review and submission between the Governor's Office and Legislative Council would occur, I am pleased to see the product before the Legislature and the Administration for consideration at this time.

The bills address the long recognized need for a codification of child-related law. Clarification of existing laws, emphasis on the child's welfare and needs and correction of some inconsistencies in statutes are just a few of the positive aspects of the legislation. In general, the purpose and direction of the bills are sound and I support them.

In reviewing the comments from state agencies, constituents interested in the bill, and others directly involved in the procedures related to the functions covered by this legislation, the Governor's Office has received very few negative comments. However, I feel that some concerns which have been articulated need to be brought to your attention as they may require amending the bills. I would like to address those concerns briefly.

1. Adoption procedures: Some parents experienced in the adoptive process and some individuals with court responsibilities related to the adoptive process object to section 7, page 4 of the bill (reference to AS 20.15.060) and question the necessity for or wisdom of the appearance of a consenting parent in court. This particular section addresses the procedures involved when a parent knows the persons adopting the child, has arrived at the

decision to consent to that adoption and has, in fact, consented. The situation of relinquishing a child for adoption is, to say the least, an emotional experience. Court formalities and surroundings may have subtle and inhibiting effects on persons involved in the proceedings. The surroundings may induce sorrow, regret and guilt regarding the adoption decision, however rational that decision might have been. The court appearance seems unnecessary for the consenting parent and may cause tension and anxiety on the part of the adoptive parents. Apparently most hearings now occur after the child has already become used to and familiar with the adoptive parents. The aura of uncertainty connected with parental presence at the hearings seems inconsistent with the need to proceed with as little trauma and as much consideration for the child, as well as the adults.

Additionally, many of the proceedings in rural Alaska now typically involve written interrogatories and informal, less threatening procedures to allow consenting and adopting parents to execute the arrangements for the permanent adoption of the child. If the intent is to give opportunity for the consenting parent to be sure that he or she is considering all alternatives and has had time to deliberate on the decision, perhaps a stipulation for a "cooling off period" or deliberation time could be instituted with a copy of necessary information provided to the parent with the consent papers. At any rate, the vexing situation of court appearance and the necessitated travel perhaps should be avoided. Additionally, the cost of travel expenses would often not be affordable by the consenting parent or the adoptive parent and the implication is that the State might be responsible for these costs.

The section on relinquishment of parental rights and adoption raises another question. Interpretation of the proceedings under this bill indicates that a parent wishing to give up a child for adoption must file a petition and appear in court in every case, a costly and cumbersome proceeding that does not fulfill the need for privacy and consideration to the parent and the child. In rural Alaska particularly, this means the mother might not be able to return to her home village from the hospital following the birth of a child that has been voluntarily relinquished for adoption.

2. Publication of Notice: Some feel that publication of notice brings few or no results, and that this requirement can serve little purpose for the child's benefit. It fosters undue public awareness of what should essentially be as private and personal an action as possible. The ideal step

would be to eliminate the procedure and rely on the other means of notice. According to some, the notice requirement guarantees fullest possible protection of the rights of the missing or unknown parent prior to adoption of the child. However, if the records indicate not one instance of the procedure resulting in the finding of such a parent and the reunion of a child with a natural parent, it seems both unnecessary and undesirable to require this procedure.

According to AS 20.15.080 (a), the titles of cases are designated only by the proposed name of the child after adoption approval and the birth date. Therefore, publication of notice to missing or unknown parents seems perfunctory, for in most cases it is quite obvious that the recognition of a possible offspring would occur only if the natural mother's name were attached to the notice for identification. Such publications would do little to promote positive concern for the child or the mother, and probably would have little effect on any potential for a reunion of a missing or unknown parent with the child.

3. Extension of Supervision: The questions regarding the extension of supervision beyond age 18 have been for the most part centered around the curiosity of recommending extension of supervision while at the same time adopting age 18 as the age of majority. Selecting age 18 as the age of majority seems to make good sense and develops a greater consistency with other age provisions in statutes, but the extension beyond the age of majority for _ venile supervision does not seem reasonable in that light Additionally, provisions which would allow for ext sion with the consent of the person involved seem not only unrealistic but would be unlikely to produce any positive benefits on behalf of either the individual or the society.

Aside from these suggestions and any recommendations for minor drafting changes, I urge your support of SB 106 and HB 204.

Sincerely,

Jay S. Hammond
Governor

MEMORANDUM April 7, 1977

SUBJECT: SB 54 and SSHB 419
TO: Representative Terry Gardiner, Chairman House Judiciary Committee
FROM: Andrew Brown

SB 54 is on adoption assistance and Sections 6 - 10 of SSHB 419 are also on adoption assistance. The Senate bill is an administration one, while the House bill is based on the Children's Code Revision TaskmForce's proposals. While both bills would result in expanded coverage of adoption assistance, the House bill would allow broader applicability, and also mandate that information about adoption assistance would be disseminated in rural areas.

While the Task Force would prefer so see its version enacted, if it appears that SSHB 419 is not going to pass the House soon, then I think it would be best to either amend SB 54 so that it reflects some of the aspects in SSHB 419 or just pass out SB 54 as is. Therefore, an expansion of the adoption assistance program which is desired by the administration, the Task Force and others would become a reality.

You might want to take this this up at the Judiciary Committee meeting on April 11, 1977 when you will be discussing HB 204 on Children's Laws.

HB

2

Joyce 2/12/79

HOUSE BILL 2

Amend

Sec. 47.30.655 Purpose. (Page 2, Line 2)

Add:

(6) that persons who are mentally ill but not dangerous to others be committed only if there is a reasonable expectation of improving their mental condition.

Adopted

Delete

Sec. 47.30.665 Prayer Treatment. (Page 3, Line 16)

Adopted

Delete

In Sec. 47.30.670 Standards for Voluntary Admission (Page 3, Line 23-24)

"14 years of age or older"

Delete a d Substitute

For Sec. 47.30.690 Voluntary Adminssion of Minors (Page 4, Line 24)

(a) A minor under the age of 14 may be admitted for 30 days evaluation, diagnosis and treatment at the designated facility if his parent or guardian signs the admission papers and if

(1) he is suffering from mental illness;

(2) as a result of this mental illness he is likely to cause serious harm to himself or others; serious harm to self may include inability to provide for basic needs

for food, clothing, shelter, or personal safety in the case of persons who are gravely disabled as a result of mental illness;

(3) there is no less restrictive alternative available for his treatment; and

(4) there is reason to believe that the patient's mental condition could be improved by the course of treatment.

(b) The district official must be notified of the admission on the first working day and must monitor appropriateness of admission and continued hospitalization during the 30 day period.

(c) The minor may be released at any time during the 30 day period by the facility if the professional person in charge of the treatment facility or his designated mental health professional determines the minor would no longer benefit from continued hospitalization and the patient is not dangerous. The minor's parents or his guardian must be notified by the facility as to the contemplated release and, unless they start proceedings for involuntary commitment, the minor will be released.

Delete and Substitute

For Sec. 47.30.695 Notice of Request ....(Page 4, Line 28)

(a) The minor or his parent or guardian may request and obtain immediate release or the minor at any time during the 30 day evaluation period if the minor is not dangerous.

HB 2 (Continued)

Add

Sec. 47.30.696 Judicial Review After 30 Day Admission of Minor

(a) Prior to the expiration of the 25th day of the initial 30 day evaluation and treatment period, a petition for Court approved admission to a treatment facility must be filed in Superiod Court if the professional person in charge of the treatment facility or his designated mental health professional, deems necessary continued treatment at the facility. the petition must be signed by a physician and a mental professional who have examined the minor. The peition must:

1. Allege that the minor, by reason of mental illness, is likely to cause serious harm to himself or others;

2. Allege the facts and specific behavior of the minor which supports the findings of mental illness and that he is likely to cause serious harm or is in need of care and treatment;

3. Allege that the evaluation staff has found that there are no less restrictive alternatives available that would adequately protect the minor or others or would provide the necessary care and treatment, or if a less restrictive form of treatment is sought, specify the treatment and the basis for supporting it;

4. Allege that there is reason to believe the minor's mental condition could be improved by the course of treatment sought;

5. Allege that a specified treatment facility appropriate to the minor's condition has agreed to accept the minor or that the minor is to be sent to a state operated facility.

6. List the prospective witnesses who will testify in support of Court approved admission.

(b) Upon the filing of the petition, the Court shall appoint an attorney and/or a guardian ad litem to represent the interest of the minor.

(c) Copies of the petition for court approved admission shall be served on the parents or guardian of the minor or their attorney if they are represented, and the minor's attorney/guardian ad litem. The petition shall be filed with the Clerk of the Court, and a date for a hearing shall be set, by the end of the next judicial day, for no later than five judicial days from the date of filing of the petition. The Clerk shall notify the minor's parents or guardian ad litem and the petitioner, of the hearing date at least three days in advance of the hearing.

(d) At the hearing the minor has the rights specified in this chapter, considering his age. In addition, he has the right to be present at the hearing unless the court finds that the minor's presence would be harmful to the minor.

(e) At the conclusion of the hearing, the court may commit the minor for treatment

Delete and Substitute

For Article 8 Involuntary Admission for Treatment (Page 5, Line 3)

Section 47.30.700. COMMITMENT STANDARD. A person may be involuntarily committed to a treatment facility under the procedures set out in this chapter only if

(1) he is suffering from mental illness;

(2) as a result of this mental illness he likely to cause serious harm to himself or others; serious harm to self may include complete neglect of basic needs for food, clothing, shelter, or personal safety in the case of persons who are gravely disabled as a result of mental illness;

(3) there is no less restrictive alternative available for his treatment;

(4) there is reason to believe that the patient's mental condition could be improved by the course of treatment sought, if the person is dangerous only to himself.

Add

Sec. 47.30.701 Non-Emergency Detention for Evaluation Involving District Office or Official.

(a) A person seeking the commitment of another to a treatment facility may initiate the proceedings by executing a petition for evaluation and presenting it to a district office or official. The petition must allege:

(1) the facts and specific behavior of the respondent showing that the conditions established in Sec. 47.30.700 (commitment standard) of this chapter are met; and

(2) the names, addresses and phone numbers of all persons known to the petitioner who have knowledge of the facts through personal observation.

(b) A district official who receives a properly executed petition for evaluation shall investigate of cause to be investigated and evaluated the specific facts alleged and the reliability and credibility of the person providing the information. If after investigation the district official determines that there is good reason to believe that the allegations are true and the respondent does not agree to come voluntarily to a facility for evaluation, the district official may obtain from the court and cause to be served on the respondent and his guardian, if there is one, a summons requiring the respondent to appear at a specified evaluation facility for an evaluation period of not more than 72 hours. If there is no evaluation facility in the respondent's community, the district office shall determine whether the respondent should be transported to the nearest available evaluation facility at no cost to him. The summons shall then specify, as the place for the respondent to appear, the place of transport. The evaluation facility or personnel shall be given a copy of the petition and summons.

(c) The summons shall contain the following information:

(1) date and time within which the respondent must appear, not less than 24 hours after service of the summons;

(2) address of the evaluation facility, other place of evaluation, or place of transport to which the respondent is to report;

(3) name, business address and phone number of the district official issuing the summons;

(4) a statement that if the respondent fails to appear at the appointed place or before the date and time stated in the summons, he may be involuntarily taken into custody and transported to the appointed place;

(5) a copy of the petition for evaluation and a notice of rights regarding commitment procedures as set out i sec. 71 of this chapter; and

(6) the name of an attorney appointed by the court to represent the respondent.

(d) No summons may be served when more than seven days have passed since its issuance. No petition for evaluation may be used as the basis for issuance of a second summons after the first has expired unless subsequent investigation by the district official revelas at the gounds for evaluation still exist.

(e) If the person summoned fails to appear on or before the date and time specified, the evaluation facility shall immediately notify the district official, who shall cause the person to be taken into custody and transported to the evaluation facility. A peace officer may take the respondent into custody and convey him to an evaluation facility at the request of the district official.

HB 2 (Continued)

Add

Sec. 47.30.702 Non-Emergency Detention for Evaluation When No District Office or Official in Geographical Area. A person seeking the commitment of another to a treatment facility in a geographical area when there is no district office or official may execute a petion for evaluation containing the allegations in Sec. 47.30.701(a) and present it to a court. The court shall cause the allegations of the petition to be investigated. If the court determines there is good reason to believe that the allegations are true, it shall issue a summons containing the information set out in Sec. 47.30.701 (c), with the exception of (c)(3). No summons may be served when more than seven days have passed since its issuance. If the person summoned fails to appear at the designated evaluation facility on or before the date and time specified, the evaluation facility shall immediately notify the court, who may cause the person to be taken into custody and transported to the evaluation facility by a peace officer.

Amend

Sec. 47.30.705 Emergency Detention for Evaluation. (Page 6, Line 3)

Add

(a) If, upon investigation under Sec. 47.30.702(b) (non-emergency detention for evaluation), of this chapter, the official determines that the respondent is likely to

cause serious harm to himself or others if allowed to respond to a summons rather than beging taken into custody immediately, the official may cause the person to be taken into emergency custody in an evaluation facility for not more than 72 hours. A peace officer may assit the district official provided in Sec. 47.30.701(e) (non-emergency detention involving district officials) of this chapter.

Add

(b If there is no evaluation facility in the respondent's community or the evaluation personnel are not presently there and the respondent needs to be detained for the arrival of evaluation personnel or transportation under Sec. 47.30.701 (b) (non-emergency detention involving district official) of this chapter, the emergency custody under (a) and (b) of this section may include detention as long as the first available transportation out of the community for the respondent, or into the community for evaluation personnel, is utilized. Under no circumstances may the respondent be held in a jail or correctional facility if there is any other possible place of detention providing adequate security. In no event may a person be detained after the emergency has passed or longer than seven days, whichever limit is reached first. While detained, the respondent shall be given care and treatment that is appropriate and available in the community.

HB 2 (Continued)

Add

Sec. 47.30.710 Examination. (Page 6, Line 9)

"mental health professional or physician who..."

Add

Sec. 47.30.725 Commitment Proceeding Rights; Notification (Page 8, Line 9)

adopted

(f) A respondent, if he is represented by counsel, may waive orally or in writing the 72-hour time limit on the probable cause hearing and have the hearing set for a date no more than seven calendar days after initial detention.

Amend

Sec. 47.30.730 Procedure for 14-Day Commitment; Petition for Commitment (Page 8, Line 17)

"The petition must be signed by one mental health professional and doctor or two mental..."

Amend PS. 9 Line 26

Adopted

(1) to be present at the hearing; unless the court finds that the respondent's presence would be seriously ~~disruptive~~ injurious to the respondent; this right may be waived only with the respondent's informed consent, ~~and~~ or by stipulation of the petitioner's and respondent's attorneys that there is a substantial likelihood that the respondent's presence would be severely injurious to his mental or physical health; or if the respondent is incapable of giving informed consent, the respondent may be excluded from the hearing only if the court,

Bill's Amdt.

the court finds

after hearing, finds that there is such incapacity and that there is in fact a substantial likelihood that the respondent's presence at the hearing would be severly injurious to his mental or physical health;

Add

Section 47.30.740 Procedure for 90-Day Commitment Following 14-Day Commitment. (Page 12, Line 14)

(f) The respondent has the right to be free of the effects of medication at the hearing by discontinuance of medication no later than 48 hours before the hearing unless, in the opinion of the prescribing physician, the medication is necessary (1) to prevent bodily harm to the respondent or others, or (2) to prevent deterioration of the respondent's mental condition such that subsequent treatment might not enable him to recover, or (3) to allow the respondent to prepare and participate in the proceedings.

Change

(f) (Line 14) to (g) and (g) (Line 18) to (h)

Amend

Sec. 47.30.775 Commitment of Minors (Page 14, Line 13)
A minor who refuses voluntary admission may not be involuntarily admitted to a treatment facility, regardless of his parent's or guardian's consent, without adherence to the procedures set out in Secs. 700-820 of this chapter for adult detention and commitment. However, all notices required to

be served on the respondent ins Secs. 700-820 of this chapter shall also be served on the parent or guardian of respondents who are minors, and parents or guardians of minor respondents shall be notified that they may appear as parties in any commitment proceeding concerning the minor and that as parties they are entitled to retain their own attorney or have one appointed for them by the court. A minor has the same rights to waiver and informed consent as an adult under this chapter; however, he shall be represented by counsel in waiver and consent proceedings.

Add

Section 47.30.801 RECORDS AND PROCEEDINGS. A verbatim transcript may be made of all court hearings conducted under this chapter and a copy shall be provided to the respondent upon request for purposes of appellate or other court review of the proceedings.

Add

To Section 47.30.915 Definitions. (Page 30, Line 11)

(16) "district official" means a mental health professional.

2/9/79

RECOMMENDED CHANGES FOR HOUSE BILL 2

Division of Mental Health & Developmental Disabilities

PAGE 4, LINE 25

Substitute: A minor under 14 years of age may be admitted voluntarily if his parent who has legal custody of the minor or the minor's guardian signs the voluntary admission papers and the professional person in charge of the treatment facility or his designated mental health professional agrees that he is suffering from a mental illness. Any statement or conduct by a minor under the age of 14 indicating that the minor does not agree to admission to the facility should be noted on the application for admission.

PAGE 4, LINE 28

Substitute: Section 47.30.095 NOTICE OF REQUEST FOR RELEASE OF MINORS UNDER 14 YEARS OF AGE FROM VOLUNTARY DETENTION AND COMMITMENT.

(a) The minor or the minor's parent who has custody of the minor or the minor's guardian may request release of the minor at any time.

(b) Upon receipt of a request for release, the professional person in charge of the treatment facility or his designee shall immediately notify the parent who has custody of the minor or the minor's guardian. If the professional person in charge of the treatment facility or a designated mental health professional, who shall evaluate the minor in writing, or the parent who has custody of the minor or the minor's guardian does not petition for involuntary commitment within 48 hours of receipt of the request for release made by the minor or

the minor's parent who has custody of the minor or the minor's guardian, the minor shall be released.

(c) If a minor is admitted to an inpatient treatment facility while under 14 years of age, and if upon reaching age 14 is in need of further inpatient care and treatment, the professional person in charge of the facility shall request the minor to execute an application for voluntary admission. If the application is not executed by the time the minor's 14th birthday, the minor shall be discharged unless a petition is filed for involutnary commitment or protective placement by the end of the next day in which the court transacts business.

Purpose: More clearly defines the minor's ability to seek discharge from the facility. Clarifies the process by which the minor obtains discharge including time frames.

PAGE 5 LINE 4

Add: Section 47.30___ STANDARD. A person may be involuntarily committed to a treatment facility under the procedures of AS 47.30 only if the person evidences:

(1) a substantial probability of physical harm to himself or herself as evidenced by recent threats of or attempts at suicide or serious bodily harm;

(2) a substantial probability of physical harm to other persons as manifested by evidence of recent homicide or other violent behavior on his or her party or by evidence that others are placed in

reasonable fear of violent behavior and serious physical harm to them, as evidence by a recent overt act, attempt to threat to do such physical harm on his or her part; or

(3) a very substnatial probability of grave disability due to mental illness, as manifested by evidence of a pattern of recent acts or omissions. Such acts or omissions may include complete neglect of basic needs for food, clothing, shelter or personal safety. The probability of physical impairment or injury may not be deemed very substantial under this subdivision if reasonable provision for the individual's protection is available in the community;

(4) there is no less restrictive alternative available for his or her treatment.

Purpose: Although the standards for commitment are stated elsewhere in the bill, we feel that a clear exposition of these standards in a single place, although redundant, would greatly assist the physicians, mental health professionals and citizens having to interpret this terribly complex legislation and help the Department interpret these standards to the persons who will be judged by these standards. The less obscure our laws are to the average citizen, the more useful they become.

Section 47.30.__ NON-EMERGENCY DETENTION FOR EVALUATION INVOLVING DESIGNATED EXAMINER.

(a) A person seeking the commitment of another to a treatment facility may initiate the proceedings by executing a petition for evaluation

and presenting it to a designated examiner. The petition must allege:

(1) the facts and specific behavior of the respondent as evidence by standards set forth in AS 47.30;

(2) the names, addresses and phone numbers of all persons known to the petitioner who have knowledge of the facts through personal observation.

(b) A designated examiner who receives a properly executed petition for evaluation shall investigate or cause to be investigated and evaluated the specific facts alleged and the reliability and credibility of the person providing the information. If, after investigation, the designated examiner determines that there is good reason to believe that the allegations are true and the respondent does not agree to come voluntarily to a facility for evaluation, the designated examiner may obtain from the court and cause to be served on the respondent and his guardian, if there is one, a summons requiring the respondent to appear at a designated evaluation facility for an evaluation period of not more than 72 hours. If there is no evaluation facility in the respondent's community, the court shall determine whether evaluation personnel shall be brought into the community or whether the respondent should be transported to the nearest available evaluation facility at no cost to him. The summons shall then specify, as the place for the respondent to appear, the place of evaluation by evaluation personnel or the place of transport. The evaluation facility or personnel shall be given a copy of the petition and summons.

(c) The summons shall contain the following information:

(1) date and time within which the respondent must appear, not less than 24 hours after service of the summons;

(2) address of the evaluation facility, other place of evaluation, or place of transport to which the respondent is to report;

(3) name, business address and phone number of the designated examiner issuing the summons;

(4) a statement that if the respondent fails to appear at the appointed place or before the date and time stated in the summons, he may be involuntarily taken into custody and transported to the appointed place;

(5) a copy of the petition for evaluation and a notice of rights regarding commitment procedures as set out in AS 47.30.___ of this chapter; and

(6) the name of an attorney appointed by the court to represent the respondent if the respondent cannot afford or has no knowledge of any other attorney.

(d) No summons may be served when more than seven days have passed since its issuance. No petition for evaluation may be used as the

basis for issuance of a second summons after the first has expired unless subsequent investigation by the designated examiner reveals that the grounds for evaluation still exists.

(c) If the person summoned fails to appear on or before the date and time specified, the evaluation facility shall immediately notify the designated examiner, who shall cause the person to be taken into custody and transported to the evaluation facility. A peace officer may take the respondent into custody and convey him to an evaluation facility at the request of the designated examiner.

Section 47.30.052 NON-EMERGENCY DETENTION FOR EVALUATION WHEN NO DESIGNATED EXAMINER IN GEOGRAPHICAL AREA. A person seeking the commitment of another to a treatment facility in a geographical area when there is no designated examiner may execute a petition for evaluation as set forth in AS 47.30.___ and present it to the court. The court shall cause the allegation of the petition to be investigated. If the court detemrines there is good reason to believe that the allegations are ture, it shall issue a summons containing the information set out in AS 47.30.___ (3), with the exception of (c) (3). No summons may be served when more than seven days have passed since its issuance. If the person fails to appear at the designated evaluation facility on or before the date and time specified, the evaluation facility shall immediately notify the court, who may cause the person to be taken into custody and transported to the evaluation facility by a peace officer.

Purpose: This added section establishes early contact with the person responsible for delivery of treatment and allows for early evaluation of the circumstances surrounding the need for treatment. It allows the person to voluntarily

seek help from a qualified professional. It clearly sets out the procedures and evidence necessary. It relieves peace officers and courts of initial diagnosis and allows for trained professionals to evaluate the circumstances. In perhaps 50 percent of cases, it should relieve the necessity for involuntary commitment.

Since the community mental health centers' professional staff often function in this role as informally arranged by local communities, this section simply codifies the procedure and makes it more likely to be utilized.

PAGE 5, LINES 4-22

Delete: Lines 4-22.

Purpose: This provision provides that a judge may issue an ex parte order orally or in writing and may direct a peace officer take the allegedly mentally ill person into custody and deliver the person to the "nearest" designated appropriate facility for examination and treatment. A probable cause hearing is to follow within 72 hours. The Department's concern is not that an order of this type abrogates a person's due process rights but rather that there be sufficient staff in the courts and other involved agencies to allow for implementation of such a provision. It would be possible for a person to be picked up and sent to the Alaska Psychiatric Institute from a rural area in Alaska without a local mental health professional or paraprofessional being involved in an investigation or determination as to whether there is a less restrictive alternative nearer to the patient's residence. The Alaska Psychiatric Institute is at present the only designated facility in Alaska. The entry into the system is the most critical period both from a legal stand point as well as from a treatment point of view.

Early intervention by trained personnel cannot only avoid unnecessary hospitalization but also can prevent unnecessary court proceedings. This procedure is similar to that in use by the juvenile justice system in their use of the intake officer appointed by the court to investigate the police report or petition prior to or in lieu of adjudication by the court.

The present law allows for the initiation of an emergency involuntary commitment only after a licensed physician signs a certificate stating that the person is in need of emergency hospitalization. The only mental health or professional person to look at the person is removed in this bill. It goes further to state that regardless of whether or not the patient is in need of hospitalization, the admitting facility must receive the patient.

This section violates the intent of the rest of the bill. It deprives the patient of an early treatment opportunity and gives powers to the police that are ripe for misuse.

PAGE 5, LINE 4

Substitute: INITIATION OF INVOLUNTARY COMMITMENT PROCEDURES.

(a) Upon petition of any adult person, a judge may appoint a designated examiner to determine if the allegations of the petition are factual; evaluate whether there is probable cause to believe the person is gravely disabled or is mentally ill and that condition causes the person to present a likelihood of serious harm to himself or others; and recommend disposition of the petition. Upon the findings of the designated examiner, the court may issue an ex parte order orally, or in writing, within 48 hours of the

petition. The court shall appoint an attorney to represent the respondent, and may direct that a peace officer take the person into custody and deliver him to the nearest designated appropriate facility for evaluation. The ex parte order shall be provided to the respondent and made a part of the respondent's clinical record.

(b) The petition required in (a) of this section shall allege that the respondent is reasonably believed to present the conditions of AS 47.30.___(Standards) and shall specify the factual information on which that belief is based including the names and addresses of all persons known to the petitioner who have knowledge of those facts through personal observation.

Purpose: Introduces designated examiner into procedure.

PAGE 5, LINE 7

Substitute: (a) a peace officer who has probable cause to believe that a person who is gravely disabled or a mentally ill person who is likely to cause serious harm to himself or others of such an immediate nature that considerations of safety do not allow preliminary intervention by a "designated examiner", may cause the person to be taken into custody and delivered to an evaluation facility. Upon arrival at the evaluation facility, the peace officer shall complete a petition for evaluation and be interviewed by a mental health professional or a physician at the facility. A copy of the petition shall be given to the respondent and to his guardian, if any.

(b) The designated examiner or physician shall examine the person immediately upon arrival at the evaluation facility to determine if there is probable cause to involuntarily detain the person pursuant to AS 47.30.___ Involuntary Commitment Procedures.

(c) If there is no evaluation facility in the respondent's community or the evaluation personnel are not presently htere and the respondent needs to be detained for the arrival of personnel or transportation under AS 47.30.___, the emergency custody under AS 47.30.___ may include detention as long as the first available transportation is utilized. The respondent may not be held in a jail or correctional facility if there is any other possible place of detention providing adequate security. A person may be detained until the emergency has passed or for seven days, whichever limit is reached first. While detained, the respondent shall be given care and treatment that is appropriate and available in the community.

Purpose: Again, the intermediate step of local evaluation is interposed to further avoid court action or an unnecessary trip to Alaska Psychiatric Institute. Often untrained personnel, when encountering bizarre behavior, immediately consider that behavior a safety problem. Often police frighten mentally ill persons. Experience with emergency psychiatric teams responding to report of a person in need of assistance are able to either resolve the person's conflict situation causing the acting out behavior or often can talk persons who need hospitalization into going voluntarily.

PAGE 6, LINE 9

Substitute: "mental health professional and the physician who perform"

Purpose: Consistency of language.

PAGE 6, LINE 13

Substitute: "the physician may hospitalize"

Purpose: Only physicians have admitting privilege to hospitals.

PAGE 6, LINE 15

Substitute: "the head of the facility or his designee"

Purpose: Should be accomplished by administrator, mental health professional or physician. Gives more administrative flexibility.

PAGE 7, LINE 2

Change notation of standards to reflect revised standards section.

PAGE 8, LINE 17

Substitute: "a mental health professional and physician"

Purpose: Consistency.

PAGE 9, LINE 6

Substitute: "to a designated treatment facility."

Purpose: Consistency of language.

PAGE 9, LINE 7

Delete: "or less restrictive alternative for a period of not exceed 14 days"

Purpose: Redundant.

PAGE 13, LINE 5-6

Substitute: "by the program of the respondent"

Purpose: Original intent was to allow less restrictive programs to accept or reject patient not vice versa.

PAGE 14, LINE 16

Add: "parent who has custody of the minor"

Purpose: Consistency.

PAGE 14, LINE 17

Add: "parents who have custody of the minor"

Purpose: Consistency.

PAGE 15, LINE 13

Add: "custody by a peace officer and"

Purpose: Makes it clear mental health professionals do not have police powers.

PAGE 19, LINE 17

Delete: "or mental health professional"

Purpose: Mental health professionals cannot legally practice medicine.

PAGE 27, LINE 14

Substitute: "within one year"

Purpose: 4 years seems an unnecessarily long period to store personal effects and unclaimed funds.

PAGE 31, LINE 1

Add: "designated examiner" - a mental health professional or physician designated by the Department of Health and Social Services with the concurrence of the court to examine, evaluate and recommend disposition of persons alleged to be mentally ill or having impaired judgment.

PAGE 31, LINE 8-9

Delete: who conduct evaluations in places in which no staffed evaluation facility exists.

Purpose: With addition of definition of designated examiner, this definition becomes a general definition.

PAGE 31, LINE 27

Delete: "and substantial"

Purpose: Almost impossible to judge what substantial bodily harm is--a hangnail or loss of a limb. Both can kill.

PAGE 32, LINE 1

Delete: "and substantial"

Purpose: Consistency.

PAGE 32, LINE 10-11

Add: "social worker with a Masters of Social Work degree"

Purpose: More specifically defines professional social worker.

PAGE 32, LINE 20-21

Delete: "state, municipal, or other local health officer, public health nurse"

Purpose: Defining these groups as peace officers is inconsistent with the retirement programs and other Alaska Statutes.

Addendum

PAGE 2, LINES 19, 20, & 21

Substitute: Unites States Agency.

Purpose: Gives a wider range of potential treatment facilities with which to enter into contracts.

Introduced: 1/24/79
Referred: Health,Education & Social Services and Finance

IN THE HOUSE

BY CHATTERTON,MALONE AND PHILLIPS

HOUSE BILL NO. 66

IN THE LEGISLATURE OF THE STATE OF ALASKA

ELEVENTH LEGISLATURE - FIRST SESSION

A BILL

For an Act entitled: "An Act providing an exemption for senior citizens from payment for land leased from the state."

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

* Section 1. AS 38.05 is amended by adding a new section to read:

Sec. 38.05.098. SENIOR CITIZENS EXEMPTION. (a) The real property occupied as a permanent place of abode by a resident 65 years of age or over and leased by that resident from the state in accordance with AS 38.05.070 - 38.05.105 is exempt from the payment of an annual lease rent. Only one exemption may be granted with respect to the same property and, if two or more persons are eligible for an exemption with respect to the same property, the parties shall decide between or among themselves which shall receive the benefit of the exemption. No exemption may be granted for any portion of the lease is used by the leaseholder for any purpose other than his permanent place of abode.

(b) No exemption may be granted except upon written application for the exemption on a form provided by the director of land and water management. The leaseholder must file the application not later than 60 days before the anniversary date of the lease, and shall file a separate application for each lease year for which the exemption is sought. If an application is filed within the required time and is approved by the director, he shall allow a rental exemption for the lease year commencing on the anniversary date in accordance with the provisions of this section. The director may at any time require proof in the form he considers necessary of the right to an exemption claimed under this

section.

(c) The legislature shall annually appropriate from the general fund to any trust fund the sums necessary to reimburse the trust fund for amounts lost to it by the operation of (a) of this section.

SECTIONAL SYNOPSIS FOR THE RULES COMMITTEE SUBSTITUTE FOR HB 472:

AN ACT RELATING TO MENTALLY ILL ~~AND DEVELOPMENTALLY DISABLED PERSONS~~

Sec. 47.30.655. page 1 thru line 1 of page 2:

This states the purpose of this act and lists principles of mental health care.

Sec. 47.30.660. page 2, lines 2 thru 29, and page 3, lines 1 thru 15:

This section lists the powers and duties of the Department of Health & Social Services.

Sec. 47.30.665. page 3, lines 16 thru 21:

This section allows prayer as a method of treatment.

Sec. 47.30.670. page 3, lines 23 thru 26:

This section allows a person age 14 or older to be voluntarily admitted to a treatment facility if he voluntarily signs the admission papers.

Sec. 47.30.675. page 3, lines 27 thru 29, and page 4, lines 1 thru 8:

This section requires a person applying for voluntary admission to be notified of his rights which includes notification that if he is mentally ill and wishes to leave the facility, the facility can initiate involuntary commitment proceedings against him. Rights must be explained in a language the applicant understands.

Sec. 47.30.680. page 4, lines 9 thru 12:

This section allows a person no longer in need of treatment to be released from a facility.

Sec. 47.30.685. page 4, lines 13 thru 23:

This section requires a voluntary patient, 14 or older, to submit a written notice of intent to leave to the facility. Evaluation must be immediately after the notice is given, put into writing, and the the patient must either be released immediately, or given written notice that involuntary commitment proceedings will commence. The facility can keep the patient no more than 48 hours after notice to leave is given.

Sec. 47.30.690. page 4, lines 24 thru 27:

This section allows a person under age 14 to be voluntarily admitted to a facility if his parents or guardian signs admission papers and the facility agrees that person is in need of treatment.

Sec. 47.30.695. page 4, lines 28 thru 29, and page 5, lines 1 thru 2:

This section allows the parent or guardian of any person under 14 to request and obtain release of that person at any time.

Sec. 47.30.700. page 5, lines 4 thru 22:

This section allows a judge to issue an ex parte order if there is probable cause that a person is gravely disabled or a harm to himself or others. The court may direct a peace officer to take a person to a facility for emergency evaluation or treatment.

Sec. 47.30.705. page 5, lines 23 thru 29, and page 6, lines 1 thru 3:

This section allows a peace officer to take a person who is a serious harm to himself or others to a treatment or evaluation facility. The peace officer must complete an application for examination of the person and be interviewed by a mental health professional.

Sec. 47.30.710. page 6, lines 4 thru 18:

This section states that any person taken into custody under either section 700 or 705 shall be examined and evaluated by both a mental health professional and a physician within 24 hours after arrival at the facility. A person may then be hospitalized on an emergency basis.

Sec. 47.30.715. page 6, lines 19 thru 28:

This section says that when a facility receives an order for evaluation, it must accept the person for an evaluation period with a maximum of 72 hours. At that time the facility shall notify the court and the court shall set a date, time and place for a probable cause hearing. The facility, the patient, his attorney, evaluation personnel, and the prosecuting attorney shall be notified of the hearing arrangements.

Sec. 47.30.720. page 6, line 29, and page 7, lines 1 thru 6:

This section allows a person to be released if he is not a harm to himself or others and that is determined by a mental health professional during the 72-hour evaluation period. If hearing arrangements have started, the court must be notified of the patient's release.

Sec. 47.30.725. page 7, lines 7 thru 29, and page 8, lines 1 thru 11:

This section establishes a person's rights during commitment proceedings.

Sec. 47.30.730. page 8, lines 12 thru 29, and page 9, line 1 thru 9:

This section explains the proceedure for a 14-day commitment.

Sec. 47.30.735. page 9, line 10 thru 29, and page 10, line 1 thru 11:

This section explains the 14-day commitment court hearing.

Sec. 47.30.740. page 10, line 12 thru 29, and page 11, line 1 thru 7:

This section sets up the procedure for a 90-day commitment following a 14-day commitment.

Sec. 47.30.745. page 11, line 8 thru 29, and page 12, line 1 thru 21:

This section lists 90-day commitment hearing rights.

Sec. 47.30.750. page 12, line 22 thru 24:

This section refers to the conduct of the hearing.

Sec. 47.30.755. page 12, line 25 thru 29, and page 13, line 1 thru 5:

This section says the court or jury must find clear and convincing evidence that the allegations in sec. 740 are true and can then commit a person to a facility for no more than 90 days. The court may order a less restrictive alternative treatment not to exceed 90 days.

Sec. 47.30.760. page 13, line 6 thru 19:

This section states where, or which treatment facility will be used.

Sec. 47.30.765. page 13, line 20 thru 22:

This section allows a person the right to appeal any order of involuntary commitment.

Sec 47.30.770. page 13, line 23 thru 29, and page 14, line 1 thru 11:

This section sets the procedure for a 120-day involuntary commitment. It further states that no order of commitment may exceed 120 days.

Sec. 47.30.775. page 14, line 12 thru 22:

This section explains involuntary commitment of minors. It is the same as for adults except that all notices required to be served in secs. 700-820 shall also be served on the parents or guardian.

Sec. 47.30.780. page 14, line 23 thru 28:

This section allows a person committed to be released any time during commitment if a professional discovers he is no longer a serious harm to himself or others.

Sec. 47.30.785. page 14, line 29, and page 15, line 1 thru 6:

This section allows an involuntary patient to get appropriate authorization to be absent from a facility if the absence is in his best interests and he is not likely to cause harm to himself or others.

Sec. 47.30.790. page 15, line 7 thru 13:

This section allows a facility to return a person to treatment if that person 's absence is not authorized or is excessive.

Sec. 47.30.795. page 15, line 14 thru 29, and page 16, line 1 thru 18:

This section allows out-patient care to be substituted for involuntary in-patient care and sets up to criteria for it.

Sec. 47.30.800. page 16, line 19 thru 29, and page 17, line 1 thru 5:

This section allows involuntary out-patient care to be changed to involuntary in-patient care.

Sec. 47.30.805. page 17, line 6 thru 26:

This section states how time periods for commitment are determined.

Sec. 47.30.810. page 17, line 27 and 28:

This gives a person the right to a writ of habeas corpus.

Sec. 47.30.815. page 17, line 29, and page 18, line 1 thru 15:

This section limits the liability of persons'actions regarding commitment proceedings and established a penalty for those not having good cause.

Sec. 47.30.820. page 18, line 16 thru 23:

This section says the terms of this chapter are not retroactive, but will apply to all persons committed 90 days after October 1, 1978 (the effective date of the bill).

Sec. 47.30.825. page 18, line 25 thru 29, and page 19, line 1 thru 29, and page 20, line 1 thru 29, and page 21, line 1 thru 15:

This section gives patient rights including knowledge of medication given, access to records, restricted use of a "quiet room" or other physical restraints, the right to refuse medication or electro-convulsive therapy, and to refuse psychosurgery or lobotomy. In addition, no psychosurgery or lobotomy may be performed without a court order after a hearing. This section also provides a discharge plan for a patient when he leaves a facility.

Sec. 47.30.830. page 21, line 16 thru 29, and page 22, line 1 thru 3:

This section prohibits experimental treatments.

Sec. 47.30.835. page 22, line 4 thru 9:

This section guarantees a person's civil rights when undergoing evaluation or treatment.

Sec. 47.30.840. page 22, line 10 thru 29, and page 23, line 1 thru 5:

This section gives persons undergoing evaluation or treatment the right to privacy and personal possessions.

Sec. 47.30.845. page 23, line 6 thru 26:

This section states that all records nd information obtained during evaluation, examination or treatment shall be kept confidential.

Sec. 47.30.850. page 23, line 27 thru 29, and page 24, line 1 thru 4:

This section allows all court records to be destroyed after a person has been discharged from a facility.

Sec. 47.30.855. page 24, line 5 thru 9:

This section states that the rights set out in secs. 825-855 shall be posted in all treatment facilities and patients not understanding English shall have their rights explained to them in a language they understand.

Sec. 47.30.860. page 24, line 10 thru 14:

This section says that all notices and documents required in this chapter shall be explained in a language the person understands.

Sec. 47.30.865. page 24, line 15 thru 29:

This section states that the fact that a person has been evaluated or treated for mental illness is not a basis for discrimination.

Sec. 47.30.870. page 25, line 2 thru 18:

This section allows the department to arrange and pay for a person's transportation to be evaluated, involuntarily committed, or to attend a judicial hearing. It further allows a friend or relative to travel with the patient when necessary, and the department may pay for that person's travel also.

Sec. 47.30.875. page 25, line 19 thru 29, and page 26, line 1 thru 19:

This section describes the treatment of nonresident patients.

Sec. 47.30.880. page 26, line 20 thru 25:

This section ratifies the "Interstate Compact on Mental Health".

Sec. 47.30.885. page 26, line 26 thru 29, and page 27, line 1:

This section mentions patient's rights outside the state.

Sec. 47.30.890. page 27, line 2 thru 9:

This section secures clothing, money, and a place to live for those released from a treatment facility.

Sec. 47.30.895. page 27, line 10 thru 23:

This section explains what to do with personal effects and unclaimed funds if a patient dies before discharged from a facility.

Sec. 47.30.900. page 27, line 24 thru 29, and page 28, line 1 thru 6:

This section says that when a patient leaves a facility without authority or dies, the department must make inquiries to find that person's legal heirs or representatives. Any money or articles of personal property must be turned over to the proper person. Claims to the money or property may be presented.

Sec. 47.30.905. page 28. line 7 thru 24:

This section tells who pays the fees and expenses for judicial proceedings.

Sec. 47.30.910. page 28, line 25 thru 29, and page 29, line 1 thru 29, and page 30, line 1 thru 25:

This section explains who is liable for expenses in a treatment facility. If a person is voluntarily committed, his monthly charge is based on his ability to pay, as determined by the department. After a voluntary patient has been in a facility for 12 months, his monthly fee is $50.00. If a person is involuntarily committed, his monthly fee is $50.00.

Sec. 47.30.915. page 30, line 26 thru 29, page 31, line 1 thru 29, page 32, line 1 thru 29, page 33, line 1 thru 12:

This is the definition section for chapter 30.

Sec. 47.30.010. page 34, line 1 thru 16:

This section states that persons with handicaps have the same legal rights as all other persons.

Sec. 47.80.020. page 34, line 17 thru 24:

This section says the Department of Health & Social Services shall protect and advocate the rights of persons with handicaps.

Sec. 47.80.030. page 34, line 27 thru 29, and page 35, line 1 thru 6:

This section establishes the Governor's Council for the Handicapped and Gifted.

Sec. 47.80. 040. page 35, line 7 thru 27:

This section sets out the composition of the council.

Sec. 47.80. 050. page 35, line 28 & 29, and page 36, line 1 thru 10:

This section sets out the terms of office for members of the council.

Sec. 47.80.060. page 36, line 11 thru 13:

This section says council members receive no salary, but do get per diem and travel money.

Sec. 47.80. 070. page 36, line 14 thru 21:

This section allows for officers and staff for the council.

Sec. 47.80.080. page 36, line 22 thru 28:

This section sets out the bylaws of the council.

Sec. 47.80.090. page 36, line 1, and page 37, line 1 thru 29, and page 38, line 1 thru 24:

This section states the responsibilities of the council.

Sec. 47.80.100. page 38, line 26 thru 29, and page 39, line 1 thru 13:

This section allows for programs for the handicapped with the Departments of Health & Social Services and Education and other appropriate departments and for those departments to plan, develop, and implement a comprehensive system of services.

Sec. 47.80.110. page 39, line 14 thru 19:

This section sets out program principles.

Sec. 47.80.120. page 39, line 20 thru 29, and page 40, line 1 thru 4:

This section requires habilitation plans for those receiving services.

Sec. 47.80.130. page 40, line 5 thru 29, and page 41, line 1 thru 4:

This section gives the specific duties and powers of the department.

Sec. 47.80.140. page 41, line 5 thru 23:

This section states that residential facilities must get certificates of need and be licensed.

Sec. 47.80. 150. page 41, line 24 thru 29, and page 42, line 1 thru 29, and page 43, line 1 thru 10:

This section is about liability for expense of services. Those with handicaps pay for services according to their ability to pay, and those developmentally disabled pay a maximum of $30.00 per month.

Sec. 47.80.160. page 43, line 11 thru 26:

This section allows the department to arrange and pay for the travel of persons traveling to a facility. It allows a person to accompany the patient when it is in the best interests of the patient and the individual is indigent.

Sec. 47.80.170. page 43, line 27 thru 29, and page 44, line 1 thru 5:

This section says that when a person is discharged from a facility the department is responsible that the person has suitable clothes, transportation, a place to stay, and some money.

Sec. 47.80.900. page 44, line 7 thru 29, and page 45, line 1 thru 22:

This is the definition section for chapter 80.

*Sec. 4. of the bill, page 45, line 23 thru 29, and page 46, line 1 thru 7:

This section turns all records of the Alaska Developmental Disabilities Planning Council, and the Special Education Advisory Council to the Governor's Council for the Handicapped and Gifted.

*Sec. 5. of the bill, page 46, line 8:

This section repeals AS 47.30.010 thru .340. which is the old mental health commitment procedure act, and repeals AS 18.05.031. which allows the Department of Health & Social Services to be the sole advocate of the mental retarded.

*Sec. 6. of the bill, page 46, line 9:

The effective date is October 1, 1978.

HB

4

STATE OF ALASKA
THE LEGISLATURE
LEGISLATIVE AFFAIRS AGENCY

POUCH Y · STATE CAPITOL
JUNEAU, ALASKA 99811
907-465-3800

June 2, 1978

M E M O R A N D U M

SUBJECT: Health Providers Inventory Report

TO: The Honorable Charlie Parr

FROM: Sharman Haley
Research Analyst

Enclosed please find the final report of the Health Providers Inventory Project. In our opinion the data gathered in the course of this project make a significant contribution to the health planning information available in this state and provide a basis for further useful analysis.

We will be distributing additional copies of this report to interested legislators and agencies shortly after the legislative session. In the meantime a limited number of copies are available on request from our office.

SH:dh
Enclosure

ALASKA HEALTH CARE PROVIDER'S INVENTORY

PROJECT REPORT

Prepared by:
Rochelle Plotnick
(under contract with)
Legislative Affairs Agency
Research Division
May, 1978

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PREFACE

It is my pleasure to submit the final report on the Health Care Provider's Project. The project represents many hours of many people's time and those people should be recognized.

Debbie Behr, Research Analyst for Legislative Affairs, designed and worked on the project. Sharman Haley, Research Analyst, Legislative Affairs, provided technical assistance, moral support, and the computer program and print-out for the project. Susan Kilka was the graphic artist responsible for the map. Charlie Par[illegible] was the person requesting the project. Without him it might not have happened.

Each person involved with project did a fine job and should be proud of it. I want to thank everyone for their time, hard work, and most of all, patience and understanding.

Rochelle Plotnick
May, 1978

PROJECT HISTORY

During the 1977 legislative session, Representative Charlie Parr, chairman of the Health, Education and Social Services Committee, submitted a work order to Legislative Affairs Agency for an interim project regarding distribution and accessibility of Alaskan health care providers and facilities. Debbie Behr received the work order and began to draft a research design for the study.

An early decision was made as to which facilities and professionals would be included. Representative Parr was given a list of many possibilities and made his choices from it. The professions chosen were: 1) doctors; 2) registered nurses; 3) licensed practical nurses; 4) physician assistants; 5) dentists; 6) community health aides; 7) state public health nurses; 8) psychiatrists; 9) audiologists; 10) opticians 11) optometrists; 12) pharmacists. The facilities chosen were: 1) hospitals; 2) state public health centers; 3) community mental health centers; 4) diagnostic facilities; 5) Public Health Service - village built clinics; 6) communicative disorders clinics; 7) long-term care facilities.

The project design included a computer file which would hold all the data obtained - location, specialty, special resources, number of staff, etc. It would be capable of producing a print-out listing the facilities and professions and allow specific information to be stored and pulled from the file when needed. There was no provision for updating the computer file at that time.

The final product of the project was to be a map displaying location and concentration of facilities and professions by the use of colors, symbols or pins.

By August 1977, the project was well under way. Nearly half the facilities and professions had been coded and keypunched. Those remain- to be coded and keypunched were: pharmacists, physician assistants, audiologists, dentists, state public health centers, diagnostic facilities, Public Health Service - village built clinics and communicative disorders clinics. Debbie Behr went on leave at the end of August. In late September Rochelle (MacKinnon) Plotnick contracted with Legislative Affairs Agency to complete the project. Plotnick began coding the remaining categories where Behr had stopped. Data were difficult to obtain in several of the uncoded categories, such as audiologists and physician assistants. Also, some of the categories were not well defined, such as "diagnostic facility". Despite the difficulties, all the information had been gathered and coded by December 23. What remained was the keypunching of about 500 computer cards, the writing of a computer program and getting a print-out, the production of a map, and writing the report. All has now been completed, with this report being the final phase of the project.

The following sections of this report will explain the data, and tell <u>how</u> and from <u>where</u> they were obtained. Instructions for future use of the data base are included, as well as recommendation for the future of the project. Data sources are included in the "codes" section under chart "J: source of information".

METHODOLOGY

The main theme of this project was "obtain and incorporate"--which means that information was gathered and included in a data base. Take one category for example. A list of licensed pharmacists in Alaska was obtained from the Department of Commerce & Economic Development, Division of Occupational Licensing. The following information was then coded on a coding sheet for each pharmacist, and keypunched: project code; provide identification number; village code; type of profession; whether currently practicing; type of practice; whether itinerant; geographic region; speciality; whether medicaid clients accepted; and data source and date. Information which was not available or not applicable to pharmacists was coded "unknown". Since there were 157 pharmacists, there were 157 coding sheets, each filled out as described above. Thus, pharmacists were incorporated in the data base, to be included in the computer print-out when all categories were complete.

Not all categories had the same amount of information available as this illustrative case. Sometimes there was more, sometimes less. But this will be covered more explicitly with the description of each one.

RESULTS

In this section each category will be discussed. Their order of placement for discussion is based on the overlays on which they appear on the map: overlays one, two, and three respectively. This discussion will serve as a brief description for both the map and the computer print-out. Additional information is obtainable in the notebooks containing the coding sheets and their sources, the coding explanation book, or other references listed. This report will either give basic information or tell where to go for it. It should be kept in mind that change occurs constantly so this survey is already dated. New facilities are opening frequently and additional people are being licensed. Some licensed professionals are not practicing.

MAP EXPLANATION

Three shapes are used on the map: squares, circles and triangles. Small sizes represent one professional or one facility. Large sizes represent ten. A large size with a white dot placed in it represents 100. As each profession and facility is described from overlay 1, 2, and 3, its color will be given. A key with all this information is located on the upper right hand corner of the map. Also, a red disk accompanies the map. This disk serves as a distance guide for air travel. Its radius equals one hour's flying time, or 100 miles, in a "180" airplane.

OVERLAY 1

Public Health Service - Village Built Clinics

Public Health - Village Built Clinics are village built and owned clinic facilities leased to the Alaska Area Native Health Service. Primary health care is regularly provided in the clinic by community health aides. Care is also provided by the Alaska Area Native Health Service and state health professionals on an itinerant basis. There are 116 village built clinics in Alaska, located in rural areas. In some instances they are the only health facilities in an area. They are represented on the map by purple squares. Information was obtained from Alaska Area Native Health Service, Area General Services Branch.

Community Health Aides

Community Health Aides are Alaskans trained to provide primary health care in rural areas. Their responsibilities include examining patients with simple problems, determining appropriate treatment, making referrals, providing primary treatment, arranging transportation, and working with other health professionals visiting the village. Community Health Aides are permanent residents of the village in which they work, and must be acceptable to most of the people in their community. Their salary comes from either a regional health corporation, or another Native organization which obtains funds through contracting with the Alaska Area Native Health Service. The three health aid training agencies in the state are the AANHS in Anchorage, the Yukon-Kuskokwim Health

Corporation in Bethel, and the Norton Sound Health Corporation in Nome. At the time of this survey there were 216 Community Health Aides listed, according to the AANHS. Some of these are either full or part time, or alternates. They are shown on the map as brown dots. In some cases there is no PHS clinic for an aide to use, so the aide must work in people's homes. In approximately 25 villages the health aide is the ONLY health professional in the village.

State Public Health Centers

The 28 State Public Health Centers in Alaska are staffed by State Public Health Nurses who offer a wide range of services. The centers provide immunizations, vaccines, TB tests, VD screening and treatment, women's health screening (breast exams, pap smears, pregnancy tests), contraceptives, maternity care, and child health care and nutrition. They are represented on the map by brown squares. The data on them were obtained from the State Department of Health and Social Services (DH&SS).

Licensed Practical Nurses

According to the State Department of Commerce & Economic Development, Division of Occupational Licensing, there are 655 licensed practical nurses in Alaska. Data on whether or not they are practicing were unobtainable. An LPN must graduate from an accredited practical nursing program, complete the tenth grade or its equivalent, be at least 18, and pass a written exam issued by the State Board of Nursing. Most LPN's work in institutions since they are required to be supervised by a Registered Nurse. They are shown as green dots on the map. Practical nurses are exempt from state licensure if employed by the United States Government pursuant to AS 08.68.400(1).

Registered Nurses

At the time of the survey, the State Division of Occupational Licensing reported 2,283 Registered Nurses licensed and residing in Alaska. Data on those currently practicing were not available. To qualify as an RN one must complete high school or the equivalent, graduate from an accredited professional nursing school, and pass an exam issued by the State Board of Nursing. Their training is more technical than for LPN's, including anatomy, physiology, and more specialized courses. The map shows RN's with red dots. Registered Nurses are exempt from state licensure if employed by the United States Government pursuant to AS 08.68.400(1).

Physician Assistants

According to the Alaska Academy of Physician Assistants there are 66 Physician Assistants in Alaska. The Alaska State Medical Board is writing currently proposed licensing regulations for the PA's in the state. Pursuant to AS 08.64.107, the regulations will include educational qualifications, registration procedures, the scope of activities authorized and the responsibilities of the supervising or training physician. Until the regulations are promulgated, no mandatory registration for PA's exists. When they are promulgated, the Division of Occupational Licensing will have a listing of the PA's in Alaska. The 66 Physician Assistants listed in the project are represented by blue triangles.

OVERLAY II

Hospitals

From information supplied by the Division of Certification and Licensing, DHSS, 26 hospitals in Alaska were accounted for. Of these, seven are United State Public Health Service, and two are military. Seven of these facilities also serve as nursing homes, but were not with the nursing homes to avoid duplication. Hospitals are represented by red squares on the map.

Nursing Homes

Excluding the seven hospitals mentioned in the preceeding paragraph, there are four nursing homes in Alaska: Anchorage has two; Seward and Fairbanks have one each. Nursing homes are shown on the map as blue squares. This information was obtained from Certification and Licensing, Department of Health and Social Services.

Laboratories

There are approximately 24 labs in the state. Those located within hospitals were not included, to avoid duplication. Data were obtained from the Division of Public Health, DHSS. Labs are represented by orange triangles on the map.

Diagnostic Facilities

Originally, the intent of this category was to be a "catch-all" for anything accidently left out of the survey. It was used for miscellaneous facilities such as the Breast Cancer Detection Center in Fairbanks, the Kidney Machine Center in Anchorage, the health center at the University of Alaska in Fairbanks, the Anchorage Blood Bank, and the

health center in Anchorage run by the municipality, to name a few. Also, communicative disorders clinics are counted as diagnostic facilities. This was a category originally, and later was combined with diagnostic facilities for the print-out map. There are nine communicative disorders clinics in the state offering services such as hearing tests, hearing aid fittings, diagnostic evaluations of speech and hearing impairments, and diagnosis and treatment of otitis media. This group is represented by green squares on the map. This information was obtained from various sources. They include the Directory of Human Service Organizations, published by the Legislative Affairs Agency, the House HESS files, and the Department of Health & Social Services. For more specifics, one must refer to the coding sheets and code explanation book.

Doctors

According to the Alaska State Medical Association there are 551 physicians in Alaska. Of these, 360 are in private practice, 74 are with the military, 86 are with the United States Public Health Service, 12 are with other federal agencies (such as FAA, Native Health Corps, etc.), and 19 are with the State of Alaska. Besides the State Medical Association, the Division of Occupational Licensing was used as a data source. When known, a physician's specialty has been coded, but this is not reflected on either the map or the print-out. The only exception is for psychiatrists. These doctors were placed in a separate category and will be discussed in the section for overlay three. Orange dots were used for doctors on the map. Pursuant to AS 08.64.370. physicians employed by either the military or United States Public Health Service are exempt from state licensure.

Pharmacists

The Division of Occupational Licensing lists 157 licensed pharmacists in the state. It is not known how many of these are practicing. At least one pharmacist exists in every place there is a pharmacy in the state, but not vice versa. Pharmacists are shown as blue dots on the map. Pharmacists employed in federal institutions are exempt from licensure pursuant to AS 08.80.475.

OVERLAY III

Community Mental Health Centers

There are 20 Community Mental Health Centers throughout Alaska. With an emphasis on serving rural communities, the centers offer a wide range of services including outpatient care, counseling, follow-up after treatment, crisis intervention, education, planning, and consultation. The focus on these centers is to provide psychological assistance at a local level, minimizing institutionalization at Alaska Psychiatric Institute. Also, some psychological problems are not serious and can be easily treated at the local level. These centers appear as orange squares on the map. This data was obtained from the Division of Mental Health and Developmental Disabilities, DHSS.

Facilities for the Mentally Ill & Developmentally Disabled

In Alaska, there is one in-patient facility for the mentally ill and three in-patient facilities for the developmentally disabled. Alaska Psychiatric Institute is an in-patient treatment center located in Anchorage. It is owned and operated by the State of Alaska. Though its main purpose is for the mentally ill, API does treat some retarded individuals. The State of Alaska owns and operates Harborview Development Center for the developmentally disabled. Included are the mentally retarded, those suffering from severe cerebral palsy, epilepsy, or autism, or any condition resulting in impairment of general intellectual functioning, affecting a person's ability to function normally in society. Harborview's services include vocational-occupational training, recreational and physical therapy, psychological and social services and special education.

Harborview is in Valdez, Alaska. The two additional facilities for the retarded are in Anchorage. Hope Cottages operates two residential facilities for developmentally disabled children. Occasionally, hospitals will accept psychiatric patients, but they do so reluctantly as they are not official treatment centers. These facilities are represented by green triangles on the map. Information was obtained from the Division of Mental Health & Developmental Disabilities.

Psychiatrists

Psychiatrists are medical doctors specifically trained in psychiatry. There are 30 psychiatrists in Alaska, concentrated in the Anchorage area. They are represented on the map by purple dots. Data were obtained from the Alaska State Medical Association and the Division of Occupational Licensing.

Dentists

According to a survey conducted by the Alaska Dental Society in the fall of 1977, there are 220 practicing dentists in Alaska. They are shown on the map as brown triangles. Occupational Licensing has 370 licensed dentists, with 228 listing Alaskan addresses.

Optometrists

According to both the Division of Occupational Licensing and the Alaska Optometric Association there are 25 licensed optometrists in Alaska. Optometrists are individuals specifically trained to examine, diagnose and treat conditions or impairments of the vision system. Though commonly known as "doctors", optometrists are not medical doctors. (M.D.'s trained in this specialty are ophthalmologists). However, optometrists

do receive four years of specialized professional training after a minimum of two years of undergraduate college study. By Alaskan statute (AS 08.72.300), optometrists are allowed to diagnose optical deficiencies or deformities, prescribe or apply lenses, prisms, or ocular exercises for the correction or relief of the human eye. They are represented by purple triangles on the map.

Dispensing Opticians

The Division of Occupational Licensing lists 43 licensed opticians in Alaska. Their work includes preparing and dispensing lenses, spectacles, eyeglasses, or artificial eyes to intended wearers on written prescriptions from physicians or optometrists (AS 08.71.240.(3)). In other words, the patient has to go to either an optometrist or an ophthalmologist to get a prescription for glasses or contact lenses, and the dispensing optician fills the prescription. Dispensing opticians are shown as red triangles on the map.

Audiologists

There are 15 audiologists in Alaska, but not all are practicing. Information was obtained from the Alaska Speech and Hearing Association, since there is no licensing required for audiologists. (However, licensing legislation is currently pending.) Audiologists' work includes applying principles, methods, and procedures for measurement, testing, evaluation, prediction, consultation, counseling, instruction, and rehabilitation related to hearing and disorders of hearing. This specialty requires a graduate degree. Audiologists are represented by yellow dots on the map.

RECOMMENDATIONS

The data collected for this project have a variety of uses. There are numerous specialities that could be listed in a computer print-out. For example, if we wanted to know how many pediatricians there were in Southeastern Alaska, we could obtain a print-out of that category, with the proper computer program. Information exists concerning not only specialties, but geographic locations and special resources of facilities. Of course, not all information is as complete as others, but it can always be expanded.

The Department of Health & Social Services may be eligible to receive federal funds to collect statistics on health resources and facilities in Alaska. This Cooperative Health Statistics System is possible because of the 1974 Health Services Research, Health Statistics, and Medical Libraries Act - Public Law 93-641. Many of the health occupations in this program are included in the present survey. Dental hygienists, physical therapists, nursing home administrators, chiropractors, podiatrists, and veterinarians will also be included. In September of 1976, 45 states were at least in the developmental stages of data collecting. State Health Statistics Centers are usually in the health department of a state government. To be accepted into the program the center must meet specific criteria, including being able to obtain timely reliable and comprehensive data, use acceptable statistical ability, and establish plans for future expansion.

It is my recommendation that the data collected for this project be shared with the Alaska Department of Health & Social Services, providing they want it and the information could be of some benefit to them.

This project has future potential and could be useful for a number of organizations and purposes. The design for this data base has been set up and could easily be updated, annually, bi-annually, or once every two years.

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The Final Report from the Task Force on Definitions to the Cooperative Health Statistics Advisory Committee
August 30, 1976
DHEW Publication No. (HRA) 77-1456, Series 4-No. 19

Guidelines for Primary Health Care in Rural Alaska
by Joseph C. Whitaker, R. Ph.
DHEW, Health Services Administration, Indian Health Service, Alaska Area Native Health Service - 1976

Directory of Public Health Services
Department of Health and Social Services, Division of Public Health, 1975

A Comparison of Four Years of Mental Health Service Delivery
Department of Health & Social Services, Division of Mental Health and Developmental Disabilities, 1977

1977 Medical Directory
Alaska State Medical Association 1977

Legislative Briefing Supplement
Department of Health & Social Services 1978

INDEX TO ADDITIONAL PROJECT RESOURCES AND WHERE TO FIND THEM

1. A map showing distribution of facilities and professions - located in the house HESS Committee Room (112 Capitol Bldg.).
2. The completed coding sheets organized in labeled notebooks - located in the Legislative Affairs Agency, Research Division.
3. The keypunched data cards in three boxes in Legislative Research.
4. A computer print-out, communities listed by election district with amounts of facilities and professions tabulated - located in House HESS during the session, and Legislative Research.
5. A coding notebook, with code explanations and sources - located in Legislative Research.
6. A notebook with project correspondence, development, etc. located in Legislative Research.
7. A computer generated data tape, T01-31D-HREP(#3945-4) located in the data processing tape library, due to expire January, 1980.
8. The documentation of the tape generation and formating - located in Legislative Research.

INVENTORY OF HEALTH CARE FACILITIES AND HEALTH CARE PROVIDERS IN ALASKA
STATE TOTAL

PLACE	Village Built Clinics	State Public Health Centers	Hospitals	Nursing Homes	Laboratories	Diagnostic Facilities	Communicative Disorders Clinics	Community Mental Health Centers	Intermed.Care Facilities for Mentally Retarded	Community Health Aides	Licensed Practical Nurses	Registered Nurses	Physicians Assistants	Doctors	Psychiatrists	Pharmacists	Dentists	Optometrists	Opticians	Speech Pathologists	Audiologists
ALASKA	116	28	26	4	24	22	9	20	4	216	795	2716	66	558	30	157	220	38	47	74	15
OUTSIDE											140	433						13	4		
IN STATE TOTAL	116	28	26	4	24	22	9	20	4	216	655	2283	66	558	30	157	220	25	43	74	15

PREPARED BY LEGISLATIVE AFFAIRS AGENCY, RESEARCH DIVISION FEBRUARY 1978

INVENTORY OF HEALTH CARE FACILITIES AND HEALTH CARE PROVIDERS IN ALASKA
ELECTION DISTRICT 1

PLACE	Village Built Clinics	State Public Health Centers	Hospitals	Nursing Homes	Laboratories	Diagnostic Facilities	Communicative Disorders Clinics	Community Mental Health Centers	Intermed.Care Facilities for Mentally Retarded	Community Health Aides	Licensed Practical Nurses	Registered Nurses	Physicians Assistants	Doctors	Psychiatrists	Pharmacists	Dentists	Optometrists	Opticians	Speech Pathologists	Audiologists
ANNETTE ISLAND											1										
CRAIG		1								1		1								1	
HYDABURG	1									2											
KASAAN										1											
KETCHIKAN		1	1		2			1			17	77		15	1	11	5	2			1
KLAWOCK										2		1									
METLAKATLA	1									1											
WARD COVE											2	6									
DISTRICT TOTAL	2	2	1		2			1		7	20	85		15	1	11	5	2		1	1

PREPARED BY LEGISLATIVE AFFAIRS AGENCY, RESEARCH DIVISION FEBRUARY 1978

INVENTORY OF HEALTH CARE FACILITIES AND HEALTH CARE PROVIDERS IN ALASKA
ELECTION DISTRICT 2

PLACE	Village Built Clinics	State Public Health Centers	Hospitals	Nursing Homes	Laboratories	Diagnostic Facilities	Communicative Disorders Clinics	Community Mental Health Centers	Intermed.Care Facilities for Mentally Retarded	Community Health Aides	Licensed Practical Nurses	Registered Nurses	Physicians Assistants	Doctors	Psychiatrists	Pharmacists	Dentists	Optometrists	Opticians	Speech Pathologists	Audiologists
ANGOON	1					1				2		1									
GUSTAVUS												1									
HOONAH		1								3	1	2								1	
KAKE						1				2		1									
PETERSBURG		1	1		1						3	25		2		3	1			2	
TENAKEE SPRINGS										1		1									
WRANGELL		1	1		1						2	12		2		1	1				
DISTRICT TOTAL	1	3	2		2	2				8	6	43		4		4	2			3	

INVENTORY OF HEALTH CARE FACILITIES AND HEALTH CARE PROVIDERS IN ALASKA
ELECTION DISTRICT 3

PLACE	Village Built Clinics	State Public Health Centers	Hospitals	Nursing Homes	Laboratories	Diagnostic Facilities	Communicative Disorders Clinics	Community Mental Health Centers	Intermed. Care Facilities for Mentally Retarded	Community Health Aides	Licensed Practical Nurses	Registered Nurses	Physicians Assistants	Doctors	Psychiatrists	Pharmacists	Dentists	Optometrists	Opticians	Speech Pathologists	Audiologists
ELFIN COVE														1							
MOUNT EDGECUMBE			1				1				8	12		7		1	2				1
PELICAN												3									
SITKA		1	1					1			12	43		5		4	3	1		1	
YAKUTAT	1									2		2									
DISTRICT TOTAL	1	1	2				1	1		2	20	60		13		5	5	1		1	1

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INVENTORY OF HEALTH CARE FACILITIES AND HEALTH CARE PROVIDERS IN ALASKA
ELECTION DISTRICT 4

PLACE	Village Built Clinics	State Public Health Centers	Hospitals	Nursing Homes	Laboratories	Diagnostic Facilities	Communicative Disorders Clinics	Community Mental Health Centers	Intermed.Care Facilities for Mentally Retarded	Community Health Aides	Licensed Practical Nurses	Registered Nurses	Physicians Assistants	Doctors	Psychiatrists	Pharmacists	Dentists	Optometrists	Opticians	Speech Pathologists	Audiologists
HAINES		1										6		2			1			1	
JUNEAU		1	1		1			1			29	156		23	1	10	10	2	1	6	1
KLUKWAN										1											
SKAGWAY						1						6									
DISTRICT TOTAL		2	1		1	1		1		1	29	168		25	1	10	11	2	1	7	1

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INVENTORY OF HEALTH CARE FACILITIES AND HEALTH CARE PROVIDERS IN ALASKA
ELECTION DISTRICT 5

PLACE	Village Built Clinics	State Public Health Centers	Hospitals	Nursing Homes	Laboratories	Diagnostic Facilities	Communicative Disorders Clinics	Community Mental Health Centers	Intermed. Care Facilities for Mentally Retarded	Community Health Aides	Licensed Practical Nurses	Registered Nurses	Physicians Assistants	Doctors	Psychiatrists	Pharmacists	Dentists	Optometrists	Opticians	Speech Pathologists	Audiologists
CHENEGA													3								
COPPER CENTER	1							1		1	1	4									
CORDOVA		1	1		1			1				20		2		1	1				
GLENNALLEN		1	1								2	17		1			1				
GULKANA	1									1											
HOPE												1				1					
SEWARD		1	1	1				1			12	31		2		2	1			1	
TATITLEK										1											
VALDEZ		1	1						1		10	41	2	2		3				4	1
DISTRICT TOTAL	2	4	4	1	1	—	—	3	1	3	25	114	5	7	—	7	3	—	—	5	1

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INVENTORY OF HEALTH CARE FACILITIES AND HEALTH CARE PROVIDERS IN ALASKA
ELECTION DISTRICT 6

PLACE	Village Built Clinics	State Public Health Centers	Hospitals	Nursing Homes	Laboratories	Diagnostic Facilities	Communicative Disorders Clinics	Community Mental Health Centers	Intermed.Care Facilities for Mentally Retarded	Community Health Aides	Licensed Practical Nurses	Registered Nurses	Physicians Assistants	Doctors	Psychiatrists	Pharmacists	Dentists	Optometrists	Opticians	Speech Pathologists	Audiologists
PALMER		1	1		1						10	45	1	5		3	2				
SUTTON												1									
TALKEETNA											1	4									
TRAPPERS CREEK														1							
WASILLA		1									3	17		1		2	3				
WILLOW											3	6									
DISTRICT TOTAL	---	2	1	--	1	--	--	--	--	---	17	73	1	7	---	5	5	---	---	---	---

PREPARED BY LEGISLATIVE AFFAIRS AGENCY, RESEARCH DIVISION FEBRUARY 1978

INVENTOPY OF HEALTH CARE FACILITIES AND HEALTH CAPE PROVIDERS IN ALASKA
ANCHORAGE AREA - ELECTION DISTRICTS 7-12

PLACE	Village Built Clinics	State Public Health Centers	Hospitals	Nursing Homes	Laboratories	Diagnostic Facilities	Communicative Disorders Clinics	Community Mental Health Centers	Intermed.Care Facilities for Mentally Retarded	Community Health Aides	Licensed Practical Nurses	Registered Nurses	Physicians Assistants	Doctors	Psychiatrists	Pharmacists	Dentists	Optometrists	Opticians	Speech Pathologists	Audiologists
ANCHORAGE			3	2	6	7	5	1	3		314	999	10	309	24	70	108	12	36	24	7
CHUGIAK											9	8				1			1		
EAGLE RIVER											20	63	3	1		4	2			2	
ELMENDORF AFB			1								99	37	1	9	1		17				
FORT RICHARDSON											19	28	1			1	3		1		
GIRDWOOD											3	7									
INDIAN												2									
PORTAGE	1									1											
DISTRICT TOTAL	1		4	2	6	7	5	1	3	1	374	1144	15	319	25	76	130	12	38	26	7

INVENTORY OF HEALTH CARE FACILITIES AND HEALTH CARE PROVIDERS IN ALASKA
ELECTION DISTRICT 13

PLACE	Village Built Clinics	State Public Health Centers	Hospitals	Nursing Homes	Laboratories	Diagnostic Facilities	Communicative Disorders Clinics	Community Mental Health Centers	Intermed.Care Facilities for Mentally Retarded	Community Health Aides	Licensed Practical Nurses	Registered Nurses	Physicians Assistants	Doctors	Psychiatrists	Pharmacists	Dentists	Optometrists	Opticians	Speech Pathologists	Audiologists
ANCHOR POINT												2		1						1	
ENGLISH BAY	1									1											
HOMER		1	1		1			1			6	26	1			1	2			1	
KASILOF												2									
KENAI	1	1						1			11	23	2	1		4	3	1		1	
NINILCHIK	1									1	1										
POINT GRAHM	1									1	1										
SELDOVIA												1		1							
SOLDOTNA			1		1						8	34		7		5	3			2	
STERLING												2									
TYONEK	1									1		1									
DISTRICT TOTAL	5	2	2	--	2	--	--	2	--	4	27	91	3	10	---	10	8	1	---	5	---

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INVENTORY OF HEALTH CARE FACILITIES AND HEALTH CARE PROVIDERS IN ALASKA
ELECTION DISTRICT 14

PLACE	Village Built Clinics	State Public Health Centers	Hospitals	Nursing Homes	Laboratories	Diagnostic Facilities	Communicative Disorders Clinics	Community Mental Health Centers	Intermed. Care Facilities for Mentally Retarded	Community Health Aides	Licensed Practical Nurses	Registered Nurses	Physicians Assistants	Doctors	Psychiatrists	Pharmacists	Dentists	Optometrists	Opticians	Speech Pathologists	Audiologists
KODIAK		1	1		1			1			9	29	1	9		4	2	1		3	
OUZINKIE										1											
DISTRICT TOTAL		1	1		1			1		1	9	29	1	9		4	2	1		3	

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INVENTORY OF HEALTH CARE FACILITIES AND HEALTH CARE PROVIDERS IN ALASKA
ELECTION DISTRICT 15

PLACE	Village Built Clinics	State Public Health Centers	Hospitals	Nursing Homes	Laboratories	Diagnostic Facilities	Communicative Disorders Clinics	Community Mental Health Centers	Intermed. Care Facilities for Mentally Retarded	Community Health Aides	Licensed Practical Nurses	Registered Nurses	Physicians Assistants	Doctors	Psychiatrists	Pharmacists	Dentists	Optometrists	Opticians	Speech Pathologists	Audiologists
ADAK														6							
AKHIOK										1											
AKUTAN										1											
ATKA	1									1											
CHIGNIK	1									1											
CHIGNIK LAGOON										1											
CHIGNIK LAKE										1											
COLD BAY		1										2									
DUTCH HARBOR											1										
FALSE PASS										1		1									
IVANOFF BAY										1											
KARLUK	1									1											
KING COVE												1									
LARSEN BAY	1									1		1									
NELSON LAGOON										1											
NIKOLSKI	1									1											
OLD HARBOR	1									1											
PERRYVILLE	1									1											
PORT LIONS	1									1				1							
SAND POINT										1		1									
SHEMYA					1																
SQUAW HARBOR											1										
ST. GEORGE ISLAND						1															
ST. PAUL ISLAND														1							
UNALASKA	1							1		1	1	1								1	
DISTRICT TOTAL	9	1			1	1		1		17	3	7		8						1	

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INVENTORY OF HEALTH CARE FACILITIES AND HEALTH CARE PROVIDERS IN ALASKA
ELECTION DISTRICT 16

PLACE	Village Built Clinics	State Public Health Centers	Hospitals	Nursing Homes	Laboratories	Diagnostic Facilities	Communicative Disorders Clinics	Community Mental Health Centers	Intermed.Care Facilities for Mentally Retarded	Community Health Aides	Licensed Practical Nurses	Registered Nurses	Physicians Assistants	Doctors	Psychiatrists	Pharmacists	Dentists	Optometrists	Opticians	Speech Pathologists	Audiologists
ALEKNAGIK	1									2											
CLARKS POINT	1									1											
DILLINGHAM		1	1					1			3	13		1			1			2	
EGEGIK	1									2											
EKWOK	1									1											
GOODNEWS										2											
IGIUGIG										1											
ILIAMNA										1											
KAKHONAK										1											
KANAKANAK														2							
KING SALMON	1									1	2										
KIPNUK	1									2											
KOLIGANEK	1									1											
KONGIGANAK	1									1											
KWIGILLINGOK	1									1											
LEVELOCK	1									1											
MANOKOTAK	1									2										1	
NAKNEK	1	1								2		1									
NEW STUYAHOK	1									2											
NEWHALEN	1									1											
NONDALTON										1											
PEDRO BAY										1											
PILOT POINT	1									1											
PORT HEIDEN	1									1											
QUINHAGAK	1									2											
SOUTH NAKNEK	1									1											
TOGIAK	1									2											
TWIN HILLS	1									1											
DISTRICT TOTAL	20	2	1	--	--	--	--	1	--	35	5	14	---	3	---	---	1	---	---	3	---

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INVENTORY OF HEALTH CARE FACILITIES AND HEALTH CARE PROVIDERS IN ALASKA
ELECTION DISTRICT 17

PLACE	Village Built Clinics	State Public Health Centers	Hospitals	Nursing Homes	Laboratories	Diagnostic Facilities	Communicative Disorders Clinics	Community Mental Health Centers	Intermed. Care Facilities for Mentally Retarded	Community Health Aides	Licensed Practical Nurses	Registered Nurses	Physicians Assistants	Doctors	Psychiatrists	Pharmacists	Dentists	Optometrists	Opticians	Speech Pathologists	Audiologists
AKIACHAK	1									2											
AKIAK	1									1	1			1							
ANIAK						1		1		2											
ATMAUTLAUK	1									1											
BETHEL		1	1					1			5	28		12			4				1
CHEFORNAK	1									1											
FEK	1									1	1										
KALSKAG	1									1											
KASIGLUK	1									2											
KUSKOKWIM																	1				
KWETHLUK	1									2											
LOWER KALSKAG	1									1											
MEKORYUK	1									2											
NAPAKIAK	1									2	1										
NAPASKIAK	1									1											
NEWTOK										1											
NIGHTMUTE										1											
NUNAPITCHUK	1									2											
OSCARVILLE	1									1											
PLATINUM										1											
TANUNAK	1									2											
TOKSOOK BAY	1									2											
TULUKSAK	1									1											
TUNTUTULIAK	1									1											
DISTRICT TOTAL	18	1	1	--	--	1	--	2	--	31	8	28	---	13	---	---	5	---	---	---	1

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INVENTORY OF HEALTH CARE FACILITIES AND HEALTH CARE PROVIDERS IN ALASKA
ELECTION DISTRICT 18

PLACE	Village Built Clinics	State Public Health Centers	Hospitals	Nursing Homes	Laboratories	Diagnostic Facilities	Communicative Disorders Clinics	Community Mental Health Centers	Intermed. Care Facilities for Mentally Retarded	Community Health Aides	Licensed Practical Nurses	Registered Nurses	Physicians Assistants	Doctors	Psychiatrists	Pharmacists	Dentists	Optometrists	Opticians	Speech Pathologists	Audiologists
ALAKANUK	1									2											
ANVIK	1									1											
CHEVAK	1									2		1									
CROOKED CREEK										1											
EMMONAK	1									3		1									
GALENA	1									1		1									
GRAYLING										1											
HOLY CROSS	1									1											
HOOPER BAY						1				3											
HUGHES	1									1											
HUSLIA	1									1											
KALTAG	1									1											
KOYUKUK	1									1											
LIME VILLAGE										1											
MARSHALL	1									1	1										
MCGRATH	1	1						1		1		2									
MOUNTAIN VILLAGE	1									2	1	2									
NIKOLAI	1									1											
NULATO						1				2											
PILOT STATION	1									2											
PITKAS POINT	1									1											
RED DEVIL	1									1											
RUBY	1									1		2									
RUSSIAN MISSION	2									2											
SCAMMON BAY	1									1											
SHAGELUK										1		1									
SHELDON POINT	1									1											
SLEETMUTE	1									1	1										
ST. MARY'S	1									2		1									
STONY RIVER										1											
TAKOTNA										1											
DISTRICT TOTAL	24	1				2		1		42	3	11									

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INVENTORY OF HEALTH CARE FACILITIES AND HEALTH CARE PROVIDERS IN ALASKA
ELECTION DISTRICT 19

PLACE	Village Built Clinics	State Public Health Centers	Hospitals	Nursing Homes	Laboratories	Diagnostic Facilities	Communicative Disorders Clinics	Community Mental Health Centers	Intermed.Care Facilities for Mentally Retarded	Community Health Aides	Licensed Practical Nurses	Registered Nurses	Physicians Assistants	Doctors	Psychiatrists	Pharmacists	Dentists	Optometrists	Opticians	Speech Pathologists	Audiologists
ALLAKAKET										1											
ANDERSON														3							
ARCTIC VILLAGE	1									1											
BEAVER										1											
BETTLES												1									
BIRCH CREEK	1									1											
CANTWELL												1									
CHALKYITSIK										1											
CHISTOCHINA	1									1											
CIRCLE										1											
CLEAR												1	1								
DELTA JUNCTION						1					2	6	1								
DOT LAKE	1									1											
EAGLE										1		1									
FORT YUKON						1															
GAKONA										1		2									
HEALY											2		5								
MANLEY HOT SPRINGS										1											
MCKINLEY												3									
MENTASTA										1											
MINTO										1											
NENANA	1									1		2									
NORTHWAY	1									1	1										
RAMPART										1											
STEVENS VILLAGE	1									1	1										
TANACROSS										1											
TANANA	1		1								1	3	1	3							
TETLIN										1											
TOK		1									2	2	2								
USTBELLI												1									
VENETIE										1											
DISTRICT TOTAL	8	1	1			2				20	9	23	10	6							

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INVENTORY OF HEALTH CARE FACILITIES AND HEALTH CARE PROVIDERS IN ALASKA
ELECTION DISTRICT 20

PLACE	Village Built Clinics	State Public Health Centers	Hospitals	Nursing Homes	Laboratories	Diagnostic Facilities	Communicative Disorders Clinics	Community Mental Health Centers	Intermed.Care Facilities for Mentally Retarded	Community Health Aides	Licensed Practical Nurses	Registered Nurses	Physicians Assistants	Doctors	Psychiatrists	Pharmacists	Dentists	Optometrists	Opticians	Speech Pathologists	Audiologists
CENTRAL											1										
EIELSON											6	22		3			8				
ESTER												1									
FAIRBANKS		1	1	1	5	2	3	2			64	298	28	106	3	22	26	5	4	17	2
FORT GREELY					1							1					1				
FORT WAINWRIGHT			1								17	24	2			1	3				
NORTH POLE											5	3				1		1			
DISTRICT TOTAL	---	1	2	1	6	2	3	2	--	---	93	349	30	109	3	24	38	6	4	17	2

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INVENTORY OF HEALTH CARE FACILITIES AND HEALTH CARE PROVIDERS IN ALASKA
ELECTION DISTRICT 21

PLACE	Village Built Clinics	State Public Health Centers	Hospitals	Nursing Homes	Laboratories	Diagnostic Facilities	Communicative Disorders Clinics	Community Mental Health Centers	Intermed.Care Facilities for Mentally Retarded	Community Health Aides	Licensed Practical Nurses	Registered Nurses	Physicians Assistants	Doctors	Psychiatrists	Pharmacists	Dentists	Optometrists	Opticians	Speech Pathologists	Audiologists
AMPLER	1									1											
ANAKTUVUK PASS										1											
ATKASUK										1											
BARROW		1	1					1				7		2						2	1
BARTER ISLAND										1											
KAKTOVIK	1																				
KIANA	1									2											
KIVALINA	1									1											
KOBUK	1									1											
KOTZEBUE		1	1					1			3	8		3			2				
NUATAK	1									1											
NOORVIK						1				2											
NUIQSAT	1									1											
POINT HOPE	1									2											
POINT LAY										1											
SHUNGNAK	1									1											
WAINWRIGHT	1									2											
DISTRICT TOTAL	10	2	2			1		2		18	3	15		5			2			2	1

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INVENTORY OF HEALTH CARE FACILITIES AND HEALTH CARE PROVIDERS IN ALASKA
ELECTION DISTRICT 22

PLACE	Village Built Clinics	State Public Health Centers	Hospitals	Nursing Homes	Laboratories	Diagnostic Facilities	Communicative Disorders Clinics	Community Mental Health Centers	Intermed.Care Facilities for Mentally Retarded	Community Health Aides	Licensed Practical Nurses	Registered Nurses	Physicians Assistants	Doctors	Psychiatrists	Pharmacists	Dentists	Optometrists	Opticians	Speech Pathologists	Audiologists
BREVIG MISSION	1									1											
BUCKLAND	1									1											
COUNCIL										1											
DEERING	1									1											
ELIM	1									1											
GAMBELL						1				2											
GOLOVIN	1									1											
KOTLIK	1									2											
KOYUK	1									1											
LITTLE DIOMEDE	1									1											
NOME		1	1		1			1			3	27	1	5		1	3				
SAVOONGA										2											
SELAWIK						1				2											
SHAKTOOLIK	1									1											
SISHMAREF	1									2		1									
ST. LAWRENCE ISLAND						1															
ST. MICHAEL	1									1											
STEBBINS	1									2											
TELLER	1									1											
UNALAKLEET	1	1								2	1	1									
WALES	1									1											
DISTRICT TOTAL	15	2	1	--	1	3	--	1	--	26	4	29	1	5	---	1	3	---	---	---	---

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HB

11

04-D3LH

STATE OF ALASKA

JAY S. HAMMOND GOVERNOR

DEPARTMENT OF REVENUE

OFFICE OF THE COMMISSIONER / POUCH S – JUNEAU 99811

February 2, 1979

The Honorable Thelma Buchholdt
Chairman
House Health, Education & Social
Service Committee
Juneau, Alaska

Re: House Bill No. 11

Dear Representative Buchholdt:

House Bill No. 11, an Act creating a net income tax deduction for child adoption expenses, was introduced in the House on January 24, 1979 and was referred to the House Health, Education & Social Services and Finance Committees.

For the consideration of the House Health, Education & Social Services Committee, I am enclosing a copy of a Fiscal Note prepared by Mr. Gary Jenkins, Director, Audit Division, Department of Revenue concerning the proposed legislation.

Sincerely,

R.D. Stevenson

cc: The Honorable Russ Meekins
Chairman
House Finance Committee

John Messenger
Deputy Commissioner
Department of Revenue

Cary Jenkins, Director
Audit Division
Department of Revenue

THE LEGISLATURE OF THE STATE OF ALASKA
ELEVENTH LEGISLATURE

FISCAL NOTE

I. REQUEST

Bill/Resolution No. House Bill No. 11

Title An Act creating a net income tax deduction for child adoption expenses

Requested by Health, Education & Social Services and Finance Committees Date February 1, 1979

II. FISCAL DETAIL

Agency Affected Revenue

Program Category Affected Fiscal Services

BRU, Program, or Subprogram(s) Affected Audit Division

(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars) None

		FY 79	FY 80	FY 81	FY 82	FY 83	FY 84
100	PERSONAL SERVICES						
200	TRAVEL						
300	CONTRACTUAL						
400	COMMODITIES						
500	EQUIPMENT						
600	LAND & STRUCTURES						
700	GRANTS, CLAIMS, ETC.						
	TOTAL						

FUNDING (Thousands of Dollars) None

GENERAL FUND						
FEDERAL FUNDS						
OTHER (Specify Fund Source)						

POSITIONS None

FULL TIME						
PART TIME						
TEMPORARY						

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

See attached memo to R. D. Stevenson dated February 1, 1979

IV. DATE February 1, 1979 PREPARED BY Gary Olson

AGENCY Department of Revenue, Audit Division

PHONE 465-2320

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)

33-001 (Rev. 12/78)

02-8118 (Rev. 10/78)

STATE
of ALASKA

MEMORANDUM

TO: R. D. Stevenson
Special Assistant
Department of Revenue

DATE: February 1, 1979

FILE NO:

TELEPHONE NO:

FROM: Gary L. Jenkins
Director
Audit Division

SUBJECT: House Bill No. 11

House Bill No. 11 would amend the State income tax statute by allowing taxpayers a deduction for the costs of child adoption. The amount of the deduction would be limited to $3,000. The Department of Revenue supports this bill as providing a reasonable tax deduction which would help to defray the costs of adoption.

We estimate that the annual revenue effect would be approximately $29,000. In estimating the costs of adoption which would be available for the tax deduction we have used information supplied by the Department of Health and Social Services. From that information it is estimated that the number of adoptions in the current year will be approximately 750. Of that total, approximately 70 percent are either step-parent adoptions or adoptions placed through the Department of Health and Social Services. For these adoptions the costs are relatively low and it is estimated that the average cost is about $250 per adoption. The remainder of adoptions are made through private agencies and the costs could range from $500 to $4,000, depending upon the agency used.

There would not be any added fiscal impact on the department.

HB

15

THE LEGISLATURE OF THE STATE OF ALASKA
ELEVENTH LEGISLATURE

FISCAL NOTE

I. REQUEST
Bill/Resolution No. HB 15
Title An Act relating to the Alaska longevity bonus
Requested by Representative Phillips Date February 9, 1979

II. FISCAL DETAIL
Agency Affected Department of Administration
Program Category Affected Division of Pioneers' Benefits
BRU, Program, or Subprogram(s) Affected Alaska Longevity Bonus
(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 79	FY 80	FY 81	FY 82	FY 83	FY 84
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL						
400 COMMODITIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC.	Ø	2,016.0	2,131.2	2,260.8	2,359.8	2,473.2
TOTAL	Ø	2,016.0	2,131.2	2.260.8	2,359.8	2,473.2

FUNDING (Thousands of Dollars)

GENERAL FUND	Ø	2,016.0	2,131.2	2,260.8	2,359.8	2,473.2
FEDERAL FUNDS						
OTHER (Specify Fund Source)						

POSITIONS

FULL TIME						
PART TIME						
TEMPORARY						

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)
This bill would change the residency requirement to any person who is 65 years of age and has lived in Alaska 25 years or who has intermittently maintained a domicile in the territor or state for a cumulative total of 30 years and has been physically in the state for five years immediately preceding his application and if periods cumulating 30 years are 12 months or more in length. There is no way of knowing how many recipients would be added to the program. The following figures are based upon an assumption of an immediate increase of 15% in the number of eligible recipients.

YEAR	RECIPIENTS		$		MO.		SUB-TOTAL
FY 1980	1120	x	150	x	12	-	2,016.0
FY 1981	1184	x	150	x	12	-	2,131.2
FY 1982	1256	x	150	x	12	-	2,260.8
FY 1983	1311	x	150	x	12	-	2,359.8
FY 1984	1374	x	150	x	12	-	2,473.2

IV. DATE February 9, 1979 PREPARED BY Vernon L. Perry
AGENCY Division of Pioneers' Benefits
PHONE 465-4400

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)

33-001 (Rev. 12/78)

STATE OF ALASKA

Inter-Department Route Slip

TO:
MAIL STATION NUMBER 3100

DEPARTMENT Alaska State Legislature
House RESS

ATTENTION _____

☐ Approval	☐ Note & Return
☐ Signature	☐ Initial & Return
☐ Comment	☐ Return As Requested
☐ Contact Me	☐ Return For Approval
☐ Prepare Reply	☐ Necessary Action
☐ For Your File	☐ Your Information

Remarks:

FROM:
MAIL STATION NUMBER 0208

DEPARTMENT ~~Admin/Admin. Services~~

BY Kellus Sewell DATE 2/26

1st floor 1 cop.

02-002 (REV.10/73)

STATE OF ALASKA

JAY S. HAMMOND, GOVERNOR

DEPARTMENT OF ADMINISTRATION

OFFICE OF THE COMMISSIONER / POUCH C — JUNEAU 99811

465-2200

March 17, 1980

Honorable Thelma Buchholdt
Alaska State Legislature
Pouch V
Juneau, Alaska 99811

Dear Representative Buchholdt:

Re: House Bill 15 to Amend the Longevity Bonus Program

House Bill 15 would amend the eligibility requirements for the Longevity Bonus to include persons who, in addition to meeting the necessary minimum age of 65 and domicile in Alaska on or before January 3, 1959, have been domiciled in Alaska intermittently for a cumulative total of thirty years. The bill would also require that persons who qualify for the Bonus with intermittent domicile must be physically present in the state for five years immediately preceding application and that the periods of residency comprising the cumulative total of thirty years be for twelve months or more in duration.

There is no accurate data base on which to estimate the number of persons who would be affected by this bill. It is assumed, however, that appropriately 200 recipients would be added to the Program within a short period of time after the effective date and twenty-five persons added the second year. The fiscal note which applies to this bill assumes the present benefit payment of $150.00 per month and an effective date of July 1, 1980. Based upon these assumptions, the note provides for a total increase in benefits of $360,000 the first year and $405,000 thereafter. It also provides for an increase in personal services to accommodate the added workload in the Longevity Bonus office.

Although this legislation will enable a greater number of persons to receive the Bonus, the burden of verifying segments of domicile for twelve months or more in duration could be difficult for the applicants. Throughout the years, men and women have been drawn to Alaska for periods of short duration to avail themselves of employment or were assigned to tours of duty for military or government service. They rarely established permanent domicile or considered Alaska to be their home, but moved in and out of Alaska during the course of employment or the assigned period. Seldom did those people involve themselves in the development of Alaska, but remained here to satisfy their monetary goals and then left to continue domicile elsewhere, many of them intending to never return.

Is it the intention of the State to reward those people who periodically domiciled in Alaska in the same way it rewards those who had the tenacity and perseverance to remain and maintain continuous domicile in Alaska for at least twenty-five years? If so, the Department of Administration has no particular objection to the bill, except that it will be difficult and costly in man-hours to administer.

If this bill is passed, we recommend amending line 18, page 1, to read "...in the state continuously for five years..." This would clarify intent in the event of doubt.

Sincerely,

Sue S. Greene
Deputy Commissioner
Personnel Management

SSG/mjc
cc: Keith Specking

BILL ANALYSIS

ASSIGNMENT DATE_____

UNASSIGNED_____

DEPARTMENT	SPONSOR (PRINCIPAL)	BILL NO.
Administration	Representative Randy Phillips	House Bill 15

DEPARTMENT POSITION

DIVISION DIRECTOR	DATE	COMMISSIONER	DATE
Vernon L. Perry	2-22-80	W. R. Hudson	

GOVERNOR'S OFFICE USE

☐ POSITION NOTED ☐ POSITION APPROVED ☐ POSITION DISAPPROVED

BY: DATE:

SUMMARY

(1) RELATED BILLS (SIMILAR OR CONFLICTING)

(2) a. ORGANIZATIONAL SUPPORT FOR BILL

(2) b. ORGANIZATIONAL OPPOSITION TO BILL

Increased administrative functions generated by applicants' need to verify intermittent segments of domicile in Alaska

(3) PROGRAM EFFECTS OF BILL

Increase the number of Longevity Bonus recipients by including persons who have intermittently maintained a domicile in the territory or state for a cumulative total of 30 years, provided he has been physically present in the state for 5 years immediately preceding application and periods of cumulative 30 years are for 12 months or more in length.

(4) FISCAL IMPACT: ☐ NONE ☒ FISCAL ANALYSIS ATTACHED

(5) AMENDMENTS PROPOSED:

"An Act relating to the Alaska Longevity Bonus"; Secs. AS 47.45.010(a); new section AS 47.45.010; and AS 47.45.170.

(6) COMMENTS:

The applicant's burden of verifying domicile segments for 12 months or more may be extremely difficult. Men and women have long been drawn to Alaska for periods of short duration because of employment opportunities in the fishing, mining, lumber and construction industries, for example; or were assigned to tours of duty in Alaska for military or government service. Rarely did they establish permanent domicile or consider Alaska their home, but regarded it as a temporary residence to be occupied during the course of employment or assignment. Seldom were they involved in the development of Alaska, but were more interested in the profits to be gained and soon left to continue domicile elsewhere, many of them intending never to return.

Is it the intention of the State to reward those who periodically domiciled outside of Alaska in the same way it rewards those who had the tenacity and perserverance to remain continuously for at least 25 years?

THE LEGISLATURE OF THE STATE OF ALASKA
ELEVENTH LEGISLATURE

FISCAL NOTE

I. REQUEST

Bill/Resolution No. H.B.15

Title An Act Relating to the Alaska Longevity Bonus.

Requested by _____ Date _____

II. FISCAL DETAIL

Agency Affected Administration

Program Category Affected Social Services

BRU, Program, or Subprogram(s) Affected Longevity Bonus

(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

		FY 80	FY 81	FY 82	FY 83	FY 84	FY 85
100	PERSONAL SERVICES		23.1	25.4	28.0	30.8	33.8
200	TRAVEL						
300	CONTRACTUAL		5.3	5.8	6.4	7.1	7.8
400	COMMODITIES		.5	.5	.6	.6	.6
500	EQUIPMENT		1.3	-0-	-0-	-0-	-0-
600	LAND & STRUCTURES						
700	GRANTS, CLAIMS, ETC.	0	360.0	405.0	405.0	405.0	405.0
	TOTAL	0	390.2	436.7	440.0	443.5	447.2

FUNDING (Thousands of Dollars)

GENERAL FUND	0	390.2	436.7	440.0	443.5	447.2
FEDERAL FUNDS						
OTHER (Specify Fund Source)						

POSITIONS

FULL TIME		1	1	1	1	1
PART TIME						
TEMPORARY						

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

This bill would allow an unknown number of additional recipients to become eligible for the Alaska Longevity Bonus by including those who have a cumulative total of residency in Alaska of 30 years.

These persons must meet the following residency minimums to be eligible:

1. Intermittently maintained a domicile in the Territory or State of Alaska for a cumulative total of 30 years.

2. Must have been physically present in the State for 5 years immediately preceding date of application.

3. Periods of residency, for the cumulative total of 30 years, must have been for 12 months or more in length.

IV. DATE 02/26/80 PREPARED BY George T. Michael

AGENCY Administration

PHONE 465-4401

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)

33-001 (Rev. 12/79)

Although the number of additional recipients under this bill is not known, a consensus of those connected with the program is that probably 200 would be added within a short period after the effective date, and that perhaps 25 would be added the second year as others who are eligible find out about the revised residency requirements.

This fiscal note assumes an effective date of July 1, 1980, and that the bonus payments would remain at the present rate of $150 per month.

Due to the complexities of verifying intermittent segments of domicile in Alaska, an additional Benefits Assistant (Range 9) will be needed on the Lonevity Bonus staff. Inflation is computed at 10% per year on all costs for this position beyond FY81.

Additional Bonus Payments

Year	Additional Recipients		Bonus Payments		Months		Total Increase
FY 1981	200	x	$ 150	x	12	=	$360,000
FY 1982	225	x	150	x	12	=	405,000
FY 1983	225	x	150	x	12	=	405,000
FY 1984	225	x	150	x	12	=	405,000
FY 1985	225	x	150	x	12	=	405,000

	POSITION TITLE			RANGE/STEP	BARG. UNIT.	LOCATION		APPROV.	DISAPP.
1	Benefits Assistant			9A	G	Juneau	GOV.		
	TYPE OF POSITION	STAFF MONTHS	RP No.	PCN No.	PRIORITY	FORM 12 PAGE/LINE			
2	PFT	12			1		LEG.		

	TYPE OF EXPENDITURE	1	2	AMOUNT 3
4	PERSONAL SERVICES: SALARY		17,700	
5	BENEFITS		2,682	
6	FICA		1,177	
7	HEALTH INS.		1,524	
8	TOTAL PERSONAL SERVICES			23,083
9	TRAVEL			-0-
10	CONTRACTUAL			5,300
11	COMMODITIES			500
12	EQUIPMENT			1,300
13	OTHER			
14	TOTAL COST			30,183

	CODE	FUNDING SOURCE	
15		FED RCPTS.	
16		GF MATCH.	
17		GEN. FUND	30,183
18		I-A RCPTS.	
19		PGM RCPTS	
20		OTHER	
21	CONTINUATION		
22	ADDITION	X	

FOR B&M USE ONLY

AA KEY NUMBER _____ COLUMN NO. _____

JUSTIFICATION:

This position will be needed to process applications from persons seeking to qualify under revised provisions of H.B.15. Due to the complexity of verifying intermittent periods of residency, approximately 37½ man-hours per week will be required. This extra work load cannot be absorbed by the existing staff.

AGENCY Administration PROGRAM AREA Social & Economic Asst. for the Aged

BRU Longevity Bonus

COMPONENT _____

13 REQUEST FOR NEW POSITION

Page 1 of 1

REVISED DATE _____

FY 81

02-1013 (Rev. 7/79)

THE FOLLOWING DOCUMENT(S) MAY NOT FILM LEGIBLY BECAUSE OF POOR QUALITY OF THE ORIGINAL.

BILL ANALYSIS

ASSIGNMENT DATE _____

UNASSIGNED _____

DEPARTMENT	SPONSOR (PRINCIPAL)	BILL NO.
Administration	Representative Randy Phillips	House Bill 15

DEPARTMENT POSITION

DIVISION DIRECTOR	DATE	COMMISSIONER	DATE
Vernon L. Perry	2-22-80	W. R. Hudson	

GOVERNOR'S OFFICE USE

☐ POSITION NOTED ☐ POSITION APPROVED ☐ POSITION DISAPPROVED

BY: DATE:

SUMMARY

(1) RELATED BILLS (SIMILAR OR CONFLICTING)

(2) a. ORGANIZATIONAL SUPPORT FOR BILL

(2) b. ORGANIZATIONAL OPPOSITION TO BILL

Increased administrative functions generated by applicants' need to verify intermittent segments of domicile in Alaska

(3) PROGRAM EFFECTS OF BILL

Increase the number of Longevity Bonus recipients by including persons who have intermittently maintained a domicile in the territory or state for a cumulative total of 30 years, provided he has been physically present in the state for 5 years immediately preceding application and periods of cumulative 30 years are for 12 months or more in length.

(4) FISCAL IMPACT: ☐ NONE ☒ FISCAL ANALYSIS ATTACHED

(5) AMENDMENTS PROPOSED:

"An Act relating to the Alaska Longevity Bonus" Secs. AS 47.45.010(a); new section AS 47.45.010; and AS 47.45.170

(6) COMMENTS:

The applicant's burden of verifying domicile segments for 12 months or more may be extremely difficult. Men and women have long been drawn to Alaska for periods of short duration because of employment opportunities in the fishing, mining, lumber and construction industries, for example; or were assigned to tours of duty in Alaska for military or government service. Rarely did they establish permanent domicile or consider Alaska their home, but regarded it as a temporary residence to be occupied during the course of employment or assignment. Seldom were they involved in the development of Alaska, but were more interested in the profits to be gained and soon left to continue domicile elsewhere, many of them intending never to return.

Is it the intention of the State to reward those who periodically domiciled outside of Alaska in the same way it rewards those who had the tenacity and perserverance to remain continuously for at least 25 years?

THE PRECEDING DOCUMENT(S) MAY NOT FILM LEGIBLY BECAUSE OF POOR QUALITY OF THE ORIGINAL.

HB

76

C=2. BERTRAM

FY1

State of California

BOARD OF EQUALIZATION

DEPARTMENT OF BUSINESS TAXES

ALCOHOLIC BEVERAGE TAX REGULATIONS

Regulation 2557. POWDERED DISTILLED SPIRITS.

Reference: Sections 32001 – 32556, Revenue and Taxation Code.

(a) IN GENERAL. The Alcoholic Beverage Tax Law and Alcoholic Beverage Tax Regulations apply with respect to powdered distilled spirits in the same manner and to the same extent as with respect to other distilled spirits. Tax will be paid at the same rate per wine gallon, and at a proportionate rate for any quantity, as for distilled spirits of the same proof strength in liquid form.

(b) RECORDS AND REPORTS. Transactions involving powdered distilled spirits, including any powdered alcoholic beverage containing powdered distilled spirits, must be stated by volume in wine gallons to the nearest one-hundredth of a gallon in all required records and reports. The importer, in the case of powdered distilled spirits imported into California packaged in containers for sale to the general public, and the rectifier in the case of powdered distilled spirits packaged within California shall:

(1) Label the outside of each case with the volume in wine gallons of the powdered product contained in the case and of the powdered product contained in each individual package within the case.

(2) Print on each invoice, credit memorandum, or similar document the total volume in wine gallons of the powdered product or products listed on that document.

(3) Print on each invoice, credit memorandum, or similar document the volume in wine gallons of the powdered product contained in each size case and in each individual package listed on that document.

(c) CONVERSION OF WEIGHT TO VOLUME. The weight of powdered distilled spirits, and powdered distilled spirits products, shall be converted to volume as follows:

(1) One pound equals .16 wine gallons;

(2) One ounce equals .01 wine gallons;

(3) One gram equals .000353 wine gallons.

History: Adopted May 4, 1978, effective June 21, 1978.

DISTILLED SPIRITS COUNCIL OF THE UNITED STATES, INC.

1300 PENNSYLVANIA BUILDING
WASHINGTON, D. C. 20004
202-628-3544

November 17, 1978

Mr. Sharman Haley
Research Analyst
Legislative Affairs Agency
Pouch Y - State Capitol
Juneau, Alaska 99811

Dear Mr. Haley:

We have received your letter of 10-30-78 requesting information on powdered alcohol.

Based on information we have received from the Bureau of Alcohol, Tobacco and Firearms, the powdered alcohol product has been approved and is presently being imported into the U.S. from Japan by Global Marketing, Inc. of Portland, Oregon. A taxing formula has been approved by BATF.

The base powder has the consistency of very fine sugar. It is comprised of droplets of grain neutral spirits encapsulated in "glister", a form of corn syrup. The bulk powder after having been imported in drums by Global will be sent to a rectifier in Orange County, California. Power Packaging, Inc., the rectifier, will add flavoring, blend, package and label the containers under the name "Sureshot". The types of products will be Vodka Sour, Vodka Sling, Screwdriver, Apricot Sour, Cappucino and possibly others.

It is our understanding that each can contains 2 5/8 ounces of alcohol powder at 22% alcohol by weight. When mixed with 5 ounces (one full can) of water a drink containing 6.8 fluid ounces at 22 proof will result. It is understood that the product will retail for $1.39 per can.

The product is currently being test marketed in Oregon, California and possibly some other states. California had to change its taxing guide lines to allow the sale of the product in that state. There is attached for your information a copy of the amended California regulation.

Sincerely,

George F. Bonifant
Director - International Trade

GFB:sas

Attachment

STATE OF ALASKA
THE LEGISLATURE
LEGISLATIVE AFFAIRS AGENCY

POUCH Y · STATE CAPITOL
JUNEAU, ALASKA 99811
907-465-3800

November 22, 1978

MEMORANDUM

SUBJECT: Powdered Alcohol (W.O. #5743-R)

TO: The Honorable Charlie Parr

FROM: Sharman Haley
Research Analyst

You requested information on powdered alcohol and the likelihood for marketing in Alaska. Attached you will find a letter from the Distilled Spirits Council of the United States describing the product.

Exclusive distribution rights for marketing powdered alcohol in Alaska have been awarded to K&L Distributors. I contacted the Anchorage office of K&L and was told that they are not pursuing the marketing of the product at this time, because they are not satisfied with the quality--in particular the taste of the cocktails. If and when the manufacturers improve the taste to the satisfaction of K&L, K&L plans to market powdered alcohol cocktails state-wide.

If you have any further questions please let us know.

SH:dh
Attachment

CHARLIE PARR
ALASKA LEGISLATURE

S. R. Box 50599
Fairbanks, Alaska 99701
456-5029

Pouch V
Juneau, Alaska 99811
465-3797

Dec 28, 1978

Mr Joseph A Cuttini, Esq.
Legislative Affairs Agency
Dear Joe:
Thanks for memo of Nov 29 on provisions adopted (H.C. 5743).
I'm old enough to remember "wine bricks" which were sharply marketed for a while during Prohibition days, until Fed's got a court ruling. Suspected your research didn't turn that up.
Please (or ask Bill Ginn to assign someone to) draft a bill to ensure that we can limit the powdered product if it is marketed in Alaska. (Encouraging material from Herman Kelly (California retire).
Many thanks -
Charlie Parr

HB

79

RESEARCH AND BACK-UP ON HB79

STATEMENT ON SB 75/HB 79 FOR THE

ALASKA OPTOMETRIC ASSOCIATION

by

Boyd L. Walker, O. D.

My name is Dr. Boyd L. Walker. I am a licensed optometrist in Alaska and have been in full-time practice in the state since 1973. I am a member of the Alaska Optometric Association and the American Optometric Association.

I appreciate the opportunity to speak with you today regarding HB 79, SB 75, which pertains to the use of diagnostic pharmaceutical agents (DPAs) by qualified and licensed Doctors of Optometry.

As in any argument, there are two sides to the situation, and given the abilities of statisticians and researchers today one can find supportive evidence for any point of view on practically any subject one might wish to consider. That being the case, and since I feel that this issue is of utmost importance to the consumer of vision care in this state, I am going to state my case using only one reference. By doing so I hope to avoid the confusion and suspicion which may be created by using a myriad of references of possibly questionable integrity. This reference, which I shall place at your disposal should you wish to peruse it, is an independent report to the Congress of the United States, compiled by the U. S. Department of Health, Education and Welfare in July of 1976. This report was not in any way sanctioned by the optometric community, quite the contrary it was an investigative effort on the part of H.E.W. to determine what part an optometrist should play in the delivery of eye health care today. I believe that as elected representatives of the public, you each have a commitment to your constituents to make a decision based upon substantiated fact rather than upon emotion, heresay, or unfulfilled wishes of any special interest group. It is with that in mind that I present to you the following information.

I would like to begin by giving you a definition of the scope of optometry which is excerpted directly from page 21 of the H.E.W. Report to the Congress.

> "The institute of Medicine of the National Academy of Sciences, in describing primary health professions who are direct providers of patient care, defined optometry as follows: "The Doctor of Optometry (O.D.) is a health professional who performs eye examinations to determine the presence of visual, muscular, or neurological abnormalities, and prescribes lenses, other optical aids, or therapy, such as eye exercises to enable maximum vision. Optometrists are trained to recognize disease conditions of the eye and ocular manifestations of other diseases, and to refer patients with these conditions to the appropriate health professional."
>
> This definition, as well as available documentation on the utilization of optometric services, points to the optometrist's role as a provider of primary health care services. In this role, the optometrist functions as a principal point of contact within the health care system for persons having visual complaints, including certain numbers who have symptoms or conditions that require referral to other health practitioners."

As this points out, optometrists have an ability and a responsibility to recognize and refer pathological conditions of the eye. The diagnostic pharmaceutical agents which we are asking to use in this bill are nothing more than tools which will enhance our ability to discover possible pathology and refer the patient to the proper medical authority.

At this point I must stat that it is not the intent of optometrists to use these drugs indiscriminately on all patients, but rather only upon those patients in which it cannot clearly be determined that a pathological condition does not exist. The exception to this being the use of corneal anesthetics in the measurement of intraocular pressure. Our law as it now exists prevents the optometrist from using these agents which ophthalmologists use for the exact same reasons. This clearly limits the optometrists from doing that which he is ethically and legally bound, i.e. assuring that those

patients he sees have been screened for eye disease using the highest level of technology available today.

It has been argued that Optometrists do not have the professional training to allow them to administer diagnostic agents to their patients. Some would even argue the obvious and say that optometrists are not trained to detect pathological conditions of the eye. On page 95 of the H.E.W. Report to the Congress is found the following description of optometric education:

> "All optometry schools share certain basic curricular elements which follow at least two years (and for the majority of students four years) of undergraduate studies, predominately in the biological sciences.
>
> The basic elements include:
>
> - A biological science component.
> This includes gross and microscopic human anatomy, general human physiology, biochemistry, and pharmacological principles, all presented with emphasis on the visual system and related structures.
>
> - Physiological optics.
> Vision processes, visual stimuli, accommodation mechanisms, neurophysiological mechanism, ocular motility, binocular perception.
>
> - Pathology.
> Essentials of bacteriology and virology, principles of health and disease, tissue changes in pathology, ocular diseases and abnormalities, ocular manifestations of systemic disease.
>
> - Optics.
> Light, Lenses, optical systems, ophthalmic materials.
>
> - Professional orientation (health practice).
> Epidemiological procedures, the epidemiology of specific disorders, health care organization, public health, interpersonal relations, management of practice.
>
> - Clinical skills.
> Patient history, refraction, visual performance measurement, detection and diagnosis of visual anomalies and visually-related learning and perceptual disturbances, low vision rehabilitation, care of the aging patient, contact lens fitting.

A more complete listing of this common subject matter is found in attachment B to this Section. The catalogues of the schools provide stil' more detail."

Following is a copy of Attachment B, Section 1; I would like to call your attention to subsections (h) and (i).

ATTACHMENT B

BASIC ELEMENTS OF THE CURRICULUM OF SCHOOLS OF OPTOMETRY

1. Biological science knowledge base.

   a. Gross human anatomy and microscopic anatomy, with emphasis on head, neck, and thorax.

   b. Embryology, gross and microscopic anatomy of the human nervous system - concentrating on the central nervous system.

   c. General human physiology, including the study of the fundamental organ systems and the mechanisms which regulate body function. Emphasis is on the sensory, motor and cardiovascular systems.

   d. Basic concepts of general and cellular biochemistry, with study of nomenclature, structure, and reactions of organic molecules. Emphasis is on the visual system - tears, intraocular fluids, lens, retinal photochemistry, and actions of drugs upon these.

   e. Concepts of human genetics and genetic disorders, including the frequency and distribution of genetic disease, inheritance patterns, polygenic inheritance, chromosomal abberration syndromes, multifactorial genetics, and principles of genetic counseling.

   f. Gross and microscopic anatomy of the lids, orbit, orbital content, globe, muscles, nerves, and vessels, and embryology of the eye.

   g. Vegetative physiology of the eye, extraocular and intraocular fluids, corneal and lens metabolism, ocular circulation, retina and optic nerve metabolism.

   h. General pharmacological principles, methods of administration, various systemic drugs and their pharmacological action and side effects with emphasis on those that affect the visual system, such as cataractogenic and glaucoma-producing drugs.

   i. Pharmacology; uses, doses, contraindications, and adverse effect of drugs producing miosis, mydriasis, cycloplegia, accommodation, and ocular anesthesia. The pharmacology, use contraindications, and adverse effect of drugs commonly used in treating visual and ocular problems.

As you can see there is no shortage of educational opportunity for the optometrist to become well acquainted with human ocular conditions as well as the uses, contraindications, and side effects of the use of pharmaceutical agents.

To further demonstrate this very important point regarding the quality of the education which optometrists receive on the subject of pharmacology. I would like to read the testimony given before the Oregon State Legislature by Dr. Ronald H. Winters, Assistant Dean, and Associate Professor of Pharmacology and Toxicology at Oregon State University. Before reading this, I would like to clarify Dr. Winters' title. He is a pharmacologist, any by definition is one who studies drugs in all their aspects. From pharmacologists all health care professionals, including ophthalmologists, derive information regarding all aspects of drugs. See the following pages for his testimony.

School of Pharmacy
Oregon State University
Corvallis, Oregon 97331 (503) 754-3725

29 January 1975

In studying and evaluating the proposed legislation authorizing the use of diagnostic pharmaceutical agents (DPA's) by optometrists, three principal questions have emerged relative to my areas of expertise as an educator specializing in curricular design and as a pharmacologist: 1) is the overall curricular design utilized by the College of Optometry at Pacific University appropriate for the education and training of optometrists to use DPA's in their practice; 2) is the specific curricular component concerned with pharmacology appropriately constructed; 3) from the perspective of a pharmacologist, is the use of DPA's by optometrists a safe procedure likely to result in an overall improvement in patient care?

In the course of my efforts over the past three years to coordinate the redesign of the professional curriculum of the School of Pharmacy at Oregon State University, I have had considerable occasion to review the curricula of a large number of health profession schools, both in Oregon and elsewhere. Further, as my own graduate training in pharmacology was conducted largely at the University of Oregon Medical School in Portland, I am especially familiar with the curriculum of that institution, with emphasis on the pharmacology component. Finally, I have participated in a number of national and international meetings of professionals concerned with curricular design and implementation in many of the health-related fields. In comparing the curriculum of the College of Optometry at Pacific with the curricula of other health profession

schools utilizing a pharmacological component, I am convinced the approach developed by Pacific is both efficient and effective, and is clearly educationally sound. Moreover, that structure includes what I consider to be the sine qua non of proper instructional design--the competency of the graduate is evaluated in a series of prescribed and standardized formats (i.e., institutional, Oregon State Board of Optometry, and national board examinations) prior to the awarding of a license to practice. Thus, individuals who may have succeeded in passing individual courses but who have not adequately integrated the body of knowledge as a whole are not permitted access to the public as professionals. This safeguard, in my view, is instrumental in protecting the public, the institution, and the profession, and should stimulate your confidence in the proposal at hand.

Examination of the pharmacology component of the curriculum has also led me to a favorable conclusion. It is clear that the student is well-prepared for his first exposure to courses dealing with DPA's and other drugs, and is carried through this portion of his coursework in an effective manner. It is my judgment that a program designed to prepare practitioners to utilize DPA's must rest on a sound didactic base, capped by supervised clinical experience in the use of the agents in question. I feel strongly that a quality didactic base is offered at Pacific, and that passage of the proposed legislation will quickly result in the implementation of an appropriate clinical component as already outlined by the school.

The question of the relative safety and productivity of the proposed procedures must be addressed, and in my view, these two issues cannot be rationally separated; that is, neither safety nor efficacy are unidimensional characteristics, but instead are interrelated as a cost/benefit ratio or in medicine, a therapeutic index. Three important considerations relate to the expected safety in the use of DPA's by optometrists: 1) what agents are to be used; 2) what doses of these agents are to be employed; 3) how will these agents be administered? The four principal

categories of DPA to be used are miotics (agents that constrict the pupil), mydriatics (agents that dilate the pupil), local anesthetics (substances that reduce feeling in the cornea), and cycloplegics (agents that alter the ability of the eye to focus on near objects). The most salient pharmacological feature of these compounds is their relatively short duration of action, generally measured in minutes. If nothing else, this characteristic itself tends to minimize the likelihood of an adverse reaction simply because the drug is effectively inactivated by the body in relatively short order. Secondly, the doses to be utilized in diagnostic procedures are indeed very small. Using one to two drops of solutions of one-half to two and one-half percent strength in each eye provides the patient with a total dose far less than is obtained in many over-the-counter cold remedies readily available to the patient on only his/her discretion. Thirdly, by limiting the administration of these compounds to the topical route (dropped in the eye), it is not likely that more than twenty percent of the total dose will be absorbed into the blood for general circulation in the body. At that concentration level, these agents are essentially devoid of pharmacological activity. When coupled with the virtual absence of reported adverse reactions in states where this practice is common, one cannot help but conclude that the use of DPA's in the format proposed is extremely safe.

How much benefit is to be derived from this practice is, as I've said, the other side of the coin. In my judgment, the judicious use of DPA's will permit a substantial increase in the ability of the optometrist to detect potentially harmful diseases of the eye. By allowing this health-care professional to examine the patient more completely, the optometrist will be in a better position to refer to physicians (ophthamologists, internists, pediatricians, and family practitioners) those patients requiring further diagnosis and possible treatment. In view of the established fact that optometrists serve as the primary eye-care professionals for a majority of the population, it is apparent that the anticipated gain for the patient is large.

It would appear, therefore, that a near optimal situation prevails here: the proposed use of DPA's by optometrists is clearly both very safe and likely to be most effective in patient eye care. Further, it is evident that considerable planning has been conducted by the College of Optometry at Pacific, and that the school is ready, capable, and indeed has already begun providing educationally sound classroom instruction in the use of diagnostic pharmaceutical agents, with implementation of actual clinical instruction awaiting legislative approval. Thus, with the cost/benefit or therapeutic ratio a very favorable one to all parties concerned, I respectfully encourage the swift passage of the proposed legislation.

Ronald H. Winters, Ph.D.
Assistant Dean
Associate Professor of
Pharmacology and Toxicology

I would like to explain that Dr. Winters refers to Pacific University in his statement because it is the only optometry school in the Northwest, and therefore the one with which he has had direct experience. As the information I presented earlier indicates, all optometry schools provide similar training. It is apparent from his testimony that Dr. Winters realizes a potential risk involved with the use of any type of drug, but that with proper training this risk is far outweighed by the potential benefit to the eye care patient.

Finally and most importantly, as Dr. Winters mentioned, this bill limits the use of these DPAs to those individuals who can demonstrate by passage of a licensing examination that they are indeed capable of judicious use of the drugs. One such test of an individual's knowledge in this area is the National Board of Examiners in Optometry examination. This is a national examination which consists of eight separate subjects, one of which is Ocular Pharmacology. A discussion of this examination begins on page 91 of the H.E.W. Report to the Congress. This test will soon be a prerequisite to the taking of the Alaska State Board examination for licensure.

I am sure that much more can be said regarding the use of diagnostic pharmaceutical agents by optometrists. I have tried to avoid all but the crucial questions which are: (1) Does an optometrist have a responsibility to detect pathology of the human eye in the course of an examination? (2) Does an optometrist have an educational background that will allow him to safely administer these drugs to his patients? I feel that the answer is undeniably YES.

Apparently the consultants who collaborated to make the H.E.W. report possible, as a result of their extensive investigation of optometry reached the same conclusion. The following is excerpted from the RECOMMENDATIONS AND ADDITIONAL CONSIDERATIONS OFFERED BY STUDY CONSULTANTS of the H.E.W. Report to the Congress, page vii, second paragraph:

> "During the course of the study effort, a number of additional issues and concerns were identified by the expert consultants which, although important considerations, represent matters not directly responsive to the specific legislative charge as interpreted by the Department. These recommendations and comments, made unanimously by the consultants, are presented here to provide an opportunity to bring these matters to the attention of Department Agencies and the Congress. Because the following items go beyond the requirement of this report, the Department has not fully examined them and makes no recommendation at this time.
>
> 6. ...
>
> e. Joint development of appropriate revision to State licensure laws to permit use of diagnostic drugs (mydriatics and local anesthetics) by optometrists.
>
> While such joint endeavors are evident in various areas of the country, they need to be broadened and routinized."

At the present time 24 states have identified the need for the use of DPAs by optometrists, and to date there have been no reported incidences of malpractice arising from the use of these agents. Furthermore, no state which now permits the use of diagnostic pharmaceutical agents by optometrists has yet seen evidence that would convince them that this is not in the best interest of the public.

I therefore urge you to support Senate Bill 75 and House Bill 79 for the good of the people of Alaska.

Thank you for giving your consideration to this very important piece of legislation.

USE OF DIAGNOSTIC AGENTS

By

OPTOMETRISTS

in the

UNITED STATES ARMED FORCES

All three branches of the military, either in regulations or at local hospital options, require or allow optometrists to utilize diagnostic agents to aid them in their examinations.

1. UNITED STATES AIR FORCE

   Optometrist AFM 36-1 (C13)
   2. Duties and responsibilities
      a. "Conducts examinations of eye with or without the use of diagnostic drugs,". (enclosed)

2. UNITED STATES NAVY

   Change # 57 of U.S. Navy Medical department manual gives optometrists the right to use drugs for taking intraocular tension.

3. UNITED STATES ARMY

   (local Army post option)
   Ex. Modification of regulations providing for the optometric use of diagnostic drugs at the U.S. Army General Hospital, Fort Gordon, Geogia. "to include use of diagnostic drugs such as mydriatics, cycloplegics, and topical anesthetics". (enclosed)

OFFICER AIR FORCE SPECIALTY

OPTOMETRIST

★1. SPECIALTY SUMMARY

Conducts examinations of eye to determine visual efficiency and performance by means of instrumentation and observation; prescribes corrective procedures; and applies knowledge of optics and physiology to research and teaching activities.

2. DUTIES AND RESPONSIBILITIES

★ a. *Conducts examinations of eye:* With or without the use of diagnostic drugs, examines eye to ascertain presence or absence of defects or visual anomalies which can be corrected, remedied, or relieved by use of lenses, prisms, orthoptics, contact lenses, or other ophthalmic devices. Performs external and internal examination of the eyes and refers suspected and detected pathology to the appropriate medical specialties. Determines refractive errors such as myopia, hyperopia, or astigmatism and prescribes appropriate treatment for these and other visual problems. Ascertains through clinical tests, range of vision and ability and ease with which eyes maintain clear, comfortable, binocular vision at any distance of fixation.

b. *Prescribes treatment to conserve or improve vision:* Prescribes appropriate lenses to correct various errors of refraction. Prescribes and administers orthoptic or visual training in those instances where such procedures are indicated, as in ocular muscle imbalances, fusional problems, and as an adjunct in treatment of strabismus. Refers for medical treatment or surgery, those cases characterized by disease or injury. Examines and tests lenses for proper workmanship and conformance to prescription.

c. *Conducts research:* Plans and conducts research in broad areas of clinical optometry and physiological optics; such investigative studies to include, among others, physical standards, protective and corrective eye wear, examining methods and techniques, and perceptual problems associated with aeronautics and space flight.

d. *Directs optometry personnel:* Plans work assignments for optometry personnel including preparation and maintenance of optometric records. Observes and checks work of technicians to determine compliance with procedures governing optometric activities. Instructs optometry technicians in local operational procedures, and in the use and maintenance of ophthalmic instruments.

e. *Plans and directs occupational vision programs:* Plans, supervises, and participates in eye protection programs in accordance with AFR 160-112 and AFR 167-3. Identifies eye hazardous areas and occupations, and supervises visual screening of personnel in such areas. Arranges for professional services, and procurement and dispensing of safety eye wear for military personnel and civilian employees of the Department of the Air Force.

3. SPECIALTY QUALIFICATIONS

a. *Knowledge*: Knowledge of procedures and methods used in eye examinations, and examining and testing lenses is *mandatory*.

b. *Education*:

(1) Graduate of a college of optometry approved by the Surgeon General, USAF, is *mandatory*.

(2) Master's degree or Doctor of Philosophy degree in physiological optics is desirable for research and teaching assignments.

c. *Experience*: A minimum of 12 months' experience in optometry assignments is *mandatory*. It is *mandatory* that experience include conducting examinations of the eye to determine presence of visual defects; prescribing lenses and orthoptic therapy to correct, conserve, or improve vision; and examining and testing compliance to acceptable standards and conformance to prescription.

d. *Training*: None.

e. *Other*: State license to practice optometry is *mandatory*.

4. SPECIALTY DATA

a. *Grade Spread*: Second lieutenant through colonel.

b. *Related D.O.T. Job*:
Optometrist _____ 079.108

c. *Related DOD Occupational Group*: 6H

DEPARTMENT OF THE AIR FORCE
USAF SCHOOL OF AEROSPACE MEDICINE (AFSC)
BROOKS AIR FORCE BASE, TEXAS 78235

August 1975

OPTOMETRY PROGRESS REPORT

Optometry Seminar

Brooks AFB, Texas will host the 4th USAF Optometry Seminar from 30 September through 2 October 1975. The quotas have been allotted to the Major Air Commands, and contacts should be in process for selection of the attendees. If you have not received word about whether or not you can participate in this continuing education program, see your Administrative or Executive Officer. The TDY funding for attending is not from your organization's budget, so this should not be a deterent for approval.

Special Pay

Special pay legislation was not completed prior to the June 30, 1975 expiration date for the $100/mo. award to optometrists and veterinarians. The military members in these specialties on duty prior to 1 July 1975, continue to receive the special pay without interruption; however, the professionals that enter(ed) on active duty after that date will not unless legislation authorizes it. The DOD favors the special pay legislation, and the House Committee has favorably responded with a rider to the Appropriations Bill which will make the effective date retroactive to 1 July 1975. It is expected that this authority will run to 1 October 1977.

Drug Applications

Two years ago AFR 160-12, Professional Policies and Procedures, was revised to include the following, in paragraph 3g " ... Optometrists have the knowledge and skill necessary to perform the following functions:

(1) Performs complete visual examinations with or without the use of diagnostic drugs ... " USAF pharmacies will honor prescriptions from optometrists for ophthaine, mydriacyl, etc., in compliance with their needs for ophthalmic drugs for diagnostic purposes.

It is not unusual for optometrists at some of the smaller USAF Clinics where no ophthalmologist is assigned to work in close coordination with Flight Surgeons on Sick Call and physicians in Emergency Rooms in handling ocular disease and trauma dispositions. In these circumstances therapeutic ophthalmic drugs may be recommended by the optometrist and ordered by the

medical doctor from the pharmacy. If optometrists are enjoined to order therapeutics directly, it is highly recommended that approval for this action be in writing. Capt Steiner, at Webb AFB, TX, has been accorded this courtesy by the Pharmacy and Therapeutics Committee and may order: Neosporin ophthalmic; Blephamide ophthalmic; Garamycin ophthalmic; Sodium Sylamyd; Vasocon ointment; and Darvon, plain. Note that no steroid combination drugs were authorized. Dr Steiner is a former enlisted Air Force pharmacist, had a course in Pharmacology at the University of Houston Optometry College, and is well versed in drug effects, which was a major consideration in his award of direct drug therapeutic use at Webb AFB.

Contact Lenses and Occupational Vision

Air Force Regulation 161-31, Occupational Vision Program, prohibits the use of contact lenses in eye hazardous jobs except: "Special cases where persons must wear contact lenses for medical reasons will be considered on an individual basis." A request for reappraisal of this policy was made two years ago to permit the judgment of the local optometrist to weigh whether the usual eye protective device was inadequate, and the environment constituted a greater hazard to the contact lens wearer over others in the same situation, before restricting the wear of contact lens. No change in regulation resulted from this request.

A waiver of the prohibition was recently made at Kirtland AFB following advice by Lt Col Coker, Chief of Occupational Vision in the USAF Surgeon General's Office. This was a local waiver granted by the Occupational Vision Team when Maj O'Brien, Optometrist, indicated that in his professional judgment the patient's visual performance would be compromised with spectacles in climbing poles and stringing wire. The letter of waiver, forwarded through channels, concluded: "Additionally request that you take action through AFSC to request from HQ USAF/SGPA (the OPR of AFR 161-31) that AFR 161-31, para 3c(1) be amended to permit the Base Occupational Vision Team to locally authorize persons to wear contact lenses in eye hazard area when justified by particular medical reasons." The mechanism for issuing a waiver is now apparent, but the basic issue still seems unduly restrictive.

Federal Services Optometry Seminar

The AOA sponsored a Federal Services Optometry Seminar held in early April in Washington, DC. The attendees would form a "Who's Who" in AOA, AFOS, Military, Public Health and Civil Service Optometry. The issues addressed by the workshops were: Pay and Promotion; Optometry Corps; Vision Care Delivery; Clinic Evaluation; Education; Rationale for Federal Vision Care; Interprofessional Relations and Attitudes; and the Reserves.

MEDFG-HPS-S-Opt

Modification of USAGH Regulation 40-102

CO, USAGH
ATTN: AJGMD-HPS

Ch, Optometry Section
USAGH

4 October 72
MAJ Nichols/wl/2381

1. Recommend that consideration be given to the following modification of paragraph 10 (Optometrist Privileges) USAGH Regulation 40-102, dated 28 September 1971.

2. Optometrist Privileges:

Permission to conduct examinations of the eyes to ascertain the presence of absence of defects or visual anomalies, and prescribe the appropriate optometric therapy to correct, remedy or relieve such visual anomalies by the use of lenses, prisms, orthoptics, contact lenses, as outlined by AR 40-3, C-25 dated September 1971, AR 40-121, and SOP of Elective Contact Lens Program, Optometry Clinic, USAGH, Fort Gordon, Georgia, or other optometric procedures (to include use of diagnostic drugs such as mydriatics, cycloplegics and topical anesthetics) commensurate with training and experience. Refer patients for medical consultation, treatment or surgery when ocular manifestation of disease is detected.

3. The above modifications are suggested in accordance with AR 611-101, ch 23, 13 April 1970, AR 40-1, ch25, September 1971, and AR 40-121, paragraph 4-6.

ALEX C. NICHOLS
Major, MSC
Chief, Optometry Section

1 Incl
SOP

DISPOSITION FORM

For use of this form, see AR 340-15, the proponent agency is TAGCEN.

REFERENCE OR OFFICE SYMBOL	SUBJECT
DASG-HCC	Optometry Policy Statement Update

20 THRU: ~~DASG-HC~~ 0 6 APR 1977 FROM DASG-HCC DATE 4 Apr 77 CMT 1
~~DASG-ZB~~ Rwg
COL Biehusen/ms/71917

TO: DASG-ZA

1. In view of recent civilian interest in the role of the optometrist and the recent editorial addressed to The Army Surgeon General in the Journal of the AOA of which you are aware (Inclosure 1) a firm policy statement is in order setting forth the role of the Army optometrist.

2. Existing policy is stated as portions of correspondence of General Heaton (1968, Inclosure 2) and General Jennings (1971, Inclosure 3). No policy statement as such exists.

3. Your Consultants in Ophthalmology and Optometry agree that the proposed policy statement below is fair and represents the Army policy concerning the role of the optometrist.

POLICY STATEMENT

Army optometrists provide optometric patient services in accordance with accepted medical guidelines. They examine the eyes and adnexa, to include refraction and other procedures, prescribe lenses to correct refractive error and improve vision. They refer patients to physicians for diagnosis and treatment of suspected disease. They use topical anesthetics and cycloplegic drugs to perform tonometry and cycloplegic refractions. When using these drugs immediate medical care is available in the event of adverse reaction.

Frederick C. Biehusen

FREDERICK C. BIEHUSEN, M.D.
Colonel, MC
Chief, Consultants and Ambulatory Care Division

3 Incls
as

APPROVED/~~DISAPPROVED~~ 20 Apr 77

Richard R. Taylor

RICHARD R. TAYLOR, M.D.
Lieutenant General
The Surgeon General

DA FORM 2496 REPLACES DD FORM 96, WHICH IS OBSOLETE. ☆GPO-1975-655-422/1003

EDUCATIONAL QUALIFICATION OF ALASKAN OPTOMETRISTS

1. Statement on Pharmacology Training in Optometry in Oregon, 1975
   By: L. Levine, Ph.D.

2. Curriculum Comparison on Pharmacology between:

   Oregon Medical School
   Oregon Dental School
   Oregon College of Optometry

3. Association of Schools and Colleges of Optometry (ASCO)

   This study suggests pharmacology curriculum guidelines for continuing education courses for practicing optometrists. Should legislation pass, this guide would serve as a framework for setting up such a program.

4. 1973 National Board of Examiners in Optometry

   All applicants for Board certification to practice optometry in Oregon must pass all of the written sections of the National Boards with a minimum score of 70%.

   Enclosed copies of sections related to diagnostic agents:

	Hours of Testing
Ocular Pharmacology	1.0 hr.
Ocular Pathology	2.0 hrs.

   Other sections of the Boards not included but available upon request:

	Hours of Testing
Ocular Anatomy	2.0 hrs.
Visual Science I	2.5 hrs.
Visual Science II	2.5 hrs.
Theory and Practice of Optometry	2.5 hrs.
Theoretical Optics	3.0 hrs.
Ophthalmic Optics	2.5 hrs.
Social, legal, ethical, economic and professional aspects of optometry	1.0 hr.
	19.0 hrs. testing

5. List of the United States Optometric Colleges and Schools

Statement on Pharmacology Training in Optometry in Oregon

L. Levine, Ph. D.

The most revered and the most widely used textbook in the field of pharmacology in American medical and dental colleges is Goodmand and Gilman's "The Pharmacological Basis of Therapeutics". For example, during the current academic year (1974-1975), as in previous years, this "blue bible" of pharmacology is the required textbook for the pharmacology courses offered in both the University of Oregon Medical School and Dental School. (It may be noted that during the two occasions when a formal 2-hour course in Optometric Pharmacology was taught at the College of Optometry in Forest Grove, Goodman and Gilman was the required text. It may be of further interest that the senior author is a member of a long time Portland, Oregon family, and that his original professional training was in the field of Optometry.) The current (4th) edition of Goodmand and Gilman identifies the scope of the field of pharmacology as embracing "...the history, source, physical and chemical properties, compounding, biochemical and physiological effects, mechanisms of action, absorbtion, distribution, biotransformation and excretion, and therapeutic and other uses of drugs" (p.1). It is at once apparent that the totality of the discipline of pharmacology is very large, and that students and practitioners of health-related professions must generally limit their attention to drugs that are "useful in the prevention, diag-

nosis, and treatment of human disease, or in the prevention of pregnancy..." and to "chemical agents ... commonly responsible for household poisoning as well as enviornmental poisoning." (p.1).

Even to achieve these admittedly limited objectives, the student must give attention to a number of the classical subdivisions of pharmacology. These are listed in Goodman and Gilman (pp. 1,2) as (a) the physical and chemical properties of drugs, (b) pharmacodynamics, (c) pharmacotherapeutics, and (d) toxicology. Of these, pharmacodynamics has reference to "the study of the biochemical and physiological effects of drugs and their mechanisms of action." It is largely based on "...the subject matter and the experimental technics of physiology, biochemistry, microbiology, and pathology." Further, in pharmacodynamics "...Many basic principles of biochemistry and enzymology and the physical and chemical principles that govern the active and passive transfer and distribution of substances across biological membranes are readily applied..." On the other hand the term "pharmacotherapeutics" deals with "...Many drugs (which) stimulate or depress biochemical or physiological function in man in a sufficiently reproducible manner to provide relief of symptoms..." or are useful "...because they have only minimal effects on man but can destroy or eliminate parasites." (All quotes from Goodman and Gilman, Ch. 1).

From the foregoing it is obvious that mastery of the subject matter of pharmacology requires appreciable prior training in a number of important areas of human biology: anatomy, physiology, biochemistry, microbiology, and pathology. Further, for a study of drugs of consequence to the field of Optometry, specialized additional preparation in ocular anatomy, neurology, and ocular pathology are essential prerequisites. Thus on the one hand, the study of pharmacology cannot properly be undertaken early in a professional program since it presupposes a command of, and builds on the background provided by, several of the basic biological sciences. On the other hand, neglect of the study of pharmacology once the lengthy prerequisite preparation has been negotiated, fails to complete a logical sequence, and is irresponsible since it prevents delivery of the highest level of professional vision care to the public.

Inspection of the current catalogs of the University of Oregon Medical School and Dental School (1974-1975) reveals that the programs of study leading to the M.D. and the D.M.D. follow a rational progression of courses in the basic preclinical disciplines, which are necessary prerequisites to beginning the study of pharmacology. In both institutions, classroom and laboratory introduction to pharmacology is deferred until the second year and awaits prior or parallel training in gross and microscopic human anatomy,

bicchemistry, physiology, neuroanatomy, microbiology, and pathology. Since the medical and the dental practitioner will require clinical application of his pharmacological knowledge, it is sensible and appropriate that all of the preceding courses have practical components in the form of required laboratory work, and that the initial classroom and laboratory exposure to pharmacology is followed in succeeding terms with practical training in the use of drugs under immediate supervision of qualified faculty members.

The course of study presently required of all students in the College of Optometry in Forest Grove directly parallels and is equivalent to that of the Medical and Dental Schools as regards the number and level of the basic biological science courses relevant to the study of pharmacology. Currently, the program does not provide training in human anatomy, relegating that subject to the pre-optometry status, but provides more specialized morphological instruction in ocular anatomy and neuroanatomy. The curriculum includes core courses in physiological chemistry, physiology, neurology, microbiology, general and ocular pathology. All of these courses carry required laboratory work except physiological chemistry and microbiology, and all of these courses are completed before pursuing a required 2-semester hour lecture and demonstration class in Optometric Pharmacology.

Awaiting implementation, to complete the pharmacological

training of an optometrist, is a three-year old proposal for the development and suitable staffing of a Special Clinic in Pharmacology, which a student would enter after completion of the required two-hour lecture course. This Pharmacology Clinic would provide student clinicians with medically supervised practical experience in the use of topically-applied "eye drops", belonging to the group called Diagnostic Pharmaceutical Agents (DPA's), on themselves and on clinic patients.

Attached are (a) a synopsis of the biological science coursework offered in the Colleges of Optometry in the U.S., (b) a topical outline of the course in Optometric Pharmacology offered at the College of Optometry in Forest Grove, and (c) current curricula of Colleges of medicine, dentistry, and optometry in the State of Oregon.

The total learning experience leading to competence in optometric pharmacology is thus spread over all four years of the professional program. The faculty responsible for the teaching of the relevant basic biological science coursework all possess earned doctorates (Ph.D.'s) in the disciplines in which they provide instruction, hold memberships in the appropriate professional societies, and the majority are actively engaged in research programs in their specialized areas. The course in Optometric Pharmacology is staffed by a Ph.D. in Physiology, with extensive research experience

involving the experimental use of all classes of DPA's, with membership in the American Physiological Society and nomination for membership in the American Society for Pharmacology and Experimental Therapeutics (pending); a practicing O.D. with military experience in Viet Nam, during which he acquired extensive training in the use of all classes of DPA's from ophthalmological colleagues; and a practicing physician in Forest Grove with special interst and experience in ocular drugs. Thus the graduating O.D. is provided with all of the background and training necessary to equip him to deliver optimal vision care to his patients through the appropriate utilization of Diagnostic Pharmaceutical Agents.

CURRICULUM

COLLEGE OF OPTOMETRY 1974-1975

Courses in the Professional Curriculum

The duration of the regular professional curriculum in Optometry is four academic years and requires completion of 135 approved semester hours. This is preceded by a minimum of two years of pre-optometry.

First Professional Year

Optometry 333 Geometrical Optics	3
Optometry 334 Laboratory Geometrical Optics	1
Optometry 335 Ocular Anatomy and Physiology	3
Optometry 336 Laboratory-Ocular Anatomy	1
Optometry 337 Optometric Orientation	1
Optometry 338 Physical Optics	3
Optometry 339 Laboratory-Physical Optics	1
Optometry 340 Physiological Chemistry	3
Optometry 341 Laboratory-Physiological Chemistry	1
Optometry 342 Ophthalmic Optics	3
Optometry 343 Laboratory-Ophthalmic Optics	1
Optometry 344 Advanced Human Physiology	3
Optometry 345 Laboratory-Advanced Human Physiology	1
Optometry 346 Physiological Optics I	3
Optometry 347 Laboratory-Physiological Optics I	1
Optometry 348 Experimental Psychology	3
Optometry 349 Laboratory-Experimental Psychology	1
Optometry 399 Optometric Procedures I	3

Second Professional Year

Optometry 400 Optometric Procedures II/ Receiving Clinic	2
Optometry 401 Optometric Procedures III/ Receiving Clinic	3
Optometry 433 Bases of Pathology	3
Optometry 434 Laboratory-Bases of Pathology	1
Optometry 435 Physiological Optics II	3
Optometry 436 Laboratory-Physiological II	1
Optometry 437 Structure and Function of the Nervous System	3
Optometry 439 General and Ocular Pathology	2
Optometry 440 Ocular Pathology Detection and Visual Fields	3
Optometry 441 Optometry I/Theory and Methods of Clinical Refraction	3
Optometry 442 Optometry II/Basic Case Analysis	4
Optometry 444 Contact Lenses	3
Optometry 445 Laboratory-Contact Lenses	1

Third Professional Year

Optometry 518 Psychophysiology of Vision	3
Optometry 519 Psychology of Vision Laboratory	1
Optometry 520 Human Visual Perception	3
Optometry 521 Laboratory-Psychology II	1
Optometry 533 Optometry III/Advanced Case Analysis of Motor Dysfunctions	3
Optometry 534 Laboratory-Optometry III	1
Optometry 537 Visual Training I	3
Optometry 538 Laboratory-Visual Training	1
Optometry 539 Basic General Clinic I	1
Optometry 540 General Clinic II	2
Optometry 541 Optometry IV/Low Vision and Geriatrics	2
Optometry 542 Laboratory-Optometry IV	1
Optometry 545 Environmental Vision	3
Optometry 551 Optometry V/Strabismus and Amblyopia	3
Optometry 552 Laboratory-Optometry V	1

Fourth Professional Year

Optometry 633 National Problems of Health Care	3
Optometry 635 General Clinic III**	2-5
Optometry 639 Optometry VI/Advanced and Contemporary Clinical Procedures	2
Optometry 640 General Clinic IV	2-5
Optometry 641 General Clinic V.	2-6
Optometry 642 Optometric Pharmacology	2
Optometry 646 Specialty Clinics	1-4
Optometry 690 Research	2-6

*During the last three years and a half a minimum of 12 hours of general clinic is required. Only 6 hours of general clinic are shown. The remaining 6 hours may be scheduled whenever is convenient.

**Scheduled Summer between third and fourth years.

CURRICULUM DENTAL SCHOOL 1974-1975

First Year

	Credit Hours
Fall Interval	
*An 417, 418, 419, 421 Human Morphology	—
BCh 411-2 Biochemistry	—
BeS 411 Omnibus	2.0
BeS 411 Principles of Behavior Management	1.0
BeS 411 Personal Adjustment	1.0
CB 411 Crown and Bridge Technic	1.2
CJT 411 Cell Biology	0
*DA 411-2 Dental Anatomy	—
*DM 411 Dental Materials	—
MB 411 Microbiology	2.0
OD 411 Oral Examination Technic	1.5
*PD 411-2 Preventive Dentistry Technic	—
PD 411 Public Health Dentistry	2.0
Winter Interval	
An 417, 418, 419, 421 Human Morphology	—
BCh 411-2 Biochemistry	7.9
CB 412 Crown and Bridge Technic	2.1
CJT 412 Biology of Inflammation	2.0
*CJT 412-3 Infectious Diseases	—
CJT 412 Mineralization	1.5
DM 412 Dental Materials	—
DA 411-2 Dental Anatomy	3.0
MB 412 Immunology	3.5
PD 411-2 Preventive Dentistry Technic	2.0
PD 412 Nutrition	1.0
Per 412 Periodontics Technic	1.5
*Phy 412 Physiology	—
Spring Interval	
An 417, 418, 419, 421 Human Morphology	13.3
CB 413 Crown and Bridge Technic	1.2
CJT 412-3 Infectious Diseases	5.0
CJT 413 Caries	2.5
DM 413 Dental Materials	2.0
Op 418 Operative Technic Lecture	2.0
Op 419 Operative Technic Laboratory	2.0
Per 613 Periodontics Clinic	.5
Phy 413 Physiology	6.0
First Year Total	67.7

Second Year

Fall Interval	
An 421 Neuroanatomy	1.3
†CB 420 Crown and Bridge Technic	3.0
DM 421 Dental Materials	1.0
Op 420 Operative Technic Lecture	1.0
Op 421 Operative Technic Lab	2.0
OS 420 Medical Emergency Procedures	1.0
*Per 620 Oral Hygiene Clinic	—
Phy 420 Physiology	3.0
Pth 420 Pathology	4.0
Winter Interval	
†CB 421 Crown and Bridge Technic	2.0
DM 422 Dental Materials	2.0
Op 423 Operative Technic	1.0
Op 424 Operative Technic Laboratory	2.0
Ord 423 Orthodontics	1.0
Ord 428 Orthodontics Technic	1.0
OS 421 Local Anesthesiology Exo.	1.0
OS 423 Intro Oral Surgery	1.0
Pedo 422 Child Development	2.0
*Per 621 Oral Hygiene Clinic	—
Phr 420 Pharmacodynamics I	3.0
Pth 421 Pathology	3.0
Ro 420 Oral Radiology	1.0
Spring Interval	
An 423 Head and Neck Anatomy	3.0
†CB 422 Crown and Bridge Technic	1.0
Endo 423 Endodontics	2.0
OD 429 Oral Diagnosis	1.0
Op 623 Operative Clinic	0
OS 422 Local Anesthesiology Exo.	2.0
Pedo 423 Child Development	1.0
Pedo 429 Pedodontic Technic	1.0
Per 423 Principles of Periodontology	1.0
Per 622 Oral Periodontology Clinic	2.0
Pr 422-3 Prosthetics Conference Lab	2.0
Ro 421 Oral Radiology Lecture	1.0
Ro 422 Oral Radiology Lab	1.0
Second Year Total	54.3

Third Year

Fall Interval	
CB 431 Principles of Crown and Bridge	1.0
CB 630 Crown and Bridge Clinic	1.0
Endo 431 Endodontics	1.0
*Endo 642 Endodontics Clinic	—
OD 430 Oral Diagnosis Treatment	1.0
Op 633 Operatives Clinic	1.0
Ord 431 Facial Growth	1.0
OS 430 Oral Surgery	1.0
Pedo 630 Pedodontics Clinic	1.0
Per 42. Periodontology Lecture	1.0
*Per 631 Periodontology Clinic	—
Pr 430 Principles of Clinical Prosthetics	1.0
Pr 633 Prosthetics Clinic	1.0
Pth 434 Pathology	2.0
*Ro 630 Oral Radiology Clinic	—
Winter Interval	
CB 631 Crown and Bridge Clinic	1.0
*Endo 642 Endodontics Clinic	—
OD 437 Clinical Conference	0
Op 634 Operatives Clinic	1.0
Ord 432 Orthodontics	1.0
OS 431 Oral Surgery	1.0
PD 430 Caries Prevention	1.0
Pedo 631 Pedodontics Clinic	1.5
*Per 632 Periodontology Clinic	—
Phr 430 Pharmacodynamics II	3.0
Pr 634 Prosthetics Clinic	1.0
Pth 435 Pathology	2.0
*Ro 630 Oral Radiology	—
Spring Interval	
CB 632 Crown and Bridge Clinic	1.0
*Endo 642 Endodontics Clinic	—
Med 439 Principles of Medicine	1.0
OD 438 Clinical Conference	2.0
Op 430 Principles of Clinical Operatives	1.0
Op 635 Operatives Clinic	2.0
OS 432 Oral Surgery Lecture	1.0
OS 630 Oral Surgery Clinic	1.0
PA 432 Dental Jurisprudence	1.0
Pedo 632 Pedodontics Clinic	1.0
Per 633 Periodontology Clinic	3.0
Pr 635 Prosthetics Clinic	2.0
Pth 436 Pathology	2.0
Ro 630 Oral Radiology	1.0
Third Year Total	44.0

Fourth Year

Fall Interval	
CB 640 Crown and Bridge Clinic	2.0
DM 441 Dental Materials	1.0
*Endo 640 Endodontics Clinic	—
Med 440 Principles of Medicine	1.0
*Med 443 Hospital Clinic	—
OD 440 Clinical Conference	0
Op 643 Operatives Clinic	3.0
*Ord 447 Orthodontics Conference	—
†PA 433 Professional Adjustment	1.0
†PA 436 Professional Viewpoints	1.0
Pedo 440 Pedodontics Conference	1.0
Pedo 640 Pedodontics Clinic	0
*Per 440 Periodontology Clinic Seminar	—
*Per 641 Periodontology Clinic	—
Pr 643 Prosthetics Clinic	0
*Ro 640 Oral Radiology	—
Winter Interval	
CB 441 Principles of Crown and Bridge	1.0
CB 641 Crown and Bridge Clinic	2.0
Endo 640 Endodontics Clinic	1.0
Med 442 Principles of Medicine	1.0
*Med 444 Hospital Clinic	—
OD 441 Clinical Conference	2.0
Op 644 Operatives Clinic	3.0
*Ord 442 Orthodontics Conference	—
PD 440 Public Health Dentistry	1.0
Pedo 641 Pedodontics Clinic	1.0
*Per 440 Periodontology Clinic Seminar	—
*Per 642 Periodontology Clinic	—
Pr 440 Principles of Clinical Prosthetics	1.0
Pr 644 Prosthetics Clinic	1.0
†Pth 445 Pathology	2.0
*Ro 640 Oral Radiology	—
Spring Interval	
CB 642 Crown and Bridge Clinic	2.0
Med 445 Hospital Clinic	1.0
OD 642 Oral Diagnosis Clinic	1.0
Op 645 Operatives Clinic	3.0
Ord 442 Orthodontics Conference	1.0
OS 440 Clinical Surgery	1.0
OS 640 Oral Surgery Clinic	1.0
OS 644 Hospital Dental Clinic	1.0
PA 401 Dental Psychology	—
PA 445 Ethics Case Study	1.0
Pedo 643 Pedodontics Clinic	1.0
Per 440 Periodontology Clinic Seminar	1.0
Per 643 Periodontology Clinic	1.0
Pr 645 Prosthetics Clinic	1.0
Pth 441 Oral Pathology	1.0
Ro 640 Oral Radiology Clinic	1.0
Fourth Year Total	44.0

Recapitulation

First Year	67.7
Second Year	54.3
Third Year	44.0
Fourth Year	44.0
Totals	210.0

CURRICULUM

MEDICAL SCHOOL 1974-1975

The curriculum in medicine requires a total of seven years' work beyond high school. The first three years must be satisfactorily completed before admission to the Medical School in Portland. Since facilities for instruction provide for the acceptance of only a limited number of applicants, completion of premedical studies does not guarantee admission to the Medical School.

The four years spent in the Medical School in Portland are devoted to subjects of the regular four-year curriculum in medicine required by law.

The prescribed and recommended subjects for the three premedical years are described under *Admissions and Scholastic Regulations*. In the first, second, third, and fourth years at the Medical School there are 5,044 class hours of required work. Descriptions of courses are to be found under the several departmental headings.

Prescribed Work

First Year		Term Hours
Con 410	Cell Organization and Function	5
Con 411	Medical Genetics	2
Con 412	Developmental Biology	2
Con 413	Introduction to Patient Evaluation	3
Con 414	Immunology	2
An 410	Gross Anatomy	12
An 411	Histology	4
An 412	Neuroanatomy	4
BCh 410	Basic Biochemistry	3
MPs 410	Medical Psychology	2
Pth 410	General Pathology	3
Phy 410	Human Physiology	7
Psy 410	The Human Context of Medical Practice	2
PH 410	Public Health and Epidemiology	3
		54

Second Year		
Con 610	Pathophysiology of Skin, Bone and Connective Tissue	3
Con 611	Patient Evaluation	5
Con 612	Cardiovascular Pathophysiology	5
Con 613	Respiratory Pathophysiology	3
Cor 614	Renal Pathophysiology	5
Con 615	Blood and Reticuloendothelial Pathophysiology	5
Con 616	Endocrine Pathophysiology	3
Con 617	Gastrointestinal Pathophysiology	5
Con 618	Reproductive Pathophysiology	5
Con 619	Pathophysiology of the Central Nervous System, Muscle and Special Sensory Organs	8
Mb 610	Microbiology	4
Phc 610	Pharmacology	3
		54

Third Year		
Con 620	Child Health	18
Con 621	Neurosciences	9
Con 630	Law and Medicine (May be taken 3rd or 4th year)	2
Med 620	Third-Year Medicine	18
RadD 620	Radiographic Diagnosis	1½
Special Programmed Instruction		9
		57½

Fourth Year		
ObG 630	Fourth-Year Obstetrics and Gynecology	9
Psy 630	Psychiatry Clinical Clerkship	9
Sur 630	Fourth-Year Surgery	18
Special Programmed Instruction		18
		54

A list of elective courses will be made available to every student.

* Includes holidays

ASSOCIATION OF SCHOOLS AND COLLEGES OF OPTOMETRY

Pharmacology Curriculum Guidelines for Continuing Education Courses

Prepared by the Council on Academic Affairs of the
Association of Schools and Colleges of Optometry,
Richard Hazlett, O.D.,
Chairman

December 1974

1730 M Street, N.W., Suite 411, Washington, D.C. 20036, (202) 833-3373

This Is The Recommended Content Of The Above Courses As Reported By The Council On Academic Affairs Of The Association Of Schools And Colleges Of Optometry

Pharmacology Curriculum Model

A Report of the ASCO Council on Academic Affairs

The role of the optometrist as a health care practitioner and a primary vision care provider has encouraged a movement in optometry to modify state optometry laws so that pharmaceutical agents can be utilized in the practice of optometry. This has also focused attention on the scope of the pharmacology programs in the schools and colleges of optometry. Sensing this attention, the Council on Academic Affairs of the Association of Schools and Colleges of Optometry (ASCO) selected a committee and prepared the following curriculum model to be utilized by the various schools and colleges in assessing the scope of their individual programs in pharmacology.

We want to thank the members of the committee who devoted considerable time and effort to this project. Dr. David Amos, private practice, Kansas City, Missouri, Dr. Freddy Chang, faculty member, School of Optometry, Indiana University, Dr. Siret Jannus, faculty member, Southern California College of Optometry; Dr. Jerry Rapp, faculty member, State University of New York, State College of Optometry, Dr. Tom Stelmack, faculty member, Illinois College of Optometry; and Dr. Jess Boyd Eskridge, faculty member, University of Alabama in Birmingham, School of Optometry.

GENERAL PHARMACOLOGY

I. Introduction to Basic Principles of Drug Action

A. Definitions
1. General Concepts
a. Definition of a drug
b. Absorption and elimination
c. First order kinetics
d. Biological half-like
e. Volume of distribution
f. Dosing concepts

B. Sources of Drugs
1. Naturally occurring
2. Synthetic
3. Semi-synthetic

C. Drug Classification
1. Site of action
2. Functional group
3. Nomenclature

D. Dosage forms
1. Oral
2. Parenteral
3. Suppositories
4. Sustained release

E. Pharmacodynamics - pharmacokinetics
1. Routes of administration
a. Enteral
b. Parenteral
c. Rectal
2. Absorption
a. Passive versus active transport
b. Acid—base characteristics
c. Lipid solubility
d. Molecular size and charge characteristics
3. Distribution
a. Lipid solubility
b. Free versus bond
c. Blood-brain barrier
d. Protein binding (plasma, tissue)
4. Metabolism
a. Oxidation - reduction
b. Hydrolysis
c. Acetylation
d. Conjugation
e. Other
5. Excretion
a. Renal
b. Lungs
c. Skin

F. Pharmacogenetics
1. Idiosyncratic effects
2. Inborn errors of metabolism

G. Mechanisms of drug action
1. Kinetics of drug action
a. Michaelis—Menten
b. Biological half-life
c. Dose—response curve
d. Volume of distribution
e. Maintenance of dose, dosing interval, loading dose
2. Receptors and acceptors
a. Primary versus secondary
3. Agonist and antagonist
4. Drug tolerance
a. Tachyphylaxis
b. Physiological
c. Psychological
5. Drug—Receptor Interactions
a. Synergism
b. Additivity
c. Potentiation
d. Inhibition

H. Evaluation of Drug Action
1. Animal Studies
a. ED_{50}
b. LD_{50}
c. Therapeutic index
d. Drug efficacy
e. Drug potency
2. Clinical Investigations
a. Host factors
b. Placebo effect
3. Legal Regulations
a. Laws and Rules
b. Agencies (federal and state)
4. Drug Standards
a. Bioassays

I. Prescription Writing
1. Composition of the prescription
2. Laws governing drug dispensing

J. Ethical Factors of Drug Use

K. Psychological Factors of Drug Use

II. Drugs Acting on the Peripheral Nervous System

A. Neurohumoral mediators

B. Autonomic drugs
1. Drug action on the parasympathetic system
a. Parasympathomimetics
1) a) Acetylcholine
b) Methacholine
c) Carbachol
d) Pilocarpine

2) Indirect acting
a) Physostigmine
b) Neostigmine
c) Edrophonium
d) Echothiophate
e) Diisofluorophosphate

b. Parasympatholytic
1) Anti-Muscarinic
a) Atropine
b) Scopolamine
c) Homatropine
d) Cyclopentolate
e) Tropicamide
2) Nicotinic
a) D-tubocurarine
b) Succinylcholine

2. Drugs Acting on the Sympathetic System
a. Sympathomimetics
1) Direct acting—alpha stimulators
a) Norepinephrine
b) Phenylephrine
c) Naphazoline
d) Tetrahydrozoline
e) Ephinephrine
2) Direct acting—beta stimulators
a) Isoproterenol
b) Epinephrine
3) Indirect acting
a) Ephredrine
b) Vasodilator—amphetamines
c) Parahydroxyamphetermine

b. Sympatholytics
1) Alpha blockers
a) Ergot alkaloids
b) Dibenzyline
c) Tolazoline
2) Beta blockers
a) Propranolol

c. Neuronal blocking agents
1) Guanethidine
2) Bretylium
3) Rauwolfia Alkaloids

3. Drugs Acting on Autonomic Ganglia
a. Ganglionic stimulants
b. Ganglionic blocking agents

C. Drugs Modifying Neuromuscular Transmission
1. Stimulating agents for transmission
2. Blocking agents of transmission

III. Autacoids

A. Histamines

B. Kinins

C. Prostaglandins

IV. Drugs Acting on the Central Nervous System

A. Stimulants
1. Amphetamines
2. Non-amphetamines

B. Anti-depressants
1. MAO inhibitors
2. Tricyclic antidrepressants
3. Sympathomimetic agents

C. Anti-convulsants
1. Barbiturates
2. Phenytoins
3. Miscellaneous

D. Anti-Parkinsonism
1. Levodopa
2. Anti-cholinergic

E. Anti-spasmodic agents
1. Anti-cholinergics
2. Gastric antacids

F. Sedatives and hypnotics
1. Barbiturates
2. Non-barbiturates

G. Psychotherapeutic agents
1. Phenothiazine derivatives
2. Thioxanthene derivatives
3. Benzodiazepine drugs
4. Miscellaneous agents

H. Analgesics
1. Narcotics
2. Non-narcotic

I. Alcohol and Related Agents
1. Alcohols
2. Disulfiram

J. Antipyretics and Anti-inflammatory (non-steroid)
1. Salicylates
2. Pyrazolon derivatives
3. Para-aminophenol derivatives

K. Drug Abuse
1. Opiates
2. Barbiturates and sedative-hypnotics
3. Amphetamines
4. Cannabinoids
5. Psychotomimetics

L. Drug Dependence

V. Anesthetics

A. Pharmacology of General Anesthesia
1. History and theory
2. Signs and stages
3. Mechanics
4. Gas anesthetics (nitrous oxide, cyclopropane, ethylene)
5. Volatile anesthetics (ether, holothane, chloroform)

B. Pharmacology of Local Anesthesia
1. Cocaine
2. Procaine

VI. Drugs Acting on the Cardiovascular System

A. Digitalis and allied cardiac glycosides

B. Diuretics
1. Thiazide derivatives
2. Carbonic anhydrase inhibitors
3. Osmotic agents
4. Miscellaneous

C. Anti-arrhythmic drugs
1. Quinidine
2. Local anesthetics
3. Miscellaneous agents

D. Anti-hypertensive drugs
1. Hydralazine
2. MAO inhibitors
3. Diuretic agents

E. Anti-coagulants
1. Heparin
2. Oral anti-coagulants
3. Miscellaneous agents

F. Vasodilators
1. Nitrates and nitrites
2. Theophyline compounds

G. Anti-atherosclerotic agents
1. Hyperlipidemic drugs
2. Female sex hormones
3. Nicotinic acid

VII. Hormones and Drugs Modifying Endocrine Activity

A. Pituitary Hormones and their actions
   1. Anterior pituitary hormones
   2. Posterior pituitary hormones

B. Thyroid hormones and anti-thyroid agents
   1. Thyroid hormone
   2. Anti-thyroid drugs

C. Insulin and other hypoglycemic agents
   1. Insulin
   2. Biguanides
   3. Sulfonylureas

D. Adreno-cortical hormones
   1. Glucocorticords
   2. Mineralocorticords
   3. Androgenic steroids

E. Gonadal hormones—oral contraceptives
   1. Estrogens
   2. Androgens
   3. Progesterone

F. Parathyroid hormones

G. Agents Affecting Immune Systems
   1. Corticosteroids
   2. Cytotoxic agents

VIII. Drugs Affecting Metabolic Activity

A. Antianemic drugs
   1. Iron
   2. Copper
   3. Cobalt
   4. Pyridoxine
   5. Vitamin B12
   6. Folic acid

B. Uricosuric drugs
   1. Colchicine
   2. Allopurinol

C. Vitamins, Minerals and Other Nutrients
   1. Fat-Soluble Vitamins
   2. Water-Soluble vitamins

D. Metals
   1. Heavy metals
   2. Heavy-metal antagonists

IX. Chemotherapeutic Agents

A. Introduction
   1. History of chemotherapy
   2. Mechanisms of action of chemotherapeutic agents

B. Antibiotics
   1. Synergism and antagonism
   2. Classification
   3. Methods of selection for clinical use

C. Sulfonamides
   1. Chemistry
   2. Classification
   3. Toxicity and hypersensitivity

D. Antiviral agents
   1. Idoxuridine
   2. Amantadine
   3. Miscellaneous agents

E. Anti-fungal agents
   1. Nystatin
   2. Amphotericin B
   3. Griseofulvin
   4. Miscellaneous agents

F. Anti-parasitic agents
   1. Ectoparasites
   2. Endoparasites
   3. Antimalarial

G. Drugs used in treatment of tuberculosis and leprosy
   1. Streptomycin
   2. Isoniazid
   3. Para-aminosalicylic acid
   4. Dapsone
   5. Ethambutol

H. Drugs used in the treatment of neoplasia
   1. Alkylating agents
   2. Anti-metabolites
   3. Hormonal agents
   4. Radioactive isotopes

I. Antiseptics and disinfectants
   1. Benzalkonium chloride
   2. Thimerosal
   3. Phenylmercuric nitrate

X. Over the Counter Medications

A. Types of drugs found in OTC preparations

B. Concentrations used

C. Potential hazards

XI. Toxicology

A. Adverse drug reaction
   1. Classification
   2. Frequency of occurrence
   3. Drug factors
   4. Patient factors
      a) Age
      b) Weight
      c) Race
      d) Pathological factors
      e) Other
   5. Drug contraindication in pregnancy and lactation

B. Environmental Factors
   1. Poisons
   2. Carcinogens
   3. Pollutants

XII. Principles of Immunopharmacology

A. Immunosuppressive agents

B. Cellular aspects of the immune response

C. Effector mechanisms and mediators in immune injury

D. Immunosuppressive and anti inflammatory drug action

OCULAR PHARMACOLOGY

I. Properties of Ophthalmic Preparations

A. Physical properties of ophthalmic solutions
   1. Tonicity
   2. PH
   3. Stability
   4. Sterility
   5. Viscosity
   6. Surface activity

B. Physical properties of ophthalmic ointments
   1. Tonicity
   2. PH
   3. Stability
   4. Sterility
   5. Viscosity
   6. Surface activity

C. Other dosage forms
   1. Suspension
   2. Time release systems

D. Packaging
   1. Single dose
   2. Multiple dose

II. Routes of Drug Administration

A. Topical
B. Subconjunctival injections
C. Retrobulbar injections
D. Intracameral and intravitreal injections
E. Iontophoresis
F. Other

III. Ocular Drug Pharmacodynamics and Pharmacokinetics

A. Absorption and penetration
B. Distribution
C. Metabolism
D. Routes of removal

IV. Techniques and Procedures in Clinical Administration

A. Pre-instillation
   1. Case history
   2. Ocular tissue integrity
   3. Angle evaluation
   4. Tonometry

B. Installation Techniques
   1. Solution
   2. Ointments
   3. Miscellaneous

C. Injections
D. Ophthalmic Prescription Nomenclature

V. Drugs Affecting the Autonomic Nervous System of the Eye (Mechanisms of Action, Indications, Precautions, Contraindications, Dosage, Adverse Reaction, and Side-Effects)

A. Sympathomimetics (Mydriatics)
   1. Direct acting
      a. Norepinephrine
      b. Epinephrine
      c. Phenylephrine
      d. Isoproterenol
   2. Indirect acting
      a. Cocaine
      b. Hydroxyamphetamine
      c. Ephedrine

B. Sympatholytics
   1. Alpha blockers
   2. Beta blockers

C. Neuronal blockers

D. Parasympathomimetics (Miotics)
   1. Direct acting
      a. Acetylcholine
      b. Methacholine
      c. Pilocarpine
      d. Carbachol
   2. Indirect acting (Anticholinesterases)
      a. Reversible (short acting)
         1) Physostigmine
         2) Edrophonium
         3) Neostigmine
      b. Irreversible (long acting)
         1) Demecarium
         2) Echothiophate
         3) Isofluorophosphate

E. Parasympatholytics (Cycloplegics—Mydriatics)
   1. Atropine
   2. Scopolamine
   3. Homatropine
   4. Cyclopentolate
   5. Tropicamide
   6. Oxyphenonium

VI. Pharmacological Diagnosis and Treatment of Neuro Muscular Disorders

VII. Local and Topical Anesthetics (Mechanisms of Action, Indications, Precautions, Contraindications, Dosage, Adverse Reactions, and Side Effects)

A. Cocaine
B. Procaine
C. Lidocaine
D. Tetracaine
E. Proparacaine
F. Benoxinate
G. Piperocaine
H. Butyn-Sulfate (Butacaine)

VIII. Miscellaneous Ophthalmic Preparations

A. Hyperosmotic Agents
B. Antihistamines
C. Ocular lubricants
D. Decongestants
E. Dyes
F. Irrigating Solutions
G. Vitamins
H. Ophthalmic Preparations in Contact Lens Wearing
I. Preservatives
J. Antiseptics

IX. Corticosteroids and Other Anti-Inflammatory Agents (Mechanisms of Action, Indications, Precautions, Contraindications, Dosage, Adverse Reactions, Side Effects)

X. Ocular Chemotherapeutic Agents (Spectrum, Mechanisms of Action, Indications, Precautions, Contraindications, Dosage, Adverse Reactions, and Side Effects)

A. Antibiotics
B. Sulfonamides
C. Antiviral
D. Anti-fungal
E. Antiparasitic
F. Germicidal

XI. Therapeutic Management of Ocular Disorders (Mechanisms of Action, Indications, Precautions, Contraindications, Dosage, Adverse Reactions, and Side Effects)

A. Diseases of the eyelids
B. Diseases of the lacrimal apparatus
C. Diseases of the conjunctiva
D. Diseases of the cornea
E. Diseases of the sclera
F. Glaucoma

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22nd Annual Examination

NATIONAL BOARD OF EXAMINERS IN OPTOMETRY

Question Sheet for Part II, Section 6, OCULAR PHARMACOLOGY
Number of Test: 9

Tuesday, May 1, 1973 (1 hour) 9:00 - 10:00 p.m.

Instructions: Read carefully before starting. See also general instruction sheet. This examination consists of one group of 40 questions. On the answer sheet supplied with this examination, blacken the proper box to indicate the single best answer for each question. Be sure to indicate that this is test number 9.

1. The mechanism whereby neostigmine (Prostigmin) in small doses induces a pupillary constriction is because neostigmine
   a. stimulates formation and release of acetylcholine.
   b. reacts directly with receptor groups in the same fashion as acetylcholine.
   c. reacts with receptor groups to block them.
   d. blocks cholinesterase so acetylcholine can accumulate.
   e. activates cholinesterase to destroy acetylcholine more rapidly.

2. Epinephrine and norepinephrine are both released by stimulation of the sympathetic nervous system. To distinguish between them experimentally small doses may be intravenously injected into a suitably prepared experimental animal. Which effect list below would be seen with epinephrine, but not with norepinephrine?
   a. An increase in blood pressure
   b. A cutaneous vaso-constriction
   c. An increase in heart rate
   d. A decrease in gut tone and motility
   e. Bronchiolar dilitation

3. Which of the following mydriatics has the shortest duration of action when applied topically to the normal eye?
   a. homatropine
   b. atropine
   c. epinephrine
   d. phenylephrine
   e. oxphenonium

4. Which of the following side-effects might result from the topical application of epinephrine preparations?
   a. a decrease in heart rate
   b. palpitations
   c. rebound hyperemia
   d. both b. and c. above
   e. all of the above

5. Cocaine exhibits which two types of pharmacological activities?
   a. local anesthesia and miosis
   b. miosis and cycloplegia
   c. local anesthesia and mydriasis
   d. tachycardia and miosis
   e. none of the above

6. Which of the following pharmacological activities is (are) common to phenylephrine but not to atropine?
   a. mydriasis
   b. conjunctival decongestion
   c. cycloplegia
   d. both a. and c. above
   e. none of the above

7. When applied topically, drugs such as pilocarpine, isofluorphate and echothiophate can be expected to produce
   a. mydriasis
   b. cycloplegia
   c. mydriasis and cycloplegia
   d. miosis
   e. none of the above

8. Used in the management of ocular hypertension, acetazoleamide, dichlorphenamide and methazolamide are classed as
   a. carbonic anhydrase inhibitors
   b. anticholinesterases
   c. direct-acting cholinergic stimulants
   d. cholinergic inhibitors
   e. adrenergic stimulants

9. Prolonged use of topical corticosteroids is known to
   a. induce open-angle glaucoma in normal eyes and aggravate pre-existing glaucoma.
   b. intensify ocular inflammation of allergic origin.
   c. promote corneal scarring subsequent to traumatic injury.
   d. cause corneal pitting.
   e. none of the above

This examination consists of 4 pages. See that your copy is complete and that no questions are overlooked.

10. Which of the following drugs can be classed as a corticosteroid?
    a. phenylephrine
    b. tetrahydrozoline
    c. dexamethasone
    d. piperocaine
    e. antazoline

11. Many ophthalamic solutions contain small amounts of benzalkonium chloride (Sephiran) in order to
    a. solubilize the active drug.
    b. buffer the preparation to pH 7.
    c. render the preparation isotonic with tears.
    d. inhibit the growth of contaminating microbes.
    e. none of the above.

12. The term potency refers to
    a. the margin of safety of a drug
    b. the amount of drug required to produce a certain effect
    c. the ratio between the toxicity and efficacy of a drug
    d. the toxicity of a drug
    e. none of the above

13. The term therapeutic index refers to
    a. a classification of drugs by usage
    b. a measure of drug potency
    c. a measure of drug efficacy
    d. the ratio between the number of times a drug is used and the toxicity observed
    e. none of the above

14. Most drugs are broken down in the
    a. skin
    b. kidneys
    c. liver
    d. lungs
    e. none of the above

15. The term synergism refers to
    a. an effect greater than additive produced when two or more drugs are combined
    b. drug antagonism
    c. an additive effect produced by the combination of two or more drugs
    d. a long duration of drug action
    e. none of the above

16. Drugs cross biological membranes by the process(es) of
    a. active transport
    b. passive diffusion
    c. filtration
    d. all of the above
    e. none of the above

17. Local anesthetics act by
    a. producing an irreversible depression of neuronal conduction.
    b. facilitating neuronal depolarization.
    c. preventing neuronal influx of sodium ions.
    d. increasing the permeability of neuronal membrane to sodium ions.
    e. none of the above

18. Vasoconstrictors are often added to solutions of local anesthetics which are intended for injection in order to
    a. retard absorption.
    b. prolong the duration of action.
    c. decrease the chance of systemic toxicity.
    d. all of the above
    e. none of the above

19. The absorption of excessive amounts of topical anesthetic from mucosal surfaces may lead to
    a. marked sedation
    b. bronchial constriction
    c. hypertension
    d. central nervous system stimulation
    e. none of the above

20. Which of the following is not true concerning the use of tetracaine (Pontocaine) as a topical local anesthetic?
    a. duration of action is 10-20 minutes
    b. can produce superficial corneal epithelial lesions
    c. can be safely prescribed for routine home use by patients
    d. allergic reactions are known to occur
    e. all of the above

21. Which of the following is not true concerning cocaine?
    a. can produce marked topical anesthesia when applied to the cornea
    b. topical application produces miosis
    c. has been used in the differential diagnosis of Horner's syndrome
    d. can produce damage to the corneal epithelium
    e. all of the above

22. Drugs administered in the subconjunctival space cross through the sclera and into the eye primarily by
    a. facilitated diffusion
    b. active transport
    c. filtration
    d. passive diffusion
    e. phagocytosis

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23. If a patient came to you and was lethargic and had pinpoint pupils, you might suspect that he had recently taken
    a. pentobarbital
    b. LSD
    c. marijuana
    d. morphine
    e. amphetamine

24. Methyl mercury, a compound which is causing great concern today as an environmental pollutant, can cause many diverse symptoms involving the eye. Which of the following has been soundly established as a characteristic of poisoning with this agent?
    a. pigmentary retinopathy
    b. concentric constriction of visual fields
    c. nystagmus
    d. oculogyric crisis
    e. glaucoma

25. Pilocarpine reduces intraocular pressure by the following mechanism:
    a. Drug inhibits the enzyme acetylcholinesterase.
    b. It inhibits the formation of aqueous humour.
    c. Drug acts directly on the ciliary muscles and iris sphincter. The contraction of these muscles helps to open canal of Schlemm. Hence, the pressure is reduced.
    d. It inhibits choline acetylase, the enzyme involved in the formation of aqueous humour.
    e. The drug causes a fall in intracranial pressure which helps to reduce IOP.

26. Miotic effect of echothiophate results from
    a. depletion of the neurotransmitter acetylcholine.
    b. irreversible inhibition of the enzyme acetylcholinesterase.
    c. short lived inhibition of the enzyme acetylcholinesterase.
    d. irreversible inhibition of monoamine oxidase.
    e. depletion of the neurotransmitter norepinephrine.

27. Which of the following drugs produce mydriasis without significant loss of accommodation?
    a. homatropine
    b. scopolamine
    c. tropicamide
    d. eserine
    e. phenylephrine

28. Side effects from the systemic absorption of atropine will include
    a. central nervous system stimulation, tachycardia, dry mouth.
    b. diuresis, salivation, marked fall in blood pressure.
    c. piloerection.
    d. fall in body temperature, diarrhea and vomiting.
    e. sweating.

29. Which of the following drugs acts through liberation of endogenous norepiphrine and recently was introduced for the diagnosis of Horner's pupil?
    a. P-OH-amphetamine
    b. methacholine
    c. procaine
    d. neostigmine
    e. D.F.P.

30. Chronic administration of which of the following drugs is reported to cause a rise in intraocular pressure?
    a. aspirin
    b. oral contraceptive
    c. epinephrine
    d. isoproterenol
    e. propranolol

31. All of the following groups of drugs are used in the treatment of hypertension. Which group of drugs is likely to produce miosis?
    a. Ganglionic blockers, like pentolinium
    b. Monoamine oxidase inhibitors, like Pargyline
    c. Diuretics, like chlorthiazide
    d. Norepinephrine depletors, like reserpine.
    e. Veratrum alkaloids, like Protoveratrines

32. Large, repeated doses of tranquilizers, like chlorpromazine used in psychiatry, can cause
    a. mydriasis.
    b. marked rise in IOP.
    c. complete loss of accommodation.
    d. vasoconstriction in iris.
    e. corneal pigmentation, stellate form cataract and retinopathy.

33. If 10% solution of phenylephrine is applied topically as a mydriatic in children, the systemic side effect will include
    a. central nervous system depression.
    b. marked rise in the systemic blood pressure.
    c. marked relaxation of skeletal muscle.
    d. loss of hair.
    e. urination, vomiting and diarrhea.

34. Acetazolamide, given orally, reduces intraocular pressure by
    a. reducing the formation of aqueous humour.
    b. its vasoconstrictor action which reduces the permeability of blood aqueous barrier.
    c. its action like physostigmine.
    d. opening the canal of Schlemm.
    e. reducing the protein content of aqueous.

35. A local anesthetic agent used in the differential diagnosis of Horner's syndrome and Raeder's paratrigeminal syndrome is
    a. procaine
    b. Holocaine
    c. cocaine
    d. Pontocaine
    e. Dorsacaine

36. Of the following agents, which one is not used in o-t-c ophthalmic decongestant preparations?
    a. naphazoline
    b. phenylephrine
    c. zinc salts
    d. tetrahydrazoline
    e. All are used for this purpose.

37. Which one of the following statements is true? Anticholinergic drugs such as Belladonna group of alkaloids used in the treatment of peptic ulcers
    a. have no ocular effects.
    b. may cause constriction of pupil.
    c. may induce spasm of accommodation.
    d. may produce conjunctival congestion.
    e. produce temporary loss of accommodation.

38. Which one of the following statements is not true?
    a. Acetazolamide or Diamox inhibits carbonic anhydrase.
    b. Diamox reduces intraocular tension in a glaucomatous eye.
    c. Diamox is a diuretic used in the treatment of glaucoma.
    d. Diuretics are generally useful in the treatment of glaucoma.
    e. Diamox produces myopia in some individuals.

39. Which one of the following statements is true?
    a. Chlorpromazine or thorazine is a drug with a wide safety margin and because of this reason, it is used extensively.
    b. Chlorpromazine and other drugs belonging to its group are used in the treatment of open angle glaucoma.
    c. Chlorpromazine does not cause any damage to the retina.
    d. Chlorpromazine is known to cause cataract.
    e. Chlorpromazine is stored in the choroid and pigment epithelium of the retina and may cause irreversible retinal damage.

40. In the case of a known open-angle glaucoma being treated with miotics, which one of the following drugs should be used to dilate the pupil for ophthalmoscopy?
    a. cyclopentolate
    b. phenylephrine
    c. homatropine
    d. scopolamine
    e. atropine

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22nd Annual Examination

NATIONAL BOARD OF EXAMINERS IN OPTOMETRY

Question Sheet for Part II, Section 4, OCULAR PATHOLOGY
Number of Test: 3

Monday, April 30, 1973 (2 hours) 3:30 - 5:30 p.m.

Instructions: Read carefully before starting. See also general instruction sheet. This examination consists solely of multiple-choice questions. There are 100 test items. On the answer sheet supplied with this examination, blacken the proper box to indicate the single best answer for each question. Each question has a point value of 1. Total value is 100 points. Be sure to indicate that the number of this test is 3.

1. Which of the following is the most valid method of detecting acute glaucoma?
   a. tonometry (indentation type)
   b. ophthalmodynanometry
   c. tonometry (applanation type)
   d. visual-field testing
   e. ophthalmoscopy

2. Magnification of a visual-field defect can be obtained by
   a. viewing it with an indirect, binocular ophthalmoscope
   b. increasing the testing distance
   c. having the patient wear a +2.50 D lens
   d. having the patient wear a meridional magnifier axis 90
   e. none of the above is correct

3. The best biomicroscope illumination for discovery of posterior corneal endothelial opacities is
   a. retro-illumination
   b. direct illumination
   c. specular illumination
   d. indirect illumination
   e. sclerotic-scatter illumination

4. A patient has a bilateral field defect in which the left eye field has an inferior-nasal quadranopia and the right eye has a nasal hemianopia. The pathology is most likely located in or near the
   a. optic nerve
   b. retinal ganglion cell layer
   c. lateral geniculate body
   d. optic chiasma
   e. anterior optic tract

5. Which of the following is NOT a field defect associated with glaucoma?
   a. baring of the blind spot
   b. nasal step
   c. Guilstrand extension of the blind spot
   d. Seidel scotoma
   e. arcuate scotoma

6. A patient with a chemical burn of the eye should generally receive the following treatment: immediate
   a. referral to an ophthalmologist
   b. examination with the biomicroscope
   c. instillation of a miotic and lid closure
   d. irrigation of the eye with water or, if available, saline
   e. instillation of a mydriatic and anesthetic

7. Observation of the fundus with the yellow-green ophthalmoscopic filter is used for detecting
   a. hemorrhages
   b. drusen of the disc
   c. macular degeneration
   d. pigment spots
   e. venous pulsation

8. Which of the following hemorrhages is located near the ganglion-cell layer of the retina?
   a. circular-shaped
   b. subhyaloid-shaped
   c. flame-shaped
   d. streak or circular-shaped
   e. star or fan-shaped

9. Ptosis may occur in
   a. myasthenia gravis
   b. Horner's syndrome
   c. 3rd nerve paralysis
   d. senile patients
   e. all of the above are correct

10. Epicanthus inversus is
    a. an inversion of the outer canthal folds
    b. a recessively inherited autosomal characteristic
    c. a redundant skin fold originating from the lower lid
    d. associated with blepharochalasis
    e. a genetic defect of the temporal plica semilunaris

11. A hordeolum is a staphylococal infection of which glands?
    a. Zeis and Moll
    b. Meibomian
    c. Kraus
    d. Wolfring
    e. a and b both are correct

This examination consists of 9 pages. See that your copy is complete and that no questions are overlooked.

12. Nodular episcleritis usually
    a. is located deep to the conjunctiva which can be shown by movement of the conjunctiva
    b. is a chronic and recurrent condition
    c. doesn't affect vision even with prolonged duration
    d. is bilateral
    e. all of the above are correct

13. A patient with a progressive nuclear sclerosis generally will have
    a. iridodenesis
    b. increasing myopia
    c. increasing hyperopia
    d. increasing astigmatism
    e. increased long-wavelength absorption

14. Which of the following is characterized by retinal changes of cotton-wool patches, focal constrictions, hard exudates, retinal edema, and right-angle vessel crossings?
    a. arteriosclerosis
    b. diabetes
    c. hypertension
    d. polycythemia
    e. all of the above are correct

15. Asteroid hyalitis
    a. occurs in the posterior chamber and thus vision is not disturbed
    b. consists of dark spots that move when the eye moves
    c. has a dull appearance with focal illumination
    d. is another name for synchysis scintillans
    e. none of the above is correct

16. Cotton-wool exudates are
    a. pigment epithelium secretions
    b. microinfarcts in the nerve-fiber layer
    c. lamina vitrea changes which occur with age
    d. soft arteriolar secretions
    e. soft venule secretions, associated with cell-wall changes

17. Diabetic changes in the eye may include
    a. lens opacities
    b. neovascularization of retinal vessels
    c. degenerative changes in vessel walls
    d. microaneurysms
    e. all of the above are correct

18. There is profuse mucous discharge in
    a. catarrhal conjunctivitis
    b. vernal conjunctivitis
    c. follicular conjunctivitis
    d. purulent conjunctivitis
    e. allergic conjunctivitis

19. In retinal detachment
    a. the location is usually peripheral
    b. vessels in the detached area are normal in color
    c. there is usually progression in the temporal direction
    d. an associated retinal tear presents a greenish color
    e. all of the above are correct

20. Regarding tonography
    a. in normal eye the Po/C ratio will exceed 100
    b. the tonometer remains on the cornea for about 2 minutes
    c. a majority of untreated open-angle glaucomatous eyes will have a Po/C ratio of 140 or higher
    d. tonography is performed with an applanation tonometer
    e. all of the above are correct

21. Seborrheic blepharitis differs from staphlococcic blepharitis in that
    a. the former exhibits remissions and exacerbations
    b. loss of eye lashes is present in the latter
    c. the latter is associated with dandruff
    d. the former is usually caused by Morax-Axenfeld bacillus infection
    e. none of the above is correct

22. Dislocation of the lenses is a characteristic finding in
    a. Von Recklinghaussn's syndrome
    b. thyrotoxicosis
    c. Marfan's syndrome
    d. Sjogren's syndrome
    e. none of the above is correct

23. Regarding Hassal-Henle bodies,
    a. they are present in a majority of young persons
    b. they are best detected by use of the specular reflection technique in slit-lamp biomicroscopy
    c. they are caused by degeneration of corneal stroma
    d. they are caused by infiltration of fat droplets in Bowman's membrane
    e. both a and c are correct

This examination consists of 9 pages. See that your copy is complete and that no questions are overlooked.

24. Bilateral cecocentral scotoma with no other ocular symptoms or signs of fundus pathology is most likely caused by
    a. pituitary tumor
    b. cavernous sinus thrombus
    c. posterior cerebral hemorrhage
    d. tobacco amblyopia
    e. multiple sclerosis

25. Fundus examination of an infant's eyes shows a whitish macular area with a cherry-red fovea and a white, atrophic disc. This appearance could be caused by
    a. occlusion of central-retinal artery
    b. occlusion of central-retinal vein
    c. Tay-Sachs disease
    d. all of the above are correct
    e. only a and c are correct

26. A patient 40 years old complains of blurring. Fundus examination shows the foveal reflex is missing, and the macular area is slightly elevated. Field tests show a central scotoma. The contralateral eye is normal in appearance and function. The probable pathology is
    a. senile macular degeneration
    b. central serous retinopathy
    c. retrobulbar neuritis
    d. syphilitic uveitis
    e. retinitis pigmentosa

27. The visual aura in migraine is
    a. present in about 10 percent of migraine cases
    b. caused by vasodilation
    c. usually accompanied by recognizable fundus changes
    d. all of the above are correct
    e. none of the above is correct

28. Fundus examination shows a marked narrowing of retinal arteries and veins, a yellowish disc, and scattered pigment masses resembling bone corpuscles in shape. The patient complains of poor vision at night. The probable diagnosis is
    a. chorioretinitis
    b. retinoblastoma
    c. retinitis pigmentosa
    d. choroideremia
    e. all of the above could cause these signs and symptoms

29. Ophthalmoscopy shows a pale fundus in which arteries and veins are distended, tortuous, pale yellow in hue, and difficult to tell apart. Hemorrhages of various sizes occur, some with white centers. The diagnosis is
    a. leukemic retinopathy
    b. diabetic retinopathy
    c. occlusion of the central retinal artery
    d. nephritic retinopathy
    e. none of the above is correct

30. Fundus examination shows that the disc has hazy margins, an irregular surface, and is greyish in color. Field tests show no visual loss. The retinal blood vessels and the retina appear normal. The probably cause of the abnormally appearing disc is
    a. papillitis
    b. papilledema
    c. retrobulbar neuritis
    d. pseudopapillitis
    e. none of the above is correct

31. A patient complains of deep pain in one eye. The eye is sensitive to palpation. The optic disc is reddish and moderately elevated with indistinct margins. Field tests show a central scotoma. The probable diagnosis is
    a. glaucoma
    b. papillitis
    c. papilledema
    d. pseudo-optic neuritis
    e. occlusion of central retinal artery

32. Secondary glaucoma is frequently caused by
    a. iridocyclitis
    b. occlusion of central-retinal artery
    c. papillitis
    d. keratitis
    e. toxoplasmosis choroiditis

33. A patient exhibits fever, general malaise, and glossy red, edematous, demarcated patches involving the eyelids and adjacent facial skin. Probable diagnosis is
    a. dacryocystitis
    b. dacryoadenitis
    c. erysipelas
    d. atopic dermatitis
    e. obital cellulitis

34. After a few weeks of mild bilateral conjunctivitis, a severe conjunctivitis follows with swollen eyelids, opaque follicles on the upper palpebral conjunctiva. A vascular membrane invades the upper cornea. The patient probably has
    a. follicular conjunctivitis
    b. swimming-pool conjunctivitis
    c. vernal conjunctivitis
    d. trachoma
    e. syphilis

35. Sattler's veil refers to hazy vision caused by
    a. scratching of the corneal epithelium
    b. corneal subepithelial edema resulting from oxygen deprivation
    c. corneal stromal edema resulting from high intraocular pressure
    d. tears in Descemet's membrane
    e. Fuch's endothelial dystrophy

This examination consists of 9 pages. See that your copy is complete and that no questions are overlooked.

36. A patient complains of severe pain on one side of the face. Small vesicles are found on the skin of the upper eyelid. Corneal examination shows punctate white dots and reduced corneal sensitivity on the same side of the face. The probable diagnosis is
    a. chicken pox
    b. small pox
    c. Herpes Zoster ophthalmicus
    d. Herpes simplex
    e. tic douloureux

37. The Kayser-Fleischer ring
    a. is a circle of blood and pigment in the cornea
    b. indicates a dystrophy of endothelium of the cornea
    c. is caused by faulty sugar metabolism
    d. indicates a hereditary excessive absorption of copper by the alimentary tract
    e. all of the above are correct

38. A mature senile cataract is
    a. likely to cause increased intraocular pressure
    b. appears shrunken, with soft, milky cortex
    c. shows fine dust-like opacities scattered throughout the lens
    d. appears opaque, dull grey, amber or brown in color
    e. shows radiating opaque streaks from periphery toward the center of the lens

39. A layer of pigment granules deposited on the anterior lens surface after trauma is called
    a. Kayser-Fleischer ring
    b. Maxwell's ring
    c. Vossius' ring
    d. Soemmering's ring
    e. Krukenberg's spindle

40. Mittendorf's dot, situated on the posterior surface of the lens, is
    a. the earliest sign of posterior subcapsular cataract
    b. an unimportant congenital anomaly
    c. a significant sign of vitreous detachment
    d. a sign of synchysis scintillans
    e. a sign of retrolental fibroplasia

41. A patient has noticed for several weeks a gradual deterioration of vision. There is no ocular pain. The vitreous is cloudy; the fundus shows small yellow-grey, ill-defined foci of inflammation. The diagnosis is
    a. retinitis pigmentosa
    b. retinitis proliferans
    c. disseminated choroiditis
    d. diabetic retinopathy
    e. hypertensive retinopathy

42. A patient over 60 years of age has numerous white spherical bodies in the vitreous, which move when the eye moves and return to their original position when the eye is at rest. There are no signs of present or past inflammation. These bodies are
    a. cholesterol crystals
    b. muscae volitantes
    c. synchysis scintillans
    d. calcium-lipid soaps
    e. mutton-fat bodies

43. An aqueous flare would lead one to suspect
    a. glaucoma
    b. iritis
    c. posterior uveitis
    d. cyclitis
    e. brain tumor in the medulla

44. Which of the following ocular symptoms does NOT occur in multiple sclerosis?
    a. weak convergence
    b. ptosis
    c. loss of accommodation
    d. diplopia
    e. none of the above is correct

45. Severe deficiency of vitamin A in the diet or in intestinal absorption may cause
    a. Bitot spots on the conjunctiva
    b. grey indolent corneal ulcer
    c. xerophthalmia
    d. keratomalacia
    e. all of the above are correct

46. Retrobulbar neuritis often occurs as a complication of
    a. multiple sclerosis
    b. sinusitis
    c. pernicious anemia
    d. acquired syphilis, secondary stage
    e. all of the above are correct

47. A patient complains of seeing double, lids drooping, and difficulty in swallowing, particularly towards the end of the day. The probable diagnosis is
    a. Marfan's syndrome
    b. myasthenia gravis
    c. Graves' syndrome
    d. myotonic dystrophy
    e. multiple sclerosis

48. Itching eyes, stringy exudate containing eosinophiles, and many papillae on the upper tersal conjunctiva indicate
    a. catarrhal conjunctivitis
    b. membranous conjunctivitis
    c. vernal conjunctivitis
    d. gonorrheal conjunctivitis
    e. epidemic keratoconjunctivitis

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49. The patient exhibiting bilateral congruent inferior hemianopia probably has a lesion in the
    a. ventral fibers
    b. upper lip of both calcarine fissures
    c. area between proximal parts of both optic nerves
    d. posterior communicating artery
    e. optic chiasma

50. Simple chronic glaucoma
    a. occurs most frequently in individuals whose IOP varies diurnally by 3-4 mm/Hg
    b. causes loss of vision by pressure on the fovea
    c. occurs in all individuals who have an IOP over 30 mm/Hg
    d. all of the above are correct
    e. none of the above is correct

51. In optic nerve atrophy associated with Leber's disease, the expected field defect is
    a. peripheral field contraction
    b. ring scotoma
    c. bitemporal hemianopia
    d. concentric blind spot enlargement
    e. centrocecal scotoma

52. One of your elderly patients complains of the transient loss of vision in one eye. His blood pressure is normal. His fundus appears normal on examination. The loss of vision
    a. was probably imaginary
    b. can be ignored
    c. was probably due to infarction
    d. may be a warning of possible central-retinal artery occlusion
    e. may be a warning of possible retinal detachment

53. You see a central-retinal artery occlusion a day after it occurred. The statement that "there is no need to refer this case because the damage has been done and nothing can be done for the patient" is
    a. true because a referral would be a waste of time and money
    b. false because vision may return with treatment
    c. false because with care the patient's other eye and perhaps life may be saved
    d. true because treatment is only effective if given within one hour

54. Bacterial conjunctivitis is most likely cause
    a. profuse tearing
    b. purulent discharge
    c. marked itching
    d. follicular formations
    e. membrane formations

55. A contact-lens patient telephones to say that his left eye is red, sore, and blurred. The right eye is without symptoms even though both lenses were overworn by six hours at a party. You should recommend
    a. leaving the lenses out a day before trying again
    b. rest, aspirin, closer adherence to the wearing schedule
    c. an eye exam to rule out iritis or glaucoma
    d. a refitting of the left lens
    e. none of the above is correct

56. Optic neuritis results in
    a. central scotoma
    b. peripheral constriction of the visual field
    c. cecal scotoma
    d. enlarged blind spot
    e. both a and b are correct

57. Your patient says he sees better in bright sunlight than indoors. He is also having increased difficulty reading. Which of the following cataracts is most likely to produce these symptoms?
    a. cuneiform cataract
    b. nuclear cataract
    c. cupuliform cataract
    d. nuclear sclerosis
    e. posterior polar cataract

58. A patient says he sees sparks and flashes in the lower field of the right eye. He also says that everything is cloudy in that area. If both symptoms are of recent origin, you would suspect
    a. retinitis
    b. Coats' disease
    c. angiospastic retinopathy
    d. retinal detachment
    e. atypical migraine

59. On fundus examination you notice whitish spots edged with pigment clumps scattered about the fundus. Visual-field examination shows multiple scotomas that are absolute. Your diagnosis is
    a. drusen deposits
    b. old, inactive disseminated chorioretinitis
    c. active, central choroiditis
    d. old, inactive central choroiditis
    e. active, disseminated chorioretinitis

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60. The grayish or yellowish coloration of the lens seen using oblique illumination in most eyes in old age is due to
    a. discoloration of lens capsule
    b. sclerosis of lens fibers
    c. nuclear cataract
    d. reflection from the iris
    e. all of the above are correct

61. Diabetic retinopathy and retinal vein occlusion are alike in that both
    a. occur following hypertension
    b. result in blindness in 50% of the cases
    c. are the first signs of systemic diseases
    d. may result in neovascularization of the fundus and rubeosis iridis
    e. all of the above are correct

62. Using the direct ophthalmoscope and viewing through a red lens you would enhance which item in the fundus the most?
    a. hemorrhages
    b. edema
    c. pigment
    d. blood vessels
    e. optic nerve fibers

63. The prognosis of a retinal detachment is best if the cause of the detachment is
    a. vitreous detachment and traction on the retina
    b. retinal tear
    c. edema from toxemia of pregnancy
    d. diabetic retinopathy
    e. choroidal tumor

64. Which tumor primarily occurs before the age of 6 years?
    a. malignant melanoma
    b. lid epithelioma
    c. retinoblastoma
    d. all of the above are correct
    e. none of the above is correct

65. A conjunctival nevus should be referred for consideration of removal if it
    a. enlarges and becomes vascular
    b. produces irritation
    c. is chronically inflamed
    d. is cosmetically poor
    e. all of the above are correct

66. Which of the following is NOT true of choroidal nevi?
    a. frequently becomes malignant
    b. the retinal area appears flat
    c. often cause a field defect
    d. all of the above are correct as none are true statements
    e. none of the above is correct as all are true statements

67. Which of the following is NOT seen in absolute glaucoma?
    a. optic atrophy
    b. iris atrophy
    c. corneal edema
    d. vitreous hemorrhage
    e. intense pain

68. A lid pathology including hyperemic and swollen lid margins, foamy secretion, and which yields yellowish fluid with pressure on lid margin, indicates
    a. meibomianitis
    b. hordeolum
    c. angioneurotic edema
    d. tarsitis
    e. acute blepharitis

69. Occlusion of the central retinal vein may result in
    a. blanching of the retina
    b. pain at the onset
    c. hemorrhagic glaucoma
    d. all of the above are correct
    e. none of the above is correct

70. The most significant ophthalmoscopic finding in chronic simple glaucoma is the
    a. depth of the cup
    b. vessel displacement
    c. clarity of the disc margins
    d. size ratio between arteries and veins as they cross the disc margin
    e. width of the cup

71. The major cause of diplopia in the over 60 age group is
    a. orbital tumor
    b. multiple sclerosis
    c. cerebrovascular accident
    d. diabetes mellitus
    e. luxation of the lens

72. A patient has recently experienced a severe infection of an upper molar tooth. He now has swelling of the eyelids, exophthalmos, impaired ocular motility, and high fever. The probable diagnosis is
    a. thyrotoxicosis
    b. tenonitis
    c. iritis and secondary glaucoma
    d. orbital cellulitis
    e. scleritis

73. Aqueous flare, photophobia, and keratic precipitates indicate
    a. posterior uveitis
    b. anterior uveitis
    c. scleritis
    d. intraocular parasitic infestation
    e. angle-closure glaucoma

This examination consists of 9 pages. See that your copy is complete and that no questions are overlooked.

74. According to the Keith-Wagener-Barker classification of hypertensive retinopathy
    a. edema residues are first seen in group 2
    b. arteriovenous ratio may be 1:3 in group 2
    c. hemorrhages are present in group 1
    d. papilledema is present in group 3
    e. all of the above are correct

75. The usual first arteriovenous crossing defect in arteriosclerotic retinopathy is
    a. depression or elevation of the vein
    b. deviation of the vein
    c. concealment of tapering of the vein
    d. ~~banking of the vein distal to artery crossing~~
    e. increased arterial tortuosity near the crossing

76. Administration of large doses of corticosteroids over an extended period may cause
    a. nuclear cataract
    b. posterior subcapsular opacities in lens
    c. fine, superficial cortical lens opacities
    d. dense, disc-like opacity of the lens
    e. stromal opacities of the cornea

77. Which of the following may be a sign or symptom of malignant melanoma?
    a. hyperopic shift of refraction error
    b. relative scotoma
    c. metamorphopsia
    d. both a and b are correct
    e. all of the above are correct

78. The fundus reveals hemorrhage, edema, cotton-wool patches, generalized attenuation of the arterioles and papilledema. The diagnosis is
    a. hypertensive retinopathy grade IV
    b. arteriosclerotic retinopathy grade III
    c. diabetic retinopathy stage III
    d. hypertensive retinopathy grade III
    e. diabetic retinopathy stage IV

79. Retinal arterial pulsation seen in the fundus
    a. may be a normal variation
    b. may be associated with aortic regurgitation
    c. occurs when intraocular pressure is less than diastolic pressure
    d. occurs with retinal vein occlusion
    e. none of the above is correct

80. With regard to pseudo-optic neuritis
    a. the eye is usually highly myopic
    b. venous engorgement is present
    c. the blind spot is enlarged
    d. the cause is excessive glial tissue in the disc
    e. all of the above are correct

81. Disciform degeneration of the macula
    a. occurs most frequently in young people
    b. is caused by degeneration of the neuroglia cells of the retina
    c. does not affect visual acuity
    d. causes progressive contraction of the peripheral field
    e. none of the above is correct

82. Retinitis proliferans often occurs in
    a. syphilitic retinopathy
    b. diabetic retinopathy
    c. recurrent retinal hemorrhage
    d. all of the above are correct
    e. none of the above is correct

83. A patient has moderate conjunctival inflammation with the greatest injection in the lower fornix region. There is a nonprofuse watery or mucoid discharge, tearing, and itching. This is most likely
    a. bacterial conjunctivitis
    b. viral conjunctivitis
    c. fungal conjunctivitis
    d. chronic atopic (allergic) conjunctivitis
    e. ocular phemphigoid

84. Which of the following is true of perforated detachments of the retina?
    a. result from penetration of fluid from the vitreous space into the subretinal space
    b. rarely occur in a healthy eye, but do occur in an eye suffering from degenerative changes of myopia or aging
    c. only rarely occur at the macula even when a hole in the macula exists
    d. all of the above are correct
    e. only a and c are correct

85. Bitot's spots
    a. are found primarily in children as a result of malnutrition
    b. appear to be hard, dark masses deep to the conjunctiva in the episclera
    c. may be followed by marked corneal changes of softening, exfoliation of the epithelium, development of ulcers, and loss of transparency
    d. all of the above are correct
    e. only a and c are correct

86. Which of the following is NOT true of keratoconus?
    a. usually becomes manifest in youth
    b. is usually unilateral
    c. slit-lamp observation shows marked corneal thinning at the apex
    d. there is often a ring (Fleischer's ring from deposition of iron) around the cone
    e. none of the above is correct as all are true statements concerning keratoconus

87. Which of the following is NOT a senile or aging change of the cornea?
    a. Hassall-Henle bodies
    b. lipid arcus
    c. white limbus girdle
    d. all of the above are correct as none are aging changes
    e. None of the above is correct as all are aging changes

88. The patient's eye shows conjunctival swelling with considerable red hyperemia near the fornices; has a watery discharge mixed with mucus and leucocytes; and small papillae in the tarsal region of the lids. The patient reports a "foreign body" sensation. The probable diagnosis is
    a. acute catarrhal conjunctivitis
    b. chronic catarrhal conjunctivitis
    c. purulent conjunctivitis
    d. pseudo-membranous conjunctivitis
    e. acute angle-closure glaucoma

89. A vitreous detachment
    a. causes the patient to see floaters and occasional light streaks, usually in the temporal field
    b. ophthalmoscopically may appear as a hole in a membrane floating in front of the retina
    c. leads to retinal detachment in a majority of cases
    d. both a and b are correct
    e. a, b, and c are all correct

90. Vitreous detachment most commonly occurs
    a. anteriorly separating the vitreous from the lens
    b. posteriorly separating the vitreous from the posterior pole of the eye
    c. laterally separating the vitreous from the temporal ora
    d. superiorly separating the vitreous from the superior ora
    e. inferiorly separating the vitreous from the inferior ora

91. Which of the following is true of cataracts with diabetic patients?
    a. senile cataracts occur more frequently and at an earlier age as compared to nondiabetics
    b. the specific diabetic cataract occurs primarily in young persons
    c. the specific diabetic cataract typically shows opacities in the anterior and posterior cortex
    d. both a and c are correct
    e. a, b, and c are all correct

92. An early choroidal tumor or early serous pigmentary epithelial detachment is most likely to be revealed by a
    a. peripheral field loss detected by perimetry examination
    b. relative scotoma detected with the multiple pattern screener
    c. relative scotoma detected by tangent screen examination
    d. relative scotoma detected on the Amsler grid
    e. metamorphopsia detected on the Amsler grid

93. With regard to the swinging light test
    a. it is also called the pupillary release test
    b. a flashlight beam, in a dark room is passed alternately before the two eyes
    c. dilation of the pupil of the right eye as the light is shown into the right eye indicates that the direct light reflex for the right eye is weaker than the consensual light reflex from the left eye
    d. dilation of the pupil of the right eye as the light is shown into the right eye indicates that the retina or optic nerve of the right eye is deficient and possibly undergoing pathological changes
    e. all of the above are correct

This examination consists of 9 pages. See that your copy is complete and that no questions are overlooked.

94. With regard to topical anesthetics,
    a. the use of anesthetics retards repair of the corneal epithelium
    b. corneal anesthesia is produced by blockage of impulse conduction at nerve synapses
    c. while uncommon, allergic reactions are severe and require medical treatment
    d. both a and b are correct
    e. a, b, and c are all correct

95. Congenital ptosis is
    a. often associated with superior rectus palsy
    b. often associated with a miotic pupil
    c. usually unilateral
    d. all of the above are correct
    e. none of the above is correct

96. The Schirmer test measures
    a. corneal sensitivity
    b. corneal sensibility
    c. rate of aqueous production
    d. rate of aqueous outflow
    e. rate of tear formation

97. A chalazion
    a. is a painless swelling of the lid without gross inflammatory signs
    b. may disappear upon massage of the lids
    c. requires immediate removal if secondary infection is to be avoided
    d. a and b are both correct
    e. a, b, and c are all correct

98. Which of the following is true of closed-angle glaucoma?
    a. is most likely to occur in hyperopic eyes with a shallow anterior chamber
    b. may occur either as the result of an iris bombe or as the result of mydriasis bunching the iris into the filtration angle
    c. acute attacks usually occur suddenly without prodromal symptoms
    d. both a and b are correct
    e. a, b, and c are all correct

99. Studies by Armaly and other investigators indicate that there is a genetic basis for
    a. ~~high increase in intraocular~~ topical steroids pressure from topical steroids
    b. the cup-disc ratio of the optic nerve
    c. open-angle glaucoma
    d. both a and b are correct
    e. a, b, and c are all correct

100. Which of the following would counterindicate the use of neosynephrine for facilitating ophthalmoscopy?
    a. an aqueous space at the limbus equal to the corneal thickness
    b. an aqueous space at the limbus less than one-half of the corneal thickness
    c. a family history of open-angle glaucoma
    d. both a and b are correct
    e. a, b, and c are all correct

This examination consists of 9 pages. See that your copy is complete and that no questions are overlooked.

UNITED STATES

OPTOMETRIC COLLEGES

1. University of Alabama in Birmingham (School of Optometry at the Medical Center)
2. University of California (School of Optometry)
3. University of Houston (College of Optometry)
4. Illinois College of Optometry
5. Indiana University (Division of Optometry)
6. Southern California College of Optometry
7. Massachusetts College of Optometry
8. Pacific University (College of Optometry)
9. Pennsylvania College of Optometry
10. Southern College of Optometry
11. State College of Optometry (State University of New York)
12. Ohio State University (College of Optometry)
13. Ferris State College (College of Optometry)

OSU

CORVALLIS, OREGON 97331

OREGON STATE UNIVERSITY

SCHOOL OF PHARMACY
Reply to: OFFICE OF THE DEAN
Area code 503; telephone 754-3191; 754-3283

Statement of
Charles O. Wilson
Dean Pharmacy
Oregon State University

My interest in this bill is in the provision which it provides for a health professional, in this case the optometrist, to utilize his special knowledge to the fullest extent in order to benefit the patient.

As a pharmacist, and Dean of Pharmacy at Oregon State University, I have observed a primary service of a pharmacist lies in his ability to recognize disease states and to urge his ill customers to see a physician.

The need for services of a physician is not always known by an individual. This is the reason for today's mass testing for diabetes, hypertension, heart disease, and the reason why women are instructed to check themselves for breast cancer. These activities are all designed to bring the patient into the health-care system.

Optometrists can, through this legislation, offer a diagnostic service to eye patients and facilitate their entrance into the health-care system. There must be many people who, having a pathological eye condition unknown to them, seek the services of an optometrist for the fitting of glasses.

This Bill will make it possible for optometrists to carry out diagnostic procedures to identify any pathological condition during

the course of the examination for the fitting of glasses. On those accasions when a pathological condition is identified, the patient will be referred to an ophthalmologist for treatment.

I see in this Bill a very positive effect upon the practice of optometry and another means of mass eye examination for the prevention of blindness.

Charles O. Wilson

IV.

TESTIMONY

BY

PETER P. LAMY, PH.D., F.C.P.

Professor and Director
Institutional Pharmacy Programs
Chairman, Department of Pharmacy
Practice and Administrative Science

UNIVERSITY OF MARYLAND
SCHOOL OF PHARMACY

SENATE ECONOMIC AFFAIRS COMMITTEE

March 8, 1979

I am pleased to support the request by the Maryland Optometric Association for legislation which would allow board certified optometrists to use certain specified classes of topically administered pharmaceutical agents for diagnostic purposes.

Some Background Information:

I think it will be helpful to review very briefly the professional practice of optometrists in at least one other country:

In Britain, optometrists have been trained in and accustomed to the use of certain drugs in eye examinations for more than 50 years. In 1949, a select Committee under Lord Crook, a committee which included five physicians, unanimously concurred in the use of certain specified drugs by optometrists for eye examinations. British optometrists perform over 80% of the eye examinations in that country. The British position was reveiwed in 1970 by a joint committee of ophthalmologists and optometrists and they concluded that "it is proper for an optometrist to use appropriate drugs for eye examinations."

What is Needed:

The citizens of Maryland are entitled to a continuum of care, ranging from primary to specialized care, delivered in the best and most cost-efficient manner. As far as eye examinations are concerned, it is reasonable to envision a cycle with optometrists providing initial examination and triage, ophthalmologists having the opportunity to exert the full range and benefit of their extensive medical education in the treatment of eye diseases. As a matter of fact, a similar course of events is already taking place, with the great majority of patients already seeking out optometrists for an initial eye evaluation. Passage of this bill would give optometrists the opportunity to deliver more careful and valuable care to our citizens.

As a health professional greatly interested in the fields of geriatrics and gerontology, I might point out that the National Center for Health Statistics, in 1975, reported that approximately 50% of our elderly citizens suffer from impaired vision. Many of these do not seek help, often owing to economic constraints. As a matter of fact, the Central Maryland Health Systems Agency has reported that in Baltimore City, approximately 25% of the population would be classified as "gray area" persons, that is those who do not qualify for medical assistance but are simply too poor to look for adequate health care. An enlarged role for optometry which does not encroach on the role of ophthalmology would probably be greatly helpful to those citizens.

What Questions Must Be Answered?

It is clear that this bill must be viewed from a benefit-risk point of view. What would be patient benefit, what would be patient risk? As already outlined the benefits would seem to be large, both from an economic point of view and a health care point of view.

What about risk? The eye is a very sensitive organ. Blindness, precipitation of angle-closure glaucoma, and infection are probably the greatest risk when eye preparations are administered. YET, very few cases of glaucoma precipitated by dilation of the pupil are reported, in the range of 1:15,000 patients. It is difficult to envision blindness caused by a one-time application of the classes of drugs which are being discussed.

Sodium fluorescin solution, which is known to support the proliferation of bacteria easily, was routinely used by optometrists as well as ophthalmologists without causing a high incidence of eye infections.

On the other hand, the benefits from the topical use of drugs for diagnostic purposes far outweigh the risk to vision. There is simply no good way to obtain a satisfactory view of the interior of the eye unless the pupil is dilated. In addition, it is highly probable that optometrists, properly trained, and being able to practice in a more efficacious manner, will be able to recognize more eye abnormalities, which can and will then be referred to ophthalmologists, increasing public benefit and the level of public health.

Is This Bill Reasonable?

I believe it is.

The bill asked only that certain drugs could be used by optometrists in eye examinations. It does not ask that optometrists be granted the right to treat eye diseases.

The bill asked that only properly trained, and qualified optometrists be given this professional privilege. It specifically does not ask for a grandfather clause and, indeed, asks that optometrists can only be qualified after they have been trained and educated in the pharmacological action and proper use of these drugs.

Thus, weighing risks and benefits, I must believe that the benefits to the citizens of Maryland far outweigh the risks, and that is the reason why I support this bill.

Sincerely,

Peter P. Lamy, Ph.D., F.C.P.

STATEMENT

ALASKA BOARD OF EXAMINERS IN OPTOMETRY

ALASKA STATE

MANPOWER

regarding

VISION AND EYE HEALTH CARE

The optometrists of Alaska are geographically more evenly distributed so as to meet the needs of the people. Ophthalmologists are primarily concerned with eye surgery and, therefore, are concentrated around larger population areas where more extensive hospital facilities are available.

As the National Health Care program emerges, along with other increasing group insurance programs, the need for better referral channels must be established. Diagnostic agents can make pathology detection more effective and those referrals more accurate.

Enclosed are:

1. Alaska Distribution Map on Vision and Eye Health Care.

2. 1979 listing on:

    a. Resident Optometrists in Alaska (32)
    b. Resident Ophthalmologists in Alaska (17)

PRIVATE PRACTIONERS

OPTOMETRISTS

by cities (32)

FAIRBANKS

Hammond
Johnson
LeFevre
Lounsbury
Schmidt

ANCHORAGE

Bach, E.
Bach, P.
Bigelow
Falconer, M.
Falconer, J.
Faulkner
Hall
Harbour
Miller
Roselius
Sternberg
Walker
Albert
Gonnason

JUNEAU

Box
Kemp
Matson

KENAI

Swarner
O'Connel

NORTH POLE

Cobbett

KETCHIKAN

Craig
Smith
Swearingen

BETHEL

Demskey

EAGLE RIVER

Keene

SITKA

McLaughlin

VALDEZ

Mastolier

KODIAK

Swank

Through branch offices, these communities are served by optometrists:

Petersburg
Wrangel
King Salmon
Naknek
Galena
Seward
McGrath
Unalaklett
Kotzebue
Barrow
Cordova
Haines
Skagway
Kake
Yukutut
Nome
Prudhoe
Deadhorse
Delta Junction
Homer
King Cove
Sand Point
Wasilla
Dillingham
Yakutat

OPHTHALMOLOGISTS

by cities (17)

ANCHORAGE

Skille
Dippe
Harrison
Patterson
Grendahl
Richardson
Nyboer
Rigg
Sheisl
Shoff

FAIRBANKS

Kinn
Wolf
Dicksheet
McConkey

JUNEAU

Page

SOLDOTNA

Canava

ANCHOR POINT

Fritz

KETCHICAN

Tokar

PROBABLE OBJECTION

Based on experience elsewhere opposition will probably come from ophthalmologists based on the alleged:

1. Adverse side effects of drugs and the incapacity of optometrists to deal with them.
2. Lack of qualification of optometrists in the use of these diagnostic agents.

AMERICAN ASSOCIATION OF OPHTHALMOLOGY

PUBLIC RELATIONS PAMPHLET "WHY DROPS"

Typically this pamphlet is displayed in ophthalmologists offices or handed out to other interested persons or groups.

1. The pamphlet states that drops must be used in order to perform an adequate visual and eye health examination.

   The following are quotes from the pamphlet:

   DROPS TO ENLARGE THE PUPILS:

   -"to look through the open door instead of through the keyhole".
   -"drops make it possible for him to study not only the lens through which the light must pass, but also the retina where the image is formed, and the optic nerve which transmits the picture to the brain."

   RELAX THE FOCUSING MUSCLE:

   -"This is often necessary to determine the TRUE degree of refractive error that has to be corrected by glasses."
   -"The use of these drops is especially important when examining children."
   -"When a physician examines a young child with strabismus (crossed eyes), it is essential..."

   ANESTHETIZE THE EYE:

   -"They are required for the all-important testing for glaucoma."

2. The pamphlet alleges that drops can not be used by optometrists but only by an ophthalmologist.

   The following quotes make their points:

   -"Of course, all drops are medicine and they can be prescribed only by a physician..."
   -"You should never let anyone else put anything in your eye."

3. The final statement from this pamphlet says: Drops..."are often the key to the prevention of blindness and even the saving of the eye itself."

   If the American Association of Ophthalmology feels strongly about all those points made in this pamphlet, and is able to recognize that 70% of the people in the United

States are seen by optometrists for eye care, what conclusions must have been reached? Are all those 70% seen by optometrists receiving poor eye care? Are plans being made to train more ophthalmologists? What positive efforts has ophthalmology made to correct this? If the answers to those questions are disheartening, is the only basis for this pamphlet one of economics, self esteem, or P.R.?

Alaskan optometrists are sincerely interested in improving the scope of their eye care to Alaskan residents. They are prepared to encompass quality educational standards as insurance that the usage of diagnostic agents by Alaskan optometrists will result only in improved vision and eye health care for the people of Alaska.

why drops?

Patients sometimes ask their eye physician, "Why do you use 'drops' when you examine my eyes?"

A clear answer to this question will help one understand the fundamentals of medical eye care and the relationship of his eyes to the health of his body.

"Drops" are of several kinds and they serve several important medical purposes.

One of the commonest uses of drops is to enlarge the pupils, so that the physician may examine more thoroughly the interior of the eye—to "look through the open door instead of through the keyhole." There, for the trained medical man to see, may be the first sign of disease elsewhere in the body. Drops make it possible for him to study not only the lens through which the light must pass, but also the retina where the image is formed, and the optic nerve which transmits the picture to the brain.

Such drops are particularly important in examining older people, who are prone to eye diseases, and often have a small pupil that becomes even smaller under the light of the examining instrument. Dilation of the pupil is necessary in examining the eye for suspected cataract, diabetes, hardening of the arteries, high blood pressure—to name a few examples. The effect of drops used merely to dilate the pupils lasts only a matter of hours, and frequently causes little or no blurring of vision.

A second common use of drops is to relax the focusing muscles in the eye. This is often necessary to determine the true degree of refractive error that has to be corrected by glasses. Because the focusing muscles in the eye are relaxed by these drops, the eye cannot focus and the vision is blurred until the effect of the drops wears off. These drops also cause the pupil to dilate; however, it is not the dilated pupil but the relaxed focusing muscle that causes blurring of vision. The use of these drops is especially important when examining children. When a physician examines a young child with strabismus (crossed eyes), it is essential to use drops that relax the focusing muscles in order to determine what corrective glasses are required.

A third use of drops is to anesthetize the eye, to permit the physician to perform certain diagnostic tests without discomfort to the patient. These drops cause little or no blurring of vision. They are required for the all-important testing for glaucoma. Anesthetic drops are also necessary for the relief of pain resulting from injury.

Finally, there are several ways in which drops are used in the treatment of the eye. Some drops are used to destroy bacteria, some to relieve inflammation within the eye, others to relieve a bloodshot condition, and still others to make the pupil small in order to lower the pressure within the eye. Drops to dilate the pupil are used in certain diseases to keep the muscles resting while the eye recovers, or to prevent complications which might develop if the muscles controlling the focus and the pupil were not kept at rest.

Of course, all drops are medicine and they can be prescribed only by a physician, who is licensed to practice medicine and surgery, and administered only by him or someone acting on his order. You should never let anyone else put anything in your eye. Sometimes drops are prescribed by your family doctor, to whom you can always turn for advice about your eyes. He or any other Doctor of Medicine can also tell you of a Doctor of Medicine who specializes in the eye—an ophthalmologist.

Whether or not drops of any kind are to be used is a decision for the attending physician. Only the Doctor of Medicine who examines your eyes can say whether drops are needed.

• • •

Why drops? Because they are useful medicines in the modern scientific care of the eyes—as useful in their place as any other drug or instrument that physicians have at hand for the relief of pain and the restoration of health. They are often the key to the prevention of blindness and even the saving of the eye itself.

American Association of Ophthalmology
1100 17TH STREET, N.W. • WASHINGTON, D. C. 20036

SUPPORTIVE LETTERS

from

MEDICAL DOCTORS OUTSIDE OF ALASKA

These letters speak directly to the minimal adverse side affects and maximal benefit to the patient.

JAMES S. JORDAN, M. D.
SUITE 209-210
225 NO. WASHINGTON AVENUE
SCRANTON, PENNSYLVANIA 18503

May 8, 1973

Senator Robert J. Mellow
Mears Building
Scranton, Pennsylvania

Dear Senator Mellow:

I have been in practice as a Board Certified Ophthalmologist for 39 years. In all this time, I have never seen, nor have I read about, cardiac arrest due to the application of topical anesthetics, mydriatics, cycloplegics, atropine or miotics. In all my 39 years, I have never seen an Angle Closure Glaucoma due to the use of any of the dilator drugs, when used properly.

In doing some research, I have found the arguments against the use of drugs cannot possibly hold any truth with the exception of Angle Closure Glaucoma. However, with proper training in the educational requirements currently in effect at Optometric Colleges, the rick is minimal. The risk to the undetection of Glaucoma, however, is sizable when anesthesia is not used. If any Ophthalmologist were to be called to the stand to testify under oath, I am certain that he in all honesty would have to say that there are no risks to the topical use of these drugs.

Occasionally an eye may become injected, but the injection leaves within a matter of half an hour or so and I can't help but wonder how the test for Glaucoma can be performed comfortably and accurately without the use of topical anesthesia. I also wonder how you can get a very thorough look at the Fundus without the use of mydriatics in very small pupils. This is significant when one considers the fact that optometrists see 70% of the population.

In consulting Cardiologists, they are unaware of any incidents after the application of any of the above drugs wished to be used by the Optometrists. In researching the education of Optometrists, I have found out that they have had a Pharmacology course for many years and were taught the effect of drugs on the eye. They have been taught in most instances by Medical Doctors. An additional safety factor is written into the bill which will necessitate any

Optometrist who wishes to use these drugs routinely to take a transcript quality course in Pharmacology and Gonioscopy to "bone up" on their past training.

In the last year's entering class, approximately 80% of the Optometric students have had four years of college education with a Bachelor's or Master's degree before entering the Optometric College, which is in itself a four year program. Their program consists of General Anatomy, Ocular Anatomy, Physiology, General Ocular with a minimum of three years training in recognition of referal of pathological cases plus Histo Pathology. At present, the Pathology courses are taught by two Board Certified Ophthalmologists, Dr. Herbert Nevyas and Dr. Joseph Towland.

The Pennsylvania Academy of Ophthalmology and Otolaryngology has raised some opposition regarding Senate Bill 570 which provides for the use of diagnostic pharmaceutical agents by optometrists.

This opposition is not well founded, nor in my opinion for the general public's welfare. Patients, not individual or group self-esteem, should come first.

I would like to re-emphasize once again that there has never been a single death reported in the entire world's literature of a fatal reaction in a diagnostic office procedure of the type we are requesting in this legislature to my knowledge.

Sincerely,

James S. Jordan, M. D.

JSJ/jmf

cc: Donald H. Evans, O.D.
Patrick Kennedy, M.D.
Alfred C. Lucier, M.D.

JAMES S. JORDAN, M. D.
SUITE 203-210
228 NO. WASHINGTON AVENUE
SCRANTON, PENNSYLVANIA 18503

In 1931, I received my Medical Degree from Jefferson Medical College. While at Jefferson, I was a member of the Alpha Omega Alpha Honor Society and upon graduation I received the HENRY M. PHILLIPS Award for the highest honors and excellence in medicine.

While serving my internship at Scranton State Hospital, I first became interested in diseases of the eye and pursued my interest at the University of Pennsylvania. I finished my residency at Wills Eye Hospital in 1935 and was President of the Wills Eye Hospital Society in 1948.

I was the founding President of the Diocesan Council of Catholic Men and have been on the executive committee of the National Council of Catholic Men at Washington, D. C. For my many accomplishments in this capacity, I was given the ST. THOMAS MORE Award by the national council, the 11th man to be so honored in the United States.

I was made a Knight of the Equestrian Order of the Holy Sepulcher of Jerusalem by the late Pope John XXIII and in June of 1972 I was invested into the Order of Malta by Pope Paul VI.

In 1956, I was named Chief of Surgery at Mercy Hospital in Scranton and served in that capacity until 1965. I am Chief of Ophthalmology at Mercy Hospital. In 1962 I was awarded the honorary degree of DOCTOR OF LAWS by the University of Scranton, in 1966 was elected President of the Advisory Board of Marywood College. Since 1969 I served as a member of its Executive Committee.

I am a member of the American Academy of Ophthalmology and Otolaryngology, a fellow of the American Board of Ophthalmology, the American Medical Association, and the Lackawanna Medical Society.

On February 2, 1973, I was presented with THE SILVER TRAY by Wills Eye Hospital on the occasion of the 25th silver anniversary of the annual clinical conference by the staff and society of Ex-Residents of the Wills Eye Hospital Society.

On April 30, 1973, I was awarded and admitted into the ALPHA SIGMA NU HONOR SOCIETY at the University of Scranton

M. M. GOLDSTEIN, M.D.
EYE AND EAR BUILDING
WILLOW AND FLORAL
VISALIA, CALIFORNIA

July 29, 1974

The Honorable Howard Way
California Legislature
State Capitol
Sacramento, California

Re: Senate Bill 1989

Dear Mr. Way:

This letter concerns Senate Bill 1989. Since you have had cataract surgery in your family in the past I feel you will have more than passing interest in this bill.

As I understand this bill permits optometrists to instill certain drops into their patients' eyes for diagnostic purposes only. I am strongly in favor of this bill; as a matter of fact several years ago on my own initiative I wrote to Assemblyman Gordon Duffy about proposing such a bill but apparently there was not much interest at the time.

The reason I am so strongly in favor of this bill is briefly this: fifth to sixty percent of all patients consult optometrists regarding their eyes and the fitting of glasses. In order to do a thorough examination of the retina, i. e. the posterior portion of the eye which is the all important anatomical segment, it is necessary to have a wide pupil so that the examining doctor can look around the corners, etc. It permits them to do as thorough an examination as the ophthalmologist can do. There are several conditions of the retina, which if recognized early can prevent serious sequela.

The ophthalmologists are of course opposed to this bill. However, I wish to go on record as saying that such opposition must be based on human frailities of jealousy and monetary consideration rather than the welfare of the

M. M. GOLDSTEIN, M.D.
EYE AND EAR BUILDING
WILLOW AND FLORAL
VISALIA, CALIFORNIA

Re: Senate Bill 1989

patient. I know they will state that if you dilate certain eyes it is possible to produce an acute attack of glaucoma. In my thirty eight years of dilating tens of thousands of eyes I have never had this occur. Furthermore, if it did occur, it would be a blessing in disguise because such a patient would undoubtedly develop an acute attack of glaucoma later on under certain circumstances. Besides, this is no catastrophe because recognized reasonably early it can be corrected with medication and then surgery.

After all, optometrists are licensed by the State of California to perform certain aspects of eye examinations and why not help them do the best examination possible. It just makes good common sense.

If there is any further information you desire please let me know.

Very sincerely,

M. M. Goldstein, M. D.

MMG:kh

ROBERT E. ROWELL, M.D.
LEXINGTON PROFESSIONAL ARCADE BLDG.
10728 E. RAMONA BLVD.
EL MONTE, CALIFORNIA 91731
448-9854

August 1, 1974

George N. Zenovich
State Capitol
Sacramento, California

Dear Senator Zenovich:

As a practicing M.D., I would like to voice my support for SB 1989. Optometrists are members of a highly trained profession and at this time are doing an excellent job without the use of topically applied diagnostic drugs. Their diagnostic capabilities, however, would be greatly enhanced with the use of the above mentioned diagnostic drugs.

Prohibiting Optometry this addi_ion to their diagnostic capabilites is in some respects similar to denying a dentist the use of X-rays in his daily routine.

I urge serious consideration and passage of this bill. It is for the public benefit that the optometrist be able to use whatever he needs to diagnose ocular problems and refer to the proper medical practitioner. It should be remembered that approximately 70% of all visual examinations in California are done by optometrists and that the optometrist is many times the only Health Care Professional that is regularly seen.

Sincerely,

Robert E. Rowell, M.D.

GLYER MEDICAL GROUP

Founded by R. T. Glyer, M. D.

280 Hope Street, Mountain View, California 94040 (415) 967-5701

Offices of

C. Hartley Glyer, M.D.
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Joachim H. Buchholz, M.D.
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James B. LeRoy, M.D.
Douglas E. Downey, M.D.
Curt E. Peterny, M.D., F.A.C.O.G.

John R. Young, M.D.
George J. Kricorian, M.D.
Seymour A. Rapaport, M.D.
S. B. Fee
Administrator

June 3, 1974

Senator George N. Zenovich
State Capitol
Sacramento, CA 95814

Dear Senator Zenovich:

I have been asked by an optometrist acquaintance of mine to write you concerning SB 1989 (definition of optometry).

I support SB 1989. I am particularly interested in their ability to use pharmaceutical agents topically to assist in diagnosing disease. They should be permitted to do this. They do an excellent and professional job at the present time without the capability of using these pharmaceutical agents and permitting them the use of these agents would enable them to do their job even better. This is for the benefit of society and any argument that this bill could be construed to benefit optometrists and harm ophthalmologists or physicians is, to my mind, ridiculous.

Limiting optometrists from diagnosing disease by the use of topical pharmaceutical agents in the eyes would be like asking dentists to diagnose disease without x-ray. The optometrists are highly trained professionals and certainly have a great deal more knowledge about the eye plus much more sophisticated equipment than the average non-ophthalmologist physician who is permitted to use all sorts of agents in both diagnosis and treatment of eye disease, and I therefor cannot see why optometrists should not be permitted the use of pharmaceutical agents for diagnosis.

In summary, for the above reasons I support SB 1989.

Sincerely,

F. R. Williams, M.D.
FRW:st

cc. Senate Health & Welfare Committee; California Optometric Association

JOSEPH C. TOLAND, M.D.
PROFESSIONAL CORPORATION

5927 N. FIFTH STREET
PHILADELPHIA, PA. 19120

LIVINGSTON 8-2323

1270 MILL ROAD
MEADOWBROOK, PA. 19046

June 15, 1973

Dear Representative:

I would appreciate it if you would support Senate Bill 570, Printers No. 810. This bill would amend the Optometry Act to permit optometrists the use of diagnostic pharmaceutical agents when examining the patients' eyes.

I have been trained both as an optometrist and an ophthalmologist. As such, I am well informed as to the training of both eye care practitioners. I can assure you that the present day trained optometrists are well qualified, by virtue of their training in pharmacology and practical therapeutics, in the use and effects of diagnostic drugs.

By being permitted to use diagnostic pharmaceutical agents, optometry will be enabled to join with the other health care professions, such as dentistry and podiatry, to provide a more complete service to the citizens of the Commonwealth.

Please ask your friends to support this bill.

Sincerely,

Joseph C. Toland, M. D.

JCT:js

CEDARS-SINAI MEDICAL CENTER

Reply to:

Mount Sinai Hospital Division
Box 48750
Los Angeles, California 90048

July 19, 1974

Preston B. Ervin, O.D.
138 South Golden Mall
Burbank, Calif.

Dear Dr. Ervin:

I am writing to you in support of Senate Bill # 1989 presently being considered by the legislatures in Sacramento. It is my hope that you will pass on my views to whomever you deem appropriate.

Because of my experience in the treatment and epidemiologic aspects of high blood pressure control I have had the opportunity to work closely with optometrists trying to guide their efforts in detecting and referring patients with high blood pressure. The information gained from our recent experience as well as from the medical literature strongly demonstrates the importance of a funduscopic examination by whomever examines the patient's eyes. High blood pressure which is often not associated with any physical symptoms can be detected early on by changes in the retinal vessels. It is essential that optometrists who have the knowledge and experience in funduscopic examination be allowed to examine retinal vessels in the most appropriate way possible. Often this necessitates the use of medication for dilation of the pupils.

I will not mention the numerous other medical conditions that can be diagnosed through proper examination of the fundus, I will leave this for other authorities on the subject. It is obvious to all interested observers and those with knowledge of systemic disease that early detection for many conditions, hypertension being a prime example, often can delay or prevent the development of complications. It is essential, therefore, that those providing professional services for the patients be able to use all the available tools at their disposable.

Sincerely, yours,

Andrew Lewin

Andrew J. Lewin, M.D.
Deputy Director
Hypertension Detection and Follow-Up Program
Assistant Professor of Medicine
UCLA

COMMONWEALTH OF PENNSYLVANIA
OFFICE OF THE GOVERNOR
HARRISBURG

April 27, 1973

Donald H. Evans, OD
Administrative Director
Pennsylvania Optometric Association, Inc.
218 North Street
Box 3312
Harrisburg, Pennsylvania 17105

Dear Dr. Evans:

Thank you very much for sending me a copy of Senate Bill 570. I have also been asked to analyze this bill by Lieutenant Governor Kline.

I believe that Senate Bill 570 is in the best interest of the people of Pennsylvania and have suggested to the Governor and Lieutenant Governor Kline that they support this legislation.

Best personal regards.

Sincerely,

Leonard Bachman, M.D.

Leonard Bachman, M.D.
Governor's Health Services
Director

LB/sjs

SPENCER I. RICHMOND, M.D.
64 NO. HANOVER STREET
POTTSTOWN, PENNSYLVANIA 19464

Telephone 326-9306

April 27, 1973

Elmer S. Friedberg, O.D.
130 King St.
Pottstown, Pa. 19464

Dear Elmer:

This is to inform you that I have no objection to Senate Bill 570 P. N. 599. I support its passage.

I certainly do believe that optometrists should be permitted to use diagnostic drugs provided they have the proper training. Otherwise many types of ocular pathology could go undetected to the great detriment of the patient. This, I feel, makes passage of the bill definitely in the public interest.

Allergic or anaphylactic reactions to local anesthetics, mydriatics or cycloplegics are so rare that when it does occur, it is reported as an interesting case in the ophthalmological journals.

Naturally, I strongly maintain that the medical and surgical treatment of any and all types of pathologic conditions should remain in the domain of the ophthalmologist by virtue of his training in these fields.

Cordially,

Spencer I. Richmond, M.D.

Spencer I. Richmond, M. D.

SIR/jsd

WILLIAM R. NELSON, M.D. F.A.C.B.
1400 Florida
Modesto, California 95350

Telephone: 524-3726

July 5, 1974

Senator George N. Zenovich
State Capitol
Sacramento, CA 95814

Dear Senator Zenovich:

This letter is in support of SB 1989 which would give optometrists the right to use topical pharmaceutical agents for the sole purpose of the examination of the human eye or for any disease or pathological conditions. I am an ophthalmologist, certified by the American Board of Ophthalmology and a fellow of the American College of Surgeons, and I have been in private practice in California for twenty years.

In my experience, optometrists do a conscientious job in examination of the eye and do the best that they can, considering the fact that they are not allowed to use diagnostic medications, in the recognition of present pathological conditions that might require treatment. I think that the commongood would be served if they were allowed to use topical pharmaceutical agents for diagnostic purposes. One of the main benefits would be in the recognition of glaucoma which causes more irreversible blindness than any other condition in this country. Although optometrists now have instruments to test for glaucoma; nevertheless, this test is ordinarily uncomfortable or slightly painful unless a topical anesthetic is used on the cornea. The accuracy of the test is considerably improved if the patient cannot feel it and is therefore relaxed.

In my opinion, the possible benefits to the population from the use of dilating drops for diagnostic purposes by optometrists would far outweigh the dangers. There are a number of pathological conditions of the eyes as well as some ocular manifestations of systemic conditions which in many cases cannot be satisfactorily visualized and recognized without the use of dilating drops. I would be remiss, however, not to mention the fact that there would be an occasional adverse reaction in the form of an acute congestive glaucoma which can occur from the use of such drops. Due to the specialized nature of my practice, I have seen ten such cases during my twenty years of practice. I am sure this is far more than the ophthalmologist with the average type of practice would see. Of these ten cases, the vision was lost completely in one eye and two others required emergency surgery. The other seven all responded satisfactorily to medical treatment. Although thousands of cases would benefit for each possible adverse reaction; nevertheless, adverse reactions do occasionally occur and therefore adequate training of optometrists in prevention of such adverse reactions and in other recognition of them, so a prompt referrel to an ophthalmologist could be made, would be a must. I am sure that there would be several hundreds of thousands of people benefitted by the use of this and other types of diagnostic eye medications. There are some risks with the use of all types of drugs or medications, and in this case, the possible benefits would far outweigh the possible adverse reacions.

In summary, it is my opinion that the citizens of California would materially benefit, if optometrists were allowed to use topical pharmaceutical agents for the sole purpose of examination of the human eye for disease or pathological conditions and that the benefits from such use would far outweigh the danger of occasional adverse reactions.

Sincerely yours,

William P. Nelson, M.D.

WRN:sm
cc: Senate Health & Welfare Committe
Dr. Stanley Hinkley

H. JAMES WALL, M.D.

PHYSICIAN - SURGEON

TELEPHONE
DAY OR NIGHT
479-7400

2400 LAS GALLINAS AVENUE
CNR. LAS GALLINAS & MILLER CREEK ROAD
MARINWOOD, SAN RAFAEL
CALIFORNIA 94903

July 12, 1974

Honorable Randolph Colier, Senator
California Legislation
State Capitol
Sacramento, California 95814

Dear Senator Collier,

As a member and chairman of the Senate Finance Committee, I would like to urge you to give favorable consideration to Senate Bill 1989 (Zenovich). This bill would permit, under careful regulation and administration, the use of topical pharmaceutical agents by optometrists in the examination of the eye for any pathological condition.

This bill would allow more comprehensive eye evaluation by optometrists and appropriate referrals for further definitive study and treatment by the appropriate provider. I understand only those optometrists who have satisfactorily completed the appropriate courses will be eligible to use the topical pharmaceuticals.

I ask your support for SB 1989.

Sincerely,

H. J. Wall, M.D.
Fellow of the American College of Emergency Physicians- candidate to the American College of Surgeons

VI.

THE TOPICAL USE OF DRUGS FOR DIAGNOSTIC PURPOSES BY OPTOMETRISTS

ALBERT N. LEMOINE, JR., M.D., F.A.C.S.

My opinions and conclusions, as you will read, are not those of most ophthalmologists or organized medicine. These opinions are based on more than thirty years of experience in the practice of ophthalmology and medical education. Since 1950, more than half of my time has been devoted to academic ophthalmology as Professor and Chairman of the Department of Ophthalmology at the University of Kansas School of Medicine, with the remainder of the time in the private practice of ophthalmology, but involving a medical school environment. I do feel that it is important to realize that I have not limited my practice to a subspeciality in ophthalmology and that my associates and I have been more than ninety five (95) percent self supporting, receiving no federal funds and very little state monies. I am well aware of the problems of private practice, earning an income from patient care and not being limited to an Ivory Tower. Since 1971, I have not performed surgery nor had a private practice, but have devoted full time to administration, primarily in ophthalmology, and teaching. My teaching of ophthalmology over the past thirty years, has involved direct contact with paramedical students, nurses, undergraduate medical students, residents in ophthalmology and other specialities that relate to ophthalmology. I have also been involved in continuing education of physicians and ophthalmologists. I have had somewhat limited but direct experience in undergraduate and continuing education of optometrists.

It should be obvious that with this background my perception of the issues and problems of health care, health care delivery systems and the use of drugs by optometrists may be quite different from those of the average ophthalmologist in private practice. The opinions and conclusions that are expressed concerning the use of drugs for diagnostic purposes by optometrists are mine and should not be interpreted as those of the University of Kansas, the University of Kansas College of Health Sciences or any other organization of which I am a member.

Based on the testimony of previous hearings concerning the use of drugs by optometrists, and articles that have been published, there are in general seven areas that are repeatedly considered. I will list these areas and express my opinions and conclusions in each area followed by a brief summary.

I. THE TYPE OF DRUGS USED AND THE REASONS FOR THE USE OF THE DRUGS: I am in favor of the topical use of anesthetics, mydriatics and cycloplegics by optometrists for diagnostic purposes. I am unequivocally opposed to the topical or systemic use of drugs for therapeutic purposes by optometrists. In my opinion, there should not be a "grandfather clause" in legislation permitting the use of drugs by optometrists for diagnostic purposes. All optometrists who use such drugs should pass an examination that encompasses both the pharmacological action of the drugs, but in particular the clinical effects and side effects.

II. THE RISK TO THE PATIENT WHEN OPTOMETRISTS USE TOPICAL DRUGS FOR DIAGNOSTIC PURPOSES TO LIFE AND VISION: **In my personal experience, involving over one million outpatient and hospital patients, the majority involving the direct supervision of medical students and residents, I have never seen nor heard of a death or critical side effect when topical drugs were used for diagnostic purposes.** In addition, I have talked to many private practitioners and colleagues who are directors of ophthalmology training programs and have been unable to find anyone who has seen or heard of a verified death from the topical use of anes-

thetics, mydriatics or cycloplegics for diagnostic purposes. I am certain that somewhere there has been a death, but considering the millions of persons given topical drugs for diagnostic purposes, the risk is extremely low. The most common adverse side effect is an epithelial corneal abrasion following the topical use of an anesthetic for the measurement of the intraocular pressure, especially when the Schiotz tonometer is used. Although this will produce a temporary period of blurred vision and pain, I have never seen permanent loss of vision. This **must not** be confused with the use of a topical anesthetic for the removal of a foreign body that may produce a corneal ulcer and vision loss because this use of the topical anesthetic is for **therapy and not diagnosis.** The most serious threat to vision or blindness is acute closure glaucoma following pupil dilatation with the use of topical mydriatics or cycloplegics. It is unusual for blindness to result if an early diagnosis of angle closure glaucoma is made and treatment is provided. This condition is rarely difficult to diagnose, if one considers the possibility, and especially if one is limiting his practice to ocular and visual problems. The incidence of angle closure glaucoma, following pupil dilatation, is probably in the range of one in forty to fifty thousand persons who have had their pupils dilated. To me there are no other blinding conditions, secondary to the topical use of drugs for diagnostic purposes, that occur with any significant frequency. One of the most common objections to the topical use of drugs for diagnostic purposes by optometrists is that they will not recognize disease and seek consultation for definite diagnosis and therapy. **To me this is not germane to the issue of the use of drugs for diagnostic purposes because only the health care provider makes the diagnosis.** A failure of recognition of conditions where referral for definite diagnosis and/or treatment is serious. In my opinion, when an optometrist uses topical drugs for diagnostic purposes, he assumes exactly the same medical/legal responsibility as any other health care providers using drugs for the same purpose. In no manner can he or she be excused from the diagnostic error because he or she is an optometrist.

III. THE RISK OF COMPLICATIONS AS AGAINST BENEFITS: In my opinion, the benefits from the topical use of drugs for diagnostic purposes far outweigh the risk to life or vision. Despite all new instrumentation, there is no good way to obtain a satisfactory view of the interior of the eye unless the pupil is dilated. One area of controversy is the measurement of intraocular pressure by the use of a noncontact tonometer. In my opinion, the $4,000 cost of the instrument is not insignificant when one can obtain more accurate intraocular pressure measurements with one of the contact tonometers in a majority of the patients. In my experience, and that of the majority of ophthalmologists whom I have asked, the applanation contact tonometer is the most accurate instrument available to measure intraocular pressure.

IV. THE USE OF THE TERM **DIAGNOSIS**: It is my opinion that this word causes more difficulty than all other issues combined when there is a discussion of optometrists using topical drugs for diagnostic purposes. The basic difficulty is the failure for both groups to recognize and accept the fact that they use the term diagnosis in a different manner. The word itself covers a broad spectrum of concepts. One can correctly use the term diagnosis when defining what may be wrong with an automobile engine, the economic system, the weather, etc. To the physician and ophthalmologist the term diagnosis is used in a very restrictive manner. It is used to define a disease or process, usually as the initial step in treatment or ordering other diagnostic tests. Despite this restrictive use of the word in medicine, there frequently is not agreement as to the specific diagnosis in a particular patient. One of the most obvious examples in the area of ocular diagnosis is the term glaucoma. Although there is agreement that

there is nearly always an increase in the intraocular pressure (low tension glaucoma being an exception), there is not uniform agreement as to just what is abnormal pressure or what, if any other parameters, are necessary to make a specific diagnosis of glaucoma. While physicians and ophthalmologists use the word diagnosis as above, in my experience, most optometrists use the term diagnosis and the diagnostic terms (glaucoma, iritis, keratitis, etc.) in a different framework. The optometric diagnosis of disease may more accurately be defined as a deviation from the normal with referral indications for definitive diagnosis and therapy. In other areas, the optometric diagnosis may be just as definitive as the ophthalmologist, e.g. refractive errors, muscle paralysis, muscle imbalance, etc. To me the fact that a diagnostic term is not preceeded by a qualifying word, such as presumed, probable, possible, etc., does not present a serious problem. This is not true for most ophthalmologists and physicians who believe that to use specific diagnostic words is an invasion of their sphere of practice and expertise, which is definite diagnosis and therapy of ocular problems or problems of the visual system. It is at this point that I have strong personal convictions that many, if not most, of my colleagues in ophthalmology do not accept. **It is my firm belief that ophthalmologists have a serious obligation to the public in providing educational opportunities to all health care professionals, including optometrists, at both the undergraduate and continuing education level.** I am unable to comprehend that many of my colleagues do not wish to accept this responsibility in view of the ophthalmologists educational experiences in the diagnosis and treatment of problems involving the eye and visual system. **It is imperative that we educate all health care providers to recognize abnormalities where referral to an ophthalmologist for definitive diagnosis and therapy is indicated if needless blindness is to be avoided.** One cannot ignore the fact that there are more than 20,000 optometrists in active practice in the United States who are providing the initial or total eye care of a majority of the citizens. In rural states, the percentage is quite high because of the distribution of eye health care providers. Whether ophthalmologists like it or not, optometrists do and will continue to make diagnosis after an examination of a patient.

V. LEGISLATION PERMITTING OPTOMETRISTS TO USE TOPICAL DRUGS FOR DIAGNOSTIC PURPOSES IS THE FIRST STEP IN LEGISLATION TO USE DRUGS FOR THERAPY: I fail to see that this statement is germane to the present issue of the use of drugs for diagnostic purposes. In my opinion, the legislation permitting optometrists to use drugs for both diagnostic and therapeutic purposes, enacted in West Virginia, is not in the best interest of the public. There is no doubt that this law has provided a strong stimulus for organized medicine and ophthalmologists to unite against any legislation that will permit the optometrist to use drugs for any purposes. In my opinion, the present educational programs in optometric schools or their continuing education programs **do not** provide the necessary knowledge to use drugs for therapeutic purposes in any manner. I believe that the public will be endangered if optometrists are permitted to use drugs for therapeutic purposes, unless their education is essentially the same as that of a physician or osteopath. At the same time, I do believe that optometrists, at this time, should be able to use topical drugs for diagnostic purposes in order to enhance their ability to recognize ocular conditions where referral is indicated.

VI. LEGISLATION PERMITTING THE TOPICAL USE OF DRUGS FOR DIAGNOSTIC PURPOSES BY OPTOMETRISTS WILL OPEN THE DOORS TO USE OF DRUGS BY NONPHYSICIANS: It is obvious that this statement is not true because already legislation permits dentists and podiatrists to use both medicine and surgery for therapeutic purposes.

It is also true that nurse clinicians and physician assistants, in some states, are permitted to prescribe drugs, change drug dosage and perform minor surgical procedures. In each of the above instances there have been significant changes in the educational process of each group. In all instances there are definite restrictions as to what can be done and in none of these situations is there an open license to practice the healing arts as is true for the physician and surgeon or osteopath. Whether the future will bring about an alteration in the optometric education that would justify entering the areas of medical and surgical therapy of ocular problems, only time will tell. Because the eye and visual system may be involved in nearly, if not all, disease processes in the body, any type of restrictive license, such as in dentistry and podiatry, would be difficult to justify. In my opinion, the educational programs, to protect the public, would need to be essentially the same as an ophthalmologist. When one considers the vast demand for eye service is in the area of refraction and contact lenses and not medical and surgical treatment, the type of eye health care provider is significant. What is needed is more cooperative efforts to provide a team approach to eye health care, at least in the area of dense population concentration.

VII. THE DISTRIBUTION OF OPTOMETRISTS AND OPHTHALMOLOGISTS: Although this issue is rarely considered as a distinct entity beneath all discussions, it is important in the present legislative conflicts. All data indicates that there is a significant difference in the distribution of optometrists and ophthalmologists. Opthalmologists, in general, practice in urban and suburban areas, whereas, percentage-wise more optometrists practice in rural areas and the inner city. It is in the areas where there is a surplus of ophthalmologists and optometrists for the population that conflicts occur. If one is honest the primary conflict in this latter situation is economic.

In summary, on the issue of legislation for the use of drugs by optometrists, I support the following positions:

I. The topical use of drugs for diagnostic purposes, in specific anesthetics, mydriatics and cycloplegics by optometrists may provide significant benefits to the public with minimal danger to either life or vision. I find it difficult, if not impossible, to justify the inclusion of miotics for diagnostic purposes.

II. I am unequivocably opposed to the use of drugs, either topical or systemic, for the therapeutic purposes by optometrists.

III. I am opposed to any legislation that would "grandfather" the optometric use of drugs for diagnostic purposes by optometrists.

IV. Legislation should require the passage of an examination on the action of drugs and **in particular the clinical effects and side effects of drugs** used for diagnostic purposes before an optometrist is licensed to use them.

I hope that this lengthy response to the question of the use of drugs by optometrists is justified, because this is a highly complex issue, of concern to the public that has evoked extreme emotional response from both ophthalmology and optometry. In my opinion, the time has passed when we can retain the status quo and it behooves all involved (health care providers and members of the legislature) to carefully examine the facts and provide the best possible legislation for the public welfare at this time. If I can be of further assistance in this matter, please feel free to contact me.

Sincerely yours,

Albert N. Lemoine, M.D.

VII.

DR. HOWARD C. LUCAS, FLORIDA OPHTHALMOLOGIST TESTIMONY BEFORE THE SENATE ECONOMIC AFFAIRS COMMITTEE

Mr. Chairman, Members of the Committee:

Briefly my background is a medical degree from the Cornell Medical College in 1951 followed by two years rotating internship at Genessee Hospital, Rochester, New York. I then practiced general medicine for three years in Winter Haven, Florida. In 1957, I served a three year residency in Ophthalmology at the Institute of Ophthalmology, Columbia Presbyterian Medical Center, New York City. In 1960 I started my private practice of Ophthalmology in Winter Haven, Fla. and in 1961 was certified by the American Board of Ophthalmology.

You are here to decide the question of who has the right to use mydriatics, cycloplegics, and topical anesthetics, referred to as diagnostic pharmaceutical agents. The medical doctors claim squatters rights to the territory of diagnostic pharmaceutical agents, demand an absolute monopoly in their use. The optometrists feel that their patients would also benefit by using diagnostic pharmaceutical agents to make the eye examination more precise and complete.

The diagnostic pharmaceutical agents belong neither to the optometrists or the medical doctors. They are the property of the patients and should be used to benefit the patients who are your constituents. The proper question here is "Who is to be awarded the exclusive use of these agents to be administered for the benefit of the patients?" Both medical doctors and optometrists use the same tools, lenses, prisms, tonometers, biomicroscope, and ophthalmoscopes to determine the presence or absence of disease and the correct prescription for glasses. Enlarging the pupils with drops makes the examination easier and more precise in many cases. The use of topical anesthetics makes the measurement of intraocular pressure more accurate, and this facilitates the diagnosis of glaucoma.

The prime consideration here is what is best for the patient. Since both optometrists and medical doctors are performing similar examinations with the ultimate goal of arriving at the best refraction and diagnosis then both medical doctors and optometrists should be using the diagnostic pharmaceutical agents.

The next question is safety or danger of these diagnostic agents. I have been practicing ophthalmology for twenty-two years. I have not had any serious reaction to diagnostic pharmaceutical agents. The serious and lethal reactions as described by the medical doctors are not subtle or difficult to recognize. They describe convulsions, anaphylactic shock, strokes, cardiac arrest and death due to these agents. I have never had to do cardio-pulmonary resuscitation, call an ambulance, or send one of my patients to the morgue as a result of using diagnostic pharmaceutical agents.

It is true that these agents are dangerous if improperly administered such as being swallowed or injected, or multiple drops being used over a period of one hour or more. One or two drops in each eye, with the excess being blotted out with a tissue will not cause a serious reaction. This is not difficult to do. The optometrists know how to do this properly.

Here, the proper question is:

Why are certain medical doctors getting so many dangerous reactions to these diagnostic pharmaceutical agents?

The majority of medical doctors do not get serious reactions when using diagnostic pharmaceutical agents. Therefore, the ones who are getting the bad reactions must be doing something wrong. They should carefully and critically examine their techniques and take a refresher course in pharmacology to discover the cause of these bad reactions.

Diagnostic pharmaceutical agents, when properly used, are safe and essential to an adequate eye examination. Optometrists should use them.

Respectively submitted,

Howard C. Lucas, M.D.
560 Ave. K, S.E.
Winter Haven, Florida 33880

Distinguishing among eye specialists

dr. lester coleman

In this morning's mail were letters from two readers in different parts of the country. Both asked questions about optometrists and how they differ from medical eye specialists.

Ophthalmologists are medical doctors who have had special training in the medical and surgical aspects of diseases of the eye.

Optometrists are not M.D.s, yet they, too, have had excellent training. Their field is limited to the diagnosis and correction of defective vision. It does not include any aspect of surgery.

The eye is a remarkable index of diseases that may exist elsewhere in the body. Vascular disturbances, neurological problems and diabetes are only a few of the many conditions that are diagnostically recognized by a careful inspection of the eye. Intrinsic diseases of the eye itself — infections, glaucoma, cataract formations, viral infections, allergies and tumors — are treated by the ophthalmologist.

It should be pointed out that many skilled optometrists recognize when a problem exists and immediately refer their patients to an eye specialist for confirmation and treatment.

Dr. Coleman welcomes questions from readers. Please write to him in care of The Daily News, Pouch 6616, Anchorage 99502.

SUPPORTIVE LETTERS

from

MEDICAL DOCTORS AND OPTOMETRISTS INSIDE ALASKA

These letters speak of authorized use of diagnostic agents by optometrists throughout Alaska.

MEMORANDUM

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Public Health Service
Alaska Native Medical Center
P.O. Box 7-741
Anchorage, Alaska 99510
DATE: October 21, 1977

TO : SEE BELOW

FROM : ANC-EYE

SUBJECT: Use of Diagnostic Medications by Staff Optometrists

Drs. Donald E. Bigelow and James N. Matson, Staff Optometrists, conduct field eye clinics as part of the Eye Care Program. Often is is necessary to use cycloplegics in order to obtain a refraction on certain individuals and anesthetic drops to take ocular pressures. Both doctors are aware of the possibilities of provoking an acute angle closure glaucoma, or an allergic reaction by the use of these drugs. They have my permission to use these ocular diagnostic medications when they feel the medications are needed, and I take full responsibility for any adverse reactions that might occur.

Should an acute angle closure be provoked, the following steps should be initiated:

1. Pilocarpine Ophthalmic Solution, 4% 1 gtt. installed q. 15 min. 4 doses; then, q. hour x4 doses, or until pupil constricts. Once constricted, the patient should be maintained on Pilocarpine 1 gtt. O.U. q.i.d. until referred in for surgery.

2. Simultaneously, at the initiation of Pilocarpine, the patient should be given Diamox 250 mg. I.M. and Osmoglyn (if available) 6 oz. mixed with grapefruit juice P.O.
DIAMOX ONE TABLET EVERY SIX HOURS BY MOUTH-
3. He should be referred to ANMC as soon as possible for evaluation and surgery.

Donald W. Dippe

Donald W. Dippe, M.D.
Chief, Ophthalmology

DIST: Clinical Directors - All Service Units
Chief, A-OPCSSE
Eye Care Coordinators and Assistants
Public Health Nurses and Community Health Aides

7-320B "I" Street
Elmendorf AFB, AK 99506
1 March 1978

Dr. Box
611 W. Willoughby
Juneau, AK 99801

Dear Dr. Box,

I was asked to write to you and give you the latest information from the Air Force that I have concerning the use of diagnostic drugs that we can use.

Air Force Regulation 36-1 (dated 1 March 1977) states on Page A27-37: OPTOMETRIST

2. Duties And Responsibilities
   a. Conducts Examinations of Eye: With or without the use of diagnostic drugs, examines eyes..... etc.

I know of no other regulation since then that states anything different. There is no place in the regulation that any of our professional activity is under the direct supervision of an ophthalmologist or other physician.

As you know, there are many places where the optometrist functions where there is no ophthalmologist assigned. At those locations the optometrist usually is called upon by the professional staff to do many of the more routine ophthalmological duties, because he knows more about these functions than do the other medical corps specialties. Even at locations such as Elmendorf where we have ophthalmological services, we can use diagnostic drugs and do minor ophthalmological services on our own, but we usually let the ophthalmologist or his technicians do these services.

I am licensed here in Alaska, and would appreciate being on the mailing list of any material associated with the changing of the optometric laws within the state. I am still a few years from retirement, but plan on coming back up here when I retire.

ROGER C. FITCH, Lt Col, USAF, BSC
Chief, Optometry Services
Elmendorf AFB, Alaska

2320 Palos Verdes Drive
Eagle River, Alaska 99577
May 2, 1978

Rep. Randy Phillips
Pouch V
Juneau, AK 99811

Dear Rep. Phillips:

I am presently practicing with the Public Health Service at the A.N.S. Hospital in Anchorage and anticipate going into private practice in the very near future. I am interested in the progress of House Bill #664 and would like to urge you to support the passage of this legislation. I am a graduate of Pacific University, College of Optometry, which is in Forest Grove, Oregon. Oregon has had similar legislation to House Bill #664 for several years which, of course, is mandated that Pacific University provide experience in the use of these agents along with a complete pharmacological background for its graduating students. I've also been a medic in the Army and have had some experience with the various drugs and agents used in emergency medical treatment. It has been my experience with the Public Health Service and in the military that there are no serious adverse reactions from the agents optometrists will use and I've had experience as an observer in the military and, of course, first hand with the Public Health Service where the Alaskan Public Health Service optometrists have had directive from Dr. Dippé to use these agents both at the hospital clinic in Anchorage and whenever we are on bush eye clinics. These agents are used in the bush eye clinics by the optometrist as an independent practitioner with only telephone and mostly not very good radio contact with the Public Health Service Hospital in Anchorage which would be much poorer in case of emergency than the in office setting most private practicing optometrists in Alaska now enjoy. I also work directly with the ophthalmological staff at the A.N.S. Hospital in Anchorage and have heard the various arguments that have been presented concerning optometrists' ability to manage patients when they use these drugs and can say from personal experience that these arguments are a smoke screen and that the few minor side effects caused by some of these agents are relieved by either reducing the dosage or stopping the cycloplegic agent in the case of cycloplegia. I have had an opportunity to also work with the Public Health Service optometrist who has served with the Public Health Service for many years and have had discussions with the military optometrist in Anchorage and can find no instances where patients have suffered serious adverse affects from these drugs, but know from personal experience that they do aid in earlier detection

of eye disease. I also know from my close association with the ophthalmological community in Alaska that if any serious effect had occured in either the Public Health Service or military use of these agents your committee would have heard about it. The unexplainable morbid fear ophthalmologists have from optometrists granting the use of these drugs is ridiculous in my opinion and can only result in their possible fear of losing patients which I also don't understand because as I viewed the situation as a non-private practicing optometrist the ability of the doctor to make people like him and provide good services are what draw patients to offices and not whether or not they use eye drops. If the fear is based on loss of patients from ophthalmology offices, which is the only thing I can see could be the real source of their concern, then it certainly should not be a concern of the legislature. Again I would like to urge you to support the passage of House Bill #664 as it will aid the private sector optometric patient as it has aided the Public Health Service and military optometric patient.

Yours very truly,

James N. Matson, O.D.

JNM:jc

DEPARTMENT OF THE ARMY
HEADQUARTERS, US ARMY MEDICAL DEPARTMENT ACTIVITY, ALASKA
FORT WAINWRIGHT, [redacted]
ALASKA 99703

AFZT-MD-CL

28 February 1978

STATEMENT

I am presently an Alaska licensed optometrist (#85) practicing in the U.S. Army at Fort Wainwright, Alaska. I have been here over three years, and in the military for over seven years. During all my years as a practicing optometrist in the U.S. Army, I have been authorized to use diagnostic pharmaceuticals in my practice. The use of diagnostic anesthetics, mydriatrics, miotics, and cycloplegics are required for flight physicals, tonometry, internal examinations, cycloplegic exams, etc., required by military regulations.

Upon arriving at Bassett Army Hospital here at Fort Wainwright in 1974, I submitted a request to the hospital Credentials Committee to use certain diagnostic drugs in my practice of optometry which was approved by the committee and endorsed by the Hospital Commander. In my experience in using diagnostic drugs on thousands of patients, I have never had an adverse drug reaction.

Robert P. Hammond

ROBERT P. HAMMOND, O.D.
CPT, MSC
Chief, Optometry

RECOMMENDATION OF

LEGISLATIVE ADVISORY COMMITTEE OF

THE MUNICIPAL HEALTH COMMISSION

Primary Legislative Contact: _____
(907)

LEGISLATIVE REVIEW

pre-do pass

BILL NUMBER AND TOPIC: Senate Bill 75
House Bill 79

BRIEF SUMMARY: An Act relating to the practice of optometry. These bills are the same. They define the term "optometry" and define what is included in the practice. The bill also outlines the use of drugs for diagnosis.

BILL STATUS: House Bill 79 was introduced by Representatives Martin, McKinnon, Meekins, Miller and Parr, and was referred to Health, Education and Social Services and Judiciary Committees.

Senate bill 75 was introduced by the Rules Committee by request, and was referred to the senate Health, Education and Social Services and Judiciary Committees.

The series of questions below are presented to assist persons responsible for reviewing proposed legislation. Answering each question will help the reader to better understand the intent or meaning of a specific bill. Question #12 asks the Legislative Advisory Committee to formulate a recommendation, which will then be forwarded to legislators, lobbyists, other review bodies, etc., as appropriate. Action taken by this committee automatically sends the bill and comments through 1) Municipal Legal Department, 2) Municipal Administration, and 3) Municipal Health Commission, time permitting.

1. What is the time frame for influencing the bill's outcome by this committee or Commission? This legislative session

2. What does the bill do? Defines the term "optometry" and defines what is included in the practice; and outlines the use of drugs for diagnosis.

3. Who does it affect? Both the medical and consumer areas.

4. How much does it cost? Unable to determine

5. Is it directed to a specific geographic area? No
What area? _____

6. How would enactment of this bill effect Anchorage? IT WOULD INCREASE THE AVAILABILITY, IT ALSO ACTS AS A ALTERNATIVE INITIATIVE TO IMPROVE THE HEALTH SYSTEM, IT WOULD ALSO HELP REDUCE COST. IT WOULD ALLOW THE USE OF TOPICAL drugs IN OFFICES

September 2, 1979

7. Is it directed to a specific group? Yes
Which group? Optometrist.

8. How does it affect others? IT DOES NOT EFFECT OTHERS

9. What are its strengths? (1) ALLOW. USE OF TOPICAL DRUGS IN OFFICE (2) IT WOULD BE COST EFFECTIVE; (3) EDUCATIONAL REQUIREMENTS (4) INCREASE AVAILABILITY, (5) WOULD ACT AS AN ALTERNATE ENTERING POINT INTO HEALTH SYSTEM.

10. What are its drawbacks, weaknesses? NONE

11. Is the concept new? NO Are there precedents? YES
Where? IN THE LOWER 48 (24 STATES HAS PASSED THIS LAW)

12. Is there pending or existing legislation which is similar in focus, and/or which would impact implementation of this bill? proposed drug Bills is STATE LEGISLATION

13. How would this bill affect the Anchorage Health Services Plan? IT WOULD INCREASE AVAILABILITY, IT WOULD ACT AS AN ALTERNATE NATION ENTERING INTO THE HEALTH SYSTEM.

14. What is the Committee's recommendations? do PASS

15. What agencies or bodies should this committee notify regarding action on this Legislation? State RULES, HEALTH SOCIAL SERVICE MUNICIPAL ADMINISTRATN. HSA

✓ HSA

BILL FAULKNER Committee Chairman of the following Committees
A BARBEN, B. FAULKNER J UNUSED
R HAGER, C HEINKE, C RIDEN
L SHERWOOD, L ICE SADDEN, K AUTOR
A. CONNOSS, K BRUNSBERG

_____ Individual Committee Members of the following Committees

_____

_____

_____

_____

_____ State Health Coordinating Council
_____ Governor
_____ Bill Sponsor
_____ Other: list

Committee procedure automatically sends the bill through:

1. Municipal Legal Department
2. Municipal Administration
3. Municipal Health Commission, if timely

REFERENCE QUOTATIONS FROM AUTHORITATIVE AND QUALIFIED PERSONS REGARDING USAGE OF DIAGNOSTIC AGENTS BY OPTOMETRISTS

A. SUBSTANTIATING MINIMAL RISKS TO ADVERSE DRUG REACTIONS

1. "In a series of more than 1000 patients anesthetized with benoxinate, no toxic effects were encountered, either locally or systemically."

   Havener, William H., M.D., M.S. (Ophth.), Ocular Pharmacology, P. 51.

2. "There have been no reported systemic toxic reactions in amounts used for topical anesthesia for the eye."

   Leopold, Irving, M.D., Ocular Therapy Vol. 1, p. 16

3. "None of the drugs I shall be discussing were available fifty years ago...they are all less toxic, less irritating and shorter acting than their predecessors."

   Garston, Mathhew J., O.D., "A Closer look at Diagnostic Drugs for Optometric Use", Massachusetts College of Optometry Boston, Mass.

4. "After having seen the use of local anesthetics discussed here in over 20,000 patients I have yet to see any adverse reactions. I have seen the dilating agents discussed here in over 10,000 patients and likewise have seen no ill effects. (this includes not causing an angle-closure glaucoma)."

   Garston, Matthews, J., O.D., ibid.

5. Seventy to eighty percent of drug reactions are predictable and most are preventable."

   "New England Journal of Medicine" Vol. 285, pg. 1361, June 1971 cited by Lyle W.M., O.D., "Relationship of Pharmaceuticals to Optometry", American Academy of Optometry, 1971.

6. "Abraham in 1933 surveyed the literature for reports of acute glaucoma produced after the use of mydriatics in patients previously free from clinical signs of glaucoma. He calculated an incidence of one case of acute glaucoma for each 18,400 instances of application of anticholinergic eyedrops for refraction of other eye examination.

In Abraham's data it was strikingly evident that age was an important factor in determining susceptibility to acute glaucoma from topical application of anti-cholinergic drugs. In nearly all instances of acute glaucoma the patients were over 30 years of age. Among patients younger than 30 years, Abraham found only four instances of this type of adverse effect in the literature. Also, it must be emphasized that the above one case in 18,400 patients was from a population group who were dilated without the aid of angle evaluation techniques."

Leopold, Irving, M.D. (ed.) Ocular Therapy, Vol. III, Chapter 4 "Conservatism in Glaucoma Management" by Robert Shafferf, M.D. and John Hetherington, Jr., M.D. p. 63

7. "Beach noted that increased intraocular tension from the use of a mydriatic does not occur one in 10,000 examinations."

   Lyle, W.M., O.D. Op. Cit.

8. "Havener says that a physician who dilates many eyes may expect to precipitate not more than one case of acute glaucoma in his lifetime."

   Havener, W. H., Synopsis of Ophthalmology cited by Lyle, W.M., O.D. ibid.

9. "It was reported in Australia that in only one case out of 12,000 can glaucoma be precipitated and then only in people who have a predisposition to react in that way to the drug."

   Parliament, 2nd Session, Vols. 59, 60, 73, Act. No. 34, 1963 the Optometrists Act. 1963, Cited by Lyle W.M., O.D. ibid.

10. "After the child is first examined, the doctor usually tells the mother to instill atropine drops or ointment into the child's eye...Atropine is used because it is the most powerful cycloplegic drug...One in 500 children develops a sensitivity reaction to this cycloplegic drug... The mother should not become alarmed; she should simply discontinue the drug."

    Abrahamson, Ira A. Jr., M.D. Know your Eyes, Medcom Press, 1972, pp. 76-77.

B. ESTABLISHING THE LARGER RISK TO THE PUBLIC HEALTH IF THESE DRUGS ARE NOT ADMINISTERED BY OPTOMETRISTS:

1. "Newell reports that there is more danger of missing a significant ocular of systemic disease by failing to dilate than there is of precipitating glaucoma by dilation."

   Newell, F.W. Ophthalmology, Principles and Concepts, 2nd Edition, C.V. Mosby Co. 1969, p. 140, cited by Lyle W.M., O.D., "Relationship of Pharmaceuticals to Optometry", American Academy of Optometry, 1971.

2. "In their role as the first line of defense against glaucoma and other vision-threatening conditions (Optometrists) must be free to utilize all appropriate tests if they are to continue to bear these responsibilities."

   "Should the patient be deprived of a variety of tonometry test, or of gonioscopy or of tonography because his optometrist was not permitted to utilize a broad spectrum of diagnostic procedures?" Cited by Lyle, W.M., O.D. Ibid p.6

3. "A recent opinion of the attorney general of New York State affirms that it is the duty of the optometrist to use his training to uncover any need for the patient to seek further medical advice."

   Forgotson, E.H. et al Report of the National Advisory Commission on Health Manpower, Vol II, Nov. 1967, U.S. Gov't Printing Office, cited by Lyle W.M. O.D., Ibid p.7

4. "...In view of the unavailability of appropriate medical services, for example in remote areas and in other unusual circumstances, there appears to be a need for optometrists to employ topical anesthetics...optometrists...in many cases... are the first trained person consulted."

   Anon, Joint Declaration on Behalf of Ophthalmologists and Ophthalmic Opticians (optometrists). The Ophthalmic Optician, Feb., 21, 1970 p. 173, cited by Lyle W.M., O.D. Ibid p.7.

5. "In those parts of the world where high quality vision care is generally available, 60% to 80% of this health service is the responsibility of optometrists."

   Lindsey A. Socialized Medicine in England and Wales, National Health Service, 1948-1961, University of North Carolina Press 1962.

6. Woodruff, M.E. "Statement Relating to the Effective Utilization of Optometry and Optometric Services in Fulfillment of the Aims and Objectives of the United States Dept. of HEW", American Optometric Assoc, 1964 cited by Lyle W.M., O.D., Ibid p. 11

7. "With regard of mydriatics, most ophthalmologists agree that any risk produced by employment of mydriatics is far outweighed by the potential risk from failure to see more of the fundus."

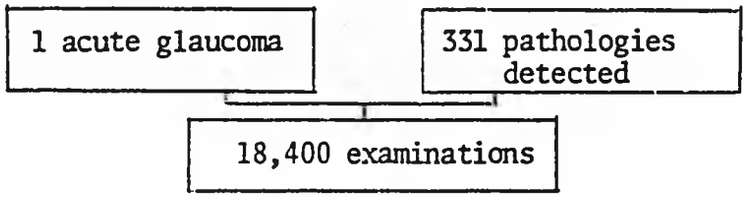
   Lyle, W.M., O.D., Ibid p. 13

8. "Teachers and research workers in the field of vision use mydriatics, miotics, cycloplegics, topical anesthetics and other drugs."

   School of Optometry, Faculty of Science, University of Waterloo, Optometry Education, "The practice and Services of Optometry in Ontario" Part 3 of a Brief supporting and supplementary to the College of Optometry's Brief Submitted to the Committee on the Healing Arts, Nov. 1967, cited by Lyle, W.M., O.D., "Relationship of Pharmaceuticals to Optometry", American Academy of Optometry, 1971.

ABRAHAM: One case of acute glaucoma for each 18,400 instances of application.

HEW: 1.79% of all eye examinations yield an eye pathology.



Safety factor for the one case of glaucoma precipitated:

include in the bill:

"Miotics for emergency use only."

NOT FOR PUBLICATION

THE USE OF DIAGNOSTIC DRUGS IN RHODE ISLAND - A SURVEY

by

Herbert L. Moss, O.D., F.A.A.O.
Associate Professor of Optometry
Pennsylvania College of Optometry

NOT FOR PUBLICATION

Additional remarks regarding the use of DPAs:

1. Greatest advantage to patients, pathology referrals increased, integrity of the profession increased.
2. Mydriatics and binocular ophthalmoscopy are the greatest benefit.
3. Uses ophthaine only for tonometry, hard contact lenses, and first aid.
4. Applanation tonometry with anesthesia is accurate and reliable. Stops over-referrals and promotes proper referral. Perfectly safe in trained hands.
5. Beneficial to patients. Speeds referral to proper practitioner without delay.
6. Patient acceptance is gratifying. I.O.P. measurements are easier, smoother, and faster.

SUMMARY

In summarizing the results of this survey, several generalizations seem to stand forth:

1. From the optometrists' viewpoint, the overall impact on practice and professional status has been positive to very positive.
2. The overall effect upon most segments of the public and other professions has been positive although not as much so with public health and elected officials.
3. The use of DPAs is higher as the age bracket of the patients increases and this could be anticipated because of the high usage of topical anesthetics in tonometry.

4. The 9.5% usage of mydriatics seems to be in keeping with the statistics on the usage of mydriatics in general ophthalmological practice.
5. The very low incidence of the use of miotics as a post-mydriatic also reflects the state of the art today.
6. In regard to the effect upon practice, it appears that DPAs tend to simplify optometric practice, but increased the time spent per patient in collateral activities.
7. DPAs seem to have increased the number of procedures and the variety of equipment that optometrists utilize.
8. One crucial issue raised during the legislative hearings was the supposed adverse reactions to DPAs that would occur. The responses to this survey indicate that those claims were totally unfounded.
9. One area that should be stressed is the increase in the referral rate across the board and particularly the increase in the referral for suspected glaucoma by more than two thirds of the responding optometrists.
10. The question of whether optometrists should become involved in limited ocular therapy brought a 72% favorable response. However, five of those responding in the affirmative made an unsolicited point that additional education and clinical training should be part of this activity.

In substance, it appears that the use of DPAs by optometrists in Rhode Island has been beneficial to all parties involved, even those who opposed the legislation, and that the concerns raised by the opponents were exaggerated.

CONCLUSION

We, the optometrists of Alaska at this point in our development, submit our qualifications in an effort to protect our patients against preventable eye disease. We must now close the gap between what the courts are demanding of us and what the laws are allowing of us.

With emerging national health care, we see only a future of increased visual and eye health care needs. We enthusiastically accept that with a sincere dedication. Yet, in so doing, we find ourselves in need of some diagnostic tools.

The optometry motto remains clearly in the minds of all Alaskan optometrists: "Next to life itself, God's greatest gift is sight."

1979--TESTIMONY BEFORE

HOUSE HES COMMITTEE

TESTIFYING

Dr. Sam McConkey: Physician and surgeon, diplomat of the American Board of Ophthalmology, Fellow in the American Academy of Ophthalmology, Practicing ophthalmologist in Fairbanks.

Dr. Marvin Grendahl: Physician and surgeon, Ph.D. in Physiology, Practicing ophthalmologist in Anchorage.

Dr. Roger Page: Physician and surgeon, board certified ophthalmologist, practicing ophthalmologist in Juneau.

Dr. Boyd Walker: Optometrist, private practice in Anchorage.

NO ALASKA OPTOMETRIST HAS BEEN TAUGHT BY A M.D. OR PH.D. OR OPHTHALMOLOGIST

Dr. McConkey speaking: "After reviewing the professionals and staff of their schools, I can tell you that not one optometrist in Alaska has had any pharmacology training from any M.D. or Ph.D. in pharmacology. I can tell you that not one optometrist in Alaska has had any instruction in anything that a full time M.D. on any staff and not one optometrist in Alaska has had any full or part time instruction either in class or in clinic study by an ophthalmologist."

Answer by optometric legislative committee--not on tape

University of Alabama Optometry Faculty (total instructors 65)

Jerry Christensen, B.Sc., M.Sc., Ph.D.
Kenneth Cinffreda, B.A., Ph.D.
Boyd Eskridge, B.Sc., M.Sc., Ph.D.
Jack Geer, B.S., M.D.
Thomas Johnson, B.S., M.S., Ph.D.
Robert Kleinstein, B.S., M.P.H., Ph.D.
Homin Lin, B.S., Ph.D.
Michael Loop, B.S., Ph.D.
Andrew Lorincz, Ph.D., B.S., M.D.
Jerry McGhee, B.S., Ph.D.
John McKibbin, B.A., M.S., Ph.D.
Thomas Norton, B.A., Ph.D.
Clyde Oyster, B.S., Ph.D.
John Pierce, B.S., M.S., Ph.D., O.D.
William Rosenblum, B.S., M.S., Ph.D.
Harold Schnuper, A.B., M.D.
James Sheetz, M.S., Ph.D.
Richard Shoemaker, B.S., M.S., Ph.D.
Ellen Takahuski, B.S., M.Opt., Ph.D.
David Whikehart, B.S., Ph.D.
Bradford Wild, A.B., B.S., M.S., O.D., Ph.D.
Graeme Wilson, M.Sc., O.D., Ph.D.

University of California School of Optometry (total instructors 96)

Irving Fatt, Ph.D.
Darrell Carter, O.D., Ph.D.
Hans J. Bremeumann, Ph.D.
Russell L. DeVolvis, Ph.D.
Merton Flem, O.D., Ph.D.
Ernest K. Goodner, M.D. (ophthalmologist)

Monroe J. Hirsch, O.D., Ph.D.
Russell Jones, Ph.D.
Robert Mandell, O.D., Ph.D.
Elwin Marg, O.D., Ph.D.
Robert Mishell, M.D.
Meredith Morgan, O.D., Ph.D.
Lawrence Stark, M.D.
Anthony Adams, O.D., Ph.D.
Richard Brand, Ph.D.
Theodore Cohn, Ph.D.
Ralph Freeman, O.D., Ph.D.
Wayne Hubbell, Ph.D.
Kenton Kerr, O.D., Ph.D.
Robert Stamper, M.D.
Howard J.D. Abreva, Ph.D.
Julie Jose, O.D., Ph.D.
Sheldon Miller, Ph.D.
Clifton Schor, O.D., Ph.D.
Richard Van Sluyters, O.D., Ph.D.
Howard Cohen, M.D.
Robert Johnson, O.D., M.D.
Leon Metz, M.D.
Robert Litwin, M.D.
Joseph F. Terdiman, M.D.
Tommy Y. Hayashi, Ph.D.
Gary Liberman, O.D., Ph.D.
Frank Zisman, O.D., Ph.D.

THE TREND IS CLEAR, INFORMED PUBLIC AND LEGISLATURE WILL DECIDE. 31 STATES ALLOW DPA'S

Dr. McConkey speaking: "In 1977, 17 states defeated this form of legislation. There were four states that allowed it. In 1978, fifteen states said no. Two allowed. The trend is clear. That once an informed public and legislature is aware of the fact, it has been overwhelmingly defeated in legislature across the country."

Answer by optometric legislative committee--not on tape

Name of State	Date of Enactment
Rhode Island	July 16, 1971
Pennsylvania	March 1, 1974
Tennessee	May 8, 1975
Oregon	May 20, 1975
Maine	June 24, 1975

Louisiana	July 6, 1975
Delaware	July 10, 1975
*West Virginia	March 4, 1976
California	July 9, 1976
Wyoming	February 17, 1977
New Mexico	March 4, 1977
Montana	April 12, 1977 (at 10:10 a.m.)
Kansas	April 12, 1977 (at 2:00 p.m.
*North Carolina	June 3, 1977
Kentucky	March 29, 1978
Wisconsin	April 29, 1978
Nebraska	February 13, 1979
South Dakota	March 15, 1979
Utah	March 21, 1979
North Dakota	March 22, 1979
Arkansas	April 2, 1979
Nevada	May 25, 1979
Iowa	June 8, 1979

*Both diagnostic and theraputic

In addition, there are eight (8) other states that do not statutorily prohibit the use of DPAs by optometrists; several of these states have attorney general opinions (+favorable) (-unfavorable) on this point:

Alabama (AG-)
Florida (AG+)
Idaho (State Board Statement +)
Indiana (AG+)
Michigan
Minnesota
New Jersey (AG+)
Virginia (AG-)

DIALATING THE EYES IS NOT NECESSARY IN MAKING A DIAGNOSIS OF EYE DISEASE OR SUPPLYING CHILDREN WITH PROPER GLASSES CORRECTION. (CONTRARY TO DR. GRENDAHL'S TESTIMONY)

Dr. McConkey speaking: "Dialating the eyes is not a prerequisite of making a diagnosis of eye disease. The truth is that general practitioners and other physicians across the country routinely exam eyes thousands of days without dialating eyes that are quite capable of diagnosing problems that they see. Dialating the eye with drops is not a prerequisite to supplying children with the proper glasses correction.

WHY DO YOU DIALATE THE PUPIL?

Legislator's question to Dr. McConkey: "Can an adequate examination be made of the eye without dialating pupils, and if it can, as I think you indicated here, then why do you use, why do you dialate the pupil when you are examining the eye?"

MY OBLIGATION IS TO DETECT ANY ASPECT OF DISEASE AND DIALATING THE EYE GIVES ME A BETTER CHANCE.

Dr. McConkey's Answer: "To the first question, the answer is yes, an adequate exam can be done but the second part, why do I dialate the eye? My obligation is to detect any aspect of disease that might be present and in some cases of decreased vision, sometimes I can't even tell that even if dialating the eye but it would give me a better chance. You're suppose to know what to look for. Some of these conditions are very far peripheral and can't be seen easily but their vision is decreased. It certainly helps us in evaluating what the problem is, and I think I have an obligation with the first time patients to make sure that's what kind of base we are starting on."

DIAGNOSIS NOT IN OPTOMETRY LAW.

Dr. Grendahl speaking: "The state statutes in Alaska specifically limit the definition of optometry. Not only do they not use drugs, no language is put in there about diagnosis."

Answer by optometric legislative committee--not on tape

Sec. 08.72.300 Definitions.

(3) "Practicing optometry" means the diagnosis by mean or methods other than the use of drugs, of an optical

deficiency or deformity, visual or muscular anomaly of the human eye, or the prescription of lenses, prism or ocular exercises for the correction or relief of the human eye or the holding of oneself out as being able to do so;

IF DROPS ARE SO HAZARDOUS, WHY DO YOU USE THEM?

Legislator's question to Dr. Grendahl: "I hear considerable testimony on the hazardous nature of the drops in question and the question I have for you is that if, in fact, they're such a hazardous nature at the present time that you elect not to use it on many of the natives, why do you use it on anyone?"

YOU HAVE TO DIALATE TO SEE IF THE BACK OF THE EYE IS FREE OF DISEASE.

Dr. Grendahl's answer: "Let me describe the eye as a sphere, okay? Front aspect of it is a lens system. Back surface is a film. If a person comes in with a complaint of flashing lights or seeing spots, or a white curtain comes down over the eye. We have to dialate the eye with, like with the element in neosynophrin, in order to see that retinal detachment, okay? In order to see that retinal detachment you have to get way out to the periphery, way out to the front edge of the film. . . . So by dialating the eye fully we can get way out to the periphery but we need to know their systems. . . . That's why we use dialating drops in the eye for that instance."

YOU HAVE TO USE DROPS TO GET A PRESCRIPTION FOR A CROSS-EYED CHILD.

Another instance why we use dialating drops is that the patient comes in, a little child comes in with a crossed eye, okay? If a child has a crossed eye, we have to do a psychoplegic refraction. All that means is we put a drop in the eye not to dialate the pupil but to put the lens at the primary station. That way we can determine the whole

refractive error of the eye and determine the therapy. Number one would be to prescribe the whole psychoplegic refraction of the glasses. If they have the eye deviating in after the full psychoplegic refraction, with glasses prescribed, then surgery has to be done. . . . So that's why we as ophthalmologists use dialating eye drops.

IF DROPS ARE DANGEROUS, WHY DOES MY EYE DOCTOR USE THEM EVERYTIME ON MYSELF AND MY CHILDREN.

Legislator's question to Dr. Grendahl: "I wear glasses. I've had drops several times. My two children that I've taken in have their eyes examined. There was no black curtain or crossed eye or any of these particular things you've described and every, every time I've gone in, their eyes have been dialated, and I guess what I'm hearing is that the drops are very dangerous. All sorts of things can happen. . . . They've been used very frequently when I've gone in."

DIALATE EVERYONE OVER 52 YEARS OLD.

Dr. Grendahl's answer: "If you come into my office, if I don't see any indication to use the drops, I don't use them. I will use it though in someone that's over age, like 52 or 53. Why? Because the incidence of pathology in a 52 year old and older is higher, namely methostatic breast cancer, prostatic cancer, lung cancer. So in those cases, I will dialate everyone over that particular age, but for routine refraction, and if you were not in that age group, I wouldn't probably dialate your eye unless I saw some real reason to: visual imbalance, field imbalance, pupil abnormality, pigmentation of the iris. My only comment is that other physicians have other feelings about it."

PHYSICIAN ASSISTANTS DIAGNOSE AND PRESCRIBE MEDICINE.

Legislator's question to Dr. Page: "Is it not a fact that physician assistants in this state do diagnose and prescribe medicine without the same benefit of training as the medical doctor?"

Dr. Page's Answer: "That's true."

HOUSE BILL #79

"PRACTICE OF OPTOMETRY"

To Include

DIAGNOSTIC AGENTS

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I. WRITTEN TESTIMONY

1. GEORGE HALL, O.D.
President, Alaska Optometric Association

Doctor Hall represents approximately 95% of the state's optometrists. He shows how the diversity of the state's population and the need for vision care in remote areas make it essential that optometrists be allowed to use diagnostic agents.

2. ROBERT HOLCOMB, O.D.
Past President, Oregon Optometric Association

Doctor Holcomb represents approximately 80% of the Oregon optometrists. He indicates the concerned need to enact legislation which would allow optometrists an increase in their visual examination capabilities through the use of diagnostic agents.

3. WILLARD BLEYTHING, O.D., M.S.
Dean, College of Optometry
Pacific University

Doctor Bleything refers to the professional curriculum which presently qualifies optometrists to utilize diagnostic agents. Over 50% of Alaska's optometrists obtained their professional training at Pacific University.

4. RONALD H. WINTERS, Ph.D.
Assistant Dean, School of Pharmacy
Associate Professor of Pharmacology and Toxicology
Oregon State University

Doctor Winters has reviewed the pharmacology curriculum at Pacific University, College of Optometry, and found it to be appropriately constructed and the use of diagnostic agents by optometrists to be a safe procedure for the improvement of patient care.

II. SUPPLEMENTARY INFORMATION REGARDING HB #79 (OPTOMETRISTS DIAGNOSTIC AGENTS USAGE)

A. The Usage of Topical Eye Examination Drugs by Optometrists

By: Darrell B. Carter, O.D., Ph.D.
Clinical Professor of Optometry
School of Optometry
University of California

This paper was prepared to present to members of state legislatures and to other interested persons the reasons why optometrists desire legislative authorization for the use of ocular examination drugs.

B. Questions and Answers on the Optometry Bill (HB #79)

This summarizes and briefly answers the key questions most frequently asked.

C. Some Points Relative to the Use of Drugs by Optometrists

By: Leonard Levine, Ph.D.
Professor
College of Optometry
Pacific University, Oregon

Dr. Levine has received numerous grants to research the chemistry and physiology of diseases such as muscular dystrophy. He is highly respected as a professor as well as researcher in the areas of physiology and neurophysiology. In order to be effective as such, a special understanding of pharmacology is inherent.

He makes a number of important points relative to the use of drugs by optometrists.

D. Statutory and Judicial Aspects

1. House Bill #79

This bill would re-define A.S. 08.72.300(2) "OPTOMETRY" and (3) "Practicing Optometry".

Addition of a new A.S. § 08.72.305 "USE OF DRUGS FOR DIAGNOSIS".

A.S. 17.15 is amended by adding to Article 1, § 17.15.055 "Sales to Optometrists".

2. Complete Alaska Revised Statutes

3. Supreme Court of Oregon, 1947

State ex rel. Sisemore v. Standard Optical Co., 182 Or. 452-467

The following are some points made in this case:

a. An optical company cannot employ an optometrist because this interfers with the optometrists' trusted and fiduciary relationship with his patient.

b. Optometry must be classified a true "profession" and not a "trade".

". . . an optometrist . . . training enables him to diagnose pathological conditions . . . The fact that he is trained to diagnose pathological conditions in itself indicates that the optometrist is not a mere skilled craftsman or mechanic."

(The entire Supreme Court case may be obtained upon request.)

4. Civil Action No. F 76-35 Civ.

Ferdinard v. Board of Dispensing Opticians (page 104 and 105) defines "routine visual examination" as given by optometrists. The extensiveness the optometrist must examine for eye pathology is expressed.

d. External Examinations (lids, cornea, sclera, etc.)

e. Internal Ophthomoscopic Examination (media, fundus, etc.)

f. Ocular motility

g. Neurological integrity

k. Confrontation fields

l. Tonometry

5. Diagnostic Drugs Terminology Clarification from Oregon Law

a. Oregon Attorney General Opinion #5807 (1964) clarification regarding the term: DIAGNOSIS.

This Oregon Attorney General Opinion states that the "Practice of Optometry" includes pathology diagnosis. In addition, Oregon statutes governing the practice of medicine, do not prevent diagnosis by optometrists

after reference to the 1947 Supreme Court case, State ex rel. Sisemore v. Standard Optical Co., 182 Or. 452, Attorney General Thornton says:

". . . an optometrist, as a part of his services . . . has a duty to use his professional training, skill and knowledge, while he is performing his primary function, to determine whether his patient is afflicted with an abnormal or pathological condition of the eye . . . ."

b. Alaska Statutes Clarification regarding the term: DRUGS.

The inclusion into the Optometry Statutes of the term diagnostic pharmaceutical agents does not conflict with Chapter 64, Medicine.

Section 08.64.380 definitions:

(2) "Practice of medicine" or "Practice of Osteopathy" means:

(D) for a fee prescribing, directing, or recommending for the use of a person, a drug or medicine for the treatment, cure or relief of a disease, infirmity, bodily injury or defect; . . . .

Diagnostic drugs are not mentioned in the practice of medicine, only drugs or medicine for treatment are spoken to.

6. Report from the Secretary of the Department of Health, Education and Welfare (HEW), 1971

This report concerns itself with the optometrists' responsibilities for disease detection.

E. How the Diagnostic Agents relate to:

1. Other States:

Thirty-one states allow optometrists to use diagnostic agents. Other states are making legislative efforts.

2. Other Countries:

a. Within the large english speaking countries of Canada, Australia, and England, optometrists may use diagnostic drugs.

b. England's joint declaration February, 1970, by optometrists and ophthalmologists confirm the many beneficial years and announce the continuation for the usage of diagnostic agents by optometrists in the future.

3. The United States Armed Forces:

All branches of the military either allow or specify in their regulations that optometrists shall be permitted the usage of diagnostic drugs.

F. Educational Qualification by Oregon Optometrists

1. Statement on Pharmacology Training in Optometry in Oregon, 1975
By: L. Levine, Ph.D.

2. Curriculum Comparison on Pharmacology between:

Oregon Medical School
Oregon Dental School
Oregon College of Optometry

3. Association of Schools and Colleges of Optometry (ASCO)

This study suggests pharmacology curriculum guidelines for continuing education courses for practicing optometrists. Should legislation pass, this guide would serve as a framework for setting up such a program.

4. 1973 National Board of Examiners in Optometry

All applicants for Board certification to practice optometry in Alaska must pass all of the written sections of the National Boards with a minimum score of 70%.

Enclosed copies of sections related to diagnostic agents:

	Hours of Testing
Ocular Pharmacology	1 hr.
Ocular Pathology	2 hrs.

Other sections of the Boards not included but available upon request:

	Hours of Testing
Ocular Anatomy	2.0 hrs.
Visual Science I	2.5 hrs.
Visual Science II	2.5 hrs.
Theory and Practice of Optometry	2.5 hrs.
Theoretical Optics	3.0 hrs.
Ophthalmic Optics	2.5 hrs.
Social, legal, ethical, economic and professional aspects of optometry	1.0 hrs.
	19.0 hrs. testing

5. List of the United States Optometric Colleges and Schools

G. Oregon State University, School of Pharmacy statement
By: Charles O. Wilson, Ph.D.
Dean of Pharmacy
Oregon State University

Emphasis is on the importance of bringing the patient into the Health-Care System. He states:

> "This Bill will make is possible for optometrists to carry out diagnostic procedures to identify any pathological condition during the course of the examination . . ."

University of Maryland, School of Pharmacy statement
By: Peter P. Lamy, Ph.D., F.C.P.
Director of Pharmacy Programs
University of Maryland

Dr. Lamy concludes saying:

> "The benefits from the topical use of drugs far outweighs the risk to vision. There is simply no good way to obtain a satisfactory view of the interior of the eye unless the pupil is dilated."

H. Alaska Board of Examiners in Optometry

Just as all other regulatory responsibility on optometrists is placed with this Board, likewise, it would be charged with the additional responsibility of certification of optometrists for diagnostic drug use. This Board would see that not only the

educational course work had been completed but that through examination, a clear understanding of pathology and disease detection with the use of diagnostic agents does in fact exist.

I. Alaska Manpower Regarding Vision and Eye Health Care

The optometrists of Alaska are geographically more evenly distributed so as to meet the needs of the people. Ophthalmologists are primarily concerned with eye surgery and, therefore, are concentrated around larger population areas where more extensive hospital facilities are available.

As the National Health Care program emerges, along with other increasing group insurance programs, the need for better referral channels must be established. Diagnostic agents can make pathology detection more effective and resulting referrals more accurate.

Enclosed:

1. Alaska Distribution Map on Vision and Eye Health Care
2. 1979 listing on:
   a. Resident Optometrists in Alaska (32)
   b. Resident Ophthalmologists in Alaska (17)

J. Probable Objections to HB #79

K. American Association of Ophthalmology Public Relations Pamphlet on "Drops"

The emphasis is that only a proper examination can be made with eye drops. It then strongly states that only ophthalmologists are allowed to use them. The P.R. results are obvious.

L. Supportive Letters from Medical Doctors Outside of Oregon

These letters speak directly to the minimal adverse side affects and maximal benefit to the patient.

M. Supportive Letter from Medical Doctors and Optometrists Within the State of Alaska

These letters speak directly to the use of diagnostic agents by optometrists in the State of Alaska.

N. Reference Quotations from Authoritative and Qualified Persons Regarding Usage of Diagnostic Agents by Optometrists

1. Substantiating minimal risks to adverse drug reactions.

2. Establishing the larger risk to the public health by not having these drugs administered by optometrists.

O. Long-Term Study of the Use of Diagnostic Agents in Rhode Island by Optometrists

For eight years optometrists have been using diagnostic agents with the overall effect of increased number of referrals, with no adverse effects. The overall benefit to the patient was emphasized because of pathology detection and speedy, proper referrals. (Only summary and conclusion included. Further information can be had on request.)

P. Conclusion

The
ALASKA OPTOMETRIC ASSOCIATION
AFFILIATED WITH
AMERICAN OPTOMETRIC ASSOCIATION

PRESIDENT

I. My name is George L. Hall, O.D. I am a Doctor of Optometry. My education consists of a B.S. in Math and Biology in 1967 from Regis College, Denver, Colorado, and received my Doctorate of Optometry from the University of Houston in 1971. I have practiced full time in a group practice in Anchorage.

Today you are going to have to make a very difficult decision between two points of view from two well-meaning professions. There may be emotion and accusation in some of the statements made, but I urge you to decide on fact and fact alone.

By introduction of this bill, Optometry is asking to use a very limited number of drugs in furthering its attempt to provide the finest vision care to all Alaskans. We feel passage of this bill will enable early detection of pathology in all patients and at the same time provide a more efficient, less costly eye health care system. We intend to use these only in a limited diagnostic manner, and in no way, or at no time, intend to extend their use to theraputics. Don't be mislead by critics who see in our request to use diagnostic agents the desire of optometrists to treat pathologic conditions. Our sole aim is to improve our detection skills and refer--not treat. Diagnostic agents are not treating agents. We do not wish to practice medicine!

II. Major questions concerning HB 79.

1. Is the legislation necessary?

Statistics from the Health, Education and Welfare Department show that 52% to 58% of the population is estimated to have correctible vision disorders (Myopia, Hyperopia, Astigmatism, etc.).

The Better Vision Institute says that 45% of the population wears glasses and that one-third of those wearing them are in need of re-examination at any given time.

H.E.W. says that 63% of visual examinations last year were conducted by optometrists. Here in Alaska I feel the number may be as high as 75%.

H.E.W. says 17.9 per thousand patients have a condition that requires further medical care.

These statistics point to the need for this legislation since it is well known that many who seek vision care do not routinely seek general medical care, and, therefore, the optometrist is the first to see many pathological conditions which need to be referred for medical care.

It was for these, and other reasons that the Secretary of H.E.W. in 1971, Elliott Richardson, filed a report with the President and Congress which says in part ". . . the Optometrist is a primary entry point into the health care system since he sees the majority of patients seeking eye care in the nation."

In addition, the report contained the following language concerning optometry's role in the health delivery system.

> "Optometrists are trained to detect any departure from the optimally healtny eye. The scope of optometric services has expanded beyond basic clinical refractions, fabricating, and dispensing eyewear; now included are visual screening examinations, clinical instrumentation, contact lens fitting, visual training, orthoptics, low-vision aids for the partially sighted, artificial eyes, industrial visicn consultation and public and community health . . . The Optometrist is trained, and bound by professional ethics, to refer patients in whom indications of disease have been found, to a physician or other health practitioner for definitive diagnosis and appropriate medical, surgical, or other treatment."

H.E.W., in its desire to promote the highest quality of health care for the public, has made a number of policy decisions concerning optometry.

In its Health Professional Project Grant for 1975, it has mandated the optometric profession to ". . . devise, demonstrate, and implement provision for inter-discipline training which will encourage the use of health care teams, and to devise projects to develop affiliation between optometric training programs and medical, osteopathic, and other health professions training programs, and academic institutions, . . . including programs for cooperative interdisciplinary training in the use of the team approach to the delivery of health services."

Therefore, to the question "Is there a need for this legislation?", the answer we strongly feel is Yes!

In 1947, the Supreme Court of the State of Oregon in the case of Sisemore v. Standard Optical, 182 Or 452, 460-461, 188 and 309-312-313, has unequivocally answered the question. The court stated on page 460:

> As to the liability of Optometry in the area of diagnosis, the practice of Optometry is undoubtedly one of the subdivisions of the practice of medicine.

The court went on to say on page 461:

> While it is true that an optometrist is not permitted by law to treat diseases of the eye, nevertheless his training enables him to diagnose pathological conditions, and his duty requires him to refer the patient to a practitioner who is qualified to treat such conditions. The fact that he is trained to diagnose pathological conditions in itself indicates that the Optometrist is not a mere skilled craftsman. His failure to diagnose a pathological condition, with resultant delay or neglect in proper treatment therefore, might result in serious impairment of the patient's eyesight, or even in blindness.

In a letter from Robert Thornton, Attorney General, State of Oregon, dated May 12, 1964, to Mr. Howard Bobbitt, Executive Secretary, State Board of Medical Examiners, citing the same decision he says:

> It thus appears that the term practice of optometry as construed by our Supreme Court contemplates that an Optometrist as a part of the services he renders his patient, has a duty to use his professional training, skill and knowledge while he is performing his primary function, to determine whether his patient is afflicted with an abnormal or pathological condition of the eye which may require treatment by a person legally qualified to render such service. He is also required to advise such patient if he finds what appears to be a pathological condition so that the patient may seek treatment from a legally qualified person.

Therefore, the answer to the question of whether we as optometrists are qualified to detect pathology has been already, very explicitly, answered by the courts in Oregon and nationwide.

From our early beginnings as a profession, we have over the years vastly improved, through our educational institutions, the state of the art and science of optometry to a place where we are recognized now as a highly specialized member of the health care team devoted to the visual well being of the public.

Use of these drugs can aid in the early detection of both eye diseases such as retinal tears, glaucoma, cataract formation and in the systemic diseases such as diabetes, arterial sclerosis, high blood pressure or cancer, to name a few. According to literature put out by the American Association of Ophthalmology in which they answer the question of the necessity of using drops, the literature answers by stating that it enables the doctor to observe the first signs of eye disease or sometimes the first signs of disease elsewhere in the body. It goes on to say that these drops are especially useful in older people and children and are necessary to test for glaucoma. It closes by saying that these drops are "often the key to the prevention to blindness and even the saving of the eye itself."

It should be clear that <u>both the profession of optometry and the profession of medicine are in agreement on the value of these drops</u> even though there may be a few individuals who feel threatened by passage of this type of legislation.

The issue then stems not from whether these drops are safe or unsafe, good or bad, but on whether an optometrist is sufficiently trained to diagnose eye disease and to use these drugs in a proper manner.

I am certain that you will be told by a few ophthalmologists that only they should be able to use these drugs. They have chosen to ignore our responsibilities and our extensive training in what they refer to as medical subjects. They may tell you that these drugs could have some side affects such as increasing a patient's blood pressure, his heart rate, or result in an allergic reaction.

We do not disagree with the possibility of this happening but wish to point out that these reactions are considered in ophthalmological literature to be extremely rare. I would also like to point out that all optometry

students are being trained in contraindications for the use of these drugs and the bill provides that all practicing O.D.s who wish to use them must return for this additional schooling and re-certification by the State Board of Examiners.

It is also worthy to note that according to ophthalmological literature, one case of angle closure glaucoma will occur in every 18,400 patients whose eyes are dilated in a routine basis. Optometrists who will be dilating eyes, however, are trained to screen out those individuals for whom this procedure could be hazardous.

Along with this extremely minimal risk, however, should be mentioned the great benefits which will result. H.E.W. tells us that in those same 18,400 individuals there will be 329 cases of disease which, if undetected, could cause possible blindness or have other serious consequences. It is also interesting to note that our opponents have chosen not to complain about other professions such as dentistry who have similar training and responsibilities or medical emergencies and yet use stronger injectable drugs.

As stated previously, optometry conducts a great majority of visual examinations: 63% nationwide to possibly as high as 70-75% in Alaska. In my practice alone, there are five optometrists seeing between twenty to sometimes thirty people per day, and there are six to seven other practices in Anchorage just as busy not to mention the rest of the state where ophthalmolical density is even lower than it is in Anchorage. NOTE: Distribution may included.

In 80% of our patients there is little difficulty seeing the back of the pupil, but, in the rest, difficulty in seeing the retina can produce doubt; therefore a referral may be necessary.

On the one hand we are expected to continue to do a most thorough visual examination of our patients and are encouraged by governmental agencies such as H.E.W. to expand our efforts to work with other health care professions in providing wider health care.

On the other hand we are held legally responsible for the detection of pathological conditions but are denied the use of important aids to detect them for the Alaska Optometric Law excludes our employment of valuable tools such as diagnostic agents to aid in the detection of pathologic conditions in the eye.

We ask for relief from that situation.

affiliated with the american optometric association

Oregon Optometric Association

My name is Robert Holcomb, I am a Doctor of Optometry and President of the Oregon Optometric Association. The object of our Association as stated in our constitution is to improve the vision care and health of the public.

Before I get into the Association's reasons for supporting this bill I would like to clear up two areas of confusion. They have to do with the safety of these pharmaceuticals and with an optometrist's training in this area. So that you might have an opportunity to hear and question the top men in these fields, I have asked both the Deans of the College of Optometry Pacific University, Dr. Willard Bleything and the Assistant Dean of the Pharmacy School at Oregon State University, Dr. Ronald Winters, to speak to these points.

You have heard the facts about the relative safety of these drugs and the exstensive training of an Optometrist. I would now like to go into the detail about the two reasons that Optometrists wish to use these drugs. First of all, I am sure that every Doctor of both optometry and medicine would agree that it is in the interest of the public to have their eyes routinely examined for both vision problems and health problems which can be observed within the eye. Ophthalmologists have been saying for years that these drugs are necessary tools for the early detection of disease and for the evaluation of vision problems.

A few of the off hand remarks heard in earlier testimony expressed the opinion that the diagnosis of disease conditions is outside the scope of the practice of optometry. I respect the opinions of these individuals but wish to point out that they are only opinions in direct contrast to the law written as the Optometric Practice Act and interpreted by the highest court in our state, the Oregon Supreme Court. If I may quote from their decision handed down in the case of Sisemore versus Standard Optical "the practice of optometry is undoubtedly one of the subdivisions of the practice of medicine."

The court went on to say "his training enables him to diagnose pathological conditions ... his failure to diagnose pathological conditions with resultant delay or neglect in proper treatment therefore might result in serious impairment of the patients eyesight or even in blindness." The Attorney General has so informed the State Board of Medical Examiners. Despite this opinion of the Optometric Practice Act by the Supreme Court there are a few individuals who insist on issuing their own opinions.

The first reason for this bill then is simply that since Optometrists have the responsibility to detect disease they should have the tools with which to carry it out.

The second reason is that the use of these diagnostic agents would be in the interest of the public. Health Education and Welfare tells us the 63% of all vision examinations in the United States were conducted by O. D. s in 1974. H. E. W.

identifies optometry as an entry point into the health delivery system since we see many patients who routinely get vision examinations — but not physical exams.

The State of Oregon Department of Human Resources tells us that in 1974 85% of all Welfare patients were examined by Optometrists.

Use of these drugs can aid in the early detection of both eye diseases such as retinal tears, glaucoma, cataract formation and in the systemic diseases such as diabetis, arterial sclerosis, high blood pressure or cancer, to name a few. According to literature put out by the American Association of Ophthalmology in which they answer the question of the necessity of using drops, the literature answers by stating that it enables the Doctor to observe the first signs of eye disease or sometimes the first signs of disease elsewhere in the body. It goes on to say that these drops are especially useful in older people and children and are necessary to test for glaucoma. It closes by saying that these drops are "often the key to the prevention to blindness and even the saving of the eye itself."

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individuals there will be 329 cases of disease which if undetected could cause possible blindness or have other serious consequences. It is also interesting to note that our opponents have chosen not to complain about other professions such as dentristry who have similar training and responsibilities for medical emergencies and yet use stronger injectable drugs. If you have any questions we stand ready to answer them.

Robert Holcomb, O.D.
President
Oregon Optometric Association

TESTIMONY

House Bill 2740 Practice of Optometry to include Diagnostic Agents

Willard B. Bleything, O.D., M.S., Dean
Pacific University College of Optometry
Forest Grove, Oregon
April 22, 1975

My name is Willard B. Bleything and I am the Dean of the Pacific University College of Optometry, the only professional institution in the Northwest in the discipline of optometry. In addition to the Bachelor of Science (B.S.) degree I have a Doctor of Optometry degree (O.D.) from Pacific University along with a Master of Science degree (M.S.) in Clinical Optometry. I have been on the faculty of Pacific University and the USAF School of Aviation Medicine, Air University. My experience also includes sixteen years of private practice. Offices held include President of the Oregon Optometric Association, Oregon Board of Optometry (Examiners) and a member of the Professional Development Division, American Optometric Association. I am a Fellow of the American Academy of Optometry.

It is my pleasure to present these remarks on HB 2740. The bill is well constructed, technically sound and is consistent with the well-founded direction that public policy is taking in the other states. Most important of all, it is consistent with the best interests of the public welfare and the ways by which optometry better can serve public need. The legislature of Oregon first caused the profession of optometry to be recognized, licensed and regulated in 1925. The optometry law, much like that in each of the states prescribes the conditions by which a recent graduate from one of the schools and colleges of optometry, following rigorous and well tandardized inquiry by a multi-faceted written and practical board examination, is then licensed to practice

and is regulated in the practice.

Today the curriculum of the thirteen (soon to be fifteen) schools and colleges of optometry consists of an intensive four years of professional collegiate work preceded by a minimum of two years of pre-professional undergraduate collegiate experience. The vast majority of students are entering the optometric colleges with a bachelor's degree. Thus six, and in most instances eight years of university level education and training comprise the very substantial background of the modern optometrist. The number of qualified and acceptable applications for each seat available are better than thirteen to one with outstanding academic and personal credentials.

Our clinical program at Pacific University encompasses care in a variety of social and professional settings including a full scope general and specialty clinic on the main campus and in downtown urban Portland; a general practice clinic in the Albina Action Center and a geriatric-low vision clinic in the Masonic Home, Forest Grove. Students are also exposed to public health optometry in their involvement in visual screening clinics throughout the state serving more than 4,000 citizens annually in this activity alone. Many of these are conducted at the request of County Health Departments and local school districts. Incidentally, I must add that in more than thirty years of clinical operation encompassing hundred of thousands of patient-visits the institution has never experienced a malpractice suit-indeed a remarkable record in the field of health care. More than fifty professionals make up our faculty - all with earned doctorate degrees represent expertise as anatomists, physiologists, microbiologists, neuroanatomists, biochemists, clinical psychologists, optometrists, and ophthalmologists. To follow a general pattern it can be seen that the Ph.D. offers instruction in the basic sciences, the O.D., - Ph.D. combination offers

instruction in the visual sciences, and the O.D. and M.D. offer instruction in the clinical sciences. The optometric student thus gets formal transcript quality university level courses in Human Anatomy, Ocular Anatomy and Physiology, Human Physiology, Microbiology, Neurology, General Pathology and Ocular Pathology and Ocular Pathology Detection and Visual Fields, or a method of examining for and differentiating between various eye disease processes. They also receive a didactic comprehensive course in Pharmacology. All of this material is taught by doctorates in the appropriate disciplines parallel to the same professional positions of any health professions school. In addition to this one of the various specialty clinics during the clinical years is entitled Pathology Detection. Patients suspected of having pathological disorders are referred for consultation to this clinic. Presently this is staffed by a Board Certified Ophthalmologist (M.D.). Patients suspected of having conditions that may benefit from the services of a physician are referred to sources in the community for consultation. For example, over the past years Pacific University Optometric Clinic (Portland) has sent an average of two hundred and fifty patients per year to the Good Samaritan Hospital Devers Eye Clinic for consultation purposes.

During the past generation as optometric education significantly increased its scope of learning and competence with the attendant expansion of all knowledge in the sciences of health care it was recognized that the use of diagnostic pharmaceuticals would add a useful and important opportunity to render more comprehensive visual care services to the public it now serves. In recognition of this newer direction courses for the profession in core areas in the basic sciences were substantially strengthened.

The Bill proposed deserves the support of this legislative body.

1. Optometry is prepared educationally and intellectually to undertake the use of diagnostic pharmaceuticals in the practice of the profession.

2. Passage of the proposed legislation does not advance professional responsibilities of the scope of the license of the optometrist as a vision care practitioner. Rather it offers the public a more rational and intelligent use of the present educational expertise.

3. There is no fiscal implication in this legislation since the methods not the scope of legal responsibility would be advanced.

4. Like our professional counterparts in dentistry and podiatry, two professions outside the discipline of medicine, the use of pharmaceuticals with an appropriate knowledge and educational base have been well established in law and in practice. There is provision in this Bill for additional education. Pacific University College of Optometry stands ready to provide this additional education to the practicing community of optometry.

In looking into the future I close with this comment. Dr. Albert N. Lemoine, a physician, professor and chairman of the Department of Ophthalmology, University of Kansas Medical Center states, "The number of residents in training in ophthalmology programs will be reduced in the near future." He goes on to say,"One year of the optometric students educational experience should be where they can observe patients with disease. Optometry will be recognized as one of the primary care entrances to the eye health care system and especially in rural areas and smaller cities. Optometrists will be able to use topical drugs for diagnostic purposes in all or nearly all states and an increasing number of optometrists will be practicing in the multi-disciplinary setting." Dr. Lemoine goes on to say, and I quote "I realize that many of my

colleagues will not agree with the above position but if we are truly interested in the public welfare this should and can be done."

It seems there is general agreement among the educators in ophthalmology and optometry as to the new trends and mode of practice. We, as an institution, are committed to supplying these educational needs of the future. Legislative assistance is needed to carry out this commitment.

School of Pharmacy

Oregon State University

Corvallis, Oregon 97331 (503) 754-3725

29 January 1975

In studying and evaluating the proposed legislation authorizing the use of diagnostic pharmaceutical agents (DPA's) by optometrists, three principal questions have emerged relative to my areas of expertise as an educator specializing in curricular design and as a pharmacologist: 1) is the overall curricular design utilized by the College of Optometry at Pacific University appropriate for the education and training of optometrists to use DPA's in their practice; 2) is the specific curricular component concerned with pharmacology appropriately constructed; 3) from the perspective of a pharmacologist, is the use of DPA's by optometrists a safe procedure likely to result in an overall improvement in patient care?

In the course of my efforts over the past three years to coordinate the redesign of the professional curriculum of the School of Pharmacy at Oregon State University, I have had considerable occasion to review the curricula of a large number of health profession schools, both in Oregon and elsewhere. Further, as my own graduate training in pharmacology was conducted largely at the University of Oregon Medical School in Portland, I am especially familiar with the curriculum of that institution, with emphasis on the pharmacology component. Finally, I have participated in a number of national and international meetings of professionals concerned with curricular design and implementation in many of the health-related fields. In comparing the curriculum of the College of Optometry at Pacific with the curricula of other health profession

schools utilizing a pharmacological component, I am convinced the approach developed by Pacific is both efficient and effective, and is clearly educationally sound. Moreover, that structure includes what I consider to be the sine qua non of proper instructional design--the competency of the graduate is evaluated in a series of prescribed and standardized formats (i.e., institutional, Oregon State Board of Optometry, and national board examinations) prior to the awarding of a license to practice. Thus, individuals who may have succeeded in passing individual courses but who have not adequately integrated the body of knowledge as a whole are not permitted access to the public as professionals. This safeguard, in my view, is instrumental in protecting the public, the institution, and the profession, and should stimulate your confidence in the proposal at hand.

Examination of the pharmacology component of the curriculum has also led me to a favorable conclusion. It is clear that the student is well-prepared for his first exposure to courses dealing with DPA's and other drugs, and is carried through this portion of his coursework in an effective manner. It is my judgment that a program designed to prepare practitioners to utilize DPA's must rest on a sound didactic base, capped by supervised clinical experience in the use of the agents in question. I feel strongly that a quality didactic base is offered at Pacific, and that passage of the proposed legislation will quickly result in the implementation of an appropriate clinical component as already outlined by the school.

The question of the relative safety and productivity of the proposed procedures must be addressed, and in my view, these two issues cannot be rationally separated; that is, neither safety nor efficacy are unidimensional characteristics, but instead are interrelated as a cost/benefit ratio or in medicine, a therapeutic index. Three important considerations relate to the expected safety in the use of DPA's by optometrists: 1) what agents are to be used; 2) what doses of these agents are to be employed; 3) how will these agents be administered? The four principal

categories of DPA to be used are miotics (agents that constrict the pupil), mydriatics (agents that dilate the pupil), local anesthetics (substances that reduce feeling in the cornea), and cycloplegics (agents that alter the ability of the eye to focus on near objects). The most salient pharmacological feature of these compounds is their relatively short duration of action, generally measured in minutes. If nothing else, this characteristic itself tends to minimize the likelihood of an adverse reaction simply because the drug is effectively inactivated by the body in relatively short order. Secondly, the doses to be utilized in diagnostic procedures are indeed very small. Using one to two drops of solutions of one-half to two and one-half percent strength in each eye provides the patient with a total dose far less than is obtained in many over-the-counter cold remedies readily available to the patient on only his/her discretion. Thirdly, by limiting the administration of these compounds to the topical route (dropped in the eye), it is not likely that more than twenty percent of the total dose will be absorbed into the blood for general circulation in the body. At that concentration level, these agents are essentially devoid of pharmacological activity. When coupled with the virtual absence of reported adverse reactions in states where this practice is common, one cannot help but conclude that the use of DPA's in the format proposed is extremely safe.

How much benefit is to be derived from this practice is, as I've said, the other side of the coin. In my judgment, the judicious use of DPA's will permit a substantial increase in the ability of the optometrist to detect potentially harmful diseases of the eye. By allowing this health-care professional to examine the patient more completely, the optometrist will be in a better position to refer to physicians (ophthamologists, internists, pediatricians, and family practitioners) those patients requiring further diagnosis and possible treatment. In view of the established fact that optometrists serve as the primary eye-care professionals for a majority of the population, it is apparent that the anticipated gain for the patient is large.

It would appear, therefore, that a near optimal situation prevails here: the proposed use of DPA's by optometrists is clearly both very safe and likely to be most effective in patient eye care. Further, it is evident that considerable planning has been conducted by the College of Optometry at Pacific, and that the school is ready, capable, and indeed has already begun providing educationally sound classroom instruction in the use of diagnostic pharmaceutical agents, with implementation of actual clinical instruction awaiting legislative approval. Thus, with the cost/benefit or therapeutic ratio a very favorable one to all parties concerned, I respectfully encourage the swift passage of the proposed legislation.

Ronald H. Winters, Ph.D.
Assistant Dean
Associate Professor of
Pharmacology and Toxicology

THE USES OF TOPICAL EYE EXAMINATION DRUGS BY OPTOMETRISTS[1]

Darrell B. Carter, O.D., Ph.D.
Clinical Professor of Optometry
School of Optometry, University of California

Introduction

Eye examination drugs (topical anesthetics, mydriatics, miotics, and cycloplegics) are used by optometrists to facilitate the examination of patients' eyes for the possible presence of disease conditions or to aid in determining the refractive error of the eye. These drugs are for examination purposes only and are not for treatment.

Until about 1960, only a few optometrists in the United States used examination drugs as part of their examination procedure. Optometrists in England have used these drugs for over 25 years.

During the period of 1960 to the present time (1974), some optometrists have started to use these drugs whenever it is in the patients' benefit to do so. However, in only eight states (as of July 1974) are optometrists specifically authorized to use these drugs by either legislative act or by a ruling of the attorney general of the state.

At present, efforts are being made by optometrists in many states to secure legislative authorization of the use of these drugs for examination purposes only. The recent efforts by optometrists in the United States, Australia, Canada, and elsewhere to obtain legislative authorization for the use of examination drugs is not an attempt to enter into the field of therapy for ocular disease.

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[1]This paper was prepared to present to members of state legislatures and to other interested persons the reasons why optometrists desire legislative authorization for the use of ocular examination drugs.

Optometrists recognize the desirability of limiting the scope of their practice to the correction of refractive errors of the eye and anomalies of binocular vision. The use of examination drugs is for the purpose of allowing more effective and earlier discovery of eye disease when such disease exists. Patients with the possible presence of eye disease or general disease are referred to an ophthalmologist or other physician for medical evaluation and care. In this way, the most efficient use of the skills of both optometrists and ophthalmologists is obtained.

Topical Anesthetics

Topical anesthetics are used primarily by optometrists to facilitate tonometry in evaluation of the eye for the possible presence of glaucoma. While tonometry can be done without anesthesia of the cornea, it is usually more accurate when done with anesthesia. Moreover, the most accurate tonometer, the Goldmann applanation tonometer, requires anesthesia of the cornea.

Some ophthalmologists have objected to the use of corneal anesthesia by optometrists. This objection is based on the assertion that these drugs can cause fatal heart or respiratory stoppage. Anesthetics are dangerous when injected.. The death rate in eye surgery by ophthalmologists is apparently about one in every 2000 to 5000 operations. While local injection into tissue is necessary in eye surgery by ophthalmologists, only topical (dropped on the surface) use of anesthetics is employed by optometrists. There are no reports of fatal reactions from eye topical anesthetics.[2]

There are three topical corneal anesthetic agents used by optometrists: tetracaine (trade name, Pontocaine), proparacaine (Ophthaine), and benoxinate (Dorsacaine). None of these three drugs are used for local injection anesthesia

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[2] The real objection of ophthalmologists to the use by optometrists of pharmaceutical agents, including topical anesthetics, arises from economic and prestige reasons. Unfortunately, in the United States, strong economic rivalry over the examination of eyes for glasses and contact lenses have often resulted in economic and prestige considerations playing a major role in the attitudes of many members of both groups

These drugs are toxic and are dangerous if absorbed by the body in large quantities as could happen if these drugs were used topically on the throat. For example, 5 ml. of a 2% solution of tetracaine (the most toxic of the three drugs) is considered to be a potentially lethal dose if completely absorbed.[3] However, it should be understood that 5 ml. is 100 drops and that the strength used by optometrists is 0.5%. Thus, in using one drop of a 0.5% solution in each eye, the optometrist is using 1/200 of the potential lethal dosage. Moreover, drugs placed on the normal eye are very poorly absorbed (approximately one-fifth) into the blood stream. In topical use on the eye, the optometrist thus is using only 1/1000 of the potential lethal dosage. This is a wide safety margin.

Proparacaine and benoxinate are less toxic than tetracaine. According to James R. Householder, M.D., and John E. Harris, M.D.,[4] these drugs are safe for topical application to the eye. On Ophthaine, these authors state "there have been no reported systemic toxic reactions in amounts used for topical anesthesia for the eye." However, "the chemical structure would predict such reactions if large amounts were to be applied to a vascular area such as the upper respiratory tract," (page 100). On Dorsacaine, these two authors state "there has been no reported systemic toxic effects from its use in 1 cc. amounts," (page 99). One cc. is 10 times the dosage that is used by the optometrist in preparation for tonometry.

According to William Havener, M.D.[5] fatal reactions "occur from ignorant use of excessive quantities of anesthetic" (page 47). These rare reactions

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[3] William Havener, M.D. Ocular Pharmacology, Mosby 1970.

[4] In Ocular Therapy, Mosby 1966. Edited by Irving Leopold, M.D.

[5] William Havener, M.D. Ocular Pharmacology, Mosby 1970

have occurred following anesthesia of the throat for throat or lung examination, or from injection of an anesthetic. Havener states "since generalized reactions to the topical application of anesthetic solutions are due to systemic absorption of excessive quantities of drug, such reactions are virtually nonexistent after topical ocular anesthesia," (page 47).

In England, optometrists have been using corneal anesthesia for over twenty-five years. No report of any fatality from ocular anesthesia by optometrists has been received by the British Ministry of Health during this entire period.

On rare occasions, patients faint because of apprehension of something being placed on the eye. Such fainting (syncope), has been mistaken for a toxic reaction. However, the patient quickly regains consciousness. In summary, the use by optometrists of anesthetics applied topically to the eye is an entirely safe procedure. Such use by optometrists will result in the saving of the eyesight of patients by allowing early detection of glaucoma.

Mydriatics and Miotics

Drugs which dilate the pupil are called mydriatics. The common mydriatic drugs are phenylephrine (Neosynephrine), hydroxyamphetamine (Paradrine), and tropicamide (Mydriacyl). The use of these drugs is to facilitate the ophthalmoscopic examination of the inside of the eye for pathological changes. Miotic drugs are used to shrink the pupil following the use of a mydriatic drug. The only miotic used by optometrists is pilocarpine.

Mydriatic drugs can produce an attack of angle-closure glaucoma (a special type of glaucoma) in a person with anatomical predilection. Before the use of mydriatic drugs, the eye should be examined with a biomicroscope for the presence of a narrowed angle, an anatomical abnormality. About two or three persons in 100 of those who are over 50 years of age have an anatomical narrowe angle such that they could have an attack of angle-closure glaucoma under

adverse conditions.[6] This two percent can be detected by prior examination and mydriatics should be avoided or used only under controlled conditions.

The actual incidence of angle-closure glaucoma is approximately 1 in 1000 (4 in 4123) persons in the general population over the age of 50, according to the careful study of Hollows and Graham.[7] The low incidence of actual angle-closure glaucoma compared with those who have narrow angles, 2 or 3 in 100, shows that the vast majority of individuals with a narrowed angle go through life without developing an actual attack, and thus do not suffer from their narrow angle.

Some ophthalmologists do not examine the eyes of patients for the presence of a narrowed angle prior to routine use of mydriatic drugs. The drug is instilled by a nurse prior to the patient seeing the ophthalmologist. This routine is justified on the basis that if a mydriatic drug will trigger an attack of angle-closure glaucoma, the patient is almost ready to experience an attack even without the mydriatic drug. The argument is made that it is better to trigger an attack while the patient is in a professional office and treatment for the attack can be quickly instituted. These ophthalmologists consider this to be a useful provocative test.

It has been estimated by S.V. Abraham, M.D.[8] that the use of a strong mydriatic - atropine or homatropine - (stronger than those used by optometrists) without prior examination for the presence of a narrowed angle would result in a glaucoma reaction in one in 4600 patients over the age of 30 and much less often for patients under 30 years of age. The incidence of glaucoma reaction

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[6] Van Herick, Shaffer and Schwartz. American Journal of Ophthalmology, October 1969.

[7] F. C. Hollows and P. A. Graham. Intra-ocular pressure, glaucoma, and glaucoma suspects in a defined population. British Journal of Ophthalmology, pp. 570-586, 1966.

[8] S. V. Abraham, M.D. Mydriatic glaucoma. Archives of Ophthalmology, pp. 757-762, 1933.

is further reduced when mild mydriatics are used and when a miotic is used following the use of a mydriatic. While the author of this paper does not believe that optometrists should ever use mydriatic drugs without prior biomicroscopy study of the angle of the eye, it is obvious that adverse reactions are rare even without the precaution of prior examination of the eye.

It is possible, although quite rare, for an attack of angle-closure glaucoma to occur after use of a mydriatic drug even with prior screening by the optometrist for narrow angles. In these rare cases an optometrist will send the patient for medical care. The patient will have had the advantage of having his attack under conditions where medical care is available. In optometric use of mydriatics, with prior evaluation of the anterior angle and with use of the milder mydriatics, a glaucoma reaction can be expected no more than once in every 15,000 to 25,000 patients over 30 years of age. These attacks will only occur in persons who are in great danger of such an attack even without the use of the mydriatic drug. Discovery of the potentiality of angle-closure glaucoma will help save the vision of these patients.

The author strongly supports the use of mydriatic drugs by optometrists. The use of mydriatic drugs will enable earlier detection of retinal disease conditions. Such earlier detection will result in the saving of vision or even life. The potential of earlier detection of disease by the use of mydriatic drugs far outweights the very rare situation of a glaucoma reaction.

Cycloplegics

Cycloplegic drugs temporarily paralyze the accommodative mechanism of the eye and thus facilitate measurement of refractive error with some patients, chiefly children less than seven or eight years old. Rarely is the use of a cycloplegic desirable with an adult patient.

The only cycloplegic drug used by optometrists is the 1% solution of Cyclopentolate (Cyclogyl). There have been no reported serious side-effects

with the use of this drug. From its low toxicity, none would be expected. There have been a few literature reports of temporary (up to four hours) of faulty orientation and hallucinations in children following use of several drops of the 2% solution of cyclopentolate or repeated usage on several days of the 1% solution.[9] These temporary psychological disturbances have not been reported to occur with the use of one or two drops per eye of the 1% solution - the mode of usage by optometrists.

Summary

(1) The most efficient use of the skills of optometrists in supplying visi care will be obtained by the use of examination drugs by optometrists.

(2) Use of examination drugs by optometrists will allow earlier detection of eye disease and the saving of vision or even life.

(3) The use of drugs by optometrists is for facilitation of examination and not for treatment purposes.

(4) Patients with the possible presence of eye or general disease are referred by optometrists for medical evaluation and care.

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[9] William Havener, M.D. Ocular Pharmacology, Mosby 1970, page 198.

HOUSE BILL #79

QUESTIONS AND ANSWERS ON THE OPTOMETRY BILL

1. Why was the "Diagnostic Agents" Bill introduced?

   a. In Oregon, May 12, 1964 (Attorney General Opinion No. 5807), the Attorney General said that an optometrist "has a duty to determine whether his patient is afflicted with an abnormal or pathological condition of the eye." (Reference to Supreme Court Case: State ex rel. Sisemore v. Standard Optical, 182 Or. 452.)

   b. In malpractice lawsuits throughout the nation, optometrists have been charged with the responsibility of eye disease detection.

   c. In 1971, the HEW Secretary Elliot Richardson said "Optometrists are trained to detect any departure from the optimally health eye. The scope of optometric services has expanded beyond basic clinical refractions."

   Optometry has been charged with the responsibility of a primary entry point to health care. This bill will increase the examination capabilities to allow better eye or systemic pathology detection for referral for medical diagnosis and treatment.

2. What is the current role of the optometrist in patient care?

   The optometrist is the general practitioner in the field of vision care. His emphasis is on the functional aspects of vision--the ability of a child to learn or a person to function optimally in his occupation or environment. However, in examining a patient he also makes a comprehensive internal and external examination of the eyes to detect evidence of eye or systemic diseases revealed through the eye for referral for medical diagnosis and treatment. This latter feature is particularly important to the many persons who due to various factors do not routinely seek medical care.

3. What is the experience of other states in the use of diagnostic agents by doctors of optometry?

   Since HEW Secretary Richardsons' statement, Rhode Island, Pennsylvania, Oregon, and twenty other states have enacted positive legislation. Other states which previously had no prohibitive laws and thus allow for the usage of diagnostic agents include: Florida, Idaho, Indiana, Minnesota, Nevada, and New Jersey.

New Jersey optometrists have had the right to use these agents since 1919. In that state "there have been no cases reported regarding any problems caused by optometrists using any of the diagnostic drugs." On the contrary, this report states "the use of diagnostic drugs by optometrists is definitely in the public interest."

4. What is the experience of the Armed Forces in the area of diagnostic agents used by optometrists?

All three branches of the military, either in the regulations or at local hospital options, require or allow optometric commissioned officers to utilize diagnostic agents to aid them in their examinations or aid or consult with other commissioned health professionals. In the critically important visual examinations of aviators, diagnostic agents have been widely utilized by optometrists.

5. What is the current educational background of an optometrist?

Alaskan optometrists presently receive eight years education in order to receive a doctor of optometry (O.D.) degree.

4 years undergraduate education
(Some applicants are admitted with a minimum of two years undergraduate.)
4 years professional optometric education
8 years total

Today's optometric education includes such scientific studies as: optics, pharmacology, disease processes, disease detection, microbiology, zoology, neurology, physics, physiology, anatomy, psychology and public health.

6. How do practicing optometrists keep up with advances?

To assure that optometrists who are currently in practice are kept abreast of new developments and techniques, the Alaska Board of Examiners in Optometry requires a minimum of twenty-four hours of continuing education every two years. The quality and certification of these courses is controlled by the state Board.

7. Are optometrists educated in the use of pharmaceutical agents for ocular examinations, including adverse reactions?

Yes. Pacific University, College of Optometry, in Forest Grove, Oregon, educates its students in pharmacology. Adverse reactions are covered in the courses which are taught by qualified experts. In addition, an important portion of the four-year professional curriculum covers pathology and related subjects.

8. Under this bill, would every optometrist be able to use diagnostic agents in eye examinations?

No. There would be no "grandfather" clause. Only those optometrists currently in practice who fulfill educational requirements set by the Board of Examiners in Optometry would be able to use such diagnostic agents.

9. Under this bill, what limited types of diagnostic agents would optometrists be able to use?

Only topically applied (placed on the eye, like "eye drops") diagnostic agents could be used for examination purposes. Other agents such as for treatment purposes could not be used.

Generically, these diagnostic agents would be limited to: dyes, anesthetics, mydriatics, miotics, and cycloplegics.

10. Will this bill permit an optometrist to make a definitive medical diagnosis?

No. The optometrist would retain his professional responsibility to recognize any abnormalities of a pathological nature, make a tentative diagnosis, and then refer the patient for definitive medical diagnosis and treatment.

11. What about adverse reactions to diagnostic agents?

According to medical literature, the possibility of adverse reaction on persons to whom these topical diagnostic agents are applied is considered rare or virtually non-existant. However, should a reaction occur, a physician would be consulted.

12. How often would an optometrist use diagnostic agents in examinations?

These agents would not be used routinely but only in those instances when considered appropriate in the examination for possible visual or pathological defects.

13. Do practitioners other than physicians use diagnostic agents?

Yes. Dentists and podiatrists not only use pharmaceutical agents for diagnostic purposes, but for treatment purposes as well. It may be worthwhile noting that the optometrists' educational foundation regarding pharmacology is comparable to the pharmacology background received by both dentists and podiatrists.

Some Points Relative to the Use of Drugs by Optometrists

by: Leonard Levine, PhD.
Professor
College of Optometry
Pacific University, Oregon

Dr. Levine has received numerous grants to research the chemistry and physiology of diseases such as Muscular Dystrophy. He is highly respected as a professor as well as researcher in the areas of physiology and neurophysiology. In order to be effective as such, a special understanding of pharmacology is inherent.

He makes a number of important points relative to the use of drugs by optometrists.

SOME POINTS RELATIVE TO THE USE OF DRUGS BY OPTOMETRISTS

Leonard Levine, PhD.

A. Optometrists have been using "drugs" both diagnostically and therapeutically for some time.

1. Optometrists routinely use a corneal dye, fluoroscein, as an aid to facilitate contact lens fitting. This is a substance not normally found in the body, hence a pharmaceutical agent, and its widespread use means that optometrists have already been involved with diagnostic pharmaceutical agents (DPA's).

2. Flexible contact lenses are classified as drugs by the Food and Drug Administration (FDA). Since optometrists fit these lenses, technically they are applying drugs to the eye for <u>therapeutic</u> purposes.

   a. Optometrists may also use flexible contact lenses for diagnostic purposes, as part of a gonioscopic procedure concerned with measurement of the internal angle of the eye.

3. Thus the question is not really the qualitative one of whether or not optometrists are to be allowed to use drugs, but rather the quantitative one relating to which and how much.

B. The public may now buy without prescription, examples of the types of drugs which optometrists wish to be allowed to use.

1. There are a number of ophthalmic preparations which are available to the lay public without prescription <u>ad libitum</u>, for treatment of certain ocular conditions, so-called "over-the-counter" (OTC) drugs. There are also a large number of other preparations for treatment of non-ocular conditions (such as allergies, colds, coughs, insomnia, motion sickness, and surface pain) which the public may buy in unlimited amounts without prescription. These preparations are usually intended for systemic administration, and contain one or more active ingredients which affect the ocular structures and/or vision.

2. The active ingredients of these OTC preparations include examples of all of the types of drug classes which optometrists wish to be allowed to use in a controlled manner for specific diagnostic purposes. The only exception is the drug class which causes the pupil to constrict, and optometrists would use this type only in a limited and specialized way.

C. The classes of DPA's which optometrists wish to use are:

1. Corneal dyes: Fluoroscein is an inocuous, non-prescription drug already used by optometrists in contact lens practice.

2. Local anesthetics: Optometrists wish to be able to use these kinds of drugs to permit them to check intraocular pressure in glaucoma screening, to measure the internal angle of the eye with a gonioscope as part of the check on the possibility of "narrow-angle" glaucoma, and in exceptional cases as an adjunct to contact lens practice. The purpose of the local anesthetic is to eliminate the corneal blink reflex for a few minutes while the diagnostic procedure is performed, and not for the elimination of pain per se, since none of the procedures employed by the optometrist is inherently painful. Optometrists wish to be able to use relatively few local anesthetics of very low risk, to be applied directly to the eye in the form of eyedrops, in a controlled fashion and with observance of any needed precautions to insure their patients' safety. Preferred agents are proparacaine and benoxinate.

   At least one OTC ophthalmic preparation (M-Z eyedrops, Tilden Yates) is available to the public without prescription which contains a concentration of a local anesthetic, piperocaine, which is approximately that sought by optometrists.

3. Mydriatic agents: Optometrists wish to use such drugs to cause the pupils of certain patients to dilate so that the interior of the eye may be examined with special instruments such as the opthalmoscope and the biomicroscope. Such diagnostic examinations are important in cases of cataract, glaucoma, and vision-threatening conditions of the

retina. But they are also important with respect to diagnosis and prognosis of systemic conditions such as diabetes mellitus and arterial hypertension.

Technically there are two classes of drugs which dilate the pupil by different mechanisms. The simpler of these acts directly on the dilating muscle, while the other acts by inhibiting the constricting muscle.

Optometrists need to be able to use drugs belonging to both catagories because the simpler drug type will not work satisfactorily in subjects with very dark eyes. The drug of choice in the first category is phenylephrine, an agent found in low concentration in many OTC ophthalmic preparations. It is also available without prescription in many non-ophthalmic preparations, in concentrations as high as 1% (NeoSynephrine nose drops, Winthrop), which is approximately the level at which optometrists wish to use it.

The other type of drug which optometrists wish to use for causing the pupil to dilate includes the specific agents, cyclopentolate and tropicamide. Both of these are synthetic products developed specifically for the purpose for which optometrists wish to use them, and are much safer and preferred to several naturally occuring substances, which have been widely used by ophthalmologists in the past. It should be noted that these latter, more dangerous drugs are all available to the public without prescription in OTC cough medicines and sleeping aids.

Thus optometrists seek only to use drugs of the types already on the market to the lay public without prescription, and to employ them in a controlled manner for specific diagnostic tests, entailing a minimum of risk to their patients.

4. Miotic Agents: The only other type of drug which optometrists wish to use is one which constricts the pupil. Drugs of this type would be used only to reverse the effect caused by a dilating drug following the diagnostic examination, in select patients. These are the limited number of patients in whom it is not desirable to allow the pupil to remain dilated for the several hours needed for the dilating drug to wear off.

The pupil contricting drugs which optometrists wish to use are physostigmine and pilocarpine. Both drugs have been widely in use as ophthalmic products for over 100 years, and are of low toxicity and high safety margin, especially in the way in which optometrists will use them.

D. British optometrists, whose professional training is on a lower level and less thorough than that of their counterparts in the U.S., have had legal entitlement to use all of the drugs sought here (and more) for many years, and have used them with intelligence and skill, the only effect on their patients being improved vision care.

STATUTORY AND JUDICIAL ASPECTS

1. House Bill #79

   This bill would re-define A.S. 08.72.300(2) "OPTOMETRY" and (3) "PRACTICING OPTOMETRY".

   Addition of a new A.S. § 08.72.305 "USE OF DRUGS FOR DIAGNOSIS".

   A.S. 17.15 § 3 is amended by adding to Article 1, § 27.25.055 "SALES TO OPTOMETRISTS".

2. Complete Alaska Revised Statutes

3. Supreme Court of Oregon, 1947

   State ex rel. Sisemore v. Standard Optical Co., 181 Or. 452-467

   The following are some points made in this case:

   a. An optical company cannot employ an optometrist because this interfers with the optometrists' trusted and fiduciary relationship with his patient.

   b. Optometry must be classified a true "profession" and not a "trade".

      ". . . an optometrists' . . . training enables him to diagnose pathological conditions . . . The fact that he is trained to diagnose pathological conditions in itself indicates that the optometrist is not a mere skilled craftsman or mechanic."

   (The entire Supreme Court case may be obtained upon request.)

4. Civil Action No. F 76-35 Civ., December 7, 1977

   Ferdinand v. Board of Dispensing Opticians (pages 104-105) defines "routine visual examination" as given by optometrists. The extensiveness the optometrist must examine for eye pathology is expressed.

   d. External Examination (lids, cornea, sclera, etc.)

   e. Internal Ophthomoscopic Examination (media, fundus, etc.)

   f. Ocular motility

g. Neurological integrity

k. Confrontation fields

l. Tonometry

5. Diagnostic Drugs Terminology Clarification from Oregon Law

a. Oregon Attorney General Opinion (1964) No. 5807 clarification regarding the term: DIAGNOSIS.

This Oregon Attorney General Opinion states that the "Practice of Optometry" includes pathology diagnosis.

In addition, Oregon Statutes governing the practice of medicine do not prevent diagnosis by optometrists after reference to the 1947 Supreme Court case (State ex rel. Sisemore v. Standard Optical Co., 181 Or. 452), Attorney General Thornton says:

> ". . . an optometrist, as a part of his services . . . has a duty to use his professional training, skill and knowledge, while he is performing his primary function, to determine whether his patient is afflicted with an abnormal or pathological condition of the eye . . ."

b. Alaska Statutes Clarification regarding the term: DRUGS.

The inclusion into the Optometry Statutes the terms: diagnostic agents, diagnostic drugs, or diagnostic pharmaceutical agents does not conflict with Chapter 64, Medicine. (Section 08.64.380 Definitions):

(2) "Practice of medicine" or "practice of osteopathy" means:

(D) for a fee prescribing, directing or recommending for the use of a person, a drug or medicine for the treatment, cure or relief of a disease, infirmity, bodily injury or defect, . . .

Diagnostic drugs are not mentioned in the practice of medicine. Only drugs or medicine for treatment are spoken to.

c. A.S. 17.15 § 3 addition to Article 1 "Sales to Optometrists" § 17.15.055.

Chapter 15, Drugs, is included to show how the addition of the amendment is necessary under Alaskan law.

6. Report from the Secretary of the Department of Health, Education and Welfare (HEW), 1971

This report concerns itself with the optometrists' responsibilities for disease detection.

Introduced: 1/24/79
Referred: Health, Education & Social Services and Judiciary

BY MARTIN, MCKINNON, MEEKINS, MILLER AND PARR

IN THE HOUSE

CS for HOUSE BILL NO. 79

IN THE LEGISLATURE OF THE STATE OF ALASKA

ELEVENTH LEGISLATURE - FIRST SESSION

A BILL

For an Act entitled: "An Act relating to the practice of optometry."

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

* Section 1. AS 08.72.300(2) and (3) are amended to read:

(2) "optometry" is the employment of means or methods [, OTHER THAN THE USE OF DRUGS,] for the diagnosis of an optical deficiency or deformity, visual or muscular anomaly of the human eye, or the prescription or application of lenses, prisms or ocular exercises for the correction or relief of the human eye;

(3) "practicing optometry" means the diagnosis [, BY MEANS OR METHODS OTHER THAN THE USE OF DRUGS,] of an optical deficiency or deformity, visual or muscular anomaly of the human eye, or the prescription of lenses, prisms or ocular exercises for the correction or relief of the human eye, or the holding of oneself out as being able to do so;

* Sec. 2. AS 08.72 is amended by adding a new section to read:

Sec. 08.72.305. USE OF DRUGS FOR DIAGNOSIS. (a) No person practicing optometry may use drugs for diagnostic purposes unless he has

(1) passed the board's examination on the subject of pharmacology as it relates to optometry and the use of topically applied drugs; and

(2) completed courses and clinical experience approved by the board and offered by a recognized and accredited school or college of optometry and passed an examination, given by that school or college, which relates to topical application of drugs to the eye, including proper responses to reactions which may result from topical applications

of drugs to the eye.

(b) No person practicing optometry may administer drugs except for recognition of pathology and diagnosis of a vision anomaly.

(c) Topical anesthetics, mydriatics, miotics and cycloplegics may be used by a person practicing optometry under conditions approved by the board.

* Sec. 3. AS 17.15 is amended by adding a new section to Article 1 to read:

Sec. 17.15.055. SALES TO OPTOMETRISTS. A person licensed to practice optometry under AS 08.72 who has been authorized by the Board of Examiners in Optometry to use topically applied drugs under AS 08.72.305 may purchase topical anesthetics, mydriatics, miotics and cycloplegics.

ALASKA REVISED STATUTES

STATE OF ALASKA

BOARD OF EXAMINERS IN OPTOMETRY

OPTOMETRY STATUTE, AS 08.72.

OPTOMETRY REGULATIONS, 12 AAC 48.

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Department of Commerce and Economic Development

Division of Occupational Licensing

Pouch D

Juneau, Alaska 99811

CHAPTER 72. OPTOMETRY LAW.

Article
1. Board of Examiners in Optometry (secs 08.72.010-08.72.100)
2. Licensing and Registration (secs 08.72.110-08.72.270)
3. Unlawful Acts (secs 08.72.275-08.72.290)
4. General Provisions (secs 08.72.300-08.72.310)

Article. 1. Board of Examiners in Optometry

Section
10. Creation of board of examiners
20. Membership of board and terms of office
30. Source of appointments
40. Qualifications
50. Power of board to adopt rules and regulations
60. Miscellaneous powers and duties of board
70. Applicability of Administrative Procedure Act
80. [Repealed]
90. Record of proceedings
100. [Repealed]

Sec. 08.72.010. Creation of board of examiners. There is created the Board of Examiners in Optometry. (sec 35-3-132 ACLA 1949)

Am. Jur., ALR and C.J.S. references.-41 Am. Jur., Physicians and Surgeons, sec 28.

Optometrist within statute relating to practice of medicine, 22 ALR 1173.

Constitutionality of stature prescribing conditions of practicing medicine as affected by discrimination against or in favor of optometrists, 37 ALR 682.

Constitutionality of statutes and validity of regulations relating to optometry, 98 ALR 905; 22 ALR2d 939.

Right of corporation, or individual not himself licensed, to practice optometry through licensed employee, 102 ALR 343; 128 ALR 585.

One who fills prescription under reciprocal arrangement with optometrist, as subject to charge of practice of optometry without license, 121 ALR 1455.

What constitutes practice of "optometry," 141 ALR 883.

70 C.J.S. Physicians and Surgeons secs 1, 3, 5, 6, 8, 10, 12.

Sec. 08.72.020. Membership of board and terms of office. The board consists of three persons, appointed by the governor. The term of each member is three years. One member only is appointed each year, except when vacancies for unexpired terms are filled. (sec 35-3-132 ACLA 1949)

Sec. 08.72.030. Source of appointments. The governor shall fill vacancies on the board by appointment for the unexpired term. (sec 35-3-132 ACLA 1949)

Sec. 08.72.040. Qualifications. A board member shall be a licensed, practicing optometrist residing in the state who has been a resident for at least three years. (sec 35-3-132 ACLA 1949)

Sec. 08.72.050. Power of board to adopt rules and regulations. The board shall adopt rules and regulations

(1) necessary for the proper performance of its duties;
(2) governing the applicants and applications for licensing;
(3) for the registration of optometrists;
(4) necessary to govern the practice of optometry. (sec 35-3-133 ACLA 1949)

Chapter contains sole powers of board.-The board, being purely a creature of the legislature, has no powers other than those contained in this chapter. Edmunds v. Board of Examiners in Optometry, 9 Alaska 462, aff'd, 9 Alaska 627, 106 P.2d 904 (1939).

And must be strictly construed.-This chapter and the powers invested in the board are to be stricly construed. Edmunds v. Board of Examiners in Optometry, 9 Alaska 462, aff'd, 9 Alaska 627, 106 P.2d 904 (1939)

Sec. 08.72.060. Miscellaneous powers and duties of board. (a) The board or a member designated by the board, may issue subpoenas, administer oaths and take testimony concerning any matter within its jurisdiction.

(b) The board may adopt a seal.

(c) The board shall elect a president and secretary from among its members.

(d) Repealed by sec 3 ch 59 SLA 1966.

(e) The board may define professional conduct and adopt rules of professional conduct.

(f) Repealed by sec 3 ch 59 SLA 1966. (secs 35-3-133, 35-3-140 ACLA 1949;am sec 3 ch 59 SLA 1966)

Effect of amendment.-The 1966 amendment repealed subsections (d) and (f).

Sec. 08.72.070. Applicability of Administrative Procedure Act. The board shall comply with the Administrative Procedure Act (AS 44.62).

Sec. 08.72.080. Compensation of board and secretary. Repealed by sec 3 ch 59 SLA 1966.

Sec. 08.72.090. Record of proceedings. The Department of Commerce shall keep a record of all proceedings including the name of each applicant for examination and registration. These records shall be open for public inspection. (sec 35-3-133 ACLA 1949;am ch 76 sec 1 SLA 1969)

Sec. 08.72.100. Bond of Secretary. Repealed by sec 3 ch 59 SLA 1966

Article 2. Licensing and Registration.

Section	Section
110. License required	191. Fees
120. Registration	200. [Repealed]
125. Registration of branch office	210. [Repealed]
130. Optometry register	220. [Repealed]
140. Qualifications for examination	230. Fees and disbursements
150. Application for and issuance of certificate	240. Revocation of registration certificate or exemption
160. Examination	250. Board action on revocation and renewal
170. Issuance of certificate by waiver of written examination	260. Revocation of license by court
180. [Repealed]	270. Practice not at place of business
190 [Repealed]	

Sec. 08.72.110. License required. No person not licensed as an optometrist may fit, sell, or dispose of or take, receive or solicit an order for fitting, sale or disposition of spectacles, eyeglasses or lenses for the correction or relief of an optical or visual defect of the human eye or sell spectacles, eyeglasses or lenses from house to house, or in the streets or highways. This chapter does not apply to the sale of toy glasses, goggles consisting of plano-white or plano-colored lenses or ordinary colored glasses, or complete ready-made spectacles and eyeglasses sold only as merchandise, or the sale or repair of eyeglass frames, or repair or replacement of lenses without pretense of adapting them to the eyes (sec 35-3-134 ACLA 1949)

Sec. 08.72.120. Registration. It is unlawful for a person to practice, or attempt, or offer to practice, optometry without first obtaining a certificate of registration from the board, and without filing the certificate with the clerk of the superior court in each judicial district in which he practices. (sec 35-3-135 ACLA 1949)

C.J.S. reference.-70 C.J.S. Physicians and Surgeons sec 10.

Sec. 08.72.125. Registration of branch offices. (a) The board may issue to an Alaskan licensee who maintains a full-time practice in the state but who serves other communities in the state on a part-time basis a branch office certificate of registration.

(b) It is unlawful for a person to practice, attempt or offer to practice, optometry in communities on a part-time basis without obtaining a branch office certificate of registration from the board, and without filing the certificate with the clerk of the superior court in each judicial district in which he maintains a branch office. The board shall prescribe in the regulations the factors to be considered in issuing a branch

office certificate of registration. (ch 76 sec 2 SLA 1969)

Sec. 08.72.130. Optometry register. The clerk of the superior court in each judicial district shall keep a record known as the "Optometry Register" and record the certificate of registration of each optometrist who files his certificate. The clerk shall charge the regular filing fee for registration. When an optometrist dies, or when his certificate is suspended or revoked, the clerk shall note that fact on the record. (sec 35-3-147 ACLA 1949)

Sec. 08.72.140. Qualifications for examination. The board shall admit to the examination a person who furnishes proof that

(1) Repealed (ch 76 sec 3 SLA 1969)

(2) he has normal color perceptions and a visual acuity of a standard of at least 20/40 in at least one eye as corrected;

(3) he is not afflicted with a contagious or infectious disease;

(4) he has had education equivalent to four years attendance at a state high school;

(5) he is a graduate of a recognized school or college of optometry;

(6) he is of good moral character. (sec 35-3-141 ACLA 1949; am sec 1 ch 95 SLA 1966; repealed (1) ch 76 sec 3 SLA 1969; am (2) ch 76 sec 4 SLA 1969; added (6) ch 76 sec 5 SLA 1969)

Effect of amendment.-The 1966 amendment substituted "is a graduate of recognized" for "has had professional training in optometry of not less than 2,000 hours in attendance at a reputable" in paragraph (5) and deleted former paragraph (6), which required a certificate of registration in the basic sciences.

Cited in Edmunds v. Board of Examiners in Optometry, 9 Alaska 627, 106 F.2d 904 (1939)

C.J.S. references.-53 C.J.S. Licenses sec 34; 70 C.J.S. Physicians and Surgeons sec 12.

Sec. 08.72.150. Application for examination and issuance of certificate. An applicant shall apply for the examination by filing an application with the department together with the examination fee at least 15 days before the examination. Upon successful completion of the examination by the applicant and payment of the fee, the board shall issue a certificate of registration as a licensed optometrist to the applicant. After the applicant has properly filed his certificate of registration he may practice optometry in the state. (sec 35-3-141 ACLA 1949;am ch 76 sec 6 SLA 1969)

Sec. 08.72.160. Examination. (a) The examination shall be written, practical, and oral in nature. The oral portion of the examination shall be recorded and retained for two years.

(b) An applicant who fails the practical or the oral portion of the examination may take a re-examination in that portion without paying an additional examination fee.

(c) An applicant who fails the written portion of the exam-

ination may take a re-examination in the written portion upon payment of an additional examination fee.

(d) An applicant who fails more than one portion of the examination must retake the entire examination and pay the full examination fee. (sec 35-3-141 ACLA 1949;am ch 76 sec 7 SLA 1969)

Sec. 08.72.170. Issuance of certificate by waiver of written examination. (a) The board may waive the written portion of the examination requirement to an applicant who:

(1) meets the qualifications of sec. 140 of this chapter;

(2) holds a current license by examination in another state, territory or foreign country and has been established in ethical optometric practice for at least three years before the application, or shows satisfactory evidence of having passed the written portion of the examination given by the National Board of Examiners in Optometry; and

(3) has not had a certificate or license revoked for cause in any state, territory or foreign country.

(b) No waiver of the practical or oral portions of the examinations may be given. (sec 35-3-142 ACLA 1949; repealed and enacted ch 76 sec 8 SLA 1969)

Cited in Edmunds v. Board of Examiners in Optometry, 9 Alaska 627, 106 F.2d 904 (1939).

Sec. 08.72.180. Annual renewal of license. Repealed by sec 7 ch 94 SLA 1968.

Sec. 08.72.181. Renewal of license and application. (a) To remain in force a license must be renewed biennially.

(b) An optometrist licensed in this state and serving in the military service of the United States, while in the discharge of his official duties, may maintain his eligibility to practice in this state without paying a renewal fee by registering his name and place of residence with the department.

(c) An application for license renewal shall contain the name, office and post office address, date and license number of the licensee, and other information the board considers necessary.

(d) Before a license may be renewed the licensee shall submit to the board evidence of 24 hours post graduate education as prescribed by regulations of the board. (ch 76 sec 9 SLA 1969)

Sec. 08.72.190. Fee for license by reciprocity. Repealed by ch 76 sec 10 SLA 1969.

Sec. 08.72.191. Fees. The following fees shall be imposed

under this chapter when applicable:

(1) examination fee	$35
(2) re-examination fee for written portion	25
(3) waiver of examination fee	25
(4) certificate fee	50
(5) biennial renewal fee	50
(6) branch office biennial registration fee	25

(ch 76 sec 11 SLA 1969)

Sec. 08.72.200. Examination fee. Repealed ch 76 sec 10 SLA 1969.

Sec. 08.72.210. Certificate fee. Repealed ch 76 sec 10 SLA 1969.

Sec. 08.72.220. Renewal fee. Repealed ch 76 sec 10 SLA 1969.

Sec. 08.72.230. Fees and disbursements. The department shall collect all fees and keep a record of each transaction, and shall remit to the Department of Revenue all money received. (sec 35-3-138 ACLA 1949; repealed and enacted ch 76 sec 12 SLA 1969)

Sec. 08.72.240. Revocation of registration certificate or exemption. The board may revoke a certificate of registration or exemption granted by it if the holder

(1) has violated a rule, order or regulation of the board; or

(2) has violated this chapter or is guilty of a crime; or

(3) is grossly incompetent, afflicted with a contagious disease, habitually drunk or guilty of unprofessional conduct. (sec 35-3-140 ACLA 1949)

C.J.S. references.-53 C.J.S. Licenses sec 44; 70 C.J.S. Physicians and Surgeons, secs 10, 15.

Sec. 08.72.250. Board action on revocation and renewal. In a proceeding for the revocation of a certificate of registration or for the annulment of registration the board shall make a complete written report of its findings, and if the board finds that any of the charges are sustained, the board may revoke the certificate of the accused, or annul his registration, or both. If the board annuls the registration, it shall transmit to the clerk of the judicial district in which the accused is registered as an optometrist, a certificate under its seal, certifying that his registration has been annulled. The clerk shall, upon receipt of the certificate, file it and mark the registration "annulled." The board may, after the expiration of one year, entertain an application for the renewal of a revoked certificate, in the same manner as an original application for a certificate and may exempt the applicant from the examination. (sec 35-3-140 ACLA 1949)

Full and substantial hearing. It is not necessary that the board follow technical legal procedure. A full and substantial hearing of the charges, where denied, is all that is required. Edmunds v. Board of Examiners in Optometry, 9 Alaska 462, aff'd, 9 Alaska 627, 106 F.2d 904 (1939)

Under this section the board may not entertain an application until the expiration of one year. Edmunds v. Board of Examiners in Optometry, 9 Alaska 627, 106 F.2d 904 (1939)

Order revoking renewal certificate cannot be set aside in a mandamus proceeding. Edmunds v. Board of Examiners in Optometry, 9 Alaska 627, 106 F.2d 904 (1939).

Conduct justifying treatment of charge as confessed.- Where a written complaint and notice were served on an optometrist requiring him to appear and answer charges against him by the board, but where no answer, denial or appearance was ever made, it was not incumbent upon the board to call any witnesses or receive any evidence in support of the charges, and the board was justified in treating the charge as confessed and entering its findings accordingly. Edmunds v. Board of Examiners in Optometry, 9 Alaska 462, aff'd, 9 Alaska 627, 106 F.2d 904 (1939)

Sec. 08.72.260. Revocation of license by court. A license may be revoked by the superior court upon proof of violation of law or for a cause for which the board may refuse admittance to its examination. The attorney general shall prosecute appropriate judicial proceedings upon request of a member of the board. (sec 35-3-146 ACLA 1949)

Sec. 08.72.270. Practice not at place of business. (a) A registered optometrist, who temporarily practices optometry away from his regular place of business, shall display his registration certificate and deliver to each patient or person fitted or supplied with glasses a receipt with his signature showing his permanent place of business or post office address, certificate number, and the amount charged. A licensee who fails to comply with any of the foregoing provisions for six months after issuance of the certificate shall forfeit his certificate.

(b) Nothing contained in this section shall be construed as permitting peddling or canvassing by licensed optometrists. (sec 35-3-136 ACLA 1949)

Article 3. Unlawful Acts.

Section		Section	
275.	Lenses and frames for eyeglasses and sunglasses	290.	Penalty
280.	Violations		

Sec. 08.72.275. Lenses and frames for eyeglasses and sunglasses. (a) No person may fabricate, distribute, sell, exchange, deliver or have in his possession with intent to distribute, sell, exchange or deliver eyeglasses or sunglasses unless they are fitted with plastic lenses or with glass lenses

which are tempered or case hardened. Glass lenses shall have a minimum thickness of two millimeters.

(b) No person may fabricate, distribute, sell, exchange, deliver or have in his possession with intent to distribute, sell, exchange or deliver eyeglasses or sunglasses having frames manufactured from cellulose nitrate or other highly flammable materials.

(c) A person who violates this section is punishable by a fine of not less than $50 nor more than $100. (1 ch 220 SLA 1968)

Revisor's note.-Section 2, ch 220, SLA 1968, provides: "The provisions of this bill take effect one year after date of passage." Legislative action on SCSHB 68 am (ch. 220, SLA 1968), was completed on April 14, 1968 and the bill was signed by the governor on May 6, 1968.

Sec. 08.72.280. Violations. No person may falsely personate a registered optometrist, nor buy, sell or fraudulently obtain a certificate of registration issued to another or advertise the practice of optometry in violation of rules of the board. Practicing or offering to practice optometry is sufficient evidence of a violation of this chapter. (sec 35-3-144 ACLA 1949)

Sec. 08.72.290. Penalty. A person who violates this chapter is guilty of a misdemeanor and is punishable by a fine of not less than $50 nor more than $500, or by imprisonment for a term of not less than 10 days nor more than 90 days, or by both. (sec 35-3-145 ACLA 1949)

C.J.S. reference.-53 C.J.S. Licenses secs 62 to 65.

Article 4. General Provisions.

Section 300. Definitions
Section 310. Short title

Sec. 08.72.300. Definitions. As used in this chapter

(1) "board" means the Board of Examiners in Optometry;

(2) "optometry" is the employment of means or methods, other than the use of drugs, for the diagnosis of an optical deficiency or deformity, visual or muscular anomaly of the human eye, or the prescription or application of lenses, prisms or ocular exercises for the correction or relief of the human eye;

(3) "practicing optometry" means the diagnois, by means or methods other than the use of drugs, of an optical deficiency or deformity, visual or muscular anomaly of the human eye, or the prescription of lenses, prisms or ocular exercises for the correction or relief of the human eye, or the holding of oneself out as being able to do so;

(4) "lenses" means conventional or contact lenses. (sec 35-3-131 ACLA 1949; am sec 2 ch 95 SLA 1966)

(5) "recognized school or college of optometry" is one which is approved by the American Optometric Association or one of its committees;

(6) "department" means the Department of Commerce. (sec 35 3-131 ACLA 1949;am sec 2 ch 95 SLA 1966;am by adding (5) & (6) sec 13 SLA 1969)

Effect of amendment.-The 1966 amendment added paragraph (4).

This chapter is a valid exercise of the legislative power. Edmunds v. Board of Examiners in Optometry, 9 Alaska 462, aff'd, 9 Alaska 627, 106 F.2d 904 (1939).

Sec. 08.72.310. Short Title. This chapter may be cited as the Optometry Law. (sec 35-3-150 ACLA 1949)

Board of Examiners In Optometry

TITLE 12. PROFESSIONAL AND VOCATIONAL REGULATIONS

CHAPTER 48. BOARD OF EXAMINERS IN OPTOMETRY

Section
10. Board membership
20. Biennial license
30. Branch office certificates
40. Display of certificate
50. When a practice is conveyed to another
60. Visual analyses records
70. Unprofessional conduct further defined
80. Definitions

12 AAC 48.010. BOARD MEMBERSHIP. The secretary shall notify the office of the governor of Alaska whenever a vacancy occurs. The secretary shall supply the governor with a list of all Alaska registered optometrists who have resided in Alaska for a period of three years or more, and are qualified as the statute provides, AS 08.72.040. (in effect before 7-28-59; am 5-19-62 and 10-20-62; am 9-10-65, Register 21; am 4-25-71, Register 37)

Authority: AS 08.72.030
AS 08.72.050(1)

12 AAC 48.020. BIENNIAL LICENSE RENEWALS AND REINSTATEMENT. (a) The post graduate education may be obtained any time within the two-year renewal period, but may not be carried over from one renewal period to the other.

(b) Courses that will be accepted are: educational courses given at the American Optometric Association Annual Convention or any AOA affiliate state optometric convention; seminars held by committees of the American Optometric Association or organized regional Optometric Extention Program Foundation seminars for educational purposes; post graduate courses offered by recognized schools or colleges of optometry. Other post graduate courses may be approved by the board if course titles, instructors' names, and a brief description of the course material is submitted to the board 30 days before the commencement of the educational program. Licensees who submit satisfactory proof that they were prevented from attending an educational program because of illness or other reasons may be exempted from this requirement. A form shall be provided with the biennial renewal application that must be validated by the instructor teaching the course. Correspondence courses will not be accepted as fulfilling the requirements of AS 08.72.101. (Eff. 4-25-71, Register 37)

Authority: AS 08.72.101

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12 AAC 48.030. BRANCH OFFICE CERTIFICATES. (a) A branch office certificate may be issued for the purpose of serving some community in the state, which cannot support an optometrist and which can be shown to the satisfaction of the board to need the service of a licensed optometrist on a part-time basis may be issued a semi-annual branch office certificate of registration. The name of an associate practicing in a branch office shall appear on the entrance door to the office used and upon all stationery; no commercial name or designation may be used in connection with any branch office nor may such a practice have any commercial lay connections, nor may there be anything in the nature of "chain exploitation" of licenses. Nothing in this section requires an active licensee to obtain a branch office certificate for the purpose of rendering necessary optometric services for his patients confined to their homes.

(b) No branch office certificate will be issued in a community where a full time optometric practice is available and any certificate in force when a full-time practice is established will not be renewed.

(c) No branch office certificate will be required for a licensee to participate in bonafide vision and eye screening projects outside of his regular or branch office. Vision and eye screening projects must be organized under the auspices of an established service organization not composed primarily of optometrists.

(d) Optometrists who participate in vision and eye screening projects may not receive remuneration for their services other than for travel and living expenses and for emergency care as required. (in effect before 7-28-59; am 5-19-62 and 10-20-62; am 9-10-65, Register 21; am 4-25-71, Register 37)

Authority: AS 08.72.125(c)

12 AAC 48.040. DISPLAY OF CERTIFICATE. A licensee's registration certificate and renewal certificate shall be displayed in the office in which the holder practices oprometry, but not in such a manner that the certificate may be seen from the street. Every licensee, whenever requested, shall exhibit the certificate to a member of the board or person authorized to represent the board and shall notify the department or board of his address and changes of his address. (in effect before 7-28-59; am 5-19-62 and 10-20-62; am 9-10-65, Register 21, am 4-25-71, Register 37)

Authority: AS 08.72.050(4)

12 AAC 48.050. WHEN A PRACTICE IS CONVEYED TO ANOTHER. When an optometrist disposes of his established practice to a successor, the successor shall, within a reasonable time, remove from all signs, cards, stationery, and directories connected with the practice he has acquired or is acquiring, all words or phrases such as "successor to", "associate of", or words of like import.

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Under no circumstates may the use of these signs, cards, stationery or advertising continue for more than two years. (in effect before 7-28-59; am 5-19-62 and 10-20-62; am 9-10-65, Register 21, am 4-25-71, Register 37)

Authority: AS 08.72.050(4)

12 AAC 48.060. VISUAL ANALYSES RECORDS. Every optometrist shall keep a record of examinations and visual analyses made and prescriptions issued and for whom the prescriptions were prepared. The record shall be preserved for a period of at least five years from the date services were rendered, except in the case of death of the patient. (in effect before 7-28-59; am 5-19-62 and 10-20-62; am 9-10-65, Register 21, am 4-25-71, register 37)

Authority: AS 08.72.050(4)

12 AAC 48.070. UNPROFESSIONAL CONDUCT. (a) "Unprofessional conduct", referred to in AS 08.72.240(3), includes:

(1) Soliciting patients by advertising of any nature or description regardless of means or media employed; however, upon the opening, reopening or removal of any office for the practice of optometry, an optometrist may publish, in local newspapers an announcement, which announcement shall be limited to a statement of his name, title, profession, degrees, address, telephone number and office hours; such an announcement may not be published for more than 90 days after the opening, reopening, or removal of the office; such an announcement may not exceed eight square inches in area.

(2) Displaying any spectacle, eyeglasses or eyeglass or spectacle frames or mountings, gogles, lenses, prisms, spectacle or eyeglass cases, opthalmic material of any kind, optometric instruments or optical tools or machinery, or any merchandise, material or displays of a commercial nature in office windows or reception rooms or display cases outside the office, where the display of the merchandise, material or display would make it visable from outside the office.

(3) Using display or bold face type or type that is in any way dissimilar in size, shape or color to that used for others of the healing arts in the same directory. Announcements in directories may not contain more than one specialty for each optometrist listed.

(4) Advertising regardless of means or media employed, the price or any type or style of opthalmic prosthetic device, or any of the materials entering into the assembling thereof, or the price of optometric professional services, when the service of prosthetic devices, of necessity must vary in quality and cost.

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(5) Using "bait" advertising such as "low prices", "moderate prices", "discounts", "liberal credit terms", "glasses on credit", "guaranteed glasses", "satisfaction guaranteed", or words or phrases of similar import which are not in keeping with ethical practice of a learned profession.

(6) Using signs, whether painted, neon, decalcomania, colored or otherwise, and whether constructed in the form of eyes or structures resembling them, or frames or mountings for any type of opthalic prosthetic devices displayed in any manner or place connected with the practice of optometry.

(7) Using publicly, a sign, card, stationery or other publicity medium which fails to clearly identify the individual optometrist or optometrists engaged in practice in an office or practice location, or using a name other than the name under which the optometrist is licensed, including such designations as "optical company", "optical laboratory", or words or phrases of like import which are out of keeping with the use of the title "Doctor of Optometry" and the practice of optometry as a profession.

(8) Soliciting, personally or through agents, from house to house for the rendering of optometric services or advertising for sale prosthetic devices or materials including contact lenses or opthoptic aids or devices.

(9) Advertising self-styled superiority or the performance of services in a manner presumed to be superior, or the making of untruthful, improbable or impossible claims regarding treatments cures or values.

(10) Advertising by any means or media in a manner contrary to the professional standards, lending, leasing, renting or in any other manner placing his certificate of registration at the disposal of or in the service of any person not licensed to practice optometry in this state.

(b) A registered and licensed optometrist may not associate himself with a corporation or voluntary association for the practice of optometry, or in any manner practice the profession, on a salary or commission basis, or a corporation or voluntary association. However, this subsection does not prohibit professional incorporation under the Professional Corporation Act 10.45. The fact that an officer, trustee, director, agent, or employee or a corporation or voluntary association is a registered and licensed optometrist does not permit the corporation or voluntary association to do the acts prohibited in this section, nor is that fact a defense to the board action against any of the persons mentioned in this subsection for a violation of this section; however, this subsection does not apply to a partnership of two or more registered and licensed optometrists who practice under their own names.

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(c) It is unlawful for a registered optometrist to practice his profession as an employee, lessee, or sublessee of a commercial or mercantile establishment or to practice his profession in connection with one, or to advertise either in person or through a commercial or mercantile establishment that he is a registered practitioner and is practicing or will practice optometry as an employee, lessee, or sublessee of a commercial or mercantile establishment or in connection with one. Nothing in this subsection prohibits the rendering of professional services to the officer and employees of a person, firm, or corporation by an optometrist, whether or not the compensation for the services is paid by the officers and employees or by the employer or jointly by all or any of them.

(d) No optometrist may practice in or on premises where any materials other than those necessary to render his professional services are dispensed to the public.

(e) No optometrist may display a sign containing other than his name, profession, one specialty, and office hours, which sign may be used only on office windows or at an entrance to his office. Letters may not be luminous or illuminated. (in effect before 7-28-59; am 5-19-62 and 10-20-62; am 9-10-65, Register 21, am 4-25-71, Register 37)

Authority: AS 08.72.050(4)

12 AAC 48.080. DEFINITIONS. Unless the content in this chapter otherwise states,

(1) "Act", "law" or "statute", refers to AS 08.72.;

(2) "regulations", referred to are those made by the board in keeping with AS 08.72.;

(3) "registration", means registration under AS 08.72.;

(4) "chain exploitation", means establishments that provide vision care in various locations either in one community or throughout a geographic area, where the service is provided by one or more than one optometrist in each or more than one location, and who is under the employ or have an agreement based on a lease, rental agreement partnership, stockholder, or other binding agreement; where control over these establishments are exercised by an individual or group of individuals.

(5) "established service organizations" means an organization who holds a charter from a parent organization whose primary established goal is public service without profit.

(6) "vision and eye screening projects" means a project organized with the intent of identification and referral of vision and eye disorders.

BOARD OF EXAMINERS IN OPTOMETRY

(7) "prescription" means a written formula prepared by a person licensed under AS 08.72 and which contains the following essential elements when applicable to eyeglasses, contact lenses or other visual therapy, dioptric power of spheres, cylinders and prisms, axis of cylinders and position of prism base; designation of inter-pupilary distances; size, base curve, power, color and type, when a contact lense; and the name of the patient, date of prescription and name and office location of prescriber. (in effect before 7-28-59; am 5-19-62 and 10-20-62; am 9-10-65, Register 21, am 4-25-71, Register 37)

Authority: AS 08.72.050

12 AAC 1100 - 12 AAC 1121 are repealed. (Eff. 4-25-71, Register 37)

Dec 7 77
CLOSED

AVRUM M. GROSS
Attorney General

By: JOSEPH K. DONOHUE
Assistant Attorney General
Pouch K, Capitol Building
Juneau, Alaska 99811

(907) 465-3600

Attorney for Defendants

Henry C. Ream, Jr.
Frederick Torrici
William B. Schendel
Alaska Legal Services Corporation
763 Seventh Avenue
Fairbanks, Alaska 99701
(907) 456-5401

Attorneys for Plaintiffs

FILED
DEC 1 0 1977
UNITED STATES DISTRICT COURT
DISTRICT OF ALASKA
By _____ Deputy

IN THE UNITED STATES DISTRICT COURT

DISTRICT OF ALASKA

RODGER LEE FERDINAND, et al.,

Plaintiffs,

vs.

THE ALASKA BOARD OF DISPENSING OPTICIANS, et al.,

Defendants.

Civil Action No. F 76-35 CIV

CONSENT DECREE

All parties to the above entitled and numbered cause, through their undersigned counsel of record, do hereby consent to a final judgment being entered by the court herein upon the parties' agreement by consent as follows:

I

The defendant Board of Examiners in Optometry shall

ATTORNEY GENERAL STATE OF ALASKA
STATE CAPITOL
POUCH K, JUNEAU, ALASKA 99811
PHONE (907) 465-3600

not initiate administrative, civil or criminal enforcement or disciplinary action against any licensee who engages in the truthful advertisement of prices, terms of payment, discounts, comparative costs, credit terms, the availability and type of credit, and the valuation of ophthalmic prosthetic products and ophthalmic services unless such advertisements violate the relevant statutes or regulations of the Board restricting time, place or manner of such advertisements.

II

The defendant Board of Dispensing Opticians shall not initiate disciplinary action or revoke, suspend or deny the license of a person who engages in the truthful advertisement of prices, terms of payment, discounts, comparative costs, credit terms, the availability and type of credit, and the valuation of ophthalmic prosthetic products and opthalmic services unless such advertisements violate the relevant statutes or regulations of the Board restricting the time, place or manner of such advertisements.

III

Nothing contained in this Decree shall restrict or prohibit the authority of either the Board of Examiners in Optometry or the Board of Dispensing Opticians from establishing minimum standards for professional advertising and/or for initial routine vision examinations. Consistent with this Decree, nothing herein shall restrict or prohibit the authority of either of the aforesaid Boards from promulgating and enforcing regulations or enforcing statutes which otherwise impose restrictions upon their respective licensees who engage in deceptive or misleading advertising of ophthalmic prosthetic products and/or opthalmic services or which impose reasonable restrictions upon the time, place or manner of such advertisements.

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PHONE: (907) 465-3600

IV

The Board of Examiners in Optometry within a reasonable period shall promulgate standards for professional advertising applicable to licensed optometrists practicing in the State of Alaska.

V

For purposes of this Consent Decree and until standards for professional advertising have been promulgated by the Board of Examiners in Optometry an advertisement for "routine vision examination" as it relates to licensed optometrists means that the licensed optometrist shall at a minimum adhere to the following standard:

A.

In the initial examination of the patient, the licensed optometrist shall make and record the following findings of the condition of the patient:

a. Complete Case History (ocular, physical, occupational, medical and other pertinent information);

b. Chief ocular complaint;

c. Aided and unaided visual acuity, at both near and far;

d. External Examination (lids, cornea, sclera, etc.);

e. Internal Opthalmoscopic Examination (media, fundus, etc.);

f. Ocular motility;

g. Neurological integrity;

h. Far Point Subjective Examination, Static retinoscopy and subjective refraction;

i. Near Point Subjective Examination; Dynamic retinoscopy and subjective refraction;

j. Test of accomodation and convergence and binocular coordination at far and near; test preferably made with phoropter;

k. Confrontation Fields.

1. Tonometry test.

B.

The Minimum Standards for Examination and Fitting of Contact Lenses which are necessary in order to insure an adequate examination of patient for whom a licensed optometrist signs or causes to be signed a prescription for a contact lens:

a. All items contained in the Minimum Standards for an Optometric Examination,

b. Slit Lamp Evaluation;

c. Fluorisine Examination;

d. Diagnostic Evaluation (for soft lenses);

e. Reexamination and reevaluation within the following periods of time:
Firm lenses - 3 months
Flexible lenses - 6 months.

VI

With the exception of the limitations contained in Paragraph I of this Decree, the Board of Examiners in Optometry shall continue to have and exercise all of the statutory authority conferred upon it by AS 08.72 and persons licensed under that chapter shall continue to enjoy all the rights and benefits inherent in their status as a licensee.

With the exception of the limitations contained in Paragraph II of this Decree, the Board of Dispensing Opticians shall continue to have and exercise all of the statutory authority conferred upon it by AS 08.71 and persons licensed under that chapter shall continue to enjoy all the rights and benefits inherent in their status as a licensee.

Nothing herein shall be construed to either expand or restrict the areas of professional practice which are set forth in AS 08.72 and AS 08.71. Nothing herein shall be

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PHONE (907) 465-3600

construed as requiring the two Boards to promulgate identical standards for professional advertising in those areas where their respective fields of practice should overlap.

VII

For purposes of the interpretation and the implementation of this Decree, the following definitions shall control:

A. "Opthalmic prosthetic products" shall consist of eyeglasses, lenses, contact lenses, frames or any component thereof or any other device used for or incident to the correction of any visual anomaly.

B. "Ophthalmic services" consist of the measuring, fitting and adjusting of ophthalmic prosthetic products to the face and eyes.

C. "Routine vision examination" is the process of determining the refractive condition of a person's eyes or the presence of any visual anomaly by the use of objective and subjective tests.

CONCLUSION

A. Jurisdiction

The jurisdiction of this cause is to be retained by the court for the purpose of making such other and further orders as may become necessary. However, with respect to defendants Board of Examiners in Optometry and members thereof this decree shall be terminated and rendered null and void upon the expiration of 30 days following the subsequent promulgation of regulations by the said Board relating to the area of professional advertising practices. Furthermore, with respect to defendants Board of Dispensing Opticians and members thereof, this decree shall be terminated and rendered null and void upon the expiration of 30 days following the subsequent promulgation of regulations by the said Board or immediately upon the effective date of any amendments to the relevant provisions of AS 08.71 which may be enacted by the

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PHONE (907) 465-3600

Alaska State Legislature.

B. Costs and Attorneys' Fees.

Defendants have agreed to pay reasonable attorneys' fees to plaintiffs counsel and the parties agree that all other costs and attorneys' fees incurred in the prosecution or defense of this action as of the date this Decree is entered shall be borne by each party respectively.

C. Notice Requirement.

Defendants further agree to notify all optometrists licensed under AS 08.72 and all dispensing opticians licensed under AS 08.71 of the terms of this Decree by mailing to each licensee a copy thereof within 60 days of the entry of this Decree.

WHEREAS, the parties having presented to the Court the instant Consent Decree and having consented to it serving as the final judgment of the Court in this cause;

IT IS ORDERED, ADJUDGED AND DECREED that judgment be and hereby is granted pursuant to Consent Decree as the final judgment of this Court with regard to this cause.

DATED at Anchorage, Alaska, this 13 day of December, 1977.

JUDGE OF THE UNITED STATES DISTRICT COURT

ATTORNEY GENERAL STATE OF ALASKA
STATE CAPITOL
POUCH K, JUNEAU, ALASKA 99811
PHONE 465-3600

OREGON STATE
ATTORNEY GENERAL OPINION
5807

Use of an electronic tonometer by an optometrist does not violate the provisions of the Medical Practice Act under ORS chapter 677.

No. 5807 May 12, 1964

Mr. Howard I. Bobbitt
Executive Secretary
State Board of Medical Examiners

You have requested an opinion as to whether the use by an optometrist of an instrument known as an electronic tonometer is a violation of the Medical Practice Act, ORS chapter 677.

You state that the facts indicate that an optometrist has been advertising that he uses an electronic tonometer which is a device that measures intraocular pressure by electronic means to detect certain pathological conditions but does not require use of any anesthetic or drug. The facts also indicate that other instruments have been in use by the optometric profession for many years, such as the Wolf scleral tonometer and Schiotz type tonometer.

It appears that intraocular pressure may be an indication of various pathological or abnormal conditions of the human eye and may affect "the scope of its functions."

Under the medical practice provisions of the Oregon law ORS 677.020 provides:

"*Except as provided in ORS 677.060* no person shall practice medicine or surgery in this state without being licensed so to do by the State Board of Medical Examiners." (Emphasis supplied)

ORS 677.030 provides in part:

"A person is regarded as practicing medicine and surgery if he does one of the following:

* * *

"(4) Offer or undertake to diagnose, * * * in any manner, or by any means, * * * any disease, illness, pain, * * * deformity, defect or abnormal physical * * * condition of any person."

ORS 677.010 (1)(c) defines the word "diagnose" as:

"* * * examine another person in any manner to determine the source or nature of a disease or other abnormal physical or mental condition, or to hold oneself out or represent that a person is so examining another person. * * *"

ORS 677.060 provides in part:

"This chapter shall not be construed to affect or prevent the following:

* * *

"(8) The practice of * * * optometry * * * by any person legally authorized by this state * * *."

It is clear, therefore, that ORS 677.060 (8) permits a duly authorized optometrist to render all services contemplated and included within the term "practice of optometry."

The phrase "practice of optometry" is defined in part in ORS 683.010 (2) as:

"'Practice of optometry' *means the employment of any means other than the use of drugs* for the measurement * * * of the human vision or the determination of the accommodative and refractive states of the human eye or the *scope of its functions in general* * * *." (Emphasis supplied)

It is to be noted that the only limitations imposed on an optometrist with respect to determining the "accommodative and refractive" state of the human eye or the "scope of its functions" is with respect to the use of drugs. Aside from drugs, an optometrist may use "any means" to make these determinations. Obviously an electronic tonometer is not a drug.

The crucial question implicit in your request is, what activities with respect to pathology of the eye are encompassed by the term "practice of optometry."

The Supreme Court of Oregon in State ex rel. Sisemore v. Standard Optical Company, (1947) 182 Or. 452, 460-461, 186 P. (2d) 309, 312-313, has unequivocally answered that question. The court stated at page 460:

"The practice of optometry is undoubtedly one of the subdivisions of the practice of medicine * * *."

The court went on to say at page 461:

"While it is true that an optometrist is not permitted by law to treat diseases of the eye, nevertheless his training enables him to diagnose pathological conditions, and *his duty requires him to refer the patient to a practitioner who is qualified to treat such conditions*. The fact that he is trained to diagnose pathological conditions in itself indicates that the optometrist is not a mere skilled craftsman or mechanic. His failure to diagnose a pathological condition, with resultant delay or neglect in proper treatment thereof, might result in serious impairment of the patient's eyesight, or even in blindness." (Emphasis supplied)

It thus appears that the term "practice of optometry" as construed by our Supreme Court contemplates that an optometrist, as a part of the services he renders his patient, has a duty to use his professional training, skill and knowledge while he is performing his primary function, to determine whether his patient is afflicted with an abnormal or pathological condition of the eye which may require treatment by a person legally qualified to render such service. He is also required to advise such patient if he finds what appears to be a pathological condition so that the patient may seek treatment from a legally qualified person. This does not mean that an optometrist has a duty to subject his patient in every possible type of examination for all manner of conditions, whether apparent or hidden. Nor does the "practice of optometry" allow an optometrist to so advertise that he indicates directly or indirectly that he examines and treats diseases of the eye. It is our understanding that the questioned advertising has been withdrawn and the optometrist reprimanded by the Oregon State Board of Examiners in Optometry. Within that area, defined as the "practice of optometry," the optometrist has the right to use any instruments or aids which in his professional judgment assist him in performing his functions, provided he is not administering "drugs."

It is, therefore, our opinion that the use of the electronic tonometer by an optometrist in the circumstances described herein is encompassed within the phrase "practice of optometry" and hence not prohibited by the provisions of the Medical Practice Act.

ROBERT Y. THORNTON,
Attorney General.
By Louis S. Bonney, Assistant

ALASKA CONSENT DECREE

Routine Visual Examination

ALASKA DRUG TERMINOLOGY RELATING TO USAGE OF

"DIAGNOSTIC AGENTS"

BY OPTOMETRISTS

The following reviews an accepted dictionary definition and the Alaska Statutes' definition regarding "drug" terminology.

Dorlands Medical Dictionary defines:

> DRUG: Any chemical compound or any non-infectious biological substance, not used for its mechanical properties, which may be administered to or used on or for patients, either human or animal, as an aid in the diagnosis, treatment, or prevention of disease or other abnormal condition, for the relief of pain or suffering, or to control or improve any physiological or pathological condition.

From this definition one could conclude that an accepted aspect of the usage of a "drug" is in "diagnosis". However, pertinent terminology regarding drugs does not make any reference to "diagnostic drugs, or agents."

OPTOMETRISTS Section 08.72.300 (3)

> (2) "Practice of optometry means the diagnosis, by means or methods other than the use of drugs . . ."

MEDICINE Section 08.64.380 Definitions:

> (No specific def or drug is given but intent can be recognized under the definition of practice of medicine)
>
> (2) Practice of medicine or practice of osteopathy means:
>
> (D) for a fee prescribing, directing or recommending for the use of a person, a drug or medicine for the treatment, cure or relief of a disease, infirmity, bodily injury or defect; . . .

To clarify Medicine's definition, Dorlands Medical Dictionary defines:

CURE: 1. The course of treatment of any disease, or of a special case. 2. The successful treatment of a disease or wound. 3. A system of treating diseases. 4. A medicine effective in treating disease.

PRESCRIBING: Giving instructions concerning the use of a remedy.

TREATMENT: The means employed in effecting the cure of disease.

RELIEF: The removal of anything distressing; the alleviation of pain or discomfort.

INFIRMITY: Weakness; a disease producing feebleness.

The point here is that the term "diagnostic agent" does not come within the boundaries of the definition of "drug" within the Alaska Statutes for medicine. From this, three conclusions can be drawn:

1. At present time, the current usage of diagnostic agents by optometrists does not infringe on the Alaska Medicine Statutes.

2. If positive "diagnostic agents" wording is added to the Alaska Optometrists Statutes, no infringement will exist upon the Alaska Medicine Statutes.

3. Positive "diagnostic agents" wording should be added to the Alaska Optometrists Statutes because while § 08.72.300, "Practice of Optometry means the employment of any means other than the use of drugs . . ." does not conflict with § 08.64.380 on Medicine, it does, however, conflict with an accepted dictionary definition: "Drug is any chemical . . . used . . . as an aid in the diagnosis . . ."

which are tempered or case hardened. Glass lenses shall have a minimum thickness of two millimeters.

(b) No person may fabricate, distribute, sell, exchange, deliver or have in his possession with intent to distribute, sell, exchange or deliver eyeglasses or sunglasses having frames manufactured from cellulose nitrate or other highly flammable materials.

(c) A person who violates this section is punishable by a fine of not less than $50 nor more than $100. (1 ch 220 SLA 1968)

Revisor's note.-Section 2, ch 220, SLA 1968, provides; "The provisions of this bill take effect one year after date of passage." Legislative action on SCSHB 68 am (ch. 220, SLA 1968), was completed on April 14, 1968 and the bill was signed by the governor on May 6, 1968.

Sec. 08.72.280. Violations. No person may falsely personate a registered optometrist, nor buy, sell or fraudulently obtain a certificate of registration issued to another or advertise the practice of optometry in violation of rules of the board. Practicing or offering to practice optometry is sufficient evidence of a violation of this chapter. (sec 35-3-144 ACLA 1949)

Sec. 08.72.290. Penalty. A person who violates this chapter is guilty of a misdemeanor and is punishable by a fine of not less than $50 nor more than $500, or by imprisonment for a term of not less than 10 days nor more than 90 days, or by both. (sec 35-3-145 ACLA 1949)

C.J.S. reference.-53 C.J.S. Licenses secs 62 to 65.

Article 4. General Provisions.

Section 300. Definitions
Section 310. Short title

Sec. 08.72.300. Definitions. As used in this chapter
(1) "board" means the Board of Examiners in Optometry;
(2) "optometry" is the employment of means or methods, other than the use of drugs, for the diagnosis of an optical deficiency or deformity, visual or muscular anomaly of the human eye, or the prescription or application of lenses, prisms or ocular exercises for the correction or relief of the human eye;
(3) "practicing optometry" means the diagnois, by means or methods other than the use of drugs, of an optical deficiency or deformity, visual or muscular anomaly of the human eye, or the prescription of lenses, prisms or ocular exercises for the correction or relief of the human eye, or the holding of oneself out as being able to do so;
(4) "lenses" means conventional or contact lenses. (sec 35-3-131 ACLA 1949; am sec 2 ch 95 SLA 1966)

(5) "recognized school or college of optometry" is one which is approved by the American Optometric Association or one of its committees;
(6) "department" means the Department of Commerce. (sec 35 3-131 ACLA 1949;am sec 2 ch 95 SLA 1966;am by adding (5) & (6) sec 13 SLA 1969)

Effect of amendment.-The 1966 amendment added paragraph (4).

This chapter is a valid exercise of the legislative power. Edmunds v. Board of Examiners in Optometry, 9 Alaska 462, aff'd, 9 Alaska 627, 106 F.2d 904 (1939).

Sec. 08.72.310. Short Title. This chapter may be cited as the Optometry Law. (sec 35-3-150 ACLA 1949)

Effect of amendment. — The 1974 amendment repealed paragraph (4).

Legislative committee report. — For report on ch. 127, SLA 1974 (SCSHB 817 am S), see 1974 House Journal, p. 657.

Sec. 08.64.380. Definitions. As used in this chapter

(1) "board" means the State Medical Board;

(2) "practice of medicine" or "practice of osteopathy" means

(A) maintaining an office or place of business for the purpose of treating the sick or injured for pay; or

(B) the public display of one's name and the letters "M.D.", "M.B." or "D.O." or the words "physician" or "osteopath" or "osteopathic physician", or "osteopathic surgeon", or "osteopathic physician and surgeon", or a specialist designation such as "surgeon" or "dermatologist", "psychiatrist", or the like; or

(C) the assumption or promulgation of a title which tends to show that the person is willing or qualified to diagnose or treat the sick or injured; or

(D) for a fee prescribing, directing or recommending for the use of a person, a drug or medicine for the treatment, cure or relief of a disease, infirmity, bodily injury or defect; or

(E) for a fee performing a surgical operation for the cure, relief or reduction of disease, bodily injury, deformity, or defect; or

(F) Repealed by § 1 ch 117 SLA 1971.

(3) "unprofessional or dishonorable conduct" means

(A) a violation of the provisions of AS 11.15.060 or regulations lawfully adopted by the State Medical Board concerning abortion procedures and practice;

(B) habitual overuse of alcoholic beverages or depressant, hallucinogenic or stimulant drugs, as defined in AS 17.12.150(3), or addiction to the use of narcotic drugs as defined in AS 17.10.230(13);

(C) conviction of an offense involving moral turpitude,

(D) advertising professional services to the public except for notice of opening, closing, or removing practice, and except for directories listing physicians in a community on a uniform and nondiscriminatory basis, containing only factual, truthful descriptions of physicians and their services;

(E) making untruthful or fraudulent statements in the application for examination, or deceiving or cheating during the examination for license, or procuring a license by deceit or fraud;

(F) violating the Controlled Substances Act (P.L. 91-513; 84 Stat. 1242) or any other federal law pertaining to medical practice and drugs;

(G) violating the principles of medical ethics of the American Medical Association and of the Alaska State Medical Association;

(4) Repealed by § 27 ch 148 SLA 1970.

(5) "department" means the Department of Commerce.

this title and that covered by this chapter. Speas v. State, Sup. Ct. Op. No. 889 (File No. 1555), 511 P.2d 130 (1973).

Quoted in Fresneda v. State, Sup. Ct. Op. No. 573 (File No. 1045), 458 P.2d 134 (1969); John Doe v. State, Sup. Ct. Op. No. 701 (File No. 1240), 487 P.2d 47 (1971); Egner v. State, Sup. Ct. Op. No. 784 (File No. 1443), 495 P.2d 1272 (1972); Gray v. State, Sup. Ct. Op. No. 1068 (File No. 2043), 525 P.2d 524 (1974).

Chapter 15. Drugs.

Article
1. Sale or Other Transfer of Certain Drugs (§§ 17.15.010—17.15.050)
2. Seizure of Conveyances Used in Narcotics Violations (§§ 17.15.060—17.15.110)

Article 1. Sale or Other Transfer of Certain Drugs.

Section
10. Written order or prescription required for dispensing of certain drugs
20. Authority of prescriber required for refill
30. Exceptions
40. Penalty for violations
50. Selling poison without label

Sec. 17.15.010. Written order or prescription required for dispensing of certain drugs. It is unlawful for a person to sell, give away, barter, exchange or distribute

(1) amytal, luminal, veronal, barbital, acid diethylbarbituric, or any of their salts, derivatives, or compounds, or a preparation or compound containing any of these substances, or their salts, derivatives or compounds, or a registered, trademarked or copyrighted preparation or compound registered in the United States Patent Office containing more than one grain to the avoirdupois or fluid ounce of the substances, except upon the written order or prescription of a physician, surgeon, dentist or veterinary surgeon licensed to practice in the state;

(2) chloralhydrate and para-aminobenzene, sulfonamide, sulfanilamid, sulfamidyl, prontylin, prontosil, neo prontosil, neo protylin, edimalin, sulfonamide or a salt, derivative or compound of any of them or a registered, trademarked or copyrighted preparation or compound registered in the United States Patent Office containing these substances, except upon authority, order or prescription of a physician, surgeon, dentist or veterinary surgeon duly licensed to practice in the state. (§ 40-3-31 ACLA 1949; am § 1 ch 85 SLA 1949)

Sec. 17.15.020. Authority of prescriber required for refill. Prescriptions composed of the substances enumerated in § 10 of this chapter shall not be refilled without the authority of the prescriber. (§ 40-3-31 ACLA 1949; am § 1 ch 85 SLA 1949)

Sec. 17.15.030. Exceptions. Sections 10 and 20 of this chapter do not apply to the sale at wholesale by drug jobbers, drug wholesalers and drug manufacturers to pharmacies, hospitals, physicians, dentists or veterinary surgeons, nor to each other, nor to the sale at retail in pharmacies by pharmacists to each other or to physicians, surgeons, dentists or veterinary surgeons licensed to practice in the state. (§ 40-3-31 ACLA 1949; am § 1 ch 85 SLA 1949)

P.2d 47 (1971); Op. No. 784 (File (1972); Gray v. 1068 (File No.

7.15.110)

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Sec. 17.15.040. Penalty for violations. A person violating §§ 10 and 20 of this chapter is punishable by a fine of not less than $100 nor more than $500, or by imprisonment for not more than 180 days, or by both. (§ 40-3-32 ACLA 1949)

Am. Jur. reference. — 17A Am. Jur., Drugs and Druggists, §§ 31 to 35.

Sec. 17.15.050. Selling poison without label. A person who sells or delivers arsenic, corrosive sublimate, prussic acid, or other poison, without having the word "poison" and the true name of it in English written or printed upon a label attached to the vial, box, or parcel containing it, upon conviction, is punishable by a fine of not less than $20 nor more than $100. (§ 40-3-33 ACLA 1949)

Am. Jur. and ALR references. — 17A Am. Jur., Drugs and Druggists, § 41.

Liability for injury or death in swallowing poison in article not intended to be eaten or tasted, 50 ALR 1462.

Validity of statutes regulating sale of poisons, 54 ALR 730.

Article 2. Seizure of Conveyances Used in Narcotics Violations.

Section
60. Seizure and forfeiture of conveyance
70. Order for seizure and forfeiture
80. Hearing, forfeiture and sale
90. Limitations on seizure and forfeiture
100. Person having interest in conveyance may appear in proceeding
110. Definition of illegally possessed narcotic drug

Sec. 17.15.060. Seizure and forfeiture of conveyance. A vessel, vehicle, aircraft or other conveyance used in the transportation of an illegally possessed narcotic drug shall be seized and forfeited to the state. (§ 1 ch 104 SLA 1961)

Am. Jur. reference. — 17A Am. Jur., Drugs and Druggists, § 1 et seq.

Sec. 17.15.070. Order for seizure and forfeiture. The conveyance shall be seized and forfeited in a proceeding in rem by order of the court which issues the process under which the conveyance is seized, or the court before which the person or the conveyance is taken by the officer making the seizure. (§ 1 ch 104 SLA 1961)

Sec. 17.15.080. Hearing, forfeiture and sale. The court shall order an immediate hearing on the question of whether or not the conveyance was used in the transportation of an illegally possessed narcotic drug. The court shall hear evidence and determine the question as in civil cases. If the court finds from a preponderance of the testimony that the conveyance seized was being used for the transportation of an illegally possessed narcotic drug, it shall give judgment accordingly and declare the conveyance forfeited to the state. The conveyance shall be delivered to the Department of Public Safety under the court order, and sold at public auction. (§ 2 ch 104 SLA 1961)

Sec. 17.15.090. Limitations on seizure and forfeiture. (a) No conveyance used as a common carrier in the transaction of business as

a common carrier may be forfeited under §§ 60—110 of this chapter unless the owner or other person legally in charge of the conveyance was at the time of the illegal act a consenting party or privy to it.

(b) No conveyance may be forfeited because of an act or omission established by the owner of the conveyance to have been committed or omitted by another person while the conveyance was unlawfully in the possession of a person who acquired possession of it in violation of the criminal laws of the United States or this state.

(c) No conveyance may be forfeited under §§ 60—110 of this chapter, unless the owner of the conveyance was, at the time of the illegal act, a consenting party to the illegal act or privy to it. (§ 3 ch 104 SLA 1961)

Sec. 17.15.100. Person having interest in conveyance may appear in proceeding. A person holding a lien, mortgage or conditional sales contract on a conveyance seized under §§ 60—110 of this chapter may appear before the court in the proceeding for forfeiture to petition for remittance or mitigation of the forfeiture. The court shall remit or mitigate the forfeiture if it finds that the petitioner has an interest in the conveyance which he acquired in good faith and without knowledge or reason to believe that the conveyance was being or would be used in the transportation of an illegally possessed narcotic drug. (§ 3 ch 104 SLA 1961)

Sec. 17.15.110. Definition of illegally possessed narcotic drug. In §§ 60—110 of this chapter

(1) "conveyance" means a vessel, vehicle, trailer, aircraft or other conveyance used in the transportation of an illegally possessed narcotic drug;

(2) "illegally possessed narcotic drug" is a narcotic drug (A) possessed with intent to sell or offer for sale in violation of any law or regulation of the United States or this state, or (B) acquired, possessed, sold, transferred, or offered for sale in violation of any law of the United States or this state, or (C) acquired by theft, robbery or burglary;

(3) "narcotic drug" means a narcotic drug defined by the federal internal revenue laws and the regulation issued under them. (§§ 1, 4 ch 104 SLA 1961; am § 4 ch 225 SLA 1968)

Chapter 20. Alaska Food, Drug and Cosmetic Act.

Article

1. Food (§§ 17.20.010—17.20.070)
2. Drugs and Devices (§§ 17.20.080—17.20.130)
3. Cosmetics (§§ 17.20.140—17.20.150)
4. False Advertising (§§ 17.20.160—17.20.170)
5. Enforcement (§§ 17.20.180—17.20.280)
6. Prohibited Acts and Penalties (§§ 17.20.290—17.20.330)
7. General Provisions (§§ 17.20.340—17.20.380)

Section

10. Definitions
20. Adulterated
30. Tolerances
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40. Misbranded

Sec. 17.20
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could not say that the sentencing court was clearly mistaken in imposing a five-year sentence for selling amphetamines in violation of AS 17.12.010. Thurlkill v. State, Sup. Ct. Op. No. 1279 (File No. 2735), 551 P.2d 541 (1976).

Where defendant was convicted, upon his plea of guilty, of four counts of sale and one count of distribution of marijuana, the superior court was not clearly mistaken in imposing a sentence of five years, with two suspended, on each count, to be served concurrently, the court also having fined defendant $5000, suspending payment of $3000. Wolfe v. State, Sup. Ct. Op. No. 1301 (File No. 2766), 553 P.2d 472 (1976).

Sentence of three years imprisonment for selling LSD was not excessive. Aceveda v. State, Sup. Ct. Op. No. 1534 (File No. 2900), 571 P.2d 1013 (1977).

Where defendant was convicted of possession of an hallucinogenic drug with intent to sell or distribute and was sentenced to seven years, with execution of the sentence suspended for five years, defendant being placed on probation for 30 months on condition that he: (1) complete school; (2) be employed while not in school or incarcerated; and (3) report to a correctional institution in September 1976 to serve six months, subject to school release and credit for the 45 days he had already served, and this sentence was to run concurrently with the sentence for his conviction on an earlier offense, with probation in that case to be revoked by the judgment in the instant case, such sentence was not too lenient under the facts of the case. Clark v. State, Sup. Ct. Op. No. 1570 (File Nos. 2943, 2964), 574 P.2d 1261 (1978).

Sentence held excessive. — Imposition of two consecutive five-year terms for the sale of small quantities of marijuana was excessive. Salazar v. State, Sup. Ct. Op. No. 1404 (File No. 2567), 562 P.2d 694 (1977).

Case remanded for resentencing. — The supreme court remanded for resentencing where the trial court had improperly considered the goal of community condemnation of the offender in sentencing defendant to five years' imprisonment for possession of marijuana for the purpose of sale or distribution. Snyder v. State, Sup. Ct. Op. No. 1744 (File No. 3321), 585 P.2d 229 (1978).

Applied in Barrett v. State, Sup. Ct. Op. No. 1225 (File No. 2299), 546 P.2d 161 (1976); State v. Buckalew, Sup. Ct. Op. No. 1391 (File No. 3143), 561 P.2d 289 (1977).

Cited in State v. Erickson, Sup. Ct. Op. No. 1547 (File No. 3250), 574 P.2d 1 (1978).

Sec. 17.12.130. Forfeiture.

Difference between AS 11.45.040 and this section and AS 16.05.195. — Both this section and the fish and game forfeiture statute, AS 16.05.195, define broadly the property subject to forfeiture to include "accessories" and "paraphernalia," respectively, used to violate the law. Furthermore, both of them provide optional dispositions for forfeited property, unlike the gambling forfeiture statute, AS 11.45.040 which mandates destruction of property seized. One Cocktail Glass v. State, Sup. Ct. Op. No. 1437 (File No. 2729), 565 P.2d 1265 (1977).

Sec. 17.12.150. Definitions.

Cocaine does not appear specifically in paragraph (3). State v. Erickson, Sup. Ct. Op. No. 1547 (File No. 3250), 574 P.2d 1 (1978).

Quoted in State v. Buckalew, Sup. Ct. Op. No. 1391 (File No. 3143), 561 P.2d 289 (1977).

Cited in Belgarde v. State, Sup. Ct. Op. No. 1206 (File No. 2447), 543 P.2d 206 (1975).

ELLIOT RICHARDSON, SECRETARY, DEPARTMENT OF HEALTH, EDUCATION AN WELFARE, FILLED A 1971 REPORT WITH THE PRESIDENT AND CONGRESS ON ADMINISTRATION OF THE HEALTH PROFESSIONS EDUCATIONAL ASSISTANCE ACT.

The report contained the following language concerning optometry:

"Optometrists are trained to detect any departure from the optimally healthy eye. The scope of optometric services has expanded beyond basic clinical refractions, fabricating and dispensing eyeware; now included are visual screening examinations, clinical intrumentation, contact lens fitting, visual training, orthoptics, low-vision aids for the partially sighted, artificial eyes, industrial vision consultation and public and community health. The most rapidly expanding area of service is in school consultation and remedial services for low achievers. The optometrist is trained and bound by professional ethics to refer patients in whom indications of disease have been found to a physician or other health practitioner for definitive diagnosis and appropriate medical surgical or other treatment."

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HOW THE DIAGNOSTIC AGENTS BI L IN ALASKA RELATES TO:

1. Other States:

Thirty-one states al ow optometrists to use diagnostic agents. Other states such as Alaska are currently making legislative efforts to broaden this.

2. Other Countries:

a. The large english speaking countries of Canada, Australia, and England all certify optometrists to use diagnostic drugs.

b. England's joint declaration (February, 1970) by the ophthalmologists and optometrists of England confirm the many beneficial years as well as pronounce the future continuation for the usage of diagnostic agents by optometrists.

3. The United States Armed Forces:

All branches of the military either allow or specifically state in the regulations that optometrists shall be permitted the usage of diagnostic agents or drugs.

HOW THE DIAGNOSTIC AGENT BILL IN ALASKA

RELATES TO OTHER STATES

1. Recent positive state law changes: (23 state law changes)

   a. Rhode Island enacted optometry redefinition law in 1971:

      Optometrists "shall be permitted to apply drugs topically to the eye for the purpose of detecting any disease or pathological condition of the eye."

   b. Pennsylvania enacted optometry redefinition law in 1974:

      Optometry shall include the use of "diagnostic pharmaceutical agents, known generically as cycloplegics, mydriatics, topical anesthetics and miotics."

   c. Iowa enacted optometry redefinition law most recently in June, 1979:

      Certified licensed optometrists may employ cycloplegics, mydriatics and topical anesthetics as diagnostic agents topically applied . . .

   d. Louisiana

   e. Oregon

   f. Delaware

   g. Maine.

2. States which have no prohibitive laws on diagnostic agent usage by optometrists:

   a. Florida

   b. Idaho

   c. Indiana

   d. Minnesota

   e. Nevada

   f. New Jersey

Total of (31) states allow the use of diagnostic agents by optometrists. Map showing dates--geographic locations.

3. Experience of states where diagnostic agents are used:

Letter enclosed from E.C. Nurock, Secretary-Treasurer, Department for Law and Public Safety, Board of Optometrists, State of New Jersey.

New Jersey optometrists have had the right to use these diagnostic agents since 1919. "In the state there have been no cases reported regarding any problems caused by optometrists using any of the diagnostic drugs. The use of diagnostic drugs by optometrists is definitely in the public interest."

RHODE ISLAND DEFINITION

(Enacted at 1971 Session)

Optometry is defined as the profession whose practitioners are engaged in the art and science of the evaluation of vision and the examination of vision and the examination and refraction of the human eye which includes:

The employment of any objective or subjective means for the examination of the human eye or its appendages;

The Measurement of the powers or range of human vision or the determination of the accommodative and refractive powers of the human eye or the scope of its functions in general and the adaptation of lenses, prisms, and/or frames for the aid thereof;

The prescribing, directing the use of or administering ocular exercises, visual training, vision training, or orthoptics, and the use of any optical device in connection therewith;

The prescribing of contact lenses for, or the fitting or adaptation of contact lenses to the human eye;

The examination or diagnosis of the human eye to ascertain the presence of abnormal conditions or functions; and

The topical application of drugs to the eye, to wit, mydriatics, miotics, and the use of topical anesthetics, provided, however, that no optometrist licensed in this state shall treat by the use of these drugs or attempt to perform any surgery and shall be used only for the purpose of detecting any diseased or pathological condition of the eye, or the effects of any disease or pathological condition of the eye, further provided however, that with respect to presently licensed optometrists, only presently licensed optometrists who

1. have satisfactorily completed a course in pharmacology, as it applies to optometry, at an institution accredited by a regional or professional accreditation organization which is recognized by the national commission on accreditation, with particular emphasis on the topical application of drugs to the eye for the purpose of detecting any diseased or pathological condition of the eye; or the effects of any disease or pathological condition of the eye, approved by the board of examiners in optometry and the chief of pharmacy of the department of health, and

2. have successfully completed an examination given by the board of examiners in optometry in conjunction with the chief of pharmacy of the department of health, shall be permitted to apply drugs topically to the eye for the purpose of detecting any diseased or pathological condition of the eye, or the effects of any disease or pathological condition of the eye. Said chief of pharmacy shall consult and advise the board of examiners in optometry with respect to that portion of the examination dealing with pharmacology.

PENNSYLVANIA REDEFINITION

(Enacted in early 1974)

Section 1. That the practice of optometry is hereby defined to be the employment of any means or methods, other than the use of surgery, or drugs, except diagnostic pharmaceutical agents, known generically as cycloplegics, mydriatics, topical anesthetics and miotics, which are administered topically for

The examination of the human eye and the analysis of ocular functions, or

The prescribing, providing, furnishing, adapting or employing any or all kinds and types of lenses and prisms, visual training, orthoptics, ocular exercises, and any and all preventive and corrective methods for the aid, correction or relief of the human eye, its associated structures, appendages and functions, other than the use of drugs or surgery:

The Secretary of Health shall designate the specific agents to be used under the above generic classification. Provided, however, that with respect to optometrists licensed at the time of the effective date of this amendatory act, only such licensed optometrists who

1. have satisfactorily completed a course in pharmacology, as it applies to optometry, by an institution accredited by a regional or professional accreditation organization which is recognized or approved by the National Commission on Accrediting or the United States Commissioner of Education, with particular emphasis on the topical application of diagnostic pharmaceutical agents to the eye for the purpose of examination of the human eye and analysis of ocular functions, approved by the State Board of Optometrical Examiners, and

2. who upon successful completion of such course shall be permitted by the State Board of Optometrical Examiners in Optometry to use diagnostic pharmaceutical agents topically in the practice of optometry.

Whenever an optometrist during the course of his examination shall determine the possibility of the existence of a pathological condition he shall advise the person of such opinion, and refer such person to physician for further evaluation.

XTRAS

American Optometric Association

BULLETIN
from
OFFICE OF COUNSEL

VOL. XXXVII, BULLETIN NO. 70 June 11, 1979

TO: O, T, DEC-C, Statutory Definition Advisory Committee, EMS, E, State Association Presidents, Executives, Legislative Chairmen, Attorneys, Legislative Counsel, Statutory Definition Chairmen, Optometric Legislators, IAB-EC, State Board Presidents, Secretaries, Attorneys, Administrative Heads of Schools and Colleges, Mr. Adams, Mr. Andrew, Mrs. Martin, GC, NE

SUBJECT: Iowa Legislation

FROM: Thomas E. Eichhorst, Counsel

On June 8, 1979, Iowa Governor Robert D. Ray, a Republican, signed into law Senate File 93. This law, entitled, "AN ACT RELATING TO THE USE OF DIAGNOSTIC PHARMACEUTICAL AGENTS BY OPTOMETRISTS" is enclosed.

The bill passed the Senate on March 7, 1979 by a vote of 29 to 17. It passed the House, as amended, on April 19, 1979, by a vote of 67 to 25. It was concurred in by the Senate on May 1, 1979 by a vote of 29 to 20.

Iowa is the twenty-third (23rd) state to enact legislation specifically authorizing optometrists to utilize pharmaceutical agents. Twenty-one (21) states authorize optometrists to utilize diagnostic pharmaceutical agents; two states authorize optometrists to utilize pharmaceutical agents for diagnostic and therapeutic purposes. The list (and dates of enactment) of these states is as follows:

American Optometric Association
243 North Lindbergh Blvd.
Saint Louis, Missouri 63141
314 991 4100

Executive Offices in St. Louis and Washington, D.C.

PD F 5685

SENATE FILE 93

AN ACT

RELATING TO THE USE OF DIAGNOSTIC PHARMACEUTICAL AGENTS BY OPTOMETRISTS.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF IOWA:

Section 1. Section one hundred fifty-four point one (154.1), Code 1979, is amended by adding the following new unnumbered paragraph:

NEW UNNUMBERED PARAGRAPH. Certified licensed optometrists may employ cycloplegics, mydriatics and topical anesthetics as diagnostic agents topically applied to determine the condition of the human eye for proper optometric practice or referral for treatment to a person licensed under chapter one hundred forty-eight (148) or one hundred fifty A (150A) of the Code. A certified licensed optometrist is an optometrist who is licensed to practice optometry in this state and who is certified by the board of optometry examiners to use diagnostic agents. A certified licensed optometrist shall be provided with a distinctive certificate by the board which shall be displayed for viewing by the patients of the optometrist.

Sec. 2. Section one hundred fifty-four point three (154.3), Code 1979, is amended by adding the following new subsections:

NEW SUBSECTION. A person applying to be licensed as an optometrist after January 1, 1980, shall also apply to be a certified licensed optometrist and shall, in addition to satisfactorily completing all requirements for a license to practice optometry, satisfactorily complete a course consisting of at least one hundred contact hours in pharmacology and receive clinical training as it applies to optometry with particular emphasis on the topical application of diagnostic agents to the human eye for the purpose of examination of

the human eye, and the diagnosis of conditions of the human eye, at an institution accredited by a regional or professional accreditation organization which is recognized or approved by the council on postsecondary accreditation or the United States office of education.

NEW SUBSECTION. A person licensed as an optometrist prior to the effective date of this Act who applies to be a certified licensed optometrist shall first satisfactorily complete a course consisting of at least one hundred contact hours in pharmacology as it applies to optometry including clinical training as it applies to optometry with particular emphasis on the topical application of diagnostic agents to the human eye and possible adverse reactions thereto, for the purpose of examination of the human eye and the diagnosis of conditions of the human eye, provided by an institution accredited by a regional or professional accreditation organization which is recognized or approved by the council on postsecondary accreditation or the United States office of education, and approved by the board of optometry examiners.

NEW SUBSECTION. In addition to the examination required by section one hundred fifty-four point three (154.3), subsection three (3) of the Code, a person applying to be a certified licensed optometrist shall also pass an examination prescribed by the optometry examiners in the subjects of physiology and pathology appropriate to the use of diagnostic pharmaceutical agents and diagnosis of conditions of the human eye, and pharmacology including systemic effects of ophthalmic diagnostic pharmaceutical agents and the possible adverse reactions thereto, authorized for use by optometrists by section one hundred fifty-four point one (154.1) of the Code.

Sec. 3. Chapter one hundred fifty-four (154), Code 1979, is amended by adding the following new section:

NEW SECTION. A certified licensed optometrist employing diagnostic pharmaceutical agents as authorized by this Act shall be held to the same standard of care in the use of such agents and in diagnosis as is common to persons licensed under chapter one hundred forty-eight (148) or one hundred fifty A (150A) of the Code in this state.

Sec. 4. Section one hundred fifty-five point twenty-two (155.22), Code 1979, is amended to read as follows:

155.22 EXCEPTIONS. Sections 155.20 and 155.21 do not apply to sales by wholesalers of drugs and medicines to licensed physicians, dentists, podiatrists or veterinarians

or to sales by wholesalers to certified licensed optometrists of those diagnostic pharmaceutical agents which are authorized for use by certified licensed optometrists pursuant to this Act.

Sec. 5. Section one hundred fifty-five point twenty-six (155.26), Code 1979, is amended by adding the following new unnumbered paragraph:

NEW UNNUMBERED PARAGRAPH. This section shall not apply to the possession by a certified licensed optometrist of those diagnostic agents which are authorized for use by certified licensed optometrists pursuant to this Act. The dispensing by pharmacists to certified licensed optometrists of those diagnostic agents which are authorized for use by certified licensed optometrists pursuant to this Act shall be permitted.

Sec. 6. This Act is effective January 1, 1980.

Terry E. Branstad

TERRY E. BRANSTAD
President of the Senate

Floyd H. Millen

FLOYD H. MILLEN
Speaker of the House

I hereby certify that this bill originated in the Senate and is known as Senate File 93, Sixty-eighth General Assembly.

Frank J. Stork

FRANK J. STORK
Secretary of the Senate

Approved June 8, 1979

Robert D. Ray

ROBERT D. RAY
Governor

Regular Session, 1975

HOUSE BILL NO. 107

BY MESSRS. BREAUX AND J. JACKSON

ACT 123

LOUISIANA

AN ACT

To amend and reenact Paragraph (3) of Section 1041, Section 1051, and Paragraph (15) of Section 1061 of Title 37 of the Louisiana Revised Statutes of 1950 and to amend Section 1041 of Title 37 by adding thereto a new Paragraph to be designated as Paragraph (4) thereof, and to add a new Section to be designated as Section 1067 of Title 37 of the Louisiana Revised Statutes of 1950, relative to defining the practice of optometry; to provide for a definition of diagnostic pharmaceutical agent; to provide regulations for the examination required by applicants for a license as an optometrist; to provide for procedures regulating the employment of topical ocular diagnostic pharmaceutical agents by a licensed optometrist; and to provide with respect to the causes for refusal, suspension, or revocation of a certificate of license, and otherwise to provide with respect thereto.

ORIGINATED

IN THE

Rec'd by the Governor
June 26, 1975 at 2:15 PM
Doris C. Davenport

House of Representatives

Received by Secretary of State
this 7th day of July, 1975
Wade O. Martin, Jr.
Secretary of State

David R. Poynter
Clerk of the House of Representatives

Regular Session, 1975

ACT 123

HOUSE BILL NO. 107

BY MESSRS. BREAUX AND J. JACKSON

AN ACT

To amend and reenact Paragraph (3) of Section 1041, Section 1051, and Paragraph (15) of Section 1061 of Title 37 of the Louisiana Revised Statutes of 1950 and to amend Section 1041 of Title 37 by adding thereto a new Paragraph to be designated as Paragraph (4) thereof, and to add a new Section to be designated as Section 1067 of Title 37 of the Louisiana Revised Statutes of 1950, relative to defining the practice of optometry; to provide for a definition of diagnostic pharmaceutical agent; to provide regulations for the examination required by applicants for a license as an optometrist; to provide for procedures regulating the employment of topical ocular diagnostic pharmaceutical agents by a licensed optometrist; and to provide with respect to the causes for refusal, suspension, or revocation of a certificate of license, and otherwise to provide with respect thereto.

Be it enacted by the Legislature of Louisiana:

Section 1. Paragraph (3) of Section 1041 and Section 1051 of Title 37 of the Louisiana Revised Statutes of 1950 are hereby amended and reenacted to read as follows:

§1041. Definitions

* * *

(3) "Optometry" means that practice in which a person employs or applies any means other than surgery, for the measurement of the powers and testing the range of vision of the human eye, and determines its accommodative and refractive state, general scope of function,

and the adaptation of frames and lenses, including contact lenses in all their phases, to overcome errors of refraction and restore as near as possible, normal human vision. The practice of optometry does not include the use of drugs or medication, except the use of topical ocular diagnostic pharmaceutical agents and then only by a licensed optometrist and in accordance with the provisions of this Chapter. The practice of optometry does not include the use of pharmaceutical agents, in the treatment of disease.

* * *

§1051. Examinations and educational requirements

Examinations given by the board shall be based upon subjects taught in approved schools and colleges of optometry, such as general anatomy, physics, chemistry, biology, physiology, anatomy and physiology of the eye, general physiology, general pathology, ocular pathology, ocular neurology, ocular myology, psychology, physiological optics, optometrical mechanics, vision therapy, visual field charting, orthoptics, clinical optometry, contact lenses, general pharmacology and ocular pharmacology as it applies to optometry with emphasis on the topical use of diagnostic pharmaceutical agents to the eye, and the applications of the general law of optics and refraction and such other materials and subjects as are essential in the practice of optometry. Examinations shall be conducted at least once annually on dates fixed by the board.

All written examinations held by the board and the answers of applicants shall be kept as records by the board for at least one year.

Section 2. Paragraph (4) of Section 1041 and Section 1067 of Title 37 of the Louisiana Revised Statutes of 1950 are hereby enacted to read as follows:

§1041. Definitions

* * *

(4) "Diagnostic pharmaceutical agent" means any chemical in solution, suspension, emulsion, or ointment base other than a narcotic which when applied topically to the eye, results in physiological

changes which permit more efficient, or otherwise facilitate, examination of the external eye or its adnexa or the evaluation of vision, or which is necessary to determine normal physiological function as part of an examination regimen.

* * *

§1067. Chemical agents used in examination, board authorization required

Prior to the employment of topical ocular diagnostic pharmaceutical agents by a licensed optometrist, that licensed optometrist must submit to the Louisiana State Board of Optometry Examiners, satisfactory evidence that the optometrist has successfully completed courses approved by the board, in pharmacology as they apply to optometry, with particular emphasis on topical application of diagnostic pharmaceutical agents to the eye.

Section 3. Paragraph 15 of Section 1061 of Title 37 of the Louisiana Revised Statutes of 1950 is hereby amended and reenacted to read as follows:

§1061. Causes for refusal, suspension, or revocation of certificate

* * *

(15) Using, prescribing, giving away, selling or offering for sale, or having in his possession any eye remedy, lotion, salve, or medicine of any kind or description, or practicing medicine or surgery for the use of carrying on the practice of optometry; provided, however, that this Paragraph shall not prevent the possession or use of topical ocular diagnostic pharmaceutical agents by a licensed optometrist in accordance with the provisions of this Chapter.

* * *

Section 4. If any provision or item of this Act or the application thereof is held invalid, such invalidity shall not affect other provisions, items or applications of this Act which can be given effect without the invalid provisions, items or applications, and to this end the provisions of this Act are hereby declared severable.

Section 5. Nothing in this bill shall in any way apply to a licensed physician or to any nurse, technician, or allied health personnel acting

under a physician's prescription, supervision, or direction nor to any screening, testing or teaching program conducted by the state of Louisiana or in any parish or city eye program.

Section 6. All laws or parts of laws in conflict herewith are hereby repealed, with the exception noted in Section 5.

SPEAKER OF THE HOUSE OF REPRESENTATIVES

LIEUTENANT GOVERNOR AND PRESIDENT OF THE SENATE

GOVERNOR OF THE STATE OF LOUISIANA

APPROVED: July 6, 1975

Enrolled

House Bill 2740

Sponsored by Representatives OTTO, GRANNELL, GWINN, WALDEN, Senators HOWARD, JERNSTEDT

CHAPTER_____

AN ACT

Relating to the practice of optometry; amending ORS 683.010, 683.040, 683.060 and 683.270.

Be It Enacted by the People of the State of Oregon:

Section 1. ORS 683.010 is amended to read:

683.010. As used in this chapter, unless the context requires otherwise:

(1) "Board" means the Oregon Board of Optometry.

(2) "Practice of optometry" means the employment of any means other than the use of drugs, except diagnostic agents, topically applied, known generically as cycloplegics, mydriatics, topical anesthetics, dyes such as fluorescein, and, for emergency use only, miotics, for the measurement or assistance of the powers or range of human vision or the determination of the accommodative and refractive states of the human eye or the scope of its functions in general or the adaptation of lenses or frames for the aid thereof, subject to the limitations of ORS 683.040.

(3) "Trial frames" or "test lenses" means any frame or lens used in testing the eye which is not sold and not for sale.

Section 2. ORS 683.040 is amended to read:

683.040. (1) Every person desiring to commence the practice of optometry in this state must show by satisfactory evidence that he is of good moral character and has graduated from a school of optometry which is recognized and approved by the board and which maintains a standard of four school years of at least nine months each.

(2) Every person desiring to commence the practice of optometry after January 1, 1976, or employ the use of diagnostic agents shall in addition to the requirements of subsection (1) of this section have satisfactorily completed a course in pharmacology, as it applies to optometry, by an institution accredited by a regional or professional accreditation organization which is recognized or approved by the National Commission on Accrediting or the United States Commissioner of Education, with particular emphasis on the topical application of diagnostic agents to the eye for the purpose of examination of the human eye and the analysis of ocular functions, approved by the Oregon Board of Optometry.

Section 3. ORS 683.060 is amended to read:

683.060. (1) Any person who has signified to the board his desire to be examined by it and who has filed proof that he is qualified under this chapter and the rules of the board to take such examination shall appear before the board at such time and place as the board may designate, and before beginning the examination the applicant shall pay $50 to the secretary of the board. At the examinations the board shall examine applicants in the anatomy of the eye, in the use of diagnostic agents as used topically, in normal and abnormal refractive and accommodative and muscular conditions and coordination of the eye, in subjective and objective

optometry, including the fitting of glasses, the principles of lens grinding and frame adjusting, and in such other subjects as pertain to the science and practice of optometry, such subjects to be enumerated in a publication by the board.

(2) The board may, in its discretion, accept the certificate of successful examination of the National Board of Examiners in Optometry in one or more areas of the examination in lieu of its written examination in such areas.

(3) If an applicant shall fail to pass a second examination, the board may permit additional examinations upon compliance by the applicant with the law and the rules of the board.

Section 4. ORS 683.270 is amended to read:

683.270. The powers and duties of the board are as follows:

(1) To organize and elect from its membership a president and secretary of the board, each of whom shall hold office for one year, or until the election and qualification of a successor.

(2) To adopt and use a common seal.

(3) To employ agents, attorneys and inspectors to secure evidence of, report on, and prosecute all violations of this chapter and to employ other necessary assistance in the carrying out of the provisions of this chapter, and to pay the same from the funds provided in this chapter.

(4) To hold regular meetings at least once a year at which an examination of applicants for certificates of registration shall be held at such places as the board shall from time to time designate, and special meetings upon request of a majority of the members of the board or upon the call of the president.

(5) To keep an accurate record of all proceedings of the board and of all of its meetings, of all prosecutions for violations of this chapter, and of all examinations held for applicants for certificates of registration, with the names and addresses of all persons taking examinations and their success or failure to pass such examinations. All the records of the board shall be public and shall be kept in the office of the board.

(6) To keep an accurate inventory of all property of the board and of the state in the possession of the board and to obtain a receipt therefor from its successor.

(7) To keep a register of optometrists which shall contain the names and addresses of all persons to whom certificates of registration have been issued in the State of Oregon, together with the date of the issuance of such certificate and the place or places of business in which each optometrist is engaged, and all renewals, revocations and suspensions thereof.

(8) To grant or refuse to grant certificates of registration as provided in this chapter and to revoke the certificate of registration of any optometrists for any of the causes specified in ORS 683.140.

(9) To designate diagnostic pharmaceutical agents for topical use in the practice of optometry from among the generic categories enumerated within subsection (2) of ORS 683.010. Said designation shall take place not later than January 1, 1976, and shall be with the advice and guidance of the Board of Medical Examiners for the State of Oregon.

[(9)] **(10)** To administer oaths and take testimony upon granting and revoking or suspending any certificate of registration.

[(10)] **(11)** To make rules not inconsistent with the laws of this state as are deemed necessary or proper to carry out the lawful powers and duties of the board, as may be necessary or proper to determine the qualifications of applicants for a certificate to practice optometry in this state, and to establish educational, moral and professional standards for such applicants, subject to the laws of this state. If an applicant fails to pass a second examination the board may adopt rules which may provide the required courses of study before further examination.

Chapter , Oregon Laws 1975

ENROLLED

House Bill

Passed by House

Repassed by House

Chief Clerk of House

Philip D. Lang

Speaker of House

Passed by Senate

Repassed by Senate

Jason Boe

President of Senate

Received by Executive Department:

3:15 p.m. May 14 1975.

Approved: 12:07 p.m. May 20 , 1975.

Governor

Filed in Office of Secretary of State:

M., 1975.

Secretary of State

HOUSE OF REPRESENTATIVES

128TH GENERAL ASSEMBLY

FIRST SESSION - 1975

HOUSE BILL NO. 63

AS AMENDED BY

HOUSE AMENDMENT NO. 1

AN ACT TO AMEND CHAPTER 21 OF TITLE 24, DELAWARE CODE, RELATING TO THE USE OF DRUGS OR SURGERY IN EXAMINATIONS.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF DELAWARE:

Section 1. Amend §2116 of Chapter 21, Title 24, Delaware Code, by striking said section in its entirety and substitute a new section to read as follows:

"§2116. Use of Drugs or Surgery in Examinations

Nothing in this Chapter shall be construed as conferring on the holder of any certificate of registration for license, issued by the Board the right to make use of drugs or surgery in the treatment of eye diseases. He may employ topical ophthalmic drugs for diagnostic purposes only, the drugs that he may use for such diagnosis will be limited to the following four classes of drugs: Topical Anesthetics, Mydriatics, Cycloplegics and Myotics; provided however, that the Delaware State Board of Examiners in Optometry will include an examination on the subject of pharmacology as it relates to optometry and

the use of topically applied diagnostic drugs for all new applicants for licensure; further provided that no presently licensed optometrist shall be permitted to make use of topically applied diagnostic drugs until he shall have completed a refresher course in pharmacology as it relates to optometry and the use of topically applied diagnostic drugs given by an institution accredited by a regional or professional accrediting organization which is recognized by the National Commission on Accreditation, and is approved by the Delaware State Board of Examiners in Optometry."

APPROVED

JUN 24'75

BY GOVERNOR

CHAPTER

563

PUBLIC LAW

STATE OF MAINE

IN THE YEAR OF OUR LORD NINETEEN HUNDRED SEVENTY-FIVE

S. P. 169 — L. D. 556

AN ACT to Further the Conservation of Vision.

Be it enacted by the People of the State of Maine, as follows:

Sec. 1. 32 MRSA § 2411, as enacted by PL 1973, c. 788, § 156, is repealed and the following enacted in place thereof:

§ 2411. Definitions

1. Practice of optometry. The practice of optometry is defined as any one or any combination of the following practices:

A. Eye examination. The examination of the eye and related structures to ascertain defects or abnormalities and to detect the presence of eye diseases.

B. Functional examination. The determination of the accommodative or refractive states of the human eye and evaluation of visual functions.

C. Correctional treatment. The correction of vision problems without the use of drugs, medicine or surgery by prescribing or adapting ophthalmic lenses, including contact lenses and other optical aids, and by using other corrective procedures to preserve, restore or improve vision.

D. Fitting of eyeglasses. The fitting, bending and adjusting of eyeglasses with ophthalmic lenses, except that this subsection shall not be considered as the practice of optometry providing the fitting, bending and adjusting is by order of and under the responsibility of an optometrist or ophthalmologist.

E. Replacement of lens. The replacement or duplication of an ophthalmic lens without a written prescription from a person licensed under the laws of this State to practice either optometry or medicine. . .

Nothing in this section shall be construed to prevent an optical mechanic from doing the merely mechanical work associated with adapting, fitting, bending, adjusting, replacing or duplicating of eyeglasses with ophthalmic lenses.

An ophthalmic lens within the means of this section shall be any spectacle lens or contact lens which has a spherical, cylindrical or prismatic power or value or any lens ground pursuant to a written prescription.

2. Optometrist. "Optometrist" means a person who has obtained a certificate of registration from the Maine State Board of Optometry and a license to practice optometry in the State of Maine.

3. Diagnostic drug. "Diagnostic drug" means a diagnostic pharmaceutical agent known generically as topical anesthetic and mydriatic which is

administered topically. The Commissioner of Health and Welfare shall designate the specific agents to be used under the generic classifications.

Sec. 2. 32 MRSA § 2419 is enacted to read:

§ 2419. Use of drugs

1. Diagnostic drugs. The use of diagnostic drugs is permitted only by an optometrist who has obtained a diagnostic drug license under section 2427 or who has passed the examination under section 2422.

2. Standards for use of diagnostic drugs. The following shall constitute the minimum standards for use of diagnostic drugs:

A. The optometrist shall complete or have completed a course in general and ocular pharmacology as it applies to optometry approved by the board.

B. The diagnostic drug shall be used solely for the purpose of detecting any pathological condition or functional abnormality of the eye.

C. Each use of a diagnostic drug shall be noted in writing and shall be made part of the permanent record of each examination and placed on file in accordance with section 2417, subsection 3.

Sec. 3. 32 MRSA § 2422, as enacted by PL 1973, c. 788, § 156, is amended by adding after the 2nd sentence 2 new sentences to read:

The board shall include an examination on the subject of general and ocular pharmacology as it relates to optometry and the use of topically applied diagnostic drugs for all new applicants for a certificate of registration and license. Presently licensed optometrists shall be permitted to use diagnostic drugs only if they obtained a diagnostic drug license under section 2427.

Sec. 4. 32 MRSA § 2427 is enacted to read:

§ 2427. Diagnostic drug license

Every presently licensed optometrist desiring to use diagnostic drugs shall:

1. Have satisfactorily completed a course and examination in general and ocular pharmacology as it applies to optometry approved by the board.

2. Upon satisfying the foregoing requirements, an optometrist shall be granted a diagnostic drug license.

Sec. 5. 32 MRSA § 2432, sub-§§ 13 and 14 are enacted to read:

13. If such person uses diagnostic drugs without first obtaining either a diagnostic drug license or passing the examination under section 2424 after the effective date of this Act;

14. If such person fails to display his diagnostic drug license issued under section 2427.

Sec. 6. 32 MRSA § 2446 is enacted to read:

§ 2446. Drugs

Any optometrist who uses diagnostic drugs, without first having obtained a license under section 2427 or being duly registered as provided in section 2421 and 2424 after the effective date of this Act shall be deemed guilty of a misdemeanor and shall be punished by a fine of not less than $50 nor more than $200.

UTILIZATION OF PHARMACEUTICAL AGENTS BY OPTOMETRISTS

NAME	DATE OF ENACTMENT
Rhode Island	July 16, 1971
Pennsylvania	March 1, 1974
Tennessee	May 8, 1975
Oregon	May 20, 1975
Maine	June 24, 1975
Louisiana	July 6, 1975
Delaware	July 10, 1975
*West Virginia	March 4, 1976
California	July 9, 1976
Wyoming	February 17, 1977
New Mexico	March 4, 1977
Montana	April 12, 1977 (at 10:10 a.m.)
Kansas	April 12, 1977 (at 2:00 p.m.)
*North Carolina	June 3, 1977
Kentucky	March 29, 1978
Wisconsin	April 29, 1978
Nebraska	February 13, 1979
South Dakota	March 15, 1979
Utah	March 21, 1979
North Dakota	March 22, 1979
Arkansas	April 2, 1979
Nevada	May 25, 1979
Iowa	June 8, 1979

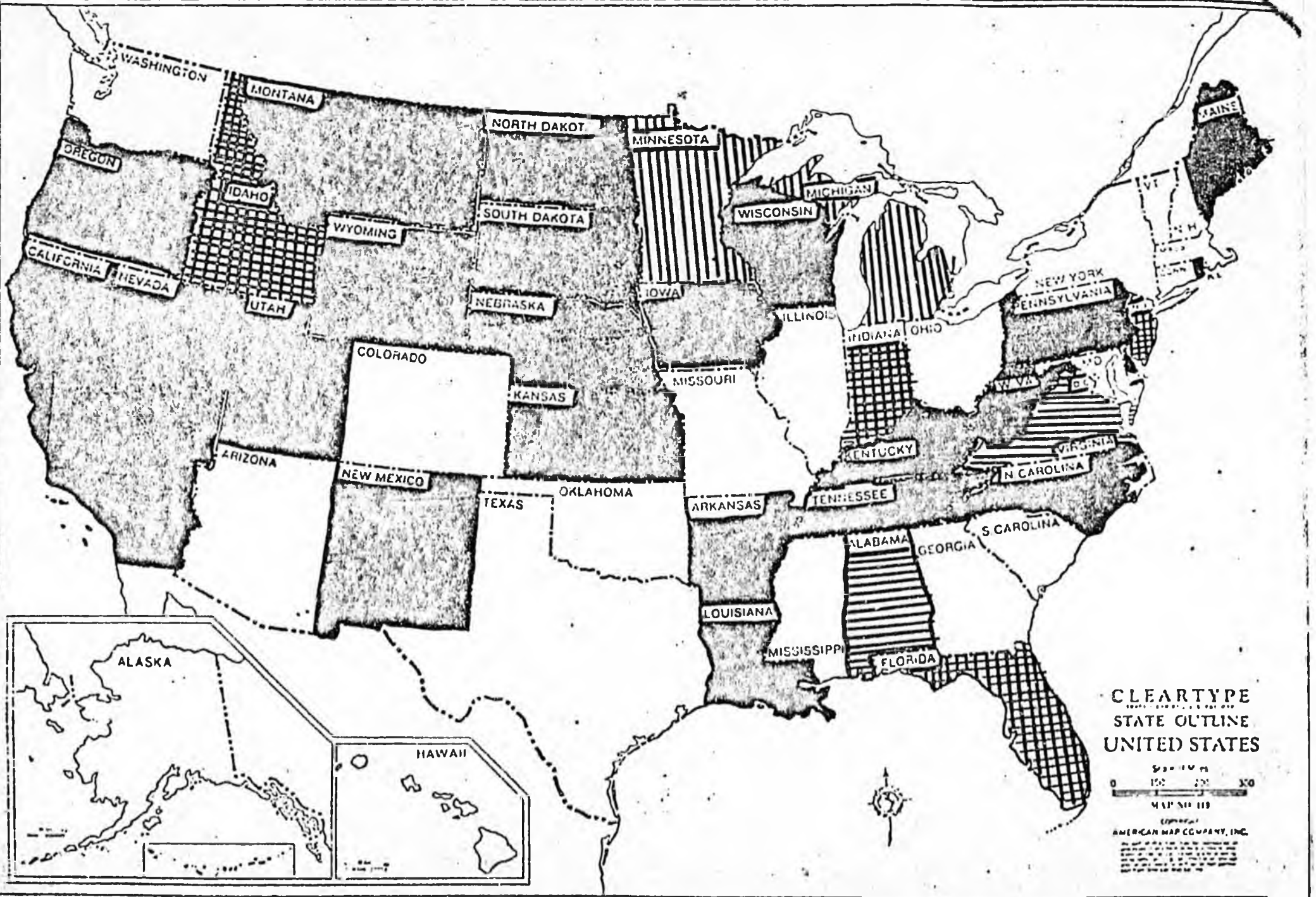
*both diagnostic and therapeutic

[In addition, there are eight (8) other states that do not statutorily prohibit the use of DPAs by optometrists; several of these states have attorney general opinions (+favorable) (-unfavorable) on this point: Alabama (AG-), Florida (AG+) Idaho (State Board Statement +), Indiana (AG+), Michigan, Minnesota, New Jersey (AG+), Virginia (AG-).]

For your information we are including an updated map showing geographically the utilization of pharmaceutical agents by optometrists as of June 8, 1979.

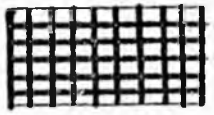
UTILIZATION OF PHARMACEUTICAL AGENTS BY OPTOMETRISTS

JUNE 8, 1979



UTILIZATION OF PHARMACEUTICAL AGENTS BY OPTOMETRISTS

Authorized by Optometrists by Statute



Permitted by Opinion of Attorney General or State Board Statement

No Statutory Prohibition

No Statutory Prohibition but Negative A.G. Opinion

ENGLAND, FEBRUARY 1970

JOINT DECLARATION ON BEHALF OF

OPHTHALMOLOGISTS AND OPHTHALMIC OPTICIANS (OPTOMETRISTS)

Following discussions between the General Optical Council, the Faculty of Ophthalmologists and the Joint Committee of Ophthalmic Opticians, the following declaration on matters relating to Hospital and the practice of orthoptics has been agreed on behalf of ophthalmologists and ophthalmic opticians.

1. Hospital Experience for Ophthalmic Opticians

It is desirable in the public interest that ophthalmic opticians should, in their pre-registration year and subsequently, have the opportunity of hospital experience to enable them, in the course of eye examinations, to widen their clinical experience in the recognition of deviations from the normal.

2. Contact Lenses - The Faculty accepts the policy of the General Optical Council in respect to the fitting of contact lenses.

3. Drugs

It is proper for an ophthalmic optician, if necessary, to use appropriate drugs for eye-examination or for first-aid treatment in emergencies.

(The following are examples of appropriate drugs for particular purposes:

a. Atropine - 1% or an alternative cycloplegic for refraction in children up to school-learning age.

b. An appropriate mydriatic and cycloplegic e.g. homatropine 1% for examination of the eye in older children and adults up to the age of 45.

c. A weaker mydriatic such as cyclopentolate hydrochloride 0.5% for patients over 45 years of age.

d. A miotic such as eserine 0.25% or pilocarpine 2% for use when required to overcome the effect of a mydriatic or cycloplegic.

e. In contact lens fitting a suitable local anesthetic such as amethocaine 0.5%).

On pages 8 and 9 of this issue, AOA Trustees Albert A. Bucar, O.D., of Antioch, IL, and Gerald J. Easton, O.D., of Coronado, CA, give some frank, honest and personal answers to questions posed during a recently-conducted AOA *News* interview session concerning their first year in office.

An interprofessional "Older Americans Health Fair Day" screening program is being offered May 5 in more than 200 communities throughout the nation. Doctors of optometry and members of the Auxiliary to the AOA will have the opportunity to participate since vision screening has been suggested as an important part of the program, which is being sponsored by the U.S. Administration on Aging, state and local Agencies on Aging, the Red Cross and the National Health Screening Council for Volunteer Organizations (NHSCVO). The event is one of several public service suggestions the AOA has offered in observance in next month's celebration of Older Americans Month. All suggestions are contained in a planning guide which has been distributed to state and auxiliary public information chairmen and state leaders. O.D.s and auxiliary members interested in participating in Older Americans Month and/or the May 5 event should contact their state association office, which has been furnished with a list of screening sites and local sponsors by the AOA through the NHSCVO.

The next issue of the AOA *News* will be an expanded one featuring several items of interest to doctors of optometry. Included in the May 1st issue will be the "Continuing Education Quarterly" supplement. Prepared by the Education & Manpower Division, this supplement will list about 150 continuing education courses which will be offered throughout the United States from July through September. The next issue of the *News* will be devoted partially to the upcoming AOA Congress. Numerous photos and articles, including highlights of the June 17-23 event, will be published. The May 1st issue also will contain several stories on membership services for association members, including results of the recent readership survey on the AOA *News*.

AOA News Apr. 15, 1979.

determined by the doctor involved, the FDA said, and it is recommending leaving the contact lenses in place for 30 days at a time under normal circumstances.

Europeans, Australians and Canadians have been able to buy prolonged-wear contact lenses for three to six years, with mixed results reported. A handful of people have gone blind in one eye or required corneal transplants because of serious infections caused by the lenses. A more significant proportion of wearers — half or more in some instances — stopped using the lenses. And, the lenses can be dropped and lost as easily as conventional ones, although manufacturers expect replacement of the lenses won't cost as much as the first pair.

Major companies and firms expected to be vying for a share of the anticipated market for the new lenses include Danker & Wohlk, Inc.; American Hospital Supply's subsidiary, Heyer-Schulte Corp.; Continuous Curve Contact Lenses, Inc.; Rynco Scientific Corp.; Dow Corning; Syntex Ophthalmics, and Cooper Laboratories, Inc.

Arkansas okays DPA legislation

LITTLE ROCK, AR — Gov. Bill Clinton has signed into law H.B. 843, making Arkansas the fifth state in the nation to specifically authorize optometrists to utilize pharmaceutical agents.

The April 2nd signature by Gov. Clinton makes Arkansas the fifth state this year to enact such legislation. An additional six states do not prohibit, either statutorily or administratively, such utilization.

According to Virgil L. Rhodes, O.D., of Manchester, TN, chairman of the AOA Statutory Definition Advisory Committee, the Arkansas law has special significance because a diagnostic pharmaceutical agent (DPA) bill was vetoed in 1977 by the previous governor.

The Arkansas bill was passed, in final form, by the state Senate by a 20 to 10 vote and in the state House of Representatives by a 77 to two vote.

NEWS

American Optometric Association

Vol. 18, No. 7
April 1, 1979

DPA laws

(See map, page 4)

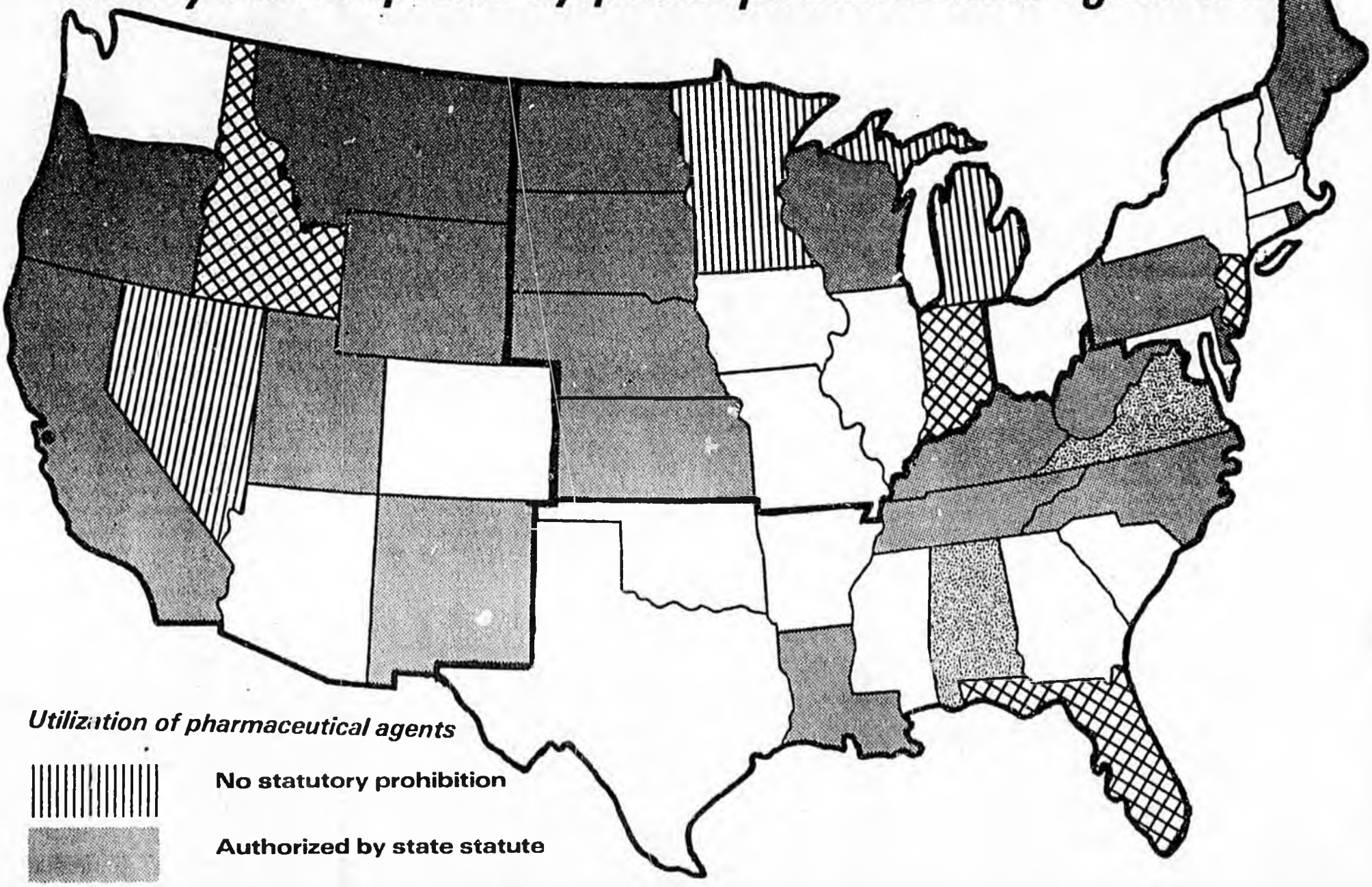
Diagnostic pharmaceutical agent (DPA) bills in North Dakota, South Dakota and Utah have become law, creating 20 states which specifically authorize the use of pharmaceutical agents by O.D.s. An additional six states do not prohibit, either statutorily or administratively, such utilization.

South Dakota became the 18th state when Gov. William J. Janklow signed into law S.B. 85, a measure which had passed the State Senate by a 22:11 vote and, in the House, by a 64:2 vote.

Utah's H.B. 98 became the 19th law on March 21, when the governor did not sign or veto the measure. The legislation had passed the State House by a 50:12 vote and by a 20:4 in the Senate.

North Dakota Gov. Arthur Link signed S.B. 2356 the following day, making the 20th such enactment. The bill passed the Senate earlier by a 41:7 vote and, in the House by an 85:10 vote.

Twenty states specifically permit pharmaceutical agent use



Utilization of pharmaceutical agents

- No statutory prohibition
- Authorized by state statute
- No statutory prohibition but negative attorney general opinion
- Permitted by opinion of attorney general or state board statement

Four successful enactments this year of legislation permitting the use of pharmaceutical agents by optometrists bring to 20 the number of states with laws specifically authorizing such usage. An additional six states do not prohibit such utilization, either statutorily or administratively. According to Virgil L. Rhodes, O.D., of Manchester, TN, chairman of the AOA Statutory Definition Advisory Committee, similar legislation is pending in 12 other states, with several pieces reported near passage. Bills in Arizona and Arkansas have been approved by their respective House of Representatives, while bills in Iowa and Oklahoma have been passed by their respective state Senates, Dr. Rhodes said.

In a related development, the Virginia Senate has decided not to vote on overriding Gov. John Dalton's recent veto of a bill which would have allowed O.D.s in the state to use diagnostic pharmaceutical agents. According to the Virginia Optometric Association, the State Democratic Caucus made the decision in a recent closed session, basing the action on the grounds the legislation was a health issue and not a political partisan one. The legislation, which was supported by more than 30 sponsors from the Virginia House of Delegates, had passed both legislatures by large majorities — by a 74 to 19 vote in the House and a 25 to 15 vote in the Senate. The bill was identical to legislation the Republican governor vetoed last year.

NEW!
MITY
TIME

Don Hostak, Director
Div. of Occupational Licensing

02 13 79

Byron Perkins BP
Licensing Examiner

I spoke with Eldon Ulmer, President of the Board of Pharmacy, and he asked me to convey the following to you in response to your teletype to him last week.

RE House Bill 79 regarding optometrists and particularly their ability to prescribe legend drugs and pharmaceuticals, the Alaska Board of Pharmacy has not changed its position on this issue. The board is not primarily concerned with whether or not an optometrist should be given this priviledge, but rather, that the proposed bill in no way addresses the legal question of how they are to obtain legend drugs. Current Federal and State statutes do not permit pharmacists to fill prescriptions for legend drugs by any one but Medical Doctors, Veterinarians, and Dentists.

Re House Bill 101 and Senate Bill 65, the Uniform Controlled Substances Act, this is the number one legislative priority for the Board of Pharmacy, and the board supports it conceptually. However, the current bill is primarily a police bill, and needs to be ammended substantially to make it palatable to the industry. There is not enough language addressing the rights and responsibilities of professionals authorized to handle controlled substances. The Board of Pharmacy is pushing for a Uniform Controlled Substances Act that parallels the federal guidelines.

cc: Eldon Ulmer, R.Ph.
Chairman, Board of Pharmacy

Rep. Buchholdt

Alaska State Legislature

POUCH V
JUNEAU, ALASKA 99811

P.O. BOX 9
KENAI, ALASKA 99611

REPRESENTATIVE HUGH MALONE

24 January 1979

Peter E. Cannava, M.D.
Box 1629
Soldotna, AK 99669

Dear Peter:

I received your letter and court brief regarding the optometric drug bill and have forwarded a copy to Rep. Thelma Buchholdt. She is the new chairperson of the Health, Education and Social Services Committee. As yet, no legislation has been introduced regarding this issue, however, I expect it will be soon.

Thank you for the information.

Sincerely,

Hugh Malone

jk

Peninsula Eye Clinic
PETER E. CANNAVA, M.D.
OPHTHALMOLOGY
BOX 1629
SOLDOTNA, ALASKA 99669

TELEPHONE 262-4462

Hugh Malone
State Capitol Building
Pouch V
Juneau, Alaska 99811

Dear Hugh:

I gave the enclosed talk to the legislators present at our political meeting and I thought it would be helpful to you to receive a copy of it considering your vote of last session.

The case illustrates the fact that the optometric drug bill represents more than a political "power play" but in fact has and will mean loss of eyes of our fellow Alaskans. We have at least two other cases documented where vision was lost because of inadequate medical knowledge on the part of optometrists.

The judges decision clearly states that there is no reason why optometrists can be permitted to make medical diagnosis on a legal basis. In addition the testimony by the "professor of optometry" clear illustrates the lack of medical knowledge on the part of optometrist educators.

Sincerely,

Peter

Peter E. Cannava, M..D.

PEC/bc

Hugh,
Please have one of your staff save the court brief as it will have to be used for the "HESS" committee hearings & also for future discussions I will have w you.
Good Luck this yr & I wish you a short 90 day session. P.

13Dec78.

American medicine has estabilished a tradition which dates back well over 200 years! Despite the ups and downs of certain aspects of American medicine the very basic integrity of the system has never and will never be challanged. This is fact because the system rests upon a foundation of sound scientific principle. American people may not like what type of treatment is offered them but they at least can rest assured that any prescription promulagated by our traditional medical system is based upon a scientific method, and those practitioner licensed with-in the system have completed a satisfactory curriculum approved by both private and governmental bodies who attest to the fact that medical practitioners are qualified to practice with the use of drugs and other modalities. In addition to the traditional modality of medical care there are two other broad categories of health care which our people choose to utilize. One is not based upon scientific methodology, cannot be supported by established objective data. Examples of these would be naturopathic healing and chiropractic.
The second category of non-medical health care sought by Americans is based upon scientific principles but is not traditionally associated w[illegible] medical education. Examples of those are psychology and optometry. In past years no major conflict has arisen between traditional medicine and other forms of health care. However, of late there is a movement on by non medical people to seek enactment of legislation which would grant them privileges which traditionally have been the provence of medical practitioners. Examples would include attempts by chiropractors to utilize medical facilities for laboratory testing and more germane to our state the attempt by optometry to seek legislation approved for their use of drugs within their practice.

Legislators must be aware of the short and long term implications of such legislation! Granting non-medical practitioners medical priveleges obscures the traditionally clear cut lines between the dicipline of medicine and the non-medical practices. Such obscuration of lines of deliniation serves to thoroughly confuse the public as to what type of health care is to be expected from each type of practitioner! In such confusion the public will have no clear concept of what type of "product" to expect of each health care practitioner. I wish now to focus upon a problem which confronted last years legislators and may surface again! Optometrists as you may be aware are non-medical practitioners by virture of their ancestory, training, current definition and as of several months ago defined by U.S. District judge for Alaska. They are requesting the legislature to grant them privilege of using drugs in their practice! Such a priviliege would have two fold effect and firstly it would set a precident with-in our state and open the door to all non-medical health personell to seek similar privilege. Secondly it would further endanger the people of Alaska to the risk of loss of sight because of the injudicious use of drugs and false sense of security the use of drugs imparts upon the recipients of such treatment. Indeed as time goes on I will supply you with case histories of Alaska residents who have lost eyes because they were lured into feeling they had been examined by eye physicians or ophthalmologists. I will also supply you with a legal suit prompted by such a loss of eye and additional pertinent information. I urge you not to grant non-medical health practitioners by legislation what they should rightfully earn by education that is the right to join the ranks of traditional medicine thru time honored institutions, estabilished testing procedures and time tested licensing procedures.

P E Carnava, M.D.

Rep. Buchholdt

5 February 1979

Peter E. Cannava, M.D.
Peninsula Eye Clinic
Box 1629
Soldotna, AK 99669

Dear Pete:

Yes, I did receive your packet of information and I apologize for the length of time it took me to respond.

I will forward the new information to Rep. Buchholdt as I did earlier for her files.

Again, thank you.

Sincerely,

Hugh Malone

jk

Peninsula Eye Clinic
PETER E. CANNAVA, M.D.
OPHTHALMOLOGY
BOX 1629
SOLDOTNA, ALASKA 99669

TELEPHONE 262-4462

February 1, 1979

Representative Hugh Malone
Pouch V
Juneau, Alaska 99811

Dear Hugh:

I hope you received my last packet of information on HB79 (optometric drug bill) As you will recall it included a copy of Judge Fitzgeralds decision regarding the loss of a childs eye because of optometric mis-managment! Since I have not heard from you I presume you are quite busy and I wish you luck in your difficult task.

Enclosed please find two items: 1. the copy of"P E N" describing optometric education, 2. Veto message of Gov. Rhodes, Ohio.

Sincerely,

Peter E. Cannava M.D.

Peter E. Cannava, M.D.

PEC/bc

Governor's Veto Message

(Unofficial Copy)

December 15, 1978

Pursuant to Article 2 Section 16 of the Constitution of Ohio, I return herewith to the Clerk of the Senate for presentation to the Senate Amended Substitute Senate Bill 163 which I disapprove and have not signed. Amended Substitute Senate Bill No. 163 would expand the definition of the practice of optometry to allow the use by optometrists of specific diagnostic drugs to the eye in the form of eyedrops. If the specified drugs are used solely for the purpose of detecting disease and are of a specific level of potency the matter of health care is of vital concern they must insure to all Ohio citizens that they receive the highest quality health care possible. Health care is an area in which we can take no risks because any mistakes can bring tragic and irreversible results. We must be committed to our citizens to provide practitioners that are highly skilled individuals and who will at the same time provide the best health care at the lowest cost.

Optometrists have been doing an excellent job in working with the medical profession to bring quality eye care to Ohio citizens. The tools that the optometrists are presently using are not dangerous and are effective in screening for eye disease. However, Amended Substitute Senate Bill No. 163 would allow optometrists to use drugs in order to make a full diagnosis of the medical condition of the eye. If the individuals involved were properly trained this procedure would be in the best interest of Ohio citizens, however without proper training the bill would allow unwarranted risks without corresponding benefits. The drugs involved are dangerous and have a potential of causing a great deal of pain including blindness. The adverse reactions associated with these drugs are not common but they do occur and medical and emergency treatment must be administered in those instances. While this bill does provide for mandatory training of 180 clock hours this amounts to little more than a month of isolated training in a clinical use of the drugs involved. The goal of this legislation should be to build a working relation between optometrists and the medical community. The issue of using drugs should be an issue decided by the professions rather than by the legislature. Both professions have taken an oath to provide quality health care, they should work together toward that end. I pledge the aid of my office for that purpose. For the foregoing reasons I have vetoed Amended Substitute Senate Bill No. 163 and urge the General Assembly to sustain my veto.

James A. Rhodes
Governor

Official Business

House ,

Committee on

Health, Education & Social Services

Pouch V
State Capitol
Juneau, Alaska 99811

February 7, 1979

Peter E. Cannava, M.D.
Peninsula Eye Clinic
Ophthalmology
Box 1629
Soldotna, Alaska 99503

Dear Dr. Cannava:

Thank you very much for your letter and back up material regarding HB-79. I do appreciate your taking the time to send this information to the committee.

We have, to date, received this same information from Rep. Hugh Malone, and I am sure it will be of help to members of this committee.

At this time, I have not yet scheduled the bill for hearing, but I will keep you informed as to when the bill will be up for a hearing.

Again, thank you for your interest.

Sincerely yours,

THELMA BUCHHOLDT
Chairman
House HESS Committee

TB/ch

Peninsula Eye Clinic
PETER E. CANNAVA, M.D.
OPHTHALMOLOGY
BOX 1629
SOLDOTNA, ALASKA 99669
TELEPHONE 262-4462

February 1, 1979

Thelma Bucholt, Representative
Pouch V
Juneau, Alaska 99811

Dear Mrs. Buckhodt:

HB 79 (optometric drug bill) has been sent to your committee for review. It is essential that you review the enclosed court decision concerning the loss of a young Alaskans eye due to optometric irresponsibility. As you will recall the issue last year was whether ot not optometrists were qualified to use dangerous drugs on the eyes of Alaskana. Judge Fitzgerald's decision should settle that question in the minds of Alaskans.

In addition you will find enclosed the Ohio Governors veto message of such a dangerous bill.

I would appreciate your response to the material.

Sincerely,

Peter E. Cannava, M.D.

PEC/bc

THE FOLLOWING DOCUMENT(S) MAY NOT FILM LEGIBLY BECAUSE OF POOR QUALITY OF THE ORIGINAL.

Deputy

IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF ALASKA

RECEIVED

OCT 24 1978

Parnish Law Office

ROBERT K. STEELE, as the Natural father and next friend of TIMOTHY R. STEELE, and ROBERT K. STEELE, individually,

Plaintiffs,

v.

UNITED STATES OF AMERICA,

Defendant.

NO. F 75-27 Civil

O P I N I O N

Timothy Steele is an eight year old boy whose father is a soldier in the United States Army. Timothy received medical care as a medical dependent at the Eye Clinic, Bassett Army Hospital, Fort Wainwright, Alaska, in 1973 and 1974. This litigation stems from a claim brought on Timothy's behalf by his father against the United States for loss of Timothy's right eye. The Federal Tort Claims Act [1] furnishes the required jurisdiction.

In October and November of 1973, Timothy's mother noticed Timothy's eyes crossing. On December 19, 1973, she took Timothy to the Eye Clinic, Bassett Army Hospital. There Timothy saw Dr. John Shank, an optometrist in charge of the clinic.

1/ 28 U.S.C. 1346(b). Plaintiffs' original complaint founded jurisdiction on the Federal Tort Claims Act but mistakenly cited the section as 1366(b).

Dr. Shank made an extended examination and diagnosed Timothy's eye condition as an accomodative esotropia correctable by eyeglasses. Following his examination of Timothy, Dr. Shank wrote Mrs. Steele a prescription for eyeglasses and made an appointment for her to return Timothy to the clinic January 29, 1974, for a checkup.

During the January visit to the clinic Timothy's mother reported to Dr. Shank that she thought the eyeglasses were helping since Timothy's right eye was not crossing as frequently. However, Dr. Shank's clinical record noted "no good reflex" in Timothy's right eye. The optometrist wrote a different prescription for eyeglasses and instructed Mrs. Steel to make a follow-up appointment for Timothy four months after Timothy would begin wearing the new eyeglasses.

By early May, Mrs. Steele noticed that Timothy frequently removed his eyeglasses. When questioned Timothy told her that sometimes he wasn't able to see well. An appointment at the eye clinic was scheduled for Timothy on June 10. When Dr. Shank examined Timothy on that date he found vision in Timothy's right eye limited to light perception. At this point Dr. Shank made an appointment for Timothy with ophthalmologist, Dr. Bruce Wolf, [illegible]

When Dr. Wolf examined Timothy on June 17th he found Timothy's visual acuity in the right eye limited to hand motion although capable of perceiving light. Essentially Timothy's right eye was blind. The doctor diagnosed Leucocoria, right eye, with right esotropia. In his medical opinion the inflammatory cause was a vitreous hemorrhage with possible involvement of toxocara canis or retinoblastoma. Since either disease was extremely serious, Dr. Wolf ordered a complete workup by a pediatrician hoping to rule out one or both. The pediatric workup proved negative and Dr. Wolf then arranged for ophthalmologist, Dr. William Kim, as consultan

Dr. Kinn, a highly qualified ophthalmologist, before opening a prac in ophthalmology at Fairbanks spent ten years as a military medical officer. His last three years of military service were spent at Fort Wainwright where he was chief of ophthalmology and supervised the optometrists assigned to Bassett Army Hospital.

On examination of Timothy July 9th, Dr. Wolf and Dr. Kinn observed a retinal detachment of the right eye with a sub-retinal tumor. "Tumor" in this context was defined as a mass rather than a malignancy. Their diagnosis was possible retinoblastoma, but toxocara canis was also to be considered. The doctors concluded specific tests were necessary so that the precise identity of the disease might be known.

Arrangements were made to airvac Timothy from Fairbanks to Letterman Army Medical Center at the Presidio in San Francisco. At Letterman, Timothy was examined July 12 by a team of medical doctors, including Dr. Michael Hogan who was internationally recogn in the field of ophthalmologic pathology.

On examination the medical team observed a retinal detachment involving a grayish yellow tumor. The doctors diagnosed the cause of the tumor as possibly retinoblastoma or toxocara canis. Eye condition at that point in time made it impossible to differentiate between either disease. Because of the danger of retinoblastoma, a particularly fast-spreading and life-threatening malignancy, the doctors recommended to Timothy's parents that his right eye be removed. Timothy's parents immediately consented to the operation and Major Bradley C. Black, a resident assigned to the ophthalmology unit at Letterman, performed the surgery.

After the eye was enucleated it was sent to the ophthalmolo pathology laboratory at the University of California, Berkeley, California, for examination. The laboratory report revealed total retinal detachment of the eye with giant reaction and massive disorganization of the retina. The pathological examination ruled out a

retinoblastoma but concluded the cause of the disease to be granulomatous retinitis,[2/] etiology unknown. Unlike as in most eye removals, an implant was not inserted into the socket of Timothy's right eye immediately following surgery as there was a substantial possibility that the pathology report might confirm retinoblastoma. The malignancy would necessarily require radiation treatment and a follow-up examination not possible with an implant. When the pathological report ruled out retinoblastoma Timothy was returned to surgery and an implant was placed in the socket.

Dr. Black continued to treat Timothy following the second operation until Timothy returned to Fairbanks. After Timothy returned to Fairbanks he was treated by Dr. Wolf who noted that Timothy's recovery was excellent with the exception of periodic socket inflammation.

Timothy returned in September to Letterman where a prosthesis was inserted into the eye socket with good cosmetic result. Probably the prosthesis will never appear similar to a natural eye since it could not be inserted immediately following the operation.

It is claimed in this litigation that the optometrist, Dr. Shank, failed to provide adequate care required of an optometrist when he treated Timothy in December of 1973 and January of 1974.

OPTOMETRIC RESPONSIBILITY

Dr. Shank graduated with a degree in optometry from Pacific University at Forest Grove, Oregon, in 1971. He was commissioned in the United States Army as a Captain in the medical services and during the summer of 1973 was assigned to Fort Wainwright, Alaska. In November of 1974 he left the Army and now is in the practice of optometry at Kodiak, Alaska.

2/. Retinitis is an inflammation which chiefly involves the retina. "Granulomatous" is a type of inflammation. Thus, the pathology conclusion was that of a general retinal inflammation of unknown origin.

When Dr. Shank made his first examination of Timothy's eyes on December 17, 1973, he recorded a brief history:

Hist: Past 2 years problem. Unable to see clearly. Father nearsighted. Age 4 was tested. Both eyes crossed. Patient complained of blurred vision. Headaches & dizziness. No allergies

In addition he also tested Timothy's unaided vision using a standard AO chart (pictures) for children. The best possible visual acuity when measured with an AO chart is 20/30. Dr. Shank recorded Timothy's visual acuity 20/30 OD and OS (both eyes). After dilating Timothy's eyes he made an internal examination and noted:

Internal Exam: Optic - Sclera Shows clearly OD: Distinct 10/10 Disc at 1:30 OD (R) Vitr. Impr. Lens Lenses

what this is

Upon completing the examination, Dr. Shank concluded that Timothy's eye problem was caused by an accomodative esotropia[3/] correctable by a prescription for eyeglasses. He did not think it necessary to refer Timothy to an ophthalmologist.

Dr. Willard Bleything, Dean of the College of Optometry, Pacific University, Forest Grove, Oregon, who was called as a government witness at trial, agrees with Dr. Shank. According to Dr. Bleything, the findings of Dr. Shank's December examination are entirely consistent with an accomodative esotropia, hence, there was no need to send Timothy to a medical doctor.

Refrac

3/ Estropia, meaning pointing inward.

In his testimony Dr. Bleything touched on the scope of training provided in a school of optometry. A significant part of optometric training is given over to recognition of diseases in the eye. In this case no one questions the principle requiring optometrists to refer their patients to medical doctors once disease is detected in the eye. In Timothy's case, however, Dr. Bleything would distinguish between an active vitreous hemorrhage and an inactive vitreous hemerrhage. He classifies an inactive vitreous hemorrhage as a scar and suggests referral to a medical doctor is indicated only in the event that an active vitreous hemorrhage were detected. It is implicit by this reasoning that to Dr. Bleything a scar is not an indication of existing disease. Scar tissue, according to Dr. Bleything's opinion, when old or inactive, is typically black. This is consistent with Dr. Shank's testimony that the vitreous hemorrhage detected in his December examination was old because it appeared black or dark.

OD's only need refer active hemorrhages ??

wrong Professor!

Actually a black or dark color in a vitreous hemorrhage has nothing at all to do with its age, but rather is a result of its magnitude or extent. The black or dark color indicates a lack of reflected light from the retina behind the hemorrhage. Blood in a vitreous hemorrhage is not black; it is only the shadow that appears black. Indeed, as Dr. Black states in his deposition, an old vitreous hemorrhage would appear as white strands in the vitreous and settle to the lower part of the vitreous. And Dr. Kinn testified that he had personally observed hemorrhages in the vitreous more than a year old which were red in color. He explained that a hemorrhage would appear to be black because it was sufficiently thick with blood to absorb all the light reflecting off the retina during an examination, not because of an innate darkness of color.

The interrelationship between optometric and medical responsibility is discussed in considerable depth in the scientific text referred to at trial, "The Optometric Profession," by Hirsch

& Wick. The text notes that responsibility for recognizing eye disease has not always been a part of optometry, nor indeed is it now a part of optometric services in parts of the world outside of the United States and English speaking countries. In some European countries an optometrist is expressly forbidden to examine the eye to determine whether it is healthy or not.[4/]

Some of the diseases which may be discovered by examination of the eye are brain tumors, diabetes, kidney disorders, hypertension, as well as some diseases caused by microorganisms such as tuberculosis. Optometrists study about these and other diseases in order to recognize eye manifestations of diseases. An optometrist should not attempt to complete a definitive diagnosis but recognize this responsibility is part of the practice of medicine. This principle is clearly stated in "The Optometric Profession."

> The difference between optometric and medical responsibility to the patient may be clarified by example. If an optometrist observes a hemorrhage in the fundus, he recognizes that it may be due to any of the diseases already enumerated. It also may have resulted from a vascular accident or from undue capillary fragility. The important consideration for the optometrist, however, is that he see and identify the hemorrhage. It is his responsibility to refer the patient to the appropriate medical practitioner for diagnosis and treatment of the disorder. The optometrist's understanding about disease is sufficient to recognize the various diseases that can cause hemorrhage. He does not attempt to differentiate between them. Medical technology has advanced so greatly in the past few decades that there are now many laboratory tests the physician can use in making the correct diagnosis. Disease is diagnosed by many procedures. The appearance of the eyeground is only one of them. The Optometric Profession

I am not persuaded with Dr. Bleything's reasoning that referral to a medical doctor ought to depend on whether the optometrist

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4/ The Optometric Profession by Monroe J. Hirsch and Ralph E. Wick, (1968 edition) Chilton Book Co. at page 17.

has diagnosed a vitreous hemorrhage as active or inactive. The authors, Hirsch & Wick, suggest in their text that the important consideration is that the optometrist be able to see and identify the hemorrhage. It then becomes his responsibility to refer the patient to a medical doctor for diagnosis and treatment. Since Dr. Shank detected the vitreous hemorrhage of the right eye during his December examination, it was his immediate responsibility to promptly refer Timothy to a medical doctor. In point of fact, ophthalmological services were then readily available to military personnel at Fort Wainwright and to their dependents under a federal contract with Dr. Wolf.

Dr. Shank was aware of symptoms other than vitreous hemorrhage which are of significance to an optometrist. Esotropia in a child of four, Timothy's age in 1973, is a serious matter. Dr. Black states that esotropia in a four year old child is very rare. Most cases of congenital esotropia caused by muscle imbalance develop before age two. This condition is correctable by an operation on the muscles of the eyes. Accomodative esotropia, such as diagnosed by Dr. Shank in December, 1973, develops in most cases at age two to two and a half, although it occasionally develops as late as age four or five. This condition is correctable by eyeglasses and the esotropia usually corrects itself after eyeglasses are worn. An esotropia may also indicate some type of retinal or vitreous pathology in the visual axis. This will often involve a disease in the macula, the central part of the retina. This condition reduces visual acuity in the eye and as a result the eye turns inward. In Dr. Black's opinion the most important thing to rule out when a child does present an esotropia is retinal or vitreous pathology. But even more, when a vitreous hemorrhage is observed in a child, it is very important that retinoblastoma be immediately considered until that disease can be completely ruled out.

Dr. Wolf, who treated Timothy at Fairbanks before and after his hospitalization at Letterman, agrees with Dr. Black that Dr. Shank should have referred Timothy to an ophthalmologist in December. Dr. Wolf believes that referral to a medical doctor ought to have been made immediately when Dr. Shank learned of the esotropia from Timothy's mother. Dr. Kinn, who consulted with Dr. Wolf, also agrees that referral was indicated in December. Indeed, Dr. Zimmerman, an eminent ophthalmic pathologist, who testified for the government at trial, concurs that further investigation should have been undertaken at the time the lesion was observed in Timothy's right eye.

I am persuaded from credible, convincing medical opinion, as well as the scientific publication referred to, that Dr. Shank failed to meet the standards required of his profession when he examined Timothy in December of 1973. He knew that Timothy presented an esotropia and in the course of his examination he observed a vitreous hemorrhage in the right eye. An optometrist's responsibility is to observe during his eye examinations any manifestation of disease visible in the eye. Upon detecting disease in the eye, it is then his obligation and duty to the patient to make known what the optometrist has observed. In such cases he may not undertake to diagnose the disease, but should inform his patient that the matter is beyond his competence and advise the patient to see a qualified medical doctor. Certainly in January when Dr. Shank detected the poor reflex in Timothy's right eye, he should have sent Timothy to a medical doctor. Instead, he delayed making a referral to an ophthalmologist until after his last examination in June, 1974. By that time Timothy was essentially blind in his right eye and by then the retina had pulled away from the rear of Timothy's right eye. As it was to turn out, nothing thereafter could be done to restore the vision or to save the eye. Time had run out.

Several questions arise at this juncture. Was the disease which ultimately caused the eye to be removed present when Dr. Shank made his examination in December, 1973? What was the nature of the malady and could it have been diagnosed? Could the disease have been treated had it been timely discovered?

There is general agreement in the testimony of the physicians that the disease which brought about the removal of Timothy's right eye was present when Dr. Shank made his initial examination.

When Dr. Wolf examined Timothy in June, 1974, he diagnosed a vitreous hemorrhage with the possibility of either retinoblastoma or toxocara canis. The team of medical doctors who examined Timothy at Letterman Hospital in July considered four possibilities. The first was persistent hyperplastic primary vitreous, a congenital defect of the eye present at birth and generally noticed shortly after birth. With such a condition as persistent hyperplastic primary vitreous, the eye is usually a bit smaller. The front part of the eye is ordinarily not normal so there are distinguishing factors for that disease. The medical doctors at Letterman were able to rule out this possibility. They were also able to rule out a vitreous hemorrhage as a cause since the vitreous of the eye was fairly clear when the doctors made their examination. The two remaining considerations related to some type of inflammatory response, most probably either toxocara canis or retinoblastoma.

Retinoblastoma is an extremely dangerous malignancy, sometimes found in the eyes of young children. When diagnosed, retinoblastoma requires removal of the diseased eye to prevent the malignancy from escaping outside the eye, possibly through the optic nerve into the brain.

Retinoblastoma was ruled out in the University of California pathological report following examination of the eye after the operation. A negative finding of retinoblastoma eliminated any

need for radiation treatment. In Dr. Black's medical opinion the cause of the inflammation of Timothy's eye was probably toxocara canis. Dr. Black observed that although the larva was never found in the few sectionings of the eye, it is known that the larva may disintegrate or completely disappear in the eye.

Toxocara canis is a parasitic round worm frequently found in dogs. The eggs of the parasite may be ingested by children playing in dirt and the eggs hatch in the intestines of the child into a larva. The larva bores through the intestinal wall and enters the blood stream and is disseminated to different parts of the body. In every instance, with possible rare exception, the parasite is not able to complete its life cycle in a human host and the larva dies without developing into an adult worm. The most common locations where it has been found are in the liver or the lungs. Inflammation of the eye by toxocara is fairly rare. But when it does appear it tends to result in a massive inflammation which usually involves the retina and sometimes may intrude into other structures inside the eye. The presence of toxocara in the body often leads to visceral larva migrans syndrome. The child can have a fever and may have some type of lung disorder, his liver may be enlarged and tender and there may be some abnormalities in certain blood tests. However, an ocular toxocara inflammation frequently occurs without a visceral larva migrans syndrome occurring and some studies suggest that in only three or four percent of ocular toxocara inflammation is the syndrome present. With ocular toxocara, so long as the larva remains alive, there is usually not much effect on the eye. There may be a local inflammation in the retina or a small whitish elevated lesion in the retina at the site of the larva or where it penetrated the retina, but the stage at which the parasite usually becomes very damaging is when the larva dies and decomposes. This leads to an extensive lesion in the eye eventually.

resulting in a massive scar. If the larva is able to work itself into the vitreous cavity of the eye , it brings about an even more severe inflammatory process.

Dr. Iris Krupp of Tulane University in New Orleans, Louisiana, is a widely renowned expert in the field of parasitology. She began her work on toxocara as a graduate student in 1954. Since then, she, in association with several opthalmologists, has done extensive work in the detection and treatment of toxocara. She developed a reliable serologic test for the detection of toxocara which was announced in an article[5/] published in the "American Journal of Tropical Medicine" in May, 1974.[6/] After examining the medical records, including the pathology report, in Dr. Krupp's opinion the probability was 90 percent that the disease in Timothy's right eye was toxocara.

Ophthalmic pathologist Dr. Lawrence Zimmerman was a principal government witness at trial. He agreed that the University of California pathological report required that retinoblastoma be ruled out as a cause. However, he noted Dr. Helenor Foerster, a widely known ophthalmic pathologist also performed a pathological examination on Timothy's eye. Dr. Foerster has published a number of important scientific papers, one of which presented the initial description of toxocara infection of the eye. Dr. Foerster prepared a pathological report in connection with a paper which she presented to the Western Ophthalmic Club. In her report Dr. Foerster observed many pigment-

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5/ Hemoglutination Test for the Detection of Antibodies Specific for Ascaris and Toxocara Antigens in Patients with Suspected Visceral Larva Migrans.

6/ Since the article did not appear until May, 1974, the physicians who treated or examined Timothy were probably not aware of Dr. Krupp's serological test.

laden macrophages and giant cells in the retina. Dr. Zimmerman believed this was significant since it implied substantial bleeding into the eye, or alternatively, that a foreign body containing iron might have been introduced into the eye. He postulated that bleeding may have been brought about by several causes, including persistent hyperplastic primary vitreous. In addition, Dr. Zimmerman suggested another possibility of the cause of the inflammation might be a low grade bacterial infection. He did not, however, conclusively rule out toxocara as a possible cause but noted that the larva was not found in either pathological examination. Also, in Dr. Zimmerman's opinion the iron pigment described by Dr. Foerster in her pathological report would not be characteristic of toxocara infection. For these reasons he discounted toxocara as the cause.

Dr. Zimmerman concluded that in this instance it is unlikely that the cause of Timothy's eye inflammation can ever be reliably known, hence the doctor's final diagnosis was chronic sclerosing endophthalmitis, cause undetermined.

It is true that the larva was not found during pathological examination. But as Dr. Fleck explained, the larva may decompose and disintegrate. The University of California pathological report following examination of the eye was prepared by Dr. Joseph Eliason, an ophthalmologist. In his deposition testimony Dr. Eliason stated the pathological diagnosis was granulomatous retinitis, etiology unknown. As stated above, this is a general inflammation involving the retina. Toxocara canis characteristically causes this type of inflammation although other causes are possible.

In the course of the pathological examination,

a technician prepared 30 to 40 sections from the eye. A section is less than a tenth of a millimeter and unless the entire eye is sectioned it is possible to miss the larva. In Dr. Krupp's opinion insufficient sections of the eye were examined to exclude the possibility that the larva was in the eye. Other possibilities suggested by Dr. Zimmerman that bleeding into the vitreous was caused by persistent hyperplastic primary vitreous were ruled out during the medical examination in July at Letterman, nor is there anything to suggest the possibility of a foreign metallic object as the cause of the inflammation.

I find on the basis of the testimony of the treating physicians, including Dr. Wolf, Dr. Kinn and Dr. Black, that toxocara canis was the probable cause of the inflammation in Timothy's right eye. The opinions of the treating doctors are substantially similar to the opinion of Dr. Krupp whose qualifications in this field are outstanding. I find in all probability the larva entered the eye through the retina prior to the time Dr. Shank made his examination in December of 1973. Probably the vitreous hemorrhage observed by Dr. Shank was caused by underlying lesion in the retina of the eye.

While it cannot be known with absolute certainty what an ophthalmologist would have done or been able to do if Timothy had been seen in December, 1973, Dr. Kinn testified that the ophthalmologist would have been immediately concerned with making a diagnosis. At that time the physician might have had some indication of a retinal lesion which would cause him to suspect either a granulomatous reaction or a retinoblastoma. The ophthalmologist would have been able to examine the

inflammatory cells were observed, the doctor could have concluded that an inflammatory reaction was present. In such circumstances a diagnosis of toxocara would be likely. Dr. Kinn explained that since the eye was functioning in December it would not have been prudent to remove the eye even if retinoblastoma was suspected. Rather, Dr. Kinn would recommend a therapeutic trial of steroids be undertaken and if the response would be favorable, then the eye not be removed. But if the mass continued to grow despite the treatment and if retinoblastoma could not be ruled out, it would be necessary to enucleate the eye.

Although in Dr. Zimmerman's opinion there is no recognized treatment for toxocara canis, in fact according to Dr. Krupp, the use of steroids in treating toxocara appeared in the medical literature as long ago as 1961. And since that time, Dr. Krupp maintains there have been numerous reports in the literature on the use of steroids. In her own right, Dr. Krupp has participated in treating approximately 20 cases involving ophthalmic toxocara. Her treatment for toxocara includes thiabendozole and steroids, generally used in combination. Thiabendozole is an anthelmintic medicine which kills the larva. The steroid is an anti-inflammatory agent which reduces the [illegible] of inflammation generally associated with toxocara. In each of the cases in which Dr. Krupp participated treatment was able to arrest the loss of vision at the stage it was when the patient was first seen. Results of treatment can usually be observed within three to four weeks. In the event a patient does not respond to treatment, retinoblastoma may be indicated.

7/ By Schneider at the Oxnard Clinic.

Dr. Black was also aware of several cases where inflammation of the eye was treated with steroids, and in isolated cases steroid treatment has decreased the inflammation, resulting in minimal scarring. But in Dr. Black's opinion in most instances toxocara is not seen by the ophthalmologist until it has been quite destructive. However, assuming that visual acuity in Timothy's right eye was 20/30 in December of 1973 and treatment with steroids was instituted, some vision might have been salvaged.

In Dr. Wolf's opinion if Timothy had been seen by an ophthalmologist in 1973, very possibly the eye could have been saved. Since a granulomatous inflammation is a cellular reaction to a foreign object, treatment would be taken to block the reaction. Steroids are a recognized form of treatment for granulomatous inflammation.

I find it probable that an ophthalmologist examining Timothy's right eye in December, 1973, would have diagnosed possible granulomatous reaction, toxocara canis or retinoblastoma. Although there was a lesion in the eye that to some extent impaired Timothy's vision, his visual acuity in the eye was 20/30, the best that could be measured on Dr. Shank's eye chart. The ophthalmologist under such circumstances would almost certainly institute a course of treatment involving steroids in order to reduce the inflammation. The treatment would have prevented further loss of vision and toxocara inflammation would have caused minimal scarring. The eye would have been saved.

Since the jurisdiction of the court is found under the Torts Claims Act, Alaska tort law controls. Richards v. U.S., 369 U.S. 1; U.S. v. English, 521 F.2d 63 (9th Cir. 1975).

The concept of liability arising out of negligence has been recently stated by the Alaska Supreme Court to be:[8/]

> It is elemental that in order for liability to be imposed in a negligence action, the plaintiff must establish a duty of due care owed him by the would-be defendant, a breach of that duty, and finally, that the injury was proximately caused by the breach of duty. Generally speaking, the duty of due care or ordinary care is the duty to act with that amount of care which a reasonably prudent person would use under the same or similar circumstances.
>
> Leigh v. Lindquist, 540 P.2d 492, 494 (1975).

Dr. Shank's failure to promtly inform Mr. and Mrs. Steele of the vitreous hemorrhage in their child's eye and his accompanying failure to refer Timothy to an ophthalmologist was a breach of the standard of care owed to Timothy Steele and his parents. I find Dr. Kinn's testimony as the duty owed to be especially persuasive. Not only is he a board certified ophthalmologist who continually deals with optometric referrals, but Dr. Kinn was previously chief of the eye clinic at Bassett Army Hospital for three years. During those years, he was in charge of the optometrists at the eye clinic and had overall responsibility for all medical and optometric care at the clinic. Additional evidence of the breach of the standard of care is found in the established text "The Optometric Profession." That authoritative work explicitly

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8/ The standard of care required of medical doctors, osteopaths, and dentists is found at AS 09.55.540. Optometrists were not included. In 1976 the statute was broadened to include all health care providers. 34 Ch. 102 SLA 1976. The amendment was limited, however, to actions filed after the effective date, May 29, 1976. Since Steele v. U. S. was filed August 20, 1976, the amendment is not applicable.

states that an optometrist is bound not to try to differentiate between pathologies such as hemorrhages. Instead, an optometrist must refer the patient to a medical practitioner for prompt examination.

I conclude that competent optometric practice required that Timothy's parents be notified and that the child be referred. The failure to inform and refer was not a "judgment call" but a violation of the governing principles of professional standards.

Optometrist are trained to recognize symptoms of many diseases which may be discovered by eye examination. They are not permitted under recognized optometric standards to undertake a definite diagnosis but recognize this as the responsibility of a medical doctor. 9/ Obviously, it is foreseeable that failure to refer to a qualified medical practitioner, when required to do so, will result in delay of diagnosis and the institution of treatment; so it proved to be in Timothy's case. At the time the referral was finally made to an ophthalmologist, it was too late. Time had run out, and the only thing that could be done was to remove the eye.

I conclude that the plaintiff is entitled to recover in this action from the United States for the loss of Timothy's right eye.

DATED at Anchorage, Alaska, this 20th day of October, 1978.

JAMES M. FITZGERALD
United States District Judge

9/ The Optometric Profession, pp 6, 17.

THE PRECEDING DOCUMENT(S) MAY NOT FILM LEGIBLY BECAUSE OF POOR QUALITY OF THE ORIGINAL.

ALASKA STATE MEDICAL ASSOCIATION
1135 W. Eighth Avenue • Suite 6 • Anchorage, Alaska 99501 • (907) 277-6891

February 26, 1979

Respresentative Thelma Buchholdt, Chairman
House of Representatives
Health, Education, and Social Services Committee
Pouch V, Mail Stop #3100
Juneau, Alaska 99811

Dear Ms. Bushholdt:

The Alaska State Medical Association Legislative Committee has reviewed House Bill 79, an act relating to the practice of optometry.

Enclosed is a copy of correspondence relating to the issue during the 1978 Legislative Session. The position of the Association remains essentially the same, namely:

(1) We are unable to determine how this legislation will improve eye care or specifically benefit the public.

(2) Specifically, we know of no diagnostic use for the drug class, miotics, requested; in converse, their use would be appropriate for treatment of narrow angle glacoma, precipitated by a mydriatic/ cycloplegic use. This condition, we understand, is more prevalent amongst the Alaska natives than the general population, such that bush use of these drugs could carry increased risk.

(3) We approve the educational requirements added in the 1979 legislation. It follows that should the Legislature believe the proposed legislation is in the broad public rather than for special interest, no grandfather type clause should be allowed.

Sincerely,

W Fish

Winthrop Fish, M.D.
Chairman, Legislative Committee
Alaska State Medical Association

WF:mlm

Enclosure

February 14, 1978

Representative Charlie Parr
Chairman, House HFSS Committee
Alaska State Legislature
Juneau, Alaska 99801

Dear Representative Parr:

The Alaska State Medical Association Council has reviewed HB 664, An Act Relating To The Practice Of Optometry. We see no purpose identified or expressed within the substance of the Bill. We further see no areas where the public interest will be served by its passage and several areas where compromised eye care, duplication and cost increases are possible if not likely.

At the outset, please understand that the ASMA properly has no interest or intent to interfere with the practice of optometry in Alaska. However, if an enlargement of the scope of optometry into the sphere of medical practice is comtemplated, it reasonably becomes our concern for the welfare of the public, not a simple jurisdictional dispute.

Optometry by derivation, definition, tradition, training and current practice means measurement of the eye for refractive error and a prescription of corrective lenses. Current practices also allows dispensing and sale of lenses and spectacles by the prescribing optometrist.

The current statute defining optometry is unfortunate in that it suggests diagnosis of visual impairment, apart from refractive error, lies within the responsibility of optometry.

Non-refractive visual impairment may be a most difficult and subtle medical diagnostic problem, at times challenging the combined expertise of ophthalmologist, neurologist, radiologist, and internists, and requiring sophisticated diagnostic equipment. Causes range from simple cataracts to subtle brain tumor, from transient vascular insufficiency to obscure metabolic disorders. The visual problem may be the first and only lead to a serious medical disease. Almost all non-refractive visual impairments will come to confirmatory diagnosis and treatment by a physician. It goes without saying that missed or delayed diagnosis can have serious potential consequences.

Before extending the scope of optometry, well beyond refraction and the sale of contact lenses and spectacles, into the intricate area of complex ophthalmological diagnosis, we ask that you assure yourself of the following:

(1) That there is a clearly demonstrated and defined unmet public health problem, that this legislation will solve it, and it is the most appropriate solution.

(2) That the general level of training of the practicing optometrist in Alaska at present is at a standard which will preclude frequent mis-diagnosis, delay, duplication of expense and inappropriate trials of corrective lenses for non-refractive disorders of the eye.

(3) That the use of ophthalmologic drugs in the practice of optometry is free of risk.

(4) That the expanded drug use is necessary and essential to increased accuracy in refractive error diagnosis.

We feel the answers to the above are not obvious, we see no urgency to enact the legislation without the most careful study of the implications and therefore urge that you allow ample time for its consideration.

Sincerely,

WFish

Winthrop Fish, M.D.
Chairman, Legislative Committee

WF:mlm
cc. ASMA Council
ASMA Legislative Committee

why drops?

"WHY DROPS?"

Patients sometimes ask their eye physician, "Why do you use 'drops' when you examine my eyes?"

A clear answer to this question will help one understand the fundamentals of medical eye care and the relationship of his eyes to the health of his body.

"Drops" are of several kinds and they serve several important medical purposes.

One of the commonest uses of drops is to **enlarge the pupils**, so that the physician may examine more thoroughly the interior of the eye—to "look through the open door instead of through the keyhole." There, for the trained medical man to see, may be the first sign of disease elsewhere in the body. Drops make it possible for him to study not only the lens through which the light must pass, but also the retina where the image is formed, and the optic nerve which transmits the picture to the brain.

Such drops are particularly important in examining older people, who are prone to eye diseases, and often have a small pupil that becomes even smaller under the light of the examining instrument. Dilation of the pupil is necessary in examining the eye for suspected cataract, diabetes, hardening of the arteries, high blood pressure—to name a few examples. The effect of drops used merely to dilate the pupils lasts only a matter of hours, and frequently causes little or no blurring of vision.

A second common use of drops is to **relax the focusing muscles** in the eye. This is often necessary to determine the true degree of refractive error that has to be corrected by glasses. Because the focusing muscles in the eye are relaxed by these drops, the eye cannot focus and the vision is blurred until the effect of the drops wears off. These drops also cause the pupil to dilate; however, it is not the dilated pupil but the relaxed focusing muscle that causes blurring of vision. The use of these drops is especially important when examining children. When a physician examines a young child with strabismus (crossed eyes), it is essential to use drops that relax the focusing muscles in order to determine what corrective glasses are required.

A third use of drops is to **anesthetize the eye**, to permit the physician to perform certain diagnostic tests without discomfort to the patient. These drops cause little or no blurring of vision. They are required for the all-important testing for glaucoma. Anesthetic drops are also necessary for the relief of pain resulting from injury.

Finally, there are several ways in which drops are used in the **treatment of the eye.** Some drops are used to destroy bacteria, some to relieve inflammation within the eye, others to relieve a bloodshot condition, and still others to make the pupil small in order to lower the pressure within the eye. Drops to dilate the pupil are used in certain diseases to keep the muscles resting while the eye recovers, or to prevent complications which might develop if the muscles controlling the focus and the pupil were not kept at rest.

Of course, all drops are medicine and they can be prescribed only by a physician, who is licensed to practice medicine and surgery, and administered only by him or someone acting on his order. You should never let anyone else put anything in your eye. Sometimes drops are prescribed by your family doctor, to whom you can always turn for advice about your eyes. He or any other Doctor of Medicine can also tell you of a Doctor of Medicine who specializes in the eye—an ophthalmologist.

Whether or not drops of any kind are to be used is a decision for the attending physician. Only the Doctor of Medicine who examines **your** eyes can say whether drops are needed.

* * *

Why drops? Because they are useful medicines in the modern scientific care of the eyes—as useful in their place as any other drug or instrument that physicians have at hand for the relief of pain and the restoration of health. They are often the key to the prevention of blindness and even the saving of the eye itself.

American Association of Ophthalmology
1100 17TH STREET, N.W. • WASHINGTON, D. C. 20036

Joyce -

Dave Walker has added a sec. to this (Sec. 4) on the last pg. You might want to take a look @ it.

Sloan

Work Order #5987
(for Walker)

Original sponsors: Martin, McKinnon,
Meekins, et al

IN THE HOUSE

BY THE HEALTH, EDUCATION AND
SOCIAL SERVICES COMMITTEE

CS FOR HOUSE BILL NO. 79

IN THE LEGISLATURE OF THE STATE OF ALASKA

ELEVENTH LEGISLATURE - FIRST SESSION

A BILL

For an Act entitled: "An Act relating to the practice of optometry."

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

* Section 1. AS 08.72.300(2) and (3) are amended to read:

(2) "optometry" is the employment of means or methods [, OTHER THAN THE USE OF DRUGS,] for the diagnosis of an optical deficiency or deformity, visual or muscular anomaly of the human eye, or the prescription or application of lenses, prisms or ocular exercises for the correction or relief of the human eye;

(3) "practicing optometry" means the diagnosis [, BY MEANS OR METHODS OTHER THAN THE USE OF DRUGS,] of an optical deficiency or deformity, visual or muscular anomaly of the human eye, or the prescription of lenses, prisms or ocular exercises for the correction or relief of the human eye, or the holding of oneself out as being able to do so;

* Sec. 2. AS 08.72 is amended by adding a new section to read:

Sec. 08.72.305. USE OF DRUGS FOR DIAGNOSIS. (a) No person practicing optometry may use drugs for diagnostic purposes unless he has

(1) passed the board's examination on the subject of pharmacology as it relates to optometry and the use of topically applied drugs; and

(2) completed courses and clinical experience approved by the board and offered by a recognized and accredited school or college of optometry and passed an examination, given by that school or college, which relates to topical application of drugs to the eye, including proper responses to reactions which may result from topical applications

of drugs to the eye.

(b) No person practicing optometry may administer drugs except for recognition of pathology and diagnosis of a vision anomaly.

(c) Topical anesthetics, mydriatics, miotics and cycloplegics may be used by a person practicing optometry under conditions approved by the board.

* Sec. 3. AS 17.15 is amended by adding a new section to Article 1 to read:

Sec. 17.15.055. SALES TO OPTOMETRISTS. A person licensed to practice optometry under AS 08.72 who has been authorized by the Board of Examiners in Optometry to use topically applied drugs under AS 08.72.305 may purchase topical anesthetics, mydriatics, miotics and cycloplegics.

* Sec. 4. AS 08.80.260(7) is amended to read:

(7) conviction of selling federal legend drugs without prescription of a licensed physician, surgeon, dentist, optometrist, or veterinarian;

KB79

REPORT TO THE CONGRESS: REIMBURSEMENT UNDER PART B OF MEDICARE FOR CERTAIN SERVICES PROVIDED BY OPTOMETRISTS

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE • Public Health Service • Health Resources Administration

The Bureau of Health Manpower projects the overall number of active ophthalmologists in the United States to rise to 13,300 in 1980 and to 18,400 by 1990; this compares with projected levels of 22,000 and 28,200 for optometrists in the same time intervals. The proportion of ophthalmologists as a percent of total professional vision care manpower is projected to grow from 35 percent in 1973 to 38 percent in 1980 and 39 percent in 1990. These estimates should be interpreted cautiously, and should be undertaken in the context of written documentation available from the Bureau of Health Manpower. Available data preclude such projections on a detailed geographic basis.

More specific data indicates that in recent years many areas of the country, particularly non-metropolitan areas, are served only by optometrists. Approximately 40 percent of counties have an optometrist but no ophthalmol gist. Another 27 percent have neither.

Optometric Practice

The Institute of Medicine of the National Academy of Sciences, in describing primary health professions who are direct providers of patient care, defined optometry as follows: "The Doctor of Optometry (O.D.) is a health professional who performs eye examinations to determine the presence of visual, muscular, or neurological abnormalities, and prescribes lenses, other optical aids, or therapy, such as eye exercises to enable maximum vision. Optometrists are trained to recognize disease conditions of the eye and ocular manifestations of other diseases, and to refer patients with these conditions to the appropriate health professional."

This definition, as well as available documentation on the utilization of optometric services, points to the optometrist's role as a provider of primary health care services. In this role, the optometrist functions as a principal point of contact within the health care system for persons having visual complaints, including certain numbers who have symptoms or conditions that require referral to other health practitioners.

The scope of practice for optometry, similar to that for other health care providers, is difficult to define precisely. However, information is available from a number of sources to develop valid concepts of a profession's role and function. Such sources include State laws, judgments of courts concerning the responsibilities of practitioners, the usual and customary practices of the profession, and the objectives, content, and standards of education and training for the profession.

An examination of a variety of such sources suggests that optometry is a profession qualified to provide a broad range of services which are effective in patient management, including the management of aphakic and cataract patients. (See discussion in Part II of this report for detail on sources cited and information examined.) It is reasonable to infer that such services correspond to many specific

HB79

ATTACHMENT B

BASIC ELEMENTS OF THE CURRICULUM OF SCHOOLS OF OPTOMETRY

1. Biological science knowledge base.

   a. Gross human anatomy and microscopic anatomy, with emphasis on head, neck, and thorax.

   b. Embryology, gross and microscopic anatomy of the human nervous system - concentrating on the central nervous system.

   c. General human physiology, including the study of the fundamental organ systems and the mechanisms which regulate body function. Emphasis is on the sensory, motor and cardiovascular systems.

   d. Basic concepts of general and cellular biochemistry, with study of nomenclature, structure and reactions of organic molecules. Emphasis is on the visual system - tears, intraocular fluids, lens, retinal photochemistry, and actions of drugs upon these.

   e. Concepts of human genetics and genetic disorders, including the frequency and distribution of genetic disease, inheritance patterns, polygenic inheritance, chromosomal abberration syndromes, multifactorial genetics, and principles of genetic counseling.

   f. Gross and microscopic anatomy of the lids, orbit, orbital content, globe, muscles, nerves, and vessels, and embryology of the eye.

   g. Vegetative physiology of the eye, extraocular and intraocular fluids, corneal and lens metabolism, ocular circulation, retina and optic nerve metabolism.

   h. General pharmacological principles, methods of administration, various systemic drugs and their pharmacological action and side effects with emphasis on those that affect the visual system, such as cataractogenic and glaucoma-producing drugs.

   i. Pharmacology; uses, doses, contraindications, and adverse effect of drugs producing miosis, mydriasis, cycloplegia, accommodation, and ocular anesthesia. The pharmacology, use contraindications, and adverse effect of drugs commonly used in treating visual and ocular problems.

As is evident from the discussion above, the Department endorses the first recommendation. For reasons cited, however, Department endorsement of the second recommendation is viewed as inappropriate and premature at this time.

During the course of the study effort, a number of additional issues and concerns were identified by the expert consultants which, although important considerations, represent matters not directly responsive to the specific legislative charge as interpreted by the Department. These recommendations and comments, made unanimously by the consultants, are presented here to provide an opportunity to bring these matters to the attention of Department Agencies and the Congress. Because the following items go beyond the requirement of this report, the Department has not fully examined them and makes no recommendation at this time.

1. Refractive services for aphakic patients

Aphakic patients, specifically, should be considered as having special needs given their disabled condition. Refractive services for such patients represent non-routine and necessary services in the provision of prosthetic devices, i.e., lenses.

Study advisors recommend that consideration be given to extending coverage under Part B of Medicare to include refractive services for aphakic patients when provided by either ophthalmologists or optometrists.

2. Low vision services and aids

For those patients who have inoperable cataracts or have less than optimal results from cataract surgery, that is, those who have reduced visual acuity, low vision services and aids represent essential components of reasonable and necessary health care services for these patients.

Study advisors recommend that coverage under Part B of Medicare be extended to include the provision of appropriate low vision services and optical aids for the above-referenced patients, when provided by either ophthalmologists or optometrists.

3. Prevention, health maintenance, and health education

In the interests of health care cost advantages, effects on productivity, and the overall improvement of benefits that can be afforded our population, the expert consultants recommend that a more effective effort be made to improve preventive, health maintenance, and health education measures. While this is needed in all areas of health services, the vision/eye care field offers a particularly promising area for such approaches.

4. Other service provided by optometrists

Vision/eye care services currently covered by Part B of Medicare, when provided by ophthalmologists or other physicians, include eye conditions other than cataract and aphakia. Optometrists can provide appropriate services for some of these conditions. It is recommended that extension of reimbursement to include the services of optometrists for such appropriate conditions is a desirable subject for further consideration.

5. Administrative considerations

Also during the course of the study effort, expert advisors raised several concerns pertinent to the administration of the Medicare program. These issues, also applicable to other Medicare services, include the following: (a) inconsistent application of coverage and reimbursement policies by individual carriers, (b) the problem of payment duplication for services and reimbursement for similar diagnostic procedures when performed for specific individuals by more than one provider, and (c) need of improvement in coding and billing procedures for vision/eye care services.

6. Cooperative working relationships between vision/eye care professionals

It became clear during the course of this study that more effective working relationships between optometry and ophthalmology and other providers in the vision/eye care field would enhance patient care and result in improved services to individual patients. While improved interdisciplinary coordination applies to all the health disciplines and specialties, it is a problem of particular concern in the vision/eye care field. Such working relationships could be significantly strengthened by

a. Development of joint educational programs at the undergraduate and graduate levels, including rounds, clinics, conference, and meetings and publications.

b. Establishment of interdisciplinary clinics with optometrists and ophthalmologists working together.

c. Facilitation of referral of patients between the optometrist and the ophthalmologist when in the best interest of the patient.

d. Joint development of quality standards for service and materials by peer review mechanisms. By materials, particular reference should be assigned to varying quality of lenses and frames and the need for furnishing laboratory invoices of material costs for reimbursement.

e. Joint development of appropriate revision to State [illegible] laws to permit use of diagnostic drugs, [illegible] and local anesthetics by optometrists

While such [illegible] are sufficient in various areas of the country, they need to be broadened and reinforced.

Alaska State Legislature

House of Representatives

Committee on

Health, Education & Social Services

Official Business

Pouch V
State Capitol
Juneau, Alaska 99811

March 13, 1979

Ms. Maureen Roche
3311 Eureka Street #3
Anchorage, Alaska 99503

Dear Ms. Roche:

Thank you for your recent letter regarding HB-79, "An Act relating to the practice of optometry."

This bill did pass the House last year as HB-664 but was held up in Senate Rules. This year, the House Health, Education and Social Services Committee has held three hearings on the bill so far. We've heard testimony from both Optometrists and Optomologists and have had work sessions on the bill. We do plan to hold at least one more hearing on HB-79, which will probably be another work session to mark up the bill.

So, at this time, we are still giving consideration to HB-79, hence, your letter of suggestions will help.

I do appreciate your taking the time to write to me to express your feelings on this bill. I will keep your suggestions in mind when I make my vote.

Sincerely yours,

THELMA BUCHHOLDT
Chairman
house HESS Committee

TB/ch

3311 EUREKA St.#3
Anchorage, Ak.99503
March 3,1979

Dear Ms. Bucholdt,

It is my understanding that House Bill 79 is under view by your committee in the eleventh legislature-first session. If at all possible I would appreciate being informed as to the status of this "act relating to the practice of optometry".

My interest in this matter takes on a fervent stance due to the fact that I have been directly involved in the delivery of eye care services to to those recipients in the Bering Straits Region. In light of this Ifeel obligated as well as deeply concerned with this notion of introducing Sec.08.72.305 to the enactment of the legislature.

I need not inform you that we both share a vested interest in this matter since we are potential candidates of optometric services; let alone the populus that this bill will effect if passed.

This missive serves you in a genuine tone of concern since Alaska now is beseiged by the "drug bill", SEC. 08.72.305. Pursuant to this is the idea that health care, specifically, the medical health eye care aspect should be viewed under a microscope for what is to be understood as a redefinition of the scope of the optometrist. Or, if you would , a broadening of the defined scope of the optometrist. To wit... allowing the utilization of pharmaceutical agents (drugs). I beseechingly ask that you read the following paragraphs for the sole purpose of another outlook from a concern citizen, not to mention for the sake of the public whom you represent in this permissive matter of eye care.

The decision that confronts the legislative body is a precarious one. Due to the fact that a question mustbe brought forth & posed , what constitutes the optometrists in this state to utilize drugs in their non-medical profession.

An apparent exigency is prevalent to bring to attention the delination between the non-medical profession (optometrists-O.D.) & the medical profession, (ophthalmologists-M.D.). Both are distinguished in their own right & certainly are awarded the recognition & respect from our society. However the oohthalmologist has gone through an intense array of medical education & training for his endavour of the total encompassing diagnosis, treatment, & care of the eye. The optometrist need only attend a few years of schooling for gainful knowledge of a cognizance of an optical deficiency correctable as he sees it by administering & prescribing lenses &/or prisms. Hencefore, the medical profession is more adequately & better prepared for the entire entity of tending to the eye than the optometrist, merely by training & education. Be it stated here that the above mentionned was not meant in a derogatory fashion nor a demeaning one towards the optometric profession.

In conjunction with this is the question posed , why would a non-medical profession such as optometry effaciously invade the medical profession in medicine. Both are sciences,but, both are concerned with different concentrations intrinsically related to their science. Optometry was established with the initial purpose as a profession to aid in "vision improvement" acting as a liason for the ophthalmologists.

At this propitious time of concern with rising health care at an annual rate of 12% & an approaching make-up of 10% of the GNP the non-medical profession of optometry has sought an entrance into & engagement in being a medical provider of health care delivery by the pursuit of practicing ophthalmology .I can only surmise this from reflecting observations of the events & recent developments between these two professions & what is taking place in the state house / senate in Alaska.

This issue becomes sensitive not only for the reason that the eye as an organ is one of mans' most cherished & most relied upon senses but primarily how Alaska will handle, cope, & decide upon what constitutes the profession of optometry to utilize drugs in their profession. Advertently, how health care will be delivered to its constituents. All legislative powers are in throes of controlling this predicament. However, I fail to see how amending this bill will alleviate & eliminate the cost of medical care, let alone upgrade & enhance the quality of medical health eye care.

As with any service rendered in our society one seeks the quality of service for the least amount of cost to them. The same holds true in medicine. I believe as you might concur that a patient seeks a physician eye doctor for his knowledge, skill, ability,talent in his area of medicine with a degree of trust for all intents & purposes of effaciously being relieved of whatever objective &/or subjective sign &/or sympton that the individual had to seek the M.D. in the first place. For you to fully understand the topic in deliberation, this missive necessiates that you be privy to the condition of glaucoma. The example to be cited is stated in order to stress the full impact & seriousness of Sec. 08.72.305

Pertinent to this is the prevailing factor that Alaska is different than the other states that have considered the "drug bill" in regards to its recipients of eye care health services. For the Alaskan Natives are predisposed to the condition of glaucoma, particularly of the four types, narrow angle glaucoma This is due to their anatomical trait of a shallow anterior chamber.

I ask that you bear with me in a basic description of the eye & vocabulary related to it.

Affecting 1 out of every 100 people over 40 & being the second leading cause of blindness in the U.S.:glaucoma is an afflicting disorder. There exists within the eye an intricate drainage system, so established that the aqueous humor (fluid which aids in maintaining the shape of the eye & its nourishment for it) continuously leaves the eye through the drainage network. In the case of an individual afflicted with glaucoma the exit route is complicated.Basically, a squelching effect of that which is a composite of the angle of drainage in the anterior chamber of the eye becomes narrow,or more fluid is produced than what is considered the normal. Hence, the subsequent build-up of pressure within the eye. IT IS THIS intraocular pressure that jeopardizes the sight of an individual. For glaucoma is that injurious increase of pressure within the eye pressing on the optic nerve. The optic nerve being the running umbilical cord to the brain for the interpretation of vision. If you will, it is the M.D.'s insight & his ability to detect this disorder that is quite significant , whether or not the individual will maintain good vision. For this is an eye condition that is not curable, solely controllable with medication &/or surgery.

Narrow angle glaucoma may be precipitated when the pupil (black portion of the eye) dilates (enlarges) as it encounters darkness or after the administration of mydriatics (dilating drugs).

The latter precipitory factor arises when a doctor utilizes one of many mydriatic drugs during the course of an eye exam , fundus exam (viewing the posterior portion within the eye) & for evaluating refractive errors. (Sec. 08.72.305 2,c) Mydriatics facilitate examinations of that already mentionned.

A patient with an underlying condition of narrow angle glaucoma may be subjected to medication by the attending physician whether it be for any one of the mentionned eye examinations. In view of this, induced is the incidence of an attack of acute narrow angle glaucoma.. WHY? The iris, (colored portion of the eye) had been induced to dilate by the administered drug. Consequently, this inhibits the muscle to constrict therefore closing off the escape route for the aqueous fluid. What now ocurrs is excruciating & intense pain due to the escalating intraocular pressure upon the optic nerve. If not quickly tended to with the attention of rectifying the precarious situation by a counter effect of medication whether this be administered orally, or intravenously irreversible damage will ensue.

Obviously, at this point & time the reflexive resposes of the attending eye examiner is weighted with responsibilities of anothers vision AS you & your committee are weighted with the responsibility of answering what constitutes the optometrists in this state to utilize drugs in their non-medical profession. My faith lies herein with your time & consideration of Sec. 08.72.305.

Sincerely,

Maureen Rock

Peter E. Cannava, M.D.
OPHTHALMOLOGY
BOX 1629
SOLDOTNA, ALASKA 99669
TELEPHONE 262-4462

March 15, 1979

Representative Thelma Bucholdt
Pouch V.
Juneau, Alaska 99811

RE: HB79

Dear Mrs. Bucholdt;

Many legislators have asked about the harm which can come to Alaskans as a result of HB 79 (optometric drug bill). In addition to the Fairbanks case which you are well aware, please see the enclosed list of patients across the country whom have suffered as a result of optometrists attempting to practice medicine. A study of the individual cases is educational and provocative.

Sincerely,

Peter E. Cannava, M.D.

ENC;PEN

PEC/bc

PUBLIC DANGER DOCUMENTED

SPECIAL SUPPLEMENT

ANNUAL REVIEW OF SELECTED CASE HISTORIES

As published in THE PEN...— during 1977-78

TUMOR OVERLOOKED

Mrs. Lois McWalters

•

Massachusetts Widow

Vol. 1, No. 1, July 15, 1977

The first issue of THE PEN featured a tragic testimonial headlined "Massachusetts Widow: 'It Seems Bizarre.'" Excerpts follow:

Five years ago my husband began complaining about his eyesight. He decided to see an optometrist and he continued to do so for 2½ months. As his vision deteriorated at this time, he experienced headaches so violent they would awaken him from a sound sleep. I pleaded with him to see an ophthalmologist or some person with a medical background. He became increasingly irritated at my suggestions and I was forced to bow to his decision or submit to an unhappy home life.

As each day passed, before my eyes his personality changed; this sweet gentle man became verbally abusive and the general tenor of our home was unbearable. At that time our four children were 6, 7, 8, and 9 years old. They watched their father hold a cup of coffee, his hand tremors so pronounced he would spill it and leave the table in a terrible rage.

I pleaded again, to no avail. How does a wife forcibly take a grown man to a doctor? He *trusted*

SPECIAL ANNUAL PERSONAL EXPERIENCE REVIEW ISSUE

During its first year, THE PEN has published numerous carefully documented cases of eye damage resulting from attempts by non-medical practitioners to practice medicine. These four pages are a collection of selected excerpts of those cases which have prompted expressions of maximum interest from readers.

While there has been no official response or challenge from organized optometry, individual optometric lobbyists have advised legislators that these cases are "isolated instances." The steady flow of similar testimony pouring into PEN headquarters prompts us to suggest that the cases are not "isolated," but rather "the tip of an iceberg."

The Editors

OPTOM-PSYCHIATRY

Barbara Cosgrove

•

"Lack of Love"

Vol. 2, No. 3, Feb. 1, 1978

A Connecticut woman, interviewed by Jeffrey Gold, M.D. of New Haven, told how an optometrist

DANGER AND WASTE IN THE VA

Robert B. Nolan

•

Disabled Veteran

Vol. 2, No. 8, April 15, 1978
Vol. 2, No. 11, June 1, 1978

In these issues, a totally and permanently disabled veteran told how he got less than the deserved in-depth investigation into the problem of allowing VA optometrists medical functions. Mr. Nolan again found more evidence of danger and waste in the VA. Excerpts from the first story follows:

". . . The VA would not permit me to receive outpatient treatment from a private physician unless I lived 30 to 50 miles from a VA treatment center. I didn't, so I decided to pay for my own doctor and then go to the VA and see their M.D. for medication only.

"My wife called the VA in the federal building in downtown St. Petersburg for an appointment early in August of 1977. She told the girl on the phone that I needed an eye doctor because I had glaucoma.

"My first visit to the VA eye 'doctor' was August 22, 1977. I presumed that the doctor I saw was an M.D. ophthalmologist. His name was on the door and it said 'doctor.' . . .

"The 'doctor' finally tested my tension with a hand tonometer after the [illegible]

the optometrist. The optometrist changed his glasses three times - each prescription being for stronger lenses - during those 2½ months. Each time his eyesight and the pain was not even slightly improved by the change of glasses. He was told it would take time to get used to them. The optometrist never suggested he see a medical person.

His suffering increased to such a point he could not work or concentrate. I suggested a vacation and he agreed. . . . He now had a black patch over one eye "to rest it" prescribed by the optometrist.

I was frightened; I felt he was dying and I was helpless. After a few days of rest I gently broached the subject again and very unlike me, burst into tears. . . .

Our vacation was cut short because he was so ill. He insisted upon going to work when we got home, but surprised me by phoning from the hospital. He had seen an ophthalmologist who immediately spotted the problem and within minutes called in a neurosurgeon. The neurosurgeon admitted him to the hospital at once. I discovered later that when the ophthalmologist's *secretary* heard the symptoms over the telephone, she had insisted Dick come to the office immediately.

The neurosurgeon told me frankly he felt that Dick had a brain tumor. At our community hospital, tests were done in the next few days; the consensus was a brain tumor.

Surgery was at nine. . . .

Bad news it was, a malignant brain tumor called an astrocytoma. "I would give him about eighteen months," the doctor said, "but be prepared for some horrible times ahead." Twelve days later God mercifully took his beautiful soul and left his tired, worn body. . . .

In retrospect, it seems bizarre to me that when one (in this case the optometrist) realizes a situation is out of his control, that he wouldn't immediately make a referral, especially when seeing a patient suffer so much. ●

claimed her child's blurred vision could be cured with "more love and understanding at home" in a story headlined "O.D. Calls Diabetes A 'Lack of L. c'." Passages of that interview follow:

Dr. Gold: "Mrs. Cosgrove, why did you bring Barbara to me?"

Mrs. Cosgrove: "We were referred here by our family doctor who just found diabetes in Barbara. She is 11 years old. I told him I had just had her eyes checked by an optometrist."

Dr. Gold: "Do you mean Barbara was examined by an optometrist lately?"

Mrs. Cosgrove: "Yes, she failed the school vision test in November and they said to have an examination. He (the optometrist) has a great big sign out in front, that says 'Doctor,' and I thought he was one."

Dr. Gold: "What did he find?"

Mrs. Cosgrove: "He said there was nothing wrong with her eyes and when I asked him why she kept getting blurred vision, he told me that she was a nervous child and when she gets up-tight, her eyes get blurry. My reaction was to take her to a social worker, but he (the optometrist) told me she just needs more love and understanding at home and that there was no reason to do any more than see him again next year."

Dr. Gold: "Then what happened?"

Mrs. Cosgrove: "I thought I was some kind of a rotten mother with such a nervous child, and I cried that night."

Dr. Gold: "Did you pursue the blurred vision at that time?"

Mrs. Cosgrove: "During December, Barbara seemed to have the flu, but it didn't go away and by Christmas Eve, I real-

Continued on page 6

a hand tonometer after the eye test for glasses and said the pressure was 19 in each eye. I showed him the prescription I had received from Kenneth Safko, M.D., my own ophthalmologist, and he said, 'Wait until I xerox this as it is no good here. I will have to write my own prescription.'

"After copying Dr. Safko's prescription and putting it in my file, he wrote his own prescription and took it next door to get it co-signed. . . .

"On my way to the pharmacy with my wife, she looked at the prescription and said it didn't look right. We took it back and the 'doctor' changed it from pilocarpine to 3/4% carbachol with six refills. Another doctor (probably an M.D.) co-signed the new prescription. . . .

"On our next trip to the VA center, my wife asked the woman at the front desk if the doctor we saw was an M.D. and an ophthalmologist. The woman at the desk replied, 'Yes, he is a full-fledged doctor and an ophthalmologist fully qualified to treat eyes.' . . .

"When I finally got the glasses, sometime in late November or early December of 1977, I discovered I could see much better without them.

"On my next trip to the VA on December 19, 1977, I returned the glasses. The 'doctor' told me the reason the glasses had been so long coming was because he rejected them two or three times, since they were not to his prescription. When he took the glasses to the next office to check them, my wife and I looked at his diploma on the wall. It said 'Doctor of Optometry.' When I told him we thought he was an ophthalmologist, he became very angry and said, 'Do you question my qualifications?' I told him I certainly did question his qualifications to treat glaucoma or any other eye disease. He told me that the people at the front desk didn't know the difference between an ophthalmologist and an optometrist. I said, 'If this is true, what if my eyes need surgery?' He said if that were the case, I would have to go to the Tampa VA Hospital or the Bay Pines VA Hospital and some other doctor would operate. . . .

"Talking to people in the waiting room, we

Continued on page 6

Tragic Case Histories Dramatize The Need To

NETWORK TV WARNING

Totie Fields

•

Comedienne

Vol. 1, No. 8, Nov. 1, 1977

The following is a portion of an interview between TV-talk show host Merv Griffin and comedienne Totie Fields, during which she warned all diabetics to seek eye care only from ophthalmologists:

MERV: It was kept very quiet; but all of a sudden, about two months ago we all heard rumors that, now you were losing your eyesight from the diabetes.

TOTIE: It's true, it's true! — and you know why I want to talk about it?

MERV: Blue Cross must hate you!

TOTIE: They have lost so much money on me.

MERV: Have they?

TOTIE: Yeah, but you want to know? I didn't know it, Merv, I swear to you I saw 20/20! . . . this is what I want to make a point of, I went to an optometrist all the time and he said, "Totie you're doing wonderfully, everything is fine," . . . I've been a diabetic since I was nineteen years old, and you know how I watch myself; I weighed 200 pounds; all I ever thought about was eating. I swear to God they told me I couldn't eat and that was the end of it!!! I mean, I just ate myself into oblivion! I used to do a show and in the I did "Fight for Sight" — the benefit "Fight for Sight" for about five, six years in a row and that's the money that helped this whole thing! (applause) To get this discovery! Isn't that incredible? (applause) And you won't believe how I can see every wrinkle in your face, Merv, every wrinkle in your face, I never could see them before . . . ●

GLAUCOMA UNDETECTED

Mrs. Agnes Karrman

•

Connecticut Housewife

Vol. 1, No. 5, Sept. 15, 1977

Appearing in this issue of THE PEN under the headline "Conn. O.D. Tells Housewife: 'You Don't Have Glaucoma'," a Conn. woman told of an optometrist who failed to recognize her glaucoma. Excerpts follow:

"I was a nervous wreck before I visited the ophthalmologist that day in October, 1975, and then the bottom had just dropped out of everything. My fears had been justified because the ophthalmologist had just told me that I was suffering from far-advanced glaucoma. For some time I had experienced increasing difficulty with my vision. I couldn't read the paper without a magnifying glass. My eyes were constantly watering and sometimes I awakened at night with a headache. I could no longer see well enough to play the piano or organ.

"...Yet, despite these complaints, my optometrist had assured me for over a year there was nothing seriously wrong with my eyes.

meantime, my vision had continued to get worse and I could no longer enjoy any activities that required good eyesight.

"As I said earlier, my first visit to the ophthalmologist was a shocker. It was such a different examination! Not only did the ophthalmologist find that my pressure was higher than normal, he also found that my optic nerves had been severely damaged by this long-standing pressure and that my side vision had been destroyed. I could only see as though I were looking down a gun barrel . . . He discovered that I did have cataracts, but they were only a small part of my eye health care difficulties.

"The ophthalmologist's diagnoses and explanation of the extent of my problems not only added to my nervousness but made me very angry. I was angry with myself for not having listened to my sister's advice months ago to see an ophthalmologist and not an optometrist, and I was plenty angry with the optometrist! The doctor told me that an optometrist is not trained in medicine nor to diagnose or treat eye diseases. How can an optometrist act like an 'eye specialist' and flatly assure people that he is capable of this type of decision making? How can he keep peddling new glasses and sell eyewash types of eyedrops with implied assurance that they can cure? How can he stand by and literally watch one of his long-time customers go blind?" ●

EXTENSIVE EYE DAMAGE

Denton Livensparger

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Double Jeopardy

middle I used to think where could I get a pizza around here; you know I thought of nothing but food, Mallomars if I could only eat a Mallomar! Oreos, you know I was an Oreo freak . . . Oh, I talk about them and my mouth gets filled with saliva!!! I saw a little thing floating in my eye like a little hair, you know, that you couldn't get rid of and so I went to an ophthalmologist. Diabetics should never go to an optometrist, they must go to ophthalmologists because they see behind the eye. He said, "Totie, you've got to go . . . the best man in the country is in San Francisco and you must get to him right away." The next morning I was there and this man was telling me I was going blind, and I said, "You're crazy! Why didn't anybody else . . ." Well, they were so busy worrying about everything else, no one thought of my eyes, and I've never (incidentally, no one's ever heard this story before) — Well, to make a long story longer . . . yeah! I want, because I really want diabetics to be so aware because this operation is only two years old, Merv, and ironically enough, my dad died blind, my brother died blind, and I would have. . . .

One day you get to that age where all the print is gone and the paper comes and you say why did they send me a white paper (laughter) — you know, and you'd go to the toilet and drop it on the floor and read it there (laughter) . . . you know what I mean. But, I can read proof! I mean, to open a menu and be able to see it without looking for my glasses is the most exciting thing, but I want you to know, everybody out there that is a diabetic, please, please go to an ophthalmologist . . . because you can be saved! You know the ironic part of this entire story,

"I had been going to an optometrist regularly for about seventeen years — ever since he had opened his office. He was always pleasant and the glasses he fitted for me were generally satisfactory. In 1974 I went to him complaining of blurred vision. He gave me new glasses but they didn't help. I went back to him and he told me that they were the right glasses and that I just hadn't allowed enough time to get used to them. I told him that I was worried about glaucoma because my brother had had surgery for glaucoma and is almost blind, and my sister was being treated for glaucoma by an ophthalmologist. She is doing well because her problem was discovered early. The optometrist assured me that he had checked for glaucoma and that I didn't have it.

"Several months later, because of increasing trouble with my vision, I returned to the optometrist . . . He again changed my glasses. At that visit I again voiced my fear of glaucoma and once again he assured me that my eye pressure was normal and that I didn't have glaucoma. He said my eyes were just tired. Well, the new glasses didn't help at all. They seemed to be no different than the previous pair he sold me . . .

". . . After another month and a half had passed I returned to the optometrist because my eyes pained at times and I often awoke at night with headaches. My vision was getting worse and my eyes watered constantly. This time I really pressed about my fear of glaucoma. He re-examined me and again sold me a pair of glasses — the third pair in less than a year! He told me that his $3,000 special instrument measured accurately for glaucoma and that a referral to an ophthalmologist was not necessary. In fact, he told me that I had nothing to worry about, that my eyes were perfectly clear. He said, *'You don't have glaucoma and you don't have cataracts.'* He gave me some eye drops to use three or four times a day. I used them regularly for the next four months until my sister finally persuaded me to see her ophthalmologist. In the

Vol. 2, No. 7, April 1, 1978

In a story headlined "Misuse of Drugs Plus Misdiagnosis Puts Floridian In Double Jeopardy," a Florida ophthalmologist told of how an optometrist missed signs of glaucoma and serious corneal abrasions requiring surgery in both eyes of a male patient. Excerpts follow:

"Misdiagnosis combined with the misuse of powerful drugs by untrained practitioners poses a frightening threat to public health and places our citizens in double jeopardy," says John D. Mallonee, M.D., a practicing ophthalmologist in Ft. Pierce, Florida. "The advanced years of many of our patients makes this menace even more serious and the public must be made aware of this grave danger," Dr. Mallonee said.

In support of his forthright statement, Dr. Mallonee detailed the following case history.

"On February 4, 1978, I first saw Denton Livensparger. This 65-year-old man came to my office of his own volition, and without referral. He told me he lived at 1196 Proctor Lane in Port St. Lucie, Florida, a nearby retirement community, and had been suffering severe pain in both eyes for some time. Mr. Livensparger voluntarily gave the following account of his experience to date."

"In early November 1977, I think it was the 8th," the patient said, "I went to see an optometrist about the pain I had in both eyes . . . I told them that for a long time, maybe nine or ten months, I felt as though I had something in both of my eyes, and that the pain was just getting worse all the time. After they examined me, they told me all I had was an eyelid infection and they gave me some antibiotic drops called Neodecadron. I went back again the next day and they told me I didn't have glaucoma, and all that was the matter with me was a minor eyelid infection that would clear up if I used the drops."

Continued on page 6

Protect The Public From Sub-Standard Eye Care

GLAUCOMA UNNOTICED

Mrs. Florence Hubbard

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Blinded High School Student

Vol. 1, No. 2, Aug. 1, 1977

The following excerpts are from a byline story by a Massachusetts student headlined "'They Call Themselves Doctors' - . . Blinded High School Student," in which she told how an optometrist could not recognize advanced glaucoma.

"In August 1967 I was walking home from a friend's house when I knocked over a trash can because I didn't see it. A couple of days later I noticed that things looked blurry. I couldn't read signs or make out faces and when I looked at lights, there was a rainbow around them.

"I went to an optometrist in September and told him about all of this and that I had a throbbing pain in my eyes. My left eye was worse than my right eye. The optometrist asked me to read his eye chart but I couldn't see where it was. He examined my eyes and told me not to worry, he could help me. He said I had a lazy left eye and astigmatism, and he had just the cure for me — he was going to prescribe some glasses.

"Before the glasses were ready, the pain got much worse and my eyesight got more and more blurry. However, I trusted the doctor. I figured you go to a doctor and he knows how to treat you. I had always thought optometrists were doctors. They call themselves doctor.

"When I went in to get my glasses in October, I told him that my vision was much worse and he

Similar heartbreaking circumstances have accompanied many of the cases in PEN's growing file. Here's a random sampling.

● From the Wills Eye Hospital, a division of the Thomas Jefferson Medical School in Pennsylvania, - when a female patient complained of pain in the eye, an optometrist gave her an anesthetic drop to use. Later, he refused to see her. She developed a pseudomonas ulcer (infection) and the eye had to be removed.

● Also from Wills, a female patient told an optometrist that for seven years she had episodes of blurred vision brought on by reading. They usually lasted about an hour and when severe were associated with headaches. She was followed by an internationally famous optometrist throughout the seven years and was reassured nothing was wrong. Later, an M.D. found textbook symptomatology of chronic angle-closure glaucoma and advised immediate surgery on both eyes.

GOING BLIND

Mrs. Anita Oliver

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Baltimore Cook

Vol. 1, No. 10, Dec. 1, 1977

The following passages are from an interview between a blinded Baltimore cook and ophthalmologun

LED TO BLINDNESS

Charles B. Wilson

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Arizona Steelworker

Vol. 1, No. 10, Dec. 1, 1977

The following are excerpts from the story of an Arizona man headlined "Arizona Steelworker 'Led To Blindness'," in which he told how an optometrist informed him he would eventually go blind, but gave no reason, and his misadventures with more optometrists:

"When I first thought I needed glasses 25 years ago, there was only one place to go in my home town in Ohio — and that was to an optometrist. He had the whole works — he gave examinations and sold glasses.

"He checked me one time, gave me glasses and then he said, 'In about 20 years, you're going to think you're going blind.'

"I asked him why, but he wouldn't give me a definite answer. He just said, 'Well, your eyes are going to change that much and you're going to think you're going blind.' To this day, I still don't know what he was talking about.

"I just figured it was my nearsightedness or the opposite, whatever that was. I wasn't bothered with anything until I came out here 17 years ago.

"I worked in a steel mill and once my glasses got all burned up in there, so I went to an optometrist in Mesa.

"He just checked my eyes like everyone else does. I got a new pair of glasses there.

"In the meantime, the Union got into the plan

got out the glasses and said, 'These should take care of you.'

"I went home with the glasses but they weren't helping. I was banging into desks at school, I kept banging into people, I couldn't see the blackboard. I must have called the optometrist about 10 times and he kept telling me I would be all right, that I was getting too worked up and making myself not see.

"When my mother and I went to see him the next day, my mother said he looked a little worried. He told us that I lacked something in my body, that I had a deficiency, and he would make an appointment for me with an ophthalmologist but not until after Christmas. He said I should go home and have a nice Christmas.

"When my mother and I went to the ophthalmologist on December 27, it was the first time I heard the word 'glaucoma.' He said I had all the classic signs.

"The ophthalmologist found that I had a pressure of 95 in both eyes — normal is 20, and total blindness is 100, he said.

"In April the pressure in my eyes went up again and this time the ophthalmologist thought it would be necessary to operate. By now my parents were so upset they had decided that they should be extra careful and get another opinion and I should go to Massachusetts Eye and Ear Infirmary. I did and it was decided I should have surgery on both eyes, to save what little sight I had left. I've lost 99 percent in my left eye and I have only the very center of the vision in my right eye — I can only see things that are straight ahead.

"After I got out of the hospital and began to feel better, my little eight-year-old cousin began to take me all around Gloucester by the hand so I could learn my way around. I still don't like going to new places and there are some things I can't do for myself. Once I set myself on fire trying to reach something over the gas stove and I didn't even know it. I was lucky my husband was home and saw it." ●

resident Larry Thompson, M.D. In a story headlined "Mrs. Oliver: 'I Told Him These Are My Eyes'," she told how a vision-center optometrist became annoyed when she told him the glasses he prescribed did not work:

Mrs. Oliver: "I came to University Hospital because I was getting this blindness, and I couldn't see. I was at church on the fourth Sunday in July, and I fell down those steps."

• • •

Dr. T: "You were seen for your eyes before coming here — when, back in February of 1977?"

Mrs. O: "Yes, it was February."

Dr. T: "And you were seen at - - - - Vision Center?" (an enterprise which employs optometrists, but has no medical personnel.)

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Mrs. O: "Yes, I was there for glasses. They examined me but they didn't tell me anything. I asked the doctor why I couldn't see. The doctor got angry with me when I said I could not see out of my left eye like I should. I was trying to read the board, the letters and the numbers. And when he put the glass to my eye, I couldn't see and I told him that I couldn't see. He got very, very angry. He told me that he was doing the examination, not me. *I told him that these were my eyes and I should know whether I could see or whether I couldn't.*"

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Dr. T: "OK, he prescribed new glasses for you at that time. After you got those glasses, you could not see with those glasses, is that correct?"

Mrs. O: "Yes. I went back to them again and had that left lens changed. It was supposed to have been changed."

Dr. T: "Did they ever measure the pressure in your eye, touch your eye with anything to measure the pressure?"

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Dr. T: "Did they ever measure the pressure in your eye, touch your eye with anything to measure the pressure?"

Continued on page 6

and the company had to furnish eyeglasses. So, another optometrist in Tempe gave me a cut-rate price for an eye examination, since I was an employee. It was a ridiculously low price. After that exam, I went to that optometrist all the time, about every two years. I went through this same routine for about 10 years.

"I started noticing that I was stumbling a lot out at the steel mill. I was falling and tripping over things, which I don't ordinarily do, I tried to get an appointment with the optometrist, but most of them in town were at a convention. I finally found one to examine my eyes.

"He examined me and said he saw something in one eye, but he admitted that he didn't know what it was. He recommended that I see an ophthalmologist.

(At this point, Mr. Wilson was asked whether or not the optometrist who checked him every two years for a decade ever checked anything besides his vision, such as his eye pressure.)

"No, sir, he never did anything like that. I figured I was getting a complete eye exam, like I'd had all of my life. He was called a doctor, and to me an eye doctor was an eye doctor.

"An ophthalmologist was just a long word as far as I was concerned! I'd never been around one, and where we came from there wasn't any. This last optometrist I asked point blank what was in my eye and he said he did not know and that he recommended my coming to see one of you fellas. He said you would have to 'lift the pupil up and look behind it and see what was in that eye.' ...

"Well, here I am. I was legally blind. Now I've had surgery to save what vision I had left, but I'm still in bad shape. I believe this other guy that I went to should have seen something and checked it. But I didn't know he should have looked into my eyes with all those lights and stuff that he didn't do it. He never gave me a pressure check or anything like that.

"So now I'm disabled. I was led to blindness for 25 years." ●

OPTOM-PSYCHIATRY

Continued from page 3

ized that she had lost her appetite and was losing weight; also she was always thirsty and urinating excessively, so I took her to our family doctor."

Dr. Gold: "What did he find?"

Mrs. Cosgrove: "He found diabetes. Her sugar was 790!" *(Normal is around 100)*

Dr. Gold: "Did the optometrist ever mention to you the possibility that variably blurred vision could be a sign of diabetes?"

Mrs. Cosgrove: "No, never. I don't think he should be allowed to be out there, on the street, calling himself a doctor! He doesn't know anything about disease. Why is he there? What's wrong?"

Dr. Gold: "Mrs. Cosgrove, do you give us your permission to publicize the danger to people inherent in Barbara's story?"

Mrs. Cosgrove: "Yes, I do."

Dr. Gold: "Thank you very much." ●

NEW YORK SPECIAL REPORT

The following case histories of optometric failure to recognize and refer medical eye patients were collected by Karl J. Marchenese, M.D. of Rochester. All patients except one were personally interviewed by Dr. Marchenese. Except where indicated, the source of information was the patient. All cases came to the attention of Dr. Marchenese within the past 12 months through his practice as an ophthalmology resident. The patients reported in this paper as incidents of failure to recognize or refer medical eye problems, outnumber appropriate referrals to the clinic by four to one.

● A young college student called a local HMO (prepaid health insurance in which the patients have little choice of physician) with complaints of an irritated red eye. He was seen the same

GOING BLIND

Continued from page 5

Mrs. O: "No."

Dr. T: "Did they ever suggest that you see a medical doctor?"

Mrs. O: "No, never."

Dr. T: "Do you feel that poor people — people that haven't had a lot of education — are at a particular disadvantage since they probably do not understand the difference between an optometrist and a medical eye doctor?"

Mrs. O: "I sure do think so. I was getting blind."

Dr. T: "Do you realize that you would have been totally blind in another couple of months if you had not come down here?"

Mrs. O: "I sure do." ●

EXTENSIVE EYE DAMAGE

Continued from page 4

Mr. Livensparger continued, "I took the drops just like they told me, but my eyes got even worse and I went back to see them on November 14. They told me just what they said before, that I had an eyelid infection that would go away if I kept taking the drops, even though I told them my eyes felt worse, not better. I continued using the medicine they gave me but it didn't help at all and I went back again to see them (the optometrists) on January 10th of this year.

"Again, they examined my eyes. They didn't mention glaucoma or pressure — just looked into my eyes with a light. They told me the medicine I was using wasn't doing the job and gave me something called Vasocidin. I used the new drops for about eight days and my eyes only got worse, so I went back again on the 18th of January. They said just keep using the new stuff and your infection will go away.

"Since I was getting worse all the time and the medicine wasn't helping, I thought I should see somebody else," Mr. Livensparger concluded.

"When I talked to Mr. Livensparger on Feb. 4," Dr. Mallonee said, "he told me, 'I have continuous pain in both of my eyes. I can't stand the light, and keep my eyes closed most of the time.

DANGER AND WASTE

Continued from page 3

found many had gotten the wrong glasses. One man didn't get bifocals and he had used them all of his life. This whole farce left me with little faith in the VA health care system. . . .

"On February 27, 1978, I returned to the VA and asked to see the M.D. I had seen on my last visit. I was told that he had retired, so they sent me to another M.D. This doctor assured me that he was an M.D. and an ophthalmologist, and when I told him of my previous experience, he agreed that optometrists should not treat eye disease, but explained that since he was new with the VA, he couldn't change the rules, and he didn't want to 'make waves.' He told me that he also co-signed prescriptions for the optometrists even though he never sees the patients. This doesn't seem right to me . . ." ●

TREATMENT DELAYED

Mrs. Clara Jones

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Writes Iowa Legislature

Vol. 2, No. 2, Jan. 15, 1978

The following excerpts are from a story headlined "Damaged Patient Writes Lawmakers," which carried a letter that an Iowa woman wrote to the entire Iowa Legislature, reminding them that optometrists have no medical training:

"For the last 25 years my family has been going to an optometrist for our eye care needs.

"Some time after the most recent change of lenses, I began experiencing difficulty with my vision. Consequently, I reduced [illegible]

day by an "eye doctor" whom he believed was a physician but was in fact an optometrist. The optometrist diagnosed "iritis" and gave the patient a prescription for two therapeutic eye medications (homatropine and a steroid preparation) which was filled in the HMO pharmacy. The patient reports that the prescription had another physician's signature preprinted on it. The patient was examined only by the optometrist. He was subsequently examined by the optometrist four additional times over a six-month period. The optometric records were obtained and revealed that several therapeutic agents had been prescribed and no mention was made of consultation with or referral to a physician. Ocular examinations and evaluations for systemic disease were inadequate. The optometrist was unsure of the diagnosis, at times referring to "recurrent conjunctivitis" and "episcleritis" as well as iritis. Finally on the last visit the patient was referred to an ophthalmologist.

Comment: The optometrist clearly exceeded the limits of his licensure by attempting to make a medical diagnosis and prescribing therapy. It is illegal for an optometrist to fill in (and for an organization to provide) presigned prescription forms. It is inappropriate for an HMO to use an optometrist to care for patients with acute eye problems.

● A 73-year-old woman with diabetes was followed for 15 years by an optometrist who knew about her disease but referred her for a medical eye evaluation only when cataracts caused a significant deterioration in her vision. The patient had evidence of diabetic retinopathy (blood vessel disease of the back of the eye) which was more difficult to evaluate because of the presence of cataracts.

Comment: All patients with diabetes are at a significant risk of major ocular complications (including total blindness) and should have a medical eye examination at regular intervals. The examination requires special expertise which only the ophthalmologist can provide. Treatment is available for retinopathy at some stages.

because they water when I try to open them. The pain is bad, and I have it all the time.'"

Dr. Mallonee reported that his external examination revealed a very obvious problem. A condition existed whereby the patient's lower lids had turned in, causing the lashes of the lower lids in both eyes to rub against the corneas causing recurrent and chronic corneal abrasions. It was lashes rubbing on the cornea that gave the patient the feeling he had a foreign body in his eyes. He was in so much pain that he kept his eyes closed almost constantly since the abrasions were causing him severe pain.

"I found on further examination that much of the corneal tissue was gone due to the constant irritation," Mallonee said, "I also found early vertical cupping of the optic nerve head — an early sign of glaucoma.

"I recommended immediate surgery on both lower lids to eliminate the severe irritation. This has been done since and the patient is much better at this point in time. I also discontinued the medication prescribed by the optometrists, both of which cause glaucoma in susceptible patients. The eye pressure is now down, verifying that the long use of drugs had contributed to increased pressure. In addition, we performed a complete glaucoma work-up, which was clearly indicated." ●

● A 30-year-old woman was seen six weeks previously at work by an industrial nurse for complaints of a red, irritated eye. She was referred that day to a local HMO where she was seen by an "eye doctor" whom the patient thought was a physician, but was in fact an optometrist. He diagnosed an allergic problem, recommended "Sinutabs," and referred her to an internist in one to two weeks.

Comment: The patient was inappropriately evaluated by an optometrist for an acute eye problem. HMO's should not use optometrists to evaluate patients with acute eye problems without direct physician supervision.

and told him my sight in my right eye was blurred and that something was wrong. After his examination he told me my glasses were correct, the blood vessels were healthy, and further there were no signs of glaucoma or cataracts.

"I still believed that something was wrong in my right eye but believed the doctor must know, so accepted his diagnosis. However, as the difficulty continued and gradually increased, after five months I decided to consult a medical eye specialist. In his preliminary examination he immediately suspected glaucoma which was subsequently verified in both eyes and that the disease had been there for a long time. Also the cataracts are starting. I am informed that a considerable portion of my vision has been lost due to the delay of treatment and cannot be restored, all due to a false sense of security given me by my optometrist.

"My medical doctor tells me that an optometrist is not trained in medicine nor to diagnose eye diseases.

"Because of this lack of training, the optometrist, in my opinion, should be severely penalized when he tries to perform such services which could well end in blindness for his patient.

"I strongly urge you to give this matter your most rigid study and action."

Mrs. Jones later told her ophthalmologist that vision loss was not the only way she suffered due to the optometrist's bold attempts to practice medicine.

"I fell twice," she said, "broke my right arm near the shoulder and the second time my left wrist. I still can't see a step."

Her physician, Leo J. Plummer, M.D., reports that her glaucoma is currently under control, on a program of medications. The Des Moines ophthalmologist notes that dense and extensive visual defects in both eyes are permanent, and that it is necessary for her to learn to walk with her head down to avoid tripping. Dr. Plummer has noted that the drugs Iowa optometrists seek to use are not necessary for the trained physician to suspect, or in most cases, diagnose glaucoma. ●

the University of Alabama in Birmingham / UNIVERSITY STATION / BIRMINGHAM, ALABAMA 35294

the Medical Center / SCHOOL OF OPTOMETRY

February 27, 1979

Representative Thelma Buchholdt
Pouch V
Mail Stop Number 3100
Juneau, Alaska 99811

Dear Representative Buchholdt:

It is my understanding that the Legislature of the State of Alaska is considering legislation (HB 79, SB 75), sponsored by the Alaska Optometric Association, to authorize optometrists to use drugs for diagnostic purposes when qualified by the State Board of Optometry. A graduate of this School of Optometry, Dr. Aharon Sternberg of Anchorage, has written me about this matter and requested that I write you regarding the inaccurate statements contained in the letter from Dr. Sam A. McConkey to you on February 14, 1979.

First, I completely and wholeheartedly support the use of drugs for diagnostic purposes by optometrists. I believe this is in the public interest and an essential tool for the optometrist in the discharge of his moral, ethical and legal responsibilities for the early detection of ocular disease and ocular manifestations of systemic disease. This school has regularly provided, as part of its required curriculum, courses in general and ocular pharmacology for all optometry students from its beginning in 1969, as well as courses in general, systemic and ocular pathology. These courses (pharmacology and pathology) are presented by faculty of the Joint Basic Science Departments of the Medical Center, the School of Medicine and the School of Optometry include lecture, laboratory and clinical instruction.

I am enclosing a copy of our Bulletin for the year in which Dr. Sternberg graduated which is essentially the same as the previous four years. A casual look at the curriculum (pages 41-47, summarized on pages 48-49) and a look at the faculty, (pages 63-66) clearly indicates that Dr. McConkey is in error regarding the education of optometrists. Graduates of this institution have an extensive background in pharmacology and pathology taught by qualified faculty (O.D., M.D., Ph.D.).

This is not an Alaskan problem since optometrists in twenty-two states may now use drugs for diagnostic purposes and other states are seeking the privilege based on their qualifications and the needs of the public. I am sorry that the emotional response of some ophthalmologists leads them to circulating inaccurate information which tends to obscure the public interest.

AN AFFIRMATIVE ACTION / EQUAL OPPORTUNITY EMPLOYER

I hope this information will be of assistance to you in your deliberations on this matter.

Most sincerely,

Henry B. Peters
Dean

Enclosure

cc: Dr. Sternberg

ROBERT N. PAGE, JR., M.D.
JUNEAU MEDICAL CENTER
R.R. 3, BOX 3031
JUNEAU, ALASKA 99801

PRACTICE LIMITED TO THE EYE

February 27, 1979

Honorable Thelma Buchholdt
House of Representative
Pouch V
Juneau, Alaska 99811

Dear Representative Buchholdt:

Pending legislation in the form of House Bill No. 79 and Senate Bill No. 75 represents an attempt on the part of optometrists to gain, through legislation, the right to use drugs. This is a right heretofore granted only on the basis of educational qualifications for very sound reasons. Optometry is a measuring science and has no medical background. An optometrist is not clinically trained. They are not qualified by education to diagnose or treat disease.

However, should this legislation pass, the public will be deceived into believing that they are receiving medical evaluation by optometrists, a definite hazard to public safety. Numerous cases substantiate this. The latest case occurred in Alaska (Steele v. United States of America) and is explained by an enclosure.

I hope that you will oppose this legislation which would downgrade the quality of medical care for the people of Alaska by allowing intrusion into the field of medicine by those without medical training or expertise. It is a dangerous precedent. Absolutely no shortage of medical profession talent exists anywhere in Alaska to justify such a compromise of professional standards of care and treatment. The cost of eye examination by optometrists in many cases is higher than that of a physician (ophthalmologist).

I would be happy to discuss with you the particular risks inherent in the use of the various drugs which are indicated in this legislation, since I will be responsible for treating the various drug complications, should they occur in this area.

Also find enclosed the reports of vetoes of similar bills by the governors of Virginia and Ohio. These are well thought out conclusions by men who are only partial to public well-being. Your serious consideration and concern is appreciated.

Sincerely,

Robert N. Page, Jr., M.D.

Enclosures

"M.D. IS THE MAJOR DIFFERENCE"

THE PEN...

PRO BONO PUBLICO

Published in the Public Interest by Ophthalmology

VOL. 3, NO. 2 JANUARY 15, 1979

RHODES OF OHIO: "WE CAN TAKE NO RISKS"

Ohio Governor Vetoes Optometric Drug Law

COLUMBUS, OHIO — On December 15, 1978, Governor James A. Rhodes of Ohio vetoed amended substitute S.B. 163, which would have permitted optometrists in Ohio to use diagnostic drugs. This marks the second time this year that a state governor has rejected optometric drug legislation in order to protect the citizens of his state.

The first veto came in Virginia when Governor John N. Dalton vetoed similar legislation, noting that, "There is reason for grave concern for patients' welfare where optometrists practice in isolation from medical backup."

Governor Rhodes echoed Governor Dalton's concern when he said in his veto message, "Health care is an area in which we can take no risks because any mistakes could bring tragic and irreversible results. We must be committed to our citizens to provide practitioners that are highly skilled individuals and who will at the same time provide the best health care at the lowest cost.

"Optometrists have been doing an excellent job in working with the medical profession to bring quality eye care to Ohio citizens. The tools that the optometrists are presently using are not dangerous and are effective in screening for eye disease."

He went on to point out that S.B. 163 "would allow optometrists to use drugs in order to make a full diagnosis of the medical condition of the eye. If the individuals involved were properly trained," the Governor said, "this procedure would be in the best interest of Ohio's citizens. However, without proper training, the bill would allow unwarranted risks without corresponding benefits. The drugs involved are dangerous and have the potential of causing a great deal of pain including blindness. The adverse reactions associated with these drugs are not common, but they do occur and emergency treatment must be administered in those instances."

Noting that he vetoed the bill despite the fact that it included a provision that would require optometrists to take 180 hours of mandatory training, Gov. Rhodes said, "This amounts to little more than a month of isolated training in a clinical use of the drugs involved."

Concluding his commentary, the Governor pointed out that the issue of using drugs was one that should not be decided by the legislature.

The veto in Ohio brings to 15 the number of states that have rejected optometric drug laws this year. In only two states, Kentucky and Wisconsin, were such laws passed in 1978.

Continued on page 2

HONORABLE JAMES A. RHODES
. . . acts to protect Ohioans

Governor James A. Rhodes of Ohio has served in that capacity on two different occasions. He was first elected in 1962, serving until 1970, and was re-elected in 1974. The recently re-elected Governor, who attended Ohio State University, holds numerous honorary degrees from several institutions.

Prior to being elected governor, James A. Rhodes served as Auditor and Mayor of Columbus, Ohio and as State Auditor.

Author of three books on the Civil War, Gov. Rhodes was a delegate to the Republican National Convention in 1972, and is a member of the Professional Golfers Association Advisory Committee, and the United States Olympic Committee. ●

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WHY "THE PEN?"

The files of state and national medical associations, all learned societies concerned with the public health, overflow with a preponderance of evidence that the quality of health care is threatened by the precedent of Government encouraging the lowering of professional standards by allowing medical functions to practitioners with no medical education. Medicine accepts the responsibility to respond to epidemics. Death and trauma are resulting, and Doctors of Medicine can do no less than warn potential victims through the continuous presentation of this evidence. The public press of America, given the facts, is supporting this cause, and concerned physicians throughout the nation are pooling their knowledge and resources to package and present the truth through the PHYSICIANS EDUCATION NETWORK.

Ohio Veto Is Second Of 1978; Fourth Optometric Drug Law Veto

VIRGINIA

Hon. John N. Dalton
vetoed H.B. 205
April 11, 1978

ARKANSAS

Hon. David Pryor
vetoed S.B. 48
1977

WEST VIRGINIA

Hon. Arch Moore
vetoed H.B. 1005
1976

THE PEN is a public newspaper, international in scope. Its readers include people from every walk of life. THE PEN is freestanding and independent of any national or state association, with the exception of its sponsor, Physicians Education Network, Inc. PEN, Inc. is a Florida non-profit corporation. Submissions to this newspaper are welcome and are published at the discretion of the editors. THE PEN does not accept paid advertising or paid subscriptions.

DR. ALLEN'S

DIAGNOSES

James H. Allen, M.D.; founding president, New Orleans Acad.my of Ophthalmology; professor of ophthalmology, Univ. of Iowa and Tulane Univ. for 30 years, Senior Surgeon, Tulane Univ.; awarded the prized Gold Medal of the Ophthalmology Section of AMA, 1976.

1979 — All Eyes On West Virginia

Prohibition — often referred to as "the noble experiment" — was repealed by government because it failed.

In the eyes of those West Virginia lawmakers who, in 1976, truly believed that to permit the use of drugs to optometrists would bring eye health care to more West Virginians, the optometric drug use law was a "noble experiment."

In the single remaining eye of Mrs. Dent, whose tragic deposition appears on page 3, the "noble experiment" of 1976 has failed. She is one of many human guinea pigs who have suffered and is among a vanguard of victims who will suffer as optometrists convince themselves that they are capable of diagnosing disease and providing treatment despite the total absence of medical education.

In the eyes of medical experts throughout the nation, the 1976 West Virginia optometric drug use law is a disaster. It is inconceivable that such a law can remain on the books when available evidence in 1978 has prompted lawmakers in 13 states, last year alone, to fail to pass similar, less dangerous optometric diagnostic drug use proposals.

In two more states, these proposals were lobbied through, only to be vetoed by conscientious governors. In the eyes of Governor James A. Rhodes of Ohio (see page 1), to allow Ohio optometrists the use of diagnostic agents "would allow unwarranted risk without corresponding benefits."

In the eyes of Governor John N. Dalton of Virginia, the eye health of Old Dominion residents was threatened by H.B. 205, a diagnostic drug use proposal less ominous than the extant West Virginia law. In his veto message of April 11, 1978, Governor Dalton said: "There is concern of legislative appointment of 'medical' responsibility and authority to non-medical personnel."

In the eyes of optometric leader Dean Henry B. Peters, O.D., of the School of Optometry at the University of Alabama in Birmingham, the reckless 1976 West Virginia law was the result of a "display of legislative machismo" on the part of overambitious optometrists. "The practice of medicine is an inappropriate goal for optometry" the Dean wrote, commenting on passage of the West Virginia law.

Dean Peters further stated, "Not one of our schools is prepared by either faculty resources or availability of clinical experiences to accept this challenge (treatment of eye disease at this time . . .); no such resources exist for 1,000 graduating optometrists this year nor are they in prospect."

In 1976, West Virginia lawmakers were told that modern optometric education made restrictions obsolete. In 1978, the six non-ophthalmic physicians who serve as the medical Advisory Board to the ultra-modern University of Alabama at Birmingham, where optometric education has high standards, took a close look at their curriculum. In their eyes, their own graduates, receiving the O.D. degree, are not qualified to treat disease or use drugs. Its October 18, 1978 resolution (confirming Dean Peters' conclusion about the inadequacy of optometric education) states in part:

"This education in no way prepares these graduates with the knowledge to prescribe or use drugs to treat eye disease. This training should not be viewed as a medical credential."

In 1976, optometrists argued that the new law would make eye care more available to rural residents. Rural residents know better than to take a horse to a blacksmith for colic, but unfortunately are unaware of the total absence of medical education in optometry.

In 1976, optometry promoted the conceptual myth of "primary care." We doubt that any thinking lawmaker would want his eye examined for disease by the least qualified. To place the optometrist in a position where he may overlook a fatal tumor is unfair to him as well as his patient, and to allow him to experiment with dangerous drugs will inevitably produce more unfortunate cases.

Mrs. Dent seeks repeal of the 1976 law. A growing Citizen's Committee seeks repeal. Medicine acknowledges its failure to present a coherent case in 1976, when confusion obfuscated the inherent danger to the public.

This is 1979. Since 1976, the motives of optometry to expand into medicine at the expense of the public health, by exploiting state legislatures have become apparent. Scores of legislative sessions have rejected these efforts, and West Virginia has the most dangerous law of all.

A mass of new incontrovertible evidence attesting to the danger of the 1976 law is ready for presentation. In the eyes of the presentors there is confidence that the 1979 West Virginia lawmakers will open their eyes and ears while taking a fresh look at eye health care.

M.D.s make mistakes. So do elected officials. To acknowledge them is statesmanlike.

The eyes of the nation are on West Virginia.

JHA

THE PEN....

VOLUME 3, NUMBER 2
JANUARY 15, 1979
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EDITORS

Medical Editors: James H. Allen, M.D., New Orleans, La.; Leonard B. Abelnick, M.D., Tacoma, Wash.
Contributing Editors: Roland E. Houle, M.D., Quincy, Mass.; David W. Parke, M.D., Meridan, Conn.
Staff Editors (St. Petersburg, Fla.): George P. Russell, Frank T. Barnes
Production Manager: Edward S. Barclay

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Misinformation Provided Magazine Readers

American housewives are warned that there is a dangerous paragraph of misinformation which appeared recently in national magazines. The advertisement promoted ignorance regarding the possibility of fatal malignancy in the eyes of children.

The advertisement, sponsored by the American Optometric Association, stated:

"On the other hand, if a child who is 18 months or younger momentarily turns one eye in or out, there is probably no cause for worry. At this stage of growth your child lacks what is referred to as internal organization. He just can't seem to make anything . . . hands, feet, legs . . . work together.

"In any of these cases, your family optometrist can diagnose problems or reassure you that your child is normal."

No cause to worry?

James H. Allen, M.D., former senior surgeon at Tulane University, worries about the complacency which may result from this advertisement reassurance.

"This ad is irresponsible," he said.

Dr. Allen advises, "A child begins to coordinate eye movements in the first six months of life but may occasionally turn one eye in or out up to 12 months of age. However, if there is a constant turning in or out of one eye even before one year of age or if there is intermittent turning in or out of one eye after 9 months to one year of age, the child should have a medical eye examination.

"There are several things that can interfere with the development of coordinated eye movements, the most dangerous thing being a malignant tumor of the retina of the eye — which must be diagnosed early if the child's life is to be saved.

"Other causes, although not likely to be fatal, could destroy much or all vision in one eye if not diagnosed and treated properly as early as possible.

"An optometrist is not trained adequately to diagnose diseases of the eye or disease affecting the body as a whole. Therefore, he cannot reassure parents that their child is normal. There are numerous recorded examples in which an optometrist failed to recognize or diagnose diseases or tumors of the eye with the result that vision was lost or the life of the patient lost." ●

OHIO GOVERNOR VETOES

Continued from page 1

Commenting on Governor Rhodes' veto message, Lawrence L. Young, M.D., President, Ohio Ophthalmological Society said, "All of medicine in Ohio is impressed with the thoroughness of the Governor's investigation which led to the veto of S.B. 163. He has correctly assessed the danger to the public and his message reflects his deep concern for the eye health of the citizens of our state."

To date, four state governors have carefully reviewed the pros and cons of optometric drug legislation and concluded that passage of such a law would endanger the health of their citizens. In each instance these chief executives have exercised the power of their veto to protect their constituents. ●

An Ophthalmologist is an

M.D.

an optometrist is not.

AN OPEN LETTER SEEKS REPEAL

W. Va. Eye Victim Deplores Optometric Care

A West Virginia supermarket cashier, who is blind in her left eye and who has a serious problem with her right eye, has made a public appeal through an open letter for repeal of West Virginia's optometric drug law.

In a signed deposition, Mrs. Laura Dent of South Charleston, WV, states, "If my optometrist had been qualified to diagnose and treat diseases of the eye, maybe this disease would have been caught in time and I could read with my left eye. The people who passed this law (West Virginia law permits optometrists to use drugs for diagnosis and treatment), should stop and think what they have done; apparently some of them have never had serious eye problems or they would have known better than to do such a thing."

Saying, "I am firmly against this law allowing optometrists to prescribe medications and treat diseases of the eye, because they are not qualified," Mrs. Dent emphasized she was not offering an opinion, but was speaking from experience. Mrs. Dent related that in May of 1975 she went to see an optometrist for a general eye examination. At that time, she points out, the optometrist prescribed new glasses and advised that there were no signs of glaucoma or any other diseases of the eye. Within two weeks, Mrs. Dent said, "I was seeing distorted. I phoned my optometrist and asked what could be the problem. I was told to come in and be checked. I went in and was told it was only astigmatism, to wear my glasses all the time, and the problem would be corrected.

"It did not improve, I continued to get worse. I phoned my optometrist back in three weeks and asked just how long it would take to improve, and also asked if my family doctor could help. I was told maybe so. I will phone him; go ahead and see him.

"I went straight to my family doctor; the optometrist did not phone him. My family doctor took one look at my eye and panicked. He said there was this tremendous deterioration in both eyes, he did not know what it was, but there definitely was a problem. He sent me straight to Dr. Rashid's office. Doctors Rashid and Toma (both ophthalmologists) checked my eyes and told me I had histoplasmosis (a disease caused by a parasitic fungus) and said it was presently active in my left eye. Since I had had numerous attacks in both eyes in the past, it was likely I had the disease all my life."

Mrs. Dent further relates that after six months of treatment, the condition did not improve and in September the laser was used to arrest the disease. She says, "It stopped the disease, but it did not save my vision. *Medical editor's footnote: Histoplasmosis is a chronic disease characterized by irregular active and inactive phases. Even during the inactive phases the lesions are easily seen. In the inactive phases, treatment is neither effective nor necessary. In the active phases, treatment is available and frequently helpful to retard or eliminate visual loss. Thus, the patient should be observed by a physician with an understanding of the disease process in order to minimize loss of visual function.* I have no central vision in my left eye; I have peripheral vision but I cannot read; I cannot watch TV or do any close work at all with my left eye." In June of 1978 Mrs. Dent suffered a repeat attack in her right eye. This time the laser was used and Mrs. Dent advises she "is in pretty good shape except for the fact that I have a small blind spot."

Noting that the diagnosis made by Doctors Rashid and Toma was confirmed by Dr. Finklestein at the Wilmer Eye Institute in Baltimore, Mrs. Dent says, "I have been told that there is no hope for my left eye and it could happen again at any time in the right eye."

Calling on the legislature to take action now, Mrs. Dent writes, "I wish you would reconsider and repeal this law because a lot of innocent people are going to suffer unknowingly and maybe even go blind because they are trusting an unqualified optometrist." ●

FOUNDER SALUTED BY AMA NEWS — PART III

Ochsner: "The Harder I Work, The Luckier I Get!"

The accomplishments of Alton Ochsner, M.D., PEN's International Advisory Board Chairman, are legend in the annals of American medicine. Terming PEN, "The most potent communications effort I have ever observed in medicine," Dr. Ochsner has said, "Ophthalmology — medicine's protectors of one of God's greatest gifts — eyesight — finds itself in the trenches, doing grim battle against a potential epidemic of ineptitude foisted on the American public by some legislators who have heard only the exaggerations and half truths of the optometric side of a non-argument."

Free-lance author Nancy Vance Hoffman, in an article titled "Alton Ochsner: 82 and Still Going Strong," which appeared in the AMA Journal on August 25, 1978, Vol. 240, No. 8, has captured the essence of this man's greatness. PEN wishes to express its appreciation to Ms. Hoffman and to the JAMA for permission granted to present this material in a series of articles.

"Alton Ochsner:
82 and Still Going Strong," Conclusion:

Genial, optimistic, Alton Ochsner says that if he had his life to live over again, he would do nothing differently. Nevertheless, what was his greatest disappointment? Huey Long's dictatorship over Charity Hospital, Tulane's only teaching hospital, in Ochsner's early days in New Orleans. A boy wonder, at 31 appointed as Tulane's professor of surgery, Ochsner came south from Wisconsin, where he had been associate professor. "My family didn't arrive for six months, and I literally lived in the hospital. I slaved — and I loved it. I gave it

ALTON OCHSNER, M.D.
PEN'S International Advisory Board Chairman

everything I had, developed a good teaching program as I had promised Dean Bass I would. Everything was going along fine." He pauses, shaking his head at the irony of Huey Long's heyday, and I didn't include his desire for revenge on me for refusing a doctor's desire for revenge on me for refusing a doctor's (the doctor) to the hospital staff. to appoint him (the doctor) to the hospital staff. He was incompetent." He shrugs. "And later, while I made rounds, a letter was stolen from the pocket of my coat while it was hanging in the doctor's room of the hospital."

The letter was from the Medical College of Virginia inviting Ochsner to be professor of surgery there. As chairman ex officio of Charity Hospital's board and harboring no love for Ochsner's probity, Huey Long presented the purloined letter as evidence of Ochsner's "disloyalty" to the hospital. "Then and there, that Saturday morning, I was kicked out of the hospital. For two years, I couldn't go near our only teaching hospital. I decided that I couldn't stay in Louisiana under those circumstances, that I would take a job at the University of Illinois. But C. Jeff Miller, Tulane's professor of gynecology and my mentor, dissuaded me."

How? "Dr. Miller said, 'You can't leave under fire. You've *got* to stick it out.' 'But, Dr. Jeff,' I protested, 'Look what's happened to me. I've given this place everything I have and see how they've responded.' Dr. Jeff was adamant. He wouldn't let me quit. Because of him, I stayed." The big Ochsner smile creases his remarkably unlined face: "Sticking it out was one of the best things that ever happened to me."

Despite a life he describes as blessed by "Presbyterian luck" (defined by Ochsner as, "If you do the right thing, no matter what happens, has been no stranger to Alton Ochsner. His first wife's long terminal illness and death was a devastating blow. In the early 1950s, he obtained some of the first Cutter polio vaccine, which he

Continued on page 4

OCHSNER *Continued from page 3*

administered to his grandchildren, as well as to many Ochsner pediatric patients. His daughter's eldest son contracted polio — possibly from the vaccine — and died. The intern who cared for the boy also got polio and both his legs remain paralyzed.

In those days, medicine had a few sharp peaks and lots of deep valleys. There were a few well-trained people, while the rest had almost no training at all. Today, medicine has progressed so that almost everyone is well-trained. By the late 1930s, New Orleans had lost its reputation as a major medical center.

"I saw that the city must do better medicine. And the only way to do this was through group practice. I had two ambitions: to build a medical referral center in the deep South that would give quality care reasonably, and to develop an institution that showed care and consideration — not only to the patient, but to the family." The Ochsner hospital maintains a Family Room, adjacent to the operating rooms and intensive care units, where families receive progress reports every half hour while a patient is in surgery and where coffee and doughnuts are dispensed.

"I went to five Tulane professors," Ochsner remembers. "Professors of otolaryngology, gynecology, orthopedics, and medicine. The surgeons were interested, but the medical man was not. This was in 1939, the end of the Depression. We had no money, only an idea. The banks wanted equity, not an idea. It looked as though we were going to have to give up." Alton Ochsner, however, doesn't give up easily; he persuaded Rudolph Hecht and the Hibernia Bank to finance that first Ochsner Clinic in an old building on Prytania Street.

Not every doctor was convinced that Ochsner's idea was a good one. On Good Friday in 1941, small leather pouches filled with thirty dimes were delivered to the five Ochsner Clinic founders' homes. Inside each pouch was an anonymous typewritten note: "To the Judases of the Orleans Medical Society." The local doctors felt threatened and resentful. Ochsner argues: "We have helped the local physicians, raised the level of New Orleans medicine so that it is much higher than when we founded this place." ●

1978 American Medical Association

Mail to: James H. Allen, M.D., 9104 Quince St.
New Orleans, LA 70118

PEN MEMBER APPLICATION

"PEN MUST SURVIVE AND GROW . . . IT IS ALREADY THE MOST VIABLE, POTENT, AND ACTIVE COMMUNICATIONS FORCE IN MEDICINE — IT'S A MUST DO - CAN DO - AND WILL DO ORGANIZATION."
Alton Ochsner, M.D.

STATEMENT OF INTENT

I intend to be an active member of PEN and I endorse and support the STATEMENT OF PURPOSE.

In providing my resources I am assuring that PEN will continue to block efforts to invade medicine at the expense of the public health. I am subsidizing the ever-expanding promulgation of **truth**, the circulation of THE PEN and other publications to an ever-expanding audience. I am assuring the availability of resource materials, mass communications, legislative, and other expertise relating to this issue to all who support medicine in this cause.

I DESIRE TO INFORM AND BE INFORMED AND HEREBY PLEDGE DUES IN THE AMOUNT OF $250 ANNUALLY. (Subject to reduction as PEN grows)

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THE PEN FORUM

Editors' Note: Optometry's burning desire to invade the field of medicine was blatantly displayed when the Board of Regents of New York State, a non-medical, politically-appointed body responsible for directing the policy of higher education in New York, was persuaded to endorse optometric drug legislation.

It is unthinkable that political appointees, whose duties and responsibilities are not directly related to the issue, and who have never been informed by medicine as to the ramifications of the issue, should take such a position.

It would appear that the 15-member Board of Regents has been manipulated by optometry into taking a public political stance which will not only endanger the eye health of every New Yorker, but one which could cause that august body considerable, unnecessary embarrassment. Alden Haffner, O.D., an optometrist, is the State University of New York Vice Chancellor for Health Sciences.

Recognizing that legislators across the nation might well view this interference as an optometric credential, unless challenged, PEN has asked ophthalmologists nation-wide to express their views to all involved. Following are but a few excerpts from the flood of letters sent to the New York State Regents, the Chancellor and the State Commissioner of Education:

"The recent decision by the Board of Regents to support the use of drugs by optometrists ill-serves the public welfare as it reflects a lack of objectivity concerning this very important issue. The Board of Regents should be in the forefront of the battle to prevent non-medical measuring practitioners such as optometrists from becoming quasi-physicians by legislative fiat. Our educational system has numerous checks and balances to insure first that only the most highly qualified applicants are admitted to medical school; thereafter a medical school curriculum and periodic examinations standardized on a national level further insures scholastic fitness. The proper application of textbook knowledge to actual clinical pathology continues for the ophthalmologist throughout one year of internship and three years of specialized residency training in the diseases and surgery of the eye. The back door approach to medical school — via legislative fiat — should be a concept flatly rejected by the Board of Regents. The medical education as I outlined above should remain as the prerequisite to the use of pharmacological agents in the eye — the taking of pharmacology courses in or out of optometry school is in no way a substitute. Any optometrist who desires to assume medical functions should apply to medical school and obtain the proper training."

Seymour R. Rosen, M.D.
Sunrise, Florida

"The most important objection to optometric use of drugs is that authorization to use drugs implies the ability to judge the information obtained from such use and use it to make a medical diagnosis. Just as the possession of a stethoscope does not make one a cardiologist, the use of drugs to dilate the pupil or numb the eye will not make the optometrist equivalent to a physician. Patients will, however, be misled into believing that the optometrist is in fact qualified to make medical judgments and serious errors in diagnosis with accompanying missed opportunities to save eyes and even lives will occur.

"One has only to observe the level of optometric care throughout the State to realize the crass commercialism of many of their establishments. A little over a year ago the New York Daily News published a series of articles highly critical of the quality of eye examinations and glasses provided by many optometrists. How can the Board of Regents approve a group, which is not as yet meeting the standards for which they are licensed, to take on responsibilities for which they are not qualified?"

J. S. Nauheim, M.D.
Merrick, New York

"The recent decision by the Board of Regents of the State of New York to support optometric drug use legislation is ill-advised and myopic. In taking this decision, the Regents are permitting a group (the optometrists) to legislate medical privileges rather than obtain the medical privileges by education as the physician has."

John B. Franklin, M.D.
Hartford, Connecticut

"It seems obvious that we cannot, at this time, compromise these standards. Your decision to support optometric drug laws is just such a compromise. It is the same as suggesting that chiropractors are as well qualified to practice medicine as are physicians. Even a school such as the University of Alabama in Birmingham, has recently defined the practice of optometry as a non-medical discipline. A resolution by the Physicians Advisory Board at the University of Alabama, states, 'This education in no way prepares these graduates with the knowledge to prescribe or use drugs to treat eye diseases'. I urge you, therefore, to reverse this decision and to serve the citizens of New York State by so doing."

William C. Frayer, M.D.
Philadelphia, Pennsylvania

"I am writing to protest the action of the Board of Regents of New York State endorsing optometric drug use. It is unthinkable that highly educated people could advocate the use of medications by untrained practitioners. Furthermore, the training of optometrists in diagnosing medical eye diseases is terribly inadequate so that misdiagnosis and delayed recognition of disease is a greater danger than the complications of the pharmaceutical agents. . . . Please reconsider this issue."

Thomas S. Harbin, Jr., M.D.
Atlanta, Georgia

"The support given to the optometric drug bill must have been made without due consideration for the possible effects the legislation would have.

"Last year this legislation was voted down in fourteen other states whose legislators were given factual information concerning this issue. Most of the states which had passed the bill previously are now considering recall of the bill after documenting the serious harm done by optometrists using medication during their eye exams. It is unfortunate that in the states that passed the law the public had to suffer because of the inappropriate action of the legislators."

Daniel W. Pieroni, M.D.
Sheffield, Alabama

UNITED STATES PHYSICIANS EDUCATION NETWORK

Statement of Purpose

PEN exists solely to utilize its resources and combined influence to present, promote, and promulgate, through communication outward, and communication inward, these simple truths:

- The American people must be protected by placing and keeping health care in the hands of experts, whose abilities are established by having reached a standard level of medical education.
- The logical minimum level of education necessary for leadership to protect the public in shaping the optimum health care delivery quality standards in the United States is the degree of Doctor of Medicine or Osteopathy, earned at a school of medicine or osteopathy — at an accredited institution of higher learning.
- Government at every level should cooperate with medicine in establishing these health safety standards.

Membership in PEN is available to any law-abiding citizen who subscribes to these truths, and desires to be informed, as well as to participate in informing the public at large.

"M.D. IS THE MAJOR DIFFERENCE"

THE PEN...

PRO BONO PUBLICO

Published in the Public Interest by Ophthalmology

VOL. 2, NO. 9 MAY 1, 1978

VIRGINIA VETO MESSAGE

Governor John N. Dalton: "There Is Concern"

Virginia Gov. John N. Dalton's courageous action in failing to sign House Bill 205 into law deserves high praise from both medicine and the citizens of the Commonwealth. Gov. Dalton has reaffirmed to his constituents and to the people of this nation that only through "education, not legislation," can a person become competent enough to use drugs on the human body.

The following is Gov. Dalton's comment after vetoing the bill:

"The bill defines what constitutes the practice of optometry; and defines requirements of persons who desire to be certified in the use of diagnostic pharmaceutical agents that they be examined in general and ocular pharmacology and in the use of approved topically applied diagnostic pharmaceutical agents. Although paramedics, physician assistants, and nurse practitioners may administer drugs in specific instances, this is done (a) under the supervision of a physician, and/or (b) under specifically developed protocols regulating such procedures. Given the rare, but devastating effects of adverse reaction following administration of diagnostic agents, there is reason for grave concern for patients' welfare where optometrists practice in isolation from medical backup. There is concern over public misunderstanding that complete medical care has been effected after having an optometric examination. Finally, *there is concern of legislative appointment of 'medical' responsibility and authority to non-medical personnel* prior to this matter being carefully studied as to its impact in the Commonwealth."

Honorable John N. Dalton . . .

63rd Governor of Virginia

Gov. John N. Dalton, the 63rd governor of Virginia, took office on Jan. 14, 1978. A graduate of the College of William and Mary, he received his J. D. degree from the Law School of the University of Virginia in 1957.

Following graduation from law school, Gov. Dalton practiced law in Radford, Va. and began his political career in 1965 when he was elected to the Va. House of Delegates. After being re-elected to this post three times, he ran successfully for the State Senate in 1972. In 1973, he was elected lieutenent governor.

A 33rd degree Mason and an Eagle Scout, Gov. Dalton is a past-president of the Moneton District of Boy Scouts and a member of the Blue Ridge Council of Boy Scouts.

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Eight States Reject Optometric Drug Law Petitions In 1978

Gov. Dalton's veto marks the seventh 1978 rejection of optometry's attempts to utilize legislative "clout" to invade medicine at the expense of the public health. Other states refusing optometrists the right to use drugs this year are Georgia, Mississippi, Missouri, South Dakota, Maryland and Oklahoma. At presstime, an optometric drug bill in Nebraska was reported to have "died on the calendar," bringing the total to eight.

So far this year, only Wisconsin and Kentucky patients face eye damage as a consequence of new optometric drug laws. In Kentucky, the law was passed and signed despite charges of impropriety, plus a call for a veto by the *Louisville Times.*

Unfortunately, the public health remains imperiled in several states: Massachusetts, New York, Ohio, South Carolina, Alaska, Hawaii, Iowa, and Arizona, where "the jury is still out."

WHY "THE PEN?"

The files of state and national medical associations, all learned societies concerned with the public health, overflow with a preponderance of evidence that the quality of health care is threatened by the precedent of Government encouraging the lowering of professional standards by allowing medical functions to practitioners with no medical education. Medicine accepts the responsibility to respond to epidemics. Death and trauma are resulting, and Doctors of Medicine can do no less than warn potential victims through the continuous presentation of this evidence. The public press of America, given the facts, is supporting this cause, and concerned physicians throughout the nation are pooling their knowledge and resources to package and present the truth through the PHYSICIANS EDUCATION NETWORK.

DR. ALLEN'S

DIAGNOSES

James H. Allen, M.D.: founding president, New Orleans Academy of Ophthalmology; professor of ophthalmology, Univ. of Iowa and Tulane Univ. for 30 years; Senior Surgeon, Tulane Univ.; awarded the prized Gold Medal of the Ophthalmology Section of AMA, 1976.

Governor Dalton — We Know That Any Veto Takes Both Courage And Conviction!

Being the captain of a ship is a lonely job — and in Virginia, like all states, the ultimate decision rests with the Governor.

During the past few weeks, Gov. John N. Dalton has faced the challenge of difficult decision-making as to whether all bills passed by the 1978 Virginia Legislature should be signed into law.

The intensity of the public outcry in Virginia against non-medical optometrists being allowed to use dangerous drugs and eye drops in the practice of their profession must have made the decision as to whether to sign House Bill 205 most difficult.

In protecting the public of Virginia, Gov. Dalton did far more than simply refuse to sign the bill. He presented his own conclusions (see page one) utilizing new phraseology which convinces us that the Governor is dedicated to the welfare of all Virginians. Speaking out in support of his veto, Gov. Dalton revealed that he reached the same conclusion as 46 major metropolitan newspaper editors who studied what is actually a simple issue. He came to the conclusion that, "There is concern of legislative appointment of 'medical' responsibility and authority to non-medical personnel prior to this matter being carefully studied as to its impact on the Commonwealth."

The Governor's conclusion is simple logic. Medicine in Virginia, in the early days of the 1978 legislature, did fail to meet the challenge and provide adequate information for careful study. When it was apparent, however, that many legislators actually believed that the petition of optometry to use drugs and eye drops would in some way be of benefit, medicine rallied to the challenge.

Prior to medicine's challenge, optometry found conscientious, but uninformed (on this issue) legislators easy prey for half truths, exaggerations, and even prevarications.

When medicine rallied its forces, however, an interested delegate commented that "ophthalmologists suddenly came out of the woodwork." Indeed they did, and medicine is so proud of them.

Ordinarily, ophthalmologists stay behind the woodwork in order to concentrate on providing medical care to a steady stream of people with serious eye problems who need and deserve full attention, treatment and cure.

The political scene is unfamiliar to medical people, and it took M.D.s some time to realize that the woodwork must give way when the public health is threatened by the body politic and that they must respond as they would to an epidemic.

By the time the issue reached the Senate floor, it was obvious that medical truths had changed the minds of many of the legislators.

The Governor is right — the measure deserves more study. Make no mistake. Medicine in Virginia welcomes further study, and so does PEN. The Virginia assembly was generous in allotting time to advocates of "both sides" and so was the Governor.

While it is difficult for us in medicine to acknowledge that there are "two sides" to this issue, we know that a preponderance of evidence is on our side and we intend and welcome the opportunity to present it on behalf of the people anywhere in the United States.

Finally, if Gov. Dalton had rendered an opposite verdict, we would have concluded that he, too, ignored the facts so obvious to the press of America, and REPEAL bumper strips would have been on the way to Virginia. The people of the Old Dominion deserve no less than insistence on high quality health care, and both medicine and the Governor have demonstrated high resolve to preserve just that!

JHA

THE PEN....

VOLUME 2, NO. 9
MAY 1, 1978
ST. PETERSBURG, FLORIDA

EDITORS

Medical Editors: James H. Allen, M.D., New Orleans, La.; Leonard B. Alexnick, M.D., Tacoma, Wash.
Contributing Editors: Roland E. Houle, M.D., Quincy, Mass.; David W. Parke, M.D., Meridan, Conn.
Staff Editors (St. Petersburg, Fla.): George P. Russell, Frank T. Barnes, Richard D. Painter
Production Manager: Edward S. Barclay

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"A little learning is a dangerous thing . . . drink deep, or taste not, the Pierian Spring/Shallow draughts intoxicate the brain, and drinking deep largely sobers it again." . . . Alexander Pope

Massachusetts Wins Committee Victory

On Tuesday, March 28, 1978, the Massachusetts Senate by voice vote, accepted the recommendation of the Joint Health Committee that the optometric drug bill (Senate S 402) **"ought not to pass."**

Medicine throughout Massachusetts is saluting the Senators for their caution and awareness of the necessity of protecting the public health.

A Health Care Committee report is on the House calendar for debate. The bill, having been filed in both houses, requires that each act independently on the Health Care Committee report.

No action in the House has been reported.

BULLETIN AT PRESSTIME

An optometric drug bill in Nebraska "died on the calendar," according to PEN Advisory Board member John Ramsell, M.D. of Omaha. Nebraska becomes the eighth state to protect patients from this threat this year.

UNITED STATES PHYSICIANS EDUCATION NETWORK

Statement of Purpose

PEN exists solely to utilize its resources and combined influence to present, promote, and promulgate, through communication outward, and communication inward, these simple truths:

- The American people must be protected by placing and keeping health care in the hands of experts, whose abilities are established by having reached a standard level of medical education.
- The logical minimum level of education necessary for leadership to protect the public in shaping the optimum health care delivery quality standards in the United States is the degree of Doctor of Medicine or Osteopathy, earned at a school of medicine or osteopathy — at an accredited institution of higher learning.
- Government at every level should cooperate with medicine in establishing these health safety standards.

Membership in PEN is available to any law-abiding citizen who subscribes to these truths, and desires to be informed, as well as to participate in informing the public at large.

THE PEN is a public newspaper, international in scope. Its readers include people from every walk of life. THE PEN is freestanding and independent of any national or state association, with the exception of its sponsor, Physicians Education Network, Inc. PEN, Inc. is a Florida non-profit corporation. Submissions to this newspaper are welcome and are published at the discretion of the editors. THE PEN does not accept paid advertising or paid subscriptions.

WOULD YOU LIKE TO RECEIVE THE PEN?

THE PEN, to be published 24 times annually, is an international publication — unique in that subscriptions cannot be purchased. Non-medical persons may petition THE PEN for a complimentary subscription. Just tell us who you are and why you are interested. Medical doctors can become subscribers by joining PEN as a dues-paying member (see application elsewhere in this issue). Elected officials — state or national — and executives of health care agencies can become subscribers upon request.

Industry Co-sponsors Portland Eye Exhibit

While medicine and ophthalmology concentrate on resisting the invasion of medicine at the expense of the public health, there are many painstaking efforts to provide education to encourage patients to protect themselves.

One such effort is a major new exhibit, the Sealy Ophthalmology exhibit, which opened Saturday, March 18, at the Oregon Museum of Science and Industry (OMSI), and promises to be a major tourist attraction this summer.

Funded by the Sealy Mattress Co., and enthusiastically supported by its president, Lloyd Rosenthal, the $30,000 display was co-sponsored by the Oregon Academy of Ophthalmology, which will be responsible for its annual maintenance costs. Under the leadership of OMSI's Exhibits Director Shabtay Levy more than a year of planning and construction has gone into the exciting display.

The focal point of the exhibit is a 3 ft. in diameter, stylized anatomical model of the human eye. The model demonstrates the anatomy and functions of the human eye, and also demonstrates some pathological disorders, such as cataract, glaucoma, retinal detachment and diabetes. The viewer can actually see how these diseases affect human vision.

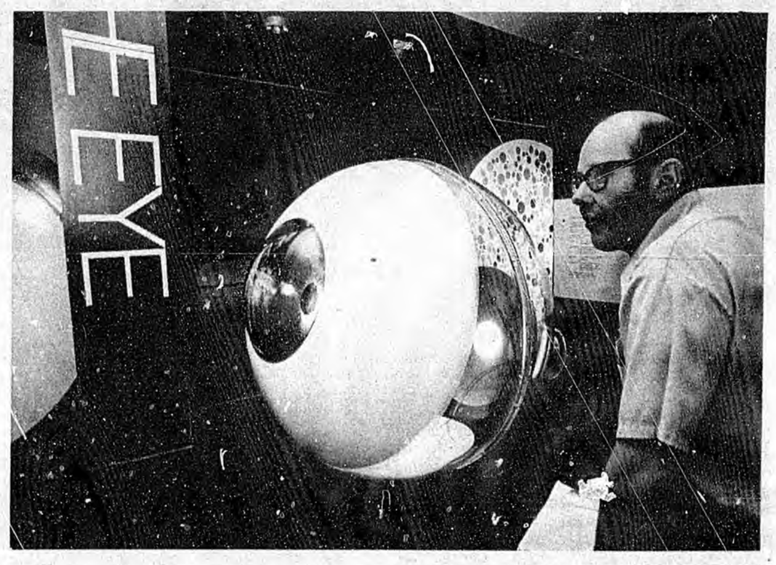
By pushing buttons, the viewer is able to activate functional parts of the exhibit to show how the iris changes its size related to changing levels of light. Supporting exhibits include visual acuity, peripheral vision, color vision, depth perception and even one which shows the viewer the pupil of his own eye dilating and contracting as light values change.

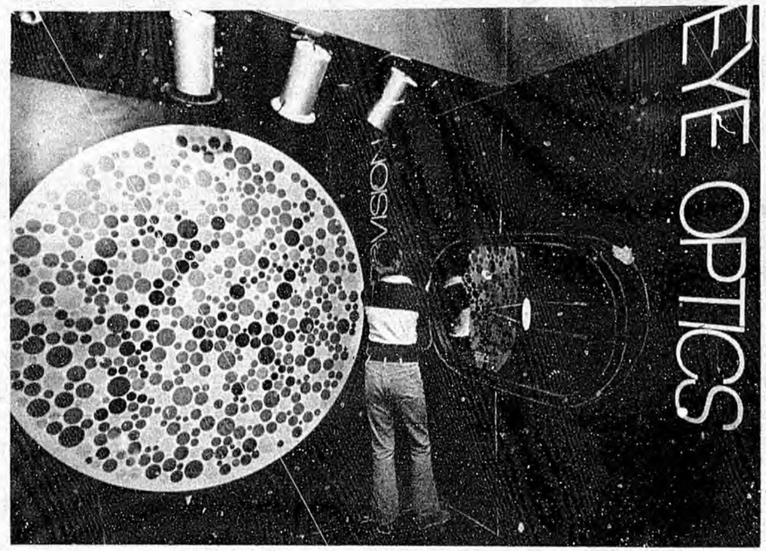
Under Mr. Levy's direction, and in cooperation with expert ophthalmologists, the entire concept, design and construction of the exhibit was completed by the OMSI Exhibits staff.

The Oregon Academy has prepared educational pamphlets complementary to the exhibit which cover various phases of eye care, including the "major difference" between ophthalmologists and optometrists, and advice on seeking out an ophthalmologist.

Members of the Oregon Academy of Ophthalmology working closely with the Exhibits staff include Merritt Linn, M.D., Donald Plumb, M.D., Robert Burns, M.D. and John Wobig, M.D., all of Portland.

The Sealy Ophthalmology exhibit opening is expected to be of great interest to the casual visitor to OMSI, and will be of special value for school tours and other interested groups for whom more detailed lectures and demonstrations will be offered.





The current "Book of Lists," a best seller, identifies PEANUTS, created by Charles Schulz, as the most popular cartoon strip in the world. At least creator Schulz, Lucy, Charlie Brown, Snoopy et al obviously know "The Major Difference," and hopefully, so do many of their readers. PEN is grateful to United Feature Syndicate, Inc. for permission to reprint this significant, educational, and as always, humorous, cartoon which has appeared in newspapers throughout the world.

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MARYLAND DAILY NEWSPAPER ADVISES READERS

THE SUN

A 14 BALTIMORE, THURSDAY, MARCH 23, 1978

WILLIAM F SCHMICK, JR., President and Chief Executive Officer, The A.S. Abell Company

DONALD H. PATTERSON, Publisher • PAUL A. BANKER, Managing Editor • J.R.L. STERNE, Editorial Page Editor

Optometrists and Drugs

Optometrists are trained in four-year schools to fit glasses, using various optical methods to determine the kinds of lenses patients need for correction of vision problems. *Opthalmologists* have had more sophisticated training. Like optometrists, they fit glasses. But because they are physicians who have specialized in opthalmology after completing medical school, they are prepared to do a great deal more. For instance, they can use and prescribe drugs, treat eye diseases and do eye surgery.

Under current Maryland law, optometrists are not allowed to use drugs in their practice. But a bill now in the Maryland Senate would give them that right in certain cases. Optometrists make superficially plausible arguments in favor of the bill, pointing out that, with amendments they support, it would allow them to use only four types of drugs, all administered topically in the eyes, and only for diagnostic purposes; and that they would be required to take a minimum of 70 hours of training in pharmacology before they could use the drugs. They add that adverse side effects of the drugs are so rare as to be almost non-existent.

Unfortunately, say opthalmologists, the side effects are not all that rare. Allergies to the drugs might, in severe cases, result in death. Certain of the drugs can cause hallucinations, and others can result in detached retinas or acute glaucoma. Coping with these side effects requires the skills and equipment of a physician. A severe allergic shock reaction, for instance, might require adrenaline and cortisone injections which only a physician is qualified to administer. As the opthalmologists point out, 70 hours of training in pharmacology—as opposed to the 2,400 hours or more physicians receive—might not even qualify optometrists to recognize the side effects for what they are, let alone be able to treat them. The bill should be defeated

THE PEN FORUM

PEN has received more than 200 pieces of mail to Veterans Administration officials and congressmen from medical doctors concerning passage of Public Law 94-581, which gives measuring scientists with no medical training a primary health care role at VA hospitals throughout the country.

About 50 United States Senators and Representatives have responded to M.D.s' claims that raising optometrists to a primary health care level will jeopardize the public health.

The following letter to James H. Parker, Jr., M.D. of Wyomissing, Pa. from Rep. Gus Yatron is typical of letters from concerned congressmen received since the circular was signed Nov. 4, 1977:

Dear Dr. Parker:

Thank you for your recent letter expressing your continued interest and concern over the possibility of optometrists being allowed to take over part of the medical care of eye patients in the Veterans Administration.

Please be assured that I feel you have raised some valuable and serious points regarding such an action. Before such a proposal is approved, I feel that all possible questions pertaining to the adequacy of optometric education must be resolved. You can be certain that I will continue to scrutinize all of the implications and possible ramifications of this change, and that I will not endorse any action that could endanger the health of our nation's veterans. Additionally, I will not support any move to downgrade the quality of care offered in veterans' hospitals.

Sincerely,
Gus Yatron

Mail to: James H. Allen, M.D., 9104 Quince St.
New Orleans, LA 70118

Founded as O.P.E.N.

PEN CHARTER MEMBER APPLICATION

This is my statement of intent to be an active member of the United States Physicians Education Network — I endorse and support the statement of purpose.

In providing my resources to guarantee the continuation of a strong and viable international entity I acknowledge and understand the following:

— That my membership in PEN will bring me a minimum of 48 mailings annually including 24 issues of a national publication as described, in keeping with the statement of purpose.

— That, as a Charter Member, I accept the responsibility of attempting to recruit members. I further understand that my state society will automatically be qualified for WATS line telephone consulting services and direct public relations advice and counseling, tailored to my state, as soon as either ten percent (10%) of the membership of my state society, or 20 members, (whichever is the least) are recruited.

I desire to inform and to be informed and to join this movement, and hereby pledge my support through dues, not to exceed $300 annually.*

— I understand that as a Charter Member, I will be issued a silver lapel emblem signifying my Charter status as soon as available after formation.

Date_____ 1978

Name_____

Address_____

City_____ State_____ Zip_____

Telephone: (Area)_____ Number_____

Ophthalmologist?_____ Other specialty_____

Profession, other than M.D.?_____

Check enclosed ($300)_____ Please bill me_____

* Charter Members (enrolled before July 1, 1978) will be awarded a dues decrease as of the second full year.

Visual and Medical

The Visual Part can be performed by an optometrist or an ophthalmologist.

The Medical Part can *only* be performed by a qualified medical doctor (an ophthalmologist).

When having your eyes examined you should know whether you are receiving a *complete* eye examination or only a part. When an optometrist (O.D.) examines a person's eyes he is qualified and licensed only to perform the visual part. He is not educated nor trained to perform the medical part.

When an ophthalmologist (M.D.) examines a patient's eyes, he performs both parts on an inter-related basis. He not only evaluates visual functions and performance, but also analyzes and diagnoses diseases and physiological disorders.

Ask the individual examining your eyes whether he is an O.D. (optometrist) or an M.D. (ophthalmologist). Only an ophthalmologist M.D. can perform a *complete* eye examination -- both visual *and* medical.

While the Massachusetts Society of Eye Physicians and Surgeons (MSEPS) energetically resists attempts to endanger the eye health of Bay State citizens, the MSEPS also endeavors to educate the public to protect themselves. The centerfold of a small but potent folder being circulated by medicine in Massachusetts is reproduced above with permission of the Society.

Name	Organization	Address	Bill No.
DR. Boyd L. Walker	Alaska Optometric Assn.	1345 W 9th ~~Anca~~	79
DR. A. RON STERNBERG	" "	1016 W. 6th Ave, Suite A, Anchorage	79
JEFF LANDRY	AK. STATE MEDICAL ASSOC.	320 W. 3RD. ST. JUNEAU, AK.	79
Dr. John T. Shank	State Board of Examiners in Opt.	Box 827 Kodiak	
Dr Maynard Falconer			
Doris P. Falconer	AK Optometic Board of Examiners	1345 - W - 9th Anch	79
Dr. T.D. McLaughlin	A.O.A. Auxilla - (Observer)	" " " "	
Ruth A. Box 0 D	~~Alaska~~ Optometric Association Board member	Box 498 Sitka	79
Rep Patrick M. O'Connell	Alaska optometrists. - State Leg. - Dist 13	Juneau	79 79

POSITION PAPER/Department of Health and Social Services

POSITION PAPER
ON
HOUSE BILL NO. 79

"An Act relating to the practice of optometry."

This bill would permit the use of selected drugs including topical anesthetics, mydriatics, cycloplegics and myotics by optometrists, and as such would delete from the definition of optometry the restriction against the use of drugs.

The intent of the bill would be to permit optometrists to use certain prescription drugs. This significantly increases the scope of optometry as presently defined and poses some increased risk and complications. The use of mydriatics is occasionally associated with the development of acute narrow angle glaucoma which may necessitate emergency surgery. The use of topical anesthetics are occasionally associated with acute, allergic reactions and some risks of danger to the cornea by foreign bodies. Recognizing the unusual, but definite risks and complicating reactions, the Department of Health and Social Services feels the use of prescription medications by optometrists would not be in the best interests of the public.

Recommended by: Robert I. Fraser

Robert I. Fraser, M.D., Director — 2/14/79
Division of Public Health

Approved by: Helen D Beirne — 2/16/79

Helen D. Beirne, Commissioner
Dept. of Health and Social Services

Rep. Buchholdt

Alaska State Legislature

POUCH V
JUNEAU, ALASKA 99811

P. O. BOX 9
KENAI, ALASKA 99611

REPRESENTATIVE HUGH MALONE

24 January 1979

Peter E. Cannava, M.D.
Box 1629
Soldotna, AK 99669

Dear Peter:

I received your letter and court brief regarding the optometric drug bill and have forwarded a copy to Rep. Thelma Buchholdt. She is the new chairperson of the Health, Education and Social Services Committee. As yet, no legislation has been introduced regarding this issue, however, I expect it will be soon.

Thank you for the information.

Sincerely,

Hugh Malone

jk

Peninsula Eye Clinic
PETER E. CANNAVA, M.D.
OPHTHALMOLOGY
BOX 1629
SOLDOTNA, ALASKA 99669

TELEPHONE 262-4462

Hugh Malone
State Capitol Building
Pouch V
Juneau, Alaska 99811

Dear Hugh:

I gave the enclosed talk to the legislators present at our political meeting and I thought it would be helpful to you to receive a copy of it considering your vote of last session.

The case illustrates the fact that the optometric drug bill represents more than a political "power play" but in fact has and will mean loss of eyes of our fellow Alaskans. We have at least two other cases documented where vision was lost because of inadequate medical knowledge on the part of optometrists.

The judges decision clearly states that there is no reason why optometrists can be permitted to make medical diagnosis on a legal basis. In addition the testimony by the "professor of optometry" clear illustrates the lack of medical knowledge on the part of optometrist educators.

Sincerely,

Peter

Peter E. Cannava, M..D.

PEC/bc

Hugh,
Please have one of your staff save the court brief as it will have to be used for the "HESS" committee hearings & also for future discussions I will have w you.
Good Luck this yr & I wish you a short 90 day session. P

Given to Legislative Meeting 13Dec78. Copy to DRC

American medicine has estabilished a tradition which dates back well over 200 years! Despite the ups and downs of certain aspects of American medicine the very basic integrity of the system has never and will never be challanged. This is fact because the system rests upon a foundation of sound scientific principle. American people may not like what type of treatment is offered them but they at least can rest assured that any prescription promulagated by our traditional medical system is based upon a scientific method, and those practitioner licensed with-in the system have completed a satisfactory curriculum approved by both private and governmental bodies who attest to the fact that medical practitioners are qualified to practice with the use of drugs and other modalities. In addition to the traditional modality of medical care there are two other broad categories of health care which our people choose to utilize. One is not based upon scientific methodology, cannot be supported by established objective data. Examples of these would be naturopathic healing and chiropractic. The second category of non-medical health care sought by Americans is based upon scientific principles but is not traditionally associated with medical education. Examples of those are psychology and optometry. In past years no major conflict has arisen between traditional medicine and other forms of health care. However, of late there is a movement on by non medical people to seek enactment of legislation which would grant them privileges which traditionally have been the provence of medical practitioners. Examples would include attempts by chiropractors to utilize medical facilities for laboratory testing and more germane to our state the attempt by optometry to seek legislation approved for their use of drugs within their practice.

Legislators must be aware of the short and long term implications of such legislation! Granting non-medical practitioners medical priveleges obscures the traditionally clear cut lines between the dicipline of medicine and the non-medical practices. Such obscuration of lines of deliniation serves to thoroughly confuse the public as to what type of health care is to be expected from each type of practitioner! In such confusion the public will have no clear concept of what type of "product" to expect of each health care practitioner. I wish now to focus upon a problem which confronted last years legislators and may surface again! Optometrists as you may be aware are non-medical practitioners by virture of their ancestory, training, current definition and as of several months ago defined by U.S. District judge for Alaska. They are requesting the legislature to grant them privilege of using drugs in their practice! Such a priviliege would have two fold effect and firstly it would set a precident with-in our state and open the door to all non-medical health personell to seek similar privilege. Secondly it would further endanger the people of Alaska to the risk of loss of sight because of the injudicious use of drugs and false sense of security the use of drugs imparts upon the recipients of such treatment. Indeed as time goes on I will supply you with case histories of Alaska residents who have lost eyes because they were lured into feeling they had been examined by eye physicians or ophthalmologists. I will also supply you with a legal suit prompted by such a loss of eye and additional pertinent information. I urge you not to grant non-medical health practitioners by legislation what they should rightfully earn by education that is the right to join the ranks of traditional medicine thru time honored institutions, estabilished testing procedures and time tested licensing procedures.

AE Lamnawa, M.D.

Rep. Buchholdt

5 February 1979

Peter E. Cannava, M.D.
Peninsula Eye Clinic
Box 1629
Soldotna, AK 99669

Dear Pete:

Yes, I did receive your packet of information and I apologize for the length of time it took me to respond.

I will forward the new information to Rep. Buchholdt as I did earlier for her files.

Again, thank you.

Sincerely,

Hugh Malone

jk

Peninsula Eye Clinic
PETER E. CANNAVA, M.D.
OPHTHALMOLOGY
BOX 1629
SOLDOTNA, ALASKA 99669
TELEPHONE 262-4462

February 1, 1979

Representative Hugh Malone
Pouch V
Juneau, Alaska 99811

Dear Hugh:

I hope you received my last packet of information on HB79 (optometric drug bill) As you will recall it included a copy of Judge Fitzgeralds decision regarding the loss of a childs eye because of optometric mis-managment! Since I have not heard from you I presume you are quite busy and I wish you luck in your difficult task.

Enclosed please find two items: 1. the copy of "P E N" describing optometric education, 2. Veto message of Gov. Rhodes, Ohio.

Sincerely,

Peter E. Cannava, M.D.

PEC/bc

Governor's Veto Message

(Unofficial Copy)

December 15, 1978

Pursuant to Article 2 Section 16 of the Constitution of Ohio, I return herewith to the Clerk of the Senate for presentation to the Senate Amended Substitute Senate Bill 163 which I disapprove and have not signed. Amended Substitute Senate Bill No. 163 would expand the definition of the practice of optometry to allow the use by optometrists of specific diagnostic drugs to the eye in the form of eyedrops. If the specified drugs are used solely for the purpose of detecting disease and are of a specific level of potency the matter of health care is of vital concern they must insure to all Ohio citizens that they receive the highest quality health care possible. Health care is an area in which we can take no risks because any mistakes can bring tragic and irreversible results. We must be committed to our citizens to provide practitioners that are highly skilled individuals and who will at the same time provide the best health care at the lowest cost.

Optometrists have been doing an excellent job in working with the medical profession to bring quality eye care to Ohio citizens. The tools that the optometrists are presently using are not dangerous and are effective in screening for eye disease. However, Amended Substitute Senate Bill No. 163 would allow optometrists to use drugs in order to make a full diagnosis of the medical condition of the eye. If the individuals involved were properly trained this procedure would be in the best interest of Ohio citizens, however without proper training the bill would allow unwarranted risks without corresponding benefits. The drugs involved are dangerous and have a potential of causing a great deal of pain including blindness. The adverse reactions associated with these drugs are not common but they do occur and medical and emergency treatment must be administered in those instances. While this bill does provide for mandatory training of 180 clock hours this amounts to little more than a month of isolated training in a clinical use of the drugs involved. The goal of this legislation should be to build a working relation between optometrists and the medical community. The issue of using drugs should be an issue decided by the professions rather than by the legislature. Both professions have taken an oath to provide quality health care, they should work together toward that end. I pledge the aid of my office for that purpose. For the foregoing reasons I have vetoed Amended Substitute Senate Bill No. 163 and urge the General Assembly to sustain my veto.

James A. Rhodes
Governor

House ...ees
Committee on
Health, Education & Social Services

Official Business

Pouch V
State Capitol
Juneau, Alaska 99811

February 7, 1979

Peter E. Cannava, M.D.
Peninsula Eye Clinic
Ophthalmology
Box 1629
Soldotna, Alaska 99503

Dear Dr. Cannava:

Thank you very much for your letter and back up material regarding HB-79. I do appreciate your taking the time to send this information to the committee.

We have, to date, received this same information from Rep. Hugh Malone, and I am sure it will be of help to members of this committee.

At this time, I have not yet scheduled the bill for hearing, but I will keep you informed as to when the bill will be up for a hearing.

Again, thank you for your interest.

Sincerely yours,

THELMA BUCHHOLDT
Chairman
House HESS Committee

TB/ch

Peninsula Eye Clinic
PETER E. CANNAVA, M.D.
OPHTHALMOLOGY
BOX 1629
SOLDOTNA, ALASKA 99669
TELEPHONE 262-4462

February 1, 1979

Thelma Bucholt, Representative
Pouch V
Juneau, Alaska 99811

Dear Mrs. Buckhodt:

HB 79 (optometric drug bill) has been sent to your committee for review. It is essential that you review the enclosed court decision concerning the loss of a young Alaskans eye due to optometric irresponsibility. As you will recall the issue last year was whether ot not optometrists were qualified to use dangerous drugs on the eyes of Alaskans. Judge Fitzgerald's decision should settle that question in the minds of Alaskans.

In addition you will find enclosed the Ohio Governors veto message of such a dangerous bill.

I would appreciate your response to the material.

Sincerely,

Peter E. Cannava, M.D.

PEC/bc

Governor's Veto Message

(Unofficial Copy)

December 15, 1978

Pursuant to Article 2 Section 16 of the Constitution of Ohio, I return herewith to the Clerk of the Senate for presentation to the Senate Amended Substitute Senate Bill 163 which I disapprove and have not signed. Amended Substitute Senate Bill No. 163 would expand the definition of the practice of optometry to allow the use by optometrists of specific diagnostic drugs to the eye in the form of eyedrops. If the specified drugs are used solely for the purpose of detecting disease and are of a specific level of potency the matter of health care is of vital concern they must insure to all Ohio citizens that they receive the highest quality health care possible. Health care is an area in which we can take no risks because any mistakes can bring tragic and irreversible results. We must be committed to our citizens to provide practitioners that are highly skilled individuals and who will at the same time provide the best health care at the lowest cost.

Optometrists have been doing an excellent job in working with the medical profession to bring quality eye care to Ohio citizens. The tools that the optometrists are presently using are not dangerous and are effective in screening for eye disease. However, Amended Substitute Senate Bill No. 163 would allow optometrists to use drugs in order to make a full diagnosis of the medical condition of the eye. If the individuals involved were properly trained this procedure would be in the best interest of Ohio citizens, however without proper training the bill would allow unwarranted risks without corresponding benefits. The drugs involved are dangerous and have a potential of causing a great deal of pain including blindness. The adverse reactions associated with these drugs are not common but they do occur and medical and emergency treatment must be administered in those instances. While this bill does provide for mandatory training of 180 clock hours this amounts to little more than a month of isolated training in a clinical use of the drugs involved. The goal of this legislation should be to build a working relation between optometrists and the medical community. The issue of using drugs should be an issue decided by the professions rather than by the legislature. Both professions have taken an oath to provide quality health care, they should work together toward that end. I pledge the aid of my office for that purpose. For the foregoing reasons I have vetoed Amended Substitute Senate Bill No. 163 and urge the General Assembly to sustain my veto.

James A. Rhodes
Governor

February 14, 1979

Representative Thelma Buchholdt
Pouch V
Mail Stop Number 3100
Juneau, Alaska 99811

Dear Representative Buchholdt:

House Bill 79 (Senate Bill 75) relating to optometrists (nonphysicians) using medications has recently been introduced this session. I hope you can take a few moments from your busy schedule to read a brief summary of what I feel are important points as regards this legislation.

1. Optometrists are not physicians. No optometrist in Alaska has had any instruction in pharmacology or drug side effects from anyone with a Ph.D. or masters degree in pharmacology, no optometrist in Alaska has ever had any instruction in anything from a full-time M.D. on any optometric school staff, and no optometrist in Alaska has ever had any formal classroom or clinical training by an ophthalmologist (a physician with specialty training in eye disease and management).

2. Legislation, as presented, would let the Optometric Board evaluate the qualifications for drug use by optometrists. The Legislative Audit Performance Review of 11-1-78, noted:

   a. The state licensing examiner was asked not to attend the last examination given by the Optometric Board.

   b. The Audit Committee also found evidence of examination results being changed, regrading of examinations, and deletion of examination questions.

   c. The Audit Review was unable to find recent oral, written, or practical exam questions and answers.

   How can this Board, who has apparently compromised its integrity and responsibility given them by state statute but has also never had any experience in pharmacology, be expected to fairly pass on the qualifications of one of its own practitioners to use medicines in the eye.

3. The trend across the country is to defeat this sort of legislation. In 1977, this type of legislation was defeated in 17 states and passed in four; in 1978, it was defeated in 15 states and passed in two; and already in 1979, it has been defeated in one state and passed in none. This legislation is not beneficial to the public welfare, further confuses the consumer as to who he is entrusting the care of his eyes, and endangers the public at the hands of nonphysicians.

4. "Diagnostic drops" is a misnomer. The drugs don't diagnose - people diagnose. Dilating the eye is not a prerequisite to making a diagnosis of eye disease, dilating the eye is not a prerequisite to supplying children with the proper correction for glasses, and anesthetic drops are not a prerequisite for the diagnosis of glaucoma.

5. Optometrists (non-M.D.s) have no training in the management of side effects of these medications; e.g., myocardial infarction (there were seven cases of documented heart attacks due to these drugs in the United States in the past 12 months) or narrow angle glaucoma caused from dilating the eyes (there's an extremely high incidence of this condition in Alaskan natives).

6. Optometrists are not trained in the detection of pathology. An optometrist, currently a member of the Alaska Optometric Board, caused an eye to be lost in a four year old child because of his inability to recognize disease and refer the child in a timely fashion. Please find enclosed an issue of PEN newsletter which, in detail, describes Judge James Fitzgerald's findings in the Fourth Judicial District, U.S. District Court in the State of Alaska in October of 1978.

7. Let me suggest some appropriate amendments to this legislation if you feel it is in the public's best interest:

   a. There should be mandatory referral if the vision cannot be corrected to 20/20 in each eye in an adult or 20/30 in a child under eight years of age (this is a current law in England).

   b. There should be no "miotic drop" inclusions. No one considers miotic drops as a diagnostic drug.

   c. It would be appropriate to ensure the availability of malpractice insurance to optometrists to protect the public.

   d. There should be no grandfather clause.

   e. Any pharmacology or pathology testing should be done by the American Board of Ophthalmology. They are the most experienced group and the logical group to design such an examination.

   f. There should be mandatory referral, as per Dr. Alfred Lemoine who is often cited by optometry as an ophthalmologist in favor of diagnostic drug use by non-M.D. optometrists (see enclosure - 10 points in the history, 33 points in the clinical evaluation).

The regulation of the practice of the various professional and paraprofessional groups is not for the benefit of the licensee but for the benefit of the state and its people. No where does case law suggest that public protection will be qualified; i.e., that the risk may be increased a little bit but not a lot. The intent is protection and the language is explicit.

A disregard for excellence, as would result with passage of House Bill 79 (SB 75), as it is presented to you, will adversely affect the superior level of eye care currently offered to the citizens of Alaska. A little bit of this Bill is like a little bit of syphilis.

Thank you for the time you have taken.

Sincerely,

Sam A. McConkey, M.D.

SAM:ls

Submitted by
Dr. Sam McConkey

SUMMARY

Albert N. Lemoine, M. D., F.A.C.S.

There are ocular complaints obtained in the history and findings during an ocular examination that almost without exception are an indication for referral to an ophthalmologist for definitive diagnosis and therapy.

HISTORY

1. Rapid visual loss - over a period of minutes or hours.
2. Episodes of intermittent periods of reduced vision.
3. Sudden onset of "floating spots" in the field of vision.
4. Flashes of light in the visual field.
5. Defects in the field of vision, scotomas.
6. Distortion of objects or lines.
7. Rapid onset of visual haze with no specific complaint of decreased visual acuity.
8. Severe pain around the orbit or in the eye.
9. Prolonged severe pain in the occipital area.
10. Diplopia or visual confusion.

CLINICAL FINDINGS

1. Best corrected visual acuity 20/40 or less, unless they nave had a prior diagnosis by an ophthalmologist.
2. Any patient whose refractive error changes one half a diopter or more, especially on the hyperopic side, within ninety days except for children with myopia.
3. Masses of the lids or adnexa either with or without inflammatory signs.
4. Defects in the lid margin.
5. Redness that is most marked ir the 2 mm. zone adjacent to the cornea.
6. Any type of corneal clouding or infiltration either with or without congestion of the conjunctiva.
7. Cloudy anterior chamber.
8. Blood in the anterior chamber.
9. Small, poorly or nonreactive pupil.
10. Dilated, poorly or nonreactive pupil.
11. White pupil reflex.
12. Cataracts or lens opacities before the visual acuity is reduced to 20/40 or less.
13. Vitreous "floaters".
14. Blood in the vitreous.
15. Papilledema.

16. Optic atrophy, primary or secondary.
17. Larger or smaller than normal disc.
18. Abnormal disc cupping.
19. Dilated veins with or without retinal hemorrhage.
20. Narrowed arteries with or without retinal hemorrhage.
21. Any masses seen in the fundus, pigmented or nonpigmented.
22. Retinal hemorrhages, one or both eyes.
23. Pigment disturbance, either increase in pigment or decrease other than the dark fundus of the black race or lack of pigment in blond or albino patients.
24. Any areas of retinal elevation.
25. Retinal tears.
26. Presence of diplopia.
27. Nystagmus.
28. Scotoma.
29. Distortion of lines Amsler Grid or objects.
30. Any visual field defect other than blind spot.
31. Ptosis.
32. Intraocular tension of 22 or more on two or more occasions.
33. Exophthalmos, unilateral or bilateral.

Don Hostak, Director
Div. of Occupational Licensing

XXXXXXXX
02 13 79

Byron Perkins BP
Licensing Examiner

I spoke with Eldon Ulmer, President of the Board of Pharmacy, and he asked me to convey the following to you in response to your teletype to him last week.

RE House Bill 79 XXXXXXXXXXXXXXXXXXXXXXXXX regarding optometrists and particularly their ability to prescribe legend drugs and pharmaceuticals, the Alaska Board of Pharmacy has not changed its position on this issue. The board is not primarily concerned with whether or not an optometrist should be given this priviledge, but rather, that the proposed bill in no way addresses the legal question of how they are to obtain legend drugs. Current Federal and State statutes do not permit pharmacists to fill prescriptions for legend drugs by any one but Medical Doctors, Veterinarians, and Dentists.

Re House Bill 101 and Senate Bill 65, the Uniform Controlled Substances Act, this is the number one legislative priority for the Board of Pharmacy, and the board supports it conceptually. However, the current bill is primarily a police bill, and needs to be ammended substantially to make it palatable to the industry. There is not enough language addressing the rights and responsibilities of professionals authorized to handle controlled substances. The Board of Pharmacy is pushing for a Uniform Controlled Substances Act that parallels the federal guidelines.

cc: Eldon Ulmer, R.Ph.
Chairman, Board of Pharmacy

Don Hostak, Director
Div. of Occupational Licensing

02 13 79

Byron Perkins BP
Licensing Examiner

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DR. M. C. FALCONER
DR. J. C. FALCONER
DR. G. L. HALL
DR. T. F. HARBOUR
DR. B. L. WALKER
DR. W. D. FAULKNER
OPTOMETRISTS

ANCHORAGE EYE AND CONTACT LENS CENTER
1345 W. NINTH AVE. PHONE: 272-2557
ANCHORAGE, ALASKA 99501

March 7, 1979

Honorable Thelma Buchholdt
House of Representatives
Pouch V
Juneau, Alaska 99811

Dear Representative Buchholdt:

It has been brought to my attention that information in opposition to HB 79 has been distributed to all legislators. Some of this information contained in an ophthalmological tabloid newspaper entitled The Pen, although a sensational distortion of fact, demonstrates the responsibility of optometrists to detect and refer pathological eye conditions. The use of drugs (DPA's) requested by optometrists in HB 79 is simply a tool to help better serve the public, so that unfortunate incidents such as those described in The Pen will be more easily detected.

I urge you to consider the following facts prior to making a committment for or against this bill. These facts are excerpted directly from a report to the United States Congress by the U.S. Department of Health, Education and Welfare which I am enclosing.

1. It is the responsibility of optometrists to detect and refer pathological eye conditions.

2. Optometrists currently receive training in detection of ocular disease as well as in the use of pharmaceutical agents including management of side effects.

3. H.E.W. consultants on this report unanimously recommended that state licensure laws be revised to allow the use of diagnostic pharmaceutical agents by optometrists. (24 states now allow this practice)

If you have any questions regarding this bill or statements made in opposition to it, I would like to have the opportunity to respond with documented facts from objective sources. I appreciate the time you have taken to consider this very important legislation.

Thank you.

Sincerely,

Boyd L. Walker, O.D.

Boyd L. Walker, O.D.

BLW:ah

REPORT TO THE CONGRESS: REIMBURSEMENT UNDER PART B OF MEDICARE FOR CERTAIN SERVICES PROVIDED BY OPTOMETRISTS

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE • Public Health Service • Health Resources Administration

The Bureau of Health Manpower projects the overall number of active ophthalmologists in the United States to rise to 13,300 in 1980 and to 18,400 by 1990; this compares with projected levels of 22,000 and 28,200 for optometrists in the same time intervals. The proportion of ophthalmologists as a percent of total professional vision care manpower is projected to grow from 35 percent in 1973 to 38 percent in 1980 and 39 percent in 1990. These estimates should be interpreted cautiously, and should be undertaken in the context of written documentation available from the Bureau of Health Manpower. Available data preclude such projections on a detailed geographic basis.

More specific data indicates that in recent years many areas of the country, particularly non-metropolitan areas, are served only by optometrists. Approximately 40 percent of counties have an optometrist but no ophthalmologist. Another 27 percent have neither.

Optometric Practice

The Institute of Medicine of the National Academy of Sciences, in describing primary health professions who are direct providers of patient care, defined optometry as follows: "The Doctor of Optometry (O.D.) is a health professional who performs eye examinations to determine the presence of visual, muscular, or neurological abnormalities, and prescribes lenses, other optical aids, or therapy, such as eye exercises to enable maximum vision. Optometrists are trained to recognize disease conditions of the eye and ocular manifestations of other diseases, and to refer patients with these conditions to the appropriate health professional."

This definition, as well as available documentation on the utilization of optometric services, points to the optometrist's role as a provider of primary health care services. In this role, the optometrist functions as a principal point of contact within the health care system for persons having visual complaints, including certain numbers who have symptoms or conditions that require referral to other health practitioners.

The scope of practice for optometry, similar to that for other health care providers, is difficult to define precisely. However, information is available from a number of sources to develop valid concepts of a profession's role and function. Such sources include State laws, judgments of courts concerning the responsibilities of practitioners, the usual and customary practices of the profession, and the objectives, content, and standards of education and training for the profession.

An examination of a variety of such sources suggests that optometry is a profession qualified to provide a broad range of services which are effective in patient management, including the management of aphakic and cataract patients. (See discussion in Part II of this report for detail on sources cited and information examined.) It is reasonable to infer that such services correspond to many specific

ATTACHMENT B

BASIC ELEMENTS OF THE CURRICULUM OF SCHOOLS OF OPTOMETRY

1. Biological science knowledge base.

   a. Gross human anatomy and microscopic anatomy, with emphasis on head, neck, and thorax.

   b. Embryology, gross and microscopic anatomy of the human nervous system - concentrating on the central nervous system.

   c. General human physiology, including the study of the fundamental organ systems and the mechanisms which regulate body function. Emphasis is on the sensory, motor and cardiovascular systems.

   d. Basic concepts of general and cellular biochemistry, with study of nomenclature, structure, and reactions of organic molecules. Emphasis is on the visual system - tears, intraocular fluids, lens, retinal photochemistry, and actions of drugs upon these.

   e. Concepts of human genetics and genetic disorders, including the frequency and distribution of genetic disease, inheritance patterns, polygenic inheritance, chromosomal abberration syndromes, multifactorial genetics, and principles of genetic counseling.

   f. Gross and microscopic anatomy of the lids, orbit, orbital content, globe, muscles, nerves, and vessels, and embryology of the eye.

   g. Vegetative physiology of the eye, extraocular and intraocular fluids, corneal and lens metabolism, ocular circulation, retina and optic nerve metabolism.

   h. General pharmacological principles, methods of administration, various systemic drugs and their pharmacological action and side effects with emphasis on those that affect the visual system, such as cataractogenic and glaucoma-producing drugs.

   i. Pharmacology; uses, doses, contraindications, and adverse effect of drugs producing miosis, mydriasis, cycloplegia, accommodation, and ocular anesthesia. The pharmacology, use contraindications, and adverse effect of drugs commonly used in treating visual and ocular problems.

As is evident from the discussion above, the Department endorses the first recommendation. For reasons cited, however, Department endorsement of the second recommendation is viewed as inappropriate and premature at this time.

During the course of the study effort, a number of additional issues and concerns were identified by the expert consultants which, although important considerations, represent matters not directly responsive to the specific legislative charge as interpreted by the Department. These recommendations and comments, made unanimously by the consultants, are presented here to provide an opportunity to bring these matters to the attention of Department Agencies and the Congress. Because the following items go beyond the requirement of this report, the Department has not fully examined them and makes no recommendation at this time.

1. Refractive services for aphakic patients

Aphakic patients, specifically, should be considered as having special needs given their disabled condition. Refractive services for such patients represent non-routine and necessary services in the provision of prosthetic devices, i.e., lenses.

Study advisors recommend that consideration be given to extending coverage under Part B of Medicare to include refractive services for aphakic patients when provided by either ophthalmologists or optometrists.

2. Low vision services and aids

For those patients who have inoperable cataracts or have less than optimal results from cataract surgery, that is, those who have reduced visual acuity, low vision services and aids represent essential components of reasonable and necessary health care services for these patients.

Study advisors recommend that coverage under Part B of Medicare be extended to include the provision of appropriate low vision services and optical aids for the above-referenced patients, when provided by either ophthalmologists or optometrists.

3. Prevention, health maintenance, and health education

In the interests of health care cost advantages, effects on productivity, and the overall improvement of benefits that can be afforded our population, the expert consultants recommend that a more effective effort be made to improve preventive, health maintenance, and health education measures. While this is needed in all areas of health services, the vision/eye care field offers a particularly promising area for such approaches.

4. Other service provided by optometrists

Vision/eye care services currently covered by Part B of Medicare, when provided by ophthalmologists or other physicians, include eye conditions other than cataract and aphakia. Optometrists can provide appropriate services for some of these conditions. It is recommended that extension of reimbursement to include the services of optometrists for such appropriate conditions is a desirable subject for further consideration.

5. Administrative considerations

Also during the course of the study effort, expert advisors raised several concerns pertinent to the administration of the Medicare program. These issues, also applicable to other Medicare services, include the following: (a) inconsistent application of coverage and reimbursement policies by individual carriers, (b) the problem of payment duplication for services and reimbursement for similar diagnostic procedures when performed for specific individuals by more than one provider, and (c) need of improvement in coding and billing procedures for vision/eye care services.

6. Cooperative working relationships between vision/eye care professionals

It became clear during the course of this study that more effective working relationships between optometry and ophthalmology and other providers in the vision/eye care field would enhance patient care and result in improved services to individual patients. While improved interdisciplinary coordination applies to all the health disciplines and specialties, it is a problem of particular concern in the vision/eye care field. Such working relationships could be significantly strengthened by

a. Development of joint educational programs at the undergraduate and graduate levels, including rounds, clinics, conference, and meetings and publications.

b. Establishment of interdisciplinary clinics with optometrists and ophthalmologists working together.

c. Facilitation of referral of patients between the optometrist and the ophthalmologist when in the best interest of the patient.

d. Joint development of quality standards for service and materials by peer review mechanisms. By materials, particular reference should be assigned to varying quality of lenses and frames and the need for furnishing laboratory invoices of material costs for reimbursement.

e. Joint development of appropriate revision to State licensure laws to permit use of diagnostic drugs (mydriatics and local anesthetics) by optometrists.

While such joint endeavors are evident in various areas of the country, they need to be broadened and routinized.

Eye-To-Eye 3/2/79

Currently before the House Health, Education and Social Services Committee is a bill (HB 79) which would allow optometrists to use certain drugs in eye drops for the purpose of making diagnoses. Optometrists could use these drugs only after completing an approved pharmacology course and passing an examination administered by the State Board of Optometry. The drugs involved would either open or paralyze the pupil of the eye or deaden pain.

Though the bill is relatively straightforward on the surface, it has acted to draw battle lines in the field of medicine in general and eye care in particular.

On one side of the line are optometrists, who historically view their profession as measuring the eye and fitting it with corrective lenses when needed. Optometrists in Alaska are required to have completed a six-year program through which they receive a doctor of optometry degree. They still may not prescribe drugs for the treatment of patients or perform surgery.

Optometrists argue that the use of the drugs would allow them to detect better problems with the eye. And as a result they argue, they could offer a higher level of service to their patients.

On the other side of the line are opthalmologists, who argue that as medical doctors who specialize in the treatment of diseases of the eye, they should retain the sole right to administer drugs, diagnostic or otherwise, to patients. Other branches of the medical profession generally agree. Ophthalmologists also point to the potential danger of adverse reactions of patients to the drugs.

To understand the basis for the argument it is essential to clear up the blurred distinction between the two professions. As we stated previously, the optometrist is not a medical doctor as such. An optometrist concentrates on detecting defects and faults in the eye and prescribing correctional lenses or exercises but not drugs or surgery. Historically, optometrists refer their patients to ophthalmologists should the problem be beyond the scope of their practice.

Ophthalmologists, on the other hand, are medical doctors, who after completing medical school continue to specialize in their field. To complete the entire program of medical school and the study of ophthalmology requires 12 years.

The crux of the problem, however, revolves around the drugs the optometrists are asking to use. There are four types: mydriatics, which open the pupil; cycloplegics, which open the pupil and paralyze the focusing mechanism; miotics, which constrict the pupil; and anesthetics, which take away the feeling.

In rare instances, though, complications can arise from the administration of these drugs. Some of them can even be dangerous. Nervous disorders, convulsions and death are known to have resulted from the administration of these drugs in rare cases, according to the Boston Globe.

But one person seems to be lost in the argument between optometrists and ophthalmologists—the patient. Will the optometrists' ability to use diagnostic drugs override the potential hazard of an adverse reaction to the drug? There is no black-and-white answer, but one conclusion can be drawn safely. The best-trained ophthalmologists in the state have agreed that the potential danger to the patient exists and that the bill under consideration contains inadequate safeguards to the public.

The question that has to be asked is if a patient of an optometrist does have an adverse reaction to one of these drugs, what would he do? Most sources agree that he would probably have to call a doctor—an ophthalmologist, to correct or treat the problem.

When it comes to the public's health, the Legislature, when approached with bills such as this, should take the prudent course and turn them away, unless there is overwhelming evidence that the public would benefit.

Without a doubt, the prudent course is to turn away HB 79.

HB 79

JAMES H. PATTERSON, M.D.
Diseases and Surgery of the Eye
Subspeciality Pediatric Ophthalmology
3500 LATOUCHE
ANCHORAGE, ALASKA 99504

Telephone 907: 274-2252

February 26, 1979

Senator Thelma Buchholdt
Chairwomen, Senate Judiciary
Committee
Pouch V
Mail Stop Number 3100
Juneau, Alaska 98111

Dear Senator Buchholdt:

As a physician and surgeon I am most concerned about SB 75 and HB 79 which propose to give nonmedical eyecare practicioners (optometrists) the privilege of applying potent medications to the eye for diagnostic purposes.

The proposed bill lists only broad general categories of the desired eye medications, not specific drug names and concentrations. The classes of drugs include such potent substances as Cocaine, Atropine, Scopolamine, Phenylephrine and Phospholine Iodide. All these drugs when applied to the eye are readily absorbed into the bloodstream and are capable of producing a wide range of total body effects.

Cocaine, a topical anesthetic and mydriatic (dilater of the pupil) is a controlled substance which is subject to wide spread abuse by addicts and requires a controlled substance registration certificate to dispense. Atropine and Scopolamine are cycloplegic agents which paralyze the eye's focusing power and in sufficient doses produce irritability, hallucinations and even coma. Phenylephrin (a mydriatric) has the ability to raise the blood pressure markedly and to alter the rhythm of the heart and has been implicated in deaths in older people through strokes and in children through cardiac arrhythmias. Phospholine Iodide, a miotic which constricts the pupil, is used in the treatment of glaucoma (elevated pressure in the eye) and in certain cases of crossed eyes, the active ingredients are related to the active substance in certain insecticides and nerve gas. This medication has been shown to produce retinal detachments and cataracts. Miotics are a therapeutic class of drugs and are listed incorrectly in the proposed bills as diagnostic drugs.

The above are only a few examples demonstrating what potential dangers exist is the various classes of the drugs listed in the proposed bills. By allowing wide spread use of these drugs by nonmedical persons the overall risk to the general public of potentially serious effects or untoward reactions are markedly increased.

This type of legislation is not unique to Alaska. The initial nationwide optometric movement, in attempting to enter the practice of medicine, was successful and approximately 20 states have some type of optometric drug legislation. In the past 2-3 years as the full implications of such legislation became known optometric drug bills have been going down to defeat by about a 3 to 1 margin.

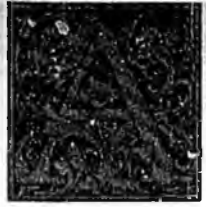
I would appreciate your support in helping prevent these bills from becoming law. I not only can but will readily answer any questions or document any items that I have commented on in this letter.

Sincerely yours,

James H. Patterson M.D.

JHP:plz

HB 11



ALASKA STATE MEDICAL ASSOCIATION

1135 W. Eighth Avenue • Suite 6 • Anchorage, Alaska 99501 • (907) 277-6891

February 26, 1979

Respresentative Thelma Buchholdt, Chairman
House of Representatives
Health, Education, and Social Services Committee
Pouch V, Mail Stop #3100
Juneau, Alaska 99811

Dear Ms. Bushholdt:

The Alaska State Medical Association Legislative Committee has reviewed House Bill 79, an act relating to the practice of optometry.

Enclosed is a copy of correspondence relating to the issue during the 1978 Legislative Session. The position of the Association remains essentially the same, namely:

(1) We are unable to determine how this legislation will improve eye care or specifically benefit the public.

(2) Specifically, we know of no diagnostic use for the drug class, miotics, requested; in converse, their use would be appropriate for treatment of narrow angle glacoma, precipitated by a mydriatic/ cycloplegic use. This condition, we understand, is more prevalent amongst the Alaska natives than the general population, such that bush use of these drugs could carry increased risk.

(3) We approve the educational requirements added in the 1979 legislation. It follows that should the Legislature believe the proposed legislation is in the broad public rather than for special interest, no grandfather type clause should be allowed.

Sincerely,

W Fish

Winthrop Fish, M.D.
Chairman, Legislative Committee
Alaska State Medical Association

WF:mlm

Enclosure

February 14, 1978

Representative Charlie Parr
Chairman, House HESS Committee
Alaska State Legislature
Juneau, Alaska 99801

Dear Representative Parr:

The Alaska State Medical Association Council has reviewed HB 664, An Act Relating To The Practice Of Optometry. We see no purpose identified or expressed within the substance of the Bill. We further see no areas where the public interest will be served by its passage and several areas where compromised eye care, duplication and cost increases are possible if not likely.

At the outset, please understand that the ASMA properly has no interest or intent to interfere with the practice of optometry in Alaska. However, if an enlargement of the scope of optometry into the sphere of medical practice is comtemplated, it reasonably becomes our concern for the welfare of the public, not a simple jurisdictional dispute.

Optometry by derivation, definition, tradition, training and current practice means measurement of the eye for refractive error and a prescription of corrective lenses. Current practices also allows dispensing and sale of lenses and spectacles by the prescribing optometrist.

The current statute defining optometry is unfortunate in that it suggests diagnosis of visual impairment, apart from refractive error, lies within the responsibility of optometry.

Non-refractive visual impairment may be a most difficult and subtle medical diagnostic problem, at times challenging the combined expertise of ophthalmologist, neurologist, radiologist, and internists, and requiring sophisticated diagnostic equipment. Causes range from simple cataracts to subtle brain tumor, from transient vascular insufficiency to obscure metabolic disorders. The visual problem may be the first and only lead to a serious medical disease. Almost all non-refractive visual impairments will come to confirmatory diagnosis and treatment by a physician. It goes without saying that missed or delayed diagnosis can have serious potential consequences.

Before extending the scope of optometry, well beyond refraction and the sale of contact lenses and spectacles, into the intricate area of complex ophthalmological diagnosis, we ask that you assure yourself of the following:

(1) That there is a clearly demonstrated and defined unmet public health problem, that this legislation will solve it, and it is the most appropriate solution.

(2) That the general level of training of the practicing optometrist in Alaska at present is at a standard which will preclude frequent mis-diagnosis, delay, duplication of expense and inappropriate trials of corrective lenses for non-refractive disorders of the eye.

(3) That the use of ophthalmologic drugs in the practice of optometry is free of risk.

(4) That the ex nded drug use is necessary and essential to increased accuracy in refractive error diagnosis.

We feel the answers to the above are not obvious, we see no urgency to enact the legislation without the most careful study of the implications and therefore urge that you allow ample time for its consideration.

Sincerely,

WFish

Winthrop Fish, M.D.
Chairman, Legislative Committee

WF:mlm
cc. ASMA Council
ASMA Legislative Committee

PUBLIC DANGER DOCUMENTED

SPECIAL SUPPLEMENT

ANNUAL REVIEW OF SELECTED CASE HISTORIES

As published in THE PEN...— during 1977-78

TUMOR OVERLOOKED

Mrs. Lois McWalters

•

Massachusetts Widow

Vol. 1, No. 1, July 15, 1977

The first issue of THE PEN featured a tragic testimonial headlined "Massachusetts Widow: 'It Seems Bizarre.'" Excerpts follow:

Five years ago my husband began complaining about his eyesight. He decided to see an optometrist and he continued to do so for 2½ months. As his vision deteriorated at this time, he experienced headaches so violent they would awaken him from a sound sleep. I pleaded with him to see an ophthalmologist or some person with a medical background. He became increasingly irritated at my suggestions and I was forced to bow to his decision or submit to an unhappy home life.

As each day passed, before my eyes his personality changed; this sweet gentle man became verbally abusive and the general tenor of our home was unbearable. At that time our four children were 6, 7, 8, and 9 years old. They watched their father hold a cup of coffee, his hand tremors so pronounced he would spill it and leave the table in a terrible rage.

I pleaded again, to no avail. How does a wife forcibly take a grown man to a doctor? He *trusted* the optometrist. The optometrist changed his glasses three times - each prescription being for stronger lenses - during those 2½ months. Each time his eyesig[illegible]d the pain was not even slightly improved by the [illegible]ge of glasses. He was told it would take time to get used to them. The optometrist never suggested he see a medical person.

His suffering increased to such a point he could not work or concentrate. I suggested a vacation and he agreed. . . . He now had a black patch over one eye "to rest it" prescribed by the optometrist.

I was frightened; I felt he was dying and I was helpless. After a few days of rest I gently broached the subject again and very unlike me, burst into tears. . . .

Our vacation was cut short because he was so ill. He insisted upon going to work when we got home, but surprised me by phoning from the hospital. He had seen an ophthalmologist who immediately spotted the problem and within minutes called in a neurosurgeon. The neurosurgeon admitted him to the hospital at once. I discovered later that when the ophthalmologist's *secretary* heard the symptoms over the telephone, she had insisted Dick come to the office immediately.

The neurosurgeon told me frankly he felt that Dick had a brain tumor. At our community hospital, tests were done in the next few days; the consensus was a brain tumor.

Surgery was at nine. . . .

Bad news it was, a malignant brain tumor called an astrocytoma. "I would give him about eighteen months," the doctor said, "but be prepared for some horrible times ahead." Twelve days later God mercifully took his beautiful soul and left his tired, worn body. . . .

In retrospect, it seems bizarre to me that when one (in this case the optometrist) realizes a situation is out of his control, that he wouldn't immediately make a referral, especially when seeing a patient suffer so much. •

SPECIAL ANNUAL PERSONAL EXPERIENCE REVIEW ISSUE

During its first year, THE PEN has published numerous carefully documented cases of eye damage resulting from attempts by non-medical practitioners to practice medicine. These four pages are a collection of selected excerpts of those cases which have prompted expressions of maximum interest from readers.

While there has been no official response or challenge from organized optometry, individual optometric lobbyists have advised legislators that these cases are "isolated instances." The steady flow of similar testimony pouring into PEN headquarters prompts us to suggest that the cases are not "isolated," but rather "the tip of an iceberg."

The Editors

OPTOM-PSYCHIATRY

Barbara Cosgrove

•

"Lack of Love"

Vol. 2, No. 3, Feb. 1, 1978

A Connecticut woman, interviewed by Jeffrey Gold, M.D. of New Haven, told how an optometrist claimed her child's blurred vision could be cured with "more love and understanding at home" in a story headlined "O.D. Calls Diabetes A 'Lack of Love'." Passages of that interview follow:

Dr. Gold: "Mrs. Cosgrove, why did you bring Barbara to me?"

Mrs. Cosgrove: "We were referred here by our family doctor who just found diabetes in Barbara. She is 11 years old. I told him I had just had her eyes checked by an optometrist."

Dr. Gold: "Do you mean Barbara was examined by an optometrist lately?"

Mrs. Cosgrove: "Yes, she failed the school vision test in November and they said to have an examination. He (the optometrist) has a great big sign out in front, that says 'Doctor,' and I thought he was one."

Dr. Gold: "What did he find?"

Mrs. Cosgrove: "He said there was nothing wrong with her eyes and when I asked him why she kept getting blurred vision, he told me that she was a nervous child and when she gets up-tight, her eyes get blurry. My reaction was to take her to a social worker, but he (the optometrist) told me she just needs more love and understanding at home and that there was no reason to do any more than see him again next year."

Dr. Gold: "Then what happened?"

Mrs. Cosgrove: "I thought I was some kind of a rotten mother with such a nervous child, and I cried that night."

Dr. Gold: "Did you pursue the blurred vision at that time?"

Mrs. Cosgrove: "During December, Barbara seemed to have the flu, but it didn't go away and by Christmas Eve, I real-

Continued on page 6

DANGER AND WASTE IN THE VA

Robert B. Nolan

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Disabled Veteran

Vol. 2, No. 8, April 15, 1978
Vol. 2, No. 11, June 1, 1978

In these issues, a totally and permanently disabled veteran told how he got less than the deserved in-depth investigation into the problem of allowing VA optometrists medical functions. Mr. Nolan again found more evidence of danger and waste in the VA. Excerpts from the first story follows:

". . . The VA would not permit me to receive outpatient treatment from a private physician unless I lived 30 to 50 miles from a VA treatment center. I didn't, so I decided to pay for my own doctor and then go to the VA and see their M.D. for medication only.

"My wife called the VA in the federal building in downtown St. Petersburg for an appointment early in August of 1977. She told the girl on the phone that I needed an eye doctor because I had glaucoma.

"My first visit to the VA eye 'doctor' was Augus[illegible] 22, 1977. I presumed that the doctor I saw was a[illegible] M.D. ophthalmologist. His name was on the doo[illegible] and it said 'doctor.' . . .

"T[illegible]e 'doctor' finally tested my tension with [illegible] and said the pressure was [illegible] in each eye. I showed him the prescription I had received from Kenneth Safko, M.D., my own ophthalmologist, and he said, 'Wait until I xerox this as it is no good here. I will have to write my own prescription.'

"After copying Dr. Safko's prescription and putting it in my file, he wrote his own prescription and took it next door to get it co-signed. . . .

"On my way to the pharmacy with my wife, she looked at the prescription and said it didn't look right. We took it back and the 'doctor' changed it from pilocarpine to 3/4% carbachol with six refills. Another doctor (probably an M.D.) co-signed the new prescription. . . .

"On our next trip to the VA center, my wife asked the woman at the front desk if the doctor we saw was an M.D. and an ophthalmologist. The woman at the desk replied, 'Yes, he is a full-fledged doctor and an ophthalmologist fully qualified to treat eyes.' . . .

"When I finally got the glasses, sometime in late November or early December of 1977, I discovered I could see much better without them.

"On my next trip to the VA on December 19, 1977, I returned the glasses. The 'doctor' told me the reason the glasses had been so long coming was because he rejected them two or three times, since they were not to his prescription. When he took the glasses to the next office to check them, my wife and I looked at his diploma on the wall. It said 'Doctor of Optometry.' When I told him we thought he was an ophthalmologist, he became very angry and said, 'Do you question my qualifications?' I told him I certainly did question his qualifications to treat glaucoma or any other eye disease. He told me that the people at the front desk didn't know the difference between an ophthalmologist and an optometrist. I said, 'If this is true, what if my eyes need surgery?' He said if that were the case I would have to go to the Tampa VA Hospital or the Bay Pines VA Hospital and some other doctor would operate. . . .

"Talking to people in the waiting room, we

Continued on page 6

Tragic Case Histories Dramatize The Need To

NETWORK TV WARNING

Totie Fields

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Comedienne

V 1, No. 8, Nov. 1, 1977

The following is a portion of an interview between TV-talk show host Merv Griffin and comedienne Totie Fields, during which she warned all diabetics to seek eye care only from ophthalmologists:

MERV: It was kept very quiet; but all of a sudden, about two months ago we all heard rumors that, now you were losing your eyesight from the diabetes.

TOTIE: It's true, it's true! — and you know why I want to talk about it?

MERV: Blue Cross must hate you!

TOTIE: They have lost so much money on me.

MERV: Have they?

TOTIE: Yeah, but you want to know? I didn't know it, Merv, I swear to you I saw 20/20! . . . this is what I want to make a point of, I went to an optometrist all the time and he said, "Totie you're doing wonderfully, everything is fine," . . . I've been a diabetic since I was nineteen years old, and you know how I watch myself; I weighed 200 pounds; all I ever thought about was eating. I swear to God they told me I couldn't eat and that was the end of it!!! I mean, I just ate myself into oblivion!! I used to do a show and in the middle I used to think where could I get a pizza around here; you know I thought of nothing but food, Mallomars, if I could only eat a Mallomar! Oreos, you know I was an Oreo freak . . . Oh, I talk about them and my mouth gets filled with saliva!!! I saw a little thing floating in my eye like a little hair, you know, that you couldn't get rid of and so I went to an ophthalmologist. Diabetics should never go to an optometrist, they must go to ophthalmologists because they see behind the eye. He said, "Totie, you've got to go . . . the best man in the country is in San Francisco and you must get to him right away." The next morning I was there and this man was telling me I was going blind, and I said, "You're crazy! Why didn't anybody else . . ." Well, they were so busy worrying about everything else, no one thought of my eyes, and I've never (incidentally, no one's ever heard this story before) — Well, to make a long story longer . . . yeah! I want, because I really want diabetics to be so aware because this operation is only two years old, Merv, and ironically enough, my dad died blind, my brother died blind, and I would have. . . .

One day you get to that age where all the print is gone and the paper comes and you say why did they send me a white paper (laughter) — you know, and you'd go to the toilet and drop it on the floor and read it there (laughter) . . . you know what I mean. But, I can read proof! I mean, to open a menu and be able to see it without looking for my glasses is the most exciting thing, but I want you to know, everybody out there that is a diabetic, please, please go to an ophthalmologist . . . because you can be saved! You know the ironic part of this entire story, I did "Fight for Sight" — the benefit "Fight for Sight" for about five, six years in a row and that's the money that helped this whole thing! (applause) To get this discovery! Isn't that incredible? (applause) And you won't believe how I can see every wrinkle in your face, Merv, every wrinkle in your face, I never could see them before . . . ●

GLAUCOMA UNDETECTED

Mrs. Agnes Karrman

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Connecticut Housewife

Vol. 1, No. 5, Sept. 15, 1977

Appearing in this issue of THE PEN under the headline "Conn. O.D. Tells Housewife: 'You Don't Have Glaucoma'," a Conn. woman told of an optometrist who failed to recognize her glaucoma. Excerpts follow:

"I was a nervous wreck before I visited the ophthalmologist that day in October, 1975, and then the bottom had just dropped out of everything. My fears had been justified because the ophthalmologist had just told me that I was suffering from far-advanced glaucoma. For some time I had experienced increasing difficulty with my vision. I couldn't read the paper without a magnifying glass. My eyes were constantly watering and sometimes I awakened at night with a headache. I could no longer see well enough to play the piano or organ.

"...Yet, despite these complaints, my optometrist had assured me for over a year there was nothing seriously wrong with my eyes.

"I had been going to an optometrist regularly for about seventeen years — ever since he had opened his office. He was always pleasant and the glasses he fitted for me were generally satisfactory. In 1974 I went to him complaining of blurred vision. He gave me new glasses but they didn't help. I went back to him and he told me that they were the right glasses and that I just hadn't allowed enough time to get used to them. I told him that I was worried about glaucoma because my brother had had surgery for glaucoma and is almost blind, and my sister was being treated for glaucoma by an ophthalmologist. She is doing well because her problem was discovered early. The optometrist assured me that he had checked for glaucoma and that I didn't have it.

"Several months later, because of increasing trouble with my vision, I returned to the optometrist . . . He again changed my glasses. At that visit I again voiced my fear of glaucoma and once again he assured me that my eye pressure was normal and that I didn't have glaucoma. He said my eyes were just tired. Well, the new glasses didn't help at all. They seemed to be no different than the previous pair he sold me . . .

". . . After another month and a half had passed I returned to the optometrist because my eyes pained at times and I often awoke at night with headaches. My vision was getting worse and my eyes watered constantly. This time I really pressed about my fear of glaucoma. He re-examined me and again sold me a pair of glasses — the third pair in less than a year! He told me that his $3,000 special instrument measured accurately for glaucoma and that a referral to an ophthalmologist was not necessary. In fact, he told me that I had nothing to worry about, that my eyes were perfectly clear. He said, *'You don't have glaucoma and you don't have cataracts.'* He gave me some eye drops to use three or four times a day. I used them regularly for the next four months until my sister finally persuaded me to see her ophthalmologist. In the meantime, my vision had continued to get worse and I could no longer enjoy any activities that required good eyesight.

"As I said earlier, my first visit to the ophthalmologist was a shocker. It was such a different examination! Not only did the ophthalmologist find that my pressure was higher than normal, he also found that my optic nerves had been severely damaged by this long-standing pressure and that my side vision had been destroyed. I could only see as though I were looking down a gun barrel . . . He discovered that I did have cataracts, but they were only a small part of my eye health care difficulties.

"The ophthalmologist's diagnoses and explanation of the extent of my problems not only added to my nervousness but made me very angry. I was angry with myself for not having listened to my sister's advice months ago to see an ophthalmologist and not an optometrist, and I was plenty angry with the optometrist! The doctor told me that an optometrist is not trained in medicine nor to diagnose or treat eye diseases. How can an optometrist act like an 'eye specialist' and flatly assure people that he is capable of this type of decision making? How can he keep peddling new glasses and sell eyewash types of eyedrops with implied assurance that they can cure? How can he stand by and literally watch one of his long-time customers go blind?" ●

EXTENSIVE EYE DAMAGE

Denton Livensparger

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Double Jeopardy

Vol. 2, No. 7, April 1, 1978

In a story headlined "Misuse of Drugs Plus Misdiagnosis Puts Floridian In Double Jeopardy," a Florida ophthalmologist told of how an optometrist missed signs of glaucoma and serious corneal abrasions requiring surgery in both eyes of a male patient. Excerpts follow:

"Misdiagnosis combined with the misuse of powerful drugs by untrained practitioners poses a frightening threat to public health and places our citizens in double jeopardy," says John D. Mallonee, M.D., a practicing ophthalmologist in Ft. Pierce, Florida. "The advanced years of many of our patients makes this menace even more serious and the public must be made aware of this grave danger," Dr. Mallonee said.

In support of his forthright statement, Dr. Mallonee detailed the following case history.

"On February 4, 1978, I first saw Dentor Livensparger. This 65-year-old man came to my office of his own volition, and without referral. He told me he lived at 1196 Proctor Lane in Port St. Lucie, Florida, a nearby retirement community, and had been suffering severe pain in both eyes for some time. Mr. Livensparger voluntarily gave the following account of his experience to date."

"In early November 1977, I think it was the 8th," the patient said, "I went to see an optometrist about the pain I had in both eyes . . . I told them that for a long time, maybe nine or ten months, I felt as though I had something in both of my eyes, and that the pain was just getting worse all the time. After they examined me, they told me all I had was an eyelid infection and they gave me some antibiotic drops called Neodecadron. I went back again the next day and they told me I didn't have glaucoma, and all that was the matter with me was a minor eyelid infection that would clear up if I used the drops."

Continued on page 6

Protect The Public From Sub-Standard Eye Care

GLAUCOMA UNNOTICED

Mrs. Florence Hubbard

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Blinded High School Student

Vol. 1, No. 2, Aug. 1, 1977

The following excerpts are from a byline story by a Massachusetts student headlined "'They Call Themselves Doctors' - . . . Blinded High School Student," in which she told how an optometrist could not recognize advanced glaucoma.

"In August 1967 I was walking home from a friend's house when I knocked over a trash can because I didn't see it. A couple of days later I noticed that things looked blurry. I couldn't read signs or make out faces and when I looked at lights, there was a rainbow around them.

"I went to an optometrist in September and told him about all of this and that I had a throbbing pain in my eyes. My left eye was worse than my right eye. The optometrist asked me to read his eye chart but I couldn't see where it was. He examined my eyes and told me not to worry, he could help me. He said I had a lazy left eye and astigmatism, and he had just the cure for me — he was going to prescribe some glasses.

"Before the glasses were ready, the pain got much worse and my eyesight got more and more blurry. However, I trusted the doctor. I figured you go to a doctor and he knows how to treat you. I had always thought optometrists were doctors. They call themselves doctor.

"When I went in to get my glasses in October, I told him that my vision was much worse and he got out the glasses and said, 'There should take care of you.'

"I went home with the glasses but they weren't helping. I was banging into desks at school, I kept banging into people, I couldn't see the blackboard. I must have called the optometrist about 10 times and he kept telling me I would be all right, that I was getting too worked up and making myself not see.

"When my mother and I went to see him the next day, my mother said he looked a little worried. He told us that I lacked something in my body, that I had a deficiency, and he would make an appointment for me with an ophthalmologist but not until after Christmas. He said I should go home and have a nice Christmas.

"When my mother and I went to the ophthalmologist on December 27, it was the first time I heard the word 'glaucoma.' He said I had all the classic signs.

"The ophthalmologist found that I had a pressure of 95 in both eyes — normal is 20, and total blindness is 100, he said.

"In April the pressure in my eyes went up again and this time the ophthalmologist thought it would be necessary to operate. By now my parents were so upset they had decided that they should be extra careful and get another opinion and I should go to Massachusetts Eye and Ear Infirmary. I did and it was decided I should have surgery on both eyes, to save what little sight I had left. I've lost 99 percent in my left eye and I have only the very center of the vision in my right eye — I can only see things that are straight ahead.

"After I got out of the hospital and began to feel better, my little eight-year-old cousin began to take me all around Gloucester by the hand so I could learn my way around. I still don't like going to new places and there are some things I can't do for myself. Once I set myself on fire trying to reach something over the gas stove and I didn't even know it. I was lucky my husband was home and saw it." ●

Similar heartbreaking circumstances have accompanied many of the cases in PEN's growing file. Here's a random sampling.

● From the Wills Eye Hospital, a division of the Thomas Jefferson Medical School in Pennsylvania, - when a female patient complained of pain in the eye, an optometrist gave her an anesthetic drop to use. Later, he refused to see her. She developed a pseudomonas ulcer (infection) and the eye had to be removed.

● Also from Wills, a female patient told an optometrist that for seven years she had episodes of blurred vision brought on by reading. They usually lasted about an hour and when severe were associated with headaches. She was followed by an internationally famous optometrist throughout the seven years and was reassured nothing was wrong. Later, an M.D. found textbook symptomatology of chronic angle-closure glaucoma and advised immediate surgery on both eyes.

GOING BLIND

Mrs. Anita Oliver

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Baltimore Cook

Vol. 1, No. 10, Dec. 1, 1977

The following passages are from an interview between a blinded Baltimore [illegible] and ophthalmology resident Larry Thompson, M.D. In a story headlined "Mrs. Oliver: 'I Told Him These Are My Eyes'," she told how a vision-center optometrist became annoyed when she told him the glasses he prescribed did not work:

Mrs. Oliver: "I came to University Hospital because I was getting this blindness, and I couldn't see. I was at church on the fourth Sunday in July, and I fell down those steps."

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Dr. T: "You were seen for your eyes before coming here — when, back in February of 1977?"

Mrs. O: "Yes, it was February."

Dr. T: "And you were seen at - - - - Vision Center?" (an enterprise which employs optometrists, but has no medical personnel.)

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Mrs. O: "Yes, I was there for glasses. They examined me but they didn't tell me anything. I asked the doctor why I couldn't see. The doctor got angry with me when I said I could not see out of my left eye like I should. I was trying to read the board, the letters and the numbers. And when he put the glass to my eye, I couldn't see and I told him that I couldn't see. He got very, very angry. He told me that he was doing the examination, not me. *I told him that these were my eyes and I should know whether I could see or whether I couldn't.*"

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Dr. T: "OK, he prescribed new glasses for you at that time. After you got those glasses, you could not see with those glasses, is that correct?"

Mrs. O: "Yes. I went back to them again and had that left lens changed. It was supposed to have been changed."

Dr. T: "Did they ever measure the pressure in your eye, touch your eye with anything to measure the pressure?"

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Dr. T: "Did they ever measure the pressure in your eye, touch your eye with anything to measure the pressure?"

Continued on page

LED TO BLINDNESS

Charles B. Wilson

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Arizona Steelworker

Vol. 1, No. 10, Dec. 1, 1977

The following are excerpts from the story of an Arizona man headlined "Arizona Steelworker 'Led To Blindness'," in which he told how an optometrist informed him he would eventually go blind, but gave no reason, and his misadventures with more optometrists:

"When I first thought I needed glasses 25 years ago, there was only one place to go in my home town in Ohio — and that was to an optometrist. He had the whole works — he gave examinations and sold glasses.

"He checked me one time, gave me glasses and then he said, 'In about 20 years, you're going to think you're going blind.'

"I asked him why, but he wouldn't give me a definite answer. He just said, 'Well, your eyes are going to change that much and you're going to think you're going blind.' To this day, I still don't know what he was talking about.

"I just figured it was my nearsightedness or the opposite, whatever that was. I wasn't bothered with anything until I came out here 17 years ago.

"I worked in a steel mill and once my glasses got all burned up in there, so I went to an optometrist in Mesa.

"He just checked my eyes like everyone else does. I got a new pair of glasses there.

"In the meantime, the Union got into the plan - - - -

OPTOM-PSYCHIATRY

Continued from page 3

ized that she had lost her appetite and was losing weight; also she was always thirsty and urinating excessively, so I took her to our family doctor."

Dr. Gold: "What did he find?"

Mrs. Cosgrove: "He found diabetes. Her sugar was 790!" *(Normal is around 100)*

Dr. Gold: "Did the optometrist ever mention to you the possibility that variably blurred vision could be a sign of diabetes?"

Mrs. Cosgrove: "No, never. I don't think he should be allowed to be out there, on the street, calling himself a doctor! He doesn't know anything about disease. Why is he there? What's wrong?"

Dr. Gold: "Mrs. Cosgrove, do you give us your permission to publicize the danger to people inherent in Barbara's story?"

Mrs. Cosgrove: "Yes, I do."

Dr. Gold: "Thank you very much." ●

NEW YORK SPECIAL REPORT

The following case histories of optometric failure to recognize and refer medical eye patients were collected by Karl J. Marchenese, M.D. of Rochester. All patients except one were personally interviewed by Dr. Marchenese. Except where indicated, the source of information was the patient. All cases came to the attention of Dr. Marchenese within the past 12 months through his practice as an ophthalmology resident. The patients reported in this paper as incidents of failure to recognize or refer medical eye problems, outnumber appropriate referrals to the clinic by four to one.

● A young college student called a local HMO (prepaid health insurance in which the patients have little choice of physician) with complaints of an irritated red eye. He was seen the same day by an "eye doctor" whom he believed was a physician but was in fact an optometrist. The optometrist diagnosed "iritis" and gave the patient a prescription for two therapeutic eye medications (homatropine and a steroid preparation) which was filled in the HMO pharmacy. The patient reports that the prescription had another physician's signature preprinted on it. The patient was examined only by the optometrist. He was subsequently examined by the optometrist four additional times over a six-month period. The optometric records were obtained and revealed that several therapeutic agents had been prescribed and no mention was made of consultation with or referral to a physician. Ocular examinations and evaluations for systemic disease were inadequate. The optometrist was unsure of the diagnosis, at times referring to "recurrent coniunctivitis" and "eposcleritis" as well as iritis. Finally on the last visit the patient was referred to an ophthalmologist.

Comment: The optometrist clearly exceeded the limits of his licensure by attempting to make a medical diagnosis and prescribing therapy. It is illegal for an optometrist to fill in (and for an organization to provide) presigned prescription forms. It is inappropriate for an HMO to use an optometrist to care for patients with acute eye problems.

● A 73-year-old woman with diabetes was followed for 15 years by an optometrist who knew about her disease but referred her for a medical eye evaluation only when cataracts caused a significant deterioration in her vision. The patient had evidence of diabetic retinopathy (blood vessel disease of the back of the eye) which was more difficult to evaluate because of the presence of cataracts.

Comment: All patients with diabetes are at a significant risk of major ocular complications (including total blindness) and should have a medical eye examination at regular intervals. The examination requires special expertise which only the ophthalmologist can provide. Treatment is available for retinopathy at some stages.

GOING BLIND

Continued from page 5

Mrs. O: "No."

Dr. T: "Did they ever suggest that you see a medical doctor?"

Mrs. O: "No, never."

Dr. T: "Do you feel that poor people — people that haven't had a lot of education — are at a particular disadvantage since they probably do not understand the difference between an optometrist and a medical eye doctor?"

Mrs. O: "I sure do think so. I was getting blind."

Dr. T: "Do you realize that you would have been totally blind in another couple of months if you had not come down here?"

Mrs. O: "I sure do." ●

EXTENSIVE EYE DAMAGE

Continued from page 4

Mr. Livensparger continued, "I took the drops just like they told me, but my eyes got even worse and I went back to see them on November 14. They told me just what they said before, that I had an eyelid infection that would go away if I kept taking the drops, even though I told them my eyes felt worse, not better. I continued using the medicine they gave me but it didn't help at all and I went back again to see them (the optometrists) on January 10th of this year.

"Again, they examined my eyes. They didn't mention glaucoma or pressure — just looked into my eyes with a light. They told me the medicine I was using wasn't doing the job and gave me something called Vasocidin. I used the new drops for about eight days and my eyes only got worse, so I went back again on the 18th of January. They said just keep using the new stuff and your infection will go away.

"Since I was getting worse all the time and the medicine wasn't helping, I thought I should see somebody else," Mr. Livensparger concluded.

"When I talked to Mr. Livensparger on Feb. 4," Dr. Mallonee said, "he told me, 'I have continuous pain in both of my eyes. I can't stand the light, and keep my eyes closed most of the time because they water when I try to open them. The pain is bad, and I have it all the time.' "

Dr. Mallonee reported that his external examination revealed a very obvious problem. A condition existed whereby the patient's lower lids had turned in, causing the lashes of the lower lids in both eyes to rub against the corneas causing recurrent and chronic corneal abrasions. It was lashes rubbing on the cornea that gave the patient the feeling he had a foreign body in his eyes. He was in so much pain that he kept his eyes closed almost constantly since the abrasions were causing him severe pain.

"I found on further examination that much of the corneal tissue was gone due to the constant irritation," Mallonee said. "I also found early vertical cupping of the optic nerve head — an early sign of glaucoma.

"I recommended immediate surgery on both lower lids to eliminate the severe irritation. This has been done since and the patient is much better at this point in time. I also discontinued the medication prescribed by the optometrists, both of which cause glaucoma in susceptible patients. The eye pressure is now down, verifying that the long use of drugs had contributed to increased pressure. In addition, we performed a complete glaucoma work-up, which was clearly indicated." ●

● A 30-year-old woman was seen six weeks previously at work by an industrial nurse for complaints of a red, irritated eye. She was referred that day to a local HMO where she was seen by an "eye doctor" whom the patient thought was a physician, but was in fact an optometrist. He diagnosed an allergic problem, recommended "Sinutabs," and referred her to an internist in one to two weeks.

Comment: The patient was inappropriately evaluated by an optometrist for an acute eye problem. HMO's should not use optometrists to evaluate patients with acute eye problems without direct physician supervision.

DANGER AND WASTE

Continued from page 3

found many had gotten the wrong glasses. One man didn't get bifocals and he had used them all of his life. This whole farce left me with little faith in the VA health care system. . . .

"On February 27, 1978, I returned to the VA and asked to see the M.D. I had seen on my last visit. I was told that he had retired, so they sent me to another M.D. This doctor assured me that he was an M.D. and an ophthalmologist, and when I told him of my previous experience, he agreed that optometrists should not treat eye disease, but explained that since he was new with the VA, he couldn't change the rules, and he didn't want to 'make waves.' He told me that he also co-signed prescriptions for the optometrists even though he never sees the patients. This doesn't seem right to me . . ." ●

TREATMENT DELAYED

Mrs. Clara Jones

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Writes Iowa Legislature

Vol. 2, No. 2, Jan. 15, 1978

The following excerpts are from a story headlined "Damaged Patient Writes Lawmakers," which carried a letter that an Iowa woman wrote to the entire Iowa Legislature, reminding them that optometrists have no medical training:

"For the last 25 years my family has been going to an optometrist for our eye care needs.

"Some time after the most recent change of lenses, I began experiencing difficulty with my vision. Consequently I returned to my optometrist and told him my sight in my right eye was blurred and that something was wrong. After his examination he told me my glasses were correct, the blood vessels were healthy, and further there were no signs of glaucoma or cataracts.

"I still believed that something was wrong in my right eye but believed the doctor must know, so accepted his diagnosis. However, as the difficulty continued and gradually increased, after five months I decided to consult a medical eye specialist. In his preliminary examination he immediately suspected glaucoma which was subsequently verified in both eyes and that the disease had been there for a long time. Also the cataracts are starting. I am informed that a considerable portion of my vision has been lost due to the delay of treatment and cannot be restored, all due to a false sense of security given me by my optometrist.

"My medical doctor tells me that an optometrist is not trained in medicine nor to diagnose eye diseases.

"Because of this lack of training, the optometrist, in my opinion, should be severely penalized when he tries to perform such services which could well end in blindness for his patient.

"I strongly urge you to give this matter your most rigid study and action."

Mrs. Jones later told her ophthalmologist that vision loss was not the only way she suffered due to the optometrist's bold attempts to practice medicine.

"I fell twice," she said, "broke my right arm near the shoulder and the second time my left wrist. I still can't see a step."

Her physician, Leo J. Plummer, M.D., reports that her glaucoma is currently under control, on a program of medications. The Des Moines ophthalmologist notes that dense and extensive visual defects in both eyes are permanent, and that it is necessary for her to learn to walk with her head down to avoid tripping. Dr. Plummer has noted that the drugs Iowa optometrists seek to use are not necessary for the trained physician to suspect, or in most cases, diagnose glaucoma. ●

Don Hostak, Director
Div. of Occupational Licensing

02 13 79

Byron Perkins BP
Licensing Examiner

I spoke with Eldon Ulmer, President of the Board of Pharmacy, and he asked me to convey the following to you in response to your teletype to him last week.

RE House Bill 79 regarding optometrists and particularly their ability to prescribe legend drugs and pharmaceuticals, the Alaska Board of Pharmacy has not changed its position on this issue. The board is not primarily concerned with whether or not an optometrist should be given this privilege, but rather, that the proposed bill in no way addresses the legal question of how they are to obtain legend drugs. Current Federal and State statutes do not permit pharmacists to fill prescriptions for legend drugs by any one but Medical Doctors, Veterinarians, and Dentists.

Re House Bill 101 and Senate Bill 65, the Uniform Controlled Substances Act, this is the number one legislative priority for the Board of Pharmacy, and the board supports it conceptually. However, the current bill is primarily a police bill, and needs to be ammended substantially to make it palatable to the industry. There is not enough language addressing the rights and responsibilities of professionals authorized to handle controlled substances. The Board of Pharmacy is pushing for a Uniform Controlled Substances Act that parallels the federal guidelines.

cc: Eldon Ulmer, R.Ph.
Chairman, Board of Pharmacy

POSITION PAPER/Department of Health and Social Servic

POSITION PAPER
ON
HOUSE BILL NO. 79

"An Act relating to the practice of optometry."

This bill would permit the use of selected drugs including topical anesthetics, mydriatics, cycloplegics and myotics by optometrists, and as such would delete from the definition of optometry the restriction against the use of drugs.

The intent of the bill would be to permit optometrists to use certain prescription drugs. This significantly increases the scope of optometry as presently defined and poses some increased risk and complications. The use of mydriatics is occasionally associated with the development of acute narrow angle glaucoma which may necessitate emergency surgery. The use of topical anesthetics are occasionally associated with acute, allergic reactions and some risks of danger to the cornea by foreign bodies. Recognizing the unusual, but definite risks and complicating reactions, the Department of Health and Social Services feels the use of prescription medications by optometrists would not be in the best interests of the public.

Recommended by: Robert Fraser

Robert I. Fraser, M.D., Director — 2/14/79
Division of Public Health

Approved by: Helen D Beirne — 2/16/79

Helen D. Beirne, Commissioner
Dept. of Health and Social Services

Name	Address	Organization	Bill
John R. Boyer	Pouch H-05	Dept. of H&SS	HB
Bill Ray			
Randy Phillips	Pouch V	Home District 8	HB#
George Mundell	Pouch H 05 F	Office of Alcoholism & D.A.	# 58
Clarice Nesbett			
William Palmer	RT 5 Box 5524 Juneau 99803	Occupational Licensing Physician	# 7
Robert Page	RT 5 Box 5525 Juneau 99803	Physician	# 79
			# 7

3701 Richmond St. #16
Anchorage, Ak. 99504
June 13, 1979

Legislative Affairs Agency
1024 W 6th Ave.
Anchorage, Alaska 99501

Dear Sir:

Enclosed is a copy of a survey undertaken by myself in March 1979 on the use and experiences of ophthalmic pharmaceutical agents by all ophthalmologists in the state of Alaska.

The impetus for this survey to have been conducted was due to the fact of House Bill 79 in deliberation under the house Health, Education and Social Service committee. In view of this I believe that the resulting responses to questions two,four,five and six are significant indicators . To wit, pertinent information for the House HESS committee members material packets.

Upon your review of this survey, I would appreciate your consideration in submitting this as relevant data and information for the HESS committee members use &/or at their disposal.

Thank you for your time and consideration in this matter.

Sincerely,

Maureen C. Roche

A SURVEY

of the
EXPERIENCES IN THE USE OF
OPHTHALMIC PHARMACEUTICAL AGENTS

A survey was conducted in March, 1979 among the Ophthalmologists in the state of Alaska concerning their experiences utilizing dilating drops.

The format of that survey was patterned after a similar survey undertaken by the Texas Ophthalmological Association in 1976. In addition to the three questions posed by the Texas Ophthalmological Association, four more were composed for the survey undertaken in Alaska. A form was devised and mailed with an enclosed addressed envelope to all twenty three Alaskan Ophthalmologists as provided from the listings on record with the Alaska State Medical Association.

As of May 8, 1979 16 (71.8%) of the 23 survey forms had been returned and those responses compiled & calculated. Below is a summary of these seven questions and the results received.

Question 1. Do you see cases in your office that must be dilated cautiously & require close medical observation?

16 (100%) of all received survey forms had responded yes to this question.

In regards to this, several respondents reported that they were more concerned with cautious dilation in the native, elderly and infant individuals and group of peoples. One Ophthalmologist reported these individuals he sees are examined carefully with the slit lamp employing the goniscope lens prior to use of dilating agents.

Question 2. Have you had cases of acute angle closure glaucoma from dilating drops that required medical &/or surgical care?

13 (81.3%) of the 16 respondents answered yes they had cases of acute angle closure glaucoma from dilating drops that required medical &/or surgical

care. 3 respondents of the 13 that replied affirmatively reported that they had seen "several" and "a number" of such cases. Yet, no specific number was supplied. 1 respondent commented that he had not seen this ocurrence since his training. A total number of cases reported among these 13 respondents was three. Two of these cases required emergency surgery to remedy the situation.

2 of the 3 (18.8%) respondents whom replied no they had not seen cases of acute angle closure from dilating drops stated they employed the method of goniscopy frequently if "suspicious of the safety of dilation". And if dilation be needed after this it would be performed with weak agents that could be counteracted readily.

Question 3. If you are aware that a patient has extremely narrow angles anatomically, and must be dilated for further studies and evaluation of the retina...
a) Do you dilate them in your office?
b) Admit them to a hospital for dilation and observation?
c) Request for a consult &/or refer them to another Ophthalmologist?

15 (93.8%) responded a)they dilate their patients within their office. Of these affirmative responses various comments were reported such as: "dilate with a weak agent that is reversible","cautiously","with phenylephrine","dilate the patient in my office but do not let them leave my office until the pupil has returned to normal","usually","also prepare my patients for admission to a hospital if necessary". One respondent answering question 3 stated that he dilates his patients in his office and then stated "there is no way to predict what the patient will choose".

3 of the 15 replying affirmatively, revealed that they have offices in a hospital complex (2) or adjacent to a hospital complex (1).

1 respondent whom did not indicate whether or not he dilates patients in his office did state "if I have a patient with extremely narrow angles that appear occludable I admit the patient to the hospital and do peripheral iridectomies. Then I dilate and examine the peripheral fundus".

Question 4. Estimate or if able, specify the number of patients you see in a year with narrow angles potential &/or precipitated.

(93.8%) reported a specific number of cases. 1 respondent failed to give a specific number when reporting; "a couple a year". Therefore this response

was disregarded in the statistical analysis. These 15 Ophthalmologists supplied a total number of 1,130 cases they would see in a year of potential and/or precipitated narrow angles. The average figure 75.3 , is the number of patients PER Ophthalmologist responding,that would be seen a year with potential and/or precipitated narrow angles.

Question 5. From your use of topically applied pharmaceutical agents have you seen other side effects? (excluding narrow angle closure glaucoma)

(100%) of the respondents replied yes to this question.

Question 6. In conjunction with question #5, can you supply what pharmaceutical agents (mydriatics,cycloplegics, miotics and anesthetics either generic or brand name) have induced these side effects in some of your patients?
Please estimate by number or if able specify how many reactions have been induced by the said pharmaceutical agents in your practice for the year 1978.

Compilation of the data revealed 13 (81.3%) respondents citing reactions in the parasympathomimetic family. Of the cycloplegics used atropine and cyclogyl appeared to be the worst offenders for inducing reactions. 8 (50%) of the Ophthalmologists reported from their use of atropine such reactions as: "hypersensitivity","poisoning","confusion", "cardiac arrest","rash & fever","convulsions", and "hypertension". 9 (56.3%) of the Ophthalmologists cited reactions from the use of cyclogyl as: "sedation","aloofness","convulsions","hallucinations", "seizures","synocope" and "central nervous system reactions".

9 (56.3%) of the respondents reported reactions with the use of the agents in the sympathomimetic family. Neo-Synephrine (phenylephrine HCL) produced problems for 7 (43.8%) Ophthalmologists' patients. These were indicated as: "hypersensitivity reactions", "conjunctivitis","toxic keratitis","cysts", and "heart dis-rythmia". Euphoria had been induced in the adult patients of one Ophthalmologist from the use of 4% cocaine.

5 (31.3%) of the Ophthalmologists cited reactions induced from the miotics. These were reported as: "conjunctivitis","retinal detachments" and "hypersensitivity reactions".

From the use of anesthetics 11 (68.8%) cited allergic reactions from the use of ophthaine (proparacaine).

3 (18.8%) of the responding Ophthalmologists stipulated they had seen many side effects from the use of pharmaceutical agents but did not report on these reactions nor state from what agents these side effects were induced from.

Question 7. In your practice up to date, being as accurate as possible how many patients are legally blind?

325 legally blind cases were supplied from 11 (68.8%) of the respondents.One Ophthalmologist reported "several cases" in his practice. This response was not calculated in the statistical figures. Three respondents (18.8%) stated such information was not availab'e. One Ophthalmologist declared that 10% of his practice involved legally blind individuals.

SUMMARY and CRITIQUE

This survey had been initiated due to the current legislative situaion in Alaska. The introduction of the so-called "drug bill", (use of pharmaceutical agents:anesthetics,cycloplegics,miotics, and mydriatics by the Optometric profession) has been in deliberation within the state house HESS committee. The subject in deliberation became of interest so much so that conducting this survey was of utmost importance to determine any established relevancy, primarily through the use and experience of dilating drops. These deliberations provided the impetus to undertake this survey.

It is a known fact among the Ophthalmologists and few others that the Native Alaskan is predisposed to narrow angle closure glaucoma. With this in mind and the awareness that dilating drops have the potential to induce and precipitate such an attack of glaucoma; questions two & four were directed at seeking a

determinacy of this precarious situation. It would be fair to say predicated from the responses to these two questions that narrow angle closure glaucoma is quite a significant matter in Alaska and cannot be denied.

Examination of all responses lends additional support that medical supervision or personnel medically trained perform dilation in order to deal with the aforementioned and unmentioned side effects that may arise. Most all respondents in this survey had indicated that they could report and list more side effects from the use of ophthalmic pharmaceutical agents. However, they declined from the arduous task of listing the vast array of side effects.

The results of this survey were forwarded to these twenty three Alaskan respondents.

Maureen Rocke
3701 Richmond #16
Anch., AK 99504

Juneau MEDICAL SOCIETY

P. O. BOX 3-3000 • JUNEAU, ALASKA 99802 • TELEPHONE (907) 586-2611

March 9, 1979

The Honorable Thelma Buchholdt
Chairman
Health, Education & Social
Services Committee
House of Representatives
Pouch V
Juneau, AK 99811

HB 79 - AN ACT RELATING TO OPTOMETRY

The Juneau Medical Society at its regular meeting on Tuesday, March 6, 1979 unanimously went on record as being opposed to the above captioned legislation as it would allow the practice of medicine by unqualified persons.

Jon C Reiswig M D

JON REISWIG, M. D.
PRESIDENT

HB 79

Peter E. Cannava, M.D.
OPHTHALMOLOGY
BOX 1629
SOLDOTNA, ALASKA 99669

TELEPHONE 262-4482

March 13, 1979

Representative Hugh Malone
Pouch V
Juneau, Alaska 99811

RE: HB 79

Dear Hugh:

There seems to be some confusion as to which drugs the optometrists are asking to use. That is one of the problems ophthalmologists see with the bill; it does not be specific as to drug but simply authorizes them to use broad classes of drugs. (anesthetics, mydriatics, cycloplegics) this of course will leave room for them to expand as they see fit rather than be limited to specific drugs as approved by the legislature.

Enclosed please find resolution from University of Alabama the optometrists claim that this institution qualifies them to use drugs on people. the resolution speaks for itself.

Sincerely,

Peter E. Cannava, M.D.
President Alaska State Ophthalmologists

PEC/bc

cc: Pat O'Conner
Margaret Branson
Joyce Munson
Charles Parr
Bill Miles
Nels Anderson
Vernon Hurlbert

THE FOLLOWING DOCUMENT(S) MAY NOT FILM LEGIBLY BECAUSE OF POOR QUALITY OF THE ORIGINAL.

University of Alabama School of Medicine Physicians Advisory Board
Adopted - 10/18/78

WHEREAS, physicians from many states have expressed appropriate concern for the fact that the existence of certain courses in the University of Alabama School of Optometry may be described by political opportunists as qualifying Optometry School graduates to attempt to safely perform medical functions; and,

WHEREAS, this Board recognizes that occasional lectures on medical subjects to optometry students are intended only to enable them to more accurately detect eye diseases and refer to physicians; and,

WHEREAS, this Board also recognizes the inherent dangers in optometry graduates believing that such cursory briefings might equip them to attempt the practice of medicine; and,

WHEREAS, Dr. Henry B. Peters has publically stated that the practice of medicine is an "inappropriate goal for optometry",

NOW Therefore be it resolved,

The University of Alabama School of Medicine Physicians Advisory Board recommends that the following public statement be issued and released to the physicians who have expressed concern:

"The education of optometrists ('specialists in the art or profession of examining the eye for defects and faults of refraction and prescribing correctional lenses or exercises but not drugs or surgery')[1] at the University of Alabama in Birmingham is designed to teach optometry principles and to enlighten optometry students in the detection of disease so as to encourage appropriate referral to physicians. This education in no way prepares these graduates with the knowledge to prescribe or use drugs to treat eye disease. This training should not be viewed as a medical credential."

J. Richard Moore, M.D., Chairman

J. Kendall Black, M.D.

E. E. Hale, Jr., M.D.

S. F. Crabtree, M.D.

Ronald E. Henderson, M.D.

[1] Webster's Seventh New Collegiate Dictionary

THE PRECEDING DOCUMENT(S) MAY NOT FILM LEGIBLY BECAUSE OF POOR QUALITY OF THE ORIGINAL.

HB79

(see previous letters re HB 79)

Peter E. Cannava, M.D.
OPHTHALMOLOGY
BOX 1629
SOLDOTNA, ALASKA 99669

TELEPHONE 262-4462

March 13, 1979

Representative Hugh Malone
Pouch V
Juneau, Alaska 99811

RE: HB 79

Dear Hugh:

There seems to be some confusion as to which drugs the optometrists are asking to use. That is one of the problems ophthalmologists see with the bill; it does not be specific as to drug but simply authorizes them to use broad classes of drugs. (anesthetics, mydriatics, cycloplegics) this of course will leave room for them to expand as they see fit rather than be limited to specific drugs as approved by the legislature.

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Sincerely,

Peter E. Cannava, M.D.

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President Alaska State Ophthalmologists

PEC/bc

cc: Pat O'Conner
Margaret Branson
Joyce Munson
Charles Parr
Bill Miles
Nels Anderson
Vernon Hurlbert

DR. M. C. FALCONER
DR. J. C. FALCONER
DR. G. L. HALL
DR. T. F. HARBOUR
DR. B. L. WALKER
DR. W. D. FAULKNER
OPTOMETRISTS

ANCHORAGE EYE AND CONTACT LENS CENTER
1345 W. NINTH AVE. PHONE: 272-2557
ANCHORAGE, ALASKA 99501

HB79

April 20, 1979

Rep. Thelma Buchholdt
Pouch V
Juneau, Alaska 99801

Dear Thelma,

Here is a little follow-up information in regard to our conversation of Friday, April 20.

South Dakota passed an Optometric Drug Bill into law early in March. The House supported the bill by a 64 to 2 vote and the Senate by a 22 to 11 vote.

March 21 saw Utah's drug bill become law, with a 50 to 12 vote in the House and 20 to 4 vote in the Senate.

North Dakota's Optometric Drug Bill became law on March 22 (House support of 41 to 7 and Senate support of 85 to 10).

The wide margin of support in these states indicates the great need for the Optometric usage of diagnostic pharmaceutical agents.

As I'm sure you are aware, our bill passed the House by an overwhelming margin last year, indicative of the faith in the Optometric community in this State.

I would greatly appreciate your help in expediting our bill through your committee this session. Thank you.

Yours truly,

Bill Faulkner

William D. Faulkner, O. D.

WDF/aeb

Municipality of Anchorage

POUCH 6-650
ANCHORAGE, ALASKA 99502
(907) 274-2525

GEORGE M. SULLIVAN,
MAYOR

MUNICIPAL HEALTH COMMISSION

March 27, 1979

Thelma Buchholt, Chairman
Senate Health, Education &
Social Services Committee
Pouch V
Juneau, Alaska 99811

Dear Representative Buchholt:

The Municipal Health Commission has reviewed and made a recommendation on House Bill 79 that is presently in your committee.

The Municipal Health Commission is a 33 member, community based group of concerned citizens. The Commission reviews community health issues, grants, problems and legislation and makes recommendations to the Municipal, State and Federal governments and legislative bodies, the general public, and the Regional Health Systems Agency. The Commission membership must meet rigid legal requirements that assure broad demographic and occupational representation as well as a consumer majority.

Attached is the review and recommendation on House Bill 79 as approved by the Legislative Committee on March 7, 1979. We hope that your committee will consider our review and recommendation before making a decision on this bill.

Thank you very much.

Sincerely,

Charles Rigden, Chairman
Municipal Health Commission

Attachment

Primary Legislative Contact: _____
(907)

LEGISLATIVE REVIEW

BILL NUMBER AND TOPIC: House Bill 79

BRIEF SUMMARY: An Act relating to the practice of optometry. This bill defines the term "optometry" and defines what is included in the practice. The bill also outlines the use of drugs for diagnosis.

BILL STATUS: House Bill 79 was introduced by Representatives Martin, McKinnon, Meekins, Miller, and Parr, and was referred to Health, Education and Social Services and Judiciary Committees.

The series of questions below are presented to assist persons responsible for reviewing proposed legislation. Answering each question will help the reader to better understand the intent or meaning of a specific bill. Question #12 asks the Legislative Advisory Committee to formulate a recommendation, which will then be forwarded to legislators, lobbyists, other review bodies, etc., as appropriate. Action taken by this committee automatically sends the bill and comments through 1) Municipal Legal Department, 2) Municipal Administration, and 3) Municipal Health Commission, time permitting.

1. What is the time frame for influencing the bill's outcome by this committee or Commission? This legislative session

2. What does the bill do? Allows optometrists to utilize certain classes of diagnostic drugs in their offices.

3. Who does it affect? Approximately 2/3 of the residents of Alaska who seek eye care.

4. How much does it cost? Will make no cost differences to the consumer.

5. Is it directed to a specific geographic area? No
What area? _____

6. How would enactment of this bill effect Anchorage? Enable the thirteen Anchorage area optometrists to utilize the diagnostic drugs.

September 6, 1979

_____ Individual Committee Members of the following Committees

_____

_____

_____

_____

_____ State Health Coordinating Council
_____ Governor
_____ Bill Sponsor
_____ Other: list

Committee procedure automatically sends the bill through:

1. Municipal Legal Department
2. Municipal Administration
3. Municipal Health Commission, if timely

American Optometric Association™

NEWS

Vol. 18, No. 5
March 1, 1979

Nebraska okays DPA usage

LINCOLN, NB — A signature by Gov. Charles Thone makes Nebraska the 17th state in the nation which has enacted legislation specifically authorizing optometrists to utilize diagnostic pharmaceutical agents (DPAs).

Gov. Thone, a former member of the U.S. House of Representatives, signed into law Legislative Bill No. 9 on February 13, the same day the state's one-house legislature passed the bill by a 33 to eight vote.

The legislation redefines and revises the 1943 state statues relating to the practice of optometry and changes state license requirements, in addition to authorizing the usage of DPAs in Nebraska.

The legislation specifies that no optometrist presently licensed in Nebraska "shall use pharmaceutical agents in the practice of optometry unless such person submits to the Board of Examiners in Optometry evidence of satisfactory

Continued on page 14

Carter proclaims 52nd SYVW

WASHINGTON, DC — To focus the attention of all Americans on the importance of good vision and the need for the public to take care of its eyes, President Jimmy Carter has proclaimed the week of March 4-10 as Save Your Vision Week (SYVW), the 52nd annual celebration of the national event.

"Good eyesight, like so many of life's blessings, is too often taken for granted," the President stated in an official proclamation. "Today, millions of Americans must cope with the burden of impaired vision. In many of

Continued on page 11

Nebraska governor signs DPA legislation

Striking a formal pose following the signing of Nebraska's diagnostic pharmaceutical agent (DPA) law are, from left, James L. Nedrow, O.D., of Beatrice, NB, past president of the Nebraska Optometric Association (NOA); Bernard G. Mullen, O.D. of McCook, NB, NOA president; Gov. Charles Thone; Sen. Bob Clark, the introducer of the bill; and David Kunz, NOA executive assistant.

Nebraska okays DPA usage

Continued from page 1

completion of all educational requirements as adopted by the (state health) department upon the recommendation of the Board of Examiners in Optometry, and has been certified by the department upon the recommendation of the Board of Examiners in Optometry as qualified to use pharmaceutical agents for diagnostic purposes."

With Nebraska's legislative action last month, there are 17 states with legislation authorizing optometrists to use DPAs, in addition to nine other states which do not statutorily prohibit the use of pharmaceutical agents.

According to Attorney D. John Pecorino, manager of Aetna's Marketing Department, Casualty & Surety Division. "We do not differentiate between states which have pharmaceutical agents and those which do not."

Currently, there are 16 states with legislation which specifically authorizes optometrists to utilize pharmaceutical agents. In addition, there are nine other states which do not statutorily prohibit the use of pharmaceutical agents.

According to Virgil L. Rhodes, O.D., of Manchester, TN, chairman of the AOA Advisory Committee on Statutory Definition, the recent Aetna reduction in malpractice coverage is important information for state legislators who are confronted by ophthalmological misinformation concerning DPA legislation.

Aetna reduces annual premium for insured AOA members

By RANDY L. WALLICK

HARTFORD, CT — More than two years of efforts between the AOA and the Aetna Life & Casualty Co. have prompted the Hartford based insurance firm to reduce professional liability rates for AOA members by 18 percent.

About two-thirds of all AOA optometrists insured for professional liability by Aetna will realize a premium reduction of $30 off the current annual primary professional liability premium of $168.

Aetna representatives state the rate reduction combines with several other improvements in the insurance program which are designed to provide AOA members with greater membership services and to make the insurance package more flexible and more competitive.

Coupled with the 18 percent reduction is the removal of surcharges for AOA optometrists. The routine 20 percent surcharge made for partnerships and/or professional corporations and the 25 percent surcharge made for employed optometrists have been removed by Aetna.

Effective February 1st, the program changes and the $30 premium reduction will be implemented upon renewal by the more than 6,000 AOA members currently enrolled in the Aetna program.

According to Ronald D. Solomon, O.D., of Colorado Springs, CO, chairman of the AOA Committee on Insurance, Aetna has agreed to provide special rates for property coverages written on a multiple account basis. "This can mean a possible 25 to 40 percent deviation from the normal price AOA members currently pay for protection," Dr. Solomon said.

According to Roger Detrich, Aetna's account executive for the improved AOA program, "Although we will seek these new rates on a nationwide basis, it is possible that in certain states our existing rates, because of the restrictions of state insurance regulations, are now below the new rates.

"Our insured optometrists in these states will realize no change or a slight increase," Detrich said. He added, however, "This will affect only a minority," he said.

Called one of the best benefit services in recent years, the new Aetna program stems from more than two years of efforts by the Committee on Insurance to gain lower rates for AOA optometrists.

Aetna, which has insured AOA members since 1970, attributes the new

Continued on page 19

NOTE: Page 19 not included in file.

ALASKA STATE LEGISLATURE

LEGISLATIVE AFFAIRS AGENCY
Pouch Y - State Capitol
Juneau, Alaska 99811

REGIONAL INFORMATION OFFICE
1024 West 6th Avenue
Anchorage, Alaska
99501
(907) 278-3668

June 19, 1979

Dear Rep. Buchholdt:

The enclosed material is being forwarded to you as HB 79 is currently in the House HESS committee.

Carol Dickason

LAA 11
(1-26-79 M)

SPECIAL TIMOTHY STEELE ISSUE

THE PEN...

PRO BONO PUBLICO

Published in the Public Interest by Ophthalmology

VOL. 3, No. 1 DEC. 15, 1978 - JAN. 1, 1979

FEDERAL JUDGE RULES AGAINST U.S.

Optometric "Primary Care" Results In Loss of Eye For Four-Year-Old Boy

In a landmark decision that could cause the army to re-examine its policy permitting optometrists to provide initial eye care treatment, Judge James M. Fitzgerald, United States District Judge for the District of Alaska, ruled that Timothy Steele, now an eight-year-old dependent of a soldier in the U. S. Army, was entitled to recover for the loss of his right eye.

> **"I conclude that the plaintiff is entitled to recover in this action from the United States for the loss of Timothy's right eye."** *JAMES M. FITZGERALD U.S. District Court*

Judge Fitzgerald's decision was rendered on October 20, 1978, in the case of Timothy R. Steele and Robert K. Steele, plaintiffs, vs. The United States of America, defendant. In his opinion, Judge Fitzgerald stated, "An optometrist's responsibility is to observe during his eye examinations any manifestation of disease visible in the eye. Upon detecting disease in the eye, it is then his obligation and duty to the patient to make known what the optometrist has observed. In such cases, he may not undertake to diagnose the disease, but should inform his patient that the matter is beyond his competence and advise the patient to seek a qualified medical doctor."

The litigation stemmed from a claim brought on Timothy Steele's behalf by his father against the United States for the loss of Timothy's right eye. Timothy Steele, as a four-year-old boy, was treated by John Shank, O.D., an optometrist in charge of the Eye Clinic at Bassett Army Hospital, Fort Wainwright, Alaska.

According to testimony in the case, it was in October and November of 1973 that Timothy's mother first noticed that his eyes were crossing. On December 19, 1973, she took him to Bassett Eye Clinic where he was seen by Dr. Shank.

During his examination, Dr. Shank measured Timothy's vision and found it to be normal. He then used drops to dilate the pupil and looked inside the eye. He diagnosed Timothy's eye condition as accommodative esotropia, which is correctable by eyeglasses. He wrote a prescription for eyeglasses and made an appointment for Timothy to return to the clinic on January 29, 1974, for a checkup.

On January 29, 1974, Timothy reported to Dr. Shank as requested. The optometrist wrote a different prescription for eyeglasses and instructed Mrs. Steele to make another appointment for Timothy four months after he would begin wearing the new glasses.

The testimony further reveals that in early May, Mrs. Steele noticed that Timothy frequently removed his glasses, saying sometimes he could not see well with them.

On June 10, 1974, Timothy was again examined by Dr. Shank and it was then that he discovered that the vision in Timothy's right eye was limited to light perception. At this point, Dr. Shank made an appointment for Timothy with ophthalmologist Bruce Wolf, M.D., of Fairbanks.

When Dr. Wolf, a medical doctor, examined Timothy on June 17, 1974, he found Timothy's visual acuity in the right eye limited to hand motions and capable of perceiving light. Essentially, his right eye was blind.

Recognizing the seriousness of the case, Dr. Wolf called in William Kinn, M.D., as a consultant. On July 9, 1974, Dr. Wolf and Dr. Kinn observed a retinal detachment of the right eye with a subretinal mass. Their diagnosis was possible retinoblastoma, but toxocara canis was also to be considered. Concluding that specific tests were necessary to identify the disease, Timothy was flown to Letterman Army Medical Center where he was examined on July 12, 1974.

At Letterman, it was determined that, because the danger of retinoblastoma, a fast-spreading, life-threatening malignancy, Timothy's eye should be removed. With parental consent, the surgery was performed by Major Bradley C. Black, M.D.

When the pathological report ruled out retinoblastoma, Timothy was returned to surgery and an implant was placed in the socket. Although recovery appeared to be good, Timothy continued to suffer from periodic socket inflammation.

In September of 1974, Timothy returned to Letterman Medical Center where a prosthesis was inserted in the socket. Testimony revealed that since the prosthesis could not be inserted immediately following the operation, it is unlikely that it will ever appear similar to a natural eye. ●

WHY "THE PEN?"

The files of state and national medical associations, all learned societies concerned with the public health, overflow with a preponderance of evidence that the quality of health care is threatened by the precedent of Government encouraging the lowering of professional standards by allowing medical functions to practitioners with no medical education. Medicine accepts the responsibility to respond to epidemics. Death and trauma are resulting, and Doctors of Medicine can do no less than warn potential victims through the continuous presentation of this evidence. The public press of America, given the facts, is supporting this cause, and concerned physicians throughout the nation are pooling their knowledge and resources to package and present the truth through the PHYSICIANS EDUCATION NETWORK.

A SAD SUMMARY:

- **When Timothy was four, his mother noticed his eyes crossing.**
- **A military dependent, he was taken to an army hospital where he was seen by an optometrist, instead of an M.D. (Current standard U.S. military procedure).**
- **The optometrist disregarded disease, infection or malignancy as causes and prescribed eyeglasses. Despite three visits, two pairs of eyeglasses and advancing blindness, Timothy was not referred to an M.D. ophthalmologist for six months, until after his right eye was blind.**
- **Ophthalmologists immediately recognized the probability of either retinoblastoma (malignancy) or toxocara canis (a parasitic worm infection), either of which is treatable in the early stages.**
- **The doctors recommended to Timothy's parents that the right eye be removed, because of the danger of an advanced life-threatening malignancy, as well as a hopelessly blind eye.**

THIS CHRISTMAS:

- **Timothy, 8, has an artificial eye which will never appear similar to a natural eye.**
- **YOU — The U.S. taxpayers have been found liable for the loss of Timothy's right eye. Who should provide primary care?**
- **Tell your legislators.**

DR. ALLEN'S

DIAGNOSES

James H. Allen, M.D.; founding president, New Orleans Academy of Ophthalmology; professor of ophthalmology, Univ. of Iowa and Tulane Univ. for 30 years; Senior Surgeon, Tulane Univ.; awarded the prized Gold Medal of the Ophthalmology Section of AMA, 1976.

TIMOTHY — WE'RE SORRY — WE'RE TRYING

In spite of the loss of his right eye, and the attendant loss of visual field and depth perception, perhaps the young Alaskan victim will grow up to have more "vision" than many U.S. officials. Nearsighted policy supported by these leaders guarantees that disasters like that which befell young Timothy Steele will continue to happen to our servicemen and women, their dependents, as well as our veterans.

The Timothy Steele case, while tragic, had a relatively happy outcome. The alternative probability — retinoblastoma — might well have resulted in death for the youngster because of the delay resulting from what optometry has designated "primary care."

The optometrist should not judged harshly. It is provable that his education did not equip him to attempt to cope with the problem Timothy presented.

The dean of the Pacific University College of Optometry, a government witness, displayed an identical ignorance of the medical facts and identified Timothy's treatment as proper medical care. It is ignorance and over-confidence at the upper level of optometric education that produces large numbers of sincere optometrists, convinced that they know much more about eye disease than they in fact do.

It would be wrong to blame the Eye Clinic, Bassett Army Hospital, or even the Medical Army leadership at Fort Wainwright. The fact that Timothy was seen first by a person with the right to use dangerous drugs to open his eye to look for what he had no training to see is the fault of the defendant — *THE UNITED STATES OF AMERICA.*

And that, dear reader, means that a Federal Court has ruled that Timothy's right eye was wasted by you . . . and me.

We have thus far failed to communicate simple logic, i.e., that a non-medical measuring scientist cannot be substituted for an M.D., no matter how critical the M.D. military manpower shortage may be.

If it takes a "Doctor Draft," so be it. The current policy of both the Military establishment and the Veteran's Administration in allowing optometrists to experiment with their own invention called "primary care" makes a travesty of Abraham Lincoln's determination "to care for him who shall have borne the battle, and for his widow, and his orphan."

Judge Fitzgerald handed down his landmark decision on October 24, 1978. During the same week, the Chairman of the U.S. House of Representatives Committee on Armed Services, Congressman Melvin Price of Illinois, was responding to concerned M.D.s across the land, as follows: *"We are also told that all military optometrists are bound by principles of acceptable and safe medical practice."*

Respectfully, Congressman Price, in the light of Judge Fitzgerald's opinion, and the disaster which has befallen Timothy, who is t lling you such nonsense?

Again respectfully, Mr. Chairman, would you really expect Robert K. Steele, as the "Natural father and next friend of Timothy R. Steele" to accept and/or respect the credibility of your informants?

Judge Fitzgerald has placed the responsibility on the American people, who look to you for leadership in this matter. We acknowledge that medicine has failed in the past to get the message to your military affairs committee, but perhaps the sad fate of Timothy Steele will at least serve the purpose of opening the eyes of your committee members to the grave danger which exists.

At this writing, a dollar value has not been placed on the loss of Timothy's right eye, but that monetary assessment, plus inevitable subsequent judgments resulting from the present policy of allowing optometrists to render medical services for which they are untrained, would serve to fund proper ophthalmologic care in the military, and provide some safeguards for the Timothys of tomorrow.

JHA

THE PEN....

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EDITORS

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Staff Editors (St. Petersburg, Fla.): George P. Russell, Frank T. Barnes, Richard D. Painter
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Author Provides Basic Information On Crossed Eyes

JOHN EDEN, M.D.
"The Eye Book"

A medical examination would have revealed the cause of Timothy's crossed eyes. No ophthalmologist would have depended on eyeglasses alone without further "medical detective work" in a case which presented crossed eyes starting at four years of age.

In **The Eye Book** *(Viking Penguin, Inc.) author John Eden, M.D. has provided basic information on crossed eyes as follows:*

Strabismus, or crossed eyes, is the second of the common childhood onset eye problems. Like amblyopia, it can seriously impair the visual learning process if uncorrected before age six. Strabismus describes two eyes that are not perfectly parallel when viewing an object. This does not mean that the eyes have to be straight ahead; they simply must be parallel to each other whichever way they are turned. But like lazy eye, "crossed eyes" is a misnomer. Although it is possible in one type of strabismus for the lines of sight (visual axes) to cross, they are not always crossed and certainly at no time do the eyes themselves cross. Some other common names for strabismus are "a cast to the eye" and "wall eyes," but these terms are even less correct than "crossed eyes."

Although strabismus is often very obvious, it is frequently impossible to spot with the naked eye. All the same, it is no more possible to be a little bit cross-eyed than it is to be a little bit pregnant. Any degree of strabismus will have the same visual effect; whether it is a slight or major deviation, the damage done to vision is the same. A particularly unfortunate bit of misinformation that contributes to the number of children who are seriously and permanently handicapped by strabismus is the notion that they will grow out of a tendency to cross their eyes. Although it is true that a certain amount of random divergence or convergence is common in infants, children past the age of one or one and a half should be able to hold both eyes in alignment. Crossed eyes after that age is not normal and cannot be left to improve on their own.

By the same token, you cannot give yourself strabismus. The often-heard warning that rolling your eyes or crossing them in play might make you permanently cross-eyed is completely fanciful. Your external eye muscles are meant to be used, and they are designed to move your eyes in all directions, as well as to hold them parallel to one another. You cannot misuse or overuse these muscles.

Like amblyopia, strabismus is damaging because the brain is constantly given an unacceptable visual message and that interferes with the development of visual skills. Use of the two eyes together is impossible since they are viewing different things. Never having had the chance to receive two similar messages, the brain is unable to learn to assemble a three-dimensional image. Without this learned skill, the individual will never have normal depth perception. And, of course, the deviant eye can become amblyopic.

There are several possible causes of strabismus, some better understood than others. And in some instances we cannot identify the cause at all. The most obvious one — that the eye muscles themselves are too weak to hold the eye in alignment — happens to be relatively uncommon. There is no question that there is a hereditary influence; children whose families have a history of strabismus will have a greater tendency to develop it. Another possible cause is a malfunction of the nerve connection to the external eye muscles. A

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"TIME HAD RUN OUT"

Full Text of Federal Judge Fitzgerald's Decision

LONG BUT IMPORTANT

Judge Fitzgerald's opinion is lengthy, but you will find it interesting reading. State legislators will find it incontrovertible evidence that optometrists, who have no medical education, should *not* be allowed to experiment with eye drops and attempt to diagnose disease. U.S. SENATE AND HOUSE Military Affairs Committee members will find it MUST READING in terms of evaluating the use of optometrists in the military to provide "PRIMARY EYE CARE."

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF ALASKA

ROBERT K. STEELE, as the Natural father and next friend of TIMOTHY R. STEELE, and ROBERT K. STEELE, individually,
Plaintiffs,
v.
UNITED STATES OF AMERICA,
Defendant.

NO. F 75-27 Civil

OPINION

Timothy Steele is an eight year old boy whose father is a soldier in the United States Army. Timothy received medical care as a medical dependent at the Eye Clinic, Bassett Army Hospital, Fort Wainwright, Alaska, in 1973 and 1974. This litigation stems from a claim brought on Timothy's behalf by his father against the United States for loss of Timothy's right eye. The Federal Tort Claims Act[1] furnishes the required jurisdiction.

In October and November of 1973, Timothy's mother noticed Timothy's eyes crossing. On December 19, 1973, she took Timothy to the Eye Clinic, Bassett Army Hospital. There Timothy saw Dr. John Shank, an optometrist in charge of the clinic.

Dr. Shank made an extended examination and diagnosed Timothy's eye condition as an accomodative esotropia correctable by eyeglasses. Following his examination of Timothy, Dr. Shank wrote Mrs. Steele a prescription for eyeglasses and made an appointment for her to return Timothy to the clinic January 29, 1974, for a checkup.

During the January visit to the clinic Timothy's mother reported to Dr. Shank that she thought the eyeglasses were helping since Timothy's right eye was not crossing as frequently. However, Dr. Shank's clinical record noted "no good reflex" in Timothy's right eye. The optometrist wrote a different prescription for eyeglasses and instructed Mrs. Steele to make a follow-up appointment for Timothy four months after Timothy would begin wearing the new eyeglasses.

By early May, Mrs. Steele noticed that Timothy frequently removed his eyeglasses. When questioned, Timothy told her that sometimes he wasn't able to see well. An appointment at the eye clinic was scheduled for Timothy on June 10. When Dr. Shank examined Timothy on that date he found vision in Timothy's right eye limited to light perception. At this point Dr. Shank made an appointment for Timothy with ophthalmologist Dr. Bruce Wolf, close by in Fairbanks.

When Dr. Wolf examined Timothy on June 17th he found Timothy's visual acuity in the right eye limited to hand motion although capable of perceiving light. Essentially, Timothy's right eye was blind. The doctor diagnosed leucocoria, right eye, with right esotropia. In his medical opinion the inflammatory cause was a vitreous hemorrhage with possible involvement of toxocara canis or retinoblastoma. Since either disease was extremely serious, Dr. Wolf ordered a complete workup by a pediatrician hoping to rule out one or both. The pediatric workup proved negative and Dr. Wolf then arranged for ophthalmologist Dr. William Kinn, as consultant. Dr. Kinn, a highly qualified ophthalmologist, before opening a practice in ophthalmology at Fairbanks, spent ten years as a military medical officer. His last three years of military service were spent at Fort Wainwright where he was chief of ophthalmology and supervised the optometrists assigned to Bassett Army Hospital.

On examination of Timothy July 9th, Dr. Wolf and Dr. Kinn observed a retinal detachment of the right eye with a subretinal tumor. "Tumor" in this context was defined as a mass rather than a malignancy. Their diagnosis was possible retinoblastoma, but toxocara canis was also to be considered. The doctors concluded specific tests were necessary so that the precise identity of the disease might be known.

Arrangements were made to airevac Timothy from Fairbanks to Letterman Army Medical Center at the Presidio in San Francisco. At Letterman, Timothy was examined July 12 by a team of medical doctors, including Dr. Michael Hogan who was internationally recognized in the field of ophthalmologic pathology.

(Life-threatening Malignancy)

On examination, the medical team observed a retinal detachment involving a grayish yellow tumor. The doctors diagnosed the cause of the tumor as possibly retinoblastoma or toxocara canis. Eye condition at that point in time made it impossible to differentiate between either disease. Because of the danger of retinoblastoma, a particularly fast-spreading and life-threatening malignancy, the doctors recommended to Timothy's parents that his right eye be removed. Timothy's parents immediately consented to the operation and Major Bradley C. Black, a resident assigned to the ophthalmology unit at Letterman, performed the surgery.

After the eye was enucleated it was sent to the ophthalmologic pathology laboratory at the University of California, Berkeley, California, for examination. The laboratory report revealed total retinal detachment of the eye with giant reaction and massive disorganization of the retina. The pathological examination ruled out a retinoblastoma but concluded the cause of the disease to be granulomatous retinitis,[2] etiology unknown. Unlike as in most eye removals, an implant was not inserted into the socket of Timothy's right eye immediately following surgery as there was a substantial possibility that the pathology report might confirm retinoblastoma. The malignancy would necessarily require radiation treatment and a follow-up examination not possible with an implant. When the pathological report ruled out retinoblastoma Timothy was returned to surgery and an implant was placed in the socket.

Dr. Black continued to treat Timothy following the second operation until Timothy returned to Fairbanks. After Timothy returned to Fairbanks he was treated by Dr. Wolf who noted that Timothy's recovery was excellent with the exception of periodic socket inflammation.

Timothy returned in September to Letterman where a prosthesis was inserted into the eye socket with good cosmetic result. Probably the prosthesis will never appear similar to a natural eye since it could not be inserted immediately following the operation.

("Failed to provide adequate care")

It is claimed in this litigation that the optometrist, Dr. Shank, failed to provide adequate care required of an optometrist when he treated Tim-

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TIMOTHY STEELE
. . . during infancy

Steeles Warn Other Parents

In an exclusive telephone interview with Timothy's parents who now live in Hawaii, where Army Sergeant Robert Steele is stationed at Schofield Barracks, PEN learned more of an unfolding tragedy.

Saying the subject was "extremely painful" to them, Sgt. and Mrs. Steele agreed to discuss the case because they wanted to warn other parents against relying on optometrists for "primary care."

Sergeant Steele told PEN that, confronted with a life-threatening alternate possibility, the family welcomed the diagnosis of toxocara canis, but he added, "We were pretty well under for about a week after they took out our boy's eye." The tragedy, Steele said, caused Timothy's mother great emotional stress that required medical treatment.

Confirming the words of attorney Nelson Parrish, Steele advised PEN that up until the time of this incident, Timothy had been a bright, well-adjusted youngster who could look forward to a promising future. Today, at nine years of age, Steele said Timothy is working hard to overcome his handicap and engage in normal activities, but despite his determination, he is encountering difficulties.

Timothy is ashamed of his condition, Steele said, and still suffers physically and psychologically. Mrs. Steele told PEN, "Timothy gets very upset if he finds out that other kids know he has an artificial eye — kids can be unkind."

While after five years, monetary damages have yet to be assessed, Mrs. Steele told PEN, "But nothing can replace Tim's eye." ●

From: Transactions of the American Ophthalmological Society — Vol. 67, 1969.

"It is well to consider that any child with strabismus (crossed eyes), and especially any child with strabismus and a poorly fixating eye, has retinoblastoma until proven otherwise."

Robert N. Ellsworth, M.D.
Director, Eye Tumor Clinic of
Edward S. Harkness Eye Institute
Columbia Presbyterian Hospital

JUDGE'S DECISION *Continued from page 3*

othy in December of 1973 and January of 1974.

OPTOMETRIC RESPONSIBILITY

Dr. Shank graduated with a degree in optometry from Pacific University at Forest Grove, Oregon, in 1971. He was commissioned in the United States Army as a Captain in the medical services and during the summer of 1973 was assigned to Fort Wainwright, Alaska. In November of 1974 he left the Army and now is in the practice of optometry at Kodiak, Alaska.

When Dr. Shank made his first examination of Timothy's eyes on December 17, 1973, he recorded a brief history:

Past six weeks mother thinks patient is cross-eyed. Father amblyopic. Age 4. Negative medical history. Rubs eyes after playing up close. Notices no real problem with depth. No allergies.

In addition he also tested Timothy's unaided vision using a standard AO chart (pictures) for children. The best possible visual acuity when measured with an AO chart is 20/30. Dr. Shank recorded Timothy's visual acuity 20/30 OD and OS (both eyes). After dilating Timothy's eyes he made an internal examination and noted:

Preliminary scoping shows opacity in right eye. Dilated with 10 percent Neo at 1430. Vitreous lesion in right eye caused from hemorrhage.

Upon completing the examination, Dr. Shank concluded that Timothy's eye problem was caused by an accomodative esotropia[3] correctable by a prescription for eyeglasses. He did not think it necessary to refer Timothy to an ophthalmologist.

Dr. Willard Bleything, Dean of the College of Optometry, Pacific University, Forest Grove, Oregon, who was called as a government witness at trial, agrees with Dr. Shank. According to Dr. Bleything, the findings of Dr. Shank's December examination are entirely consistent with an accomodative esotropia, hence, there was no need to send Timothy to a medical doctor.

In his testimony Dr. Bleything touched on the scope of training provided in a school of optometry. A significant part of optometric training is given over to recognition of diseases in the eye. In this case no one questions the principle requiring optometrists to refer their patients to medical doctors once disease is detected in the eye.

(Vitreous Hemorrhage)

In Timothy's case, however, Dr. Bleything would distinguish between an active vitreous hemorrhage and an inactive vitreous hemorrhage. He classifies an inactive vitreous hemorrhage as a scar and suggests referral to a medical doctor is indicated only in the event that an active vitreous hemorrhage were detected. It is implicit by this reasoning that to Dr. Bleything a scar is not an indication of existing disease. Scar tissue, according to Dr. Bleything's opinion, when old or inactive, is typically black. This is consistent with Dr. Shank's testimony that the vitreous hemorrhage detected in his December examination was old because it appeared black or dark.

Actually a black or dark color in a vitreous hemorrhage has nothing at all to do with its age, but rather is a result of its magnitude or extent. The black or dark color indicates a lack of reflected light from the retina behind the hemorrhage. Blood in a vitreous hemorrhage is not black; it is only the shadow that appears black. Indeed, as Dr. Black states in his deposition, an old vitreous hemorrhage would appear as white strands in the vitreous and settle to the lower part of the vitreous. And Dr. Kinn testified that he had personally observed hemorrhages in the vitreous more than a year old which were red in color. He explained that a hemorrhage would appear to be black because it was sufficiently thick with blood to absorb all the light reflecting off the retina during an examination, not because of an innate darkness of color.

The interrelationship between optometric and medical responsibility is discussed in considerable depth in the scientific text referred to at trial, "The Optometric Profession," by Hirsch & Wick. The text notes that responsibility for recognizing eye disease has not always been a part of optometry, nor indeed is it now a part of optometric services in parts of the world outside of the United States and English speaking countries. In some European countries an optometrist is expressly forbidden to examine the eye to determine whether it is healthy or not.[4]

Some of the diseases which may be discovered by examination of the eye are brain tumors, diabetes, kidney disorders, hypertension, as well as some diseases caused by microorganisms such as tuberculosis. Optometrists study about these and other diseases in order to recognize eye manifestations of diseases. An optometrist should not attempt to complete a definitive diagnosis but recognize this responsibility is part of the practice of medicine. This principle is clearly stated in "The Optometric Profession."

JUDGE JAMES M. FITZGERALD
U.S. District Judge - Alaska

"The difference between optometric and medical responsibility to the patient may be clarified by example. If an optometrist observes a hemorrhage in the fundus, he recognizes that it may be due to any of the diseases already enumerated. It also may have resulted from a vascular accident or from undue capillary fragility. The important consideration for the optometrist, however, is that he see and identify the hemorrhage. It is his responsibility to refer the patient to the appropriate medical practitioner for diagnosis and treatment of the disorder. The optometrist's understanding about disease is sufficient to recognize the various diseases that can cause hemorrhage. He does not attempt to differentiate between them. Medical technology has advanced so greatly in the past few decades that there are now many laboratory tests the physician can use in making the correct diagnosis. Disease is diagnosed by many procedures. The appearance of the eyeground is only one of them." *The Optometric Profession.*

I am not persuaded with Dr. Bleything's reasoning that referral to a medical doctor ought to depend on whether the optometrist has diagnosed a vitreous hemorrhage as active or inactive. The authors, Hirsch & Wick, suggest in their text that the important consideration is that the optometrist be able to see and identify the hemorrhage. It then becomes his responsibility to refer the patient to a medical doctor for diagnosis and treatment. Since Dr. Shank detected the vitreous hemorrhage of the right eye during his December examination, it was his immediate responsibility to promptly refer Timothy to a medical doctor. In point of fact, ophthalmological services were then readily available to military personnel at Fort Wainwright and to their dependents under a federal contract with Dr. Wolf.

Dr. Shank was aware of symptoms other than vitreous hemorrhage which are of significance to an optometrist. Esotropia in a child of four, Timothy's age in 1973, is a serious matter. Dr. Black states that esotropia in a four year old child is very rare. Most cases of congenital esotropia caused by muscle imbalance develop before age two. This condition is correctable by an operation on the muscles of the eye. Accomodative esotropia, such as diagnosed by Dr. Shank in December, 1973, develops in most cases at age two to two and a half, although it occasionally develops as late as age four or five. This condition is correctable by eyeglasses and the esotropia usually corrects itself after eyeglasses are worn. But esotropia may also indicate some type of retinal or vitreous pathology in the visual axis. This will often involve a disease in the macula, the central part of the retina. This condition reduces visual acuity in the eye and as a result the eye turns inward. In Dr. Black's opinion the most important thing to rule out when a child does present an esotropia is retinal or vitreous pathology. But even more, when a vitreous hemorrhage is observed in a child, it is very important that retinoblastoma be immediately considered until that disease can be completely ruled out.

Dr. Wolf, who treated Timothy at Fairbanks before and after his hospitalization at Letterman, agrees with Dr. Black that Dr. Shank should have referred Timothy to an ophthalmologist in December. Dr. Wolf believes that referral to a medical doctor ought to have been made immediately when Dr. Shank learned of the esotropia from Timothy's mother. Dr. Kinn, who consulted with Dr. Wolf, also agrees that referral was indicated in December. Indeed, Dr. Zimmerman, an eminent ophthalmic pathologist, who testified for the government at trial, concurs that further investigation should have been undertaken at the time the lesion was observed in Timothy's right eye.

(Credible Opinion Cited)

I am persuaded from credible, convincing medical opinion, as well as the scientific publication referred to, that Dr. Shank failed to meet the standards required of his profession when he examined Timothy in December of 1973. He knew that Timothy presented an esotropia and in the course of his examination he observed a vitreous hemorrhage in the right eye. An optometrist's responsibility is to observe during his eye examinations any manifestation of disease visible in the eye. Upon detecting disease in the eye, it is then his obligation and duty to the patient to make known what the optometrist has observed. In such cases he may not undertake to diagnose the disease, but should inform his patient that the matter is beyond his competence and advise the patient to seek a qualified medical doctor. Certainly in January when Dr. Shank detected the poor reflex in Timothy's right eye, he should have sent Timothy to a medical doctor. Instead, he delayed making a referral to an ophthalmologist until after his last examination in June, 1974. By that time Timothy was essentially blind in his right eye, and by then the retina had pulled away from the rear of Timothy's right eye. As it was to turn out, nothing thereafter could be done to save the vision or to save the eye. Time had run out.

Several questions arise at this juncture. Was the disease which ultimately caused the eye to be removed present when Dr. Shank made his examination in December, 1973? What was the nature of the malady and could it have been diagnosed? Could the disease have been treated had it been timely discovered?

There is general agreement in the testimony of the physicians that the disease which brought about the removal of Timothy's right eye was present when Dr. Shank made his initial examination.

When Dr. Wolf examined Timothy in June, 1974, he diagnosed a vitreous hemorrhage with the possibility of either retinoblastoma or toxocara canis. The team of medical doctors who examined Timothy at Letterman Hospital in July considered four possibilities. The first was persistent hyper-

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JUDGE'S DECISION *Continued from page 4*

plastic primary vitreous, a congenital defect of the eye present at birth and generally noticed shortly after birth. With such a condition as persistent hyperplastic primary vitreous, the eye is usually a bit smaller. The front part of the eye is ordinarily not normal so there are distinguishing factors for that disease. The medical doctors at Letterman were able to rule out this possibility. They were also able to rule out a vitreous hemorrhage as a cause since the vitreous of the eye was fairly clear when the doctors made their examination. The two remaining considerations related to some type of inflammatory response, most probably either toxocara canis or retinoblastoma.

(A Dangerous Malignancy)

Retinoblastoma is an extremely dangerous malignancy sometimes found in the eyes of young children. When diagnosed, retinoblastoma requires removal of the diseased eye to prevent the malignancy from escaping outside the eye, possibly through the optic nerve into the brain.

Retinoblastoma was ruled out in the University of California pathological report following examination of the eye after the operation. A negative finding of retinoblastoma eliminated any need for radiation treatment. In Dr. Black's medical opinion the cause of the inflammation of Timothy's eye was probably toxocara canis. Dr. Black observed that although the larva was never found in the new sectionings of the eye, it is known that the larva may disintegrate or completely disappear in the eye.

Toxocara canis is a parasitic round worm frequently found in dogs. The eggs of the parasite may be ingested by children playing in dirt and the eggs hatch in the intestines of the child into a larva. The larva bores through the intestinal wall and enters the blood stream and is disseminated to different parts of the body. In every instance, with possible rare exception, the parasite is not able to complete its life cycle in a human host and the larva dies without developing into an adult worm. The most common locations where it has been found are in the liver or the lungs. Inflammation of the eye by toxocara is fairly rare. But when it does appear it tends to result in a massive inflammation which usually involves the retina and sometimes may intrude into other structures inside the eye. The presence of toxocara in the body often leads to visceral larva migrans syndrome. The child can have a fever and may have some type of lung disorder, his liver may be enlarged and tender and there may be some abnormalies in certain blood tests. However, an ocular toxocara inflammation frequently occurs without a visceral larva migrans syndrome occurring and some studies suggest that in only three or four percent of ocular toxocara inflammation is the syndrome present. With ocular toxocara, so long as the larva remains alive, there is usually not much effect on the eye. There may be a local inflammation in the retina or a small whitish elevated lesion in the retina at the site of the larva or where it penetrated the retina, but the stage at which the parasite usually becomes very damaging is when the larva dies and decomposes. This leads to an extensive lesion in the eye eventually resulting in a massive scar. If the larva is able to work itself into the vitreous cavity of the eye, it brings about an even more severe inflammatory process.

(Dr. Krupp's Testimony)

Dr. Iris Krupp of Tulane University in New Orleans, Louisiana, is a widely renowned expert in the field of parasitology. She began her work on toxocara as a graduate student in 1954. Since then, she, in association with several ophthalmologists, has done extensive work in the detection and treatment of toxocara. She developed a reliable serologic test for the detection of toxocara which was announced in an article[5] published in the "American Journal of Tropical Medicine" in May, 1974.[6] After examining the medical records, including the pathology report, in Dr. Krupp's opinion the probability was 90 percent that the disease in Timothy's right eye was toxocara.

Ophthalmic pathologist Dr. Lorenz Zimmerman was a principal government witness at trial. He agreed that the University of California pathological report required that retinoblastoma be ruled out as a cause. However, he noted Dr. Helenor Foerster, a widely known ophthalmic pathologist, also performed a pathological examination on Timothy's eye. Dr. Foerster has published a number of important scientific papers, one of which presented the initial description of toxocara infection of the eye. Dr. Foerster prepared a pathological report in connection with a paper which she presented to the Western Ophthalmic Club. In her report, Dr. Foerster observed many pigment-laden macrophages and giant cells in the retina. Dr. Zimmerman believed this was significant since it implied substantial bleeding into the eye, or alternatively, that a foreign body containing iron might have been introduced into the eye. He postulated that bleeding may have been brought about by several causes, including persistent hyperplastic primary vitreous. In addition, Dr. Zimmerman suggested another possibility of the cause of the inflammation might be a low grade bacterial infection. He did not, however, conclusively rule out toxocara as a possible cause but noted that the larva was not found in either pathological examination. Also, in Dr. Zimmerman's opinion the iron pigment described by Dr. Foerster in her pathological report would not be characteristic of toxocara infection. For these reasons he discounted toxocara as the cause.

Dr. Zimmerman concluded that in this instance it is unlikely that the cause of Timothy's eye inflammation can ever be reliably known, hence the doctor's final diagnosis was chronic sclerosing endophthalmitis, cause undetermined.

It is true that the larva was not found during pathological examination. But as Dr. Black explained, the larva may decompose and disintegrate. The University of California pathological report following examination of the eye was prepared by Dr. Joseph Elinson, an ophthalmologist. In his deposition testimony, Dr. Elinson stated the pathological diagnosis was granulomatous [illegible], etiology unknown. As stated above, this is a general inflammation involving the retina. Toxocara canis characteristically causes this type of inflammation although other causes are possible.

In the course of the pathological examination, a technician prepared 30 to 40 sections from the eye. A section is less than a tenth of a millimeter and unless the entire eye is sectioned it is possible to miss the larva. In Dr. Krupp's opinion, insufficient sections of the eye were examined to exclude the possibility that the larva was in the eye. Other possibilities suggested by Dr. Zimmerman that bleeding into the vitreous was caused by persistent hyperplastic primary vitreous were ruled out during the medical examination in July at Letterman, nor is there anything to suggest the possibility of a foreign metallic object as the cause of the inflammation.

I find on the basis of the testimony of the treating physicians, including Dr. Wolf, Dr. Kinn and Dr. Black, that toxocara canis was the probable cause of the inflammation in Timothy's right eye. The opinions of the treating doctors are substantially similar to the opinion of Dr. Krupp whose qualifications in this field are outstanding. I find in all probability the larva entered the eye through the retina prior to the time Dr. Shank made his examination in December of 1973. Probably the vitreous hemorrhage observed by Dr. Shank was caused by underlying lesion in the retina of the eye.

(Ophthalmic Procedure)

While it cannot be known with absolute certainty what an ophthalmologist would have done or been able to do if Timothy had been seen in December, 1973, Dr. Kinn testified that the ophthalmologist would have been immediately concerned with making a diagnosis. At that time the physician might have had some indication of a retinal lesion which would cause him to suspect either a granulomatous reaction or a retinoblas-

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IRIS KRUPP, M.D.
Tulane University Professor

M.D. Expert Witness Comments...

Iris Krupp, M.D., of New Orleans, an authority on parasitology who testified as an expert witness in the Steele case, has issued a warning to PEN readers to seek an early medical eye examination if symptoms similar to Timothy's are noticed. Delay, as in Timothy's case, can result in blindness.

In a letter to the editor of PEN, Dr. Krupp, a Tulane University professor, indicates that early treatment with steroids and thiabendazole (an anti-parasitic drug) and/or the laser could save the eye of a patient with visceral larva migrans, which afflicted Timothy Steele.

Dr. Krupp also said that man is not a natural host for the roundworm of the dog (toxocara canis), but may affect children who have eaten dirt or food contaminated by fecal material of a dog containing the eggs of the parasite.

Once ingested, the eggs hatch and the larvae pass from the intestines into the blood stream and may settle in any organ of the child's body. Symptoms may include coughing and wheezing, excessive weariness, loss of appetite, seizures and changes in the ability to see.

Diagnosis can be made by studies of the blood and examination of the sites at which the larvae may be deposited.

Finally, Dr. Krupp emphasized that "It is extremely important that persons with ocular lesions be seen early by a physician experienced in the diagnosis and treatment of this infection, as delay may result in blindness." ●

A medical educator comments:

"In every patient with a misdirected eye and/or an abnormality in the eye, the possibility of a malignant tumor must be excluded."

Moss L. Antony, M.D.
Department of Ophthalmology
School of Medicine
Tulane University

Conclusion: Judge Fitzgerald's Ruling

Continued from page 5

toma. The ophthalmologist would have been able to examine the microscopic details with specific instruments and, if inflammatory cells were observed, the doctor could have concluded that an inflammatory reaction was present. In such circumstances a diagnosis of toxocara would be likely. Dr. Kinn explained that since the eye was functioning in December it would not have been prudent to remove the eye even if retinoblastoma was suspected. Rather, Dr. Kinn would recommend a therapeutic trial of steroids be undertaken and if the response would be favorable, then the eye not be removed. But if the mass continued to grow despite the treatment and if retinoblastoma could not be ruled out, it would be necessary to enucleate the eye.

Although in Dr. Zimmerman's opinion there is no recognized treatment for toxocara canis, in fact according to Dr. Krupp, the use of steroids in treating toxocara appeared in the medical literature as long ago as 1961.[7] And since that time, Dr. Krupp maintains there have been numerous reports in the literature on the use of steroids. In her own right, Dr. Krupp has participated in treating approximately 20 cases involving ophthalmic toxocara. Her treatment for toxocara includes thiobendazole and steroids, generally used in combination. Thiabendozle is an antihelmintic medicine which kills the larva. The steroid is an anti-inflammatory agent which reduces the mass of inflammation generally associated with toxocara. In each of the cases in which Dr. Krupp participated, treatment was able to arrest the loss of vision at the stage it was when the patient was first seen. Results of treatment can usually be observed within three to four weeks. In the event a patient does not respond to treatment, retinoblastoma may be indicated.

Dr. Black was also aware of several cases where inflammation of the eye was treated with steroids, and in isolated cases steroid treatment has decreased the inflammation, resulting in minimal scarring. But in Dr. Black's opinion, in most instances toxocara is not seen by the ophthalmologist until it has been quite destructive. However, assuming that visual acuity in Timothy's right eye was 20/30 in December of 1973 and treatment with steroids was instituted, some vision might have been salvaged.

In Dr. Wolf's opinion, if Timothy had been seen by an ophthalmologist in 1973, very possibly the eye could have been saved. Since a granulomatous inflammation is a cellular reaction to a foreign object, treatment would be taken to block the reaction. Steroids are a recognized form of treatment for granulomatous inflammation.

I find it probable that an ophthalmologist examining Timothy's right eye in December, 1973, would have diagnosed possible granulomatous reaction, toxocara canis or retinoblastoma. Although there was a lesion in the eye that to some extent impaired Timothy's vision, his visual acuity in the eye was 20/30, the best that could be measured on Dr. Shank's eye chart. The ophthalmologist under such circumstances would almost certainly institute a course of treatment involving steroids in order to reduce the inflammation. The treatment would have prevented further loss of vision and toxocara inflammation would have caused minimal scarring. The eye would have been saved.

Since the jurisdiction of the court is found under the Torts Claims Act, Alaska tort law controls. *Richards v. U.S.*, 369 U.S. 1; *U.S. v. English*, 521 F.2d 63 (9th Cir. 1975). The concept of liability arising out of negligence has been recently stated by the Alaska Supreme Court to be:[8]

> It is elemental that in order for liability to be imposed in a negligence action, the plaintiff must establish a duty of due care owed him by the would-be defendant, a breach of that duty, and finally, that the injury was proximately caused by the breach of duty. Generally speaking, the duty of due care or ordinary care is the duty to act with that amount of care which a reasonably prudent person would use under the same or similar circumstances.
>
> *Leigh v. Lindquist*, 540 P.2d 492, 494 (1975).

Dr. Shank's failure to promptly inform Mr. and Mrs. Steele of the vitreous hemorrhage in their child's eye and his accompanying failure to refer Timothy to an ophthalmologist was a breach of the standard of care owed to Timothy Steele and his parents. I find Dr. Kinn's testimony as the duty owed to be especially persuasive. Not only is he a board certified ophthalmologist who continually deals with optometric referrals, but Dr. Kinn was previously chief of the eye clinic at Bassett Army Hospital for three years. During those years, he was in charge of the optometrists at the eye clinic and had overall responsibility for all medical and optometric care at the clinic. Additional evidence of the breach of the standard of care is found in the established text "The Optometric Profession." That authoritative work explicitly states that an optometrist is bound not to try to differentiate between pathologies such as hemorrhages. Instead, an optometrist must refer the patient to a medical practitioner for prompt examination.

(Judge's Conclusion)

I conclude that competent optometric practice required that Timothy's parents be notified and that the child be referred. The failure to inform and refer was not a "judgment call" but a violation of the governing principles of professional standards.

Optometrists are trained to recognize symptoms of many diseases which may be discovered by eye examination. They are not permitted under recognized optometric standards to undertake a definite diagnosis but recognize this as the responsibility of a medical doctor.[9] Obviously, it is foreseeable that failure to refer to a qualified medical practitioner, when required to do so, will result in delay of diagnosis and the institution of treatment; so it proved to be in Timothy's case. At the time the referral was finally made to an ophthalmologist, it was too late. Time had run out, and the only thing that could be done was to remove the eye.

I conclude that the plaintiff is entitled to recover in this action from the United States for the loss of Timothy's right eye.

DATED at Anchorage, Alaska, this 20th day of October, 1978.

ss: James M. Fitzgerald
United States District Judge

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1 28 U.S.C. 1346(b). Plaintiff's original complaint founded jurisdiction on the Federal Torts Claims Act but mistakenly cited the section as 1366(b).

2 Retinitis is an inflammation which chiefly involves the retina. "Granulomatous" is a type of inflammation. Thus, the pathology conclusion was that of a general retinal inflammation of unknown origin.

3 Esotropia, meaning pointing inward.

4 **The Optometric Profession** by Monroe J. Hirsch and Ralph E. Wick, (1968 edition) Chilton Book Co. at page 17.

5 Hemoglutination Test for the Detection of Antibodies Specific for Ascaris and Toxocara Antigens in Patients with Suspected Visceral Larva Migrans.

6 Since the article did not appear until May, 1974, the physicians who treated or examined Timothy were probably not aware of Dr. Krupp's serological test.

7 By Schneider at the Oxnard Clinic.

8 The standard of care required of medical doctors, osteopaths, and dentists is found at AS 09.55.540. Optometrists were not included. In 1976 the statute was broadened to include all health care providers. 31 Ch. 102 SLA 1976. The amendment was limited, however, to actions filed after the effective date, May 29, 1976. Since Steele v. U.S. was filed August 20, 1976, the amendment is not applicable.

9 The Optometric Profession, pp 6, 17.

EDEN: CROSSED EYES

Continued from page 2

common, more readily explainable cause is an uncorrected high degree of farsightedness. Remember that young people can correct farsightedness by using their near-focusing ability. This involuntary action plays a part in strabismus because when near-focusing muscles are used the eyes automatically converge to take in the near object. Notice that when you shift from looking at a far object

Strabismus.

to looking at a near one your eyes turn in a bit. This is a natural and normal reflex, but when a farsighted child uses the near-focusing muscles to view far objects clearly, his or her eyes may converge. The reflex is stronger in some than in others, so it does not mean that all children with uncorrected farsightedness will develop strabismus, but it is a possibility.

A disease that causes poor vision in one eye is another possible cause. If one eye sees quite badly, there is not much visual benefit to be gained from using it. The brain will not tell the nerves to tell the external muscles to hold the eyes parallel, and the defective eye may simply turn in or out because there is little reason for it to hold itself parallel to the other eye.

What difference does all this make? Is strabismus more than just a cosmetic problem, a matter of looking a bit odd because the eyes are crossed? Indeed it is. Binocular use is not a skill mechanically achieved; it must be learned in that ever-important period before age six. If strabismus is uncorrected during that time, the child will never be able to learn to use both eyes together. Correction after age six will improve appearance, but it cannot provide a second chance to learn binocularity. Likewise, if the strabismus has caused the deviant eye to become amblyopic, correction of the deviance after age six will not cure the ambiyopia.

Epicanthus.

Extremely misaligned eyes can be spotted by a parent or anyone looking at the child, but strabismus is often not that pronounced. An eye doctor, however, can readily discover strabismus during the routine eye examination and can determine how it should be treated.

A condition called *epicanthus* often causes parents of young children to suspect strabismus. At birth, a wide nose bridge normal to all babies is combined with an unusual eyelid fold that often makes it seem that one eye is turned in too far when the baby looks slightly to one side. In fact a large portion of the sclera is hidden by the *epicanthal fold*, but the eye is not turned in more than normal. This is an anatomical feature that is not at all related to strabismus, and it does not interfere with learning to see. The child may look abnormal, but he or she does not see abnormally. And in most cases, the epicanthus recedes as the child's nose narrows. ●

FOUNDER SALUTED BY AMA NEWS — PART II

Ochsner: "Treat The Whole Patient"

The accomplishments of Alton Ochsner, M.D., PEN's International Advisory Board Chairman, are legend in the annals of American medicine. Terming PEN, "The most potent communications effort I have ever observed in medicine," Dr. Ochsner has said, "Ophthalmology — medicine's protectors of one of God's greatest gifts — eyesight — finds itself in the trenches, doing grim battle against a potential epidemic of ineptitude foisted on the American public by some legislators who have heard only the exaggerations and half truths of the optometric side of a non-argument."

Free-lance author Nancy Yanes Hoffman, in an article titled "Alton Ochsner: 82 and Still Going Strong," which appeared in the AMA Journal on August 25, 1978, Vol. 240, No. 8, has captured the essence of this man's greatness. PEN wishes to express its appreciation to Ms. Hoffman and to the JAMA for permission granted to present this material in a series of articles.

"Alton Ochsner: 82 and Still Going Strong," Part II:

The trend in American medicine, as in American life, toward trying to get by with mere competence while not striving for excellence, worries Ochsner. "The other thing that worries me is that physicians rely too heavily on laboratory findings. I fear we are developing a group of competent technicians, treating disease but not treating the whole patient. I stress to our young people that they must sit down with a patient, take a complete history, do a careful examination, then evaluate the findings and arrive at a working diagnosis. After that, they should order laboratory tests. If the laboratory work confirms the clinical diagnosis, accept it. If it doesn't, disregard the laboratory findings and keep on looking. Sounds like heresy, I know, but it's true."

Ochsner remembers a South American woman (the Ochsner Medical Institutions draw many Latin American patients) who had been diagnosed as a hypochondriac with severe psychiatric problems. Although Ochsner protested, "I don't know anything about psychiatry," he saw the patient, became convinced that she had no more psychiatric difficulties than the rest of us, examined her and diagnosed her case as amebiasis. The laboratory test disagreed — as did the gastroenterologists. Ochsner insisted on instituting anti-amebiasis therapy. "Three days later she walked into my office and said, 'Doctor, I'm well for the first time in years.' What convinced me? Such things as tenderness over the appendix and the liver and listening carefully to the chronology of her symptoms: 'I wake up in the morning and I could whip my weight in anything. By ten o'clock, I can't drag one foot after the other.' This complete asthenia is characteristic of amebiasis. Doctors must listen to the patient, discard their hidebound preconceptions, track down every clue, have the courage of their convictions even when their peers oppose them. I can't emphasize this enough to students."

As Ochsner looks back at his diverse medical career, he believes that his most valuable contribution to medicine has been his teaching. "I'd like to be remembered as a teacher. As Tulane's professor of surgery, I've gotten my greatest satisfactions from teaching more than 3,600 medical students and from teaching our resident fellows here at the Ochsner Foundation Hospital." No student will ever forget those harrowing sessions in the "bull pen" with Alton Ochsner. At one of these "Why Clinics," as Ochsner dubs them, he was barraging a student with questions. "Why? Why? Why?" demanded Ochsner, forcing the student to analyze and defend every assumption that was not thought through. In a classic fight-or-flight response, the student fainted. When he was revived, Ochsner interrogated him just as vehemently — with one additional question: "Why did you faint?"

Who was his best student? "Mike DeBakey. Remarkable, brilliant." Ochsner considers DeBakey "indefatigable." As for himself: "I don't know if

ALTON OCHSNER, M.D.
PEN'S International Advisory Board Chairman

I have such prodigious energy. My friends say I work too hard. That's ridiculous. I love what I do. I have fun from the time I get up in the morning until I go to bed at night. I don't work hard; I put in long hours. I think that I'm basically lazy, but I'd be miserable if I didn't work." Ochsner insists that his fabled vigor comes from not wasting energy on disappointment or regret for the road not taken. "Then, too, I've never smoked. Tobacco is the most malevolent aging factor present today. Everybody gets older, but nobody has to get old. Chronological age is irrelevant to physical and mental age. Start with a good machine, take care of it, and it will last a long time.

How to age as well as Ochsner — or, at least, to try? "Three factors accelerate aging: tobacco, our modern sedentary life (people must exercise strenuously daily, until they're out of breath, huffing and puffing), and obesity." Ochsner himself eats sparingly, usually skips lunch, and never has permitted his trim body to lose the battle of the bulge. "If I ate what I wanted," he says, "I'd weigh 300 pounds."

What was Ochsner's most interesting case? An impossible question. Separating Siamese twins; the first successful resection of a saccular aneurysm of the aorta; a thyroidectomy on Tomas Gabriel Duque, then former President of Panama, in 1942, at Cordell Hull's request; surgery on the late jazz trumpeter Muggsy Spanier, who thanked him by writing the song, "Oh, Dr. Ochsner"; or treating Ben Hogan after an automobile accident. Six weeks after the accident, ready to be discharged from an El Paso Hospital, Hogan had suffered a pulmonary embolus, had received anticoagulation therapy, then had had a massive embolus five days later.

It was Mardi Gras time. After attending the Queen's supper, Ochsner had gotten to bed at 4 A.M., arisen at 5 A.M. and had worked all day until ten in the evening. He had finally fallen into bed, "dog-tired," when the phone rang. Could he fly to El Paso? Hogan was cyanotic and comatose. As soon as Ochsner saw Hogan he said, "He's got to have his cava tied — immediately" Ochsner remembers: "Hogan was bleeding profusely. His blood was absolutely incoagulable. His prothrombin time was 0. At noon, I began giving him protamine sulfate and vitamin K and blood transfusions. By midnight, his pro-time was 30%, but we couldn't wait any longer because he was sinking fast. I operated."

Ochsner flew home, got in at 8 A.M., went directly to the foundation hospital, and started work. Hogan got well and won touraments after that.

Ochsner postscripts: "People are reluctant to tie off the vena cava, because it seems like such a horrible procedure, but it's not. It can be a life-saving act." Why? "Most patients don't develop a fatal infarction after a nonfatal pulmonary infarct, so surgeons and internists both gamble that every patient won't have a fatal embolus. But every patient who's had a pulmonary embolus is a candidate for another one. He may be lucky and not have one, but it's dicey." Again, Ochsner repeats George Dock's dictum: the importance of being careful. "Many doctors will say wait until a patient has had two or three emboli, then ligate. In my opinion, that's playing Russian roulette. **All medicine is judgment. I can bring anybody in off the street and teach him how to cut and sew in three months. It's knowing when to operate and when not to operate."**

After teaching, Ochsner considers his most important contribution to medicine his work toward the establishment of a causal link between smoking and lung cancer and, subsequently, between smoking and its deleterious effects on the vascular system. "When I was a medical student in 1919, we admitted a patient with lung cancer to Barnes. As usual, the patient died, because the mortality was almost 100%. Dr. Dock had us witness the autopsy because he said that the condition was so rare that we'd never see another case as long as we lived. I didn't see another case for 17 years — until 1936. Then there were nine cases in six months. An epidemic. There had to be a cause. They were all men, all smoked cigarettes heavily, all began smoking in the first world war. When I researched the history of smoking, I found that very few cigarettes had been consumed prior to World War I.

"In 1936, I had the temerity to state — not suggest — that cigarettes caused this new plague." He sighs. "Not that anybody believed me or listened to me. Even in 1950, when I was president of the American Cancer Society, I used to have knock-down-drag-out fights with E. Cuyler Hammond [ScD], their chief biostatistician. [Dr. Hammond, vice-president for epidemiology and statistics, now agrees with Ochsner.] It took the American Heart Association even longer to take up the cudgels against cigarettes, though they are just as noxious to the vascular system as the respiratory system."

Part III of "Alton Ochsner: 82 and Still Going Strong" will appear in the next edition of THE PEN. ●

N.C. REPEAL RESOLUTION

The resolution of the Section on Ophthalmology of the North Carolina Medical Society, was inadvertently omitted in the December 1 issue of THE PEN. The complete text follows:

RESOLUTION:

WHEREAS, the medical doctors who are members of the North Carolina Ophthalmology Section of the North Carolina Medical Society are increasingly concerned about the jeopardy to the public health inherent in the 1977 law which allows the use of drugs with their inherent dangers by medically untrained optometrists; and,

WHEREAS, such drugs are unnecessary to the practice of optometry; and,

WHEREAS, AMA medical ethics Principle 10 mandates that physicians provide their efforts, resources and expertise to the benefit of the public welfare,

NOW THEREFORE BE IT RESOLVED, that the North Carolina Society of Ophthalmology in cooperation with the North Carolina Medical Society will have legislation introduced in the North Carolina Legislature for the purpose of repealing the 1977 optometric drug use law, and will publicly campaign for repeal, maintaining this action until such time as the mission is accomplished and the protection of the people of North Carolina is assured.

Passed May 5, 1978
Pinehurst, North Carolina

H. Maxwell Morrison, M.D.
President, Section Ophthalmology, NCMS
David B. Sloan, Jr., Secretary
Section Ophthalmology, NCMS

Steele's Attorney Comments On Case

O. Nelson Parrish of Fairbanks, Alaska, attorney for the plaintiffs Robert K. Steele and Timothy R. Steele, provided PEN with his reaction to the decision as rendered by Judge James M. Fitzgerald.

"I think," Nelson Parrish said, "that the essence of the court's decision is that optometrists, and schools of optometry (compared to ophthalmology) will not be allowed to set their own standards as to what they can and cannot do. The court's decision recognized that optometrists are not sufficiently trained to make the same kinds of decisions that ophthalmologist M.D.s can, and should make, in situations similar to that presented in Timothy's case."

Continuing, Parrish stated, "The U.S. Government was, in fact, contending throughout this trial that since we (the plaintiffs) did not present an optometrist to say that what the optometrist treating Timothy did was wrong, our case ought to be dismissed. The Government, in fact, moved for a 'directed verdict' (to throw our case out of court) on the grounds that only an optometrist can say what is or is not wrong about what another optometrist does."

When questioned by PEN as to the judge's reaction to this line of reasoning, attorney Parrish replied, "The judge rejected it by saying, in effect that since an optometrist is not fully trained to recognize dangerous situations, such as presented in this case, he could not then say what he did or did not do is right or wrong. Having arrived at that point, the court then in effect said it was going to accept the position of all the medical doctors who testified, including the government's doctor, that the boy should have been referred."

In concluding his comments, Nelson Parrish told PEN that this case had convinced him that, "optometrists, with no medical education, are attempting to pull themselves up by their own bootstraps, into an invulnerable position of unaccountability."

Mail to: James H. Allen, M.D., 9104 Quince St.
New Orleans, LA 70118

PEN MEMBER APPLICATION

"PEN MUST SURVIVE AND GROW . . . IT IS ALREADY THE MOST VIABLE, POTENT, AND ACTIVE COMMUNICATIONS FORCE IN MEDICINE — IT'S A MUST DO - CAN DO - AND WILL DO ORGANIZATION."
Alton Ochsner, M.D.

STATEMENT OF INTENT
I intend to be an active member of PEN and I endorse and support the STATEMENT OF PURPOSE.

In providing my resources I am assuring that PEN will continue to block efforts to invade medicine at the expense of the public health. I am subsidizing the ever-expanding promulgation of truth, the circulation of THE PEN and other publications to an ever-expanding audience. I am assuring the availability of resource materials, mass communications, legislative, and other expertise relating to this issue to all who support medicine in this cause.

I DESIRE TO INFORM AND BE INFORMED AND HEREBY PLEDGE DUES IN THE AMOUNT OF $250 ANNUALLY. (Subject to reduction as PEN grows)

Date_____19____
Name_____
Address_____
City_____State_____Zip_____
Telephone: (Area)_____Number_____
Ophthalmologist?_____Other specialty_____
Profession, other than M.D.?_____
Check enclosed ($250)_____Please bill me_____
☐ Resident Dues $25.00
☐ Affiliate (spouses, office staff) $25.00
☐ Military M.D.s $150.00

THE PEN FORUM

Public Service by Alabama M.D.s Draws National Praise

As reported in the December 1 issue of THE PEN, the Medical Advisory Board to the University of Alabama has passed a resolution which declares that University Optometry School graduates are not trained to attempt to practice medicine. This action, to protect the public, is being saluted by M.D.s throughout the nation.

Dear Dr. Hale:

I want to thank you for the public service rendered by the Medical Advisory Board to the University of Alabama for publicly defining the limited role of optometrists. Their efforts over the past several years have been to mislead the public into the scope of services that they provide. It is important to make every effort to protect the medical well-being of the public.

Please be assured of my best wishes.

Robert A. Wiznia, M.D.
New Haven, Connecticut

Dear Dr. Moore:

Let me express my appreciation to you and the other physician members of the Medical Advisory Board of the University of Alabama. Your courage in opposing the attempts by non-practitioners (optometrists) to get into the practice of medicine is commendable. Defining the role of optometry is a public service and the actions taken by the Medical Advisory Board will be of great help in our fight to protect the high quality of medical care in this country.

Joe H. Woody, M.D.
Charlotte, North Carolina

Dear Dr. Henderson:

I found it most gratifying to see that wisdom has prevailed in the resolution to define the limited role of optometry in medicine through your efforts and convictions. The valuable limited services of optometrists has been recognized by medicine and by ophthalmology alike. False claims and false advertising, as well as impersonating physicians by optometrists is totally alien to the medical arts. Your clear perception of the problem, and your action deserves many thank-yous from all physicians, patients, and the public at large.

Georges Birenbaum, M.D.
Lexington, Kentucky

Dear Dr. Pittman:

I congratulate you, as a member of the University of Alabama Medical Advisory Board, for speaking out forthrightly regarding optometric education at your University. The public and legislators around the country need to know that optometrists are not trained to assume a medical role. Your resolution is a godsend.

The American people owes you a debt of gratitude.

Charles B. Bobo, M.D.
Greenwood, South Carolina

Dear Dr. Henderson:

As a practicing ophthalmologist and a citizen I wish to congratulate you for the role you have played and the service you have rendered to the public in defining the limited role of optometry We all know at times it takes courage to stand up on your hind legs for what is right. But remember there is only one truth and all the local political and social pressures cannot alter that.

You have helped to open the eyes of the public as to the only proper role of optometry in vision care.

Walter C. Bullington, M.D
Charlotte, North Carolina

Dear Dr. Moore:

Today I received a copy of the resolution of the University of Alabama School of Medicine Physician Advisory Board concerning the education of optometrists at that institution.

It gives me a feeling of relief and appreciation that there are fellow medical doctors in this country who have the insight and understanding that is necessary to protect our lay population from the zealous political ambitions of those people who place ego and economics above personal ability in matters of the health care of this nation.

Please accept my thanks and appreciation for your efforts in this matter.

Jerome L. Byers, M.D., P.A.
Dallas, Texas

Dear Doctor Moore:

Congratulations to you for your great effort in defining the status of optometric education with regard to the practice of medicine in the resolution passed by the Medical Advisory Committee, at the University of Alabama School of Medicine.

It was a great public service to all of the people of our country.

James W. Clower, M.D.
Daytona Beach, Florida

Aloha, Doctor Pittman!

By publicly defining the limited role of optometrists, you and your colleagues on the University of Alabama Medical Advisory Board have done your patients a real service.

Thanks . . . or as we say in Hawaii,
Mahalo!

John M. Corboy, M.D.
Wahiawa, Hawaii

Dear Dr. Pittman:

Thanks for a job well done. Your recommendation in that we issue a public statement concerning the education of Optometrists is welcomed by all of us who understand the problems related to the eye. The resolution itself is a work of art, and describes optometric education exactly as it should be described.

Please know that your efforts are greatly appreciated.

R. H. Monahan, M.D.
St. Paul, Minnesota

UNITED STATES PHYSICIANS EDUCATION NETWORK

Statement of Purpose

PEN exists solely to utilize its resources and combined influence to present, promote, and promulgate, through communication outward, and communication inward, these simple truths:

- The American people must be protected by placing and keeping health care in the hands of experts, whose abilities are established by having reached a standard level of medical education.
- The logical minimum level of education necessary for leadership to protect the public in shaping the optimum health care delivery quality standards in the United States is the degree of Doctor of Medicine or Osteopathy, earned at a school of medicine or osteopathy — at an accredited institution of higher learning.
- Government at every level should cooperate with medicine in establishing these health safety standards.

Membership in PEN is available to any law-abiding citizen who subscribes to these truths, and desires to be informed, as well as to participate in informing the public at large.

THE PEN is a public newspaper, international in scope. Its readers include people from every walk of life. THE PEN is freestanding and independent of any national or state association, with the exception of its sponsor, Physicians Education Network, Inc. PEN, Inc. is a Florida non-profit corporation. Submissions to this newspaper are welcome and are published at the discretion of the editors. THE PEN does not accept paid advertising or paid subscriptions.

2/28/79

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Ron Tuban MD	—	PO Box 6636 Ketchikan	
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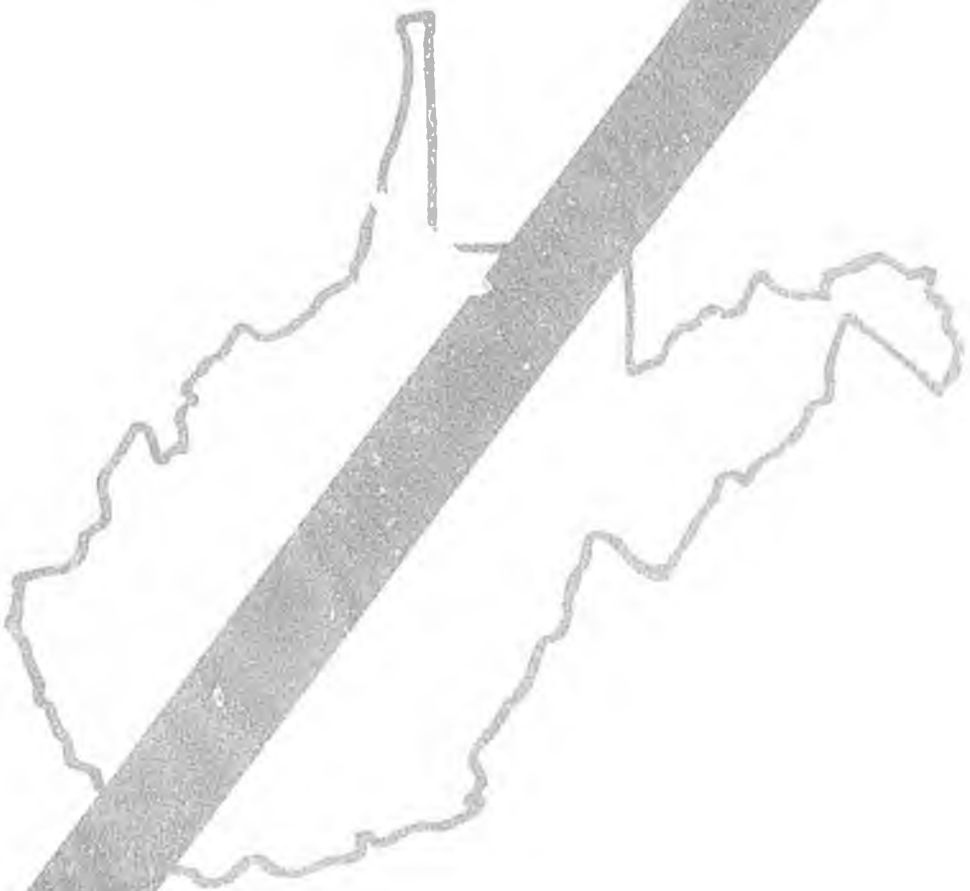
OPTOMETRY

1980

A Post Facto Report on
Enr. H.B. 1005 (1976)



Developed and Presented by

The West Virginia
Optometric Association

OFFICE OF THE
PRESIDENT
Freda J. Slaymaker, O.D.
P.O. Box 663
Charleston, West Virginia 25323
(304)342-3536

January 22, 1980

Dear Legislator:

This letter is an integral part of a report to you concerning the functioning of the 1976 updating of the West Virginia Optometry Law through H.B. 1005 which among other changes included diagnostic and therapeutic drug use by qualified optometrists.

To those of you who are "seasoned" legislators some of this is material of which you will perhaps be well aware. To those of you who have been recently elected, I will endeavor to provide you with as much pertinent material as possible without undue composition.

This law (H.B. 1005) has now been in effect since 1976 and has been functioning in the satisfactory manner as was intended by the legislature.

Optometrists have for over three and a half years been providing diagnosis and treatment to the many patients who live in the smaller towns in rural areas where no other eye care practioners are available except the local optometrist. He, along with his colleagues, has administered drugs to Thirty Thousand Six Hundred Forty-Nine (30,649) patients with a savings of Four Hundred Fifty Thousand (450,000) miles (greater details enclosed for the term involved in this report).

Educational courses are being made available to the optometrists of West Virginia on a continuing basis providing them with newer diagnostic and therapeutic methods of treatment as they occur.

The inclusion of the use of drugs by optometrists is still a major bone of contention by a number of ophthalmologists who, through their efforts and financing, have been sending what has been referred to as a "poisonous pen" letter (prepared by a public relations firm) to legislators of which you no doubt will be a recipient.

The enclosed letter from Dr. Butterfield contains results of the most recent survey conducted by the West Virginia Board of Optometry of those optometrists currently certified to use pharmaceuticals. This will provide you with greater details of the functioning of the law from the standpoint of drugs used and treatment instituted with far less travel time of which many indigent patients would not have the means and, thus, could not otherwise have received proper

treatment.

In submitting this report to you on behalf of the optometrists of the State of West Virginia we hope it will provide you with a better understanding of the results of your labor by supplying a means whereas the people of West Virginia are delivered an improved system of health care services.

Respectfully yours,

Freda J. Slaymaker

Freda J. Slaymaker, O.D.
President
West Virginia Optometric Association

FJS/scp

WEST VIRGINIA BOARD OF OPTOMETRY

J. GORDON BUTTERFIELD, O.D.
SECRETARY-TREASURER
WEST VIRGINIA BOARD OF OPTOMETRY
111 BROOKS STREET
CHARLESTON, WEST VIRGINIA 25301

January 22, 1980

The Honorable W. T. Brotherton, Jr.
President, Senate of West Virginia
State Capitol Building
Charleston, West Virginia 25305

The Honorable Clyde M. See, Jr.
Speaker, West Virginia House of Delegates
State Capitol Building
Charleston, West Virginia 25305

RE: Report on Enrolled H.B. 1005 of 1976

Dear President Brotherton and Speaker See:

The purpose of this letter is to report to each of you and your respective bodies on the Enrolled H.B. 1005 enacted on February 20, 1976 by the Sixty-Second Session of the West Virginia legislature. As you may recall, this law expanded the statutory definition of "optometry" to include, among other things, the limited use of drugs prescribable for the human eye for both diagnosis and treatment, under carefully prescribed certification authority delegated to the West Virginia Board of Optometry. This Board has endeavored continuously and faithfully to both certify and monitor the use of drugs by optometrists practicing under the registration of this Board.

Recent information compiled from the one hundred seventeen (117) West Virginia registered optometrists now certified by this Board for drug usage is as follows:

a. A total of sixty-three (63) different drugs prescribable for the human eye have been employed by these West Virginia certified optometrists since the law was enacted.

b. Thirty Thousand Six Hundred Forty-Nine (30,649) individual patients have been seen by these optometrists and conditions such as infectious or allergic conjunctivitis, corneal abrasions and blepharitis (granulated eye lids) have been treated by those certified in the compilation.

c. The distance those patients who otherwise would have had to travel to geographical locations other than those of the treating optometrists for treatment by ophthalmologists or appropriate medical specialists to whom they formally were referred would have required that over 450,000 aggregate miles be traveled by the 30,649 patients.

d. Forty-six (46) different pathological conditions have been diagnosed and treated by these West Virginia certified optometrists.

Those 117 West Virginia optometrists who have been certified are widely dispersed throughout our state and are now faithfully and well providing expanded eye health care benefits to the people of West Virginia. IT SHOULD BE ADDITIONALLY NOTED THAT THERE HAS BEEN NO REPORT TO THIS BOARD OF ANY ADVERSE REACTION IN THE DIAGNOSIS AND TREATMENT RENDERED TO PATIENTS INVOLVED BY ANY WEST VIRGINIA CERTIFIED OPTOMETRIST.

There have been reports in the newspapers during the past few months of adverse reactions allegedly caused by optometrists. These alleged reports have all been made by one oththalmologist.

Registered letters sent to him by this Board seeking his cooperation in helping to identify and fulfill this Board's responsibility have been met with only silence. This Board, therefore, considers his alleged complaints to be just that.

Please be advised that this Board is quite aware of the full responsibility placed upon it by the legislature in the enactment of this law Enrolled H.B. 1005. This data was compiled in a continuing effort to support the trust which has been reposed in it. Each of you is encouraged to call upon this Board for any additional information which may be helpful.

Sincerely yours,

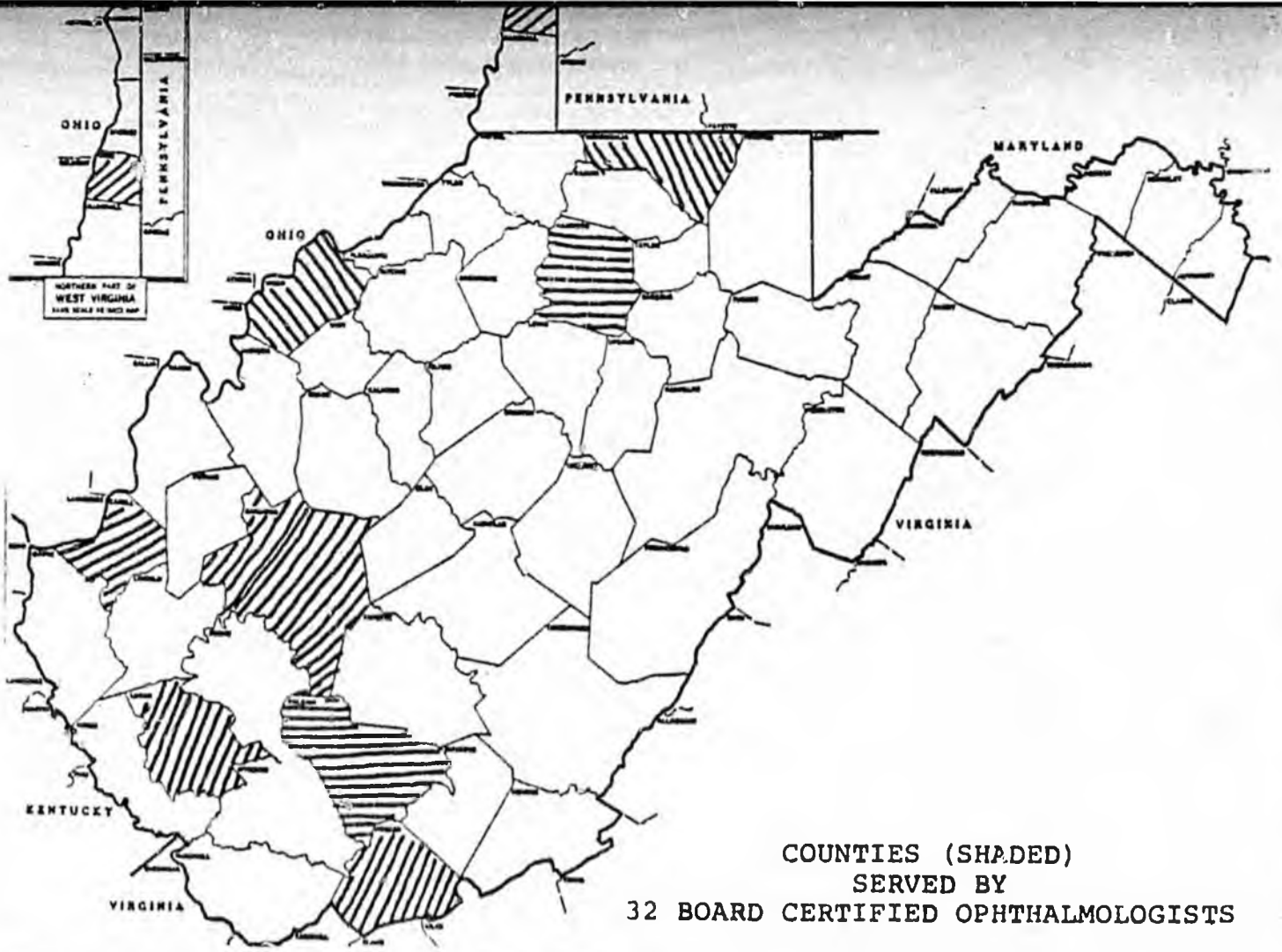
J. Gordon Butterfield, O.D.
Secretary-Treasurer

JGB/scp

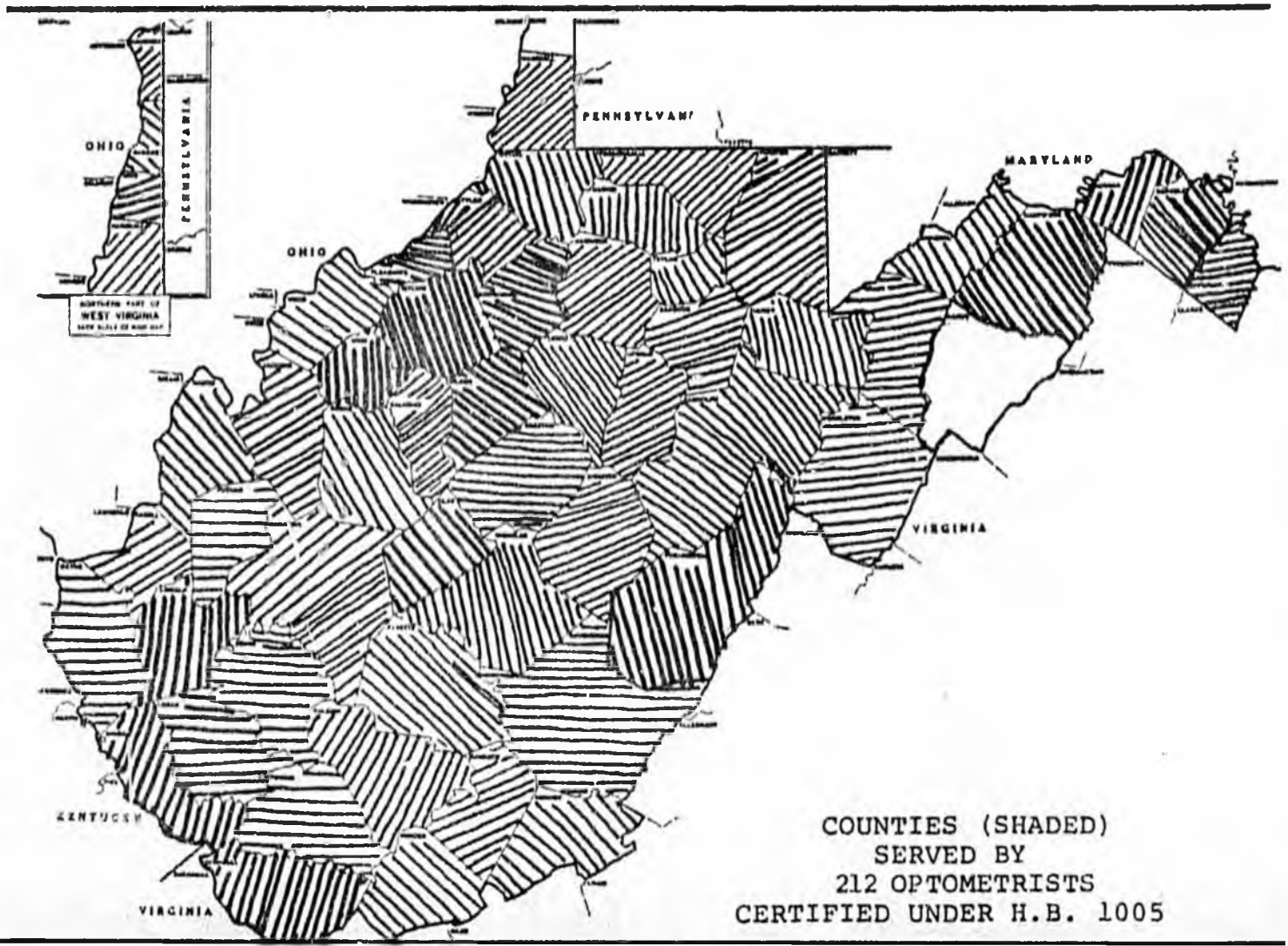
COMPARATIVE PHARMACOLOGICAL INSTRUCTION FOR

HEALTH CARE PROFESSIONS

PROFESSION	SCHOOL	PHARMACOLOGY HOURS OF INSTRUCTION	REFERENCE	RESTRICTION ON DRUG USE IN WEST VIRGINIA
Optometry	Southern College of Optometry	Total = 204 Lecture = 156 hours (Ocular & Systemic) Lab = 48 hours Plus 696 hours Clinical use of FDA Classified Drugs. Plus 180 hours of Elective Seminars attended by 80% of students.	Catalog of Southern College of Optometry 1979-80	Topically applied Ophthalmic Drugs as permitted in Enrolled H.B. 1005 March 1976
Dentistry	University of Tennessee Center for Health Sciences/ Memphis	Total = 70 hours Lecture = 40 hours Lab = 30 hours Plus Clinical use of drugs	General Catalog The University of Tennessee Center for Health Sciences/ Memphis 1978-79	NONE
Medicine	University of Tennessee Medical Units/ Memphis	Total = 187 hours Lecture = 88 hours Lab = 99 hours Plus Clinical use of drugs for 17 months *Clinical use of ocular drugs probably less than 25 of other drugs since Ophthalmology represents only 1.1% of total curriculum	General Catalog The University of Tennessee Medical Units/ Memphis 1973-74	NONE
Podiatry	Pennsylvania College of Podiatric Medicine	Total = 176 hours	Pennsylvania College of Podiatric Medicine 1977-79	NONE
Osteopathy	Philadelphia College of Osteopathic Medicine	Total = 156	Bulletin of Philadelphia College of Osteopathic Medicine 1978-79	NONE



COUNTIES (SHADED)
SERVED BY
32 BOARD CERTIFIED OPHTHALMOLOGISTS



COUNTIES (SHADED)
SERVED BY
212 OPTOMETRISTS
CERTIFIED UNDER H.B. 1005

POSITION PAPER/Department of Health & Social Services

POSITION PAPER

SENATE BILL NO. 75
(Companion to House Bill No. 79)

"An Act relating to the practice of optometry."

This bill would permit the use of selected drugs including topical anesthetics, mydriatics, cycloplegics and miotics by optometrists and as such would delete from the definition of optometry the restriction against the use of drugs. All eight of these are drugs which are instilled directly into the eye. Mydriatics are drugs which cause the pupil to open widely while miotics cause the pupil to close down. Cycloplegics cause temporary paralysis of the muscles which control the shape of the lens.

Approximately 31 states now allow optometrists to use diagnostic topical drugs, either through specific enabling legislation or through the lack of specific prohibition. The issue of use of such drugs by optometrists has been controversial and in recent years certain states have given permission while it has been denied in other states. Those in favor of the use of drugs by optometrists argue that optometric services are more widely distributed than ophthalmologic services and that the optometrist serves as an entry point for primary eye care. The use of diagnostic drugs is said to expand the ability of the optometrist to recongize eye abnormalities and to increase medical referral for diagnosis and treatment. The optometric group also states that the drugs which are proposed rarely have adverse effects.

On the other hand, the medical group argues that the use of drugs would not materially improve the capacity of optometrists to recognize abnormalities. Optometrists are not expected to diagnose diseases of the eye, and if a departure from normal is noted, the patient is expected to be referred to a physician for diagnosis. If empowered to use diagnostic drugs, the concern on the part of the medical community is that the optometrists would be making diagnostic judgments which the physicians do not believe them qualified to make. Moreover, the medical community notes that adverse reactions, while admittedly rare for certain of the drugs, can have extremely serious consequences when they do occur. For example, they cite a higher rate of predisposition to a certain type of glaucoma in Alaska Natives and the possibility of precipitating an attack through use of mydriatics.

In some states which have permitted the use of diagnostic drugs, the permissive legislation has contained certain limitations, none of which appear in the current draft of the Alaska bill. For example, Rhode Island permits the use of mydriatics, miotics and topical anesthetics while Maine permits only the use of topical anesthetics and mydriatics. A bill which may still be under consideration in the Ohio legislature specifically prohibits use of pilocarpine (a drug which constricts the pupil), atropine and homatropine (drugs which dilate the pupil and temporarily paralyze accommodation of the lens) and 10% phenylephrine (a strong mydriatic). In Oregon, the Board of Optometry

is empowered to designate the diagnostic pharmaceutical agents for topical use, but provides that the designation shall be with the advice and guidance of the Board of Medical Examiners for the State of Oregon.

Some states define the type of training in pharmacology which would be required before an optometrist would be permitted to use diagnostic drugs. For example, Pennsylvania requires that the course given by an institution be accredited by a regional or professional accreditation organization recognized or approved by the Council on Postsecondary Accreditation or the United States Office of Education.

If the Legislature chooses to authorize use of certain drugs by optometrists, the Department of Health and Social Services suggests that definitions and restrictions similar to those in use in other states may be advisable, and that the professional opinion of the medical and optometric communities should be sought to insure the health and safety of the general public.

Approved by: _____
Helen D. Beirne
Commissioner

Date: March 20, 1980

FISCAL NOTE

I. REQUEST
Bill/Resolution No. HB No. 79, SB No. 75
Title "An Act relating to optometry."
Requested by Commissioner's Office Date 3/18/80

II. FISCAL DETAIL
Agency Affected Department of Health and Social Services
Program Category Affected Health/Division of Public Health
BRU, Program, or Subprogram(s) Affected
(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

		FY 80	FY 81	FY 82	FY 83	FY 84	FY 85
100	PERSONAL SERVICES	0	0	0	0	0	0
200	TRAVEL	0	0	0	0	0	0
300	CONTRACTUAL	0	0	0	0	0	0
400	COMMODITIES	0	0	0	0	0	0
500	EQUIPMENT	0	0	0	0	0	0
600	LAND & STRUCTURES	0	0	0	0	0	0
700	GRANTS, CLAIMS, ETC.	0	0	0	0	0	0
	TOTAL	0	0	0	0	0	0

FUNDING (Thousands of Dollars)

GENERAL FUND	0	0	0	0	0	0
FEDERAL FUNDS	0	0	0	0	0	0
OTHER (Specify Fund Source)	0	0	0	0	0	0

POSITIONS

FULL TIME	0	0	0	0	0	0
PART TIME	0	0	0	0	0	0
TEMPORARY	0	0	0	0	0	0

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)

Prepared by: M. Deaver Date: 3/18/80
Division/Office: P.H. Admin. PH:
Department of Health & Social Services

33-001 (Rev. 12/79)
Modify by DHSS (11-28-79)

Approval DHSS Mgt. & Bdgt: Date: 3/20/80

Assuming the Department will fund five similar contracts on an annual basis, projected costs are as follows:

181,000 x 5 = $905,000
Adjusted for inflation, 10%/year x 2 years
Total program costs = $1,095,000

Administrative costs required by the Department are as follows:

Personnel Services			$94,300
Grants Administrator R 17		29,460	
Field Representative R 15		25,620	
PT Clerk Typist III		8,915	
PT Accounting Clerk III		10,010	
	Sub total	74,005	
	Benefits	20,311	
Travel			$16,000
Contract negotiation, monitoring and technical assistance			
Contractual			$22,300
Phones		5,000	
Rents		5,600	
Printing and Advertising		10,000	
Copier services		1,000	
Postage		600	
Repairs and Maintenance		10,000	
		22,300	
Commodities			$ 1,500
Equipment			$ 3,800
1 typing desk		459.80	
1 typing chair		136.02	
2 executive desks		1,311.00	
3 executive swivel chairs		619.00	
1 correcting selectric typewriter		902.48	
1 5-drawer file cabinet		231.48	
1 bookcase		112.49	
		3,772.29	

Department staff, a Grants Administrator and a Project Field Representative, will be responsible for negotiating and executing contracts; monitoring and providing technical assistance; and providing statewide coordination.

(End Fiscal Note Analysis)

SECTIONAL ANALYSIS OF HOUSE BILL NO. 86

Section 1. Adds a new chapter to AS 08 (Business and Professions) entitled "Veterinary Practice Act." Each section of this new chapter will be analyzed separately.

ARTICLE 1. BOARD OF VETERINARY MEDICINE

Sec. 08.95.010. CREATION AND MEMBERSHIP OF BOARD. Creates a Board of Veterinary Medicine, composed of four veterinarian members and one public member, to replace the current Board of Veterinary Examiners.

Sec. 08.95.030. SOURCE OF APPOINTMENTS FOR VETERINARIAN MEMBERS. Directs the governor to appoint each veterinarian member of the board from a list of at least three candidates recommended by the Alaska State Veterinary Medical Association.

Sec. 08.95.040. BOARD MEETINGS. Requires the board to hold a regular annual meeting and permits the chairman to call other meetings.

Sec. 08.95.050. OFFICERS. Directs the board to elect a chairman, subject to the governor's approval, and a secretary to serve one-year terms.

Sec. 08.95.060. REPORT REQUIRED. Requires the chairman and secretary to submit a report on the actions of the board to the Department of Commerce and Economic Development at the end of each examining period.

Sec. 08.95.070. MEETING OF NATIONAL VETERINARY STATE BOARD OF EXAMINERS. Authorizes the board to send one of its members to the annual meeting of the National Veterinary State Board of Examiners at state expense.

Sec. 08.95.080. POWERS AND DUTIES OF THE BOARD. Directs the board to regulate the "practice of veterinary medicine" (as defined) in accordance with the Act, to adopt regulations implementing the Act, and to authorize the issuance, renewal, or reinstatement of a license, permit, or certificate of registration to any person entitled to it. Authorizes the board to adopt regulations interpreting, clarifying, and making specific the provisions of the Act. Directs that the powers granted to the board under the Act be liberally construed.

ARTICLE 2. LICENSING.

Sec. 08.95.200. LICENSE REQUIRED. Prohibits anyone but a licensed veterinarian from practicing veterinary medicine except

(1) a veterinarian licensed in another state consulting with a licensed veterinarian in this state;

(2) the holder of a temporary permit, acting under the direction of a licensed veterinarian, who has applied to take the veterinarian's examination;
(3) a veterinarian licensed in another state who holds a temporary permit to conduct the practice of a licensed veterinarian during his absence;
(4) a person performing tasks within his competence, other than diagnosis, prescription, or initiation of treatment, under the "general supervision" (as defined) of a licensed veterinarian and in accordance with board regulations;
(5) a person performing artificial insemination of animals, who holds a permit to do so;
(6) a person giving advice on livestock management or engaging in accepted livestock management practices in accordance with board regulations;
(7) a faculty member of a "veterinary school" (as defined) engaging in his official duties;
(8) a person lecturing, giving instructions, or performing demonstrations with the approval of the board, at a veterinary school, or in connection with a continuing education course or seminar sponsored by a veterinary school or approved by the board;
(9) a veterinary student performing duties or actions assigned by his instructors;
(10) a veterinary student acting under the general supervision of a licensed veterinarian;
(11) a person engaging in scientific research that reasonably requires experiments with animals;
(12) a person gratuitously giving emergency aid to animals;
(13) the owner of an animal and his regular, full-time employees caring for and treating the animal, unless ownership of the animal was transferred to avoid application of the Act or the employees were hired primarily to treat animals;
(14) a merchant or manufacturer selling at his regular place of business products used in the prevention or treatment of animal diseases;
(15) a person selling or applying a pesticide or herbicide;
(16) a governmental employee engaging in his official duties.

Sec. 08.95.220. QUALIFICATION FOR EXAMINATION. Sets out the qualifications for taking an examination to become a licensed veterinarian. These qualifications are substantially the same as under existing law except for a new provision allowing a person who was not graduated from a veterinary school to take the examination if he has passed the Education Commission for Foreign Veterinary Graduates examination in veterinary medicine.

Sec. 08.95.230. EXAMINATION FEE. Directs the Department of Commerce and Economic Development to establish a fee to accompany applications for licensing as a veterinarian, refundable if the applicant is found unqualified to take the examination.

Sec. 08.95.240. CONTENT OF EXAMINATION. Requires that the examination be in two parts, a national examination selected by the board and a state examination prepared by the board. Requires the examination to cover subjects and techniques commonly taught in veterinary schools and permits the board to require a practical demonstration of skills.

Sec. 08.95.250. EXEMPTION FROM NATIONAL EXAMINATION. Permits the board to exempt an applicant from the national examination who meets specified criteria involving years of practice as a veterinarian in another state and recent passing of a national examination.

Sec. 08.95.260. REEXAMINATION. Allows a person failing an examination to take a subsequent examination upon payment of the examination fee.

Sec. 08.95.265. INITIAL LICENSE AND RENEWAL FEES. Directs the Department of Commerce and Economic Development to establish a fee for issuance of a veterinarian's license and a fee for biennial renewal.

Sec. 08.95.270. TEMPORARY PERMIT TO PRACTICE WITH LICENSED VETERINARIAN. Permits a qualified applicant for a veterinarian's license who has not failed a veterinarian's examination to obtain a temporary permit to practice veterinary medicine under the direction of a licensed veterinarian, pending examination. Comment. The permit holder is required to be under the "direction" of a licensed veterinarian rather than his "general supervision." "General supervision" is defined in the Act but "direction" is not. The difference between these terms is not clear but might be made so by board regulation.

Sec. 08.95.280. TEMPORARY PERMIT TO TAKE OVER PRACTICE OF LICENSED VETERINARIAN. Allows a veterinarian licensed in another state, who would be qualified to take the veterinarian's examination in this state, to obtain a temporary permit, for no longer than 60 days, to conduct the practice of a licensed veterinarian during his absence. Directs the Department of Commerce and Economic Development to establish a fee for these temporary permits and any renewals that may be permitted by the board.

Sec. 08.95.290. REINSTATEMENT OF LAPSED LICENSE. Allows a veterinarian whose license has lapsed to have it reinstated without examination within three years of its lapsing.

ARTICLE 3. REGULATION OF PRACTICE OF VETERINARY MEDICINE.

Sec. 08.95.400. DISCIPLINE OF LICENSED VETERINARIANS. Authorizes the board to revoke or suspend the license of a licensed veterinarian or otherwise discipline a licensed veterinarian for specified reasons, including unprofessional conduct as defined in board regulations.

Sec. 08.95.410. REVOCATION AND SUSPENSION OF TEMPORARY PERMITS. Authorizes the board to revoke or suspend a temporary permit for a violation of the Act or a regulation adopted under it, whether committed by the permit holder or the licensed veterinarian with whom he is associated.

Sec. 08.95.420. ARTIFICIAL INSEMINATION OF ANIMALS. Directs the board to adopt regulations providing for issuance of permits to perform artificial insemination of animals. Authorizes the board to revoke or suspend such a permit for a violation of the Act or a regulation adopted under it.

Sec. 08.95.430. REGISTRATION OF VETERINARY TECHNICIANS. Directs the board to adopt regulations providing for the registration of "veterinary technicians" (as defined). Directs that these regulations require, for registration, the completion of college programs approved by the board, but permits the board to register veterinary technicians before July 1, 1981 who have been graduated from high school and completed two years of satisfactory work experience in lieu of college programs. Sets a fee of $25 for registration and biennial renewal. Authorizes the board to revoke or suspend a certificate of registration for a violation of the Act or a regulation adopted under it. Emphasizes that a veterinary technician must be under the general supervision of a licensed veterinarian. Provides that this section does not require a veterinary technician to become registered, but authorizes the board to impose such a requirement by regulation.

Sec. 08.95.440. STANDARDS OF PRACTICE. Authorizes the board to establish standards of practice, including continuing education requirements, for (1) licensed veterinarians and holders of temporary permits; (2) holders of permits to perform artificial insemination of animals; (3) persons giving advice on livestock management or engaging in livestock management; and (4) persons acting under the general supervision of licensed veterinarians. Authorizes the board to

(1) classify persons acting under the general supervision of licensed veterinarians; (2) limit or qualify the duties which may be performed by members of a class; (3) permit or require members of a class to be registered or licensed; (4) establish qualifications for registration or licensing of members of a class; (5) provide for renewal, revocation, and suspension of certificates or licenses of members of a class; and (6) set fees for issuing and renewing certificates or licenses of members of a class.

Sec. 08.95.460. RESPONSIBILITY OF LICENSED VETERINARIAN. Requires employees of a licensed veterinarian to be under his general supervision. Makes the licensed veterinarian responsible for the performance of any person required to be under his direction or general supervision.

ARTICLE 4. ENFORCEMENT.

Sec. 08.95.600. UNLAWFUL PRACTICE OF VETERINARY MEDICINE. Makes the unlawful practice of veterinary medicine a misdemeanor punishable by a fine of not less than $50 or more than $500 or imprisonment for not more than 90 days. Makes each day of unlawful practice a separate offense.

Sec. 08.95.610. NO RIGHT TO COMPENSATION FOR SERVICES UNLAWFULLY RENDERED. Provides that a person is not entitled to compensation for services constituting the practice of veterinary medicine that are unlawfully rendered.

Sec. 08.95.620. INJUNCTION. Authorizes the board to seek an injunction to restrain a person from practicing veterinary medicine unlawfully.

Sec. 08.95.630. REMEDIES CUMULATIVE. Declares that remedies for enforcing the Act are cumulative and independent.

Sec. 08.95.640. INVESTIGATIONS. Authorizes the board to conduct investigations to determine whether violations of the Act or regulations adopted under it have occurred.

ARTICLE 5. ABANDONMENT OF ANIMALS.

Sec. 08.95.800. Authorizes a licensed veterinarian or temporary permit holder to dispose of an animal, by sale or otherwise, left in his custody and abandoned. Provides that abandonment is considered to have occurred if the animal is unclaimed within 10 days after notice is sent to the owner or his agent.

ARTICLE 6. GENERAL PROVISIONS.

Sec. 08.95.900. DEFINITIONS. Defines principal terms used in the Act, including "animal," "general supervision," "practice of veterinary medicine," and "veterinary technician."

Sec. 08.95.910. SHORT TITLE. Designates AS 08.95 as the Veterinary Practices Act.

Section 2. Makes the Board of Veterinary Medicine subject to the centralized licensing law.

Section 3. Directs the Department of Commerce and Economic Development to provide investigative services to the Board of Veterinary Medicine to assist it in matters of professional discipline.

Section 4. Gives the Board of Veterinary Medicine a termination date of June 30, 1985 for purposes of the sunset law.

Section 5. Reenacts a portion of the sunset law as a new section in the Alaska Statutes. This reenactment has no substantive effect. It is necessitated by the inclusion of the Board of Veterinary Medicine in the sunset law.

Section 6. Provides for a lien on an animal for veterinary services.

Section 7. Makes the Board of Veterinary Medicine subject to the administrative adjudication provisions of the Administrative Procedure Act.

Section 8. Repeals the current laws relating to the practice of veterinary medicine and a portion of the sunset law. The repeal of a portion of the sunset law is of no effect, other than to eliminate a reference to the Board of Veterinary Examiners, because its reenactment as a new section is provided for in Sec. 5.

Section 9. Provides for the validity of a temporary license to practice veterinary medicine issued under law that is being repealed.

Section 10. Provides for the validity of a license to practice veterinary medicine issued under law that is being repealed.

Section 11. Authorizes the reinstatement of a lapsed license to practice veterinary medicine, within five years of its lapsing, which was issued under law that is being repealed.

Section 12. Directs that the members of the Board of Veterinary Examiners automatically become veterinarian members of the Board of Veterinary Medicine and serve until their terms on the former board would have expired.

Section 13. Directs that the title "Board of Veterinary Examiners" in the laws of the state be read as "Board of Veterinary Medicine." Provides for continuation of proceedings begun, orders issued, and regulations adopted under law that is being repealed. Directs that property of the Board of Veterinary Examiners be transferred to the Board of Veterinary Medicine.

Section 14. Makes this Act effective July 1, 1979.

BILL ANALYSIS

ASSIGNMENT DATE_____

UNASSIGNED_____

DEPARTMENT	SPONSOR (PRINCIPAL)	BILL NO.
Commerce & Economic Development	Miles, Martin, Barnes, Buchholdt, Cotten, Phillips & Hayes	HB 86

DEPARTMENT POSITION

Opposed as noted below.

DIVISION DIRECTOR	DATE	COMMISSIONER	DATE
Occupational Licensing	February 2, 1979		

GOVERNOR'S OFFICE USE

☐ POSITION NOTED ☐ POSITION APPROVED ☐ POSITION DISAPPROVED

BY: DATE:

SUMMARY

(1) RELATED BILLS (SIMILAR OR CONFLICTING)
(2) OTHER AGENCIES AFFECTED BY BILL

(2) a. ORGANIZATIONAL SUPPORT FOR BILL	(2) b. ORGANIZATIONAL OPPOSITION TO BILL
Alaska Veterinary Society	Unknown

(3) PROGRAM EFFECTS OF BILL

Some major changes to existing practice act (AS 08.98) and increased costs in implementation.

(4) FISCAL IMPACT: ☐ NONE ☒ FISCAL ANALYSIS ATTACHED

(5) AMENDMENTS PROPOSED:

(6) COMMENTS:

The Division of Occupational Licensing opposes Secs. 1 through 14 of HB 86, "An Act relating to the practice of veterinary medicine; and providing for an effective date." Provisions in the Act for additional members, annual National meeting attendance, specialty permits (Sec. 420), and registration of technicians would entail substantial additional costs for regulation and administrative overhead. Many other aspects of the proposed Act are objectionable from the standpoint of standard statutory authority. These include, but are not limited to, (1) a requirement that board members be appointed only from a list submitted by the State association, (2) limits on voting power of public members,

(See reverse)

(3) a requirement that those applying for temporary permits may work only under supervision of a licensee, (4) that the board itself may conduct investigations, and (5) inappropriate revisions to AS 08.03 (Termination, Continuation and Reestablishment of Regulatory Boards).

We believe that the present practice act is workable but needs amendments. Appropriate recommendations have been made as a result of the Sunset review process that should be considered in increasing board efficiency. We do not believe, however, that the proposed new act would accomplish this nor would it be in the best overall interests of the public.

THE LEGISLATURE OF THE STATE OF ALASKA
ELEVENTH LEGISLATURE

FISCAL NOTE

I. REQUEST

Bill/Resolution No. HB 86

Title An act relating to the practice of veterinary medicine; and providing for an effective date

Requested by Miles, Martin, Barnes, Buchholdt, Cotten, Phillips and Hayes

Date 2/15/79

II. FISCAL DETAIL

Agency Affected Commerce and Economic Development

Program Category Affected Public Protection

Budget Request Unit(s) Affected Regulation and Licensing of Professions

EXPENDITURES (Thousands of Dollars)

	FY 79	FY 80	FY 81	FY 82	FY 83	FY 84
100 PERSONAL SERVICES	-0-	-0-	-0-	-0-	-0-	-0-
200 TRAVEL	-0-	1.8	1.9	2.0	2.1	2.2
300 CONTRACTUAL	-0-	3.0	3.1	3.4	3.6	3.8
400 COMMODITIES	-0-	-0-	-0-	-0-	-0-	-0-
500 EQUIPMENT	-0-	-0-	-0-	-0-	-0-	-0-
600 LAND & STRUCTURES	-0-	-0-	-0-	-0-	-0-	-0-
700 GRANTS, CLAIMS, ETC.	-0-	-0-	-0-	-0-	-0-	-0-
TOTAL	-0-	4.8	5.0	5.4	5.7	6.0

FUNDING (Thousands of Dollars)

GENERAL FUND	-0-	4.8	5.0	5.4	5.7	6.0
FEDERAL FUNDS						
OTHER (Specify)						

POSITIONS

FULL TIME	-0-	-0-	-0-	-0-	-0-	-0-
PART TIME	-0-	-0-	-0-	-0-	-0-	-0-
TEMPORARY	-0-	-0-	-0-	-0-	-0-	-0-

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

FY 80 travel includes funding for two additional board members transportation and per diem to attend presently budgeted board meetings of two a year. There will be one person making one out-of state trip per year to national organization. Contractual expense includes costs for a hearing per year. This includes costs for a hearing office and court reporters preparation, recording, and reporting of the hearings before and after organization. Inflation is computer @ 6% per year. A detailed analysis of expenditures is attached.

IV. DATE 2/15/79 PREPARED BY Don Bostak

AGENCY Occupational Licensing

PHONE 465-2534

Original: Legislative Finance

cc: Budget and Management

Prime Sponsor (First Legislator Named)

Travel

1 trip	Out-of-State Trans.	550
6 days	Out-of-State Per Diem	300
		850

Boards, Commissions and Legislators

2 trips for 2 additional members	In State Trans.	478
8 days	In State Per Diem	440
		918

Total Travel FY 80 1,768

Contractual

Cost for 8 hour hearing. This includes the cost for a hearing officer and court reporter's before and after preparation, recording, and reporting of the hearings activities. 3,000

Total Contractual FY 80 3,000

February 10,1979

Dear Sally,

A pleasure to hear from you! Thanks for sending along the Veterinary Prctice Act. I have been wondering where it stood these days. I reviewed it and discussed it at length with two Veterinarians, and have one suggestion and a question. The Vets agreed with my suggestion, but declined to write and represent themselves...sigh.

The suggestion: Page 3, Art. 2, Sec. 08.95.200 ...(15) now reads:

> "No person may practice veterinary medicine in this state who is not a licensed veterinarian except...(15) a person selling or applying a pesticide or herbicide."

I thought seriously of dropping out of school to start selling pesticides and doing sprays on the side! I think the intent is better reflected in this wording from the original draft of the act:

> "No person may practice veterinary medicine in this state who is not a licensed veterinarian. THIS ACT SHALL NOT BE CONTRUED TO PROHIBIT: ... (15) a person selling..."

My question concerns the "one public member" of the board (page 1,Art. 1, Sec.08.95.010), and also page 2, Sec.08.95.030. The bill states that the governor shall appoint each veterinarian member, etc. It does not, at this time, say who appoints nor who nominates the public member. I assume the governor appoints, but should it be specified? Hopefully the appointee would have some relevant experience and interest in the profession. I wouldn't object to the position myself!

Take care,

Tom

Tom & Joan Welsh
P.O. Box 81067
Fairbanks, Alaska
99708

HB

82

Name	Address	Organization	Bill No.
Robert J. Erwin	DHSS - Director	DH&SS	321 & 22
John R. Berg	DH&SS - Div. of Social Services	DH&SS	HB 96
Harold Spalding DOH	3504 Howard Rd Anch	Self	HB 86
DON HOSTAR	OCCUPATIONAL LICENSING		HB 86 - HB 96

POSITION PAPER/Department of Health and Social Services

POSITION PAPER
ON
HOUSE BILL NO. 22

"An Act relating to the donation of blood by those who have reached the age of 17 years."

This bill has two medical considerations:

1. Is there a shortage of blood donors in Alaska that could be relieved by allowing 17 year old persons to donate without permission of their parents or guardians? Hospital blood banks could answer this question based on their experience. The Department of Health and Social Services could investigate this issue if it is desired by the Legislature.

2. Is a 17 year old a suitable blood donor?

   Yes, at this age an adolescent can safely donate blood under the same guidelines as an adult.

This bill also has a significant sociologic consideration:

Why should the age of majority be lowered for this particular reason?

Until there has been demonstration of a compelling reason under the first medical consideration or the sociologic consideration, the Department of Health and Social Services is neutral towards this bill.

Recommended by:

Robert I. Fraser, M.D., Director 2/14/79

Approved by:

Helen D. Beirne 2/16/79

Helen D. Beirne, Commissioner
Dept. of Health & Social Services

ALASKA STATE LEGISLATURE - HOUSE OF REPRESENTATIVES

IN SESSION:

POUCH V
JUNEAU, ALASKA 99811
TELEPHONE: (907) 465-4948

SUITE 1, 1020 "I" STREET
ANCHORAGE, ALASKA 99501
TELEPHONE: (907) 277-6219

REP. M. F. "MIKE" BEIRNE
DISTRICT 7, ANCHORAGE

MEMBER OF:
FIFTH STATE LEGISLATURE
NINTH STATE LEGISLATURE
TENTH STATE LEGISLATURE
ELEVENTH STATE LEGISLATURE

COMMITTEES:
HEALTH
EDUCATION AND
SOCIAL SERVICES
COMMITTEE FOR REVIEW
OF REGULATIONS

March 13, 1979

The Honorable Thelma Buchholdt
Chairman, House Health, Education
and Social Services Committee
Pouch V, Mail Stop 3100
Juneau, AK 99811

Re: House Bill 22
Donation of Blood

Dear Representative Buchholdt:

This letter is in support of House Bill 22, which would permit 17 year olds to become blood donors without the need of obtaining specific written permission from their parents.

Many states have such legislation at this time and I am sure that Alaska blood banks and patients would benefit considerably by having this statutory privilege.

This identical bill was submitted to the previous Legislature, passed through the House and was approved by the Senate HESS Committee and was in the Senate Rules Committee at the time of adjournment. So, the bill has been considered before by the House HESS Committee and was approved.

The purpose of the bill is to permit 17 year olds to donate without the specific written permission of the parents. This substantially expands the number of young, healthy donors available for blood donations. Presently, a 17 year old may be inspired to donate blood but the simple complication of getting the

parents' written consent requires an extra trip to the blood bank and most of the donors then do not return.

Physically, there is no medical reason why a 17 year old is not physically able to donate a unit of blood. Each donor completes a medical questionnaire and takes a blood test and other medical tests prior to being approved as a donor.

The present system tends to delay and discourage the young people from joining in this community activity. All blood banks in Alaska are nonprofit operations. Permitting the young people to participate in this part of society that they can so well do builds in them a sense of belonging to the community, a community responsibility consciousness, and is in a sense a Junior Achievement program.

I can think of no reason why this privilege should not be extended to 17 year olds. Further, the blood banks would find this very helpful to them, and I have never heard any opposition to this program.

I hope that the Committee will again favorably consider this legislation.

Sincerely,

Mike Beirne/js

Dr. Mike Beirne
State Representative

MB:js

HB

86

THE ALASKA STATE VETERINARY MEDICAL ASSOCIATION

BOX 631 • ANCHORAGE, ALASKA 99501

February 7, 1979

The Honorable Thelma Buchholdt
Pouch V
Juneau, Alaska 99811

Dear Ms. Buchholdt:

The Alaska State Veterinary Medical Association has written a new practice act, known as House Bill No. 86, that will be introduced this legislative session. The purpose of my letter is to give you an understanding of the bill.

We now have a veterinary practice act which was enacted in 1963 and has had no major revisions since then. We chose to write a new act rather than revise the old because in nearly all parts of the act changes have been proposed to clarify the intent. Writing a new act seemed the easiest way to accomplish this.

We have compared the content of the old act with the proposed act. In nearly all cases, the proposed act and the old act handle regulation and licensing of the profession in the same way. Notable exceptions are as follows:

The size of the Board of Veterinary Examiners was increased from three to five members. This was done because the present board size of three members often proved inadequate due to the absence of members for various reasons.

A public member was provided as one of the members of the Board to encourage representation of the public interest in regulation of the profession.

A section was included which defines the legal responsibilities of aides and trained technicians working under the direction of a veterinarian. The present act makes no mention of persons employed by veterinarians leaving it legally open to question as to whether or to what extent a veterinarian may use these people to aid in treatment of animals.

The new act provides for the examination and registration of Animal Health Technicians. Technicians are a relatively new profession employed by veterinarians to do a wide variety of technical tasks. Many technicians are presently employed in Alaska; however, there is no provision made for them in the present statutes.

Registration is necessary for up-to-date, immediate reference of all veterinary technicians engaged in animal care in the state with reference to qualifications, addresses, license status, etc. This provision allows the Board to adopt appropriate standards for those engaged in animal technology and the issuance of permits to such persons found competent.

Temporary licensing has been changed from the existing uncontrolled situation giving temporary licenses to all applicants who qualify for a license. Under the present law a person who has never passed a national or state examination can obtain a temporary unrestricted license to practice.

The new act proposes that two classes of temporary licenses be issued:

One type would be issued to any technician qualified to take the examination provided he work with a practitioner licensed in the state.

A second type would be issued for a 60-day period to a veterinarian who is licensed in another state. The license would allow the licensee to take over the practice of a veterinarian who is absent.

Examination of licensees has been changed to require a state exam and a national exam for every applicant unless the applicant has either (1) passed a National Board Examination in the last three years, or, (2) has been an active practicing veterinarian in another state. Persons qualifying would be required to to take only the state exam.

Presently, veterinarians who have "practiced" for five of the last seven years in another state may receive a license without exam. The problem with this is that the definition of "Veterinary Practice" is so broad that people involved with activities not commonly considered to be the active practice of veterinary medicine would qualify for license. Examples of this could include meat inspectors, animal consultants, and certain types of researchers. The new act would require all applicants to take the state exam.

The new act provides a legal means by which to cope with the problem of animals left in the care of veterinarians and later abandoned. This is a frequent problem that is not dealt with in the present act.

We would appreciate your support on this bill.

Respectfully,

Jon Thomas

Jon Thomas
President, ASVMA

Sec. 08.03.010. Termination, continuation and reestablishment of regulatory boards. (a) Boards listed in this subsection have a termination date of June 30, 1979:

(1) Board of Chiropractic Examiners (AS 08.20.010);
(2) Board of Dental Examiners (AS 08.36.010);
(3) State Medical Board (AS 08.64.010);
(4) Board of Nursing (AS 08.68.010);
(5) Board of Dispensing Opticians (AS 08.71.010);
(6) Board of Examiners in Optometry (AS 08.72.010);
(7) Board of Pharmacy (AS 08.80.010);
(8) Board of Veterinary Examiners (AS 08.98.010);
(9) Board of Psychologist and Psychological Associate Examiners (AS 08.86.010);
(10) Board of Nursing Home Administrators (AS 08.70.010);
(11) Physical Therapy Board (AS 08.84.010).

(b) Boards listed in this subsection have a termination date of June 30, 1980:

(1) Board of Public Accountancy (AS 08.04.010);
(2) Board of Barber Examiners (AS 08.12.010);
(3) Collection Agency Board (AS 08.24.011);
(4) Board of Hairdressing and Beauty Culture Examiners (AS 08.28.010);
(5) Board of Electrical Examiners (AS 08.40.010);
(6) State Board of Registration for Architects, Engineers and Land Surveyors (AS 08.48.011);
(7) Guide Licensing and Control Board (AS 08.54.010);
(8) Board of Marine Pilots (AS 08.62.010);
(9) Real Estate Commission (AS 08.88.011);
(10) Board of Welding Examiners (AS 08.99.010);
(11) Board of Governors of the Alaska Bar Association (AS 08.08.040).

(c) Upon termination, each board listed in (a) and (b) of this section shall continue in existence until June 30 of the next succeeding year for the purpose of concluding its affairs. During this period, termination does not reduce or otherwise limit the powers or authority of each board. One year after the date of termination, a board not continued shall cease all activities.

(d) The termination, dissolution, continuation or reestablishment of a regulatory board shall be governed by the legislative oversight procedures of AS 44.66.050.

(e) A board scheduled for termination under this chapter may be continued or reestablished by the legislature for a period not to exceed four years. (§ 2 ch 149 SLA 1977)

Article
1. Board of Pu
2. Certified Pu
3. Public Acco
4. Regulation
5. Unlawful A
6. Miscellaneo
7. General Pro

Section
10. Creation o
20. Appointme board
30. Removal membe
40. Term of o

Sec. 08.0 accountanc Accountan

Am. Jur., A 10 Am. Jur., §§ 1 to 8.
Failure of as affecting contract, 4 Al 1226; 118 AL
Licensing accountants, ALR 1095.

Sec. 08. consists o shall be a shall be c members i shall be pu appointed the laws appointed (§ 2(2) ch

Effect of amendment for "five m deleted "a ci preceding sentence, d

Name	Organization	Address	Bill No.
Harold R. Spalding DVM	Alaska State Veterinary Medical Assoc	3504 Spenard Rd 274-5689 Anch-Ak 99503	HB-86
DAVID HOWE	Bd OF VETERINARY EXAM.	2659 BONIFACE PKWY 351-1561	HB-86
SAM. TUOMI DVM	South Central Vet. Med. Assoc.	2036 E. Northern Lights Anchorage 99504 274-5623	HB86
CLIFF LOBAUGH	Bd OF VET. EXAM.	RR6 BOX 3552 789-7551 JUNEAU 99803 789-9210	HB 86
DON HOSTAK	DIV OF OCCUPATIONAL LICENSING	JUNEAU 465-2534	HB 86

September 29, 1978

Jon Thomas, DVM
2639 Boniface Parkway
Anchorage, Alaska 99504

Dear Dr. Thomas,

Thank you for your telephone call of September 28th raising the question of bringing A.I. technicians under the Veterinary Practice Act. This question was raised in 1973 and I will attempt reaffirm my position at this time.

I would emphasize first that the A. I. technician is not practicing veterinary medicine, but is providing a breeding service whereby livestock owners in Alaska can use the technology of semen collection, preservation, and use and the advancements in animal genetics available to the livestock industry throughout our sister states in the lower 48. The A. I. technician is not trained or qualified to provide veterinary services and is in fact legally and ethically constrained from doing so. If we bring the A. I. technician under regulation by the veterinary medical profession, do we in fact reduce the stature of that profession to the level of the A. I. technician or do we attempt to raise the A. I. technician to the level of a veterinary practioner?

It is a temptation to emphasize the fact that technicians for the Matanuska Valley Breeders Association in cooperation with the University of Alaska are breeding cattle in very few major herds in addition to the University herd. However, this is irrelevant. If the public good requires regulation of the A. I. industry by the veterinary medical profession, that protection should be provided to all individuals irrespective of the total number involved.

At this time I know of no instance in the State of Alaska where semen is being collected and processed for use in artificial insemination. Therefore, by definition, all of the semen used in Alaska has been drawn, processed, and shipped from individuals and/or semen producing organizations in the lower 48. These organizations are expected to operate under the minimum standards of the National Association of Animal Breeders as well as state and federal laws where applicable. I believe that it might be of value to establish regulations relative to the importation of semen to insure that semen entering the State of Alaska would originate from responsible individuals and/or

organizations. This would limit the entry of disease organisms and/or genetic defects into the state of Alaska via frozen semen.

If you bring the A. I. technician under the Veterinary Practices Act, how would you propose to examine and license A. I. technicians? The use of a written examination exclusively is of very limited value because successful A. I. depends upon the acquisition and development of skills which can be obtained only through hands on or "arms in" experience. This is difficult to assess other than through the examination of field data. The direct contact of the A. I. technician with the animal to be inseminated may be of limited importance relative to other considerations. Disregarding the possibility of physical damage or the introduction of disease organisms, the most obvious manifestation of incompetence is failure to achieve conception. Areas of equal importance are the maintenance of an adequate semen inventory under satisfactory conditions of storage, the proper removal of semen units and their handling prior to insemination, accuracy in semen selection and records maintained, and the motivation and knowledge to use currently available knowledge in population genetics and animal breeding. I submit that these areas fall within the domains of the A. I. industry and animal science programs in animal breeding at major universities, and not in the area of veterinary medical practices.

I do not mean to imply that the A. I. industry and its adherents would not benefit from codes of ethics and performance which are presently being developed and applied within the industry itself, but that the veterinary medical profession may be mistaken in bringing that industry within the practice of veterinary medicine which veterinary control and regulation implies. I believes that we will make maximum progress in serving the livestock industry if the veterinary medical profession and professional and para-professional animal scientists work together in mutual respect and consideration.

Sincerely yours,

ARTHUR L. BRUNDAGE, Ph.D.
Professor of Animal Science
Member, American Registry of
Certified Animal Scientists

ALB/bjf

cc: Fred Husby

UNIVERSITY OF ALASKA, FAIRBANKS
Fairbanks, Alaska 99701

School of Agriculture and Land Resources Management
Agricultural Experiment Station

October 19, 1978

Dr. Jon Thomas, D.V.M.
2639 Boniface Parkway
Anchorage, Alaska 99504

Dear Dr. Thomas:

Thank you for informing me of the possible legislative action concerning the regulation and issuance of permits to artificial insemination operators and technicians. At the present time, I do not believe the State of Alaska nor the level of livestock production within the state are ready for a possible restrictive regulation.

I am not familiar with similar regulations in other states, but the National Association of Animal Breeders (PO Box 1033, Columbia Missouri 65201) has established and published codes for animal identification, health and other rules governing the use of artificial insemination. This association was organized in 1946 and the members are former owned cooperatives and private corporations and the members account for approximately 95 percent of all semen used in the United States. The health code was set forth by an American Veterinary Medical Association committee. In addition, semen producing businesses must obtain a permit from the Purebred Dairy Cattle Association to keep accurate semen inventories before offspring from their bulls can be registered. Certified Semen Services, Inc., was organized in 1976 as a subsidiary of the National Association of Animal Breeders and has a primary objective to audit procedures for bull and semen identification used in A.I. and for the issuance of properly completed records each time a semen sale is made.

The regulations and codes set forth by the above organizations serve as guidelines for the breeding associations to maintain competence and standards of production for the animal breeding industry. However, honesty and accuracy is primarily a responsibility of the individual breeding organization.

An A.I. technician is an individual who is authorized to issue breeding receipts or sales invoices in the name of the A.I. business with which he is employed or affiliated and is only responsible to that business. The A.I. business accepts certain responsibilities for the actions of its technicians. This individual represents a company in the field and it behooves the company to have technicians trained in both the physical aspects of insemination as well as a working knowledge of breeding records, sire selection and breed registration requirements. Therefore, if we consider the role of the national organizations in relation to the A.I. businesses and the competitive aspect of the industry, any additional state regulation may not be complementary to the self imposed standards of performance now in effect.

Within the State of Alaska, I know of only one A.I. operator that has been conducting business without formal training. This technician's lack of knowledge and ability to inseminate livestock has limited his business with herd owners. The other state A.I. operator, Matanuska Valley Breeder's Association, is affiliated with American Breeder's Service and has sponsered through the company a week long training school in 1974 and is currently scheduling another school the last week of October, 1978. When technician training sessions are not offered within this state, their technicians are sent to a school in the Northwest.

A regulation of the type under consideration would be difficult and costly for the state to administer. A valid test to certify technicians would have to include both proof of physical training required to inseminate livestock and knowledge of breed registration requirements, sire selection and record keeping. Would this imply that veterinarians who have had training in the physical aspects of insemination become conversant on breeding and selection programs similar to A.I. trained technicians? What criteria would be used for a waiver of an examination: a university course in artificial insemination, successful completion of a school sponsered by one of the A.I. companies or a degree in veterinary medicine? Would the permit be issued through the mail or would it require a costly trip to a central location to take a qualifying examination?

Although this letter may have posed more questions than answers, I hope that the information and personal thoughts will be of assistance to you and your committee. If I can be of further service, please contact me.

Sincerely,

Fredric M. Husby

Fredric M. Husby
Assistant Professor
Of Animal Science

FMH:ds

Berton A. Gore, D.V.M.
P. O. Box 666
Palmer, Alaska 99645
(907) 745-3219

Feb 12, 79

Dear Pat

I received your letter today regarding House Bill # 86. I concurr with your decision to oppose further regulation of Artificial insemination. Dr. Brundage and I both requested the Veterinary Assoc. ~~to~~ delete the A.I. Regulation, however, they chose otherwise. If the A.I. regulation is deleted ~~you may~~ would you consider ~~to~~ re evaluating # 86 on it remaining points? Thanks.

Sincerely,

Bert Gore

Name	Organization	Address & Phone #	VETERINARY MEDICINE BILL Bill No.
DON HOSTAK	D.V. OF OCCUPATIONAL LICENSING	JUNEAU ST. OFF. BLDG. 465-2534	HB86
Elaine Garnett	" " "		
REP PAT CARNEY		#465 3127	

TELEGRAM

RCA ALASKA COMMUNICATIONS, INC.
PHONE [illegible]-6442
JUNEAU, ALASKA 99802

02074 NL TDA PALMER ALASKA 56 02-14 0315P AST

PMS REP THELMA BUCHHOLT CHAIRMAN HEALTH EDUCATION AND SOCIAL SERVICES COMMITTEE

JUNEAU ALASKA

RE HB86 VETERINARY PRACTICES ACT.

THE NORTHLAND PIONEER GRANGE NBR 1 PROPOSES HB86 AS WRITTEN IT IS TO ALL ENCOMPASSING IT THREATENS THE ARTIFICIAL INSEMINATION PROGRAM OF ALASKAS STRUGGLING DAIRY INDUSTRY. VETERINARIANS COULD NOT SERVICE THE INDUSTRY ADEQUATELY INSEMINATORS ALREADY MUST BE NATIONALLY REGISTERED A.I. TECHNICIANS TO MAKE INSEMINATIONS VALID FOR REGISTRY.

LEGISLATIVE COMMITTEE NORTHLAND PIONEER GRANGE NBR 1

PALMER ALASKA

Jasser
3897

TELEGRAM

02074 NL TDA PALMER ALASKA 55 02-14 0315P AST

PMS REP THELMA BUCKHOLT CHAIRMAN HEALTH EDUCATION AND SOCIAL SERVICES COMMITTEE

JUNEAU ALASKA

RE HB86 VETERINARY PRACTICES ACT.

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LEGISLATIVE COMMITTEE NORTHLAND PIONEER GRANGE NBR 1

PALMER ALASKA

STATE OF ALASKA

POUCH V
JUNEAU, ALASKA 99811
(907) 465-3822

SENATOR TIM KELLY

283 MULDOON ROAD
STATION BOX 76
ANCHORAGE, ALASKA 99504
(907) 333-1179

April 2, 1979

TO: Representative Buchholdt
Chairperson, House HESS Committee

FROM: Senator Kelly

RE: HB 86, An act relating to Veterinarian Medicine

Attached is a letter from Dr. Leach, DVM with comments and suggestions on HB 86. I hope you'll consider his views when this bill comes before your committee.

Tim

CHESTER VALLEY ANIMAL HOSPITAL

1571 MULDOON ROAD
ANCHORAGE, ALASKA 99504
(907) 333-6591

March 28, 1979

Mr. Tim Kelly
State Senator
State of Alaska
Pouch V
Juneau, Alaska 99811

Dear Senator Kelly:

Thank you very sincerely for your recent letter and enclosure of pending legislation relating to veterinary medicine. Your request that HB No.86 be reviewed for comments was much appreciated.

The following comments are those I would feel important to consider:

Article 2; Sec. 08.95.200 (page 4) #14 and #15:

Both of these paragraphs I feel allow "practice" by people other than those specificcally qualified for such practice. A mercant or salesperson does not normally have the expertize to provide professional, competent veterinary services to the public.

Article 2; Sec. 08.95.200 (page 4) #16

It would seem only reasonable that if the State of Alaska is dependant upon a person for professional services such as veterinary medicine, which in many aspects also encompasses public health measures, that we should expect that individual able and competent to pass a required examination to be certified to practice their profession within the boundaries of the State of Alaska.

Sec. 08.95.290 (page 7)

It appears this section would not necessarily cause the person to maintain skills and or competence to provide high quality services to the public at large.

It would be preferable to have anyone who allows their Alaskan license to practice lapse, re-take fully and and all tests required to return to practice within the State of Alaska, including the National Board and State Board examinations. This requirement of a re-establishing of competency would prevent the return to practice of an individual who had not continuously maintained professionalism.

Sec. 08.95.460 (page 11) Second Sentence:

It is my opinion this sentence should be reworded to read:

"The licensed veterinarian is responsible for the preformance of any person under the veterinarian's direction or general supervision by this chapter or a regulation adopted under it".

Sec. 08.95.800 (page 12) Part A - last sentence:

This sentence should be reworded to read:

"Disposal of an animal under this section does not in any manner relieve the owner of the financial obligation incurred for the treatment and disposition of the animal but does extinguish all rights for claiming ownership of the animal.

Sec. 11 (page 16)

I feel this person should also be required to take the full examination for renewal or re-instatement of a license to practice; for the same reasons listed in Article 2, Sec. 08.95.20 (page 4 #16) as corrected previously in these comments.

It is gratifying to be able to have an opportunity to comment on this practice act prior to it being made into law. We do appreciate your representation and services.

Respectfully,

James B. Leach III, D.V.M.

JBL/al

Thanks for this opportunity - basicly I feel the practice act (SB 56) is a good step forward and agree with it in general.

Thanks again

3504 Spenard Road
Anchorage, Alaska 99503
March 12, 1979

Representative Thelma Buchholdt
Chairperson
Health, Education and Social
Services Committee
House of Representatives
Pouch V
Juneau, Alaska 99811

Dear Mrs. Buchholdt:

The Legislative Affairs Committee of the Alaska State Veterinary Medical Association, as well as most members of the ASVMA, would like to go on record as to the following items concerning C.S. for House Bill 86 - The Veterinary Practice Act:

1) Board of Veterinary Medicine - (SEC. 08.95.010) - The formula of three (3) veterinary members and two (2) public members will probably not be an improvement over the present situation. A total of five (5) people would be an improvement if the total board were involved in doing all the necessary work involved with the board's activities, but we feel that the majority of the work load will fall on the three (3) veterinary members. At present this is not the ideal situation and we feel that an additional veterinarian as well as a public member would be a much more workable board.

2) Board Meetings - (SEC. 08.45.030) - No other board carries the restriction of having to have prior approval of the Department of Commerce and Economic Development for the chairman of the board to call additional meetings as needed. We are sure the situation will not present itself whereby the board would be denied permission to do so, but in light of the board's increased duties and responsibilities with passage of this Act, we feel they should have some responsibility in being able to call themselves together. We just do not feel these should be in the statutes.

3) Officers - (SEC. 08.95.040) - We would like to see a limit of two (2) conservative terms that an officer may serve on the board. This would encourage turnover and yet allow continuity.

4) Qualification for Examination - (SEC. 08.95.220) - We would like some type of statement added to qualifications that would take into account possible felony convictions, malpractice convictions, pending investigations, or other such type of acts that we feel are undesirable in professional people. Only two (2) present state practice acts do not carry any statement about good moral character. The present veterinary practice act does carry such a statement and we would like the proposed one also to carry one.

5) Temporary Permit to Practice Veterinary Medicine - (SEC. 08.95.275) - We feel this is too loosely written and may allow a legal precedence to be established whereby a temporary permit may be granted, the person fail either or both examinations and then legally try to get the license to practice through the fact that he once had such and now is being denied it. There is no means available to check on persons obtaining such a permit and establishing a "bush" practice whereby they would not be under any type of review. It does not take into consideration that some people can be granted such a permit who have not been in "active" practice for a long period of time or a very recent new graduate with no practice experience at all. We feel both situations may be undesirable as pertaining to the general public's welfare.

6) Power of Injunction and Power of Investigation - Loss of these two powers by the board leaves the board totally under the division of occupational licensing. We feel these two powers should be available to the board as well as the division of occupational licensing either cumulative or independently of one another. The present act carries the power of injunction by the board. Past situations have had too little and too slow a response. We feel the board should be able to act on its own merits if need be.

We look forward to your consideration of these statements as they pertain to the Veterinary Practice Act. Please feel free to request further input if need be.

Sincerely,

Harold R. Spalding DVM

Harold R. Spalding, DVM
Vice President, ASVMA

Legislative Affairs Committee:
Pam Tuomi DVM - Anchorage
Jim Sachtjen DVM - Fairbanks
Jon Thomas DVM - Anchorage, President ASVMA
Harold Spalding DVM - Anchorage

Alaska State Legislature

House of Representatives

Committee on

Health, Education & Social Services

Official Business

Pouch V
State Capitol
Juneau, Alaska 99811

March 13, 1979

Alaska S.P.C.A
P.O. Box 776
Anchorage, Alaska 99510

Dear S.P.C.A. Members:

Enclosed you will find a copy of the latest Committee Substitute by the House Health, Education and Social Services Committee.

I have held off sending it because this is a work draft and there are amendments still to be added. But I thought you would want to look at what the committee is working with.

We plan to hold another hearing on the bill tomorrow and it may be passed out at that time. The committee, just last week, adopted the Committee Substitute to the bill so I'm sure there will be lots of changes by the time you receive this letter.

In any event, I thought this might help.

Sincerely,

Cynthia L. Hill

CYNTHIA L. HILL
Secretary to
THELMA BUCHHOLDT
Chairman
House HESS Committee

TB/ch

Name	Address	Organization	Bill No.
Robert Erwin	DHHS - Division	DHHS	321 & 22
John R. Page	DHHS - Div. of Social Services	DHHS	HB 96
Harold Spalding DJH	3504 Spenard Rd Anch	Self	HB 86
Don Hostak	Occupational Licensing		HB 86 - HB 96

THELMA SUCCHOLDT

Will appreciate your committee keeping HB 86 relating to practice of veterinary medicine, in committee until there has been much more time for input from laymen. Thank you.

Mrs. Harold De Voe
4036 Balchen Dr.,Anch.,99503
243-4827

THELMA BUCCHOLDT

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Mrs. Harold De Voe
4036 Balchen Dr.,Anch.,99503
243-4827

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(2) Board of Dental Examiners (AS 08.36.010);
(3) State Medical Board (AS 08.64.010);
(4) Board of Nursing (AS 08.68.010);
(5) Board of Dispensing Opticians (AS 08.71.010);
(6) Board of Examiners in Optometry (AS 08.72.010);
(7) Board of Pharmacy (AS 08.80.010);
(8) Board of Veterinary Examiners (AS 08.98.010);
(9) Board of Psychologist and Psychological Associate Examiners (AS 08.86.010);
(10) Board of Nursing Home Administrators (AS 08.70.010);
(11) Physical Therapy Board (AS 08.84.010).

(b) Boards listed in this subsection have a termination date of June 30, 1980:

(1) Board of Public Accountancy (AS 08.04.010);
(2) Board of Barber Examiners (AS 08.12.010);
(3) Collection Agency Board (AS 08.24.011);
(4) Board of Hairdressing and Beauty Culture Examiners (AS 08.28.010);
(5) Board of Electrical Examiners (AS 08.40.010);
(6) State Board of Registration for Architects, Engineers and Land Surveyors (AS 08.48.011);
(7) Guide Licensing and Control Board (AS 08.54.010);
(8) Board of Marine Pilots (AS 08.62.010);
(9) Real Estate Commission (AS 08.88.011);
(10) Board of Welding Examiners (AS 08.99.010);
(11) Board of Governors of the Alaska Bar Association (AS 08.08.040).

(c) Upon termination, each board listed in (a) and (b) of this section shall continue in existence until June 30 of the next succeeding year for the purpose of concluding its affairs. During this period, termination does not reduce or otherwise limit the powers or authority of each board. One year after the date of termination, a board not continued shall cease all activities.

(d) The termination, dissolution, continuation or reestablishment of a regulatory board shall be governed by the legislative oversight procedures of AS 44.66.050.

(e) A board scheduled for termination under this chapter may be continued or reestablished by the legislature for a period not to exceed four years. (§ 2 ch 149 SLA 1977)

Article
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Official Business

House [illegible] Representatives
Committee on
Health, Education & Social Services

Pouch V
State Capitol
Juneau, Alaska 99811

February 7, 1979

Dr. Harold R. Spalding, D.V.M.
Denali Veterinary Clinic
3504 Spenard Road
Anchorage, Alaska 99504

Dear Dr. Spalding:

Thank you for sending me a copy of the Veterinary Practices Act, HB-86.

I am one of the co-sponsors of the bill and will work for its passage along with Representative Miles.

HB-86 is now in my committee, House Health, Education and Social Services, and we will review the bill as soon as our committee schedule permits.

Again, thank you for writing to me. I will let you know as soon as we schedule the bill as you may wish to testify or send some kind of back up for committee review.

Sincerely yours,

THELMA BUCHHOLDT
Chairman
House Health, Education and Social Services

TB/ch

HAROLD R. SPALDING, D. V. M.

TELEPHONE 274-5689

DENALI VETERINARY CLINIC
3504 SPENARD ROAD
ANCHORAGE, ALASKA

1-26-79

Dear Mrs. Buckholdt,

Please find enclosed the final draft copy of the Veterinary Practice Act to be introduced by Bill Miller and Terry Martin. This is the form in which it was last written before introduction that I have in possession. Would you please go over it and get back in touch with me as to your comments? Our state association is backing this and there is to my knowledge no real opposition to it from within our profession. We would welcome your co-sponsoring it if you feel that you can do so.

I am sorry I contacted you so late before you were going to Juneau that we were not able to make connections here in Anchorage. Thank you and I look forward to hearing from you soon.

Sincerely,
Harold R. Spalding

SECTIONAL ANALYSIS OF HOUSE BILL NO. 86

Section 1. Adds a new chapter to AS 08 (Business and Professions) entitled "Veterinary Practice Act." Each section of this new chapter will be analyzed separately.

ARTICLE 1. BOARD OF VETERINARY MEDICINE

Sec. 08.95.010. CREATION AND MEMBERSHIP OF BOARD. Creates a Board of Veterinary Medicine, composed of four veterinarian members and one public member, to replace the current Board of Veterinary Examiners.

Sec. 08.95.030. SOURCE OF APPOINTMENTS FOR VETERINARIAN MEMBERS. Directs the governor to appoint each veterinarian member of the board from a list of at least three candidates recommended by the Alaska State Veterinary Medical Association.

Sec. 08.95.040. BOARD MEETINGS. Requires the board to hold a regular annual meeting and permits the chairman to call other meetings.

Sec. 08.95.050. OFFICERS. Directs the board to elect a chairman, subject to the governor's approval, and a secretary to serve one-year terms.

Sec. 08.95.060. REPORT REQUIRED. Requires the chairman and secretary to submit a report on the actions of the board to the Department of Commerce and Economic Development at the end of each examining period.

Sec. 08.95.070. MEETING OF NATIONAL VETERINARY STATE BOARD OF EXAMINERS. Authorizes the board to send one of its members to the annual meeting of the National Veterinary State Board of Examiners at state expense.

Sec. 08.95.080. POWERS AND DUTIES OF THE BOARD. Directs the board to regulate the "practice of veterinary medicine" (as defined) in accordance with the Act, to adopt regulations implementing the Act, and to authorize the issuance, renewal, or reinstatement of a license, permit, or certificate of registration to any person entitled to it. Authorizes the board to adopt regulations interpreting, clarifying, and making specific the provisions of the Act. Directs that the powers granted to the board under the Act be liberally construed.

ARTICLE 2. LICENSING.

Sec. 08.95.200. LICENSE REQUIRED. Prohibits anyone but a licensed veterinarian from practicing veterinary medicine except

(1) a veterinarian licensed in another state consulting with a licensed veterinarian in this state;

(2) the holder of a temporary permit, acting under the direction of a licensed veterinarian, who has applied to take the veterinarian's examination;
(3) a veterinarian licensed in another state who holds a temporary permit to conduct the practice of a licensed veterinarian during his absence;
(4) a person performing tasks within his competence, other than diagnosis, prescription, or initiation of treatment, under the "general supervision" (as defined) of a licensed veterinarian and in accordance with board regulations;
(5) a person performing artificial insemination of animals, who holds a permit to do so;
(6) a person giving advice on livestock management or engaging in accepted livestock management practices in accordance with board regulations;
(7) a faculty member of a "veterinary school" (as defined) engaging in his official duties;
(8) a person lecturing, giving instructions, or performing demonstrations with the approval of the board, at a veterinary school, or in connection with a continuing education course or seminar sponsored by a veterinary school or approved by the board;
(9) a veterinary student performing duties or actions assigned by his instructors;
(10) a veterinary student acting under the general supervision of a licensed veterinarian;
(11) a person engaging in scientific research that reasonably requires experiments with animals;
(12) a person gratuitously giving emergency aid to animals;
(13) the owner of an animal and his regular, full-time employees caring for and treating the animal, unless ownership of the animal was transferred to avoid application of the Act or the employees were hired primarily to treat animals;
(14) a merchant or manufacturer selling at his regular place of business products used in the prevention or treatment of animal diseases;
(15) a person selling or applying a pesticide or herbicide;
(16) a governmental employee engaging in his official duties.

Sec. 08.95.220. QUALIFICATION FOR EXAMINATION. Sets out the qualifications for taking an examination to become a licensed veterinarian. These qualifications are substantially the same as under existing law except for a new provision allowing a person who was not graduated from a veterinary school to take the examination if he has passed the Education Commission for Foreign Veterinary Graduates examination in veterinary medicine.

Sec. 08.95.230. EXAMINATION FEE. Directs the Department of Commerce and Economic Development to establish a fee to accompany applications for licensing as a veterinarian, refundable if the applicant is found unqualified to take the examination.

Sec. 08.95.240. CONTENT OF EXAMINATION. Requires that the examination be in two parts, a national examination selected by the board and a state examination prepared by the board. Requires the examination to cover subjects and techniques commonly taught in veterinary schools and permits the board to require a practical demonstration of skills.

Sec. 08.95.250. EXEMPTION FROM NATIONAL EXAMINATION. Permits the board to exempt an applicant from the national examination who meets specified criteria involving years of practice as a veterinarian in another state and recent passing of a national examination.

Sec. 08.95.260. REEXAMINATION. Allows a person failing an examination to take a subsequent examination upon payment of the examination fee.

Sec. 08.95.265. INITIAL LICENSE AND RENEWAL FEES. Directs the Department of Commerce and Economic Development to establish a fee for issuance of a veterinarian's license and a fee for biennial renewal.

Sec. 08.95.270. TEMPORARY PERMIT TO PRACTICE WITH LICENSED VETERINARIAN. Permits a qualified applicant for a veterinarian's license who has not failed a veterinarian's examination to obtain a temporary permit to practice veterinary medicine under the direction of a licensed veterinarian, pending examination. Comment. The permit holder is required to be under the "direction" of a licensed veterinarian rather than his "general supervision." "General supervision" is defined in the Act but "direction" is not. The difference between these terms is not clear but might be made so by board regulation.

Sec. 08.95.280. TEMPORARY PERMIT TO TAKE OVER PRACTICE OF LICENSED VETERINARIAN. Allows a veterinarian licensed in another state, who would be qualified to take the veterinarian's examination in this state, to obtain a temporary permit, for no longer than 60 days, to conduct the practice of a licensed veterinarian during his absence. Directs the Department of Commerce and Economic Development to establish a fee for these temporary permits and any renewals that may be permitted by the board.

Sec. 08.95.290. REINSTATEMENT OF LAPSED LICENSE. Allows a veterinarian whose license has lapsed to have it reinstated without examination within three years of its lapsing.

ARTICLE 3. REGULATION OF PRACTICE OF VETERINARY MEDICINE.

Sec. 08.95.400. DISCIPLINE OF LICENSED VETERINARIANS. Authorizes the board to revoke or suspend the license of a licensed veterinarian or otherwise discipline a licensed veterinarian for specified reasons, including unprofessional conduct as defined in board regulations.

Sec. 08.95.410. REVOCATION AND SUSPENSION OF TEMPORARY PERMITS. Authorizes the board to revoke or suspend a temporary permit for a violation of the Act or a regulation adopted under it, whether committed by the permit holder or the licensed veterinarian with whom he is associated.

Sec. 08.95.420. ARTIFICIAL INSEMINATION OF ANIMALS. Directs the board to adopt regulations providing for issuance of permits to perform artificial insemination of animals. Authorizes the board to revoke or suspend such a permit for a violation of the Act or a regulation adopted under it.

Sec. 08.95.430. REGISTRATION OF VETERINARY TECHNICIANS. Directs the board to adopt regulations providing for the registration of "veterinary technicians" (as defined). Directs that these regulations require, for registration, the completion of college programs approved by the board, but permits the board to register veterinary technicians before July 1, 1981 who have been graduated from high school and completed two years of satisfactory work experience in lieu of college programs. Sets a fee of $25 for registration and biennial renewal. Authorizes the board to revoke or suspend a certificate of registration for a violation of the Act or a regulation adopted under it. Emphasizes that a veterinary technician must be under the general supervision of a licensed veterinarian. Provides that this section does not require a veterinary technician to become registered, but authorizes the board to impose such a requirement by regulation.

Sec. 08.95.440. STANDARDS OF PRACTICE. Authorizes the board to establish standards of practice, including continuing education requirements, for (1) licensed veterinarians and holders of temporary permits; (2) holders of permits to perform artificial insemination of animals; (3) persons giving advice on livestock management or engaging in livestock management; and (4) persons acting under the general supervision of licensed veterinarians. Authorizes the board to

(1) classify persons acting under the general supervision of licensed veterinarians; (2) limit or qualify the duties which may be performed by members of a class; (3) permit or require members of a class to be registered or licensed; (4) establish qualifications for registration or licensing of members of a class; (5) provide for renewal, revocation, and suspension of certificates or licenses of members of a class; and (6) set fees for issuing and renewing certificates or licenses of members of a class.

Sec. 08.95.460. RESPONSIBILITY OF LICENSED VETERINARIAN. Requires employees of a licensed veterinarian to be under his general supervision. Makes the licensed veterinarian responsible for the performance of any person required to be under his direction or general supervision.

ARTICLE 4. ENFORCEMENT.

Sec. 08.95.600. UNLAWFUL PRACTICE OF VETERINARY MEDICINE. Makes the unlawful practice of veterinary medicine a misdemeanor punishable by a fine of not less than $50 or more than $500 or imprisonment for not more than 90 days. Makes each day of unlawful practice a separate offense.

Sec. 08.95.610. NO RIGHT TO COMPENSATION FOR SERVICES UNLAWFULLY RENDERED. Provides that a person is not entitled to compensation for services constituting the practice of veterinary medicine that are unlawfully rendered.

Sec. 08.95.620. INJUNCTION. Authorizes the board to seek an injunction to restrain a person from practicing veterinary medicine unlawfully.

Sec. 08.95.630. REMEDIES CUMULATIVE. Declares that remedies for enforcing the Act are cumulative and independent.

Sec. 08.95.640. INVESTIGATIONS. Authorizes the board to conduct investigations to determine whether violations of the Act or regulations adopted under it have occurred.

ARTICLE 5. ABANDONMENT OF ANIMALS.

Sec. 08.95.800. Authorizes a licensed veterinarian or temporary permit holder to dispose of an animal, by sale or otherwise, left in his custody and abandoned. Provides that abandonment is considered to have occurred if the animal is unclaimed within 10 days after notice is sent to the owner or his agent.

ARTICLE 6. GENERAL PROVISIONS.

Sec. 08.95.900. DEFINITIONS. Defines principal terms used in the Act, including "animal," "general supervision," "practice of veterinary medicine," and "veterinary technician."

Sec. 08.95.910. SHORT TITLE. Designates AS 08.95 as the Veterinary Practices Act.

Section 2. Makes the Board of Veterinary Medicine subject to the centralized licensing law.

Section 3. Directs the Department of Commerce and Economic Development to provide investigative services to the Board of Veterinary Medicine to assist it in matters of professional discipline.

Section 4. Gives the Board of Veterinary Medicine a termination date of June 30, 1985 for purposes of the sunset law.

Section 5. Reenacts a portion of the sunset law as a new section in the Alaska Statutes. This reenactment has no substantive effect. It is necessitated by the inclusion of the Board of Veterinary Medicine in the sunset law.

Section 6. Provides for a lien on an animal for veterinary services.

Section 7. Makes the Board of Veterinary Medicine subject to the administrative adjudication provisions of the Administrative Procedure Act.

Section 8. Repeals the current laws relating to the practice of veterinary medicine and a portion of the sunset law. The repeal of a portion of the sunset law is of no effect, other than to eliminate a reference to the Board of Veterinary Examiners, because its reenactment as a new section is provided for in Sec. 5.

Section 9. Provides for the validity of a temporary license to practice veterinary medicine issued under law that is being repealed.

Section 10. Provides for the validity of a license to practice veterinary medicine issued under law that is being repealed.

Section 11. Authorizes the reinstatement of a lapsed license to practice veterinary medicine, within five years of its lapsing, which was issued under law that is being repealed.

Section 12. Directs that the members of the Board of Veterinary Examiners automatically become veterinarian members of the Board of Veterinary Medicine and serve until their terms on the former board would have expired.

Section 13. Directs that the title "Board of Veterinary Examiners" in the laws of the state be read as "Board of Veterinary Medicine." Provides for continuation of proceedings begun, orders issued, and regulations adopted under law that is being repealed. Directs that property of the Board of Veterinary Examiners be transferred to the Board of Veterinary Medicine.

Section 14. Makes this Act effective July 1, 1979.

THE ALASKA STATE VETERINARY MEDICAL ASSOCIATION
BOX 631 • ANCHORAGE, ALASKA 99501

February 7, 1979

The Honorable Thelma Buchholdt
Pouch V
Juneau, Alaska 99811

Dear Ms. Buchholdt:

The Alaska State Veterinary Medical Association has written a new practice act, known as House Bill No. 86, that will be introduced this legislative session. The purpose of my letter is to give you an understanding of the bill.

We now have a veterinary practice act which was enacted in 1963 and has had no major revisions since then. We chose to write a new act rather than revise the old because in nearly all parts of the act changes have been proposed to clarify the intent. Writing a new act seemed the easiest way to accomplish this.

We have compared the content of the old act with the proposed act. In nearly all cases, the proposed act and the old act handle regulation and licensing of the profession in the same way. Notable exceptions are as follows:

The size of the Board of Veterinary Examiners was increased from three to five members. This was done because the present board size of three members often proved inadequate due to the absence of members for various reasons.

A public member was provided as one of the members of the Board to encourage representation of the public interest in regulation of the profession.

A section was included which defines the legal responsibilities of aides and trained technicians working under the direction of a veterinarian. The present act makes no mention of persons employed by veterinarians leaving it legally open to question as to whether or to what extent a veterinarian may use these people to aid in treatment of animals.

The new act provides for the examination and registration of Animal Health Technicians. Technicians are a relatively new profession employed by veterinarians to do a wide variety of technical tasks. Many technicians are presently employed in Alaska; however, there is no provision made for them in the present statutes.

Registration is necessary for up-to-date, immediate reference of all veterinary technicians engaged in animal care in the state with reference to qualifications, addresses, license status, etc. This provision allows the Board to adopt appropriate standards for those engaged in animal technology and the issuance of permits to such persons found competent.

Temporary licensing has been changed from the existing uncontrolled situation giving temporary licenses to all applicants who qualify for a license. Under the present law a person who has never passed a national or state examination can obtain a temporary unrestricted license to practice.

The new act proposes that two classes of temporary licenses be issued:

One type would be issued to any technician qualified to take the examination provided he work with a practitioner licensed in the state.

A second type would be issued for a 60-day period to a veterinarian who is licensed in another state. The license would allow the licensee to take over the practice of a veterinarian who is absent.

Examination of licensees has been changed to require a state exam and a national exam for every applicant unless the applicant has either (1) passed a National Board Examination in the last three years, or, (2) has been an active practicing veterinarian in another state. Persons qualifying would be required to to take only the state exam.

Presently, veterinarians who have "practiced" for five of the last seven years in another state may receive a license without exam. The problem with this is that the definition of "Veterinary Practice" is so broad that people involved with activities not commonly considered to be the active practice of veterinary medicine would qualify for license. Examples of this could include meat inspectors, animal consultants, and certain types of researchers. The new act would require all applicants to take the state exam.

The new act provides a legal means by which to cope with the problem of animals left in the care of veterinarians and later abandoned. This is a frequent problem that is not dealt with in the present act.

We would appreciate your support on this bill.

Respectfully,

Jon Thomas, DVM

Jon Thomas
President, ASVMA

February 10,1979

Dear Sally,

A pleasure to hear from you! Thanks for sending along the Veterinary Prctice Act. I have been wondering where it stood these days. I reviewed it and discussed it at length with two Veterinarians, and have one suggestion and a question. The Vets agreed with my suggestion, but declined to write and represent themselves...sigh.

The suggestion: Page 3, Art. 2, Sec. 08.95.200 ...(15) now reads:

> "No person may practice veterinary medicine in this state who is not a licensed veterinarian except...(15) a person selling or applying a pesticide or herbicide."

I thought seriously of dropping out of school to start selling pesticides and doing sprays on the side! I think the intent is better reflected in this wording from the original draft of the act:

> "No person may practice veterinary medicine in this state who is not a licensed veterinarian. THIS ACT SHALL NOT BE CONTRUED TO PROHIBIT: ... (15) a person selling..."

My question concerns the "one public member" of the board (page 1,Art. 1, Sec.08.95.010), and also page 2, Sec.08.95.030. The bill states that the governor shall appoint each veterinarian member, etc. It does not, at this time, say who appoints nor who nominates the public member. I assume the governor appoints, but should it be specified? Hopefully the appointee would have some relevant experience and interest in the profession. I wouldn't object to the position myself!

Take care,

Tom

Tom & Joan Welsh
P.O. Box 81067
Fairbanks, Alaska
99708

BILL ANALYSIS

ASSIGNMENT DATE_____

UNASSIGNED_____

DEPARTMENT	SPONSOR (PRINCIPAL)	BILL NO.
Commerce & Economic Development	Miles, Martin, Barnes, Buchholdt, Cotten, Phillips & Hayes	HB 86

DEPARTMENT POSITION

Opposed as noted below.

DIVISION DIRECTOR	DATE	COMMISSIONER	DATE
Occupational Licensing	February 2, 1979		

GOVERNOR'S OFFICE USE

☐ POSITION NOTED ☐ POSITION APPROVED ☐ POSITION DISAPPROVED

BY: DATE:

SUMMARY

(1) RELATED BILLS (SIMILAR OR CONFLICTING)
(2) OTHER AGENCIES AFFECTED BY BILL

(2) a. ORGANIZATIONAL SUPPORT FOR BILL		(2) b. ORGANIZATIONAL OPPOSITION TO BILL
Alaska Veterinary Society		Unknown

(3) PROGRAM EFFECTS OF BILL

Some major changes to existing practice act (AS 08.98) and increased costs in implementation.

(4) FISCAL IMPACT: ☐ NONE ☒ FISCAL ANALYSIS ATTACHED

(5) AMENDMENTS PROPOSED:

(6) COMMENTS:

The Division of Occupational Licensing opposes Secs. 1 through 14 of HB 86, "An Act relating to the practice of veterinary medicine; and providing for an effective date." Provisions in the Act for additional members, annual National meeting attendance, specialty permits (Sec. 420), and registration of technicians would entail substantial additional costs for regulation and administrative overhead. Many other aspects of the proposed Act are objectionable from the standpoint of standard statutory authority. These include, but are not limited to, (1) a requirement that board members be appointed only from a list submitted by the State association, (2) limits on voting power of public members,

(See reverse)

(3) a requirement that those applying for temporary permits may work only under supervision of a licensee, (4) that the board itself may conduct investigations, and (5) inappropriate revisions to AS 08.03 (Termination, Continuation and Reestablishment of Regulatory Boards).

We believe that the present practice act is workable but needs amendments. Appropriate recommendations have been made as a result of the Sunset review process that should be considered in increasing board efficiency. We do not believe, however, that the proposed new act would accomplish this nor would it be in the best overall interests of the public.

THE LEGISLATURE OF THE STATE OF ALASKA
ELEVENTH LEGISLATURE

FISCAL NOTE

I. REQUEST
Bill/Resolution No. HB 86
Title An act relating to the practice of veterinary medicine; and providin
Requested by for an effective date Date 2/15/79
Miles, Martin, Barnes, Buchholdt,
Cotten, Phillips and Hayes

II. FISCAL DETAIL
Agency Affected Commerce and Economic Development
Program Category Affected Public Protection
Budget Request Unit(s) Affected Regulation and Licensing of Professions

EXPENDITURES (Thousands of Dollars)

	FY 79	FY 80	FY 81	FY 82	FY 83	FY 84
100 PERSONAL SERVICES	-0-	-0-	-0-	-0-	-0-	-0-
200 TRAVEL	-0-	1.8	1.9	2.0	2.1	2.2
300 CONTRACTUAL	-0-	3.0	3.1	3.4	3.6	3.8
400 COMMODITIES	-0-	-0-	-0-	-0-	-0-	-0-
500 EQUIPMENT	-0-	-0-	-0-	-0-	-0-	-0-
600 LAND & STRUCTURES	-0-	-0-	-0-	-0-	-0-	-0-
700 GRANTS, CLAIMS, ETC.	-0-	-0-	-0-	-0-	-0-	-0-
TOTAL	-0-	4.8	5.0	5.4	5.7	6.0

FUNDING (Thousands of Dollars)

GENERAL FUND	-0-	4.8	5.0	5.4	5.7	6.0
FEDERAL FUNDS						
OTHER (Specify)						

POSITIONS

FULL TIME	-0-	-0-	-0-	-0-	-0-	-0-
PART TIME	-0-	-0-	-0-	-0-	-0-	-0-
TEMPORARY	-0-	-0-	-0-	-0-	-0-	-0-

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

FY 80 travel includes funding for two additional board members transportation and per diem to attend presently budgeted board meetings of two a year. There will be one person making one out-of state trip per year to national organization. Contractual expense includes costs for a hearing per year. This includes costs for a hearing office and court reporters preparation, recording, and reporting of the hearings before and after organization. Inflation is computer @ 6% per year. A detailed analysis of expenditures is attached.

IV. DATE 2/15/79 PREPARED BY Don Bowman
AGENCY Occupational Licensing
PHONE 465-2534

Original: Legislative Finance
Budget and Management
Prime Sponsor (First Legislator Named)

Travel

1 trip	Out-of-State Trans.	550
6 days	Out-of-State Per Diem	300
		850

Boards, Commissions and Legislators

2 trips for 2 additional members	In State Trans.	478
8 days	In State Per Diem	440
		918

Total Travel FY 80 1,768

Contractual

Cost for 8 hour hearing. This includes the cost for a hearing officer and court reporter's before and after preparation, recording, and reporting of the hearings activities. 3,000

Total Contractual FY 80 3,000

February 14, 1979

The Alaska Veterinary Technicians Association is in agreement with the Sections applying to the recognition, function and regulations of Veterinary Technicians in the Veterinary Practice Act currently being submitted to the Legislature.

We do, however, recommend that a Veterinary Technician be included in any decision making process regarding the regulation and registration of Veterinary Technicians.

Respectfully submitted,

Tamela Thomas

Tamela Thomas
Sec-Treas - Alaska Veterinary Technicians Association

POSITION STATEMENT OF THE ALASKA HEALTH COALITION ON HB 86

"An Act Relating To The Practice Of Veterinary Medicine"

10000 people

The Alaska Health Coalition wishes to go on record as being strongly in support of HB 86, "An Act Relating To The Practice of Veterinary Medicine." The present statute, having been enacted in 1963, is no longer adequate. The proposed statute addresses the issues of veterinary employees, delegation of duties, temporary licensure, size of the board and inclusion of public representation, powers of the board and registration. The Coalition feels that the proposed act clarifies the intent of each section thereby simplifying interpertation and enforcement.

Of particular importance is the addition of two members to the board: a practicing veterinarian and a public member. A three person board, as the board is now composed,is impractical. Input is limited and the members are overburdened with the responsibilities of board function. The addition of two more persons would divide the workload more evenly, make the formation of subcommittees feasible, facilitate the decision-making process by increasing information input. Addition of a public member would bring the board into partial compliance with Governor Hammond's mandate that there be two public members on each regulatory board, and would assure some balancing of opinion in matters affecting the general population as well as those affecting veterinary practitioners.

The Coalition feels that the adoption of this bill will do much to assure competency to practice veterinary medicine in Alaska and will thereby protect the public and the animals which are being treated by veterinarians.

Respectfully submitted by

Jana Varrati, Coordinator
Alaska Health Coalition

Rep. Barnes.

THE ALASKA SOCIETY FOR THE PREVENTION OF CRUELTY TO ANIMALS, INC.

ANIMAL CONTROL SHELTER
3600 E. TUDOR ROAD
ANCHORAGE, ALASKA 99507
PHONE: 279-0578

SPCA STATE HEADQUARTERS
P.O. BOX 776
ANCHORAGE, ALASKA 99510
PHONE: 279-9853

March 5, 1979

THELMA BUCHHOLDT, Chairman, Health Education & Social Services Committee

Re: HB 86 ~~Tom Martin~~, Ramona Barnes, Vernon Hurlbert
Bill Miles, Mike Beirne, C.V. Chatterton

ALASKA SPCA BOARD OF DIRECTORS VOTED UNANIMOUSLY RECOMMENDING VETERINARIAN BILL PROVIDE FOR RECIPROCITY REGISTRATION OF VETERINARIANS, SIMILAR TO PROCEDURES FOLLOWED BY OTHER PROFESSIONAL BOARDS SUCH AS ENGINEERS, ARCHITECTS, PHARMACISTS, etc.

ALSO THE SPCA REQUESTS YOUR COMMITTEE REVISE BILL NO. 86 TO DEFINE OTHER TRAINED PERSONS AS QUALIFIED TO ADMINISTER SHOTS, NOT UNDER DIRECT SUPERVISION OF REGISTERED VETERINARIAN. SPCA BOARD SUGGESTS TRAINED AND CERTIFICATED TECHNICIANS, NURSES, AND OTHERS BE QUALIFIED TO ADMINISTER SHOTS. MANY SITUATIONS ARISE IN BUSH REQUIRING EMERGENCY HUMANE TREATMENT.

WE DO NOT YET HAVE A COPY OF REVISED BILL.

WE TRUST THE COMMITTEE WILL PROVIDE FOR HUMANE PREVENTION OF PAIN IN SITUATIONS WHERE A VETERINARIAN IS NOT AVAILABLE.

THANK YOU FOR YOUR HELP.

Louise DeVoe (DeVoe)

ALASKA SPCA, INC.
P.O. BOX 776
ANCHORAGE, ALASKA 9951[illegible]

Phone: 277-4015

February 14, 1979

The Alaska Veterinary Technicians Association is in agreement with the Sections applying to the recognition, function and regulations of Veterinary Technicians in the Veterinary Practice Act currently being submitted to the Legislature.

We do, however, recommend that a Veterinary Technician be included in any decision making process regarding the regulation and registration of Veterinary Technicians.

Respectfully submitted,

Tamela Thomas

Tamela Thomas
Sec-Treas - Alaska Veterinary Technicians Association

Rep. James.

THE ALASKA SOCIETY FOR THE PREVENTION OF CRUELTY TO ANIMALS, INC.

ANIMAL CONTROL SHELTER
3600 E. TUDOR ROAD
ANCHORAGE, ALASKA 99507
PHONE: 279-0578

SPCA STATE HEADQUARTERS
P.O. BOX 776
ANCHORAGE, ALASKA 99510
PHONE: 279-9853

MARCH 5, 1979

THELMA BUCHHOLDT, Chairman, Health Education & Social Services Committee

Re: HB 86 ~~[illegible]~~, Ramona Barnes, Vernon Hurlbert
Bill Miles, Mike Berne, C.V. Chatterton

ALASKA SPCA BOARD OF DIRECTORS VOTED UNANIMOUSLY RECOMMENDING VETERINARIAN BILL PROVIDE FOR RECIPROCITY REGISTRATION OF VETERINARIANS, SIMILAR TO PROCEDURES FOLLOWED BY OTHER PROFESSIONAL BOARDS SUCH AS ENGINEERS, ARCHITECTS, PHARMACISTS, etc.

ALSO THE SPCA REQUESTS YOUR COMMITTEE REVISE BILL NO. 86 TO DEFINE OTHER TRAINED PERSONS AS QUALIFIED TO ADMINISTER SHOTS, NOT UNDER DIRECT SUPERVISION OF REGISTERED VETERINARIAN. SPCA BOARD SUGGESTS TRAINED AND CERTIFICATED TECHNICIANS, NURSES, AND OTHERS BE QUALIFIED TO ADMINISTER SHOTS. ~~XXXXX~~ MANY SITUATIONS ARISE IN BUSH REQUIRING EMERGENCY HUMANE TREATMENT.

WE DO NOT YET HAVE A COPY OF REVISED BILL.

WE TRUST THE COMMITTEE WILL PROVIDE FOR HUMANE PREVENTION OF PAIN IN SITUATIONS WHERE A VETERINARIAN IS NOT AVAILABLE.

THANK YOU FOR YOUR HELP.

Louise DeVoe (DeVoe)

ALASKA SPCA, INC.
P.O. BOX 776
ANCHORAGE, ~~XXXXXX~~ ALASKA 99510

Phone: 277-4015

STATE OF ALASKA
THE LEGISLATURE

POUCH Y - STATE CAPITOL
JUNEAU, ALASKA 99811
907-465-3800

LEGISLATIVE AFFAIRS AGENCY

M E M O R A N D U M April 17, 1980

SUBJECT: CSHB 86 (practice of veterinary medicine)

TO: House Health, Education and Social Services Committee
Attn: Shannon Garrett

FROM: Donna Spragg Pegues
Co-Revisor of Statutes

Enclosed you will find the requested committee substitute. We made the following necessary changes from the draft:

1. Effective date is changed from June 30, 1979 to June 30, 1980.

2. Section 5 relating to "sunset" of boards was eliminated because it was enacted in a different bill in 1979.

3. Section 4 relating to the sunset of the veterinary board is changed to reflect laws enacted in 1979.

4. The title to the bill is changed to add mention of the lien provisions in the amendment (in new Sec. 5) to AS 34.35.220. This addition was needed to insure that the subject of the bill is included in the title.

Please let me know if you have any questions.

DSP:ljb

Enclosure

Introduced: 1/26/79
Referred: Health, Education & Social Services and Finance

BY MILES, MARTIN, BARNES, BUCHHOLDT, COTTEN, PHILLIPS AND HAYES

IN THE HOUSE

HOUSE BILL NO. 86

IN THE LEGISLATURE OF THE STATE OF ALASKA

ELEVENTH LEGISLATURE - FIRST SESSION

A BILL

For an Act entitled: "An Act relating to the practice of veterinary medicine; and providing for an effective date."

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

* Section 1. AS 08 is amended by adding a new chapter to read:

CHAPTER 95. VETERINARY PRACTICE ACT.

ARTICLE 1. BOARD OF VETERINARY MEDICINE.

Sec. 08.95.010. CREATION AND MEMBERSHIP OF BOARD. There is created the Board of Veterinary Medicine, composed of four veterinarian members and ~~one~~ public member. Each veterinarian member shall be a licensed veterinarian who is a graduate of a veterinary school, is a resident of this state, and has been licensed to practice veterinary medicine in this state for a period of five years immediately preceding his appointment. No person may serve on the board who is, or was during the two years immediately preceding his appointment, a member of a faculty, board of trustees, or advisory board of a veterinary school. The public member is a voting member in all matters except those involving judgment of professional ability and skill.

Sec. 08.95.020. TERM OF OFFICE. Members of the board serve staggered terms of five years. An appointment to fill a vacancy occurring in an unexpired term is for the unexpired term. No person may serve consecutive five-year terms, but a person appointed for a term of less than five years is not disqualified by this section from being reappointed to a five-year term. Members serve until their successors are appointed and qualify.

Sec. 08.95.030. SOURCE OF APPOINTMENTS FOR VETERINARIAN MEMBERS. The governor shall appoint each veterinarian member of the board from a list of persons prepared by the Alaska State Veterinary Medical Association and submitted at least 30 days before the expiration of a term and not more than 60 days after a vacancy occurs in an unexpired term. The list shall contain not less than three recommended candidates for the appointment. The governor shall make the appointment within 30 days after receiving the list.

Sec. 08.95.040. BOARD MEETINGS. The board shall hold a regular annual meeting at the time and place fixed by rule of the board. The chairman of the board, with prior approval may call other meetings by giving notice as may be required by rule.

Sec. 08.95.050. OFFICERS. At its regular annual meeting, the board shall elect a chairman and secretary from among its members. The election of the chairman is subject to the approval of the governor. An officer of the board serves for a term of one year and until his successor is elected and qualifies, without limitation on the number of terms he may serve as an officer. The chairman shall preside at board meetings.

Sec. 08.95.060. REPORT REQUIRED. At the end of each examining period, the chairman and secretary shall submit to the department a report on the actions of the board.

Sec. 08.95.070. MEETING OF NATIONAL VETERINARY STATE BOARD OF EXAMINERS. The board may select one of its members to represent it at the annual meeting of the National Veterinary State Board of Examiners. This representation is authorized official business incident to the duties of the person selected as a member of the board.

Sec. 08.95.080. POWERS AND DUTIES OF THE BOARD. The board

(1) shall regulate the practice of veterinary medicine in

Covered by Dept. of Commerce

accordance with this chapter;

(2) shall adopt regulations implementing this chapter;

(3) may adopt regulations interpreting, clarifying, and making specific the provisions of this chapter; and implementing the intent of this chapter

(4) shall authorize the issuance, renewal, or reinstatement of a license, permit, or certificate of registration to any person entitled to it under this chapter or a regulation adopted under it.

(b) The powers granted to the board under this chapter shall be liberally construed.

ARTICLE 2. LICENSING.

Sec. 08.95.200. LICENSE REQUIRED. No person may practice veterinary medicine in this state who is not a licensed veterinarian except

(1) a veterinarian licensed in another state consulting with a licensed veterinarian in this state;

(2) the holder of a temporary permit under AS 08.95.270 acting under the direction of a licensed veterinarian;

(3) the holder of a temporary permit under AS 08.95.280 conducting the practice of a licensed veterinarian during his absence;

(4) a person performing tasks within his competence, other than diagnosis, prescription, or initiation of treatment, under the general supervision of a licensed veterinarian and in accordance with such regulations as may be adopted by the board;

(5) the holder of a permit under AS 08.95.420 performing artificial insemination of animals;

(6) a person giving advice on livestock management or engaging in accepted livestock management practices in accordance with such regulations as may be adopted by the board;

(7) a member of the faculty of a veterinary school engaging in his professional duties for that school;

(8) a person lecturing, giving instructions, or performing demonstrations with the approval of the board, at a veterinary school, or in connection with a continuing education course or seminar sponsored by a veterinary school or approved by the board;

(9) a student enrolled in veterinary school performing duties or actions assigned by his instructors;

(10) a student enrolled in veterinary school acting under the general supervision of a licensed veterinarian;

(11) a person engaging in bona fide scientific research which reasonably requires experiments with animals;

(12) a person gratuitously giving emergency aid to animals;

(13) the owner of an animal and his regular, full-time employees caring for and treating the animal, unless ownership of the animal was transferred to avoid application of a provision of this chapter or the employees were hired primarily to treat animals;

(14) a merchant or manufacturer selling at his regular place of business medicines, feed, appliances, or other products used in the prevention or treatment of animal diseases;

(15) a person selling or applying a pesticide or herbicide;

(16) an employee of the federal government, the state government, or a local government engaging in his official duties.

Sec. 08.95.210. EXAMINATION. The board shall hold at least two examinations each year. A person who passes the examination is entitled to be licensed as a veterinarian.

Sec. 08.95.220. QUALIFICATION FOR EXAMINATION. (a) A person is entitled to take the examination who

(1) is of good moral character;

(2) was graduated from a veterinary school or has passed the Education Commission for Foreign Veterinary Graduates examination in

veterinary medicine;

(3) has not had a veterinarian license revoked on grounds other than nonpayment of fees in another jurisdiction;

(4) has completed application forms and returned them to the department; and

(5) has paid the examination fee.

(b) If the board finds that an applicant is qualified under this section, it shall admit him to the next examination. If the board finds that an applicant is not qualified under this section, the secretary of the board shall notify the department in writing of that finding and the grounds for it.

Sec. 08.95.230. EXAMINATION FEE. The department shall establish a fee to accompany applications for licensing as a veterinarian. The department shall return an applicant's fee to him if he is found to be unqualified to take the examination, but in all other instances the examination fee is not refundable.

Sec. 08.95.240. CONTENT OF EXAMINATION. (a) The examination shall be in two parts: (1) a national examination prepared by the National Board of Veterinary Medical Examiners or other national veterinary competency examination selected by the board, and (2) a state examination prepared by the board. The examination shall be designed to test the examinee's knowledge of and proficiency in the subjects and techniques commonly taught in veterinary schools. To pass the examination, the examinee must demonstrate to the board that he has sufficient scientific and practical knowledge to practice veterinary medicine. The state examination may consist of a practical demonstration of skills as well as oral or written answers to questions.

(b) Each examinee must take the national examination and the state examination unless exempted by the board from the national examination

under AS 08.95.250.

Sec. 08.95.250. EXEMPTION FROM THE NATIONAL EXAMINATION. The board may exempt an applicant from taking the national examination who furnishes proof that he was graduated from a veterinary school and that he

(1) has for five of the seven years immediately preceding the filing of his application been a practicing veterinarian licensed in another state having licensing requirements, ~~at the time he was first licensed,~~ substantially equivalent to the present requirements of this chapter; or

(2) has within the three five years immediately preceding the filing of his application passed taken a national examination prepared by the National Board of Veterinary Medical Examiners or other national veterinary competency examination selected by the board.

Sec. 08.95.260. REEXAMINATION. A person who fails an examination may apply for a subsequent examination, but shall pay the examination fee each time he applies.

Sec. 08.95.265. INITIAL LICENSE AND RENEWAL FEES. (a) The department shall establish a fee for issuance of a veterinarian's license, payable at the time the license is issued. This fee is in addition to the examination fee.

(b) The department shall establish a fee for biennial renewal of a veterinarian's license.

Sec. 08.95.270. TEMPORARY PERMIT TO PRACTICE WITH LICENSED VETERINARIAN. (a) An applicant for licensing as a veterinarian who meets the requirements of AS 08.95.220(a) and has not failed a ~~veterinarian's~~ examination in this or another state is entitled to a temporary permit to practice veterinary medicine with a licensed veterinarian. The temporary permit may not be renewed and expires on the day after publi-

cation of the results of the first examination following the issuance of the permit. The application for the temporary permit shall be signed by the applicant and the licensed veterinarian with whom he will be associated. No fee may be imposed for the temporary permit. No person may receive more than one temporary permit under this section.

(b) The holder of a temporary permit under this section shall limit his practice of veterinary medicine to the practice of the licensed veterinarian with whom he is associated and shall be under the direction of that veterinarian.

Sec. 08.95.280. TEMPORARY PERMIT TO TAKE OVER PRACTICE OF LICENSED VETERINARIAN. A veterinarian licensed in another state who meets the requirements of AS 08.95.220(a)(1) - (3) is entitled to a temporary permit to conduct the practice of a licensed veterinarian during his absence. The temporary permit shall be valid for a period of no more than 60 days. It may be renewed at the discretion of the board. The department shall establish a fee for temporary permits and renewals of temporary permits under this section.

Sec. 08.95.290. REINSTATEMENT OF LAPSED LICENSE. A person whose license to practice veterinary medicine has lapsed is entitled to have his license reinstated without taking an examination unless his license has remained lapsed more than three years.

ARTICLE 3. REGULATION OF PRACTICE OF VETERINARY MEDICINE.

Sec. 08.95.400. DISCIPLINE OF LICENSED VETERINARIANS. The board may, after hearing, revoke or suspend the license of a licensed veterinarian or otherwise discipline a licensed veterinarian for

(1) fraud, misrepresentation, or deception in obtaining a license;

(2) an adjudication of mental incompetency by a court of competent jurisdiction;

(3) chronic drunkeness or habitual use of drugs;

(4) the use of advertising or solicitation which is false, misleading, or otherwise unprofessional under regulations adopted by the board;

(5) conviction or cash compromise of a felony or any crime involving moral turpitude;

(6) incompetence, gross negligence, or other malpractice in the practice of veterinary medicine;

(7) having professional association with or employing a person practicing veterinary medicine unlawfully;

(8) fraud or other dishonest conduct in applying or reporting diagnostic biological tests;

(9) failure to keep veterninary premises and equipment in a clean and sanitary condition;

(10) failure to report, as required by law, or making a false report of a contagious or infectious disease;

(11) fraud, other dishonest conduct, or gross negligence in the inspection of foodstuffs or the issuance of health or inspection certificates;

(12) cruelty to animals;

(13) revocation of a license to practice veterinary medicine by another state on grounds other than nonpayment of fees; or

(14) unprofessional conduct as defined in regulations adopted by the board.

Sec. 08.95.410. REVOCATION AND SUSPENSION OF TEMPORARY PERMITS. The board may, after hearing, revoke or suspend a temporary permit issued under AS 08.95.270 or 08.95.280 for a violation of this chapter or a regulation adopted under it committed by the holder of the permit or the licensed veterinarian with whom he is associated.

may delete

Sec. 08.95.420. ARTIFICIAL INSEMINATION OF ANIMALS. (a) The board shall adopt regulations providing for issuance of permits to perform artificial insemination of animals. The regulations may provide for renewal of a permit. The regulations shall establish qualifications for obtaining a permit, which may include passing an examination, and fees for issuing a permit and any renewal of it.

(b) A person meeting the qualifications established by the board and paying the required fee is entitled to permit to perform artificial insemination of animals.

(c) The board may, after hearing, revoke or suspend a permit to perform artificial insemination of animals for a violation of this chapter or a regulation adopted under it.

Sec. 08.95.430. REGISTRATION OF VETERINARY TECHNICIANS. (a) The board shall adopt regulations providing for the registration of veterinary technicians. The regulations shall establish qualifications for registration which shall include satisfactory completion of college programs approved by the board and may include passing an examination. However, the board may provide for registration, before July 1, 1981, of veterinary technicians who have not completed college programs but have completed at least two years of satisfactory experience in the employ of a veterinarian, or its equivalent as determined by the board, and have been graduated from high school. The regulations shall provide for renewal of registration biennially. The fee for registration and renewal of registration is $25.

(b) A person meeting the qualifications established by the board and paying the required fee is entitled to a certificate of registration as a veterinary technician.

(c) The board may, after hearing, revoke or suspend a certificate of registration as a veterinary technician for a violation of this

chapter or a regulation adopted under it.

(d) This section does not entitle a veterinary technician to do any act constituting the practice of veterinary medicine while not under the general supervision of a licensed veterinarian.

(e) This section does not require a veterinary technician to become registered, but such a requirement may be imposed by regulation adopted by the board under AS 08.95.440(a)(4).

Sec. 08.95.440. STANDARDS OF PRACTICE. (a) The board may adopt regulations establishing standards of practice for

(1) licensed veterinarians and holders of temporary permits under AS 08.95.270 and 08.95.280;

(2) holders of permits to perform artificial insemination of animals;

(3) persons giving advice on livestock management or engaging in livestock management; and

(4) persons acting under the general supervision of licensed veterinarians.

(b) Regulations adopted under (a)(4) of this section may

(1) classify persons acting under the general supervision of licensed veterinarians;

(2) limit or qualify the duties which may be performed by members of a class;

(3) permit or require members of a class to be registered or licensed;

(4) establish qualifications, which may include passing an examination, for registration or licensing of members of a class;

(5) provide for renewal and, after hearing, revocation or suspension of certificates of registration or licenses of members of a class; and

(6) establish fees for issuing and renewing certificates of registration and licenses of members of a class.

(c) Regulations adopted under this section may impose continuing education requirements as part of a standard of practice.

Sec. 08.95.460. RESPONSIBILITY OF LICENSED VETERINARIAN. An employee of a licensed veterinarian shall perform his duties under the general supervision of the licensed veterinarian. The licensed veterinarian is responsible for the performance of any person required to be under his direction or general supervision by this chapter or a regulation adopted under it.

ARTICLE 4. ENFORCEMENT

Sec. 08.95.600. UNLAWFUL PRACTICE OF VETERINARY MEDICINE. If a person is required by this chapter or a regulation adopted under it to have a license, permit, or certificate of registration in order to practice veterinary medicine, it is a misdemeanor for him to practice veterinary medicine without a currently valid license, permit, or certificate or in excess of the authority granted in it. Upon conviction, a person violating this section is punishable by a fine of not less than $50 or more than $500, or by imprisonment for not more than 90 days, or by both. Each day of unlawful practice is a separate offense.

Sec. 08.95.610. NO RIGHT TO COMPENSATION FOR SERVICES UNLAWFULLY RENDERED. If a person is required by this chapter or a regulation adopted under it to have a license, permit, or certificate of registration in order to practice veterinary medicine, he is not entitled to compensation for services which he renders, constituting the practice of veterinary medicine, without a currently valid license, permit, or certificate or in excess of the authority granted in it.

Sec. 08.95.620. INJUNCTION. When it appears that a person has engaged in or is about to engage in an act constituting a violation of

AS 08.95.600, the board may bring an action in the superior court to enjoin the act and enforce compliance with that section.

Sec. 08.95.630. REMEDIES CUMULATIVE. The remedies described in AS 08.95.600 - 08.95.620 and AS 08.01.087 are cumulative and independent.

Sec. 08.95.640. INVESTIGATIONS. The board may, upon its own motion, conduct investigations to determine whether violations of this chapter or regulations adopted under it have occurred. In connection with an investigation, the board may administer oaths, compel the attendance and testimony of witnesses, either before the board or by deposition, and compel the production of books, papers, records, and other documents.

ARTICLE 5. ABANDONMENT OF ANIMALS.

Sec. 08.95.800. ABANDONMENT OF ANIMALS. (a) A licensed veterinarian or holder of a temporary permit under AS 08.95.270 or 08.95.280 is entitled to humanely dispose of an animal, by sale or otherwise, which has been left in his custody and abandoned. Abandonment is considered to have occurred if the owner of the animal or his agent does not claim the animal within ten days after the licensed veterinarian or temporary permit holder sends written notice of his intent to dispose of the animal to the owner or agent, at his last known address, by registered or certified mail, return receipt requested. However, the licensed veterinarian or temporary permit holder may not dispose of an animal under this section if the owner or his agent claims the animal before the disposal occurs. Disposal of an animal under this section extinguishes all rights of the owner in the animal.

(b) A licensed veterinarian or holder of a temporary permit under AS 08.95.270 or 08.95.280 is not liable in civil damages for disposing of an animal under this section. Disposal of an animal under this section may not constitute grounds for discipline by the board.

ARTICLE 6. GENERAL PROVISIONS.

Sec. 08.95.900. DEFINITIONS. As used in this chapter, unless the context requires otherwise,

(1) "animal" means any animal other than man and includes mammals, birds, fish, and reptiles, wild or domestic, living or dead;

(2) "board" means the Board of Veterinary Medicine;

(3) "department" means the Department of Commerce and Economic Development;

(4) "general supervision" means that degree of control, by the veterinarian having actual charge of the case or animal, which will insure that the activities of the person under the general supervision of the veterinarian are within the scope of the orders, assignments, or prescriptions of the veterinarian;

(5) "licensed veterinarian" means a person who holds a currently valid license to practice veterinary medicine in this state;

(6) "practice of veterinary medicine" means

(A) to diagnose, treat, correct, change, relieve, or prevent animal disease, deformity, defect, injury, or other physical or mental conditions, including the prescription or administration of any drug, medicine, biologic, apparatus, application, anesthetic, or other therapeutic or diagnostic substance or technique and the use of any manual or mechanical procedure for artificial insemination, testing for pregnancy, or correcting sterility or infertility, or to render advice or recommendation with regard to any of the above;

(B) to represent, directly or indirectly, publicly or privately, an ability and willingness to do any act described in (A) of this paragraph;

(C) to use any title, words, abbreviation, or letters in

a manner or under circumstances which induce the belief that the person using them is qualified to do any act described in (A) of this paragraph;

(7) "veterinarian" means a person who has received a Doctor of Veterinary Medicine degree, or its equivalent as determined by the board, from a veterinary school or has passed the Education Commission for Foreign Veterinary Graduates examination in veterinary medicine;

(8) "veterinary school" means a veterinary college or division of a university or college that offers the degree of Doctor of Veterinary Medicine, or its equivalent as determined by the board, and conforms to the standards required for accreditation by the American Veterinary Medical Association;

(9) "veterinary technician" means a person who, for compensation, directly or indirectly performs an act requiring substantial specialized judgment and skill founded on formal education which provides knowledge and application of the principles of animal technology based on biological, physical, and social sciences in the care, treatment, or maintenance of health or prevention of illness of animals, but does not include a person licensed by the state to practice a healing arts skill.

Sec. 08.95.910. SHORT TITLE. This chapter may be known and cited as the Veterinary Practice Act.

* Sec. 2. AS 08.01.010(14) is amended to read:

(14) Board of Veterinary <u>Medicine</u> [EXAMINERS];

* Sec. 3. AS 08.01.050(a)(19) is amended to read:

(19) provide investigative services to the boards established under AS 08.20, AS 08.32, AS 08.36, AS 08.64, AS 08.68, AS 08.71, AS 08.72, AS 08.80, AS 08.84, [AND] AS 08.86, <u>and AS 08.95</u> for the purpose of assisting those boards in matters of professional discipline.

* Sec. 4. AS 08.03.010(c) is repealed and re-enacted to read:

(c) The Board of Veterinary Medicine (AS 08.95.010) has a termination date of June 30, 1985.

* Sec. 5. AS 08.03 is amended by adding a new section to read:

Sec. 08.03.020. TERMINATION, CONTINUATION, AND REESTABLISHMENT OF REGULATORY BOARDS. (a) Upon termination, each board listed in AS 08.03.010 shall continue in existence until June 30 of the next succeeding year for the purpose of concluding its affairs. During this period, termination does not reduce or otherwise limit the powers or authority of each board. One year after the date of termination, a board not continued shall cease all activities.

(b) The termination, dissolution, continuation or reestablishment of a regulatory board shall be governed by the legislative oversight procedures of AS 44.66.050.

(c) A board scheduled for termination under this chapter may be continued or reestablished by the legislature for a period not to exceed four years.

* Sec. 6. AS 34.35.220 is amended to read:

Sec. 34.35.220. PERSONS ENTITLED TO CARRIER, WAREHOUSE, AND <u>ANIMAL</u> [LIVESTOCK] LIENS. <u>(a)</u> The following persons shall have liens upon personal property for their just and reasonable charges for the labor, care, and attention bestowed and the food furnished, and may retain possession of the property until the charges are paid:

(1) a person who is a common carrier, or who, at the request of the owner or lawful possessor of personal property, carries, conveys, or transports the property from one place to another;

(2) a person who safely keeps or stores grain, wares, merchandise, and personal property at the request of the owner or lawful possessor of the property; and

(3) a person who pastures or feeds an animal [HORSES, CATTLE, HOGS, SHEEP, OR OTHER LIVESTOCK,] or bestows labor, care, or attention upon an animal, including veterinary services, [THE LIVESTOCK] at the request of the owner or lawful possessor of the animal [LIVESTOCK].

(b) As used in this secton, "animal" has the meaning ascribed to it in AS 08.95.900.

* Sec. 7. AS 44.62.330 is amended by adding a new paragraph to read:

(46) Board of Veterinary Medicine.

* Sec. 8. The following laws are repealed: AS 08.03.010(a)(8), (d), and (e); and AS 08.98.

* Sec. 9. A person who, on the effective date of this Act, holds a valid temporary license issued under former AS 08.98.180 is entitled to practice veterinary medicine until the results of the examination following the issuance of the license are published, so long as his temporary license is not revoked or suspended. Notwithstanding AS 08.95.200(2) and 08.95.270, enacted in sec. 1 of this Act, he is not required to practice veterinary medicine in association with or under the direction of a licensed veterinarian. In all other respects, he is fully subject to AS 08.95, enacted in sec. 1 of this Act.

* Sec. 10. A person who, on the effective date of this Act, holds a valid license issued under former AS 08.98.130 or 08.98.210 is considered to hold a license issued under AS 08.95.210 and is fully subject to AS 08.95, including provisions relating to renewal, revocation, suspension, and reinstatement of his license.

* Sec. 11. A person who, on the effective date of this Act, holds a license issued under former AS 08.98.130 or 08.98.210 which has lapsed is entitled to issuance of a license under AS 08.95.210 without taking an examination upon payment of the penalty and fees referred to in AS 08.01.100(b), unless his old license has remained lapsed more than five years at the time

he applies for the new license.

* Sec. 12. Notwithstanding AS 08.95.010 - 08.95.030, the members of the former Board of Veterinary Examiners on the day before the effective date of this Act automatically become veterinarian members of the Board of Veterinary Medicine. They serve until their terms of office on the former Board of Veterinary Examiners would have expired and until their successors are appointed and qualify.

* Sec. 13. Where the title "Board of Veterinary Examiners" appears in the laws of this state, it shall be read as the "Board of Veterinary Medicine". All litigation, hearings, investigations, and other proceedings pending under former AS 08.98 continue in effect and may be continued and completed notwithstanding the repeal of that chapter in this Act. Orders issued and regulations adopted under former AS 08.98 remain in effect until they expire by their own terms or until revoked, vacated, or otherwise modified under AS 08.95. Records, equipment, and other property of the former Board of Veterinary Examiners are transferred to the Board of Veterinary Medicine.

* Sec. 14. This Act takes effect July 1, 1979.

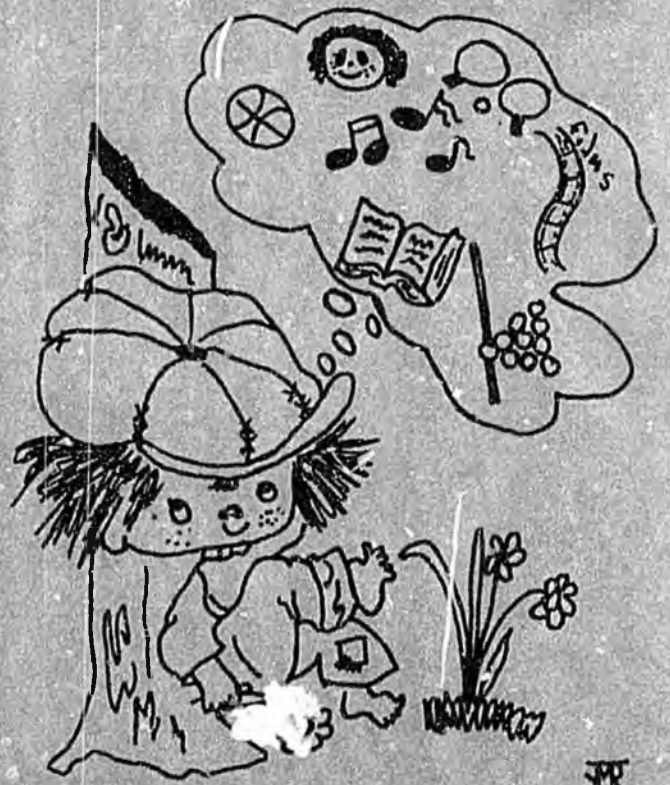
HB

125

Sitka needs a

TEENAGE CENTER FOR YOUTH GROWTH

for the well-being of the Community



WHY?

YOUTH NEEDS A PLACE TO :

- socialize
- enjoy recreation
- gain a sense of competence
  - belongingness
  - usefulness
- develop through responsibility
  - leadership
  - employment
  - participation in community services

WHO?

ALL YOUTH !
Ages : 13 - 19 years

open to family participation
and members of the community...

The Sitka Teen Service Officew
is currently located in
the Franklin Building
office hours: 1-4 p.m.
Monday-Friday

For more information, telephone 7-3500

WHAT?

A TEEN CENTER
WOULD FUNCTION AS A :

Resource Center

Films on human relations skills
small library
pamphlets available on
alcohol
drugs
nutrition
health

With:
crisis intervention
youth employment services
referral services

Workshops :
career opportunities
communication skills
personality development
crafts and technical skills
laws, rights, and responsibilities

Recreation Center

volleyball
basketball
ping pong
dances
pool
etc!

STATE of ALASKA

MEMORANDUM

TO: Trink Morimitsu
Staff Aide for Representative
Thelma Buckholt
Alaska State Legislature

DATE: February 23, 1979

FILE NO:

TELEPHONE NO:

FROM: Barbara McPherson 465-3591
Juvenile Planner
Criminal Justice Planning Agency

SUBJECT: Youth Center Programs Funded by CJPA

In the past three years Law Enforcement Assistance Administration funds have been awarded to the following youth center programs:

Petersburg Youth Program
Ketchikan Youth Advocate Program
Cordova Youth Services Center
Nome Community Center
Hoonah Youth Center
Craig Youth Center
Seward Recreational and Training Center
Tyonek Youth Program
Gambell Youth Center

As we discussed by phone, these programs have not been formally evaluated in relation to their effect on preventing juvenile delinquency, but their performance in meeting grant objectives for the delivery of services is monitored regularlary. However, the majority of these projects are able to provide measurable data on the reduction of delinquency in their communities after the implementation of these programs:

1. In the first year of operation of the Cordova Youth Services Center juvenile arrests decreased 17% and a March 1977 letter from the Cordova Chief of Police states that street contacts between police and juveniles were "well below the normal and I feel that it is mainly because of the Eyak Youth Services Center facilities and activities."

2. In Petersburg in 1977 there were 25 juvenile delinquency petitions filed with Petersburg court compared to 50 in 1976. A March 1978 letter from the Petersburg Magistrate states that "this reduction in filing may not be attributed solely to the youth program but I cannot help but feel the center and its leadership were contributing factors."

3. Juvenile arrests decreased 57% in the first year of operation of the Hoonah youth center.

4. Juvenile violations as compiled by the local police department decreased 76% during the first year of operation of the Craig Youth Center.

5. The Ketchikan Youth Advocate Program tracked juveniles with previous high arrests records during their first four months of involvement with the youth program. Of the 15, ten showed a decrease in rate of arrests and 8 of those 10 were not arrested at all during the four month period.

The lack of community financial support for the ongoing operation of these programs has been a major problem in their continuation when they are no longer eligible for LEAA funds. The most important factor in the success of these programs has been quality staff who are committed to working with youth.

TELEGRAM

RCA ALASKA COMMUNICATIONS, INC
PHONE: 586-6422
JUNEAU, ALASKA 99802

1979 MAR 5 PM 1 53

" 02064 NL TDA BARROW ALASKA 194 0-3-05 950A AST

PMS REP THELMA BUCKHOLDT

JUNEAU

THE CITY OF BARROW HAS PASSED A RESOLUTION SUPPORTING THE STATE OF ALASKAS HOUSE BILL NBR 125 ENTITLED AN ACT RELATING TO MULTI-PURPOSE YOUTH CENTERS.

WHEREAS THE COUNCIL IS DESIROUS OF PROMOTING THE MENTAL AND PHYSICAL GROWTH OF OUR YOUNG PEOPLE, AND WHEREAS, THE COUNCIL DESIRES TO OFFER EVERY OPPORTUNITY FOR THE GROWTH OF OUR YOUNG PEOPLE, AND WHEREAS THE COUNCIL DESIRES TO MAKE AVAILABLE TO OUR YOUNG PEOPLE SERVICES AND ACTIVITIES INCLUDING BUT NOT LIMITED TO HEALTH EXAMINATIONS, LEGAL ASSISTANCE, RECREATION PROGRAMS, COUNCILING, NUTRITION CLASSES, AND PROTECTIVE SERVICES, AND,

WHEREAS THE CITY OF BARROW IS OPERATING A TEEN CENTER WITH GRANTS FROM THE STATE AND CONTINUED FUNDING IS NOT ASSURED, BUT THE PASSING OF THIS BILL MAY RELEASE FUNDS TO AID THE CENTER AND,

WHEREAS THE COUNCIL SEES THE NEED FOR AND DESIRES THE ESTABLISHMENT OF A MULTI-PURPOSE YOUTH CENTER IN THE MUNICIPALITY OF BARROW.

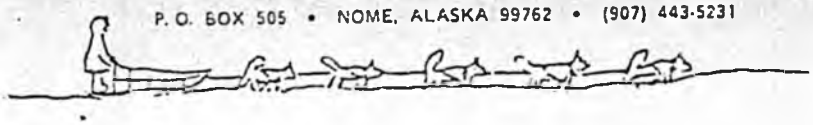
THEREFORE BE IT RESOLVED THAT THE CITY COUNCIL OF BARROW ENCOURAGES AND SUPPORTS THE PASSING OF STATE OF ALASKA HOUSE BILL NBR 125.

A COPY OF THIS RESOLUTION IS BEING FORWARDED TO YOU,

SINCERLEY

CITY OF BARROW CITY COUNCIL

KAWERAK, INC.
BERING STRAITS NATIVE ASSOCIATION
P. O. BOX 505 • NOME, ALASKA 99762 • (907) 443-5231



March 1, 1979

Representative Thelma Buchholdt
Pouch V
Juneau, AK 99811

Dear Ms. Buchholdt:

I have been recently made aware of House Bill Number 125 that you are sponsoring. As President of the Bering Straits Native Association and Kawerak I would strongly lend my support to the construction and operation of multi-purpose Youth Centers in the bush area of the state.

Nome has had a Teen Center operated by the Nome Community Center since 1971. It has provided a commendable youth recreation and counseling services helping many adolescents. A stable source of funding from the Department of Resources would enable consistent and adequate services for the youth of Nome.

Such programs are a high priority in the bush areas where recreational opportunities are limited and alcohol abuse is frequent in the teen population.

It is my sincere hope you will pass this bill with an amendment to provide for consistent funding for those communities that already have access to youth facilities.

Sincerely,

Caleb Pungowiyi

Caleb Pungowiyi
President

CP/sp

BERING STRAITS NATIVE CORPORATION

P.O. BOX 1008 · NOME, ALASKA 99762 · (907) 443-5252

March 2, 1979

Representative Thelma Buchholdt
Pouch V
Juneau, AK 99811

Dear Ms. Buchholdt:

I understand you are sponsoring House Bill #125. Youth Center programs provide very important services to teens who will be the future leaders of their community. I feel these services are especially needed in the bush areas to offer constructive alternatives to drug and alcohol abuse and to stimulate a sense of purpose and well-being.

The Community Center in Nome maintains a Teen Center which operates a successful program including recreational activities and counseling for adolescents. These youth who participate could continue to benefit from the Department of Resources.

I wish to express my support for Youth Centers to be constructed and operated in the Alaska bush areas, and I hope this bill will be passed. An ammendment should be written so the communities which already have access to facilities for youth will receive consistent funding.

Sincerely,

George Walters
President

GW/sp

CITY OF NOME

Home of the End of
IDITAROD TRAIL RACE

Office of the Mayor
LEO B. RASMUSSEN

BOX 2
NOME, ALASKA 99762
443-2919, -2798, -2900

CITY OF NOME
P.O. BOX 281 · NOME, ALASKA 99762
TELEPHONE (907) 443-5242

NOME'S A PLACE THAT YOU WILL HAVE TO VISIT:
IN MARCH - THE IDITAROD TRAIL RACE, NOME-GOLOVIN SNOWMACHINE RACE,
IDITAROD BASKETBALL TOURNAMENT, NOME JAMBOREE & CARNIVAL. IN JUNE - THE
MID-NITE SUN FESTIVAL. IN JULY - AN OLD FASHIONED 4TH OF JULY UNDER THE
MIDNIGHT SUN, TOURING YEAR-ROUND, GOLD MINING IN ACTION, ESKIMOES AND
THEIR ARTS & CRAFTS, DOG MUSHING, DO YOUR OWN GOLD-PANNING AND VISIT WITH
SOME OF THE MOST HOSPITABLE PEOPLE IN THE WORLD.

March 2, 1979

Representative Thelma Buchholdt
Pouch B
Juneau, Alaska 99811

Dear Representative Buchholdt:

I write in behalf of your house bill no. 125 which was introduced on the 6th of February relating to multipurpose youth centers. We have been operating a comparable center in Nome for several years and have noted a major change in youth arrest records during this period. Juvenile arrests in the first year were down 32% and again in the second year another 42%. It is now apparent that we will be needing program funds after March of 1980, as our funding is deadlined at that time.

If there is anything additional that we may do to assist you with this bill, please do not hesitate to let us know.

Sincerely yours,

Leo B. Rasmussen
Mayor

LBR/kp

cc: Senator Frank Ferguson
Representative Jack Fuller
Nome Community Center

Support the IDITAROD TRAIL RACE
ALASKA'S GREATEST DOG MUSHING EVENT

NOME COMMUNITY CENTER INC.

BOX 98 Nome, Alaska 99762
(907) 443-5259

TO: Alaska State Legislature Committee on Health,Education and Social Services

FROM: Nome Community Center, Box 98, Nome Alaska

SUBJECT: House Bill 125 "An Act relating to multipurpose youth centers"

The Nome Community Center has been asked to present testimony to you because we have operated a Youth Center in Nome since 1972. We would like to share with you the need for Youth Centers in the bush, the proven benefit youth and the community derive from Youth Centers and the overriding need for the State to comprehensively deliver recreational and counseling services to youth through the mechanism of Youth Center

NEED FOR MULTIPURPOSE YOUTH CENTERS IN ARCTIC ALASKA

There are three primary reasons why a youth center is important in Nome

1) Lack of adequate leisure time pursuits. There are no movie theatres, bowling alleys, commercial recreation halls or snack bars in Nome where the young people can meet one another to socialize. Other than the existing Youth Center no programs are presently avilable to provide constructive leisure activities for teens. When there is no Youth Center this group spends much time out wandering the streets of downtown Nome in search of companionship and "something to do". Concentration of the business and bars in town on Front Street means something to do is watching adults stagger from bar to bar.

2) Family problems. Many families must function under the burden of multiple problems: excessive alcohol use; separation and/or divorce; poor living conditions characterized by inadequate housing, large families and visiting relative; and general insecurity due to low educational levels and fluctuating incomes. Young people from this environment avoid their homes as much as possible. They take to the street in search of emotional committment and belonging among their peers. Before the Youth Center there was a growing marginally delinquent sub-culture which posited such values as hard drinking and fighting.

3) Dual culture environment. Eskimo youth are growing up in a non-native world with western standards of success, acciptable lifestyles and morality. The result is all too often very confued and alienated kids who belong to neither the old way of life or the new. Non-native youth must adjust to being a minority group. There is a potential for racial conflice without common leisure time and social pursuits.which is provided by the Youth Center.

EXISTING YOUTH CENTER PROGRAMS

The Nome Community Center provides a multitude of activities for youth at the Youth Center, school gyms and outdoors. These are all sponsored by the Youth Center Progra

Youth Center Activities. 30 to 60 youths come to the Youth Center each evening to play ping pong, pool or table games; watch T.V. sit quietly, read, do homework, or just interact with each other and the staff. Special times are set aside for films, discussion groups, guest speakers etc.

Gym Activities. Youth Center staff supervise basketball and volleyball for teens six nights of the week and afternoons on weekends and during summer. For gym programs we utilize either the grade school or high school gyms.

Ice Rink Activities. In the winter we operate and outdoor ice rink and warm-up shack from 3-9 daily. This is a very popular program among teens.

Day trips and overnight camping. We have taken 300 youths on day trips this past year. In the summer we go picnicing, hiking, berry picking and fishing. In the fall and winter there is hunting, cross-country skiing, and building snow caves.

Counseling for youth and parents. We have provided youth and their families with support and counseling in an effort to improve family and peer relations, reduce stress and substance abuse. This year there was 324 in depth youth counseling sessions and 100 sessions with parents and youth in their homes.

Agency Contacts. The Youth Center is a resource for agencies dealing with youth and we have had 275 agency contact this year.

EFFECTS OF YOUTH CENTER PROGRAM

Youth arrests have dropped dramatically since the youth program was adequately funded in 1977:

Youth Arrests by Year: Nome, 1974 through 1978

1974	1975	1976	1977	1978	Year
226	197	172	109	63	Number of youth arrests

Police Chief Ed Ward has stated he feels the drop in arrests is due to the presence of the Youth Center and Youth Center activites.

In December, 1978 we surveyed 60 adults to see if they felt the Youth Center was of benefit to the community and 82% replied affirmatively. The others stated they were either new in town and did not know of the Center or did not have youth.

WHY THE NEED FOR HOUSE BILL 125?

Alaska does not have a definite policy for youth programs. Services for youth are provided by a myrid of State Departments and some grants to agencies outside the State structure. The result of this is a fragmented, inefficient, possibly uneconomic and certainly ineffective approach to the needs and concerns of youth. It is time the State of Alaska recognizes the real need for consistent recreations, counseling and other services for youth in rural Alaska.

The Nome Youth Center has received only four years of funding during the past seven years of operation and none of that has come from the State of Alaska (1974 & 1975 Law Enforcement Assistance Agency; 1977, 1978 & 1979 National Institute of Drug Abuse. 1972, 1973 and 1976 volunteers only). The funding from LEAA and NIDA has been demonstration grants. That means that funding is only for a limited period of time with the theory that when the local community sees the effectiveness of the program it will pick up the program and provide local funding. This will never happen in bush Alaska where there is no community economic or tax base.

Youth need consisten not here today and gone tomorrow which is exactly what the current system fosters. Continuing to fund youth in a haphazzard manner creates a boom or bust program for kids. Just when they form attachments with a Youth Center staff member, the money runs out , no staff and one more youth who knew a real relationship with a stable adult was too much to hope for anyway. Youth need long term, reliable recreational and counseling programs sponsored by the State year after year.

We urge you as Legislators to speak up for the youth of Alaska by supporting the building and operation of multipurpose youth centers where they do not exist and the operation of youth centers and youth activities where they do exist.

Sitka Teenage Club, Inc.

SITKA TEEN SERVICE

P.O. BOX 191 • SITKA, AK. 99835

TELEPHONE 747-3500

January 25, 1979

Thelma Bucholdt
Alaska State Legislature
Pouch V
Juneau, Alaska 99811

Dear Ms. Buchholdt:

I wish to personally thank you for promoting the construction of Youth Centers in Alaska. I had received a copy of youth bills presented and did review bill 530. I would ask that this bill be resubmitted and since our incorporation has been pursuing assistance for construction of a Family Developmental and Recreational Center with priorities given to teens, I would be glad to send over any documentary of need, problems with Sitka youth and any other information you feel would be helpful in order for this type of bill to pass.

This is a very urgent matter in order to lessen the amount of vandalism, delinquency, youth suicides, motorcycle and car youth deaths that is occurring extensively in Sitka. I have reviewed three reports concerning the needs of youth in Alaska completed by Social Service and the mental health. Now, who is going to listen enough to help our youth? Do these divisions waste their time gathering this information and is it useless, if no one can see the importance of trying any type of measures in order to save lives among our youth. Our Center plans to open many programs to assist youth with small problems before they grow into the court system and such drastic measures as suicide. Are they not the future of Alaska and aren't we showing they are really not important if we cannot assist them in fulfilling their life needs.

We have completed three sets of drawings for construction - one ranging for a multi use day care and teen center, another metal building for approximately $150,000. and a set completed by the City who put aside $1500. to have Graham Associates complete the building worth $400,000. The Assembly has awarded us use of property next to the Firehall, but has restricted a metal building there. We have on hand 6,660. raised by our teens in the last year and the City is holding $8,000. that has been raised in the last 15 years by teens and interested adults. We are not asking for the complete amount of money needed - but could possibly borrow from the Farmers Home Loan enough funds to purchase $51,000 worth of supplies if the Assembly would grant use of another property for a metal building. A bond issue did go to our residents - which failed - 400 voting for and 1,000 against. There are many many reasons why individuals voted against. Cost too high, other priorities such as a hopsital or art facility, condeming nature towards youth, not in favor of using the property awarded.

I see where legislative individuals do place projects for passage and award different State divisions, such as Community and Regional Affairs and the

Transportation and Public Facilities for construction purposes - $500,000, $180,000, $216,000. I also realize when the Northern Citys of Alaska are represented heavier - we in Southeast have a time winning our fight. I do hope that each and every legislature will think broad enough to consider promoting any project that is for the betterment of each youth life.

You see a Center can be a coverup and disguise to assisting youth without labeling their problem into mental health, criminal, or alcohol and drugs. We can save much money in the long run working on preventive methods then waiting for youth to have to leave their home and unable to cope because they are sinking.

I would appreciate you making a copy of this letter, if possible, and give every legislature one in order that I may promote the need of these projects within Southeast especially, which do not offer as many preventive measures to our youth. Even though youth have a chance to take part in sports - they still enjoy their leisure time and some that show interest are not good enough to participate or do not like competitive sports. What percentage then are school s catering too? Cannot we increase this percentage to serve more youth and give them a chance to improve their self image and realize each life is important and has value.

Please send me a complete copy of bill HB 530 and let me know how we can promote our project.

Thank you so much for the efforts you have made toward a well worth project.

Enclosed you will find documentation of our efforts, successes and failures toward building a strong program in Sitka.

Sincerely,

Nina R. Bernhardt

Nina R. Bernhardt
Coordinator

PS: I believe all possibilities of construction should be made as broad as possible. For instance, the mental health has a construction clause. Our program does completely work on mental health but yet restrictions are so heavy - it is useless to try there.

The Law Enforcement offers construction funds for anti-crime programs. We are promoting anticrime, but yet restrictions again cannot be met. It seems we should take the program and fit the funding into this and not make the programs fit into the State divisions, especially when the goals can be met.

If a loan with a low interest rate could be found where we could use our $14,000. and pay monthly ourselves could be sought, we would be interested. We are willing to help in all expenses and are not asking for a hand out without working ourselves. Many of the Sitka teens are involved with our program and do enjoy what we have offered so far.

WE WISH TO SHARE WITH YOU EFFORTS MADE TOWARD A TEEN PROGRAM AND CENTER.

DATE	FUNCTION	RESULT	
8/76-11/76	CIVIC CENTER RECREATIONAL GROUP IN OPERATION NEED OF TEEN RECREATION & SOCIAL BUILDING THROUGH SURVEYS, REVIEW OF CITY MATERIAL PAST HISTORY OF TEEN & ADULT EFFORTS.	RAISED POSITIVE	$1,323.31
11/76	REACTIVATED SITKA TEEN CLUB-MONTHLY MEETINGS.		
2/28/77	ATTENDED POSSIBLE FUNDING OF CDA FUNDS	DENIED	
5/77	AWARDED A GRANT FOR SUMMER YOUTH PROGRAM FROM RURALCAP	AWARDED	$3,200.00
3/77	WROTE ALL GOVERNMENT AGENCIES FOR POSSIBLE FUNDING - FOREST SERVICE THROUGH YACC WAS WILLING TO ASSIST IN TEEN CENTER CONSTRUCTION IF CITY PROJECT	DENIED	
11/77	REVIEWED ALL CITY OWNED PROPERTY WITH PLANNING & ZONING & ASSEMBLY-SITE AT LAKE STREET.	APPROVED	
12/77	PAID ARCHITECT FOR TEEN CENTER_DAY CARE CENTER $300.00		
12/14/77	PENINSULA METAL STRUCTURES PROPOSED FOR BUILDING MATERIAL	$28,964.	
12/22/77	AWARDED A GRANT FROM THE ALCOHOL & DRUG ABUSE FOR YOUTH PROGRAMS ON A PREVENTIVE MEASURE. (categories-staff facility expense, commodities, equipment, travel, supplies,) fiscal year 1977-78.		14,414.00
3/78	SOUGHT REVENUE SHARING FUNDS THROUGH CITY	DENIED	
3/13/78	REQUESTED USE OF SCHOOL FACILITIES FOR SUMMER MONTHS	DENIED	
4/78	REQUESTED USE OF SHELDON JACKSON FACILITIES DURING SUMMER MONTHS.	APPROVED	
3/78	SOUGHT COMMUNITY DEVELOPMENTAL FUNDS THROUGH CITY FOR TEEN CENTER CONSTRUCTION	DENIED	
5/11/78	SUBMITTED TEEN CENTER CONSTRUCTION GRANT TO LAW ENFORCEMENT AGENCY-ANTI CRIME PROGRAM	DENIED	
6/78	TIMBER TRUSS COMPANY COMPLETED ARCHITECTURAL DRAWINGS FOR NO CHARGE & SUBMITTED PROPOSAL ALL BUILDING MATERIALS	$51,705.	
5/78	AWARDED A GRANT FROM ALCOHOL & DRUG ABUSE		33,833.00
	WITH ADDITIONAL FUNDS EXPENDED BY 6/78		3,500.00
9/78	TEENS HAVE SAVED FOR CONSTRUCTION & DONATED		4,781.10
	CITY HOLDING RAISED BY TEENS IN EARLIER YEARS		8,048.62

WILL SUPPORT CENTER THROUGH FUND RAISING, CLUB DUES, SNACK BAR PROFIT, ADMISSION FEES, DONATIONS, ASSEMBLY & CITY OFFICIALS ASSISTING - BOND ISSUE FOR CONSTRUCTION

OCTOBER 3 - VOTE YES * YES

(2

3/4/62 The Kodiak Jr. Chamber of Commerce offered to sponsor Teen Club for 1 year.

9/4/62 Letter to Mayor and Planning Commission for rezoning Lot 20, Block 22 F.T. Calvin, National Bank of Alaska.

11/13/62 Denial of rezoning of above lot by City. Letter from F.T. Calvin, to Mayor, lot offered to Teen Club for $3500, valued at $10,950. Had a Teenage Board of Directors, Mayor appointed Ken Brown, Cushing as chairman.

11/19/62 Board of Directors minutes - Board vacancies filled, offered rejected of purchase of property because of rushing conditions, and construction difficulty City Youth Director, when appointed, would serve on the Teen Board.

1/13/63 Teen Board of Directors meeting - needed 56 ft. by 140 ft. building for over 500 teens in the future, proposed site for building ROLLER PARK. Target date for construction was set for April 1, 1963, fund raising drive started. Mr. Brown moved and Mr. Bracken seconded, that it be recommended to the City Council through the Planning Commission that the Teen Club relinquish its claim on the PRESENT BUILDING SITE as set by the City ordinance and that the PROCEEDS the DISPOSITION of said lot by the City be added to the Teen Building Fund. The motion carried. Committments of donations were asked from the Clubs for building purposes at Roller Park, certain Clubs pledged to raise a certain amt. of funds before Sept. 15, 1963 - one pledge was $1500.00, $100.00 by Soroptomist Club, $100.00 in memory of Charles D. Jeanblanc by the American Legion Club, also $[illegible] in remembrance of Jeanblanc.

1/22/63 Revision of ordinance #306.

3/26/63 Mr. Ballard donated engineering services Linn Forrest architect $5,500.00
7/9/63 profits of 4th of July-transferred to teen bldg. $752.00 - excavation completed & materials on hand for footing - further funds needed.

9/27/63 teen committee reported Roller Park site would be PROHIBITIVE in cost. Cement be sold immediately and other materials ~~xxxxxxxx~~ held for a short time for a better and more economical site. Pulp mill, I heard, furnished cement & labor
9/24/63 Vandalism .
11/12/63 Met with library board regarding a building.
4/27/65 Jaycees use Roller Park for teenage rodeo
5/25/65 Burt Doucette - 4th of July chairman-teen sponsor queen contest
11/26/68 Youth Activities Committee - possible Moose Club $40,000 to $50,000
9/23/69 Council consider a need for a DIRECTOR. Mayor Papavich referred to Finance Co for 1970 budget
10/28/69 Mr. Christianson mentioned Unitarian Church property on Marine St., also prope owned by the Russian Orthodox Church on Monastery St.
10/1/69 Petitions to His Grace, the Rt. Rev. Theodosius, re: location of proposed Teen Center on survey #404, Tract D, Russian Church property on Lake Stree, reasons not proper parking area, building would not meet proper set-back regulations required by borough code unless a variance was granted, no outdoor recreational space available, noise factor involved when dances are held. Working people w small children live very near, no parking should be permitted on Oja St, shoul be for public safety fire trucks, oil trucks - other suggested areas were Roll Park, infront of Bayview Motel, Russian Church property by Episcopal Church, Baranof Grade school play ground.
12/23/70 Agreement of City for use of fire department space as Teen Center - would lead (By April 1, 1971 Club shall have submitted plans for the alterations and remodeling within 60 days after the Club has been informed in writing, Club must occupy premises by this time. Failrue to comply with provisions shall

NATIONAL
Bank of Alaska

SAVINGS ACCOUNT STATEMENT

STATEMENT DATE

SITKA TEENAGE CLUB
PO BOX 191
SITKA AK 99835

13

9-30-77

13-1-05410-4
ACCOUNT NUMBER

WITHDRAWALS	DEPOSITS	INTEREST	DATE	BALANCE
	BALANCE FORWARD (1977)		08-30	573.87
	DISCO DANCE -----91.00		09-07	664.87
		7.17	09-30	672.04
	rented disco equip. 60.00		10-21	732.04
	DISCO DANCE ----- 63.78		10-25	795.82
	GIFT & FOOD SALE ---- 52.30		10-27	848.12
	FLEE MARKET ---- 50.50		11-29	898.62
	DISCO DANCE ---- 64.71		11-29	963.33
	RUMMAGE & FOOD SALE-123.56		12-08	1,086.89
		10.34	12-31	1,097.23
	GIFT & FOOD SALE ---- 34.96	(1978)	01-04	1,132.19
	DISCO DANCE ----- 54.75		01-04	1,186.94
	DISCO DANCE ----- 31.29		02-21	1,218.23
	DANCE-expenses hig 7.21		03-03	1,225.44
	LIVE DANCE ------ 16.50		03-13	1,241.94
	GAMES TOURNAMENT --- 38.16		03-30	1,280.10
	YOUTH GAME TIME ---- 28.70		03-30	1,308.80
WITHDRAWALS	DEPOSITS	INTEREST	DATE	BALANCE
	BALANCE FORWARD (1978)		03-31	1,323.40
	GIFT & FOOD SALE ----- 44.23		04-05	1,367.63
	DISCO DANCE-REFRESH.-- 41.53		04-05	1,409.16
	49.20		04-05	1,458.36
	61.00		04-21	1,519.36
	POSTER-RUMMAGE SALE ----- 67.99		05-02	1,587.35
	EVENING OF MUSIC ------ 201.85		05-30	1,789.20
	DISCO DANCE-REFRESH.---- 70.90		05-30	1,860.10
	WALKATHON ---------- 24.50		06-12	1,884.60
	LIVE MUSIC DANCE ------ 55.00		06-12	1,939.60
	DONATION-ELKS CLUB ---- 510.00		06-28	2,449.60
	WALKATHON ---------- 18.05		06-28	2,467.65
	PAYMENT QUEEN DANCE -- 200.00	19.59	06-30	2,487.24
	POSTER, HAT & BAKE SALE 41.16		7-5-78	
	4th BOOTH- 698.50		7-6-78	
	DONATION CIVIC CENTER 751.96		7-7-78	
	LIVE MUSIC DANCE 136.68		7-18-78	
	WALKATHON 63.00			
	DISCO DANCE 81.80		8-20-78	
	LIVE MUSIC DANCE 285.35		8-28-78	4,781.10

Dear Sir:

The survey taken of teenagers from the Sitka school, grades 8 through 12th, of whether the Sitka Teenage Club should become active again has been completed and at this time we would like to share the information compiled with the residents of Sitka.

Out of 298 questionnaires completed, 266 teenagers voted yes to reactivating the club and 32 no. The main reasons for the students voting no were the fact if they had another building it would be too expensive, felt the Sportland and Rock was enough activity, students wouldn't take care of it, waste of time and money, too much competition for some other business people. To the question of what other programs would they like started for the teenagers in our area, the following were stated many times: priority was weekly dances and roller skating, indoor tennis (including lessons) gymnastics, miniature golf course, handball, camping out, picnics, hiking, volleyball, basketball, skateborading, mechanics course, workshops on drama, ballet, race track for motorcycles, youth employment jobs, soccer, potlucks, football, rock concerts.

To the question of "If the Sitka Teenage Club re-activated, could you see any advantage of having your own building? Although some of the following statements are similar in nature, we feel there is much value in the way they were worded: "Wouldn't have to pay rent, could have more things to do, would more likely take care of their own building, because we can put what we want in it. Because we wouldn't have to use the Centennial Building and we would be able to have events whenever we wants them, kids wouldn't get in trouble so much; can have a place to call our own; no one could kick us out of the building; you could set your own hours and do whatever you want; nothing to do, that's why some of us get into trouble; we would have a place to go and not bother people, more privacy; this could be their own responsibility and they would take more pride in keeping it in an orderly and clean manner; they would have more respect if they had their own place; our building could be decorated and looked after the way we want; where else could we get if we do not have our own building. If they have good rules and enforce them, then our own building would be great; well, people that tend to have nothing to do to get into trouble; give a place to go instead of running the streets; you could plan different activities and there could be different things going on all the time; we would have a place of our own and a place we could count on always; if we owned our own place, we could fix it up and take care of it; a roller rink could give another place for people to go and the high school could sponsor it; I would go to a building if it was close to town; if we had our own building, we wouldn't bother other people; a chance to meet a few more people and a place just to have fun or relax with friends; because it's hard to get a school gymnasium and the Centennial Building costs money; wouldn't have the problem of renting out another place; no hassles of reserving a building.

A meeting has been called for all Sitka teenagers interested in belonging to the Sitka Teenage Club. The meeting will be Sunday, October 24 at 2:30 p.m. in the upstairs of the Moose Lodge. The purpose of this meeting will be to review the Sitka Teenage Constitution and bylaws, the club rules, goals and objectives of the club, which all will be voted on election night to be held in the future. Nominations for the following officers will be taken president, vice-president, secretary, treasurer, sergeant at arms, and one year executives boy and girl from each age level — 13 through 18. Club members are asked to have a petition signed with 10 signatures for the individual they propose for a candidate. Two meetings have been held with charter members Jim Hanson, Leslie Schmidt, Mike Briggs, Joe Roth, Rus Wilson, Joan Valle, Daniel Karr. Any Sitka residents that would be interested in working with the teenagers as an advisor are welcome to come to the meeting.

Any Sitka Teenager between the ages of 13 and 18 may become a member of the Sitka Teenage Club by completing an application form, pay their year dues of $1.00 and agree to abide by the following Club rules. (1) No rowdiness or profane language (2) No smoking, (3) No one allowed into Club functions under the influence of liquor, (4) No drinking of liquor at Club activities, (5) The Club members shall be responsible for any damages to any building during Club sessions, (6) Penalty for breaking rules can be temporary expulsion or permanent suspension of membership and revoking of membership card, (7) Membership card will be shown before entrance to Club activities. Any Sitka Teenager that is interested in becoming a member may contact the following Teenage Officers: president, Terry Benneberg; vice president, Steve Craddick; secretary, Mary Howard; treasurer, Leslie Schmidt; sergeant at arms, Russ Wilson; or publicity chairmen, Mark Bovee or Spence Bovee. The object of the organization shall be to promote loyalty to members, responsibility and good fellowship and to carry out recreational and social events for members and to unify and strengthen the Club.

Teens Set Bake Sale

Sitka Teenage Club members are having a food sale at the National Bank of Alaska, Wednesday, between 12:30 and 3:30 p.m.

Featured will be pumpkin pie, fruit cake, rice krispie bars, Christmas cookies and many other items. A drawing of a winner for the Santa Claus carrot cake will be done at 3:30 and delivered to the individual. Someone will win this decorated Christmas cake for just 25 cents.

All Teen members, or anyone else that would like to donate in this fund raising drive for teen needs, is asked to leave their donations at the bank not later than 12 noon.

THANK YOU to the following from the Sitka Teenage Club.

- the Moose Lodge for the use of their upstairs area for our two disco dances.
- Mr. and Mrs. Bone, Miss Hadley and Velma Howard for chaperoning our dance.
- the following Teenage Members for donating to our food sale — Peggy Dieryck, Nicco Holt, Mary Ann Goodman, Debbie Bernhardt, Alberta Nelson, Jennifer Gomez, Marion Sutter, Sandy Jenny, Spence Bovee, Veronica Howard.
- Shirley Kimball for donating the Christmas Cake which was won by Doris Northrup.

CITY AND BOROUGH OF SITKA

RESOLUTION NO. 78-118

A RESOLUTION OF THE CITY AND BOROUGH OF SITKA INDICATING THAT THE ASSEMBLY IS SUPPORTIVE OF THE EFFORTS OF THE TEEN AGE CLUB TO PROVIDE A TEEN CENTER FOR SITKA.

WHEREAS, the history of the Sitka Teenage Club, which is recorded in the municipal office, indicates that many adults, teens, past mayors and assemblymen have worked toward a Teen Center in order to provide recreational and social opportunities for Sitka teens, and

WHEREAS, many residents and teens have seen the need for a Teen Center and have indicated that there is a need for such Center to the Assembly through written reports, surveys, resolutions, and other statements made at meetings -- such as at hearings in regard to use of Community Development Block Grant Funds, and

WHEREAS, the Sitka Teenage Club has been reactivated for a year and a half and has received a grant through the Alcohol and Drug Abuse Program to assist in the operation of the Sitka Teen Service office, hire a staff to promote recreational and social activities for all teens of the area, and

WHEREAS, the Assembly voted unanimously at their regular meeting held November 22, 1977, to give tentative approval for use of the property situated next to the Fire Hall for construction of a Teen Center,

NOW, THEREFORE, BE IT RESOLVED by the Assembly of the City and Borough of Sitka that it lend its supportive efforts to the Teen Age Club to provide a Teen Center for Sitka.

PASSED, APPROVED AND ADOPTED by the Assembly of the City and Borough of Sitka on this 14th day of MARCH, 1978.

Ben F. Grussendorf, Mayor

ATTEST:

Myrtle V. Flynn, Clerk.

Youth Alternative Services Network
P.O. Box 928
Anchorage, Alaska 99510
279-3497 272-6713

March 23, 1978

Rep. Thelma Bucholdt
Pouch V
Juneau Alaska 99810

Dear Representative Bucholdt,

I am writing in regard to your bill, HB 530, "an act relating to multipurpose youth centers." I endorse your effort to assist the development of services for young people. The need is great.

Our technical assistance project offers training to communities which wish to provide alternatives for their young people. At this time I am working with about 25 communities across the state which have recognized a need and want to meet that need locally. Their interest is in providing services locally that will prevent the necessity of state intervention through corrections or social services. For rural communities, state intervention often means that young people are removed completely from their home and town; many never return.

People who seek training from our project file an application which describes the problem in their community. It is clear from these applications that services for youth in most Alaska communities are nil. Even Fairbanks, with its share of the youth population, does not have an alternative program for young people which is specific to their needs. The Island counseling center works with young people, as does the crisis line, and Presbyterian Hospitality House is a placement facility, but even persons in these programs will tell you that there is a need for more.

Small communities are desperate for help. They describe a tragically high youth suicide rate, higher even than that for adults in Alaska. They describe young persons turning to alcohol and drugs (even in the Bush) for lack of anything else to do. One village mayor near Kotzebue wrote to say that in the recent past one

...RTER
...MBERS: Alaska Youth Advocates; Family Connection; Open Door Clinic

young girl had frozen to death driving a snowmachine drunk, and another young man in the village had shot himself through the heart. They were 15 and 16.

The smaller communities in Alaska have an advantage over us in Anchorage: they can see clearly what the problem is and they can tell more readily what needs to be done, and once that is done, if it is working. They say over and over again, that the need is for local recreational, counseling, and short-term placement facilities.

I would be happy to talk about these needs with you further. I enclose some samples of the applications for assistance which we have received. We are able to help these people plan and meet their own needs, but there must be funds made available so that they can implement these plans. Thank you.

Sincerely,

Barbara L. Hodgin
Technical Assistance Coordinator

YOUTH CENTERS IN ALASKA (BY ELECTORAL DISTRICT)

DISTRICT	POP (reg. voters)	TOWN	YOUTH POP (second. school)	SERVICES FOR YOUTH	KIND OF SERVICE
1	9,230	Ketchikan	1200	Youth Advocate Program	Counselling, drop-in center
		Craig	101	Craig Youth Center	Counselling, recreation
		Metlakatla	171	Alcohol Program	Counselling
2	4,320	Wrangell	250	Alcohol Program	Counselling
		Petersburg	189	Petersburg Youth Program	Counselling, recreation
3	4,949	Sitka	913	Sitka Teen Club	Recreation, socializing
		Hoonah	138	Hoonah Youth Center	Recreation, counselling
4	15,909	Juneau	1970	Teen Age Club	Recreation, counselling
5	8,001	Valdez	284	Valdez Teen Club	Recreation, counselling
		Seward	?	Youth Development Center	Counselling
		Cordova	256	Cordova Youth Center	Recreation, counselling
6	10,577		1,601		
7 - 12	123,186	Anchorage	18,552	Alaska YOuth Advocates	Crisis intervention
				Cook Inlet Native Assoc.	Drop-in center
13	13,056		2226		
14	4,541	Kodiak	893		
15	2,990		171		
16	3,469	Dillingham	232	Bristol Bay Area Health Corp.	Counselling
17	4,028	Bethel	527	Alcohol Program	Counselling
18	3,569				

19	6,617	Tok		Alcohol Program	Counselling
20	37,184	Fairbanks	5320	Island Counselling Center	Counselling
21	3,887	Barrow	428	Teen Center	Recreation, Counselling
22	4,109	Nome	655	Nome Comm. Center	Recreation, counselling

POSITION PAPER/Department of Health & Social Services

HOUSE BILL NO. 125

"An Act relating to multipurpose youth centers."

This Bill provides for the construction and maintenance of multipurpose youth centers in each of the state's election districts. The Department of Health and Social Services supports the concept of multipurpose youth centers. In fact, the final report of the Division of Social Services Youth Services Task Force which was submitted to the Director in June, 1977, pointed to the need for community based services, recreation programs and youth facilities. During Fiscal Year 1979, the Division of Social Services provided some support to youth centers in Barrow and Craig through contractual agreements under the division's youth services program. The department views the establishment of youth centers to be in accordance with its attempts to provide more community based services which focus on prevention and early intervention.

The department opposes the assignment of the responsibility for services supervision (as outlined in Sec. 41.20.510, Function of Multipurpose Youth Centers) to the Department of Natural Resources. The department is particularly concerned about those services which obviously come under its purview: health examination, counseling, nutrition classes, protective services, and assistance in obtaining legal representation.

In summary, the department supports the concept of community multi-purpose youth centers but questions House Bill 125's assignment of responsibility for delivery of services which are in the scope of this department's responsibility to the Department of Natural Resources. It would appear that the Department of Natural Resources would have to increase staff to include professionals to coordinate and provide such a wide range of services, in addition to the provision of physical facilities. In view of the state's budget constraints, the department cannot support an increase in state spending which duplicates services.

RECOMMENDED BY: Art Holmberg 3/7/79
Art Holmberg, Director — Date
Division of Social Services

RECOMMENDED BY: [signature] Mar 7, 1979
Robert Fraser, Director — Date
Division of Public Health

RECOMMENDED BY: [signature] 3/7/79
Charles Sothan, Acting Director — Date
Division of Corrections

APPROVED BY: Helen D. Beirne 3/7/79
Helen D. Beirne, Commissioner — Date
Department of Health & Social Services

FISCAL NOTE

I. REQUEST
Bill/Resolution No. HB 125
Title An Act Relating to Multipurpose Youth Centers
Requested by Pat Conheady Date 2/23/79

II. FISCAL DETAIL
Agency Affected Department of Natural Resources
Program Category Affected Parks and Recreation
Budget Request Unit(s) Affected Park Management and ACAC

EXPENDITURES (Thousands of Dollars)

	FY 77	FY 78	FY 79	FY 80	FY 81	FY 82
100 PERSONAL SERVICES				207,000	1,647,000	1,514,000
200 TRAVEL				20,000	20,000	10,000
300 CONTRACTUAL				600,000	300,000	300,000
400 COMMODITIES				10,000	100,000	100,000
500 EQUIPMENT				10,000	600,000	100,000
600 LAND & STRUCTURES					6,000,000	
700 GRANTS, CLAIMS, ETC.						
TOTAL				847,000	8,667,000	2,024,000

FUNDING (Thousands of Dollars)

GENERAL FUND				847,000	8,667,000	1,954,000
FEDERAL FUNDS						
OTHER (Specify)						

POSITIONS

FULL TIME				6	66	62
PART TIME						
TEMPORARY						

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

SEE ATTACHED

IV. DATE 3/2/79 PREPARED BY Nat Gc.dhue
AGENCY Division of Parks
PHONE 274-4676

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)

33-001 (Rev. 10/76)

III. Analysis

A & B. Assumptions and Program Summary

State acquisition, development, maintenance and operation of multi-purpose youth centers in every election district would entail the compensation of a large staff to include the following:

Land acquisition:	Realty Officer III (PG 18)	$38,000
	Realty Officer I (PG 13)	27,000
Land Facility Construction:	Civil Engineer I (PG 19)	40,000
and Maintenance	Civil Engineering Asst. II (PG 16)	32,000
Statewide Op.:	Social Services Fld Admin. (PG 23)	50,000
	Clerk Typist III (PG 8)	20,000
		$207,000
Multi-purpose Youth Center Operations:		
	20 Social Worker III (PG 16)	660,000
	20 Recreational Assistants (PG 11)	480,000
	20 Clerks (PG 6)	300,000
		1,440,000
	Total Personal Services (FY '80)	$1,647,000

Land Acquisition, building design and construction costs are based on the assumption that 1) land will be obtained through trades and transfers 2) construction costs for 1500 sq. ft. youth centers at $200 per square foot = $300,000 per center times 20 equals $6 million, and building design at 10% of construction costs equals $600,000.

Annual facility maintenance is estimated to cost 5% of initial construction costs which will equal $300,000 per year to be accomplished by contracts with local people.

C. Computations -- None.

Alaska State Legislature

House of Representatives

Committee on

Health, Education & Social Services

Official Business

Pouch V
State Capitol
Juneau, Alaska 99811

February 7, 1979

Ms. Nina R. Bernhardt
Coordinator
Sitka Teenage Club, Inc.
P.O. Box 191
Sitka, Alaska 99835

Dear Ms. Bernhardt:

Thank you for your recent letter regarding Youth Centers in Alaska. I do appreciate hearing from someone actively involved in these projects and I would be happy to accept any documentation or information that you may wish to send me in this matter.

I am sending you a few copies of ~~HB 530, the bill I introduced last year, and copies of~~ (HB530 last year) HB-125, which I have introduced this session. ~~This bill is in the House Health and Social Services Committee.~~ At the present time, HB-125 is in the House Health and Social Services Committee, (HESS) of which I chair, and I am hopeful that we can get the bill ~~out of the Committee this session~~ passed by the House this session.

It might be helpful if you would ~~request~~ write to your legislators (Rep. Richard Eliason and Sen. Pete Meland) ~~to support the passage of this bill this year.~~ & request their support of this bill.

~~I am making~~ Copies of your letter will be distributed to ~~for all~~ the members of ~~this~~ the legislature ~~committee~~, in hopes that it may convince those who are not familiar with this problem to vote for passage of the bill.

Again, thank you for taking the time to write to me. If I can be of further assistance please do not hesitate to call on me. I will be looking forward to hearing from you again.

Sincerely yours,

~~REP.~~ THELMA BUCHHOLDT
Chairman
House HESS

TB/ch

SAMPLE BUDGET: TEEN DROP IN CENTER

The center provides counseling guidance through a center which also provides recreational opportunities. The center is open from 2-10 p.m. on school nights and 12-12 on weekends. Individual and family counseling is available. Individual counseling and educaitonal programs cover drugs, alcohol, employment opportunities, academic help, and personal problems.
The center draws youth through a number of activities including rap groups, organized field trips, study nights, and in-center activities of interest to teenagers, including sports, speakers, and a library.

The center is staffed by a director, an administrative assistant, three counselors, and a VISTA outreach worker. The VISTA outreach worker also does job opportunity development through contacts with local businessmen and state and local employment projects.

Personnel	Direct Cost	Match	Total
Director	15,600	0	15,600
Administrative Assistant	10,800	0	10,800
Counselor (CETA)	0	10,800	10,800
Counselor "	0	10,800	10,800
Counselor "	0	10,800	10,800
VISTA	0	4,200	4,200
Fringe	2,600	0	2,800
Facility Expense			
Rent (450 mo.)	5,400	0	5,400
Telephone (100 mo.)	1,200	0	1,200
Utilities (200 mo.)	1,200	1,200	2,400
Office Supplies (75 mo.)	900	0	900
Literature	150	0	150
Typewriter rent	360	0	360
Xerox	0	140	140
Furniture (+donations)	900	500	1,400
Sports equipment	1,000	500	1,500
Insurance	500	0	500
Brochures, advertising	500	0	500
	41,110	38,940	80,050

This project could serve could serve a community of three thousand, with a variety of opportunities for kids and parents. It relies heavily on local support through some cash and material donations, and relies on the community to seek CETA positions for staffing.

SAMPLE BUDGET: RESIDENTIAL PLACEMENT EMERGENCY PROGRAM

This project provides emergency placement and short-term counseling to children and youth who cannot remain in their own homes because of abuse, parental alcoholism, neglect, or imminent danger to themselves because thay cannot or will not return home. The primary focus is on short-term placement for protection.

The project provides an all-night drop-in center with two beds and back-up of 10 volunteer foster family placements. Referrals come from the police, social worker, health aide and youth themselves.

After a placement, young children will be referred to the social worker and may remain in placement or placed elsewhere. Older youth will be referred to counseling resources, a social worker, or school counselor for appropriate intervention.

It is anticipated that the majority of children and youth will return to their own homes with appropriate community resource support.

Personnel	Direct cost	Match	Total
Director/home coordinator	15,600	0	15,600
Counselor	10,800	0	10,800
Night Staff (3-4 nights)	5,400	0	5,400
Night staff "	0	5,400	5,400
Fringe	3,100	0	3,100
Facility expense			
Rent (450 mo.)	5,400	0	5,400
Telephone(50 mo.)	600	0	600
Utilities(200 mo.)	1,200	1,200	2,400
Office supplies&literature	750	0	750
Typewriter (30 mo.)	360	0	360
Furniture	500	500	1,000
Insurance	1,000	0	1,000
Bedding, cooking supplies	2,000	0	2,000
Brochures& publicity	300	0	300
	47,010	7,100	54,110

Re HB 125 Breakdown of line item from Dept. of Health and Social Services for youth services

For F. 79:

1. Barrow Youth Center $30,192

2. Youth Alternative Services Network $38,225

3. Bidarki Corp. Cordova $14,580.50

4. Craig Youth Center $17,663.00

YOUTH ALTERNATIVE SERVICES NETWORK PROPOSED BUDGET
FOR MULTI-PURPOSE YOUTH CENTER NEEDS ASSESSMENT

	TA GRANT	NO GRANT
Salary director	$1980	7920
Salary (2nd staff person)	5301	5301
Unemployment	205	205
Phone	450	900
Travel	8100	8100
Rent	900	1800
Supplies	300	300
Xerox	300	300
Postage	225	225
Insurance	185	202
Training supplies (journals etc.)	150	150
Repair of equipment	100	100
TOTAL	$18,196	$25,503

BY BUCHHOLDT

HOUSE BILL NO. 125

For an Act entitled: "An Act authorizing state aid to non-profit organizations, citizen, community or municipal organizations for the construction, program development and/or support of multi-purpose youth centers within each election district or for the expansion or continuation of such activities of centers that may already exist within each election district."

* To be established within the Department of Health and Social Services
* Application for a grant shall be made in the form required by the Commissioner
* Funds will be granted on a match basis to be gradually shifted from state to local funding (year 1-90% state, 2-80%, 3-60%, 4-50%, 5-30%. Programs that meet criteria for funding after 5 years will be funded 20% per year).
* Land for new sites shall be selected by the sponsoring organization or non-profit group within each district.
* Sponsoring organizations must document to DHSS that they will be able to comply with the funding formula.

Funds will be appropriated for the following reasons:

I. 1) to construct new facilities. Grants will be funded for this purpose only when the sponsoring organization documents that:

a) no centers presently exist in the district and need for such a center does exist

b) centers that do exist are inadequate to meet the needs of the youth of that district and such need is documented

c) related programs, not youth centers necessarily, are inadequate to meet the needs of that district

d) expanding existing teen centers or youth programs in the district would not adequately meet the needs of the youth of that district and such need is documented

e) no buildings are available that could be altered or renovated to serve the needs of youth in the district and such need is documented

2) to renovate, remodel or expand existing buildings not currently used as teen centers when need for such activity can be documented within the election district. Grants will be funded for this purpose when the sponsoring organization documents that:

a) centers that do exist are inadequate to meet the needs of the youth of that district and such need is documented.

b) related programs, not youth centers necessarily, are inadequate to meet the needs of that district

c) expanding existing teen centers or youth programs in the district would not adequately meet the needs of the youth of that district and such need is documented

3) to renovate, remodel or expand existing teen centers where it is documented that such additions would sufficiently meet the needs of the youths of that district and where it can be documented that existing teen centers do not meet the needs of the youth of the district as they currently exist. Grants will be funded for this purpose when the sponsoring organization documents that:

a) centers that do exist are inadequate under present circumstances to meet the needs of youth of that district and such need is documented.

b) related programs, not youth centers necessarily, are inadequate to meet the needs of that district and such need is documented.

II.

1) to fund programs for newly constructed teen centers. Grants will be funded for this purpose when the sponsoring organization can document that:

a) such programs will meet the needs of youth of that election district

b) such programs do not duplicate already existing services available in that district

c) programs that do exist in the district are inadequate to meet the needs of youth of that district

d) funding for such programs is not available from any other source or is available but in inadequate amounts

2) to fund programs for existing teen centers. Grants will be funded for this purpose when the sponsoring organization documents that:

a) programs seeking funding have met the needs of youth in that district

b) continued funding of the program would continue to meet the needs of youth of that district

c) increasing funding of existing programs for existing youth centers would increase their ability to meet the needs of youth of that district

d) funding for such programs is not available from any other source or is available in inadequate amounts

III.

1) To provide funds for the acquisition of equipment for newly constructed teen centers. Grants will be funded for this purpose when the sponsoring organization can document that:

a) such acquisitions would fill the needs of the youth served in the election district

b) existing equipment does not sufficiently meet the needs of youth in the election district

2) To provide funds for the acquisition of equipment for already existing teen centers. Grants will be funded for this purpose when the sponsoring organization can document that:

a) such acquisitions would fill the needs of the youth served in the election district

b) existing equipment does not sufficiently meet the needs of youth in the election district

DOCUMENTATION OF NEED

Each sponsoring organization shall provide the following information to the Department of Health and Social Services:

I.

1) to document the need to construct new facilities when youth centers do not already exist in the district.

a) number of youths in the district

b) number of youths center anticipates serving

c) documents from municipalities, townships or local governing bodies of the election district stating that youth centers do not exist

d) crime rate or high school drop-out rate or other indicators of need in the district

e) petition of support from youths in that district

f) documents of support from a majority of youth programs or services that operate in the election district stating need for a youth center

2) to document the need to construct new facilities or expand existing facilities when youth centers already exist in the election district

a.) number of youths in the election district

b.) number of youths served by the present youth center

c.) number of youths anticipated to be served by the new or expanded center

d.) crime rate or high school drop-out rate or other indicators of need in the district

e) petition of support from youths currently using existing youth center

f) petition of support from youths anticipating use of new or expanded youth center

g) documents from a majority of existing youth services or programs that operate in the election district stating the need for both the existing youth center and the new or expanded center

II.

1) to document the need for new programs-for each program component that requires funding:

a) description of program goals and methodology

b) number to be served

c) documentation that such a program was successfully operated in another location

d) letters of support from youths who anticipate being served

e) letters of support from a majority of agencies that operate related programs in the district

f) documentation that funding is unavailable from any other source

2) to document the need for existing programs

a) description of program goals, methodology, history

b) number of youths served

c) documentation of success: events, numbers attended, letters of support, statistical evidence that program had significant positive impact

d) documentation that program funding is unavailable from any other source

e) letters of support from a majority of related agencies that operate in the election district

3) to document the need for acquisition of equipment

a) description of equipment and anticipated use

b) number of youths served by equipment (where applicable)

c) documentation that program funding is unavailable from any other source.

DEFINITIONS

Youth - persons between the ages of 13-19.

multi-purpose youth center - a structure of part of a structure to be used specifically for youth activities such as recreation, counselling, classes, health care, socializing and other specified programs.

election district - one of 22 electoral districts in the state .

related programs - programs which involve youth, such as alcohol, drug, mental or physical health, usually sponsored by local, state, or federal agencies.

equipment - items such as recreational or medical equipment to be used for specified youth center programs.

HOUSE BILL 125-Relating to multi-purpose youth centers

SUMMARY SHEET

In many areas of Alaska, there is no place for youths to go for recreation, socializing, or counselling.

Many youths who experience family problems or must deal with the pressures of adjusting to two cultures seek escape.

The result:

* Alaska has the highest rate of residential alcoholism in the United States.

* The suicide rate of 16-19-year old in Alaska is 30% higher than the national average.

* Alaska juveniles account for 57% of all arrests for Part I crimes (murder, rape, robbery, aggravated assault)

* 33% of the state's total population are drug users; young people in school and out are the largest percentage of drug users.

The thrust of this bill is to offer alternatives to youths, to give them a place to go for recreation, counselling, and other services.

Youth centers can be effective in reducing juvenile delinquency:

1. In the first year of operation of the Cordova Youth Services Center, juvenile arrests decreased 17%. A March 1977 letter from the Cordova Chief of Police states that street contacts were "well below normal and I feel that it is mainly because of the Eyak Youth Services Center facilities."

2. In Petersburg in 1977 there were 25 juvenile delinquency petitions filed with Petersburg court compared to 50 in 1976. A March 1978 letter from the Petersburg Magistrate states that "this reduction in filing may not be attributed soley to the youth program but I cannot help but feel the center and its leadership were contributing factors."

3. Juvenile arrests decreased 57% in the first year of operation of the Hoonah youth center.

4. Juvenile violations as compiled by the local police department decreased 76% during the first year of operation of the Craig Youth Center.

5. The Ketchikan Youth Advocate Program tracked juveniles with previous high aresst records during their furst four months of involvement in the youth program. Of the 15, ten showed a decrease in rate of arrests and 8 of those 10 were not arrested at all during the four-month period.

6. The Mayor of Nome states that after the Nome youth center opened, juvenile arrests were down 32% in the first year and 42% in the second year.

(Statistics compiled by Barbara McPherson, Planner, Criminal Justice Planning Agency and Leo Rasmussen, Mayor of Nome).

Some $ figures:

Cost of processing juvenile offenders:

Treatment for 1 Day at McLaughlin Youth Center	81.99/day
Processing one juvenile case thru the courts (Jan. 78 average cost to state)	1,217.00/day

In 1978, over 6,000 juvenile court cases were processed.

Name	Address	Organization	Bill No.
Blake Kazama	P.O. Box 808 Douglas, AK	Comm. Educ.	HB 204
Blanche Wilson	K-1 655 University Fairbanks	Coalition of Economic Justice	HB 125
John Coffee	Box 808, Douglas, Ak.	Juneau Schools	HB 204
Elizabeth Mukstarian	POUCH H 05	DHSS	HB125
Marie Kessler	8944 Blackberry, Anchorage	Coalition of Ec. Justice	HB 125
Cheryl Robinson	1545 South 14th ap 63 Anchorage 99504	Comm. Educ.	HB 204
Steve Hale	Pouch F	DOC	HB-54
Kim Ratz	DOE Pouch F Juneau	Comm. Ed.	HB-204
Joe Miguel	DOE	Com. Ed.	HB 204

Name	Organization	Address	Bill No.
ELIZABETH MUKTARIAN	DIVISION OF SOCIAL SERVICES	POUCH H05	125
TERRY McWILLIAMS	DIVISION OF PARKS, D.N.R.		125
Frank R Peterson	Kodiak Area Native Assoc.	Box 172, Kodiak, AK 99615	HB 200
Fred Zharoff	Kodiak Area Native Assoc.		HB 200
Andy Kahutak		Akhiok, Alaska 99615	HB 200
Bob Greene	Assn of Alaska School Boards	204 North Franklin St. Juneau	H.B. 200
Mary A. Barsdate	Juvenile Justice Advisory Board Governor's Commission on the Administration of Justice	P.O. Box 80174; College, AK; 99708	HB 125
Carol Benson	Nome Community Center	Box 98, Nome	HB 125
Charles Johnson Jr.	Kawerak Inc	Box 948 Nome 99762	HB 125
Jim Shook	ALASKA STATE TROOPERS	914 Calhoun #4 Juneau 99801	HB 125
Max Dubois	Juneau Teen Club	Juneau	HB
Melissa Middleton-Cook	Family Connection	640 Cordova St. Anchorage 99501	HB 125

WORK DRAFT PAPER WORK DRAFT PAPER

WO 6244
Berrier

Original sponsor: Buchholdt

IN THE HOUSE

BY THE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

CS FOR HOUSE BILL NO. 125

IN THE LEGISLATURE OF THE STATE OF ALASKA

ELEVENTH LEGISLATURE - SECOND SESSION

A BILL

For an Act entitled: "An Act relating to grants for day care centers and multipurpose youth centers; and providing for an effective date."

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

* Section 1. AS 44.47 is amended by adding new sections to read:

ARTICLE 8. GRANTS FOR DAY CARE CENTERS AND MULTIPURPOSE YOUTH CENTERS.

Sec. 44.47.312. DAY CARE CENTER AND MULTIPURPOSE YOUTH CENTER GRANTS. (a) There is established in the Department of Community and Regional Affairs a day care center and multipurpose youth center grant fund to provide state assistance in construction, rehabilitation and operation of day care centers and multipurpose youth centers. Within the limits of appropriations for the purpose, the Department of Community and Regional Affairs shall make grants available to nonprofit corporations and municipalities for construction, rehabilitation and operation of day care centers and multipurpose youth centers.

(b) A grant under this section may be made for only one center in a community but a day care center and a multipurpose youth center may be combined in a single center.

(c) Application for a grant shall be made in the form established by the commissioner of community and regional affairs.

(d) An application for a construction or renovation grant under this section may not be approved unless the applicant demonstrates

(1) the need for a center to serve the community;

(2) the absence or inadequacy of existing centers serving the community to meet the needs of the community;

(3) if the grant is for construction of a new facility, that the need cannot adequately be met by expansion or renovation of existing available facilities or that expansion or renovation of existing facilities would be less cost effective than construction of a new facility.

(e) An application for a grant for operation of a center may not be approved unless the applicant demonstrates that

(1) the center is appropriate to the demonstrated needs of the community;

(2) the center does not duplicate already existing services available in the community, or centers that exist in the community are inadequate to meet the demonstrated needs of the community.

(f) A grant for operation of a center may not exceed

(1) 100 percent of the total costs of operation for the first year for which a grant is made for operation of the center;

(2) 90 percent of the total costs of operation for the second year for which a grant is made for operation of the center;

(3) 80 percent of the total costs of operation for the third year for which a grant is made for operation of the center;

(4) 65 percent of the total costs of operation for the fourth year for which a grant is made for operation of the center;

(5) 50 percent of the total costs of operation for the fifth and suceeding years for which a grant is made for operation of the center.

(g) A grant may be made for acquisition of equipment for a center if the applicant demonstrates that the equipment meets needs of the community which cannot adequately be met with available existing equipment.

Sec. 44.47.314. GRANT AGREEMENTS. A grant may be made under AS 44.47.312 only in accordance with an agreement between the commissioner of community and regional affairs acting on behalf of the state and the recipient of the grant. The agreement may include terms agreed on by the parties and shall include in substance

(1) a statement of the program goals of the center and the method by which the goals are to be achieved;

(2) a system for evaluation of the program at periodic intervals;

(3) if a center is to be constructed or renovated through a grant, a covenant that the recipient of the grant will secure and retain title to the site of the center or that the recipient enjoys use of the center under a lease agreement for a term at least equal to the estimated life of the center;

(4) a method for insuring accountability for use of all grant money.

Sec. 44.47.316. As used in AS 44.47.312 - 44.47.316,

(1) "center" means a day care center or multipurpose youth center;

(2) "day care" means the care, supervision, and guidance of a child or children unaccompanied by a parent or legal guardian on a regular basis for periods of less than 24 hours a day;

(3) "day care center" means a facility the principal purpose of which is to provide day care for children;

(4) "multipurpose youth center" means a facility to provide persons up to 19 years of age with services and activities suited to their particular needs; the services and activities may include, but are not limited to, health examinations, legal assistance, recreation programs, general social activities, student tutoring programs, counseling,

nutrition classes, and protective services.

* Sec. 2. This Act takes effect immediately in accordance with AS 01.10.-070(c).

MEMORANDUM State of Alaska

TO: Marie Matsuno
Deputy Commissioner

DATE: April 28, 1980

FILE NO:

Through: Palmer McCarter
Director

TELEPHONE NO:

FROM: Terry L. Earley
State Assessor

SUBJECT: CS for HB 125

This bill proposes to establish within the Department of Community and Regional Affairs a grant program.

These grants would be to construct, rehabilitate and operate day care centers and multipurpose youth centers.

General Comments

The existing sections of this chapter deal strictly with low income families. This proposed bill would make subsidized day care facilities and youth centers available to the general populous. It also limits the number of centers receiving grants to one per community. Determining which center is eligible for a grant in large communities would be difficult to say the least.

Many villages and cities already have existing day care centers or youth centers or both. They would be eligible for grants for operation and also preclude construction grants for new facilities.

It appears that the concept advanced by this bill is sound. It also appears as though further study of the need being addressed and the desired affects should be studied further.

TLE:jh

THE LEGISLATURE OF THE STATE OF ALASKA
ELEVENTH LEGISLATURE

FISCAL NOTE

I. REQUEST

Bill/Resolution No. CS for HB 125

Title An act relating to daycare centers and multipurpose youth centers

Requested by House Health, Education & Social Services Comm. Date 4-25-80

II. FISCAL DETAIL

Agency Affected Community and Regional Affairs

Program Category Affected Social Services

BRU, Program, or Subprogram(s) Affected Local Government Assistance

(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 80	FY 81	FY 82	FY 83	FY 84	FY 85
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL						
400 COMMODITIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC.						
TOTAL	0	0	0	0	0	0

FUNDING (Thousands of Dollars)

GENERAL FUND	0	0	0	0	0	0
FEDERAL FUNDS						
OTHER (Specify Fund Source)						

POSITIONS

FULL TIME	0	0	0	0	0	0
PART TIME						
TEMPORARY						

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

There will be no fiscal impact until such time as money is appropriated to the grant program established by this bill.

The following breakdown assumes a funding level of $6,000,000 for FY 81 (per staff of House H&SS Committee):

1 Local Government Specialist IV	Range 19	$40,735
1 Account Technician I	Range 12	25,006
1 Clerk Typist III	Range 8	19,615
Total Personal Services		$85,356*
Travel 15 Trips @ 500	=	$ 7,500
30 Days per deim @ 65	=	1,950
TOTAL		$ 9,450

IV. DATE 4-25-80 PREPARED BY Terry L. Earley

AGENCY State Assessor

PHONE 465-4730

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)

33-001 (Rev. 12/79)

Central Office Space 1000 sq. ft. @ 1.50	=	$18,000
Mag Card @ 300 x 12	=	3,600
Telephone	=	5,000
Postage	=	2,000
Printing	=	5,000
Copier	=	1,500
		$35,100
Commodities		$ 3,000
Equipment		$ 3,500
GRAND TOTAL		$136,406

*Salaries include 28% for fringe benefits. Equipment includes one time start up costs.

House Health, Education & Social Services Committee — Meeting/Hearing on CSHB 125 DAY CARE + YOUTH Centers — Date: 4/28/80

	Name	Address and Phone	Organization/Self	For/Against or Observing
1/	Patricia Poland		C & RA	
2/	Palmer McCarter	- will testify if needed		
3/	Bruce Stedman		Dept H+SS	
4/	Pat Murrie	- available to speak on licensing procedure IF NEEDED		
5/				
6/				
7/				
8/				
9/				
10/				
11/				
12/				
13/				

4/28/80

FISCAL NOTE

I. REQUEST
Bill/Resolution No. HB 125
Title An Act Relating to Multipurpose Youth Centers
Requested by Pat Conheady Date 2/23/79

II. FISCAL DETAIL
Agency Affected Department of Natural Resources
Program Category Affected Parks and Recreation
Budget Request Unit(s) Affected Park Management and ACAC

EXPENDITURES (Thousands of Dollars)

	FY 77	FY 78	FY 79	FY 80	FY 81	FY 82
100 PERSONAL SERVICES				207,000	1,647,000	1,514,000
200 TRAVEL				20,000	20,000	10,000
300 CONTRACTUAL				600,000	300,000	300,000
400 COMMODITIES				10,000	100,000	100,000
500 EQUIPMENT				10,000	600,000	100,000
600 LAND & STRUCTURES					6,000,000	
700 GRANTS, CLAIMS, ETC.						
TOTAL				847,000	8,667,000	2,024,000

FUNDING (Thousands of Dollars)

GENERAL FUND				847,000	8,667,000	1,954,000
FEDERAL FUNDS						
OTHER (Specify)						

POSITIONS

FULL TIME				6	66	62
PART TIME						
TEMPORARY						

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

SEE ATTACHED

IV. DATE 3/2/79 PREPARED BY Nat Goodhue
AGENCY Division of Parks
PHONE 274-4676

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)

33 001 (Rev. 10/76)

III. Analysis

A & B. Assumptions and Program Summary

State acquisition, development, maintenance and operation of multi-purpose youth centers in every election district would entail the compensation of a large staff to include the following:

Land acquisition:	Realty Officer III (PG 18)	$38,000
	Realty Officer I (PG 13)	27,000
Land Facility Construction:	Civil Engineer I (PG 19)	40,000
and Maintenance	Civil Engineering Asst. II (PG 16)	32,000
Statewide Op.:	Social Services Fld Admin. (PG 23)	50,000
	Clerk Typist III (PG 8)	20,000
		$207,000
Multi-purpose Youth Center Operations:		
	20 Social Worker III (PG 16)	660,000
	20 Recreational Assistants (PG 11)	480,000
	20 Clerks (PG 6)	300,000
		1,440,000
	Total Personal Services (FY '80)	$1,647,000

Land Acquisition, building design and construction costs are based on the assumption that 1) land will be obtained through trades and transfers 2) construction costs for 1500 sq. ft. youth centers at $200 per square foot = $300,000 per center times 20 equals $6 million, and building design at 10% of construction costs equals $600,000.

Annual facility maintenance is estimated to cost 5% of initial construction costs which will equal $300,000 per year to be accomplished by contracts with local people.

C. Computations -- None.

YOUTH CENTERS IN ALASKA (BY ELECTORAL DISTRICT)

DISTRICT	POP (reg. voters)	TOWN	YOUTH POP (second. school)	SERVICES FOR YOUTH	KIND OF SERVICE
1	9,230	Ketchikan	1200	Youth Advocate Program	Counselling, drop-in center
		Craig	101	Craig Youth Center	Counselling, recreation
		Metlakatla	171	Alcohol Program	Counselling
2	4,320	Wrangell	250	Alcohol Program	Counselling
		Petersburg	189	Petersburg Youth Program	Counselling, recreation
3	4,949	Sitka	913	Sitka Teen Club	Recreation, socializing
		Hoonah	138	Hoonah Youth Center	Recreation, counselling
4	15,909	Juneau	1970	Teen Age Club	Recreation, counselling
5	8,001	Valdez	284	Valdez Teen Club	Recreation, counselling
		Seward	?	Youth Development Center	Counselling
		Cordova	256	Cordova Youth Center	Recreation, counselling
6	10,577		1,601		
7 - 12	123,186	Anchorage	18,552	Alaska YOuth Advocates	Crisis intervention
				Cook Inlet Native Assoc.	Drop-in center
13	13,056		2228		
14	4,541	Kodiak	893		
15	2,990		171		
16	3,469	Dillingham	232	Bristol Bay Area Health Corp.	Counselling
17	4,028	Bethel	527	Alcohol Program	Counselling
18	3,569				

19	6,617	Tok		Alcohol Program	Counselling
20	37,184	Fairbanks	5320	Island Counselling Center	Counselling
21	3,887	Barrow	428	Teen Center	Recreation, Counselling
22	4,109	Nome	655	Nome Comm. Center	Recreation, counselling

STATE
of ALASKA

MEMORANDUM

TO: Trink Morimitsu
Staff Aide for Representative
Thelma Buckholt
Alaska State Legislature

DATE: February 23, 1979

FILE NO:

TELEPHONE NO:

FROM: Barbara McPherson 465-3591
Juvenile Planner
Criminal Justice Planning Agency

SUBJECT: Youth Center Programs
Funded by CJPA

In the past three years Law Enforcement Assistance Administration funds have been awarded to the following youth center programs:

Petersburg Youth Program
Ketchikan Youth Advocate Program
Cordova Youth Services Center
Nome Community Center
Hoonah Youth Center
Craig Youth Center
Seward Recreational and Training Center
Tyonek Youth Program
Gambell Youth Center

As we discussed by phone, these programs have not been formally evaluated in relation to their effect on preventing juvenile delinquency, but their performance in meeting grant objectives for the delivery of services is monitored regularlary. However, the majority of these projects are able to provide measurable data on the reduction of delinquency in their communities after the implementation of these programs:

1. In the first year of operation of the Cordova Youth Services Center juvenile arrests decreased 17% and a March 1977 letter from the Cordova Chief of Police states that street contacts between police and juveniles were "well below the normal and I feel that it is mainly because of the Eyak Youth Services Center facilities and activities."

2. In Petersburg in 1977 there were 25 juvenile delinquency petitions filed with Petersburg court compared to 50 in 1976. A March 1978 letter from the Petersburg Magistrate states that "this reduction in filing may not be attributed solely to the youth program but I cannot help but feel the center and its leadership were contributing factors."

3. Juvenile arrests decreased 57% in the first year of operation of the Hoonah youth center.

4. Juvenile violations as compiled by the local police department decreased 76% during the first year of operation of the Craig Youth Center.

5. The Ketchikan Youth Advocate Program tracked juveniles with previous high arrests records during their first four months of involvement with the youth program. Of the 15, ten showed a decrease in rate of arrests and 8 of those 10 were not arrested at all during the four month period.

The lack of community financial support for the ongoing operation of these programs has been a major problem in their continuation when they [illegible] no longer eligible for LEAA funds. The most importa[illegible]tor in the success of these programs has been qua[illegible]ff who are committed to working with youth.

SAMPLE BUDGET: TEEN DROP IN CENTER

The center provides counseling guidance through a center which also provides recreational opportunities. The center is open from 2-10 p.m. on school nights and 12-12 on weekends. Individual and family counseling is available. Individual counseling and educaitonal programs cover drugs, alcohol, employment opportunities, academic help, and personal problems.
The center draws youth through a number of activities including rap groups, organized field trips, study nights, and in-center activities of interest to teenagers, including sports, speakers, and a library.

The center is staffed by a director, an administrative assistant, three counselors, and a VISTA outreach worker. The VISTA outreach worker also does job opportunity development through contacts with local businessmen and state and local employment projects.

Personnel	Direct Cost	Match	Total
Director	15,600	0	15,600
Administrative Assistant	10,800	0	10,800
Counselor (CETA)	0	10,800	10,800
Counselor "	0	10,800	10,800
Counselor "	0	10,800	10,800
VISTA	0	4,200	4,200
Fringe	2,600	0	2,800
Facility Expense			
Rent (450 mo.)	5,400	0	5,400
Telephone (100 mo.)	1,200	0	1,200
Utilities (200 mo.)	1,200	1,200	2,400
Office Supplies(75 mo.)	900	0	900
Literature	150	0	150
Typewriter rent	360	0	360
Xerox	0	140	140
Furniture (+donations)	900	500	1,400
Sports equipment	1,000	500	1,500
Insurance	500	0	500
Brochures, advertising	500	0	500
	41,110	38,940	80,050

This project could serve could serve a community of three thousand, with a variety of opportunities for kids and parents. It relies heavily on local support through some cash and material donations, and relies on the community to seek CETA positions for staffing.

SAMPLE BUDGET: RESIDENTIAL PLACEMENT EMERGENCY PROGRAM

This project provides emergency placement and short-term counseling to children and youth who cannot remain in their own homes because of abuse, parental alcoholism, neglect, or imminent danger to themselves because thay cannot or will not return home. The primary focus is on short-term placement for protection.

The project provides an all-night drop-in center with two beds and back-up of 10 volunteer foster family placements. Referrals come from the police, social worker, health aide and youth themselves.

After a placement, young children will be referred to the social worker and may remain in placement or placed elsewhere. Older youth will be referred to counseling resources, a social worker, or school counselor for appropriate intervention.

It is anticipated that the majority of children and youth will return to their own homes with appropriate community resource support.

Personnel	Direct cost	Match	Total
Director/home coordinator	15,600	0	15,600
Counselor	10,800	0	10,800
Night Staff (3-4 nights'	5,400	0	5,400
Night staff "	0	5,400	5,400
Fringe	3,100	0	3,100
Facility expense			
Rent (450 mo.)	5,400	0	5,400
Telephone(50 mo.)	600	0	600
Utilities(200 mo.)	1,200	1,200	2,400
Office supplies&literature	750	0	750
Typewriter (30 mo.)	360	0	360
Furniture	500	500	1,000
Insurance	1,000	0	1,000
Bedding, cooking supplies	2,000	0	2,000
Brochures& publicity	300	0	300
	47,010	7,100	54,110

TELEGRAM

RCA ALASKA COMMUNICATIONS, INC
PHONE: 586-0442
JUNEAU, ALASKA 99802

1979 MAR 5 PM 1 53

" 02064 NL TDA BARROW ALASKA 194 0-3-05 950A AST

PMS REP THELMA BUCHHOLDT

JUNEAU

THE CITY OF BARROW HAS PASSED A RESOLUTION SUPPORTING THE STATE OF ALASKAS HOUSE BILL NBR 125 ENTITLED AN ACT RELATING TO MULTI-PURPOSE YOUTH CENTERS.

WHEREAS THE COUNCIL IS DESIROUS OF PROMOTING THE MENTAL AND PHYSICAL GROWTH OF OUR YOUNG PEOPLE, AND WHEREAS, THE COUNCIL DESIRES TO OFFER EVERY OPPORTUNITY FOR THE GROWTH OF OUR YOUNG PEOPLE, AND WHEREAS THE COUNCIL DESIRES TO MAKE AVAILABLE TO OUR YOUNG PEOPLE SERVICES AND ACTIVITIES INCLUDING BUT NOT LIMITED TO HEALTH EXAMINATIONS, LEGAL ASSISTANCE, RECREATION PROGRAMS, COUNCILING, NUTRITION CLASSES, AND PROTECTIVE SERVICES, AND.

WHEREAS THE CITY OF BARROW IS OPERATING A TEEN CENTER WITH GRANTS FROM THE STATE AND CONTINUED FUNDING IS NOT ASSURED, BUT THE PASSING OF THIS BILL MAY RELEASE FUNDS TO AID THE CENTER AND, WHEREAS THE COUNCIL SEES THE NEED FOR AND DESIRES THE ESTABLISHMENT OF A MULTI-PURPOSE YOUTH CENTER IN THE MUNICIPALITY OF BARROW.

THEREFORE BE IT RESOLVED THAT THE CITY COUNCIL OF BARROW ENCOURAGES AND SUPPORTS THE PASSING OF STATE OF ALASKA HOUSE BILL NBR 125.

A COPY OF THIS RESOLUTION IS BEING FORWARDED TO YOU,

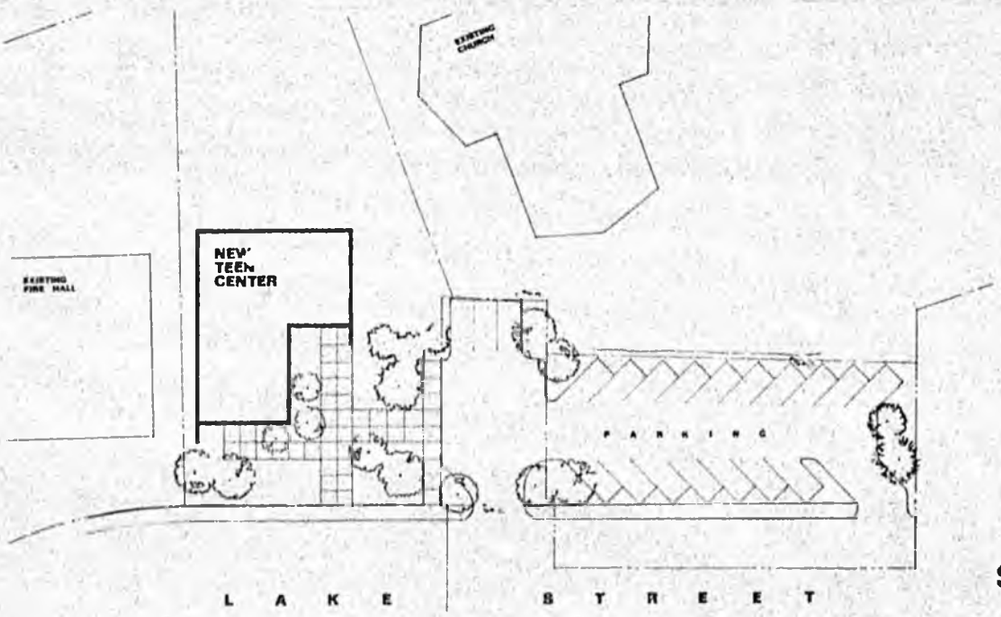
SINCERLEY

CITY OF BARROW CITY COUNCIL

A CENTER FOR TEENS

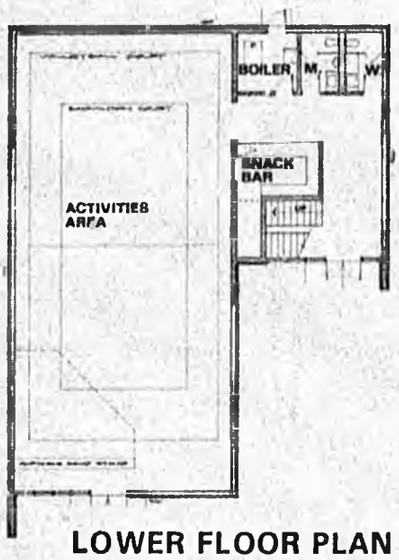
SITKA, ALASKA

WHERE

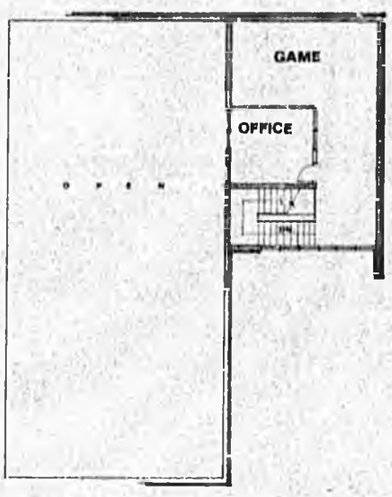


SITE PLAN

WHAT



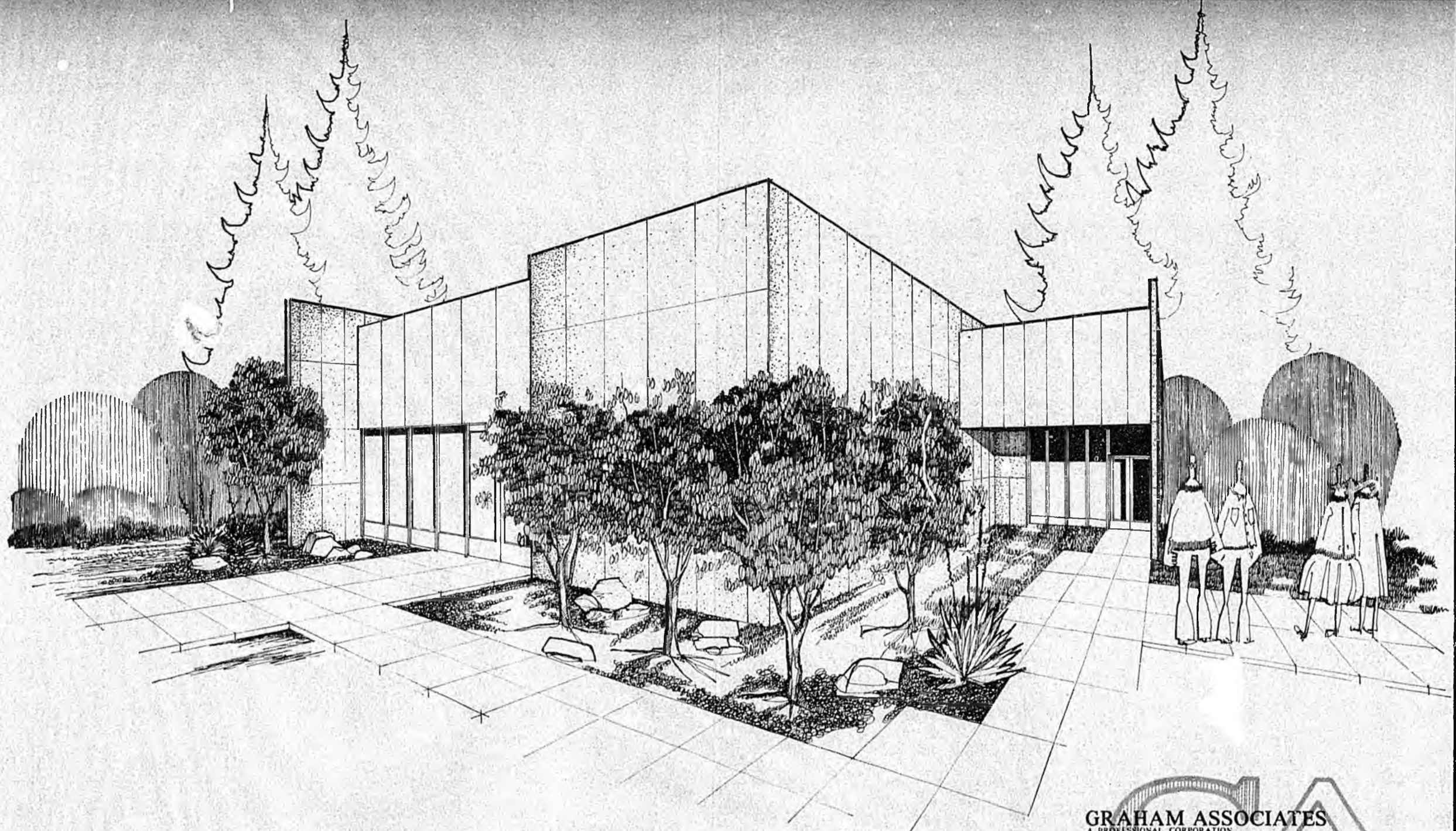
LOWER FLOOR PLAN



UPPER FLOOR PLAN

A place to go. A place to do their thing. A place where our teens can dance: Teens can communicate: Teens can have a quiet place for: crafts - games - foosball - pool - chess - bingo - art - drama - movies...

And for physical activities - volleyball - badminton - basketball - rollerskating - archery -



GRAHAM ASSOCIATES
A PROFESSIONAL CORPORATION
ARCHITECTS PLANNERS
640 PARK BOX 5560 KETCHIKAN, ALASKA 99901 907-225-6658
1551 EAST TUDOR ROAD ANCHORAGE, ALASKA 99507 907-272-3473

HB

126

ALASKA STATE LEGISLATURE

Legislative Affairs Agency
Pouch Y - State Capitol
Juneau, Alaska 99811

REGIONAL INFORMATION OFFICE
1024 West 6th Avenue
Anchorage, Alaska
99501
(907) 278-3668

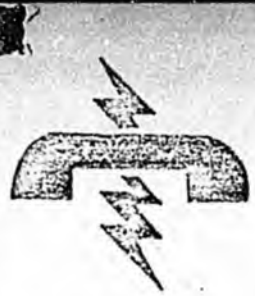
Enclosed for your information and files are materials relating to the teleconference on HB 126, HB 333 - public school foundation program held April 9, 1979, including a copy of the witness and observer list.

Judy Hopkins
Anchorage Moderator

LAA 11
(Rev. 4-29-77 M)

Alaska State Legislature

TELECONFERENCE HEARINGS



TOPIC: HB 126, HB 333 - PUBLIC SCHOOL FOUNDATION PROGRAM

COMMITTEE: House HESS (Buchholdt)

DATE: Monday, April 9, 1979 (DATE SCHEDULED: 3/27/79)

TIME: 11:00 a.m. - 1:00 p.m. A.S.T.

SITES PARTICIPATING: Anchorage only

CONFERENCE MODE: audio LOCATION: LIO MODERATOR: Hopkins

NOTES: SB 199 will not be on agenda

PUBLICITY:

___ INVITATIONAL

___ Committee making contacts

x PSAs 3/30 (date) 26 (quantity)

___ News release (date) (quantity)

? Summary to be provided
___ Text to be provided
___ Quotes to be provided

? Direct mail if instructed (date) (quantity)

✓ Phone at direction of Chairman 4/3 4/3 (date) 16 (quantity)

x Posted at Information Office

TELECONFERENCE STARTED 11:45 a.m.

TELECONFERENCE ENDED 12:20 p.m.

WITNESSES 5
OBSERVERS 0
TOTAL 5

ATTENDANCE

Public comment on House Bills 126 and 333, relating to the Public School Foundation Program, is invited by the House Health, Education and Social Services Committee in an audio teleconference starting at 11 a.m. at the Legislative Information Office, 1024 W. Sixth Ave. Area residents wishing to testify should register in advance by calling 278-3668.

today in anchorage

Alaska State Legislature

TELECONFERENCE HEARINGS

March 30, 1979

Contact: Judy Hopkins 278-3668

PUBLIC SERVICE ANNOUNCEMENT

(run through 4/8/79)

PUBLIC COMMENT ON HOUSE BILLS 126 and 333, RELATING TO THE PUBLIC SCHOOL FOUNDATION PROGRAM, IS INVITED BY THE HOUSE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE IN AN AUDIO TELECONFERENCE STARTING AT 11:00 a.m. MONDAY, APRIL 9, AT THE LEGISLATIVE INFORMATION OFFICE, 1024 WEST SIXTH AVENUE.

AREA RESIDENTS WISHING TO TESTIFY SHOULD REGISTER IN ADVANCE BY CALLING 278-3668. OBSERVERS ARE WELCOME.

######

Legislative Affairs Agency
Legislative Teleconferencing Network
State Capitol . Pouch Y . Juneau . 99811

Phone: 465-4980

PLEASE PRINT

(T) If asked

Name Larry D. Evans — Here to TESTIFY ____

Representing Woodland Park PTA

Mailing Address 3307 Woodland Park Dr. Zip 99503 — Here to OBSERVE ✓

Phone 243-2898

BROADCAST CONSENT: This proceeding may be broadcast live or recorded for later broadcast by radio or television stations. Please indicate your consent by signing below:

Larry D. Evans
(signature)

PLEASE PRINT

(T)

Name JOHN B. PEPER — Here to TESTIFY X

Representing ANCHORAGE School DISTRICT

Mailing Address ~~4700~~ 4600 DEBARR ROAD. Zip 99504 — Here to OBSERVE ____

Phone 333 9561 XIII

BROADCAST CONSENT: This proceeding may be broadcast live or recorded for later broadcast by radio or television stations. Please indicate your consent by signing below:

John B. Peper
(sighature)

Have you participated in other legislative teleconferences? Yes How many? 1

Would you have participated in this hearing if the network were not available? possibly

PLEASE PRINT

(T)

Name Tom Freeman — Here to TESTIFY X

Representing Anchorage School Dist.

Mailing Address Pouch 6-614 Zip 99502 — Here to OBSERVE ____

Phone 344-1871

BROADCAST CONSENT: This proceeding may be broadcast live or recorded for later broadcast by radio or television stations. Please indicate your consent by signing below:

T. Freeman
(signature)

Have you participated in other legislative

Would you have participated in this hearing

Name Charles R. Tunley

Here to TESTIFY ___

Representing self

Mailing Address 1016 W. 6th Ave, Rm 300 Zip 99501

Here to OBSERVE ___

Phone 274-3544

BROADCAST CONSENT: This proceeding may be broadcast live or recorded for later broadcast by radio or television stations. Please indicate your consent by signing ~~below~~:

(signature)

Have you participated in other legislative teleconferences? No How many? ___

How did you learn about this hearing? advised personally

Would you have participated in this hearing if the network were not available? ~~Yes~~

If yes, did you use the network:
___ instead of travel
✓ instead of phone conversations
✓ instead of mailed testimony

Date: 4/9/79 Subject: HB 126, HB 333 - public school foundation program Location: Anchorage

PLEASE PRINT

Name Heather Flynn

Here to TESTIFY ✓

Representing Anch. School Bd

Mailing Address 918 R St, Zip 99501

Here to OBSERVE ✓

Phone 272-5392

BROADCAST CONSENT: This proceeding may be broadcast live or recorded for later broadcast by radio or television stations. Please indicate your consent by signing below:

Heather Flynn
(signature)

Have you participated in other legislative teleconferences? yes How many? 2-3

How did you learn about this hearing? Juneau office - AASB

Would you have participated in this hearing if the network were not available? no

If yes, did you use the network:
✓ instead of travel
___ instead of phone conversations
___ instead of mailed testimony

Date: 4/9/79 Subject: HB 126, HB 333 - public school foundation program Location: Anchorage

HB

129

HB129

BRISTOL BAY BOROUGH SCHOOL DISTRICT

P. O. BOX 169

NAKNEK, ALASKA 99633

PHONE 268-4225 OR 4265
HIGH SCHOOL

DALE L. LUNSFORD
SUPERINTENDENT

March 16, 1979

Thelma Buchholdt
Alaska House of Representatives
Room 110 Capitol
Juneau, Alaska 99811

Dear Representative Buchholdt:

The citizens of the Bristol Bay Borough have been trying to correct some of the inadequacies of their high school by passing bond issues for part of the proposed additions to the school. On March 13, 1979 a referendum in the amount of $500,000 was passed by nearly a 2 to 1 margin.

The $500,000 will go toward construction on a shop facility in which auto mechanics, welding and metal work can be added to our curriculum. However, an unhoused music program including vocal music (which now meets in the girls locker room when PE classes are not using the room) and band (which meets in our small cafeteria room around lunch schedules and with very poor acoustics) needs to have an acceptable place to meet, practice and perform.

Your committee is holding HB 129 which would provide funding to build the music facility and perhaps the third phase of the proposal which is a swimming pool.

It would certainly be beneficial to the students in the Bristol Bay Borough if you and your committee could release House Bill 129 granting funds to the Bristol Bay Borough for additional school facilities.

Sincerely

Dale L Lunsford

Dale L. Lunsford

HB

145

STATE OF ALASKA

JAY S. HAMMOND, GOVERNOR

DEPARTMENT OF REVENUE

STATE OFFICE BUILDING / POUCH SA – JUNEAU 99811

February 22, 1979

The Honorable Thelma Buchholdt
Chairman
House Health, Education & Social
Services Committee
Room 112- Capitol Building
Juneau, Alaska

Dear Representative Buchholdt:

HOUSE BILL NO. 145

House Bill No. 145, an Act establishing a tuition credit under the Alaska net income tax, was introduced in the House on February 7, 1979 and was referred to the House Health, Education & Social Services and Finance Committees.

For the consideration of the House Health, Education & Social Services Committee, I am enclosing a copy of a Fiscal Note prepared by Mr. Gary Jenkins, Director, Audit Division, Department of Revenue concerning the proposed legislation.

Sincerely,

R.D. Stevenson
Special Assistant

cc: The Honorable Russ Meekins
Chairman
House Finance Committee

John Messenger
Acting Commissioner
Department of Revenue

Gary Jenkins, Director
Audit Division
Department of Revenue

04-D4LH

THE LEGISLATURE OF THE STATE OF ALASKA
ELEVENTH LEGISLATURE

FISCAL NOTE

I. REQUEST

Bill/Resolution No. House Bill No. 145

Title An Act establishing a tuition credut under Alaska net income tax

Requested by House Health, Education & Social Services and Finance Committees Date 2/16/79

II. FISCAL DETAIL

Agency Affected Revenue

Program Category Affected Fiscal Services

Budget Request Unit(s) Affected Audit Division

EXPENDITURES (Thousands of Dollars) None

	FY 79	FY 80	FY 81	FY 82	FY 83	FY 84
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL						
400 COMMODITIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC.						
TOTAL						

FUNDING (Thousands of Dollars) None

GENERAL FUND						
FEDERAL FUNDS						
OTHER (Specify)						

POSITIONS None

FULL TIME						
PART TIME						
TEMPORARY						

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

See memorandum dated 2/16/79 to R. D. Stevenson.

IV. DATE February 16, 1979 PREPARED BY Gary Alexander

AGENCY Department of Revenue, Audit Division

PHONE 465-2320

Original: Legislative Finance

cc: Budget and Management
Prime Sponsor (First Legislator Named)

33-001 (Rev. 10/78)

STATE of ALASKA

MEMORANDUM

TO: R. D. Stevenson
Special Assistant
Department of Revenue

DATE: February 16, 1979

FILE NO:

TELEPHONE NO:

FROM: Gary L. Jenkins
Director
Audit Division

SUBJECT: House Bill No. 145

It is extremely difficult to estimate the actual dollar effect of the tuition credit proposed by HB 145 because of the almost total lack of information available regarding the number of students attending vocational schools and schools of higher education. In discussions with various personnel in the Department of Education, I was advised that last year's enrollment in private elementary and secondary schools in the State was 3,130 and that there is a possible 800 to 900 in other private schools on which they did not have information. The staff working with the higher education loan funds advised me there were approximately 3,000 students going to school on loans and they estimated that number could be as high as 50 percent of the total number of students going to schools of higher education. Last, I have assumed there are at least 1,000 students going to approved vocational schools.

Assuming there are 2,667 students in private elementary schools, 2,323 in secondary and vocational schools, and 6,000 in schools of higher education, the total potential cost of this tuition credit would be $9,083,090.

One serious problem I see with the bill is in the definition of "eligible educational institution". This definition states that it is a school which "meets accreditation or approval criteria established by the department by regulation". To allow us to effectively administer this law, if enacted, it is recommended that the requisite accreditation or approval criteria be specifically defined in the Statute or that they be established by the Department of Education rather than Revenue.

HB

219

Name	Address	Organization	Bill No.
Kim I. Shelly	P.O. Box 69, Barrow, AK	NSB/DPS	219, 76
CAPTAIN RONALD WENDT	P.O. Box 6567, ANCHORAGE, AK 99502	SALV. ACTY CAS	
Joe Bechly (D- Ray Dexter)	S.R5503 Wasilla AK 99687	Mat-Su Council on Alcohol	
Bruce D. Kyle	P.O. Box 2167 Kodiak, AK 99615	Kodiak Council on Alcoholism	
Virginia Blanchard	923 W 11th Ave Anch 99501	Drug Abuse Bd alcohol Bd-	Drug & Alcohol.
ROBERT BUTTOANE	BOX 388, BETHEL, AK	CITY OF BETHEL	76 ~~HB~~ → 212
Frank J. Poplawski	unalaska		
Bernard Segal Phd.			
Brotherhood Assn.			
Rod Miller - Vice Chairman of Board			
Wanda Thompson	Box 1066, Petersburg 99833	Petersburg Council on Alcohol	
Dr. Ray Fedje			

A M E N D M E N T

Offered in the HOUSE H.E.S.S. Committee by ABC Board

TO: HOUSE BILL NO. 219

Page 1, between lines 15 and 16

Insert the following and renumber following sections of bill

"*Sec. 2 AS 04.10.020(g) is amended to read

(g) package liquor store [RETAIL] license;"

Page 1, line 22

In title delete "RETAIL" and insert "PACKAGE LIQUOR STORE" and in text delete "retail" and insert "package liquor store"

Page 2, line 7

Delete "retail" and insert "package liquor store"

Page 2, line 11

Delete "retail" and insert "package liquor store"

Page 2, line 13

Delete "retail" and insert "package liquor store" twice

Page 2, line 14

Delete "retail liquor"

Page 4, between lines 12 and 13

Insert the following and renumber subsequent sections of bill

"*Sec. 9.AS 04.10.140 is amended to read

AS 04.10.140. PACKAGE [RETAIL] STOCK SALE LICENSE. The holder of a package [RETAIL] stock sale license may sell in bulk quantities of not less than five wine gallons per sale, but not to the consumer, the entire stock of a former package [RETAIL] liquor

store, where the owner wishes to close out or terminate the business of the store. If the owner has been deprived of a package liquor store [RETAIL] license because of a violation of any law of the state the license shall not be issued. The license shall be issued for a period of 90 days only for each store closing out, and is not renewable. The package [RETAIL] stock sale license fee is $100.

"*Sec. 10 AS 04.10.150 is amended to read:
Sec. 04.10.150. RESIDENCE. No Beverage dispensary license or package liquor store [RETAIL] license may be issued to a person or association or persons who have not resided in the state for at least one year prior to the date of the application, or to a corporation not qualified to do business in the state."

Page 4, line 17

After "days" insert "before filing with the board"

Page 4, lines 21 through 28

Delete present bill material and insert the following

(b) At the time the application is posted, the applicant shall also cause announcements to be made to inform the public of the proposed issuance, renewal or transfer of a license. Such announcements shall be made by newspapers and broadcasting stations with local access and coverage. If these media will not publish the announcement as a public service, a paid notice must be ordered by the applicant. Announcements must be bilingual when necessary, and the board may direct or require that the announcement be published or delivered in a language other than English that serves to inform the public.

Page 4, between lines 28 and 29, insert a new section in the bill to read

"*Sec. 12. AS 04.10.230 is amended to read:

Sec. 04.10.230. ZONING LIMITATIONS. No licensee may operate a beverage dispensary or package [RETAIL] liquor store in any incorporated city where the zoning regulations of the city prohibit the sale of intoxicating liquors, without the approval of the city council."

Page 6, line 17

Delete present Sec. 12 of bill and insert

"* Sec. 16. AS 04.10.350(c)(4) is amended to read

(4) Unless otherwise terminated, a license which is in effect on December 31 continues in effect through the next February 28. However, if, on or before February 28, the renewal application has not been filed and the fees provided for in (2) or (3) of this subsection have not been paid, the license is automatically revoked at midnight [2:00 a.m.] February 28, and may only be reinstated

(A) upon application filed during the 30-day [SIX-MONTH] period beginning with February 28;

(B) upon proof satisfactory to the board of good cause for the failure to file and pay; and

(C) in accordance with rules or regulations promulgated by the board; the fee for filing an application for reinstatement shall, in addition to the annual fee, include the penalty fee provided in (3) of this subsection, no part of which is returnable to the applicant."

Page 14, line 8

Delete "amended" and insert "repealed and readopted"

Page 14, lines 13 through 20

Delete present material and insert the following:

"with a certified copy of the record of conviction to the board and to a city or unified municipality, if any, in which the licensed establishment is located, or to the organized borough if the licensed establishment is located outside a city in an organized borough. The council or assembly may recommend that the board suspend the license. If the board does not, within 30 days after receiving such a recommendation, place it on the agenda of its next meeting, the council or assembly may suspend the license as provided in (1) and (2) of this subsection. It may also suspend the license if the board declines to do so after considering the recommendation at its meeting. A license may be suspended under the provisions of this subsection only after adequate notice and opportunity for hearing is given to the licensee, and a majority of the members of the board, council, or assembly have directed that suspension be imposed. Upon a third violation, the board, but not a council or assembly, may revoke the license and declare the"

Page 6, between lines 19 and 20 insert new section in bill to read

"*Sec. 17 AS 04.10.390 is amended to read:

Sec. 04.10.390. CONNECTION TO LICENSED PREMISES. The business premises occupied by a holder of a package liquor store [RETAIL] license issued under this chapter shall not be connected by a door, opening, or other means of passage for the purpose of sales or for the purpose of passage by the general public to any other retail business establishment, except those licensed under this chapter."

and renumber following sections.

Page 12, line 27

Delete "1978" and insert "1980"

Page 13, line 2

Delete "1976" and insert "1978"

Page 13, line 4

Delete "1978" and insert "1980"

Page 14, line 17

Insert after comma ~~following "may" the following~~ "~~after adequate notice and opportunity for hearing~~"

Page 14, between lines 1 and 2 insert new section of bill to read

"*Sec. 21. AS 04.15.085 is amended to read

Sec. 04.15.085. CREDIT SALES OF INTOXICATING BEVERAGES. (a) No holder of a [RETAIL ALCOHOLIC BEVERAGE] license selling intoxicating beverages on a retail basis may sell intoxicating beverages other than for cash, paid promptly after receiving the beverage or the bill for it before the customer leaves the [THE VERBAL OR WRITTEN SOLICITATION FOR PURCHASE HAS BEEN RECEIVED WITHIN HIS] licensed premises; except that a hotel, boardinghouse or inn which offers lodging may sell intoxicating beverages to persons lodging there and include the charge for the beverage with the bill for lodging to be paid at the time the customer pays for the lodging.

(b) In this section "cash" means money or its equivalent, including negotiable paper or credit card voucher.

(c) A person who unlawfully sells intoxicating beverages on credit is guilty of a misdemeanor and upon conviction is punishable by a fine of not more than $500.

(d) Licensees who sell intoxicating beverages on a wholesale basis may extend credit for sale of intoxicating beverages to licensees who sell on a retail basis. However such credit may not be extended longer than 60 days from the date of purchase.

Page 15, line 15

Delete "special occasions" and insert "a wedding or similar special occasion. Approval by local law enforcement official for the issuance of the permit must be submitted with the application; no application will be considered by the board without such approval."

Page 15, line 20.

Delete "served to a large group of persons at" and insert "dispensed without charge to the guests attending a meal, reception, dance or other gathering held to celebrate"

POSITION PAPER/Department of Health and Social Services

POSITION PAPER HB 219

"An Act relating to alcoholic beverages; and proving for an effective date."

The State Office of Alcoholism and Drug Abuse supports the view that the primary mission of any Alcohol Beverage Control Board, is to protect the Public Health, Safety and Welfare. The secondary role of any such agency is to ensure the orderly process of licensure, fee collection, etc., from members of the Beverage Industry.

This bill contains a number of provisions, requested by citizens of Alaska through numerous public hearing processes, which are designed to refine Title 04 so that its principal aim is protection of the public health, safety and welfare in a way that also allows for maximum local control and flexibility in how the public health, safety and welfare is protected.

The assumption underlying this bill is that Alcoholism and Alcohol Abuse are epidemic in Alaska and that part of the reasons for that epidemic can be traced to excessive availability of beverage alcohol, which is, in turn, partly a function of the fact that no agency is able to effectively regulate the retail licensed beverage industry, in a way that protects the public health, safety and welfare, at the present time.

In order to correct this situation, this bill contains the following new provisions;

Section 2 creates a new class of retail licenses.

Section 3 creates a new class of retail licenses.

Section 4 prohibits sale of licensed beverages to persons in any community or election district that has, by referendum, voted itself "dry".

Or, any organized municipal entity, that has, by ordinance, prohibited mail order or telephone sales.

Section 6 describes the proposed new "Unlimited Community Liquor License".

Section 7 describes the proposed new "Limited Community Liquor License".

Section 8 and Section 9 include provisions which would strengthen the power of local elected officials and the public, to control the issuance or reissuance of licenses in their local communities.

Section 10 strengthens the power of the public to control the issuance or reissuance of licenses in the unorganized borough.

Section 13 provides a framework for local referenda to be conducted to decide questions of issuance of new licenses in areas where there are none now, in organized municipalities.

Section 14 provides a framework similar to Section 12 for the organized boroughs and the unorganized borough.

POSITION PAPER/Department of Health & Social Services

Section 14.10.439 provides a mechanism for reimbursing revenue lost from sales taxes to local governments which have voted for "no-sales."

Section 15 eliminates in-state advertising for beverage alcohol.

Section 16 prohibits soliciting drinks.

Section 17 strengthens and clarifies penalties to licensees who violate provisions of this act.

Section 18 sets out allowable conditions for possession of beverage alcohol in areas that have, through local referenda, voted "no-sale."

Section 19 establishes bootlegging as a felony in an area that has, by local referendum, established "no-sales", and greatly strengthens the penalty for violating the local referendum decision.

Section 20 sets out the penalities for illegal sale in violation of local referenda.

The Department of Health and Social Services supports this legislation as the thrust of the measure would empower citizens of Alaskan communities to exercise a variety of options regarding the sale, possession, and distribution of beverage alcohol in their locales.

Recommended by: Robert L. Cole — 3/15/79

Robert L. Cole, Coordinator
Office of Alcoholism and Drug Abuse

Date

Approved by: Helen D. Beirne — 3-15-79

Helen D. Beirne, Commissioner
Department of Health and Social Services

Date

AMENDMENT

Offered in the HOUSE By Hurlbert

TO: HOUSE BILL NO. 219

Page 7, between lines 6 and 7: insert

"(4) If the results of this election show a majority in favor of private licenses, would you favor all types of private licenses or only ...(listing of those types of licenses which would be allowed in the community)?"

ALL LICENCES [ ]

ONLY TYPES LISTED [ ]

Page 7, line 7:

Delete "(4)" and insert "(5)" in its place:

Page 7, line 28:

Delete "(2) and (3)" and insert "2, 3 and 4" in its place

Page 8, line 2:

Delete "4" and insert "5" in its place

Page 8, line 11:

Delete "2 and 3" and insert "2, 3 and 4" in its place

Page 9, between lines 11 and 12: insert

"(4) If the results of this election show a majority in favor of private licenses, would you favor all types of licenses or only... (listing of these licenses which would be allowed in the community)?"

ALL LICENSES [ ]

ONLY TYPES LISTED [ ]

Page 9, line 12:

Delete "(4)" and insert "(5)" in its place

Page 10, line 3:

Delete "(2) and (3)" and insert "2, 3 and 4" in its place

Page 10, line 11:

Delete "4" and insert "5" in its place

Page 10, lines 20 and 21:

Delete "2 and 3" and insert "2, 3 and 4" in its place

Page 11, between lines 12 and 13: insert

"(2) If the results of this election show a majority in favor of the sale of intoxicating liquor, would you favor having all types of private licenses or only... (listing of those types of licenses which would be allowed in the community)?"

ALL LICENSES [ ]

ONLY TYPES LISTED [ ]

Page 11, line 13:

Delete "(2)" and insert "(3)" in its place

Page 11, line 24, after "votes":

Insert "cast on question 1"

Page 11, line 27, after "precinct.":

Insert "If the majority of the votes cast on question 1 favors the sale of intoxicating liquor in the precinct, the board may issue, renew, or transfer licenses within that precinct solely on the basis of the election results on question 2."

Page 12, line 1:

Delete "2" and insert "3"

Page 12, line 8, after "precinct":

Insert "under all or any of the types of license prohibited at an earlier election held under this section"

File work
HB 219
HB 219

Municipality of Anchorage

825 "L" STREET
ANCHORAGE, ALASKA 99501
(907) 264-4111

GEORGE M. SULLIVAN,
MAYOR

DEPARTMENT OF HEALTH AND ENVIRONMENTAL PROTECTION

April 19, 1979

Rep. Thelma Buchholdt
Alaska State Legislature
Pouch V
Juneau, Alaska 99811

Dear Representative Buchholdt: Thelma

The purpose of this letter is to share with you the process the Municipality of Anchorage has adopted to make Alcoholism, Drug Abuse, and Mental Health funds available to any agency wishing to compete for government funds in Anchorage.

In the Department, we write and submit a "Grant Request" to the State for Alcoholism, Drug Abuse, and Mental Health funds. The grant applications are reviewed by the local Municipal Health Commission and the Governor's Advisory Boards for these three components. They in turn make their recommendations to the Commissioner of Health and Social Service, who then notifies us of the grant awards.

While this effort is going on, the Municipality of Anchorage issues a "Request for Proposals" (RFP) asking for those interested in bidding for the various components to submit to the Municipality of Anchorage their proposal for contract funds in accordance with the criteria specified.

We have just completed a portion of this process and have notified both the successful and unsuccessful bidders. Naturally there are some whose proposals are not recommended. This has, in the past, caused some questions to be asked relative to the process. We have reviewed this process with the Municipal Health Commission which has, wholeheartedly endorsed it.

I realize that you, as an Anchorage Legislator, may receive calls of concern regarding the process, or the results. It seemed advisable, therefore, to send to you a "review" of our process, so if you should have questions you will have some background information.

The process is put into action by the Department developing the Request for Proposals (RFP). In December 1978, the Project Review Committee examined the Behavioral Health RFP and suggested modifications, which were made. The RFP's were published by the Purchasing Division on January 15, 1979.

The Purchasing Division held a pre-bid conference on February 9, 1979. Prospective bidders attended the conference. In the pre-bid conference, the Purchasing Division went through the Request for Proposal, page-by-page, providing prospective bidders the opportunity to question and comment on each item in the RFP. As a result of the pre-bid conference, clarifications were issued by the Purchasing Division.

All responses to the RFP's were submitted to the Purchasing Division by close of business March 2, 1979. The Purchasing Division forwarded the Proposals to the Behavioral Health Division after close of business that same day.

Each proposal was reviewed by the Behavioral Health staff utilizing the "Response to RFP Checklist" (Appendix "A").

The Proposal Review Committee, appointed by the Director, was composed of:

Paul Foutz, CPA
Price Waterhouse & Company

Lt. Ted Carlson
Anchorage Police Department

Richard Grant,
Region X
HEW, Seattle

Dr. Marjorie (Judy) Hill
Criminal Justice Planning Agency, Juneau
State of Alaska

Ron Kuczek, Manager
Cook Inlet Air Resources Management District

Dr. Raymond N. Fedje, Manager
Behavioral Health (Non-Voting Chai n)

The Committee was organized to provide for primary and secondary reviews of all proposals. Each member of the Committee, with the exception of the Chairman, was assigned the responsibility to be the primary reviewer of some proposals and secondary reviewer of other proposals. These assignments were made as detailed in the "Review Committee Process" (Appendix "B"). To assist the Review Committee members, they received, in advance, copies of the recent evaluations of the existing Division Contractors (sent to you on February 21, 1979).

The Review Committee met as scheduled March 12, 13, and 14 from 9:00 a.m. through 5:00 p.m. in the 5th floor Conference Room of the Community Health Building, 825 "L" Street, Anchorage, Alaska. All organizations submitting proposals were notifed of the time and place of the Committee's meetings and that the meetings were open to the general public. The Review Committee was convened by the Chairman, March 12, 1979, at 9:00 a.m. The members of the Review Committee were provided additional information which consisted of excerpts from the Alcoholism, Drug Abuse, and Mental Health Grant Applications which provided information on cost comparison, evaluation comparison, and analysis of the progress towards meeting the goals in the 1978 contracts for all current Contractors (Appendix "C").

The format utilized by the Review Committee is detailed in "Review Committee Process" (Appendix "B"). Each component of the RFP was addressed individually with analysis and discussion about each applicant's proposal to that component of the RFP. The staff reported on the results of the technical review, the Committee questioned staff, first and second readers of the proposals reported to the Committee, and the Committee discussed each proposal.

The Review Committee formulated questions which they intended to address to each bidder the following day. These questions were written down and the Chairman directed that each organization be informed of the questions which the Committee had formulated. In this manner, the organizations could be better prepared to address the Review Committee's questions during Program Testimony.

On Tuesday, March 13, 1979, each organization was given an opportunity to discuss its proposal(s) with the Review

Committee. The representative of the organizations made a short presentation concerning their organization and the program(s) their organization intended to provide, if selected. The representative then addressed the Review Committee's questions which had been forwarded to them the previous day and discussed any additional questions with the members of the Review Committee.

As a result of the discussion, the Committe appointed a special subcommittee to review the problems concerning the programmatic and fiscal reporting of the Anchorage Community Mental Health Services Component of the RFP. This committee met briefly with staff late Tuesday afternoon March 13, 1979 and again with staff and representatives of the Mental Health Center early Wednesday, March 14, 1979.

The morning session for Wednesday, March 14, 1979, was reserved for general public input on the review process and/or any additional testimony by the bidder organizations or the general public. Because the general public input sessions did not take as long as scheduled the Committee questioned staff about funds available for the contract year and other questions they had developed about the proposals.

The afternoon of Wednesday, March 14, 1979 was reserved for decision making and voting on the proposals. The Committee first utilized the "Proposal Selection Review Checklist" and the "Instructions for Scoring the Proposal Selection Review Checklist" in their decision making process for each proposal (Appendix "D"). The composite score of each proposal is summarized in Appendix "E", "Review Committee Composite Response to Request for Proposal".

Based on the Proposal Selection Review Checklist the Committee voted to accept or reject the proposals for further consideration.

Those proposals, selected by the Review Committee for further consideration, were then submitted to the following voting procedure:

1. Each component of the RFP was addressed separately.

2. For those components where there were no competing applications the Committee voted to accept the proposals.

3. For those components which had competing applications the Committee voted in the following manner (see Appendix "F" for sample ballot).

4. Each component of the RFP was addressed separately. The Committee voted using the sample ballot in Appendix "F". The Committee rated the Proposals from one to ten; ten being the highest possible score, one being the lowest. Proposals were rated on this system by each Committee member on each ballot for each component.

After the voting was completed the Committee discussed why they had voted the way they had and offered clarification to staff on how the outcome of the vote should affect future funding.

After the discussion was completed the Review Committee invited representatives of the bidder organizations and members of the general public present to comment on the review procedure and the decisions reached by the Review Committee.

Following public comment the Review Committee made specific recommendations about how the review process should be amended in the coming year.

The Review Committee Minutes are appended for your consideration (Appendix "G").

The Behavioral Health Division reviewed the recommendations of the Review Committee and from them formulated Staff Recommendations; these were forwarded to the Director for his consideration.

Appendix "H" is a composite of the Review Committee and staff recommendations.

On April 10, the Director advised the Behavioral Health Division Manager of his decision. This is reflected in Appendix "I".

On April 13, letters were sent to all the organizations who submitted bids.

On April 17, the Department met again with the Project Review Committee of the Municipal Health Commission. The above information was shared in detail to assure them the proper procedures were in fact followed. The Committee endorsed the Department's report.

The Department is now in the process of beginning negotiations, with the successful bidders; this will lead to contracts for all services requested.

It is anticipated, that the following Health Commission review of these contracts, the contracts will be presented to the Municipal Assembly for final approval early in June.

We hope that you are impressed with the conscientious efforts being made to be good stewards of government funds.

Sincerely,

Bert Hall

Robert A. (Bert) Hall
Director

RH:lj-F-LTR13.1.2

Alaska State Legislature

REPRESENTATIVE
NELS A. ANDERSON, JR.
POX 234
DILLINGHAM, ALASKA 99576
HOME PHONE 842-5302

WHILE IN JUNEAU
POUCH V
JUNEAU, ALASKA 99811
PHONE 465-3738 OR 3739
HOME PHONE 789-7897

REPRESENTING DISTRICT 16
BRISTOL BAY — LOWER KUSKOKWIM

HOUSE MAJORITY LEADER
VICE CHAIRMAN JUDICIARY COMMITTEE
MEMBER, RULES COMMITTEE
MEMBER, SPECIAL COMMITTEE
ON SUBSISTENCE

House of Representatives

March 22, 1979

MEMORANDUM

TO: Representative Thelma Buchholdt

FROM: Representative Nels A. Anderson, Jr.

SUBJECT: HB 219

I have spoken to many people who work closely with our number one social problem - alcoholism - and I am convinced that HB 219 will help solve the problem. Also, excessive availability of alcohol is a problem that will be regulated by this bill.

The local community which has the desire to vote themselves "dry" would have the force of law behind them under this bill. There are few, if any, small villages in our State that have facilities to deal with people who are under the influence of alcohol. Giving more power to local areas to control availability will definitely reduce problems in communities that don't have means to care for people under the influence of alcohol.

I hope your committee will give this bill favorable consideration.

Alaska State Legislature

REPRESENTATIVE
NELS A. ANDERSON, JR.
BOX 234
DILLINGHAM, ALASKA 99576
HOME PHONE 842-5302

WHILE IN JUNEAU
POUCH V
JUNEAU, ALASKA 99811
PHONE 465-3738 OR 3739
HOME PHONE 789-7697

REPRESENTING DISTRICT 16
BRISTOL BAY — LOWER KUSKOKWIM

HOUSE MAJORITY LEADER
VICE CHAIRMAN JUDICIARY COMMITTEE
MEMBER, RULES COMMITTEE
MEMBER, SPECIAL COMMITTEE
ON SUBSISTENCE

House of Representatives

March 27, 1979

MEMORANDUM

TO: Representative Thelma Buchholdt

FROM: Representative Nels A. Anderson, Jr.

SUBJECT: HB 219 - Relating to Alcoholic Beverages

Thelma, I know you are well aware of the statewide concerns for problems relating to alcohol use and abuse. The focus has been on the legislature ever since the Governor first introduced his alcoholism package three years ago.

Increasingly, I am being approached by my constituents for support of a bill like HB 219. Most recently there have been several groups in Juneau, ie: Citizen's Participation Conference and ANCADA, who have expressed favor for the bill and suggested some modifications.

In short, I would like to see some legislation of this nature receive consideration this year. Many of us rural legislators are on record either privately or publically to get something done.

HB

226

HB228

Feb 25, 1979
1835 Crescent Dr.
Anchorage, AK 99504

MEMORANDUM

To: HESS Committee, Alaska House of Representatives

From: Janette P. Adasiak, Public Member, State Medical Board

Re: HB 226 and 228

HB 226 - I am in favor of this bill.

HB 228 - The spirit in which it was written is commendable, but I am opposed to this bill because it is finding fault with the wrong parties. A recent article in the Anchorage Times reveals the reason why some Anchorage physicians (obstetricians in particular) are turning away medicaid patients is the length of time it takes to have claims processed--over a year in some circumstances. They also assert that the amount of compensation is inadequate. I cannot comment on that. However, if problems with the administration of the medicaid program could be worked out the problems addressed by HB 228 would cease to exist. A physician is a businessman like any other, and it would not be fair to force him by law into a practice that was not economical.

PWTP 1566 12.34 JN01 0032 13.02 02/26/79

BOOK OF TWO

(3541)

LYNN PERKINS PWA 7
OCCUPATIONAL LICENSING
JUNEAU

Called 2630302 #0800

(3797)

THELMA BUCHOLDT PWA 3
CHAIRMAN OF HOUSE/H&SS
JUNEAU

Called 2620442 #3100

HB 226 - PURPOSE OF LEGISLATION OR NEED RESOLVED IS NOT EXPRESSED. REDUNDANT. SEE SENATE BILL 356, 1978. INCLUDES NO LANGUAGE RELATING TO PATIENT INJURY FROM KNOWLEDGE OF DIAGNOSIS. RECOMMEND NO PASS.

HB 226 - UNWORKABLE IF PRACTICED. LEGALITY SHOULD BE REVIEWED. WILL AGGRAVATE THE PROBLEM IF IT PROPOSES TO SOLVE WITHOUT MODIFICATION OF THE PROBLEM. INTRODUCED IN RESPONSE TO UNDOCUMENTED ALLEGATIONS AND LANGUAGE AMBIGUOUS. SHOULD NOT PASS.

WINTHROP FISH M.D.
MEMBER AK STATE MEDICAL BOARD
ANCHORAGE 2/26/79 MS

2/26/79

Teletype message to Thelma Buchholdt and Byron Perkins

HB 226 - Purpose of legislation or need resolved is not expressed. Redundant. See SB 356, 1978. Includes no language relating to patient injury from knowledge of diagnosis. Recommend do pass.

Winthrop Fish MD
Member Alaska State Medical Board

Teletype message to Thelma Buchholdt + Byron Perkins 2/26/79.

HB 228 - Unworkable if practiced. Legality should be reviewed. Will aggravate the problem if it proposes to without modification of the problem. Introduced in response to undocumented allegations and language ambiguous. Should not pass.

Winthrop Fish MD
Member Alaska State Medical Board.

POSITION PAPER/Department of Health and Social Services

POSITION PAPER
ON
HOUSE BILL NO. 226

"An Act amending the definition of unprofessional conduct in the practice of medicine."

This bill would redefine the definition of unprofessional or dishonorable conduct in the practice of medicine by the addition two paragraphs.

(I) requires physician to disclose to the patient the nature of the patient's illness, injury and disease; and

(J) to prevent the wilful misrepresentation by a physician to a patient of the nature of the patient's illness, injury, or disease.

(I) attempts to substitute a simplistic legal mandate to a judgmental physician/ patient relationship and ignores the sensitive paitent/physician relationship involving interface of scientific knowledge and the art of practicing medicine and in the interpretation of the patient's overall well being. An example, a potentially suicidal patient does not immediately need to know his diagnosis and impacting the knowledge is a decision of the physician and patient's family.

Paragraph (J) would already seem to be adequately covered in the principles of medical ethics of the American Medical Association and the Alaska State Medical Association.

Recommended by:

Robert I. Fraser, M.D., Director
Division of Public Health

Approved by:

Helen D. Beirne, Commissioner
Dept. of Health & Social Services

SEQUENCE OF CALCULATING THE ALLOWABLE CHARGE PAYABLE UNDER MEDICARE

A. ACTUAL CHARGE.

B. INDIVIDUAL FEE PROFILE.

1. PHYSICIAN'S CALCULATED CUSTOMARY CHARGE--MEDIAN OF CHARGES DURING THE PRECEDING CALENDAR YEAR.
2. PHYSICIAN'S CUSTOMARY CHARGE CONVERSION FACTOR FOR THE CATEGORY OF SERVICE MULTIPLIED BY THE RELATIVE VALUE UNITS FOR THE SERVICE.
3. THE 50TH PERCENTILE CHARGE LISTED ON THE PREVAILING CHARGE SCREEN.

C. PREVAILING CHARGE SCREEN.

1. PREVAILING CHARGE BY SPECIALTY (75TH PERCENTILE).
2. PREVAILING CHARGE WITHOUT REGARD TO SPECIALTY (75TH PERCENTILE).
3. PREVAILING CHARGE CONVERSION FACTOR FOR THE CATEGORY OF SERVICE MULTIPLIED BY THE RELATIVE VALUE UNITS FOR THE SERVICE.

INDIVIDUAL PRACTITIONERS

SECTION 447.34L INDIVIDUAL PRACTITIONERS: UPPER LIMITS OF PAYMENT.

(A) THIS SECTION APPLIES TO DOCTORS OF MEDICINE, DENTISTRY, OSTEOPATHY, PODIATRY, AND ANY OTHER INDIVIDUAL PRACTITIONER SERVICES THE AGENCY CHOOSES TO INCLUDE.

(B) THE AGENCY MUST NOT PAY THE INDIVIDUAL PRACTITIONER MORE THAN THE LOWEST OF --

(1) HIS ACTUAL CHARGE FOR SERVICE;

(2) HIS REASONABLE CHARGE FOR THE SAME SERVICE UNDER PART B, MEDICARE (PART 405, SUBPART D, OF THIS CHAPTER); OR

(3) HIS MEDIAN CHARGE FOR A GIVEN SERVICE.

(C) THE MEDIAN CHARGE FOR A GIVEN SERVICE IS DETERMINED FROM CLAIMS SUBMITTED DURING ALL OF THE CALENDAR YEAR PRECEDING THE FISCAL YEAR IN WHICH THE DETERMINATION IS MADE.

(D) THE AGENCY MUST NOT PAY MORE THAN THE HIGHEST OF --

(1) THE 75TH PERCENTILE OF THE RANGE OF WEIGHTED CUSTOMARY CHARGES IN THE SAME LOCALITY THAT ARE SET UNDER MEDICARE DURING THE CALENDAR YEAR PRECEDING THE FISCAL YEAR IN WHICH THE DETERMINATION IS MADE; OR

(2) THE PREVAILING REASONABLE CHARGE UNDER PART B, MEDICARE.

EXAMPLES:

THE PREVAILING CHARGE FOR A SPECIFIC MEDICAL PROCEDURE IS $100 IN A CERTAIN LOCALITY.

DOCTOR A'S BILL IS FOR $75 ALTHOUGH HE CUSTOMARILY CHARGES $80 FOR THE PROCEDURE.

DOCTOR B'S BILL IS FOR HIS CUSTOMARY CHARGE OF $85.

DOCTOR C'S BILL IS FOR HIS CUSTOMARY CHARGE OF $125.

DOCTOR D'S BILL IS FOR $100, ALTHOUGH HE CUSTOMARILY CHARGES $80 AND THERE ARE NO SPECIAL CIRCUMSTANCES IN THE CASE.

THE REASONABLE CHARGE FOR DOCTOR A WOULD BE LIMITED TO $75. THE REASONABLE CHARGE FOR A SERVICE CANNOT EXCEED THE ACTUAL CHARGE IF IT IS LOWER THAN THE PHYSICIAN'S CUSTOMARY CHARGE AND THE PREVAILING CHARGE FOR THE SERVICE IN THE LOCALITY.

THE REASONABLE CHARGE FOR DOCTOR B WOULD BE $85, BECAUSE IT IS HIS CUSTOMARY CHARGE AND IT DOES NOT EXCEED THE PREVAILING CHARGE FOR THE SERVICE IN THE LOCALITY.

THE REASONABLE CHARGE FOR DOCTOR C COULD NOT BE MORE THAN $100, I.E., THE PREVAILING CHARGE, IN THE ABSENCE OF ANY SPECIAL CIRCUMSTANCES WARRANTING A HIGHER CHARGE.

THE REASONABLE CHARGE FOR DOCTOR D WOULD BE $80, BECAUSE THAT IS HIS CUSTOMARY CHARGE. EVEN THOUGH HIS ACTUAL CHARGE OF $100 DOES NOT EXCEED THE PREVAILING CHARGE, THE REASONABLE CHARGE CANNOT EXCEED HIS CUSTOMARY CHARGE IN THE ABSENCE OF ANY SPECIAL CIR-

INDIVIDUAL PHYSICIAN FEE PROFILES COMPILED FROM CALENDAR YEAR CHARGES FOR USE DURING THE FOLLOWING YEAR.

MINIMUM OF THREE CHARGES FOR THE SAME SERVICE IS NEEDED TO CALCULATE A CUSTOMARY CHARGE FOR AN INDIVIDUAL PHYSICIAN.

PREVAILING CHARGE WITH ECONOMIC INDEX LIMITATION (FURNISHED BY THE MEDICAID BUREAU) IS SET AS THE UPPER LIMIT--THE 75TH PERCENTILE OF CHARGES.

FOUR CUSTOMARY CHARGES IS THE MINIMUM NUMBER OF SERVICES NEEDED TO CALCULATE THE PREVAILING CHARGE.

NEW PHYSICIANS ARE PAID BY THE 50TH PERCENTILE OF THE PREVAILING CHARGE WHERE IT DOES NOT EXCEED THE 75TH PERCENTILE.

CUSTOMARY CHARGE CONVERSION FACTOR FOR A CATEGORY OF SERVICE MAY ONLY BE CALCULATED WHERE AT LEAST SEVEN CUSTOMARY CHARGES FOR SERVICES HAVE BEEN MADE IN THE PARTICULAR CATEGORY OF SERVICE (MEDICINE, SURGERY, PATHOLOGY, X-RAY, ANETHESIA).

Medicaid Data

1978	OB/GYN Patient Days at Providence Hospital			4,406
	Deliveries			1,809
	Medicaid Deliveries	(approx)	150	
1978	Pediatric patient days			4,135
	Pediatric patients (medicaid)	(approx)	240	
	Pediatric patient days (medicaid)	(approx)		1,200 (¼ of total)

Anchorage Pediatric Group -------- 4 pediatricians

% of business medicaid - 15% of all patients
# of physicians with medicaid- 4
patients

# of hours spent on medicaid billings per month - 24 hours
including forms, phone calls & coupons

Turnaround time for medicaid reimbursement payments:

small billings under $30 - 6 weeks
large billings - 6 months

Total money owed Anchorage Pediatric Group for medicaid - $13,150

CHILDREN'S CLINIC _ --------- 5 pediatricians (all see medicaid patients)

% of business in medicaid patients - 35% ---since 1/79 - 38.67%
# of hours per month processing medicaid- 60 hours minimum ($450 to $500)
paper work

Total billings for medicaid from 7/1/78 to 3/5/79 ----$76,927.80

Total paid reimbursements from medicaid for same -----$11,699.85

15¢ on the dollar paid back on amount owed to Children's Clinic. Balance due -$65,288

Amount owed by medicaid prior to 7/1/78

Doctor A - $1,939; Doctor B - $6459.76; Doctor C - $2977.00
Doctor D - $5,373; Doctor E - $2145

Billed charges to medicaid vs. allowed charges by medicaid

Amount billed - $14,114 Amount Paid $11,699 (or 83¢ on the dollar)

CHAIRMAN
MARIAN T. WITT, M.D.
3300 PROVIDENCE DRIVE
ANCHORAGE, ALASKA 99504

ALASKA CHAPTER
American Academy of Pediatrics

Letter to the Editor: Anchorage Daily News

Dear Sir:

In the Saturday Forum of February 3rd regarding Medicaid, Jaime Love stated that only 2 pediatricians in Anchorage see medicaid children. This is not true. All of the pediatricians in private practice in the Anchorage-Palmer area see such children and we presently number 15.

The number of pediatricians has not increased in recent years in proportion to the population growth of the city, hence acceptance of a new family into pediatric care may be neither automatic nor easy whether one is a medicaid recipient, a merchant or a bank president. All of us accept many new families, but at times when a saturation point is reached, families are referred elsewhere. Family practitioners, as their name implies, take care of many children, medicaid included, and do so capably. The children of our community are not being denied medical care whether medicaid or not.

The Amercian Academy of Pediatrics believes that every child needs a "medical home"; for an office-based familiar, constant setting where he may receive comprehensive high quality preventive health care and specialized care during episodic illnesses or accidents. This requires 7-day, 24 hour coverage by small groups of pediatricians and cannot be provided by health department clinics or emergency rooms.

With these concepts in mind, the American Academy of Pediatrics, has initiated dialogue with HEW financing administrators to seek more effective methods of providing a "medical home" for the eleven million children enrolled in medicaid. The estimated cost is 4.5 billion dollars!

If there is a problem then, it is not that we have forgotten our role as child advocates, it is simply that there are not enough hours in the day. We are trying; and can be found at any hour of the night at any Anchorage hospital caring for sick babies or children, without concern or knowledge of "means of payment."

Marian T. Witt, M.D.
Alaska Chapter
American Academy of Pediatrics

ALASKA PUBLIC INTEREST RESEARCH GROUP
Post Office Box 1093/Anchorage, Alaska 99510/(907) 278-3661
Board of Directors: Hugh Fleischer, Chairperson; Julie Wroe, Vice-Chairperson, Molly Crenshaw, Secretary; Don Clocksin, Treasurer, Eleanor Andrews; David Case; Judy Whitney Eckholm; Bob Goldberg, Terry Stimson; Phil Voland

Martha MacDermaid
Executive Director
Alaska State Medical
Association
1135 West 8th Avenue, Suite 6
Anchorage, Alaska 99501

January 23, 1979

Dear Ms. MacDermaid,

I am writing this letter to request an appearance before the Alaska State Medical Association at its April meeting to address the group on a very grave matter, that being the failure and refusal of many of our community's doctors to accept medicaid patients for treatment.

This request is made on behalf of the Alaska Public Interest Research Group, which is a citizens' organization whose membership numbers approximately six hundred Alaskans. Our main goal is to present the point of view of the consumer on various public concerns.

Although we are involved in a great number of issues, rarely has our organization confronted a problem as disturbing as the matter before us now. There is nothing so basic to our society, as physical health. In recent years the science of medicine has grown dramatically, conquering new diseases, inventing daring new methods of surgery, and implementing new technologies that bring undreamed of efficiencies to the healthcare system. In our country we have spent billions of dollars on medical research, the construction of hospitals, and the education of our physicians. Vast sums of this money come from the public sector. Hill-Burton funds and state revenue sharing dollars finance hospital construction. The federal government funds large and small research projects. The schools where our doctors are educated receive a number of subsidies. Some are direct, like the large government funding of research programs or the tuition itself. Medical schools are tax exempt so the private foundations, corporate donors, and individuals are able to write off contributions against income taxes. The students themselves benefit from a variety of government financial aid programs.

These expenditures are necessary -- necessary for our society to develop the new technology, to build the needed hospitals and health care facilities, and to train an adequate number of doctors. The expense of the undertaking is justified by our goal of bringing adequate medical treatment to the entire society. Without these subsidies few doctors could be trained. Hospitals would cost the consumer even more than they do today. Health care would be too expensive for the average citizen. Only the wealthiest of our society would be assured of proper medical care. This alternative is unacceptable.

So we have chosen to subsidize medical care at the public cost of billions of dollars. But we have stopped far short of a nationalized health care system. It is still firmly controlled by the private, for profit sector of our economy. Doctors are as much businessmen as healers. Of all the developed countries, only the United States and the government of South Africa have yet to provide its people with comprehensive national health insurance. The result is a patchwork system, financed through dozens of different medical insurance programs, health maintenance organizations, and public assistance for those who are indigent and have no medical insurance and no money to pay for health care.

The medicaid system is managed by a government bureaucracy. The State of Alaska runs the program within very detailed guidelines established by the federal government. Since its conception, medicaid has experienced administrative problems. The state has encountered significant delays in the payment of medical vouchers.

The response by individual physicians varies. Some continue to treat medicaid patients, others do not. Doctors with certain skills are more likely to reject medicaid patients than others. Obstetricians, gynecologists, and pediatricians are among those specialties which rarely accept medicaid patients today. For example, one young mother recently traveled to Anchorage from Kotzebue for an operation. A Public Health Service doctor had determined the existence of dysplasia on her cervix. He recommended a cone biopsy at the earliest possible date, to avoid a hysterectomy later.

She contacted the two doctors she had been referred to by the Kotzebue PHS doctor. They would not treat her, nor would six other Anchorage physicians. Some were not taking any new patients, but the majority refused treatment on the basis of her participation in the state medicaid program. Surely many of you can empathize with the distress this woman felt when she was refused treatment.

She and her husband were living in a rural area of the state, supporting themselves by seasonal construction work and living off the land the rest of the year. Their small cash income was enough to provide them with all their basic needs, but the operation was unexpected and they could not afford it. To be told you may have an early stage of cancer is unnerving enough. To

sign up for a public assistance program is a dehumanizing experience. But to beg doctors to treat you, simply because you are on welfare, and to be rejected by every doctor you contact, is more trauma than any Alaskan family should endure.

This woman, of course, is not alone. The present situation with the medicaid program can only be described as a crisis for poor people. It means that health care may not be obtainable if an individual or her/his loved ones get sick. It means being deprived of routine physicals and check-ups that other families have. It means that it is very difficult to find a pediatrician for your children - if you are poor. It means that you cannot get help from every doctor in the community, as the privately insured patient can. Your choices are limited to only those doctors who still treat medicaid patients. In short, it means that poor people have a second class health care system.

In defense of the medicaid program, it should be noted that the average turnaround time for billings is now less than 60 days. The reduction in payment of usual and customary fees, which may be the real underlying cause of physician disenchantment with the program, is mandated by the federal government. The paperwork is only that required by doctors in every other state.

Our organization is upset with the behavior of the medical community. It seems incredible that poor people who need medical treatment would be refused for any reason, let alone the stated grievances of the medical community. After all, physicians as a class are doing very well in Alaska. It is difficult to accept the judgment of those doctors who have turned their backs on medicaid patients, since it is the poor, and not the government bureaucracy, who suffer.

At one time the American Medical Association required each and every member to disregard the economic status of its patients in rendering its services. This standard was formally adopted by the AMA by its House of Delegates in 1934, in the mist of the great depression.

It stated:

> ABILITY OF PATIENT TO PAY.
>
> One of the strongest holds of the profession on public approbation and support has been the age-old professional ideal of medical service to all, whether able to pay or not. That ideal is basic in our ethics. The abandonment of the ideal and the adoption of a principal of service only when paid for would be the greatest step toward socialized medicine which the medical profession could take. All our arguments as to better service to the people, freedom of choice of doctors would be naught if such service were not available to a vast proportion of the people.

This ethic does not appear in more recent publications by the AMA. According to Bruce Nortell, of the AMA legal staff, the ability-to-pay ethic just "whithered away" in the late sixties after the medicaid and medicare programs were enacted.

But since the AMA ethics are only considered the minimum ethical standards for Alaskan doctors, the Alaska Medical Association should re-enact this ethic to address today's medicaid crisis. Certainly the sentiments expressed then are applicable today. For example, how can a medicaid patient have "free choice" when only few doctors in a certain specialty are treating medicaid clients?

While we live in a materialistic world today, with an economic system that encourages the relentless pursuit of self interest, it behooves us to reflect on this isolated activity of health care.

It is like no other commodity, in that no price can be placed on good health or the security of ones family. A profession that asks for the power of self government must consider the entire public responsibility it shoulders. For unless an internal remedy is forthcoming, people will look elswhere for relief. And such relief will be sought until poor people are accorded the same quality of health care as all others.

Sincerely,

ALASKA PUBLIC INTEREST
RESEARCH GROUP

Hugh Fleischer
Chairperson

Peninsula Medical Center, Inc.
P. O. BOX 569
SOLDOTNA, ALASKA 99669
[907] 262-4401

Family Practice
Paul G. Isaak, M.D., A.A.F.P.
Roy E. Benward, M.D., A.A.F.P.
Lavern R. Davidhizer, D.O., A.A.F.P.

General Surgery
Joseph A. Sangster, M.D., F.A.C.S.

Pediatrics
Alexander B. Russell, M.D., F.A.A.P.

DEAR PATIENT:

EFFECTIVE JANUARY 15, 1979 PENINSULA MEDICAL CENTER, INC. WILL NO LONGER ACCEPT MEDICAID OR GRM COUPONS FOR SERVICES WE PROVIDE.

WE ARE RELUCTANT TO TAKE THIS STEP, HOWEVER, WE HAVE NOT BEEN PAID BY THE DEPARTMENT OF WELFARE FOR MANY SERVICES WE PROVIDED IN THE PAST. OUR CLINIC CANNOT CONTINUE TO OPERATE BY EXTENDING CREDIT TO THE STATE OF ALASKA.

WE WILL BE GLAD TO CONTINUE SERVICE TO ALL PATIENTS WHO ARE WILLING TO ADHERE TO OUR CREDIT POLICY. IF YOU CANNOT PAY FOR YOUR VISIT AT THE TIME OF THE SERVICE, FINANCIAL ARRANGEMENTS MUST BE MADE IN ADVANCE.

AS FAR AS WE KNOW, THE OTHER PHYSICIANS IN THE AREA ARE STILL ACCEPTING COUPONS FOR MEDICAL SERVICES.

RECEIVED
JAN 17 1979
Division of
Public Assistance

SINCERELY,

PENINSULA MEDICAL CENTER STAF

Dr. Martin Schlossstein
Mr. Bruce
2M E-N L 279-6429

Peninsula Medical Center, Inc.
P. O. BOX 569
SOLDOTNA, ALASKA 99669
[907] 262-9341

Family Practice
Paul G. Isaak, M.D., A.A.F.P.
Roy E. Benward, M.D., A.A.F.P.
Lavern R. Davidhizar, D.O., A.A.F.P.
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Pediatrics
Alexander B. Russell, M.D., F.A.A.P.

December 4, 1978

Dr. Helen D. Beirne
Commissioner
Department of Health and Social Services
Pouch H-01
Juneau, AK 99811

Dear Commissioner Beirne:

This letter is giving formal notice that unless all past due accounts are paid by January 15, 1979, we will no longer provide medical service to Department of Welfare recipients. The current amount due us from the Department is in excess of $42,000 and some of these accounts are almost two years old. It is impossible for us to remain in business if we continue to provide service for any person or agency with such a poor payment record. We are far better off to provide service free to those people who cannot afford to pay. At least then we don't have all the hassle of repeated billings and record keeping which essentially reduces our return for your cliental to less than fifty cents (50¢) on the dollar of services. To begin with, practically all of our regular charges are discounted to a certain amount which amounts to an average of approximately thirty per cent. In addition, we have to wait excessively long for payment which increases the amount of staff time which is required to keep the records and keep sending statements. Thirdly, a number of charges are completely disallowed and for these we have no recourse. We will continue to provide service to those obstetrics patients that we have accepted to date, but will not accept new ones from 12/1/1978.

I am informed that the Department is out of funds and is in arrears of payment of their obligations to physicians in the State. If we had reasonable expectation that we could expect payment within a certain period of time and be paid for the amount of services rendered, we could conceivably borrow funds at approximately fourteen per cent interest until payment for services to DPW cliental is forthcoming. As it is now, our present financial position is such that we have to go to the local bank to borrow money to purchase new equipment which we feel is essential in providing quality medical care to the citizens of our community.

We regret having to take this step, but must do so in order to stay in business. It just isn't worth the time and trouble that we have to go through to serve DPW cliental which in the last two or three years has been a losing proposition financially.

Sincerely,

PAUL G. ISAAK, M.D.

cc: Representative Hugh Malone
Representative Leo Rhode
State Senator Clem V. Tillion

PGI/ns

STATE OF ALASKA

JAY S. HAMMOND, GOVERNOR

DEPT. OF HEALTH AND SOCIAL SERVICES

DIVISION OF PUBLIC ASSISTANCE / POUCH H 07 -- JUNEAU 99811

January 17, 1979

Paul G. Isaak, M.D.
Peninsula Medical Center
P.O. Box 569
Soldotna, Alaska 99669

Dear Dr. Isaak:

It has come to my attention that Peninsula Medical Center (PMC) has closed its doors to new Medicaid clients effective January 15, 1979.

The reasons for this closure appear to be as follows:

(1) Large unpaid accounts receivable from Medicaid for services prior to July 1, 1978 ("prior year bills").
(2) Excessive payment delays.
(3) Excessive costing down (adjudication) of PMC's billings.

I would like to clarify the current status of each of these problems compromising your participation in the Alaska Medicaid Program.

First, according to PMC records, we hold billings for services rendered prior to July 1, 1978, in the amount of $19,700. Based on PMC's average adjudication rate of 73% of amount billed, PMC can expect to receive approximately $14,400 once the Legislature approves supplemental funds to cover PMC's prior year bills and those of other provider's similarly situated. We regret the inconvenience this shortfall of Medicaid funds must have caused PMC; however, it occurred simply because there was a much greater demand for physician services than originally anticipated for FY78. To help relieve some of the cash flow difficulties which this shortfall caused PMC and other providers, Commissioner Helen Beirne sent written notification to each provider that our supplemental request to the Legislature would include "a sum for interest of one percent a month from the approximate date each billing would normally have been paid until the date it is actually paid". If a billing would normally have been paid in September 1978, but was not paid until February 1979, 5% interest would be due the provider for that billing in addition to the provider's normal rate of reimbursement.

Your second concern is promptness of billing. Although this agency did fall behind in processing billings during the first six months of 1978, payment timeframes were reduced to six weeks or less several months ago and have remained there since. For example, today we are processing physician

billings received on December 26, 1978. PMC's billings received here in late December (for October and November services) are being processed at this time. (Note: We also have a small group of resubmitted invoices in the amount of $2700 to replace some July-September 1978 billings apparently lost in transit. We are processing these now and a check will be mailed to PMC around January 30, 1979.)

Your third concern is the rate of reduction applied against PMC's billings. You state that an average 30% reduction is taken against PMC charges, and that some charges are totally disallowed. Our records reflect generally a 27% reduction against PMC claims, quite close to your 30% claim. Unfortunately, the rate of reimbursement to PMC is governed by federal regulations which in turn are tied to Medicare limits. Although we cannot reimburse at a rate higher than Medicare we do reimburse for a broader range of services than Medicare does. This leads me to believe that PMC charges which were disallowed must have lacked required prior authorization, or appeared to be a duplicate bill. If you will provide specifics of these disallowances, I will see that the circumstances are carefully researched.

Again, I would like to emphasize that the Division of Public Assistance regrets the hardships imposed on PMC as a result of our previous slow payment timeframes, and the delay in our settling PMC's prior year claims. I am indeed sorry that this occurred and the Department is making every effort to rectify this situation. In addition, several major changes have been made to preclude reoccurrence of these same problems in the future. These include:

(1) Revision of our budgeting procedures to more accurately predict funding needs.
(2) A complete review of our Medicaid payment system by federal experts, at our request, to isolate problem areas and to recommend improvements.
(3) Development of an acknowledgement system which will notify each provider that their billings were received, and advise them of the approximate date payment can be expected.

We are determined to implement these and other improvements to make this agency more responsive to providers statewide. It is my hope that in view of this commitment, PMC will reconsider its decision and once again serve all Medicaid clients on the Kenai Peninsula in need of medical attention.

Sincerely,

Rod Betit

Rod Betit
Acting Director

RB:jf

cc: Helen Beirne
Catherine M. Lloyd

Betit
2/1/99

Jean: Copies to
- Alistair
- David
- Tony Smith
- Mc Grimis

Peninsula Medical Center, Inc.
P. O. BOX 569
SOLDOTNA, ALASKA 99669
[907] 262-4401

Family Practice
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Alexander B. Russell, M.D., F.A.A.P.

January 19, 1979

Rod Betit, Acting Director
State of Alaska
Dept. of Health & Social Services
Div. of Public Assistance
Pouch 807
Juneau, Alaska 99811

RE: Taylor, Ola W.

Dear Mr. Betit:

Currently the Peninsula Medical Center, Incorporated of Soldotna is no longer accepting State Welfare patients because of poor compliance with contractural basis on the part of the State. However, the Clinic is continuing to provide health care for people who were previously under the program. It should be noted that in addition house calls are being made including one on Ola W. Taylor, a preterminal cancer patient, who is unable to come to the office. Of course, there has been no charge made to the patient or to the State.

Thank you.

Sincerely,

L Schlosstein MD

Lee Schlosstein, M.D.

LS:sar
cc. Helen Beirne, Commissioner

CHANNEL 2 TV - "FOCUS 2"
Saturday, January 27, 1979
10:10 PM
Suzie Arnell, Newsperson TRANSCRIPT

ARNELL: Kristen Carnes lives with her husband and daughter outside a village on the Kobuk River outside of Kotzebue. They live the subsistence way mostly, which worked out fine until the couple learned Kristen had cancer and needed an operation.

KRISTEN CARNES: She came up to me on the street and said, "We've been looking for you." You see, we were camped out of town a ways so they couldn't find me. And she just said, "We've been looking for you. Your pap test showed some abnormal results and you may have cancer." At first I was really scared because they just kind of told me that I might have cancer. That was how I was told. I didn't feel any pain or hurt in my body, but I just felt panic that either I would have to have a hysterectomy, which would mean no more children and we very much want another child, or I had fears that I would die.

ARNELL: The Carnes immediately went on Medicaid and then found out that very few doctors would take it.

CARNES: We called about seven or eight doctors and a few of those were not accepting new patients, but I think we had four names altogether who just wouldn't take Medicaid patients at all. Doug said that when he called them, you know, he would mention at last, he would ask the doctor whether he would treat me and, you know, when and everything and then mention, do you take Medicaid, and there would be kind of a turnoff and they would say, no, we don't, sorry.

ARNELL: Meanwhile, she went to other doctors for second opinions. It always came back the same. The cancer was there and it seemed to be spreading. They all recommended a cone biopsy.

CARNES: Well, they just kind of go into the cervix like it's an apple and take a core out of it. And at first they stain it in order to know where to cut, then they cut out all the bad cells, hopefully. If they do have to take out a large cone, you may not be able to have children again because you could have a miscarriage; there's not enough cervix to hold the baby in. But usually, if they catch it quick enough, it's not a very serious operation and you're perfectly capable of having children. For a few months I've been thinking about it a lot and, yeah, worrying, sometimes trying not to worry because I hear that's bad. And, yeah, I was quite worried by this time. I really had made up my mind to have the surgery and wanted to get it as soon as possible.

ARNLLL: Finally, they found a Palmer doctor who took Medicaid, Dr. Carolyn Brown.

DR. CAROLYN BROWN: No, I don't care whether they're Medicaid or not.

ARNELL: But apparently many local doctors do. In November, 56 Anchorage doctors were surveyed by the Anchorage Municipal Planning Department. All are OB/GYNs. The Gehler report is startling. Only six doctors said that they accept Medicaid patients and most of those qualified their answers, saying they only accepted a few a month or during certain months of pregnancy. Eighteen doctors said flatly no, they do not accept Medicaid patients. Three doctors said that they sometimes did. And the majority---29--just didn't answer the questions at all. Doctors interviewed listed a series of complaints, the main one being that Medicaid cost the doctors money. They only get reimbursed for part of the bill and doctors say that the payments from the State take way too long in coming.

BROWN: I can appreciate why some physicians would not take Medicaid patients because if they're only paid 60 percent worth of that piece of paper for what their fee is, or 70 or 80 percent, and the physician may have his or her own overhead, I can appreciate why they would be upset at getting a piece of paper that's only worth 60, 70 or 80 percent of what they're about to deliver.

In our office, we've never had a payment come in in less than three months. We have stopped taking Medicaids as of the first of January in '78, and we hadn't taken any more coupons for the entire year and we had a substantial amount that they owed us at that time and they still owe us at the beginning of '79, the same substantial amount. So, that'll tell you where we stand with them.

BROWN: I often wonder if Medicaid patients don't often feel like they're treated as second-class citizens. And you take a very good person who works, who does what they can do to make ends meet, who is responsible to pay their bills and then, bingo, a disaster hits. And they can't really pay for that. So, they have to seek some way to do it. Maybe they don't have insurance and they don't have enough money in the bank and they're making ends meet. So, anyway, they end up going and asking for some assistance from welfare, medical assistance. They're handed a coupon. My experience in talking to Medicaid patients is that nobody explains what that coupon is for. The patient thinks that coupon is money. They think it's 100% of money. It's like solid gold. Then the patient goes to the physician's office, passes over the coupon, for those doctors who will take a coupon, and then assumes that everything is cared for. The physician

BROWN: (continued) then has got to wait six months, three months, six weeks--whatever it is--for the physician, before they're reimbursed and then only get between 60, 70 or 80 percent, if that much.

I would say it's pretty serious, you know, as far as our office is concerned. I know that they owe us quite a bit of money and the way I look at it is that we treat so many people on a credit basis that, in so many different groups and just like, the military with Champus and the Teamster organization, that it makes it very difficult during the month that no payments come in from any of the organizations and you got, you know, it makes it higher in health costs for doctors. They've got to cover that time somehow.

There is a longer time that goes by from the time the physician renders his service until the time they send the bill to us, then it takes us to get the money back to them once they send the bill to us.

BROWN: Obviously our expenses go on. We have staff, we have rents, we have bills, we have interests. These things have to be paid some way or another.

Say there are some months when not very much is coming in. I'm sure that a doctor, in order to cover his overhead, might have to take out a temporary loan on occasion which would again jack up the costs of the medical care to the other people.

That happens.

ARNELL: Hospitals get their fair share of Medicaid woes, too. Spokesman for Providence said some Medicaid patients never bring in their coupons. So the hospital never gets paid.

CHRIS BEARDSLEY, PROVIDENCE HOSPITAL: We have to bill within six months in order to get reimbursed for the coupons. That's the deadline which the Legislature has put down through regulations through the Department. And last year a bill came through, as I remember correctly, where they tried to reduce that time that we could bill Medicaid recipients. It didn't pass, thank goodness, but that would have really put a crunch on us.

Our total losses for the budget year of 1979, which are based on past history and fact, and these are losses due to contractual adjustments because of the Medicare and Medicaid programs, bad debts, charity allowances which we give, will exceed $2,300,000.

ARNELL: From ten to fifteen thousand persons in Alaska are on Medicaid at any one time. Last year the State shelled out some 26 million dollars for Medicaid. This year the figure is set at 31 million, and next year's projection is 41. But last year, reimbursement money for the doctors ran out faster than the fiscal year, leaving many doctors with bad debts from the State and bad tastes in their mouths about Medicaid.

What does the State say about the whole thing? Well, we decided to talk to the man who wrote the Medicaid bill, Fred McGinnis. McGinnis told us that the Medicaid fund itself was solvent last year; they just couldn't transfer money to pay back the doctors.

FREDERICK McGINNIS
DEPUTY COMMISSIONER
DEPT. HEALTH AND
SOCIAL SERVICES: There are rules that change from time to time as to what we can do with funds in one budget review unit or component over against another one. It was a very technical budgeting detail that created the problem. But now, that is not true for the 1979 year. It isn't a problem for this year. We can use money back and forth in the 1979 year, but we could not in the 1978 year. And that was the essential problem. When all those bills are paid and hopefully the Legislature will very soon appropriate the additional money to pick up the services for I believe it was April, May, June--that period in there--there still will be after all those are paid totally, there will be a surplus of some $600,000 in the fund.

Several times we run into problems both in the delay area where we'll send a claim in and they'll send it back with something that should be obvious, like for instance an OB claim where we'll send it in and say, the bill won't be for a total, it'll be care or routine lab work related to prenatal visits, etc., etc., and they'll send it back and say, What's the diagnosis for this patient?

McGINNIS: It is an enormously big business. People don't tend to think of it that way because they tend to think of one hospital, one clinic, one doctor's office. But when it all focuses for that number of people in one set of offices, it is an enormous flow of processing. So there will be mistakes. But the last I heard, that's true with other forms of businesses, too; not just the medical profession.

ARNELL: The State Medical Association met with the State this fall trying to iron out any snags and the State plans to get a computer soon to speed up claims. But how does all this really effect Medicaid patients, and how serious is it really?

I t ink there's really no excuse for it. I think it's an outrage that doctors will pick on poor people, poor people who are sick...

...which will instill a certain level of incentive into the Medicaid program. Incentive to the recipient as well as to the provider and that is the large thing that is missing, as far as I'm concerned.

BROWN: And when a Medicaid patient sees a physician, it is the patient's encounter with the physician; not Medicaid or the Juneau office or the Anchorage office. Therefore, the patient is accountable for that care which was rendered by the physician. I fail to see why we should treat Medicaid patients any different than we treat private carrier insurance patients, in that we bill the patient, it becomes his or her bill, for the difference. I don't understand why this can't be. I'm worried that it's against the law to do this. But I fail to understand why.

I think they're more frustrated than angry, because it puts them in a bad situation with the patients. You know, they feel bad because they can't understand why they can't get treatment and the doctors feel bad because they're not, they're working hard and they're doing a good job, but they're not getting paid for it and, you know, it's frustrating.

BROWN: We don't treat other people like that. Some of the private insurance companies don't treat people like that. They don't treat physicians like that. There's a system worked out.

CARNES: I don't usually go around telling people that I'm on welfare, but that's because I'm afraid of their coldness, I think. It hasn't been a pleasant experience at all and I would avoid it if I could next time. I'd say that the doctors and the patients--they're both the losers in this.

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CHANNEL 13 TV NEWS
Saturday, January 27, 1979
6:30 PM
Beverley Michaelson, Newsperson TRANSCRIPT

MICHAELSON: (intro) Tonight on Channel 13, if you're a pregnant young woman looking for a doctor, you would have trouble finding one in Anchorage. If you're pregnant and on Medicaid, the problem would be even worse.

MICHAELSON: Kristy Carnes came to Anchorage from Ambler with her husband and daughter looking for help as a Medicaid patient. She had cancer of the cervix and needed a cone biopsy as soon as possible.

MRS. CARNES: If it isn't arrested now, it could become what they call evasive cancer, which would mean within a varying length of time, possibly a short time, I would have to have a hysterectomy and, if it got beyond the uterus, it could eventually kill me because it would get into other areas of the body.

MICHAELSON: What was your experience when you called? How many doctors did you call and what was the response and experience you had?

MR. CARNES: I think I called nine doctors in all and the experience I had varied. Some of them I think were just not taking new patients and others were very friendly and helpful, up to the point where I asked them whether they were accepting Medicaid patients, or whether they would accept Medicaid. At that point, they said, no, no sir, I'm sorry we're not. I had a feeling of coolness at that time.

MICHAELSON: Kristy Carnes was taken care of eventually in Palmer. But her situation raised the question in Anchorage-- Are other young women having this problem? Are they having problems getting medical help? Why is there a problem, and what is being done about it?

There are 16,000 people in the state who qualify for Medicaid, according to Rod Betit, Director of the Division of Public Assistance. Over 5,000 are in the Anchorage. None are Native because the Alaska Native Hospital cares for the Native population in the state. Among those who are on Medicaid include the disabled, blind, and many single mothers with dependent children. Is there a crisis in health care for these people on Medicaid?

DR. WINTHROP FISH: Not only is there not a health care crisis for the poor, but I believe it would be difficult to find a place in the United States where everybody--poor or well--is taken care of so well and with such good facilities and competent care.

MICHAELSON: Hugh Fleischer, Chairperson of the Board of the Alaska Public Interest Research Group, disagrees and he says there is evidence of a real health care problem for the poor in Anchorage.

HUGH FLEISCHER: We have a number of specific instances that we're familiar with in which patients who have reported to us about their own direct experience of having been refused any and all medical care based on the fact that they were Medicaid patients, and we know that is the policy of a number of physicians in the community. We've done a spot survey of a number of physicians and determined from their offices, from their own statements, that they were in fact not willing to provide medical care to Medicaid patients on the basis of that fact alone.

DR. JERRY LITTLE: I don't think there is a crisis as such. I think that there is a problem in certain areas in medicine in Anchorage and the Medicaid people being seen as soon as they'd like to be seen. But that is only part of the problem, in that there are a lot of people--Medicaid or non-Medicaid, insurance or non-insurance--who have trouble getting in to see certain physicians.

MICHAELSON: Those certain physicians--is there a particular area of them that is more pressed than others?

LITTLE: Offhand, I would have to think of the obstetrical field, gynecological field and the pediatrics. We need more of these doctors.

MICHAELSON: The crunch, as Dr. Little points out, is particularly bad for young women having babies and apparently even worse for Medicaid women having babies. Public Assistance personnel verify this, saying most of the complaints they get from Medicaid clients--and they do get complaints about not finding a doctor--are that, No. 1, doctors will not perform abortions on Medicaid patients and, second, they can't get prenatal care. Doctors and hospital personnel staunchly maintain, however, that if someone really needs medical care, he's going to get it.

If I were a Medicaid patient and I needed help, I needed to come for services right now, I thought, would I be able to walk into Providence Hospital and be seen?

CHRIS BEARDSLEY
PROVIDENCE HOSPITAL: Absolutely. We never turn away any patient. I don't think you would find an incident where anyone in an emergency or in an acute illness situation has been denied medical care.

MICHAELSON: That still doesn't help the woman who is having a baby and wants to be sure everything is okay. Medicaid patients, like everyone else, need care on something other than an emergency basis.

The next question is, Why aren't some doctors seeing Medicaid patients? There seems to be three major problems. One is payment that is too late and not enough. The second is paperwork and, last, federal regulations.

FISH: There is a problem of payment, of course. And that happens to be a matter of federal law and there's a very complicated payment rigamarole that is gone through in order to determine what percentage of what is billed will be actually eventually paid, and this varies from doctor to doctor depending on how long he's been here and what is known as a fee profile. More important recently has been the relative chaos in Juneau that has delayed the payments a great deal. So that we have a double problem. One is that the government asked, or desired, and planned to get into the practice--or at least the responsibility for providing care for the indigent or the poor. Then they set it out as a cut-rate system and then they delayed it. And then finally ran out of money altogether for a certain period of last year, so that they didn't pay at all.

MICHAELSON: Even though there was enough money in the Medicaid program for 1978 to pay the doctors those last few months of the fiscal year, the doctors did not get their money. I asked Mr. McGinnis, Deputy Commissioner of the Department of Health and Social Services, why that happened.

FREDERICK McGINNIS: It's simply because the Legislature appropriated the Medicaid in about six categories. One was nursing homes, one was hospitals, one was physician services, one was early periodic screening, and so forth. And we are limited to just those line items. We cannot change from one line item to the other. So, while the Medicaid fund has a surplus of $600,000 it's not on the right line item to be paid.

MICHAELSON: How then is there a shortfall at the end of the fiscal year? In other words, have you not been paid in previous years?

BEARDSLEY: Well, there have been...the last two or three years have been shortfalls in the General Relief Medical, Medicaid type funds and of course you're familiar with the different types of pools. So there is some tradition to this; it doesn't go back a long ways, but recently I would say...

MICHAELSON: Do you expect there to be a shortfall at the end of this fiscal year?

BEARDSLEY: If tradition follows, there will be.

MICHAELSON: According to the Department of Public Assistance in Juneau, the money for 1978 will be appropriated by the Legislature shortly and the doctors should receive payment within a few weeks. And, what is more, this shortfall problem should not occur this year because now the Medicaid money can be used where it is needed. Payment delay has been one problem; another problem, as Dr. Fish mentioned earlier, is that under Medicaid doctors, hospitals and other services don't get paid their entire fee.

Do you get paid for everything you bill?

BEARDSLEY: No. Medicaid and Medicare reimburse at a rate of somewhere in the neighborhood of 65 to 75 percent--occasionally 80 percent--of our costs. There are many bad debts. There is some charity care given. And the unreimburseable costs from both Medicare and Medicaid comes to a significant dollar amount here at the hospital and I'd say two million dollars a year that we lose. Contractual allowances, charity care and bad debts.

MICHAELSON: The doctors then are virtually guaranteed payment by Medicaid; not as quickly as they would like nor as much. But ther , among other patients, similar situations must occur and thes days uncollectable bad debts plague every businessman.

Do you find that there are other problems that you have besides the fact that you're not being paid on a timely basis?

BEARDSLEY: Well, on a timely basis, I would say you do run into the tradition where Medicaid patients, in order for us to get reimbursement, when they come for service, have to bring a coupon. And, if we don't get the coupon, we can't bill the State to reimburse us. And frequently--not all that frequently, but in a number of cases--the patient is getting free care and they don't take the liberty of bringing in the coupon, and we ask them to mail it back and sometimes they do, but many times they don't.

MICHAELSON: Which gets into the second and, in many doctors' opinions, the most severe of the problems--the hassle of additional paperwork with Medicaid patients.

LITTLE: If a private paying patient comes in and has an insurance form to fill out, we do not have an insurance clerk to assist. We have a routing slip that has all the information on it--the diagnostic code, the charge, the doctor's name, the patient's signature and so forth--and they just attach their copy of the routing slip to the insurance form and send it in. I think all but three insurance companies in the country accept these. If a Medicaid patient comes in, they have a complete separate form that we have to, one of our girls has to type up. We do not only have to put in the diagnostic code; you have to type out the diagnosis, the name of the diagnosis. Each one, each office, laboratory test that's done--all that has to be typed in. So there's an extra paperwork just in filling out the form.

MICHAELSON: There is one page to the Medicaid forms similar to most insurance claims. It takes one clerk one day to type all the Medicaid billing forms for six doctors for one month. But the doctors' business office says there's more time involved in dealing with returned forms, missing coupons and the like--all amounting to extra hassle.

Dr. McGinnis, who is the Deputy Commissioner of the Department of Health and Social Services, and others feel that the paperwork is not inordinate and represents a billing procedure that would be customary in any other type of business endeavor. What the doctors see is an increasing involvement in government in the way they're doing their business, and they don't like it.

FISH: Finally, more of a problem is the ever-increasing federal regulation that comes down because it's all tied to federal programs, and there are now a new set of regulations being fomented in Juneau and ready to go on...or ready to be actually implemented that will make the problem of taking care of somebody in the system. It's not the matter of the money but it's just that once you take on the system, why then you're involved with a great deal of paperwork, a great deal of hassle, rebilling...but more than that, even the threat of being prosecuted for criminal action under fraud and abuse laws that are becoming more and more strict. You've got to understand: we object to both Medicare and Medicaid at which time we customarily delivered if you want to call it charitable medicine. That was part of the tradition of medicine and we all did it. We objected politically and otherwise to the whole concept because we realized it would bring eventually tougher government regulations which bogs the system down and makes it difficult to deliver.

MICHAELSON: The Alaska Public Interest Research Group points out, however, that doctors and hospitals receive help from the federal government regularly in the form of research grants, subsidies to medical schools, and the financing of hospital construction. So they feel the doctors should take more responsibility for making federal programs like Medicaid work.

The next question: Are some of the problems between the medical community and the Medicaid program being solved?

FLEISCHER: The Department of Health and Social Services is working on the problem. The Governor recognizes that there is a problem. But still there is quite a time lag that can sometimes reach up into 90 to 120 days. That's awful hard to say, Bev, because there's a whole new ball game coming down and there's what is known as the State Health Plan, which is a big thick document superimposed on another big thick document called the State Medical Facilities Plan, which is terribly tough reading but seems to envision the State as going to set up in the next five years some sort of state health insurance where it's all under one lump program and so the whole thing is changing. If it's as bad as Medicaid when they get it, why then you will be a Medicaid patient along with the rest of us and will enjoy the benefits of it. I don't there there's any question about it. We understand that payments now are being made within 60 days of submission of billings to the State, and I don't think that's an unreasonable period of time for physicians to wait for a payment. It's certainly in accord with I think even private insurance coverage, or perhaps even better. So I don't really think that it even exists as a problem any more. There have been problems in the past, but we've been dealing with those problems. The fact of the matter is that the care is really owed to the community, to the poor people in this community, and the fact that there have been delays or hassles in payment should not be used as an excuse to refuse to treat poor people in Anchorage or in the state.

MICHAELSON: As the tugging and pushing goes on between the government and the doctors, the fact remains that there are many doctors in Anchorage who are not seeing Medicaid patients and, as a result, it is less likely that these people will receive the kind of medical care they may need.

And finally, and the most complex issue, is one that our nation is going to be dealing with for many years to come. That is, does the doctor have the right to refuse anyone who comes to him for help?

FLEISCHER: The doctors in our community really have an obligation to provide medical care to people who are so-called Medicaid patients, the poor people in Alaska. They're entitled to medical care along with all the other citizens in the state, and they're being denied it now because of the fact that they ar poor. I think that's wrong and we ask that it be changed.

FISH: I believe that we have an obligation to take-- I particularly feel I have an obligation to take care of a certain number of people who are not otherwise able to handle the situation. And a given number of these people are truly unfortunate and have no other access to medical care, and that happens to be my feeling. I do not believe, however, that it is, should ever be, a mandated thing that a person was forced to enter a system in which he didn't believe or didn't want.

* * * * *

South Central Health Planning and Development, Inc.
1135 West Eighth Avenue Suite I
Anchorage, Alaska 99501

(907) 278-3631

OB Gyn

FROM: Dennis DeGross

SUBJECT: Community Survey on Obstetrical Services

DATE: December 26, 1978

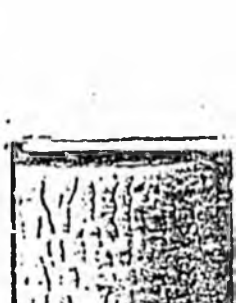
MEMORANDUM

Enclosed you will find a cover letter and the Community Survey that was sent to all survey participants.

We would welcome your ideas and suggestions on any matters upon which you might wish to comment. Please call me at 278-3631.

Thank you.

1/17/79
cc Dave Davidson, Medicaid mgr



South Central Health Planning and Development, Inc.
1135 West Eighth Avenue Suite I Anchorage, Alaska 99501
(907) 278-3631

December 12, 1978

(This is a copy of the cover letter sent
to all participants of the Childbirth survey.)

Dear:

On behalf of South Central Health Planning and Development, Inc., thank you for your willing participation in the enclosed community survey on Childbirth. I hope the information contained therein may be of some value to you and to your interest in childbirth.

As the interviews were being conducted, it became obvious that very few people are "neutral" about childbirth. It also became obvious that people who are involved in some way with childbirth want very much to communicate with others who are involved. The idea of a meeting of principal actors thus became almost inevitable. It was suggested that as a "disentangled" but not disinterested party, SCHPD Inc. might be an appropriate convener of such a meeting. Beyond saying that SCHPD, Inc. would be interested in a meeting or meetings which would attempt to deal with immediate, soluble problems, not much actual detail of possible agendas can be stated at this time.

Enclosed is an envelope addressed to SCHPD. If you are interested in participating in community meetings directed at some of the issues raised, please jot down your suggested agenda items--what subjects or problems on childbirth would you like to see addressed? You might also indicate best times for your participation (time of day, day(s) of week), and suggest other participants.

Again, thank you for your participation in this initial effort.

Very best regards,

Dennis P. DeGross
Health Planner

Encl.

CHILDBIRTH SURVEY: A LOOK AT OPINIONS ABOUT PRENATAL, DELIVERY, POSTNATAL CARE AND RELATED CONCERNS AS EXPRESSED BY VARIOUS REFERRAL AND SERVICE AGENCIES AND INDIVIDUALS IN ANCHORAGE.

Background:

In late October, medical staff from Anchorage Neighborhood Health Center, and staff from South Central Health Planning and Development, Inc. (the Health Systems Agency for South Central and Western Alaska) had discussions regarding reported claims that pregnant women (particularly women of lower economic means) were experiencing difficulty in obtaining necessary obstetrical services in Anchorage. These discussions raised the following questions:

1. Is there a shortage of obstetrical services (specialist and family practice)?

2. If there is a shortage, is it felt more in a particular economic segment of the population, such as among the poor?

3. Are Medicaid-eligible patients who are seeking OB services actually not able to obtain those services?

4. If enough prenatal work is not being performed in the community will that show up in the number and kind of unscheduled emergency deliveries being performed at the two hospitals or in any other form of "negative event" that can be documented?

5. Will a look at the volumn and quality of current home birth activities of the community reveal anything about who is not getting or who cannot afford prenatal care and delivery and hospital costs?

6. What new efforts are being put forth by physicians and hospitals, to meet the obstetrical needs of the community?

Summary of Results:

It was agreed that it would be an appropriate SCHPD, Inc. function to take a look at the community in the context of these questions, and attempt to establish some preliminary directions for future action.

The following statements are the results of interviews conducted by SCHPD Inc. staff. While they are anecdotal and hence, subjective, they would seem to confirm that some shortage of OB services does exist, and that the economically disadvantaged patients are those who are most likely to directly experience that shortage (Questions 1, 2, 3).

It is unclear from the interviews whether a scarcity of prenatal services is substantially manifesting itself in either an excessive number of unscheduled emergency room deliveries, or in other "negative event" results, such as toxemia of pregnancy, or stillbirth (question #4). That data may be retrievable with a concerted, well organized effort, and will be further explored with APRO and the two hospitals.

The interviews revealed a surprisingly substantial number of home births taking place in the Anchorage area (we estimate from 10 to 20 per month), but since many couples who choose home birth claim to do so for reasons other than finance, it is difficult to determine who has turned in that direction because they were unable to afford OB services (Question #5). One thing is clear, however, the current disdain expressed by physicians for home birth, and the lack of alternative "legitimizing controls" upon the practice, creates a potentially dangerous situation. The home birth people are a fact, albeit an unpleasant one in the eyes of the allopathic practitioners; the question is whether they (home birthers) will be allowed to continue activities as "outlaws", outside the pale of public and professional evaluation and control.

As for the efforts of the established medical system (Question #6) there are signs of change. More and more OB specialists are bringing OB nurse practitioners into their office practices, and the hospitals are beginning to discuss alternative modes of birthing. Recently, one OB specialist suggested that if each physician currently working in OB would take one Medicaid OB patient and one medically indigent OB patient per month, on a voluntary basis, the problem would probably clear up.

It has been reported that the OB section at Providence Hospital has appointed an informal committee to work with the Anchorage Neighborhood Health Center on some of these problems.

The interviews below were subjectively gathered, and are most certainly subjectively expressed. If as those of you who participated as interviewees read what we thought you said, you feel we have done violence to your intended meaning, please call, and we will circulate an errata among the participants. Copies of this report are being circulated to those people whose names appear on the list, which appears at the end of the interview section, in order that a sharing process among the principal actors may be started.

Copies are also being sent to all OB-Gyn practitioners and family practice physicians performing OB services, to Dr. Fred McGinnis, Deputy Commissioner of Alaska Department of Health and Social Services, and the administrators of all local hospitals, to the Alaska Professional Review Organization, and to all SCHPD, Inc. Board members.

At the end of the report is a survey of Anchorage OB-Gyns and family practitioners that was carried out by Jan Gehler, Human Resources Planner for the Municipal Planning Department. The survey has been invaluable to the conduct of this effort, and especially to various referral agencies in the community to whom such information is vital.

THE INTERVIEWS

Jerry Ekvall, Family Planning, Municipality

Jerry was quite aware of the difficulty in obtaining specialist services (OB-Gyn) for expectant mothers. She knows of very few who will take Medicaid patients, so she has been referring most Medicaid eligible and the medically indigent to the Anchorage Neighborhood Health Center. Jerry knew of one woman who could not afford physician or hospital costs who received no prenatal care prior to showing up at the hospital emergency room. Even though the ANHC is not able to provide the full range of OB services, referral is made because of concern that there would be more similar cases.

Cathy Bickerstaff, Planned Parenthood

Cathy has heard from many of the women who touch base with her that the OBs in town are not accepting new patients. She is quite certain that many OBs have said they won't accept Medicaid, and none will accept Medicaid for tubal ligations. She knows of a GP who will remove a uterus under Medicaid. She indicated it is becoming very difficult to obtain a legal abortion under Medicaid, but that legal abortions are difficult under normal economic circumstances, due to the limited access to services. She thinks a crucial issue is that it appears new patients are not being taken. Cathy is aware of the Medicaid snafu and is concerned that access to quality medical care for women will be seriously limited as a direct result.

Pam Albrecht and Evon Williams, Birthright

The belief of volunteers at Birthright is that a real crisis exists in obtaining adequate prenatal services for their clients--particularly among Medicaid qualified and the medically indigent. In an effort to determine which Obstetricians and Family Practice physicians would provide services for their clients, Birthright conducted a survey of all OB-Gyns and Family Practice physicians in August of 1978. With few exceptions, the results of that survey were similar to those of the enclosed survey, completed in mid-November by Jan Gehler, of the Municipal Planning Department. The Gehler survey was used to update the Birthright list (see attached).

Patty Boylan, Booth Memorial Home

It is Patty's impression that there is general difficulty in obtaining OB-Gyn services in Anchorage. She concedes that the extreme youth of the Booth Memorial Home client population may contribute to the reluctance by specialists to take them on as patients. Patty indicated that the Municipal Health Department had been very helpful in the past, in obtaining services. Patty was not particularly aware of a special problem with Medicaid.

Mrs. Wyrick, CHAMPUS Advisor, Elmendorf Hospital

Mrs. Wyrick definitely believes there is a shortage of OB services in Anchorage. She explained that only 60 deliveries per month can be performed at Elmendorf; any more than that must go into the civilian market under the CHAMPUS program. The patient is given a list of Obstetricians. Many OB specialists won't take OB patients, Mrs. Wyrick stated, and many who do seem to specialize in performing "C" Sections. Many OB specialists severely limit the number of patients they take, and very few will take CHAMPUS patients.

Jean Wolf, Community Health Nursing, Municipality

Community Health Nursing is usually not aware of a problem until they are put in the position of having to find OB services for one of their patients. Most of these referral problems involve Medicaid eligible, or medically indigent patients. The traffic has varied from one or two per day, to two to three per week. Referrals have been made to Anchorage Neighborhood Health Center for prenatal care, but most often, personnel from Community Health Nursing will stay on the telephone until a physician has been found who will take the patient.

Jean is aware that many home deliveries are being done in Anchorage, and while she is somewhat unsure as to the competence of current home delivery services, she indicated that there is a fairly large demand. Some women, either Medicaid eligible, or medically indigent, often experiencing the frustration of not obtaining physician services, simply say they will present themselves to an emergency room when it is time to deliver.

Jean acknowledged that, although the hospitals are probably "carrying" patients who are unable to pay, it is not common knowledge among the public that free services are available in a "crunch". Also, in the case of physicians who assert their willingness to accept charity cases--that fact may not be completely understood by the physician's reception personnel, who are motivated to keep the physician solvent, and who may thus discourage the charity patient.

Jean concurs with the majority medical opinion, which perceives home deliveries as basically dangerous; but on the other hand, she is sorry people who have no other alternative are forced to "sneak around" in order to deliver at home--the medical community is turning its back on this rather sizeable activity.

Jean believes a meeting of principle participants is needed in order to solve this community problem.

Gayle Stevens, Nurse, Open Door Clinic

Gayle said it has been very difficult to obtain obstetric services for their patients from time to time. It was particularly bad during the past summer--so bad that Open Door conducted a telephone survey of OB-Gyns, and Family Practice physicians, in order to determine who was taking new patients, who would provide prenatal care for home births (for those women who stated a determination to do that), who would accept Medicaid, and how much each charged for services. The results of the Open Door clinic survey were very similar to

those of the Gehler survey (see attached).

Open Door Clinic was doing some prenatal awhile back, but as the Anchorage Neighborhood Health Center began to take more prenatal visits, the number of such visits to the Open Door Clinic abated somewhat.

A considerable number of women are delivering their babies at home, but that activity is not seen as legitimate by, and is not under the control of, the established medical community. Home birth is a sizeable "in the closet" activity in Alaska.

A possible reason that physicians are reluctant to take Medicaid or CHAMPUS patients, is that the maximum allowable charges under those programs are considerably lower than their "usual and customary" charges.

William Compton, M.D., Providence Professional Bldg.

Dr. Compton agrees that there is a great demand for obstetrical services, but is unclear as to the extent of shortages. Obstetricians do have more than enough work. Many obstetricians are sliding toward elective gynecological work because it is less demanding than OB work.

Dr. Compton's own process is to see to the patient's care first, then deal with the money questions later. He thinks most patients fall into some form of financial capability, Medicaid, CHAMPUS, insurance, etc. On the other hand, he acknowledged that he has a tremendous accounts receivable situation, which he felt sure is the case with his colleagues.

See 11/9/79 Anch. Daily News clip

That physicians are somewhat reluctant to work with Medicaid and CHAMPUS is understandable, in light of the discrepancy which exists between the "maximum allowable" costs provided by those programs, and the real costs of services reflected in physician's "usual and customary" charges.

Dr. Compton indicated that the problem of obtaining OB services for Medicaid patients was not a new one, and that he favored an effort by obstetricians to voluntarily deal with the problem. He does not view current efforts by the Anchorage Neighborhood Health Center to provide additional prenatal services as ideal, since that agency has no OB-Gyn on staff, utilizes an OB consultant to the Nurse practitioners from several miles away, and will then expect emergency room, on-duty and on-call physicians to deal with crisis situations as women present themselves for delivery—all this without prior contact between patient and medical personnel.

Dr. Compton is of the opinion that home deliveries are extremely dangerous and does not support movement in that direction. He sees Providence Hospital's development of "birthing" rooms as a "maybe" compromise for families who want a more comfortable and relaxed birth experience.

Pat Vezina, Nurse, Labor and Delivery, Providence Hospital

Pat discussed the addition of the new "birthing" rooms at Providence Hospital. Except that a woman will not be moved from one room to another during

labor and delivery, she perceives that the new set up will offer minimal advantage over the existing system. The new rooms will require the same amount of staffing over time, so that, except that staff will have one less room to clean up, actual costs will not be much less than before. Of course, the rooms will be comfortably decorated in a much more homey atmosphere than previously. Naturally, if length of stay is reduced, that will substantially affect the cost for the patient, but it is not clear that length of stay will actually be reduced.

Pat suspects that the medically indigent have a good deal of trouble obtaining OB services. She estimated that several women per month show up at the emergency room for delivery without having had adequate prenatal care.

How much of the current "crisis" is related to the events surrounding Alaska Clinic is uncertain—Providence Hospital, in two months, delivered 169 babies each month, a record number.

The shortage of prenatal care is perhaps not acute, but is rather a distribution problem. Many physicians who are qualified to perform those services have moved over into elective gynecology, she stated.

Pat had a concern about the Anchorage Neighborhood Health Center's recent movement in the direction of providing additional prenatal care without delivery services. Agreements with emergency rooms notwithstanding, ERs are not in the delivery business—they don't always have the expertise. Physicians, on call or in house, will know very little about case histories of individual patients as they show up at the ER for delivery.

Pat believes some of the financial pressure, as well as reported shortages might be solved by the OB-Gyns employing more OB nurse practitioners/midwives in their practices. She was not sure this would solve the more severe financial difficulties experienced by some patients.

On the issue of home birth, Pat pointed out that she was a midwife in England, where she performed home deliveries, but where there was a mobile emergency capability especially set up for home birth. She has since discovered that in the time she has been away from England, that situation has changed—most deliveries now occur in the hospital there.

Most deliveries are normal, she said, and will present no special difficulty. She thought about 4 or 5% of deliveries will require technological intervention. A portion of that 4 to 5% can be successfully screened, so that the early detected problem could have been referred for a hospital delivery in the first place. Other serious problems (the remainder of this percentage) would not become obvious until labor and delivery had begun.

An impediment to the utilization of midwives in Providence Hospital, is that presently, only physicians and dentists are allowed to admit patients. There would need to be a change in hospital bylaws covering admitting practices, before nurse midwives could be utilized with any force.

William Ivey, M.D., Gynecologist, Alaska Hospital

Dr. Ivey did not address the question of whether or not there is a shortage of obstetrical services directly. He did say that obstetricians tend to get

bored with routine deliveries--because they are trained to deal with problems. He added that physicians in family practice could probably not allow themselves to become too heavily burdened by deliveries.

He believes there needs to be a less expensive service for routine OB, and that that may very well be in an increased utilization by the medical system, of nurse/midwives, but only in a hospital setting.

Jerry Travis, Director, Municipal Emergency Service

Jerry stated that his paramedics, up through Nov. 27, had responded to 91 calls that they classified as "OB-Gyn". He estimated that from 40% to 45% of those were births, some of which occurred in-transit in the vehicle. He did say there were no "code red" calls, which indicates that emergency personnel were primarily involved with completing the delivery.

Jerry stated that many of these responses involve economically indigent and minority (but non-Natives--he said they had had very few transports to ANS for Natives).

Judy Anderson, New Mother, Anchorage

Judy is very disappointed in the limited options available to the expectant mother in Anchorage. She is particularly critical of the hospital setting as a place to have babies, stating that hospital staff and physicians tend to be very authoritarian, which does not offer the woman any control in birthing.

Judy's notion of an ideal birthing center is a place where prenatal care, birth, and postnatal care occur. It has a "home-like" atmosphere, where the family (if desired), even children, may participate in the birthing. It is medically staffed to handle the unscreened emergencies, or has close access to that capability. Even "C" Sections might be performed there. The Birthing Center would not be available for the "pre-screened" serious complication.

Judy is of the opinion that what Providence Hospital is planning could in no way be called a Birthing Center. Doing everything in one room (birthing and after birthing) is only what every hospital should be doing anyway and should not be perceived as a great stride forward. Pictures on the wall do not make a birthing center, in her estimation, trained staff, and a major change in institutional attitude are required for that.

Judy is for home delivery as long as there is careful screening and competent personnel involved.

Peggy and Clay Newman, Homebirth Classes, Anchorage

Prenatal care is scarce for persons planning home birth, according to Peggy and Clay Newman. Currently, they utilize two or three physicians to provide prenatal services. However, since physicians tend to put patients

Freda Refuge, Information and Referral, Women's Resource Center

Freda says they have a log book full of women calling in for help in getting OB care. A lot of it is abortions but much is also prenatal care. She says there are also many complaints about not being able to get general medical care if you're Medicaid other than at ANHC. Referrals from there get "tough" as providers "won't accept Medicaid patients".

Rona Meyers, Home Birth Person, Anchorage

Rona, who is present at about five home deliveries each month, states that pregnant women are having extreme trouble in finding prenatal care in Anchorage. The Open Door Clinic has provided some, and most recently, Anchorage Neighborhood Health Center. She says she has far more demand for participation with couples wanting home delivery than she could ever handle. She screens couples intensively, therefore, and actually participates with only a small portion of those who approach her. She believes only about 40% of home deliveries are for financial reasons--the rest want to deliver in the home for other reasons.

Doris Williams, Ph.D., Naturopath, Anchorage

Dr. Williams is certain many expectant couples have been refused service, simply because the schedules of OB specialists are filled up and they aren't taking any more patients. However, she believes there is not so much a shortage of OB services in the community, as there is a limited choice.

Dr. Williams estimates that home birth may account for up to 5% of all deliveries in Anchorage. She said many who start out with the intention of delivering in the home, change their minds later--they may develop some fear about what they are doing, or they may develop complications which can only be dealt with in a hospital. In her estimation, roughly ½ of home deliveries are for reasons of finance—the remainder simply do not want to deliver in a hospital.

Judy Sharp, Social Services, Providence Hospital

Chris Beardsley, Public Relations, Providence Hospital

Mr. Beardsly believes there is a shortage of OB services if one is speaking exclusively about the number of OB-Gyns in the community, but thinks that by adding in family practitioners who are involved in delivering babies, that situation changes dramatically for the better. He thinks many people could get high quality care from family paractice physicians, but prefer a specialist, which adds to the problem, since, even among the OB-Gyn, a small number are in very high demand as opposed to others. He also stated that we might get a different picture of "shortage", if we knew whether a lot of "physician shopping" may be conducted by couples in their third trimester. The third trimester pregnancy would discourage some physicians from accepting a patient.

Judy was of the opinion that there definitely is a shortage of OB services in the community, and thought there might be a way information could be obtained from patient records, which would give the community a better understanding of how many women come into the emergency room or L and D, having had inadequate prenatal care through their gestation period. She personally could recall three

deliver at home, will refuse to continue as physician in the case. Many couples who are aware of the physician displeasure with home birthing will not inform their physician of their intention to deliver at home, thus risking the possibiljty that during prenatal some aspect of the developing pregnancy which would ordinarily rule against a safe home birth, might not be articulated.

The immediate future of the recently "stepped up" prenatal work being performed by Paula at the Anchorage Neighborhood Health Center is in doubt. From January through April, she will be attending Midwifery school in the Lower 48, during which time, prenatal care at the Center will have to be curtailed. What this will mean to the community is unknown.

Contributor/Participants of the Childbirth Survey
(In order of interview)

Jerry Ekvall - Family Planning, Municipality
Cathy Bickerstaff - Planned Parenthood
Even Williams & Pam Albrecht, Birthright
Patty Boylan, Booth Memorial Home
Mrs. Myrick, Champus Advisor, Elmendorf Hospital
Jean Wolf, Community Health Nursing, Municipality
Gayle Stevens, Nurse, Open Door Clinic
William Compton, M.D., Providence Professional Building
Pat Vezina, Nurse, Labor and Delivery, Providence Hospital
William Ivey, M.D., Alaska Hospital
Jerry Travis, Director, Anchorage Municipal Emergency Service
Judy Anderson, new mother, Anchorage
Peggy Newman, Teacher, Homebirth Classes, Anchorage
Clay Newman, Teacher, Homebirth Classes, Anchorage
Cheryl Westley, Chairman, Education Committee of Childbirth Educ. Assn.
Trudy Keller, Childbirth Ecucation Assn., Anchorage
Betsy Baker, Director, Women's Resource Center, Anchorage
Freda Refuge, Information and Referral, Woman's Resource Center, Anchorage
Rona Meyers, Homebirth person, Ancho_age
Doris Williams, Ph.D., Naturopath, Anchorage
Judy Sharp, Social Services, Providence Hospital
Chris Beardsly, Public Relations, Providence Hospital
William Larson, M.D., Anchorage Neighborhood Health Center
Kaaren Riehle, Planner, Providence Hospital
Pat Sandberg, Social Services, Alaska Hospital
Obed Nelson, Chaplain, Alaska Hospital
Jan Gehler, Human Resource Planner, Municipality of Anchorage
Paula Korn, Anchorage Neighborhood Health Center

Survey Date: November 9, 1978

SUMMARY OF SURVEY FINDINGS

N = 56 physicians (38 family practice; 16 OB-GYN)

	Family Practice	OB-GYN
Do you take OB patients?	13 Yes*	13 Yes 3 GYN only
(* one FP sees OB's for first visit only; then refers to OB-GYN)		
Are you currently accepting new OB's?	12 yes	9 yes most on limited basis; not before 3rd month.
Average waiting time first appointment?	2-4 weeks	4-6 weeks
Will you admit to either hospital?	5 both 7 only Providence 0 only Alaska	4 both 7 only Providen 2 only Alaska
Will you accept Medicaid patients?	2 limited (2-4/months) 0 unlimited	4 limited 1 unlimited
What is your deposit and/or fee for normal delivery?	Range for 1st visit deposit Range for full fee	$0 to $350 $550 to $750

Survey conducted b

Jan Gehler
Human Resources Pl

Anchorage Municipal
Planning Department

2 out of 38?

5 out of 13 –
However look at up-front fee demands which, if followed, would Eliminate in practice all Medicaid

NAME:	Specialty Type	Do you take OB patients?	Are you currently accepting new OB patients?	What is the average waiting time for first visit?	Will/Do you admit to either hospital? Which if only one?	Will/Do you accept Medicaid patients?	What is your "deposit" fee for OB patient
Agnew	FP	No (Provides list of OBs)	Taking no new pts. now		Both	Some	
Arbow	FP	Yes	Yes	< 1 week	Only Prov.	No, CHAMPUS	$600 total due within 3 months
Billings	FP	No					
Bing	FP	Yes, only 1st visit; refer to Dr. Eastburn	Yes			Yes	N.A.
Bosveld	FP	Yes	1st appt. in 3rd mo., sooner if problem	1-2 weeks	Yes, mostly Providence	No. CHAMPUS, Yes.	$560, $2 ...d
Bryan	FP	No, refer all to Dr. Eastburn.					
Burgess	FP	No, provide list of all OBs.					
Cates	FP	No.					
Colyar	FP	No, refer all to Nist.					
Compton	OB	Yes.	No, Booked annual exam thru Jan.		Yes, Prefer Providence	Yes, some. No CHAMPUS.	$600 tot
Cormack	FP	No, refer all to Eastburn.					
Crawford	FP	No.					
Eastburn	OB	Yes, current no GYN	Yes, if 6 ..., or more	6 weeks to see Nurse Pr.	Only Prov.	Yes, no ... CHAMPUS	$50 down $707.50 b 9th mon.
Erkman	OB	Yes.	Yes	2-3 weeks	Only Prov.	Yes, 3-4 mos No CHAMPUS	$700 by 9 mon., No
Exvall	OB	Yes.	NO, refers to Erkman & Hanson		Only Prov.	No	$700
Feirtag	FB	No					
Ferucci	OB	Yes	Yes	1-2 N.P. --small group 3-4 wks. DR.	Only Prov.	No. No CHAM.	$600
Foland	FP	Yes, limited to 6 mos.	No	4-6 wks.	Yes, Mostly AHMC	No	$560 tota due by P.I $250 at 1s appt.
Gibson	OB	Yes, only continuing	No	Will not see 'til 3rd mo. 2-3 weeks	Only Prov.	Yes, a few per month	$700 by 9 month

Dr.	Specialty Type	Do you take OB patients?	Are you currently accepting new OB patients?	What is the average waiting time for first visit?	Will/Do admit to either hospital? Which if only one?	Will/Do you accept Medicaid patients?	What is your "deposit" fee for OB patient
Gills	OB	Yes, only if June, Dr. will be gone summer.	due before Yes, Ltd.	At 3 months 1-2 wks.	Only Prov.	No, No CHAM.	$750 $175/mon.
Guenther	OB	Yes	Yes	At 3 months 2-3 weeks	Only AHMC	No. Yes, CHAM.	$600 plus Post-pa
Benson	OB	Yes	Yes, if 8wks or more		Only	Yes, No, CHAM.	$700 to
Ivy	OB	No, only GYN	Refers to Phone book		Only AHMC		
Jackson	FP	Yes	Yes	1-2 weeks	Only Prov	Yes, 3/mo. CHAMPUS	$600 tota $64/first
Jones, L.	FP	Yes	Yes	<1 weeks	Only Prov	No. CHAMPUS	$600 w/in months =
Jones, W.	FP	Yes	Yes	2-4 wks.	Only Prov.	None	$550; $50/ vis
Kiessling	FP	N.A.					
Laufer	FP	Yes	Yes	< 1 week	Only Prov.	No. CHAMPUS	$600/w/in
Little	FP	Yes	Yes, 1st appt. at 3 mo., earlier if problem	1-2 weeks	Yes, most Pr.	No. CHAMPUS	($560 due) $250, 1st
Manwiller	FP	Yes	Yes	2-4 weeks	Only Prov.	None	$550; $50 vi
Martin	FP	No					
Mayer	FP	No					
McCumber	FP	No					
Monlux	FP	No					
Morgan	FP	No					
Moseley	FP	No					
Newton	OB	Yes, mostly GYN, repeat C-sections	No		Both	No	
Nist	OB	Yes	Yes, 10 del. per month	1-2 weeks	Yes, Prefers AHMC	None	$350/1st
Nolan	FP	No, refers to Eastburn					
Olsen	FP	No					
Orren	OB	Yes	Yes	4-6 weeks	Only Prov.	None	$100/1st v
Persons	FP	No					

NAME:	Specialty Type	Do you take OB patients?	Are you currently accepting new OB patients?	What is the average waiting time for first visit?	Will/Do admit to either hospital? Which if only one?	Will/Do you accept Medicaid patients?	What is your "deposit" fee for OB patient
Renn	OB	Yes	Yes	4 weeks	AHMC	No. CHAMPUS	20-50% of total pri to delive
Romig	FP	No					
Smith	FP	No, refers	to Eastburn.				
St. John	FP	No					
Stransky	OB	No					
Sutherland	FP	No					
Sydnam	FP	Yes	Yes	4 weeks	AHMC only	No. CHAMPUS	20-50% pr to delive
Wagnon	FP	No					
Wallner	OB	Yes, only C-sections	No		Both	None	
White	FP	No					
Wieland	FP	Yes	Yes, 1st ap @ 3 mos., sooner if problems	1-2 weeks	Yes, mostly Providence	No. CHAMPUS	$560 tot $250 dow
Taylor	FP	Yes	Yes	<1 week	Only Prov.	None	$600 with 3 months
Addenda:							
Sangster	FP	Only Prenatal			No	Some	Blood wk. Papsmear Visit

ALASKA PUBLIC INTEREST RESEARCH GROUP

Post Office Box 1093/Anchorage, Alaska 99510/(907) 278-3661

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INTRODUCTION

The Alaska Public Interest Research Group newsletter is available to any AkPIRG member. The subscription price is the same as membership dues: $10 to individuals, $25 for institutions or businesses, and $5 for persons on limited incomes. The Alaska Public Interest Research Group is a non-profit citizens group, tax exempt under 501 (c) (3) of the Internal Revenue Code.

AkPIRG offices are located at 513 West Seventh Avenue, Anchorage, Alaska. The mailing address is P.O. Box 1093, Anchorage, Alaska 99510. The phone number is 278-3661.

Comments on the newsletter, or any other aspect of AkPIRG activities are appreciated.

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NEW DATE FOR ANNUAL MEETING

The annual meeting of all AkPIRG members has been rescheduled. Originally planned for the 17th of January, the meeting will now be held January 25, 1979 at the Pioneer School house at 3rd and Eagle. The time of the meeting is set for 7:00 P.M..

(Continued on Page 3)

DOCTORS TO CANCER PATIENT - DROP DEAD -

Early in May, right before break up, Kristi Carnes, her husband Doug and their two year old daughter Annathea, borrowed a friends dog team and traveled 200 miles from their home, near Ambler, to Kotzebue. There Kristi and her family camped out while Doug found a construction job to earn some summer money to last the rest of the year.

In early June she visited the Kotzebue health clinic for a routine medical check-up. But the check-up was anything but routine. Kristi's Pap test indicated the presence of early stages of cancer.

Kristi then contacted Dr. Ed Vandenberg, who worked at the local Public Health Service hospital. He performed two separate biopsies. The diognosis was moderate to severe dysplasia - a cancerous growth on her cervix. The doctor recommended the surgical removal of part of her cervix, a procedure known as cone biopsy. The goal of the operation was to remove the cancerous growth before it spread to the uterus and other parts of her body. No doctors at the Kotzebue hospital had ever done it before, so a visit was planned to seek medical care elsewhere. Later in the year she visited her family in Chicago, and saw another doctor who performed four new biopsies which confirmed the earlier diagnosis. He as well recommended the cone biopsy at the earliest possible date.

(Continued on next page)

After Kristi and Doug paid their doctor bills, had some dental work done, paid off old debts, and bought provisions for the winter, they were nearly broke. Kristi then turned to medicaid, the state program which provides medical care to indigent people. Doug traveled to Anchorage, where he began contacting doctors. He explained Kristi's situation. She needed the cone biopsy operation, and she needed it soon, if she was to avoid a hysterectomy. Kristi was only 23 years old, and she and Doug planned on having another child. They didn't have any money for the operation, but they were approved for medicaid.

Doug talked with Dr. Orren. His office said they were sorry, but Dr. Orren did not take any medicaid patients. Doug was given the names of other doctors to call. When none of them panned out, Doug called Dr. Orren's office back and asked once more if he would treat his wife. The receptionist said that they were sorry, but they were not taking ANY medicaid patients.

Doug talked with eight other Anchorage doctors. None of them would treat his wife. Some said that they just were not taking any new patients, while others, like Drs. Renn, Stransky, and Guenther, said they would not see her because she was a medicaid patient.

But Doug and Kristi were lucky. Through a friend they found Carolyn Brown, a Palmer doctor who had no qualms about treating medicaid patients. But the implications of her experience are shocking. There are a large number of doctors in the Anchorage area who refuse to treat poor people on medicaid.

To find out why local doctors would refuse medical treatment to poor people, AkPIRG contacted Martha MacDearmaid, the Executive Director of the Alaska State Medical Association. She was very open in explaining the situation. Lots of doctors do not treat medicaid patients, and the reason is economic. The state is chronically late on its payments, and the doctors claim that the state only pays two-thirds their normal bill.

Kristi's situation was explained, and Ms. MacDearmaid said that there was probably some doctor who would treat her on medicaid, although some patients would undoubtably go without proper medical care due to the widespread doctors boycott of the medicaid program. She indicated that there had been some meetings with state officials regarding the problem, and expressed hope that the state would improve its record and the doctors would begin treating medicaid patients once again.

After all, she said, you have to remember that those doctors have to borrow money from banks at high interest rates to pay their bills, while waiting for the medicaid checks. Lately, Ms. MacDearment said, they have been paying 13 to 14 percent interest on those loans. And, business is business.

PRUDHOE BAY PRODUCIBILITY AND THE ALCAN GASLINE

(Ed. NOTE: The following article was written by Anchorage resident Jerry McCutcheon. Jerry has taken a keen interest in the issue of managing oil producing fields, so that proper conservation methods are employed to insure the full recovery of the oil. He has embarked on a one man crusade to convince state legislators and other public offices to consider these important issues.)

Of the 22 billion barrels of oil in Prudhoe Bay, 14 to 15 billion barrels are producible with current technology similar to that being used in the Swanson River Field on the Kenai Peninsula.

This fact can be established in the technical literature and is admitted by the oil companies. It requires the injection of gas from other sources and in an amount equal to that necessary to maintain the original pressure and that gas would have to be cycled through the reservoir 3 or 4 times.

If only the existing gas is reinjected but not cycled through the reservoir and the reservoir is water flooded to help maintain pressure in the 6th year, oil recovery falls to 9 billion barrels. Had the reservoir (Prudhoe Bay) been water flooded from the start of production the oil recovery would have been 9.6 billion barrels. For every 100 pounds of pressure that Prudhoe

POSITION PAPER/Department of Health and Social Services

POSITION PAPER
ON
HOUSE BILL NO. 226

"An Act amending the definition of unprofessional conduct in the practice of medicine."

This bill would redefine the definition of unprofessional or dishonorable conduct in the practice of medicine by the addition two paragraphs.

(I) requires physician to disclose to the patient the nature of the patient's illness, injury and disease; and

(J) to prevent the wilful misrepresentation by a physician to a patient of the nature of the patient's illness, injury, or disease.

(I) attempts to substitute a simplistic legal mandate to a judgmental physician/ patient relationship and ignores the sensitive paitent/physician relationship involving interface of scientific knowledge and the art of practicing medicine and in the interpretation of the patient's overall well being. An example, a potentially suicidal patient does not immediately need to know his diagnosis and imparting the knowledge is a decision of the physician and patient's family.

Paragraph (J) would already seem to be adequately covered in the principles of medical ethics of the American Medical Association and the Alaska State Medical Association.

Recommended by: Robert I. Fraser

Robert I. Fraser, M.D., Director
Division of Public Health

Approved by: Helen D Beirne

Helen D. Beirne, Commissioner
Dept. of Health & Social Services

POSITION PAPER/Department of Health & Social Services

POSITION PAPER
ON
HOUSE BILL NO. 228

This bill is directed at resolving current difficulties in receiving medical care from Alaska physicians through the state/federal Medicaid program. The bill would expand the present definition of "non-professional or dishonorable conduct" under the state licensing provisions found at AS 08.64.380(3).

Essentially, the bill is designed to force physicians who receive public funds from any governmental source to see and treat Medicaid patients upon demand. House Bill 228 is designed to avert a crisis, such as the one that lead to the difficulties in receiving medical care under Medicaid and GR Medical in late 1978 and continuing to date.

These difficulties are the result of three factors:

(1) The Department's shortfall of funds for physicians services during FY 78. This shortfall occurred because the FY 78 Medicaid appropriation prevented transfer of available funds from one line item to another without specific legislative authorization. This system of legislative appropriation was changed in FY 79 and physicians are not experiencing any difficulty in receiving payments on current year bills.

(2) Slow turnaround of provider billings caused by an inefficient payment process. Currently, bills are paid within five weeks of receipt as compared to an average of three months in late 1978. This improvement resulted from additional temporary staff, not from a permanent improvement to the processing system. The Department is in the process of evaluating alternatives to the existing payment system.

(3) Costing-down of physician's bills paid by Medicaid and GR Medical.

House Bill 228 appears predicated on the following assumptions:

(1) Physicians should have continued to see and treat Medicaid/GR Medical clients in spite of the financial severity of the Department's shortfall of funds in FY 78 and its effect on their personal practice. (Note: Between Medicaid and GR Med, the Department fell 35% short in funds available for physicians services in FY 78.)

(2) That there are not other factors present in Alaska which may have contributed to this problem such as a shortage of doctors in certain areas of specialization.

(3) That this crisis cannot be adequately addressed by the Department through the administrative process, or by narrowing the scope of

POSITION PAPER/Department of Health & Social Services

House Bill 228 specifically to the Medicaid statute. House Bill 228 makes refusal to see Medicaid patients a violation of licensure rather than a violation of the contractual agreement between the physician and the Department. It therefore has the potential of adversely affecting physicians not currently enrolled as medical providers under Medicaid who may yet provide some public services such as those delivered in the correctional institutions.

The Department is presently involved in an independent study to determine whether this medical crisis will be largely resolved once the FY 78 supplemental is passed (House Bill 143) and pending bills are paid. Our study will attempt to ferret out those doctors who are in fact interested in seeing Medicaid patients without restriction, and determining if the resultant number of available doctors is adequate to cover all specialties. Until this effort is completed, the Department believes it premature to take a position on House Bill 228.

Recommended by: Rod Betit — Feb 20, 1979
Rod Betit, Director (DATE)
Division of Public Assistance

Approved by: Helen D. Beirne — 2/20/79
Helen D. Beirne, Commissioner (DATE)
Department of Health and Social Services

AkPIRG takes doctors to task

By SUZAN NIGHTINGALE
Daily News Staff Writer

The Alaska Public Interest Research Group says it will ask the Alaska State Medical Association to adopt a standard making it unethical to discriminate against Medicaid clients.

Many physicians around the state won't accept Medicaid patients because they don't like the state's management of the Medicaid system, which owes doctors between $500,000 and $1 million due to a 1978 budget shortage. Others say they don't want to deal with the paperwork required to treat Medicaid patients and complain that they are paid only a fraction of their total bill under the program.

BUT AkPIRG director James Love says the doctors are making poor people pay for state mistakes. "Sure the bureaucracy is screwed up," Love said, "but it's not the bureaucracy that's standing out in the halls unable to get medical care, it's people.

"We'd like the medical community to take responsibility for indigent people and health care. Their attitude is, 'It's not our fault,' but they enjoy special privilege and special status in this society and they have some responsibility for that."

Referring to the current refusal of some doctors to treat Medicaid patients, Love said if those doctors refused to treat people with insurance policies and concentrated only on cash patients, "there would be a hue and cry like you would not believe. The only reason that doesn't happen with Medicaid in this community is because they're poor people."

IN A LETTER sent to the medical association by AkPIRG board chairman Hugh Fleischer, the consumer group requested a meeting with the doctors to discuss the problem.

"The present situation with the Medicaid program can only be described as a crisis for poor people," that letter said.

In his letter Fleischer maintained that the medical profession itself has benefited from public programs in the form of grants, research, tax breaks and state-financed hospital construction, and so cannot turn its back on its public responsibility. "Our organization is upset with the behavior of the medical community. It seems incredible that poor people who need medical treatment would be refused for any reason, let alone the stated grievances of the medical community. Physicians, as a class, are doing very well in Alaska.

"ALASKA doctors deal with no more red tape regarding the Medicaid program than doctors elsewhere."

But at least one health care representative questioned that claim. Dan VanEaton, business administrator for the Alaska Clinic, said Monday that the state's Medicaid system was "a key reason" in the clinic's closure last year. VanEaton said the state owes the clinic, which treated an estimated 80 percent of the Medicaid patients in Alaska, $200,000.

"They've owed us $200,000 for seven months," VanEaton claimed. "And I'm certain, I'm certain, if and when the legislature ever appropriates a supplemental budget, they'll tell us they haven't processed the paperwork yet."

CAUSE OF the immediate health care crisis was a budget shortfall during fiscal year 1978 when the section of the Medicaid budget earmarked for doctors ran short. A new state law prevented public assistance officials from transferring funds from another section of the Medicaid budget without legislative approval.

With the legislature now in session, public assistance officials say they hope that transfer can be made soon, clearing up the backlog in 1978 Medicaid payments.

Fiscal year 1979 payments are being made.

Poor people are having trouble getting health care in Alaska, partially, doctors say, because the state's Medicaid system has burdened physicians with paperwork, expense and hassle. But what about the people who are turned away from office after office? What are the reasons? Where is the responsibility?

4—Anchorage Daily News, Saturday, February 3, 1979

ANCHORAGE
DAILY NEWS

Lawrence Fanning
Editor and Publisher, 1967 to 1971

Katherine Fanning
Editor and Publisher

Stan Abbott
Executive Editor

Alaska's Only Morning Newspaper
Founded in 1946 by Norman C. Brown

2/13/79
ADN

Saturday Forum:

Medicaid

Do poor have a 'right' to care?

By JAMIE LOVE

To say that people should have proper health care is like saying they should have food to eat and a roof over their heads. Few will readily disagree, and there will be much nodding of heads.

That poor people should have the same rights to health care as others seems to most a reasonable goal, and one that many assume is already achieved. But the stark reality of today's world is much different. Yes we have a government program to provide health care to the poor: Medicaid. But no, poor people can't get health care through the Medicaid program. Doctors, or at least growing numbers of doctors, won't accept Medicaid patients.

This is of no small concern. Real people with serious medical problems can't get treatment;

— A woman comes from Kotzebue to Anchorage for an operation. She is told she has an early stage of cancer. No doctor in Anchorage will treat her.

— A woman sits in a hospital waiting room. She has an open wound and needs attention. She waits five hours but still no doctor will see her since she is on Medicaid. She leaves and goes home.

— Another who is pregnant has placenta previa. She may bleed to death. No doctor will see her.

— Several women are told by public health nurses they have toxemea, and are poisoning their unborn children. Doctors will not treat them because they are Medicaid patients.

Since the Alaska Clinic shut down last summer it has gotten tough. At one time many doctors treated Medicaid patients. Now it is few. In Anchorage, only two pediatricians. It is next to impossible to find an OB/GYN doctor who sees Medicaid patients. Other specialties are not yet as grim, but things are getting worse.

What is the problem?

— **Doctors complain that medicaid vouchers are not paid timely.** In fact, this is only a problem for those Medicaid billings from the last quarter of fiscal year 1978, which ended on June 30, last year. Doctor billings were higher than expected, and the money ran out. This will soon be solved by a special appropriation. When doctors bill for Medicaid services being performed today, however, payment is made within five to six weeks.

— **Doctors complain about the paperwork.** But, Alaskan doctors only fill out the same forms every other doctor in the country uses. They are not particularly long, and one clerk can prepare the monthly billings for six doctors in a single day.

— **Doctors complain because Medicaid only pays 70 percent of their billings.** Indeed, this is true for some doctors. But it is only the result of a formula that is required by federal law. That formula limits the fees doctors charge to average billings from the previous year. Doctors who charge high prices for care get their bills reduced, others don't.

Why don't doctors treat Medicaid patients? Some just don't like people on welfare. For the rest, it's a combination of the reduced fees and the chance to avoid the extra hassle. Plenty of patients to choose from, so why take Medicaid patients? Blue Cross offers a better deal.

And this is it. Adam Smith's invisible hand on the market. Doctors are looking after their own economic self interest. Medicaid patients just don't pay as well as others.

This is unacceptable. Health care is not just another snowmobile or Maytag washing machine. The doctor's boycott of the Medicaid program is the worst type of blackmail. The pitch is blunt. Your money or your life. And while doctors have been quick to say they don't like the system, they offer no alternatives. They say they treat charity cases, but check with the patients — they don't.

The doctors' solution for poor people is simple: Ignore them.

The community must deal with this crisis. If doctors in private practice refuse to see Medicaid patients, and if they can't be forced to treat them, the society has a responsibility to take over where the physician's professional ethics end. And speaking of ethics, I'd like to quote from an ethical standard the American Medical Association actually adopted in 1934:

"One of the strongest holds of the profession on public approbation and support has been the age-old professional ideal of medical service to all, whether able to pay or not. That ideal is basic in our ethics. The abandonment of that ideal and the adoption of a principal of service only when paid for would be the greatest step toward socialized medicine which the medical profession could take. . . .

Too often this ethic is honored in the breach, but the message remains the same.

James Love is director of the Alaska Public Interest Research Group.

Fable of a 'sick system'

2/3/79
AdN

By WINTHROP FISH, M.D.

When I was in medical school, a lovely lady obstetrician at the university gave free care to all the nurses, doctors' wives and such. She was very, very nice, very, very popular, and very, very free. In short order, she was exhausted, going broke, and had to leave. She was prologue.

The media of late has raised a modest hue and cry over the plight of the Medicaid recipients in Alaska, suggesting that perhaps medical care was not readily available to some. The ruckus seemed to stem from two sources: a self-appointed group protecting the public interest that appeared to suggest doctors were discriminating against Medicaid recipients; and some physicians who felt economic discrimination by the state Medicaid program.

"Suppose for the moment that once upon a time most grocers felt a centuries-old, charitable obligation to contribute to the community soup-kitchens . . ."

Both are right to a point although, in Alaska at least, the doctors' complaints are probably more valid. But, if either group were transported to the barrios of East Los Angeles, to the socio-economic scene there, and confronted Medi-Cal, their troubles here would seem trivial indeed. For both complaints are simply symptoms of a sick, sick system; both are indicators, early in Alaska, of at least two evolutionary outgrowths of this sick system: 1) inflation of medical costs; and 2) what the politicians never mention in public — rationing of medical care! To understand better, a little parable is in order.

Suppose for the moment that once upon a time most grocers felt a centuries-old, charitable obligation to contribute to the community soup-kitchens. Then, suppose that a couple of decades ago the government declared nutrition a basic human right and promised equal access and quality of food for all Americans, started a program supported by Social Security tax dollars, called Nutricare and Nutricaid for the old and poor respectively; formed a huge sprawling Nutricare Administration; and offered the states matching funds for the State Nutricaid programs. The states, as usual, naturally snatched at the "free" federal dollars.

The state Nutricaid recipients received food stamps, redeemable by the state government at 50 cents on the dollar. The Nutricare Administration made it an offense, punishable by fine or imprisonment, for grocers to charge Nutricaid recipients the difference. The stamps could purchase anything in the store — lobster, steak, caviar — as much as wanted. And since it was free, naturally they tended to want quite a lot. Then the Administration passed regulations forcing grocers accepting Nutricaid Stamps to undergo regular inspections; use a special billing system; employ personnel to audit food quality; put the burden of proof on the grocers that mark-ups were reasonable and food quality for Nutricaid recipients equal to the general public. Then, when the stamps were submitted by the grocers for redemption, payment was delayed for months or simply not paid because the state Nutricaid fund was depleted. Now, what do you suppose happened to the price of food? And who do you suppose paid?

Right! The grocers, naturally, were forced to cover Nutricaid losses and extra expenses by raising the price for everyone else. Thus, the general public paid twice: in skyrocketing Social Security taxes; and a second hidden tax of inflated food prices. And who was forced to curtail buying and economize? The Nutricaid recipient or the working public? And whom do you suppose the government blamed?

Right again! The administration not only blamed the grocers for the Nutrition cost crisis, it accused them of ripping off the Nutricaid system and sent out squads of undercover agents to ferret out fraud and abuse amongst the grocers.

The state, meanwhile, noting that it was expending far more to get the matching federal bucks than it had helping subsidize soup kitchens before Nutricaid, took the logical steps to control the state's spiraling Nutricaid costs. First, it cut its food stamp redemption to 25 cents on the dollar. But more important, it put price ceilings on all food sold to Nutricaid recipients. For instance, grocers could charge Nutricaid only $1 per pound for lobster which cost the general public $10 per pound. And to prevent abuse, inspections were set up to assure that Nutricaid lobster was not inferior and that two sets of scales were not used. The inspections usually closed the store for one working day per month.

And the grocers? Well, some of them didn't like it. Those in poor neighborhoods with mostly Nutricaid customers were even in financial difficulties with rent, supply and labor costs, and refused to participate in the Nutricaid Program. That provoked an immediate response from the Public Interest Groups who shrilled that the grocers were letting people starve.

To give an appearance of doing something, the Congress passed a nationwide ceiling on food costs, leaving labor and other commodity inflation running wild. The grocers, to stay alive, had to cut costs. But they had to retain all the employees needed to comply with the federal regulations. There was only one way to go. Most of the checkers, shelf-stockers, box boys and butchers went, as well as any plans for expansion, improvements, replacement or modernization.

". . . soon there was little on the shelves for those who could afford it; the lines outside the store stretched for miles so that the elderly or weak sometimes froze or starved to death . . ."

Soon there was little on the shelves for those who could afford it; the lines outside the store stretched for miles so that the elderly or weak sometimes froze or starved to death, thus reducing the demand on Nutricare and Nutricaid funds. And the steak, caviar and lobster? What little was left was in the Federal Commissaries.

Dr. Fish is an Anchorage physician who treats Medicaid patients.

2/3/79
ADN

State ponders the problems—and solutions

BY THE DEPARTMENT OF HEALTH AND SOCIAL SERVICES

Commissioner Helen D. Beirne and the staff of the Department of Health and Social Services are very concerned about the problems being experienced by Medicaid clients and providers in Alaska. Dr. Beirne and employees of several department divisions and offices are continuing to devote a great deal of time and energy to resolving issues related to the Medicaid system and improving communications between providers, consumers, and the State.

There are approximately 19,000 persons in the state who could participate in the Medicaid program by virtue of their eligibility for financial assistance under Aid to Families with Dependent Children (AFDC), Old Age Assistance (OAA), Aid to the Blind (AB), or Aid to the Disabled (AD) programs. Eligibility is determined by federal and state law on the basis of income.

The majority of Medicaid - eligible persons are AFDC clients. For nearly 80 percent of the cases on AFDC in March 1977, public assistance was the only source of income. Currently, the average monthly AFDC payment is $350, so it's evident that persons who are eligible for Medicaid are probably unable to obtain medical services without the assistance provided by the program.

The total Medicaid budget for current FY 79 is $38.5 million, of which $2.1 million is for physicians' services. Other line items or categories of the Medicaid budget include hospitals ($4.7 million), early screening programs ($1.5 million), nursing homes ($16.9 million), state institutions ($6.4 million), Indian Health Service ($6.4 million), and other services ($.5 million). At the end of FY 78, $2.7 million remained unspent in the Medicaid budget, principally in the nursing home line item. The amount owed to physicians for Medicaid and General Relief Medical services, however, was in excess of the amount budgeted by $1.1 million.

The Department of Health and Social Services has been unable to pay the physicians' invoices because the funds had been appropriated by specific, limited line item and were not transferable from the nursing home line item to the physicians' line item without Legislative authorization. The Department has submitted a request for a supplemental appropriation and expects the legislature to take action to solve this problem in the near future, at which time Alaska's Medicaid providers will be paid for FY 78 bills. The unusable funds lapsed on June 30, 1978 will more than offset the supplemental request.

Although the current year $2 million Medicaid budget for physicians' services is a small portion of the total Medicaid budget, the processing of bills from physicians requires the greatest expenditure of man - hours. The reason for this is that there are approximately 400 physicians enrolled in the Medicaid program, and individual bills are submitted for each patient. Also, the volume of claims has been increasing rapidly. In the AFDC Medicaid - eligible caseload alone, there was a 24 percent increase from 1976 to 1978.

As a result of this continually increasing volume of Medicaid claims and the fact that bills were being processed through a manual, non-computerized system, the Division of Public Assistance fell three to four months behind in the payment of bills from physicians who had treated Medicaid patients during FY '78. Only four bill processors handled invoices from all 400 physicians in the program.

However, this problem has been solved for the moment by employing additional temporary staff to pay physicians' bills. Now, bills are being paid within five to six weeks after receipt.

ALASKA PUBLIC INTEREST RESEARCH GROUP
Post Office Box 1093/Anchorage, Alaska 99510/(907) 278-3661
Board of Directors: Hugh Fleischer, Chairperson; Julie Wroe, Vice-Chairperson; Molly Crenshaw, Secretary; Don Clocksin, Treasurer; Eleanor Andrews, David Case; Judy Whitney Eckholm, Bob Goldberg, Terry Stimson; Phil Voland

1934:
1965:

January 30, 1979

Bruce Vorteck, AMA Legal, Chicago

Rep. Bill Parker
Pouch V
Juneau, Alaska 99811

Dear Rep. Parker:

We are writing to inform you of a very serious matter which has recently come to our attention--the fact that many doctors in Anchorage will not treat patients who are on Medicaid. Consequently, we are asking the Alaska State Medical Association to adopt an ethical code which would require doctors to treat patients without regard to their ability to pay. This ethical standard was once endorsed by the American Medical Association but it was discarded in the late sixties. Enclosed is a copy of the letter which has been sent to the Medical Association explaining our position in greater detail.

We need your support. This is an important issue affecting the lives of many thousands of Alaskans. There are approximately 16,500 persons on the Medicaid rolls in the state of Alaska. It is becoming increasingly difficult for these people to find doctors who will care for them, even when an emergency exists.

In checking with doctors in the Anchorage area, we have found that the problem exists mainly in the areas of gynecology, obstetrics, pediatrics and family medicine. Since this is also where most of the demand exists, this problem probably affects the majority of those eligible for Medicaid. According to officials in the Municipal Health Department of Anchorage, many expectant mothers are not able to obtain critical prenatal care even when there is a history of problems. We have also heard of women who were dropped by their gynecologists and pediatricians because they are on Medicaid. Only two pediatricians in Anchorage treat Medicaid patients and one of those is at the Anchorage Neighborhood Health Center, a facility specifically set up to handle the health needs of low-income people. They cannot possibly handle the demands of all the children from low-income families in the Anchorage area.

We would like your support. Draft a letter to the Alaska State Medical Association explaining why you think this issue is an important one. It would be helpful, also, if you could send a copy of your letter to the Alaska Public Interest Research Group.

The problem of poor people going without proper medical care is too serious to be ignored or swept under the rug. We hope you will join us in our attempt to alter an inexcusable situation.

Thank you for your time.

Sincerely,

Rebecca E. Graham

Rebecca E. Graham
AkPIRG Staff

Enclosure

The Anchorage Times, Sunday, February 4, 1979

Health Care: A Quiet Subject No Longer

By HELEN GILLETTE
Times Staff Writer

Health care — more specifically its availability to the poor — has become a matter of debate.

One activist group — Alaska Public Interest Research Group — insists that doctors are simply ignoring welfare patients.

Medical spokesmen deny the charge, but agree that Medicaid accounts are less attractive because the government foots only 70 to 75 percent of the bill, always pays late and requires excessive paperwork.

Theoretically, everybody in Alaska gets health care. People eligible for welfare — and there are 19,000 of them — are covered by Medicaid, with bills paid by government money, half federal and half state.

(This is separate from Medicare, an insurance program for the elderly administered, but not funded, by the government.)

A survey of doctors gives conclusive proof of general dissatisfaction with the Medicaid program. The surveyor comes away with the feeling that most of them would prefer not to see any Medicaid patients. For one thing, they have to settle for the 70 to 75 percent of the fee that government pays, since they are forbidden by law from collecting the rest from the patient.

The Alaska research group has claimed that a high percentage of Anchorage doctors simply do not treat Medicaid patients. "Doctors are looking after their own economic interests," director Jamie Love said. "Medicaid patients just don't pay as well."

Dr. C.J. Little, president of the Anchorage Medical Society, says it's not only Medicaid people who have trouble getting established with a physician. Anybody who's new to the community has this problem, he said, because there aren't enough doctors for the growing population.

This is particularly true for young pregnant women, "because we're very short of obstetricians, pediatricians and general practicioners in Anchorage."

One problem, he said, is that many of the 14 or so specialists in the field here are getting older and "have been delivering babies day and night for years. They're getting burned out and turning to the field of specialized gynecology."

A spot check of 10 Anchorage medical clinics by the Anchorage Times revealed that five said they will accept new Medicaid patients. Two said they will see only their ex-

(See Page A-2, Col. 1)

SULA
RION

KENAI, ALASKA 25¢ THURSDAY, JANUARY 25, 1979

First in state

Soldotna doctors opt out of Medicaid

By RONNIE CHAPPELL
Clarion Editor

On January 15 more than half of the doctors now serving the Central Peninsula area quit accepting Medicaid and General Relief Medical coupons as payment for medical treatment.

Other doctors around the state have limited the number of Medicaid patients they will treat, while others have quietly dropped out of the program.

The local physicians, however, are the first in Alaska to officially notify the State Department of Health and Social Services that they no longer plan to participate in the welfare program.

The doctors, all members of the Peninsula Medical Center, Inc. in Soldotna, are Paul G. Isaak, M.D.; Roy E. Benward, M.D.; Lavern R. Davidhizar, D.O.; Joseph A. Sangster, M.D. and Alexander B. Russell, M.D..

Approximately 10 - 15 percent of the center's total patient load will be affected by the policy change. Obstetric patients who have yet to deliver their babies and patients with chronic conditions who are already receiving treatment under the Medicaid program will not be.

In a letter sent to the center's Medicaid patients earlier this year, the doctors said, "We are reluctant to take this step, however, we have not been paid by the Department of Welfare for many services we provided in the past. Our clinic cannot continue to operate by extending credit to the State of Alaska."

The letter also informed patients "We will be glad to continue service to all patients who are willing to adhere to our credit policy. If you cannot pay for your visit at the time of service, financial arrangements must be made in advance. As far as we know, the other physicians in the area are still accepting coupons for medical services."

Two other local doctors, Elmer E. Gaede and Peter O. Hansen plan to continue participation in the welfare program, although both claim that it costs them money to do so.

"We plan to treat patients on an individual basis," said Sangster of the Peninsula Medical Center's policy change. "If a patient wants to receive treatment he will have to come talk to us and see what type of (financial) arrangements can be worked out."

"We have not and will not refuse to give emergency care," Sangster emphasized.

"What we want to do is let the individual asume responsibility for the service we provide," said Isaak. We don't intend to deny service, but we're not playing second fiddle to the state any more."

"A patient's obligation should be to us. When we provide a service and the state doesn't pay us, we're left holding the bag," he continued.

Medicaid patients who cannot pay for treatment at the time it is delivered will be treated like the center's other patients and asked to fill in a credit application - financial statement.

The doctors do not anticipate having to deny service to many patients seeking treatment, even if the patient can only make small weekly payments towards the cost of a relatively expensive proceedure.

According to Benward, "a good faith effort to pay," is what the clinic is seeking, even if the patient can only afford $10 a week.

Patients who receive service and then fail to make an effort to pay their bills will be denied treatment of "non-emergency" problems by the clinic.

Sangster predicts this will open up the center and its medical staff to charges of "denial of medical care" to which everyone believes they have a right.

Sangster pointed out that food, clothing and shelter are just as important to a person's well being as good medical care, and noted that no one expects a grocer or clothing retailer to give away food or clothing without receiving payment.

"The decision to opt out of participation in the state

(Continued on page 12)

...Doctors opt out of state

(Continued from page 1)

Medicaid program came after 2 and a half years of haggling with the State Department of Health and Social Services for the payment of bills submitted by the Peninsula Medical Center.

According to a Debbie Kimple, who heads the center's accounting department, some of the upaid bills date to May of 1976.

The doctors at the center refused to put a dollar figure on the unpaid balance owed them by the state, but called it "considerable."

Records in Juneau, however, show that the center is currently requesting payment of approximately $20,000 in Medicaid claims, a figure that is down substantially from December of 1978 when the total debt exceeded $40,000.

The state has acknowledged the fact that it owes the Peninsula Medical Center and other health care providers for Medicaid proceedures performed prior to July of 1978. In an undated memorandum sent to doctors this fall the Department of Health and Social Services advised physicians that letters of "Prior Year Debt Acknowledgement" were available if doctors found it necessary to "borrow against the amounts owed your" for the purposes of meeting operating expenses.

"Although we cannot at this time make payment to you we will make available for you a letter of debt acknowledgement to provide you support in borrowing from a lending institution," the memorandum said.

But more than just the state's inability to pay Medicaid

Medicaid program

claims within a reasonable time frame is bothering the five Soldotna doctors. Their complaints about the Medicaid system go right to the heart of the state program.

"It is an extremely cumbersome, inefficient bureacracy," charged Benward. The doctors claim that the paperwork required by the state requires the attention of a full time clerk, and that the amount of money paid by the state, when claims are paid, is insufficient to cover the cost of providing the service billed for.

"We havn't been able to meet expenses treating Medicaid patients," said Isaak.

"We're doing this (refusing to accept Medicaid coupons) because it is an economic necessity," added Benward.

Two other doctors in the area, Elmer Gaede and Peter Hansen bear out the claims of the Soldotna physicians.

"There's no question we're losing money doing it (treating Medicaid patients)" said Hansen. "It's a matter of to what degree you can take a loss."

Hansen, who has already had to go to the bank to borrow against his Medicaid debt to stay in operation notes that he "couldn't begin to accpet all of the Medicaid patients who come in" to his office. He plans to continue treating them on a limited basis.

Gaedes, of the Soldotna Medical Clinic, said he couldn't blame the five other Soldotna doctors "one bit" for pulling out of the program and added that "we discussed it ourselves."

Sangster said that the state routinely disallows proceedures performed for Medicaid patients while discounting the value of the proceedures they do pay for.

"If a service is disallowed we have no recourse," said Sangster, "and then we are only paid a certain percentage (70 to 75 percent) of what they do allow.

"The medical profession is the only profession that accepts payment at less than face value," Sangster said, pointing out that the price of potatoes is not dropped for citizens participating in the foodstamp program.

Sangster went on to charge that the claims submitted by the 300 doctors now practicing in the state were reviewed by "personnel who know nothing about medicine. Who don't even know the words on the claims or the code numbers."

Sangster points out that these people, who have no formal medical training, decide which proceedures are paid for and which are not.

The center's physicians also have an extreme lack of faith in the state's ability to process the Medicaid claims efficiently. They point to a November meeting with George Haas of the Department of Health and Social Services at which the problem of unpaid Medicaid balances was addressed.

Haas advised the health care providers assembled for the meeting that if they had not received acknowledgement of Medicaid claims submitted prior to October of 78 that "they would be wise to resubmit them because they had probably been lost."

Haas told the Clarion earlier this week he had made such a statement, and admitted that at one time the Department did have "quite a paper handling problem.

"A lot of invoices were disappearing between the time they were sent by the provider and by the time we got around to cutting the check," Haas said.

"We were aware of the fact that some of them could have been lost," Haas said, noting that since discovery of the problem the Department has "established more paper control."

Haas said that a number of accounts had been readjusted on the basis of resubmitted claims, but did not know exactly how many.

Even if the state promptly settles the $20,000 unpaid Medicaid balance due the Peninsula Medical Center, the center's member physicians doubt they will again participate in the program.

"I'm not in favor of continuing," said Sangster. "I'm tired of third party encroachment on the practice of medicine."

"We probably will not unless they change the system," added Isaak.

"We would eventually end up in the same situation," predicted Benward.

Editor's note: Tomorrow the Peninsula Clarion will publish a related story on the Medicaid program and it problems statewide. Included will be comments from Rod Betit, Acting Director of the Division of Public Assistance, Department of Health and Social Services and the results of a survey, conducted by the Alaska Public Interest Research Group, of doctors in the Anchorage area who were asked the question "Do you treat Medicaid patients?

Poll reveals many doctors won't take Medicaid patients

By RONNIE CHAPPELL
Clarion Editor

While the five member physicians of the Peninsula Medical Center in Soldotna are the first doctors in Alaska to officially notify the State Department of Health and Social Services that they no longer plan to accept Medicaid and General Relief Medical coupons as payment for medical treatment, they are by no means the first to get out of the state welfare program.

No one knows exactly how many of the state's 300 doctors have quietly limited or completely dropped their treatment of Medicaid patients, but a survey conducted by the Alaska Public Interest Research Group (APIRG) of doctors practicing in and around the Anchorage area reveals that the number could be extremely high.

"Essentially, we conducted a spot survey," said Hugh Fleischer, "asking doctors the basic question....do you take Medicaid patients?"

All told, of the 45 physicians polled, 33 or 73 percent replied "no."

Fleischer said that the doctors polled in the survey practiced medicine in the fields of Obstetrics-Gynecology, Pediatrics, Family Practice and General Practice.

Physicians practicing these specialties were picked, Fleischer said, because many of the patients using Medicaid are young women with "female problems related to child birth."

Fleischer said that APIRG's pollsters contacted 13 of the 14 Ob-Gyn specialists listed in the Anchorage phone book. Of those, only one accepted Medicaid patients....12 did not.

Fourteen of the 15 Pediatricians listed in the directory were polled....eight did not take Medicaid patients, six did. Of the 18 Family and General Practicioners contacted, only five accepted Medicaid patients.

n"An inordinate number of physicians contacted said they would not take Medicaid patients," Fleischer said.

While Fleischer could not say how many doctors around the state had quietly

(Continued on page 3)

Poll indicates doctors not

(Continued from page 1)

stopped participating in the program, he noted that in light of the findings of APIRG's survey, it was "a reasonable question to ask."

If the motives of the Anchorage doctors who quietly stopped accepting Medicaid patients mirror those of the five Soldotna physicians who officially notifed the State that they were pulling out of the welfare program, their dissatisfaction with Medicaid revolves around one crucial element.....money.

The local doctors claim:

(1) That the rate of reimbursement, which is usually only 70-75 percent of their normal charge, is insufficient to cover the cost of rendering treatment to Medicaid patients. According to the physicians at Peninsula Medical Center, they lose money on Medicaid patients, even when the state pays the claim.

(2) That claims for payment are arbitrarily disallowed by clerks at the state level who have no medical training and therefore, no basis for judgement when deciding which proceedures are appropriate and which are not. The doctors charge that the clerks disallow claims in a "haphazard" fashion so that they, as practicioners never know what they are going to be paid for and what they are not.

(3) That payment by the state is generally slow in coming, and that often they are forced to carry large Medicaid debts on their books.

(4) That the Department of Health and Social Services lacks the ability to efficiently and fairly handle the claims submitted by doctors treating any of the 16,000 patients around the state certified to receive Medicaid benefits.

And adding to all of this dissatisfaction with the program is the fact that the state did not have the money to pay all of the Medicaid claims submitted prior to July 1978.

According to Rod Betit, Acting Director of the Division of Public Assistance, of the State Department of Health and Social Services, there was money in the division's total budget to cover the claims, but a rigid budget structure prevented state officials from moving funds from categories with surplus monies, to those running deficits.

The Department acknowledged it's fiscal difficulty in an undated memorandum sent to physicians around the state earlier this year, advising them that when the "legislature convenes in January, the first order of business of this administration will be to request an appropriation to pay the amount owed you."

According to Betit, the estimated total owed the doctors of the state for services provided under both the Medicaid and General Relief Medical programs is approximately $1.5 million.....an average of $5,000 for each of the 300 doctors now working in Alaska.

Attached to that same memorandum was a notice from the Department to the effect that "although we cannot pay you, we will make available for you a letter of debt acknowledgement to provide you support in borrowing from a lending institution."

"The state owes us a lot of money and expects us to provide service when the funds for the service have not been authorized," said Dr. Peter Hansen of Kenai who still sees Medicaid patients on a limited basis.

According to Betit, the state is powerless, under the Medicaid program to up the rate of reimbursement allowed doctors for providing treatment to Medicaid patients.

accepting Medicaid

"The rate of reimbursement is determ...ed by the Federal government," Betit said, noting that rates were the same for Medicaid as they are for Medicare. The two programs do differ, however, in that Medicare claims are paid to the patient who then uses the funds to help reimburse the physician for the total amount charged for treatment. Under Medicaid, the burden for filing the claim is placed on the physician who must accept only a percentage of the amount due for the treatment rendered.

Betit does believe that the claims submitted by physicians are "ajudicated" fairly by the three clerk-technicians who go over each invoice to determine which charges are to be allowed and which are not.

According to Betit, these technicians spend about 20 minutes on each of the invoices submitted checking claims to make sure that (1) no duplicate proceedures were performed and charged for, that (2) authorized services were performed only by physicians in whose area of specialization the service lies, and (3) that pre-authorization was obtained for those services requiring it.

Betit said that whenever there is a question about a proceedure listed on a claim submitted by a physician, the proceedure is reviewed by the state's Medical Review Officer. Betit added that "no medical judgement" is required of the technicians.

When asked if, in his opinion, the system was fair and consistant with regard to the charges disallowed, Betit responded affirmatively.

Betit also said that the Department was working to streamline it's operations so that participating physicians could (1) expect payment of claims within 30 days of their submission, and (2) not find themselves waiting on payment from the state because funding for the program ran out before the end of the fiscal year.

According to Betit, representatives from the Federal Department of Health, Education and Welfare had been to visit the state office to offer suggestions on increased computerization of the adjudication and payment process.

"The current system is cumbersome and time consuming," Betit admitted. He added that under present circumstances 3 technicians were not enough to adjudicate the claims submitted.

It is doubtful, however, that any of the solutions now being considered by the Department of Health and Social Services will be satisfactory to the state's medical community.

As long as the practice of retro-active denial of claims continues, and as long as doctors only receive a percentage of the charges submitted to the state for the treatment of Medicaid patients, those qualifying for treatment under the welfare program are going to have trouble "getting in to see a doctor."

The issue is sure to come to a head later this year when APIRG goes before the Alaska State Medical Association to request that it urge it's membership to end the practice of denying treatment to Medicaid patients. Specifically, APIRG plans to ask the association to adopt language which used to be contained in the American Medical Association's code of conduct which deals with rendering of medical care to all persons "irrespective of their ability to pay."

"We're talking about medical care for 16,000 non-native, poor Alaskans," said Fleischer. "The only reason we have heard for not treating them is a financial one. We think that adoption of the measure would be consistant with the past history of the medical profession."

Fleischer also said APIRG was considering an appearance before the state legislature and was considering the introduction of bills designed to deal with the problem of physicians refusing to treat Medicaid patients.

When asked if APIRG was planning to propose a bill which would require physicians in the state to participate in the Medicaid program he replied by saying, "It's conceivable."

THE PENINSULA CLARION

1/29/79

VOLUME 9 ISSUE 75 KENAI, ALASKA 25¢

Local pharmacies too

Hospital accepting Medicaid

By RONNIE CHAPPELL
Clarion Editor

While doctors around the state are refusing to accept Medicaid coupons as payment for medical treatment other health care providers involved with the program appear to be sticking with it.

To date, local pharmacies and the Central Peninsula General Hospital have yet to follow the lead of the five member physicians at the Peninsula Medical Center who are the first doctors in Alaska to officially notify the State Department of Health and Social Services they no longer plan to participate in the welfare program.

"We will continue to see them (Medicaid patients)," said Simon Hancock, administrator at Central Peninsula General.

According to Hancock, the Medicaid program for hospitals is similar to the one for doctors in that bills submitted are "adjudicated" or "costed down" before being paid by the state.

It is also similar, in that the state did not have ample funds to pay all of the claims submitted by Alaska hospitals prior to June 30, 1978.

According to Rod Betit, the acting Director of the Division of Public Assistance, a total of $160,000 is still owed st hospitals for claims submitted in the last fiscal year.

The Division is paying current charges submitted by Alaska hospitals, and hopes to get a supplemental appropriation from the state legislature to cover lasy year's outstanding debt.

According to Hancock, the state owes Central Peninsula General a total of $24,686 in outstanding Medicaid bills. Of that, $10,000 represents unpaid claims submitted prior to June 30, 1978.

The oldest charge dates back to April of last year.

While the debt is a large one, it has yet to work a financial hardship on the local hospital.

"We're fortunate in that we're not seeing a great percentage of Medicaid patients," said Hancock.

"Otherwise," he added, referring to Peninsula Medical Center, "we'd be hurting too."

Hancock went on to say that it was the hospital's policy to treat everyone, regardless of ability to pay.

This is especially true in the case of emergency medical treatment. Hancock emphasized that no patients are turned away. But the situation differs when it comes to "non-emergency" services and "elective surgery" such as having a hernia repaired.

In those cases, the key to hospital admission is held by local physicians.

This means, for example, that a woman in labor can report to the hospital emergency room and have her child delivered by the physician on call. She cannot, however, check into the hospital during the early months of pregnancy for tests or other types of pre-natal care unless she is admitted by one of the physicians on the hospital staff.

In terms of reimbursement, local pharmacies have fared much better than the other health care providers in the Central Peninsula area.

"From our standpoint, the reimbursement is fine," said Earl Mundell the owner of both Kenai and Soldotna Drug stores.

Unlike the claims submitted by doctors and hospitals, the bills turned in by Alaskan pharmacies are not "costed down" by the state before payment.

Doctors and hospitals in the state receive 70 to 75 percent of what they charge back from the state.

"Our system is set up so we bill the customary amount and receive that," said Judy Waring the pharmacist at Kenai Drug.

"Reimbursement on our prescriptions is pretty good," Waring added. "We submit our claims the first of the month and generally receive what we submitted."

But sometimes, the state witholds payment of some claims, making it necessary to resubmit the charges of some Medicaid patients.

"It makes for a lot of extra book work," said Mundell who noted last year he had to work through the Governor's office to obtain payment of some Medicaid claims dating back to 1972.

Mundell added that his drug stores would continue par-

(Continued on page 15)

....hospital taking Medicaid

(Continued from page 1)

ticipating in the Medicaid program as long as the state continued paying its bills.

The story is much the same at Carr's in Kenai where head pharmacist Gloria McConnell reports "no problems" with reimbursement under the program.

Carr's will continue to fill Medicaid prescriptions, McConnell said.

HB
231

STATE OF ALASKA

JAY S. HAMMOND, GOVERNOR

DEPARTMENT OF REVENUE

STATE OFFICE BUILDING / POUCH SA – JUNEAU 99811

March 6, 1979

The Honorable Thelma Buchholdt
Chairman
House Health, Education & Social
Services Committee
Room 112 - Capitol Building
Juneau, Alaska

Dear Representative Buchholdt:

HOUSE BILL NUMBER 231

House Bill Number 231, an Act establishing a tuition credit under the Alaska net income tax, was introduced in the House on February 15, 1[illegible] and was referred to the House Health, Education & Social Services and Judiciary Committees.

For the consideration of the House Health, Education & Social Services Committee, I am enclosing a copy of a Fiscal Note prepared by Mr. Gary Jenkins, Director, Audit Division, Department of Revenue concerning the proposed legislation.

Sincerely,

R. D. Stevenson

R. D. Stevenson
Special Assistant

cc: The Honorable Charles Parr
Chairman
House judiciary Committee

John Messenger
Commissioner
Department of Revenue

Gary Jenkins, Director
Audit Division
Department of Revenue

04-D4LH

THE LEGISLATURE OF THE STATE OF ALASKA
ELEVENTH LEGISLATURE

FISCAL NOTE

I. REQUEST

Bill/Resolution No. House Bill No. 231

Title An Act establishing a tuition credit under the Alaska net income tax

Requested by H.E.S.S. and Judiciary Committees Date 3/2/79

II. FISCAL DETAIL

Agency Affected Revenue

Program Category Affected Fiscal Services

Budget Request Unit(s) Affected Audit Division

EXPENDITURES (Thousands of Dollars) None

	FY 79	FY 80	FY 81	FY 82	FY 83	FY 84
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL						
400 COMMODITIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC.						
TOTAL						

FUNDING (Thousands of Dollars) None

GENERAL FUND						
FEDERAL FUNDS						
OTHER (Specify)						

POSITIONS None

FULL TIME						
PART TIME						
TEMPORARY						

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

See memo dated 3/2/79 to R. D. Stevenson.

IV. DATE March 2, 1979 PREPARED BY Gary Stevens

AGENCY Department of Revenue, Audit Division

PHONE 465-2320

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)

33-001 (Rev. 10/78)

STATE
of ALASKA

MEMORANDUM

TO: R. D. Stevenson
Special Assistant
Department of Revenue

DATE: March 2, 1979

FILE NO:

TELEPHONE NO:

SUBJECT: House Bill No. 231

FROM: Gary L. Jenkins
Director
Audit Division

It is extremely difficult to estimate the actual dollar effect of the tuition credit proposed by HB 231 because of the very limited information available regarding the number of students attending vocational schools and schools of higher education. In discussions with various personnel in the Department of Education, I was advised that last year's enrollment in private elementary and secondary schools in the State was 3,130 and that there is a possible 800 to 900 in other private schools on which they did not have information. The staff working with the higher education loan funds advised me there were approximately 3,000 students going to school on loans and they estimated that number could be as high as 50 percent of the total number of students going to schools of higher education. Last, I have assumed there are at least 1,000 students going to approved vocational schools.

Assuming there are 4,000 students in private elementary and secondary schools, 1,000 in vocational schools, and 6,000 in schools of higher education, the total potential cost of this tuition credit would be $16,500,000.

I do have some concern that there be some agency responsible for determining what might constitute an eligible educational institution. There would be a potential for abuse of this provision in that under the proposed definition anyone could set up what they call a school whether anything valid was taught or not and apparently payments made to them could be taken as a credit under this bill.

It also should be remembered that should this or a similar bill pass, it will most likely lead to a significant increase in private institutions in the State, which means the cost of the credit could increase at a very significant rate.

HB
287

[586-1083]

Bob Green

Thelma —

Re: HB 287 — Malones bills
HB 288

Spoke w/ Jim Rhode —
appropriations ~~Educ~~ for last
year

Hugh does not take responsibility for figures
figures may be readjusted

fiscal yr 79 — in gov budget
they appropriate ~~to~~ 78 plus 6% increase

Dept of Educ — Bd of T rules not considered
route expenses
Variation in Contracts
mandated cost of leases adj.
to Contractors

NC 10.6% of fiscal 78
~~Consumer~~ Consume 10.5%
pick up
dist 4.5 increase in costs

Concern — 1st time Dept Chang over
of Bus contract + State
" " + districts
1ST time dist were expected to
participate in costs
fiscal 80 15% Budget
Contract cost in 6 cases

State will cover 85% of costs

why object

~~1/2~~ dist ~~&~~ Trans Costs

other half has no trans.

1/2 Pegging
1/2 not
Education dollars

working on a survey

Contract cost
shortfalls
& state reimbursement

fiscal 80 available sometime next week

Dept developed
operating procedures
to include "leg intent" ? (passing budget)

FOG ? entitlement
how money is distributed

who have ? short on money

Bob Green

HB
333

Woodland park people

Teleconference on HB126 & HB333

Telephone Numbers

teleconference on 126 HB333

1. Chris + Rick Farley 276-6370
2. Jeffrey + Elsie Wertz
~~3111 Wildy St~~ . 243-5190
3. Mr + Mrs Robert Haupt 243-3608
4. Nancy Thompson → 333-6035
3106 W 33rd
(different address)
5. Carl + Judy Lind 243-1800
6. Larry + Eleanor Evans
243-2898
7. Merle W + Carol J Akers 243-4802
8. Brete Richards 277-4851
3004 Brookside
9. Fred Walatka 277-1433
3107 W. 29th

~~Hewitt, Karlene~~.

~~***~~

10. HEWITT, Karlene, 243-1647

11 Lloyd + Kaye Steele - No listing
P. O. Box 4006

12 Pat Eldridge 243-2611
~~2440~~

13. Laverne Meyer 272-5909

14. Stanley + Marlo Strong 243-0498

15 Charles + Carol Turnley. 274-3544 or 279-3320

16. H.M. Newell 277-3174

RURAL EDUCATION ATTENDANCE AREAS EXPENDITURES
SCHOOL OPERATING FUND

FY-78 Audited

Acumulated

REAA	Regular Instr.	Vocational Education	Special Education	Corresp.	Support Services Pupil	Support Services Instr.	General Admin.	Operation & Maintenance	Pupil Trans.	Boarding Home	Other Non-Prog.	Fund Balance (GF)	FY-77 Fund Bal. GF
Adak	995,500	107,334	21,264	---	32,051	43,901	439,270	365,314	80,209		44,337	313,258	171,308
Alaska Central	638,303	122,655	66,596	---	147	16,872	287,245	376,722	163,667		39,135	608,714*	280,287
Alaska Gateway	755,368	59,058	108,175	64,119	1,033	55,119	364,843	397,765	163,454	482	51,659	170,162	108,390
Aleutian Chain	552,521	30,580	121,688	16,700	11,423	91,838	439,877	280,890	---	---	38,497	206,142	44,503
Annette Is.	442,272	83,789	81,409	---	61,458	8,674	179,010	248,867	4,446	---	33,337	219,452	110,870
Bering Strait	727,943	146,126	124,868	11,031		57,106	642,168	961,767	21,080	308,694	152,814	399,519	43,284
Chatham	278,818	53,451	46,409	---	2,625	---	196,678	189,528	---	---	6,836	280,956	210,011
Chugach	124,736		25,529	---	1,498	---	61,561	63,096	---		6,971	176,909	115,537
Copper River	1,165,105	144,489	112,797	168,825	99,029	4,679	456,658	636,231	298,548	9,404	5,800	101,661	134,226
Delta/Greely	1,133,964	167,441	138,853	106,215	77,299	108,151	299,448	604,126	273,097		61,500	388,389	192,411
Iditarod	627,712	133,687	79,042	37,871	15,420	152,314	264,493	481,135		25,065	173,272	245,734	255,965
Kuspuk	867,694	48,845	81,833	65,292	---	27,791	420,597	620,886	16,658	5,058	86,088	340,245	141,990
Lower Kuskokwim	2,168,713	309,409	468,586		665,297	441,424	1,023,721	2,038,109	52,954		202,233	887,798	394,790
Lower Yukon	1,310,978	195,584	225,058	148	653	44,184	414,521	1,446,129	4,520	116,744	420,766	1,136,441	418,859
Northwest Arc.	2,724,554	407,493	399,192	22,243	78,511	263,440	1,154,759	2,744,593	9,480	100,453	464,590	19,794	627,355
Pribilof	321,174	59,373	94,973	---	---	---	166,140	103,406			62,265	549,207	297,091
Southeast Is.	959,029	48,221	115,069	190,333	23,872	49,684	188,243	384,945	18,071		---	206,823	202,874
Southwest	1,004,328	196,959	174,208	75,163	---	30,111	485,215	1,046,261			362,324	462,167	185,862
Lake & Pen.	855,320	104,586	82,960	10,571	30,760	94,171	417,671	865,074	17,187		112,952	474,854	251,945
Yukon Flats	640,064	101,608	75,920	46,339	20,142	654	283,834	532,123		2,421	164,013	85,372	48,511
Yukon-Koyukuk	1,211,738	243,804	170,469	210,494	77,194	64,198	581,200	1,405,649		124,554	97,443	197,968	75,019
TOTALS	19,505,834	2,764,492	2,814,898	1,025,344	1,198,412	1,554,311	8,767,152	15,792,616	1,123,371	692,875	2,586,832	7,479,565	4,311,028

RU

CITY & BOROUGH SCHOOL DISTRICT EXPENDITURES

FY-78 Audited

	Regular Instruction	Vocational Education	Special Education	Correspondence	Support Services Pupil	Support Services Instruction	General Admin.	Operation & Managemt.	Pupil Trans.	Boarding Home	Other Non-Prog.	Fund Balance FY-78	Fund Balance FY-77
Anchorage	46,916,208	3,146,750	4,785,094		1,461,107	1,310,989	10,452,233	14,327,599	4,990,316		1,190,197	10,764,926	10,145,331
Bristol Bay	383,469	103,260	66,085		40,426	46,004	195,784	252,163	73,024		64,237	159,622	240,497
Cordova	661,774	139,049	172,278		69,840	106,805	304,220	258,733	18,918		9,238	(41,330)	1,630
Craig	228,950	58,205	54,682		1,920	42,537	118,030	80,549	23,147		28,111	219,771	131,627
Dillingham	625,192	181,427	159,924		66,371	43,007	367,520	291,264	68,954		60,649	415,858	202,611
Fairbanks	10,680,671	1,203,898	1,775,702	110,149	820,814	902,697	2,796,409	5,575,082	3,369,353	26,500		-0-	-0-
Galena	216,391	81,774	56,051		43,555	13,826	111,272	152,642	14,229		70,072	450,985	249,064
Haines	654,773	82,465	139,044		46,169	14,307	172,350	217,341	35,974		15,499	350,397	160,474
Hoonah	307,312	101,985	88,028		35,771	43,947	147,560	158,152			57,570	211,268	212,276
Hydaburg	139,804	49,880	35,164		238	---	89,783	73,694			54,420	136,082	30,521
Juneau	5,533,157	577,082	646,917	40,324	527,565	439,445	1,659,893	1,669,457	610,065		128,219	400,481	559,548
Kake	255,439	96,281	81,779		7,524	7,663	160,659	121,590	12,020		70,515	220,544	210,533
Kenai	7,324,371	834,480	907,528	201,381	561,366	619,782	1,871,133	1,902,968	1,844,294	45,896	502,165	1,401,921	801,122
Ketchikan	2,919,636	460,944	424,845	68,889	455,090	256,809	554,097	1,192,667	380,605		237,746	109,645	109,645
King Cove	211,276	64,205	41,814			15,732	146,767	88,458	253	4,004	35,848	306,429	254,505
Klawock	85,023	---	17,135		5,831	3,105	61,852	33,217			22,644	169,942	26,469
Kodiak	2,675,015	298,053	452,457	81,518	188,924	253,636	752,180	1,148,482	164,292	110,540	370,832	---	---
Mat-Su	4,808,288	682,903	384,351	263,985	416,040	378,750	1,502,961	1,978,965	1,784,714		19,641	5,400	322,399
Nenana	269,297	162,256	83,348	---	23,302	14,084	154,545	177,304	26,365		76,261	139,405	150,541
Nome	1,326,242	197,752	259,997		101,813	1,075	424,772	977,463	71,588		131,520	412,181	244,502
North Slope	2,846,384	713,764	644,011	8,538	377,875	91,538	1,962,592	3,533,431	260,828		934,603	520,173	230,703
Pelican	90,974	15,783			522	2,133	24,173	31,716			2,025	31,071	37,561
Petersburg	745,227	103,770	161,227		37,900	43,455	189,221	287,630	55,127		109,106	80,998	29,548
Sitka	2,317,255	246,168	278,437	16,802	124,353	214,455	533,082	702,865	174,838		322,665	571,041	400,213
Skagway	332,216	55,225	50,402		16,358	14,006	75,850	69,328	1,119		22,343	165,797	140,265
St. Mary's	125,549	104,591	175,364			17,447	140,508	148,758			64,867	242,427	79,186
Unalaska	315,310	73,141	72,929		3,387	40,673	108,441	112,028	65,833	6,392	40,835	83,656	65,637
Valdez	1,157,845	211,985	437,557		18,573	203,299	525,354	983,294	135,868		99,399	454,109	672,318
Wrangell	774,885	117,183	117,837		46,025	40,412	206,035	155,649	47,789		20,875	59,770	126,051
Yakutat	215,215	79,675	74,456				95,099	87,222	29,974		36,137	6,717	(26,754)
TOTALS	95,143,148	10,243,934	12,644,443	791,586	5,498,659	5,181,609	25,904,375	36,789,711	14,289,487	193,332	4,798,239	18,094,916	15,854,777

CITY & BOROUGH SCHOOL DISTRICT REVENUES

FY-78 Audited

	Other Federal	Federal 874	Total Federal	Foundation	Pupil Trans	Boarding; Home & Tuition	Other State	Total State	Appropria-tion	Rental	Interest Income	Other Income	Total Local	Total All
Anchorage	53,057	2,280,063	2,333,120	53,366,996	4,784,289	2,008,958	461,678	60,621,921	22,521,854	123,326	658,522	310,737	23,614,439	86,569,480
Bristol Bay		149,700	149,700	1,021,987	59,237	18,325	11,978	1,111,527	80,000			3,089	83,089	1,344,316
Cordova		27,924	27,924	1,266,521	17,0[illegible]	52,340	55,987	1,391,918	170,765		3,492	21,569	195,826	1,615,668
Craig		99,885	99,885	558,965	23,321	22,621		604,907	13,000	5,372	185	926	19,483	724,275
Dillingham	2,000	164,341	166,341	1,601,000	61,743	44,025	5,327	1,712,095	30,000		21,294	48,892	100,186	1,978,622
Fairbanks		443,050	443,050	16,516,620	2,930,658	103,326	122,677	19,673,281	6,359,676	29,833		23,319	6,412,828	26,529,159
Galena		196,850	196,850	721,995	14,229	13,696		749,920	6,468			8,495	14,963	961,733
Haines		45,994	45,994	1,164,842	65,285	25,365	9,628	1,265,120	246,490		10,524	29,717	286,731	1,597,845
Hoonah		119,709	119,709	797,095				797,095	13,994	1,688	6,519	672	22,513	939,317
Hydaburg		40,189	40,189	413,822			11,348	425,170	---		1,648	12,245	13,893	479,252
Juneau		309,066	309,066	7,883,508	543,693	28,497	25,140	8,480,838	2,931,700	4,054		50,686	2,986,440	11,776,344
Kake		166,262	166,262	621,203	12,355	4,614		638,172	15,000		3,270	777	19,047	823,481
Kenai		357,683	357,683	11,596,365	1,800,759	32,645	6,968	13,436,737	3,520,000	7,617		58,874	3,586,491	17,380,911
Ketchikan		69,572	69,572	4,773,760	353,914	28,344		5,156,018	1,634,770			33,290	1,668,060	6,893,650
King Cove		84,865	84,865	614,541	7,697	3,766		626,004	27,146		5,105	622	32,873	743,742
Klawock		133,850	133,850	236,522				236,522	1,500		---	408	1,908	372,280
Kodiak		253,745	253,745	5,186,334	132,238	202,990	173,701	5,695,263	457,180	35,387	13,315	59,032	564,914	6,513,922
Mat-Su		42,339	42,339	7,362,022	1,746,325	64,357		9,172,704	2,536,240			95,239	2,631,779	11,846,522
Nenana		9,751	9,751	803,781	51,584	80,170		935,535	17,000		8,239	1,555	26,794	972,080
Nome		49,039	49,039	2,829,350	72,832	55,622	409,800	3,367,604	64,475	26,861	13,245	87,678	192,259	3,608,902
North Slope		1,508,098	1,508,098	4,737,769	214,013		14,402	4,966,184	5,149,100	164,639		35,245	5,348,984	11,823,266
Pelican		---	---	151,033	---	1,819	---	152,852	6,635	---	1,349	---	7,984	160,836
Petersburg		39,295	39,295	1,316,446	51,527	122,233	5,000	1,495,206	231,371	1,354	16,371	---	249,096	1,783,597
Sitka		517,106	517,106	3,434,227	145,466	3,475		3,583,168	783,288	6,477	40,356	137,689	967,810	5,068,084
Skagway		---	---	600,995	1,122	3,737	3,782	609,636	49,000		3,253		52,253	661,889
St. Mary's		140,739	140,739	723,022	---	---	48,879	771,901	---	11,350	2,247	14,088	27,685	940,325
Unalaska		42,916	42,916	634,606	55,630	9,755	---	699,991	112,500		---	1,580	114,080	856,987
Valdez		---	---	2,253,283	125,602	48,304		2,427,187	995,644		60,498	13,041	1,069,183	3,496,370
Wrangell		17,105	17,105	1,168,920	43,097	911	886	1,213,814	215,500		8,461	5,529	229,490	1,460,409
Yakutat		---	---	590,610	30,573	5,028		626,211	20,369		944	3,725	25,038	651,249
	55,057	7,309,136	7,364,193	134,948,138	13,344,259	2,984,923	1,367,181	152,644,501	48,210,665	417,958	878,477	1,058,719	50,565,819	210,574,513

REVENUE

FY-78 Audited

	Other Federal	Federal 874	Total Federal	Foundation	Pupil Trans	In Lieu Of	Boarding Home	Other State	Total State	Rental	Interest	Other Local Income	Total Local
Adak		1,469,558	1,469,558	245,201	57,737	416,240	---	---	719,178	9,088	60,417	12,889	82,394
Alaska Central		355,136	355,136	1,226,448	160,372	241,488	---	1,107	1,629,415	19,402	35,816	---	55,218
Alaska Gateway		44,531	44,531	1,551,000	163,454	290,336	482	---	2,005,272	2,183	23,248	7,616	33,047
Aleutian		187,079	187,079	1,297,921	---	160,304	10,442	---	1,468,667	2,278	12,890	72,638*	87,806
Annete Island		974,909	974,909	23,125	5,645	219,472		1,984	250,226		24,209	2,500	26,709
Bering Strait		661,549	661,549	1,981,201	21,080	304,784	305,784		2,612,849	30,133	11,348	2,768	44,249
Chatham		278,532	278,532	410,502	---	127,968	---	---	538,470	24,073	1,670	---	25,743
Chugach		72,804	72,804	230,032	---	33,024	---	---	263,056	---	---	8,903	8,903
Copper River		343,113	343,113	1,870,637	289,715	482,976	9,404		2,652,732		19,314	21,838	41,152
Delta/Greely		900,583	900,583	1,244,417	267,219	533,200	1,760		2,046,596		36,343	1,351	37,694
Iditarod		465,099	465,099	1,239,901		195,392		61,145[2]	1,496,438	20,829	3,101	---	23,930
Kuspuk	16,880	706,247	723,127	1,363,986	31,749	233,920	4,654	33,521	1,667,830	20,255	23,864	3,951[4]	48,070
Lower Kuskokwim	89,098	2,173,269	2,262,367	3,154,856	50,582	1,016,176	1,070,870		5,292,484	95,177	75,530	142,242[4]	312,949
Lower Yukon		1,480,442	1,480,442	2,227,933		615,072		51,500	2,894,505	148,234	68,122	46,405[3]	262,761
Northwest Arctic		2,316,087	2,316,087	3,992,413		1,033,376	91,811	2,711	5,120,311	169,692	50,415	22,340[4]	242,447
Pribilof		439,713	439,713	467,787		126,592		3,181	597,560		20,012		20,012
Southeast Island		896,690	896,690	720,310	12,332	294,464	23,793	3,253	1,054,152		29,415		29,415
Southwest		1,293,592	1,293,592	1,649,017		359,824			2,008,841	56,890	52,532	26,605	136,027
Lake & Peninsula		751,920	751,920	1,635,080	33,708	263,504	4,275		1,936,567	36,250	21,541	231	58,022
Yukon Flats		415,576	415,576	1,328,863		209,152	17,432		1,555,447			4,339	4,339
Yukon-Koyukuk		1,259,442	1,259,442	2,184,325		453,392		51,500	2,689,217	79,505	43,400	122,574[5]	236,479
	17,485,871	17,591,849	30,044,955	1,093,593	7,610,656	1,540,707	209,902	40,499,813	704,959	613,187	499,190	1,817,366	

* Sale of Capital Equipment
2 Includes 21,000 Insurance Proceeds
3 Federal Payments
4 Includes Indirect Cost Payments
5 Includes AVEC Subsidy

...T REPORT
...NAL EDUCATIONAL ATTENDANCE AREAS
...D SERVICE, PUPIL ACTIVITY AND SPECIAL REVENUE FUNDS

	FOOD SERVICES FUND						PUPIL ACTIVITY FUND			SPECIAL REVENUE FUNDS			
REAA	Food Srv. Sales	Federal Reim.	School Dist. Subsidy	Salaries & Benefits	Food & Milk	Other Exp.	Generated Revenue	Sch. Dist. Subsidy	Total Exp.	State Grants	Federal Grants	Local Funds	Total Grant Expenditures
Adak	$ 39,222	$ 2,202	$ 7,867	$ 22,232	$ 27,059	$ -0-	$ 25,805	$ 36,470	$ 59,497	$ 24,812	$ 36,164	$ -0-	$ 60,976
AK Central	11,349	-0-	2,272	8,593	4,233	795	35,502	36,863	75,758	31,936	30,189	3,000	65,125
AK Gateway	-0-	696	9,321	-0-	10,017	-0-	23,435	36,243	53,753	1,419	178,777	-0-	180,196
Aleutian	NO FOOD SERVICE PROGRAM						NONE REPORTED			35,441	234,561	29,074	299,076
Annette	10,156	12,356	30,429	42,100	7,982	2,859	42,479	2,595	42,452	4,512	109,725	5,675	119,912
Bering Strait	3,055	126,126	13,492	80,967	58,633	3,073	-0-	33,101	33,101	-0-	609,814	25,530	635,344
Chatham	281	11,623	-0-	1,357	9,659	888	23,120	6,836	26,898	2,889	113,399	-0-	116,288
Chugach	-0-	-0-	3,595	2,904	691	-0-	-0-	3,376	3,376	-0-	16,242	-0-	16,242
Copper River	NO FOOD SERVICE PROGRAM						60,778	-0-	60,778	33,185	132,734	-0-	165,919
Delta Greely	37,607	10,220	30,120	43,721	24,197	10,029	32,458	23,964	60,646	24,739	87,471	5,927	118,137
Iditarod	-0-	-0-	25,229	9,700	15,529	-0-	-0-	51,400	51,400	15,985	365,926	40,878	422,789
Kuspuk	4,426	22,934	56,800	35,623	48,537	-0-	9,965	-0-	9,809	-0-	163,395	6,091	169,486
Lake & Pen.	9,925	21,520	98,553	79,371	49,718	909	4,005	-0-	1,287	72,280	201,643	-0-	273,923
Lower Kusk.	33,482	-0-	406,838	233,457	133,641	73,222	-0-	63,675	63,675	89,012	1,554,691	-0-	1,643,703
Lower Yukon	-0-	157,664	129,538	129,591	145,387	12,224	29,563	-0-	32,529	166,330*	772,616	3,897	942,843
Northwest	41,146	122,835	364,296	296,295	225,951	6,031	N/A	98,632	98,632	70,832	1,048,820	-0-	1,119,652
Pribilof	NO FOOD SERVICE PROGRAM						5,563	-0-	4,291	19,212	79,514	6,086	104,812
Southeast	NO FOOD SERVICE PROGRAM						13,320	-0-	12,528	4,807	60,181	-0-	64,983
Southwest	-0-	15,554	102,847	62,136	56,265	-0-	-0-	2,904	26,301	-0-	434,781	-0-	434,781
Yukon Flats	7,022	24,029	47,334	49,056	24,674	4,655	11,822	8,729	20,551	67,974*	295,142	25,945	389,061
Yukon-Koyukuk	9,865	47,201	95,938	40,955	62,985	49,064	-0-	695	695	133,726*	462,068	810	596,604
TOTALS	$207,536	$574,960	$1,424,469	$1,138,058	$905,158	$163,749	$317,815	$405,483	$737,957	$799,091	$6,987,853	$152,913	$7,939,857

* Includes Boarding Home

FY 1978 AUDIT REPORT
CITY AND BOROUGH SCHOOL DISTRICTS
FOOD SERVICE, PUPIL ACTIVITY AND SPECIAL REVENUE FUNDS

	FOOD SERVICES FUND						PUPIL ACTIVITY FUND			SPECIAL REVENUE FUNDS			
District	Food Srv. Sales	Federal Reim.	School Dist. Subsidy	Salaries & Benefits	Food & Milk	Other Exp.	Generated Revenue	School Dist. Subsidy	Total Exp.	State Grants	Federal Grants	Local Funds	Total Grant Expenditures
Anchorage	$2,350,962	$ 895,684	$ 125,841	$1,753,214	$1,040,189	$ 579,084	$1,147,57[illegible]	$ -0-	$1,115,205	$1,829,184	$2,741,228	$ 27,768	$ 4,598,180
Bristol Bay	13,465	5,902	29,364	32,036	15,244	1,451	27,139	21,148	50,860	-0-	70,639	5,438	76,077
Cordova	17,428	9,250	8,784	26,684	7,746	1,032	34,227	36,510	70,122	-0-	180,951	454	181,405
Craig	5,031	5,792	16,347	13,251	12,348	1,571	-0-	11,764	11,764	2,637	77,542	-0-	80,179
Dillingham			NO FOOD SERVICE PROGRAM				77,282	25,000	101,662	129,899*	240,441	7,246	377,586
Fairbanks	70,748	34,906	-0-	11,681	93,427	546	407,784	149,434	647,317	256,201**	503,060	12,861	772,122
Galena	7,351	5,790	29,271	27,904	10,411	4,097	10,867	28,673	26,757	-0-	48,929	30,717	79,646
Haines			NO FOOD SERVICE PROGRAM				23,930	11,000	36,632	34,881	64,553	1,161	100,595
Hoonah	6,364	33,682	29,999	33,387	33,549	3,109	23,172	18,500	38,464	6,180	275,833	8,129	290,142
Hydaburg	-0-	12,849	14,711	16,398	9,812	1,350	6,969	11,191	8,444	1,163	67,952	-0-	69,115
Juneau			NO FOOD SERVICE PROGRAM				183,232	62,959	232,888	250,446**	384,585	-0-	635,031
Kake	1,936	16,29[illegible]	8,152	8,519	13,273	4,593	32,648	15,532	44,252	10,127	111,885	9,431	131,443
Kenai	323,511	126,363	165,188	308,913	256,548	49,601	334,749	342,665	650,377	63,654**	329,035	-0-	392,689
Ketchikan	88,874	85,613	40,868	91,529	117,032	6,794	188,886	38,600	225,429	13,512	274,197	2,733	290,442
King Cove	841	1,562	5,318	1,952	4,706	1,063	5,652	11,563	16,411	2,018	54,651	18,967	75,636
Klawock			NO FOOD SERVICE PROGRAM				-0-	-0-	-0-	1,150	39,[illegible]32	267	40,849
Kodiak	65,690	64,106	15,034	76,886	58,250	9,694	90,764	90,709	181,431	295,397*	35[illegible],431	733	650,561
Mat-Su	246,690	95,168	91,111	71,017	210,307	51,645	236,711	1[illegible],000	240,877	98,120**	320,026	10,197	428,343
Nenana	4,120	1,328	1,018	1,766	4,424	276	18,789	,433	28,134	45,123**	9,904	1,099	56,126
Nome	17,258	28,471	29,299	25,340	48,844	844	47,564	23,000	67,476	76,391	807,368	31,974	915,733
North Slope	11,514	83,918	555,278	366,636	278,640	5,434	60,150	315,382	281,488	177,627	838,207	600	1,016,434
Pelican			NO FOOD SERVICE PROGRAM				-0-	-0-	-0-	-0-	8,000	2,543	10,543
Petersburg	8,308	5,237	13,437	9,773	16,033	1,[illegible]76	17,151	28,321	45,931	23,746	58,129	36,254	118,129
Sitka	92,841	21,050	18,508	62,617	67,144	2,638	85,419	41,679	127,098	52,285	243,122	-0-	295,407
Skagway			NO FOOD SERVICE PROGRAM				7,386	21,972	27,728	1,515	17,936	-0-	19,451
St. Mary's	-0-	13,230	32,492	29,408	15,672	642	-0-	-0-	-0-	-0-	149,867	1,231	151,098
Unalaska	3,366	3,090	12,600	5,267	11,721	2,067	19,719	9,097	28,816	-0-	31,811	3,625	35,436
Vald[illegible]			NO FOOD SERVICE PROGRAM				46,817	55,486	98,842	-0-	45,[illegible]02	7,202	52,803
Wrangell			NO FOOD SERVICE PROGRAM				69,179	19,875	93,341	5,699	115,637	5,960	127,296
Yakutat	10,462	5,263	17,367	21,650	9,159	2,303	4,299	19,123	23,422	5,330	31,833	-0-	37,163
TOTALS	$3,346,760	$1,554,551	$1,259,987	$3,095,828	$2,334,460	$ 731,010	$3,208,062	$1,426,618	$4,521,168	$3,382,285	$8,496,785	$ 226,590	$12,105,660
Anchorage On-Base	131,505	58,669	2,742	116,317	79,753	46,846	-0-	-0-	-0-	-0-	-0-	-0-	-0-
Fairbanks On-Base	12,002	4,454	-0-	-0-	16,220	236	48,232	40,084	100,104	-0-	-0-	-0-	-0-

* Includes Boarding Home
** Includes RSVP

HB
374

POSITION PAPER/Department of Health & Social Servi

HOUSE BILL 374

"An Act relating to equalizing the costs of full-time residential or nursing care."

It is generally acknowledged that older persons would rather live in their communities than be separated from familiar patterns and people. The advantages of keeping people in their own communities are numerous. Most people prefer it. It enhances morale and provides security. Persons receive more individualized care, and the family and friends of the elderly in turn tend to become more involved when older persons reside close by. It is often apparent that many older people perceive institutionalization, even in a Pioneer Home, as "punishment" for getting sick and feeble. They fear the isolation and loneliness, not to mention the boredom, that comes from being displaced to a new setting. The thought of "dying alone" becomes a frightening preoccupation. Persons should not have to leave their communities, even to enter a Pioneer Home, unless it is their personal preference or they have become too ill for the treatment capacities of their community facilities.

Alaskans have been generous with their financial resources in supporting the Pioneer Home program, but that program presently revolves around facilities in four communities in the State. Fiscal reality tells us that we cannot construct and operate Pioneer Home programs in every community or even in every geographical region of the State. The cost per client is simply too prohibitive.

Considerable State resources have also been committed to the five nursing homes and the long-term care units of seven general hospitals throughout the State. All of the twelve facilities presently available have adequate bed-space to accomodate additional nursing home patients. In addition, these twelve facilities are built to Medicare/ Medicaid standards and can draw upon the resources of those programs should the patient be eligible. It would be folly to duplicate these beds, or indeed to jeopardize the financial status of the seven general hospitals which depend on their long-term care units to a large degree to assure fiscal solvency.

The approach proposed by House Bill 374 appears much more rational. This proposal suggests that we respond to the needs of Senior Alaskans by dedicating resources to a

POSITION PAPER/Department of Health & Social Service

broader based pioneer program -- one that responds to the preference of the pioneer to remain in his own community, either in a residential setting or a nursing home, if a Pioneer Home is not accessible.

The Department is interested in maximizing the residential care component suggested in House Bill 374. Recent surveys demonstrate that a significant number of current nursing home placements in Alaska are institutionalized for social rather than medical reasons. Not only is such placement a terribly expensive over-reaction to the problems of these individuals, but it does not represent a satisfactory solution either for the person or for those concerned with his welfare. Non-medical residential care can provide such individuals with a protected atmosphere in a community setting as an alternative to 24-hour nursing/medical care. The Department feels that this kind of living arrangement will help maximize the person's ability to function as independently as possible while at the same time providing necessary guidance and assistance sufficient for independent living. House Bill 374 would offer an important source of revenue to provide such residential care for those individuals qualifying for the Pioneer Home program.

The Department of Health and Social Services is most enthusiastic about the thrust of House Bill 374 and looks forward to working with the sponsor and other legislators to enact this community-oriented approach to caring for pioneer Alaskans. The attached sheet illustrates some of our initial thoughts concerning House Bill 374. The Department of Health and Social Services will be happy to work with the Department of Administration to develop cost projections along the lines of the methodology suggested in the attachment. We will also be pleased to assist in suggesting at least some initial parameters for the program to keep fiscal projections reasonable.

Approved by: Helen D. Beirne 3-20-79

Helen D. Beirne, Commissioner — Date
Department of Health and
Social Services

Attachment

HOUSE BILL 374

I. Amendments:

1. Set limits on amount allowed for residential care (rather than "amount charged," establish limit of daily or monthly rate of $_____).

2. Set criteria for eligibility in addition to (1) thru (3) of 47.25.108, to add "at risk of institutionalization" (in residential or nursing home setting). Would reduce eligibles - approximately 10% "at risk"?

II. Cost Offsets:

1. Could draw Medicare/Medicaid reimbursement for nursing care in certified nursing homes to offset Pioneer Home expenditures for nursing home care for Medicaid eligibles.

2. If limits set on amount allowed for residential care, could offset daily rate in Pioneer Home for same residential care.

3. Increased occupancy levels in LTC units of 7 general hospitals would contribute to financial viability of those community hospitals.

4. Will contribute significantly to establishment of residential alternative care settings for <u>all</u> individuals by providing a mechanism for funding those with Pioneer status.

III. Determining Cost-Impact:

1. Establish potential eligibles

   a. Population over 65 by community
   b. Exclude communities with Pioneer Homes

2. Determine likely Pioneer Home eligibles from #1;

3. Determine population "at risk of institutionalization" from #2;

4. Multiply percent likely to enter residential care times daily rate limit;

5. Multiply percent likely to enter nursing care times daily rate in communities with LTC facilities (draw from surrounding areas);

6. Substract potential Medicaid offsets;

7. Subtract decrease in daily rates for residential care vs. Pioneer Home rates for residential care.

IV. Recommentation:

That HB 374 be referred to the Special Committee on Services to the Elderly proposed by SB 179 and funded by SB 177.

OR

Request reserach analyst from Legislative Affairs to work with the Department of Health and Social Services and Department of Administration in the interim to develop program and fiscal implications.

NURSING HOME RATES AS OF FEBRUARY 23, 1979

	Current I.C.F. Rate	Current S.N.F. Rate	Certified Capacity			Current Occupancy			% Occupancy
			I.C.F.	S.N.F.	TOTAL	I.C.F.	S.N.F.	TOTAL	
reage House (Anchorage)	55.00		101		101	41		41	41%
reage North (Fairbanks)	84.50	93.00	101*		101	61	29	90	89%
rdova Hospital L.T.C.	72.72	80.80	6*		6	4	2	6	100%
pe Park and Ocean Park ICF/MR	124.36		31		31	31		31	100%
tchikan Hospital L.T.C.	65.00		48*		48	43		43	90%
koyia (Anchorage)	103.00	125.00	116	100	216	111	42	153	71%
rton Sound L.T.C. (Nome)	228.00		6		6	4		4	67%
tersburg (L.T.C)	51.30	57.00	12*		12	9	2	11	92%
uth Peninsula (Homer)	108.00		4		4	1		1	25%
. Ann's (Juneau)	75.00	82.50	45*		45	18	1	19	42%
lley Hospital L.T.C. (Palmer)	104.85		6		6	3		3	50%
rangell Hospital L.T.C.	70.00	77.00	14*		14	13		13	93%
esleyan (Seward)	42.30		64		64	54		54	84%
		TOTALS	542	100	654	393	76	469	7[illegible]%

All beds certified for both SNF and ICF.

Rod Betit — Feb 23, 1979

Rod Betit, Director — Date
Division of Public Assistance

Name	Address	Organization	Bill No.
~~St. Ctr~~			
Pat Denny	419 6th St. Juneau	St. Ann's Nursing Home	374
Rose M. Kulk	326-4th St.	American Red Cross	
Sister Patrick Mary	520 Harris Street	Senior Citizen Programs	374
Louis La Beaume	" " "	" " "	#374

STATE OF ALASKA

JAY S. HAMMOND, GOVERNOR

DEPARTMENT OF ADMINISTRATION

OFFICE OF THE COMMISSIONER / *POUCH C – JUNEAU 99811*

March 22, 1979

Honorable Thelma Buchholdt
Chairman, House Health, Education &
Social Services Committee
Alaska State Legislature
Pouch V
Juneau, Alaska 99811

Re: H B 374

Dear Representative Buchholdt:

Attached is some information you requested concerning the number of residents at the Pioneers' Homes and the cost per resident.

At this time we are still in the process of trying to determine the fiscal impact that this bill will have if passed. A number of areas are still unknown as to population of eligible applicants, the effect of Medicaid and Medicare, the net result of cost per care at effected facilities and potential impact on the existing program. We are working with the Department of Health and Social Services to answer these questions.

If you need more information or a clarification of the information presented, please let us know.

Respectfully,

Bill

W. R. Hudson
Commissioner

WRH/mjc
Attachments

FEBRUARY, 1979

	SITKA	FAIRBANKS	PALMER	ANCHORAGE	TOTAL
Available Beds					
Residence	100	65	42	133	340
Nursing	30	54	54	20	178
Vacancies					
Residence	34	11	2	9	56
Nursing	5	4	0	20	29
Waiting List					
Residence	2	17	70	97	186
Nursing	6	5	10	0	21

The current rate per month charged at the Pioneers' Homes is $225.00 for resident care and $275.00 to skilled nursing care.

PIONEERS' HOMES
AVERAGE COST PER RESIDENT
FY 1978

	Average No. Residents FY 78	Cost Per Year	Cost Per Month	Cost Per Day
Average Cost All Homes				
Resident Care	287	$ 17,819	$ 1,485	$ 49.01
Nursing Care	151	26,893	2,241	73.68
Average for Both	438	$ 21,494	$ 1,791	$ 58.89
Sitka				
Resident Care	71	$ 14,827	$ 1,236	$ 40.62
Nursing Care	48	27,174	2,264	74.45
Average for Both	119	$ 19,807	$ 1,651	$ 54.26
Fairbanks				
Resident Care	55	$ 17,433	$ 1,453	$ 47.76
Nursing Care	50	28,273	2,356	77.46
Average for Both	105	$ 22,595	$ 1,883	$ 61.90
Palmer				
Resident Care	38	$ 17,401	$ 1,450	$ 47.67
Nursing Care	53	25,231	2,102	69.12
Average for Both	91	$ 21,961	$ 1,830	$ 60.16
Anchorage*				
Resident Care	123	$ 21,613	$ 1,801	$ 59.21
Nursing Care	-0-			
Average for Both	123	$ 21,613	$ 1,801	$ 59.21

* Anchorage was only open for nine months in FY 78. These numbers have been prorated to reflect a twelve month period.

STATE OF ALASKA
DEPT. OF HEALTH AND SOCIAL SERVICES
OFFICE OF THE COMMISSIONER

JAY S. HAMMOND, GOVERNOR
POUCH H 01 – JUNEAU 99811

March 12, 1979

The Honorable Russ Meekins
Chairman, House Finance Committee
Alaska State Legislature
Pouch V
Juneau, Alaska 99811

Dear Mr. Meekins:

As per your request we submit a proposal for the Division of Public Assistance to start a Pilot Project Residential Care Program for thirteen (13) nursing home patients in the Anchorage area, and a Pilot Home Care Alternatives Project to prevent other individuals at high risk from entering nursing homes. The idea of the Residential Care Pilot Program is to identify persons currently in nursing homes who might wish to live in boarding care in the community if given supportive services to do so, to provide an alternative program to accomplish this goal, and to evaluate costs and savings potential from such a program at the end of a one-year period. (See attached project narrative.) The idea of the Home Care Alternatives Project is to identify persons currently in their own homes who, without intervention and service support would be in immediate risk of institutionalization or nursing home placement. (See attached project narrative.)

This amendment would transfer funds between Budget Request Units within the Division.

A summary of this amendment is as follows:

	TOTAL	FEDERAL	GENERAL FUNDS
Medicaid-Nursing Homes	(373.4)	(186.7)	(186.7)
General Relief-Residential Care	81.6		81.6
General Relief-Home Care	84.8		84.8
Old Age Assistance	20.3		20.3
TOTAL SAVINGS	(186.7)	(186.7)	-0-

Thank you for your consideration of this request.

Sincerely,

Helen D. Beirne

Helen D. Beirne

RESIDENTIAL CARE PROJECT NARRATIVE

It is generally acknowledged that older persons would rather live in their communities than in nursing homes. The questions have been: Can they adequately care for themselves in that environment, is their quality of life really improved, and does such an arrangement cost more or less than nursing home care?

Historically, there have been few options for the older person in Alaska who is no longer able to live independently. And persons of lower income who become unable to care for themselves currently have no recourse except either boarding homes, which generally do not provide personal care and services, or medical facilities, which are staffed and equipped for the treatment of illnesses rather than for social care. Often, for one reason or another, a nursing home or institution represents an expensive, unwanted, or even unnecessary over-reaction to the person's problems. People have had to go into nursing homes because there was no alternative. This does not represent a satisfactory solution either for the person or for those concerned with his welfare.

In response to this situation, the Alaska Department of Health and Social Services has developed an alternative residential care project. The project is designed to meet the needs of a specific group of people who are considered to have functional deficiencies in one or more of the following areas: economic, social, emotional or physical adjustment. The project will provide these adults who request the service with a protected atmosphere in a community setting as an alternative to 24-hour institutional or nursing/medical care. It is felt that this kind of living arrangement will help maximize the person's ability to function as independently as possible while at the same time providing necessary guidance and assistance to persons in those functional area that are insufficient for them to maintain independent living.

The aim of this pilot project is to develop a more humane as well as cost effective quality program with the primary focus being on social restoration rather than on medical/health care. It is a program specifically tailored to meet the needs of persons whose abilities to perform the essential activities of daily living are so impaired as to require a level of care beyond that available in an independent or room and board living situation, but whose disabilities are not such as to require 24-hour medical care. The desired result is a more satisfying and productive life for the individual. There is also a potential cost saving in that studies show a substantial number of such persons are now cared for in public or private institutions or nursing homes.

Funding for the project will consist of current state dollars already being spent on the identified pilot project population. Present state match monies already allocated through the State's Medicaid Program will be transferred to the General Relief fund and budgeted to the residential care project from the general fund.

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Funding for the project will consist of current state dollars already being spent on the identified pilot project population. Present state match monies already allocated through the State's Medicaid Program will be transferred to the General Relief fund and budgeted to the residential care project from the general fund.

The pilot project's three basic components are living arrangements; older persons who have difficulty in everyday living because of the frailities of age or due to physical, visual or mental impairments; and program supplementation. In considering the living arrangement component, all personal and community resources available to the prospective client will be evaluated. All boarding homes in Anchorage have been contacted and prospective client profiles discussed with house managers. Four homes have expressed an interest in being utilized as a placement service, and have indicated that additional staff and personal care services will be incorporated into their existing programs to help accommodate these particular persons' needs. All residential care facilities shall be in compliance with regulations licensing adult care facilities currently being promulgated by the Department of Health and Social Services. (Authority: AS 47.35.020; AS 47.35.070)

With regard to the older person component, there are currently, approximately one hundred (100) nursing home patients who have been identified throughout the State of Alaska by the Department of Health and Social Services whose level of care needs appear residential rather than skilled or intermediate nursing. All twelve (12) nursing home facilities in the State have client representatives in this population. Since there are few or no alternative residential care facilities in the eleven (11) geographically distributed communities who have nursing homes, a statewide residential care project is felt to be unrealistic at this point in time. However, a pilot project in Anchorage, which has two nursing homes representing close to thirty percent (30%) of the identified population whose level of care needs appear residential, does seem feasible. Thirteen (13) provisionally identified nursing home patients have been profiled for a possible pilot project regarding alternate residential placements in the Anchorage area. Client profiles suggest that the needs of the persons considered for this project are largely social, with observation and supervision required in their activities of daily living. Medications are being taken by several of these persons, which will need to be monitored, and considerable social support and encouragement is required.

The third component of the project is program supplementation. Arrangements will be made for physician/nurse visits, medication monitoring, and supportive services as needed in the homes. The monitoring of medications may be done through use of the Anchorage community nursing program for this small pilot project or contracting with the Nursing Registry Program in Anchorage. The Division of Social Services is now recruiting to fill a new position in Anchorage in adult services, and this position will be utilized to provide client monitoring, assessment, case-planning, and supportive services in the homes and with client placements.

The three main components described, those of homes, individuals and program supplementation, come together through the Residential Placement Agency. This project will be co-located in the divisions of Public

Assistance and Social Services, and is responsible for: assessing and certifying clients; assessing and certifying homes; and assuring the appropriateness of placement; the continuing need for the provision of care; and service management activities of case-planning, case-monitoring, and follow-up. A distinctive feature of the Residential Care pilot project is that it offers a test of an approach to use positive incentives to stimulate improved living conditions for a very vulnerable group of persons. Participation in the project is voluntary, and all persons are "grandfathered" under the new State Medicaid regulations, if no alternative living arrangements are available or until discharged from nursing home so as to insure continued funding of care for these persons after the one-year demonstration project is completed.

Projected rates are approximately $900 per month per person for providing residential care services. Current rates being paid by Medicaid and the State for these same persons in the two Anchorage nursing homes are $2,010 and $3,090 per month. It is anticipated that the pilot project involving thirteen (13) persons might result in a net savings of up to $84,000, and that a future statewide program for 100 persons could conceivably save close to $1 million. It is expected that if the project is successful, State supplementals might be continued in expanding the program throughout the State.

Savings earned as a result of the Department's residential care program are planned to be utilized in a related pilot program to allow for supportive services to be provided to prevent the inappropriate or premature institutionalization of certain high risk individuals (see attached narrative for the Home Care Alternatives Project). Such services availability will be limited by the extent of the earned savings from the residential care project.

SUMMARY OF COSTS:::NURSING HOMES--RESIDENTIAL CARE

	Patients	Gross Billings	(3rd Party Receipts)	Total	Funding Federal	Funding GF
Nursing Homes	108	2988462	(194400)[a]	2794062	1397031	1397031
(Residential Care)	108	1166400[c]	(488592)[b]	677808		677808
COST SAVINGS in MEDICAID				2116254	1397031	719223
+ Additional OAA Expense[d]				168480		168480
NET SAVINGS				2284734	1397031	887703
Nursing Homes	13	396755[e]	(23400)[a]	373355	186678	186677
(Residential Care)	13	140400[c]	(58812)[b]	81588		81588
COST SAVINGS IN MEDICAID				291767	186678	105089
+ Additional OAA Expense[d]				20280		20280
NET SAVINGS				312047	186678	125369

NOTES:
a. An average of $150 per month is used for each patient.
b. Most patients, if they were not in a nursing home, would be eligible for SSI and State Supplemental payments up to $377 per month. Very few patients would be eligible for the Longevity Bonus. For this summary, the amount of $377 has been used.
c. Estimated costs of residential care:
   Boarding costs - $750 per month
   Medical/social - $150 per month
   TOTAL $900 per month
d. Average OAA payments - $130 per month
e. Careage House: 7 patients @ $24455 annually
   Nakoyia: 6 patients @ $37595 annually

ATE OF ALASKA
ice of the Governor
dget & Management Div.

FY80 BUDGET AMENDMENT
COST ANALYSIS SUMMARY
by BUDGET COMPONENT

AGENCY	CATEGORY		
	PROGRAM		
DIVISION	SUB PROGRAM		Medicaid
	ELEMENT		Nursing Homes
	SUB ELEMENT		

CODE	EXPENDITURE BY OBJECT	FY80 GOV. BUDGET	[illegible]	FY80 GOV. BUDGET
100	PERSONAL SERVICES			
200	TRAVEL			
300	CONTRACTUAL SERVICES			
400	COMMODITIES			
500	EQUIPMENT			
600	LANDS, BUILDINGS, NON STRUCTURAL IMPROVEMENTS			
700	GRANTS, CLAIMS, SHARED REVENUE	17541.6	(373.4)	17168.2
800	MISCELLANEOUS			
	INTER AGENCY TRANSFERS (INCLUDED ABOVE)			
	TOTAL	17541.6	(373.4)	17168.2
NEW CODE				
	FEDERAL RECEIPTS	8770.8	(186.7)	8584.1
	REQUIRED GENERAL FUND MATCHING	1825.4	(186.7)	1638.7
	OTHER GENERAL FUND			
	INTER AGENCY TRANSFERS			
	OTHER: Revenue Sharing	6945.4		6945.4
	TOTAL	17541.6	(373.4)	17168.2
	PERMANENT FULL TIME POSITIONS			
	PERMANENT PART TIME POSITIONS			
	TEMPORARY (FULL TIME EQUIVALENTS)			
	NUMBER OF MAN MONTHS			

(CURRENT FY)

	FY ___	FY ___	FY ___	FY ___	FY ___	FY ___
EXPENDITURES - TOTAL						
SOURCE OF FUNDS						
FEDERAL						
REQ. G.F. MATCH						
OTHER G.F.						
OTHER (SPECIFY)						

02-1041 (Revised July, 1973)

STATE OF ALASKA
Office of the Governor
Budget & Management Div.

FY. 80 BUDGET AMENDMENT
COST ANALYSIS SUMMARY
by BUDGET COMPONENT

AGENCY	CATEGORY		
	PROGRAM		
DIVISION	SUB PROGRAM		General Relief Med
	ELEMENT		/Residential Care
	SUB ELEMENT		

CODE	EXPENDITURE BY OBJECT	FY 80 GOV BUDGET PRESENT AUTHORIZATION	REVISION INCREASE, (DECREASE)	AMENDED FY80 AUTHORIZATION
100	PERSONAL SERVICES			
200	TRAVEL			
300	CONTRACTUAL SERVICES			
400	COMMODITIES			
500	EQUIPMENT			
600	LANDS, BUILDINGS, NON STRUCTURAL IMPROVEMENTS	-0-	81.6	81.6
700	GRANTS, CLAIMS, SHARED REVENUE			
800	MISCELLANEOUS			
	INTER-AGENCY TRANSFERS (INCLUDED ABOVE)			
	TOTAL	-0-	81.6	81.6
NEW CODE				
	FEDERAL RECEIPTS			
	REQUIRED GENERAL FUND MATCHING			
	OTHER GENERAL FUND	-0-	81.6	81.6
	INTER-AGENCY TRANSFERS			
	OTHER:			
	TOTAL	-0-	81.6	81.6
	PERMANENT FULL-TIME POSITIONS			
	PERMANENT PART-TIME POSITIONS			
	TEMPORARY (FULL-TIME EQUIVALENTS)			
	NUMBER OF MAN MONTHS			

(CURRENT FY)

	FY ____	FY ____	FY ____	FY ____	FY ____	FY ____
EXPENDITURES – TOTAL						
SOURCE OF FUNDS						
FEDERAL						
REQ. G.F. MATCH						
OTHER G. F.						
OTHER (SPECIFY)						

02-1041 (Revised July, 1973)

STATE OF ALASKA
Office of the Governor
Budget & Management Div.

FY 80 BUDGET AMENDMENT
COST ANALYSIS SUMMARY
by BUDGET COMPONENT

AGENCY	CATEGORY	
	PROGRAM	
DIVISION	SUB PROGRAM	General Relief -
	ELEMENT	Home Care
	SUB ELEMENT	

CODE	EXPENDITURE BY OBJECT	PRESENT AUTHORIZATION	REVISION INCREASE, (DECREASE)	AMENDED AUTHORIZATION
100	PERSONAL SERVICES			
200	TRAVEL			
300	CONTRACTUAL SERVICES			
400	COMMODITIES			
500	EQUIPMENT			
600	LANDS, BUILDINGS, NON-STRUCTURAL IMPROVEMENTS	-0-	84.8	84.8
700	GRANTS, CLAIMS, SHARED REVENUE			
800	MISCELLANEOUS			
	INTER-AGENCY TRANSFERS (INCLUDED ABOVE)			
	TOTAL	-0-	84.8	84.8
	FEDERAL RECEIPTS			
	REQUIRED GENERAL FUND MATCHING			
	OTHER GENERAL FUND	-0-	84.8	84.8
	INTER-AGENCY TRANSFERS			
	OTHER:			
	TOTAL	-0-	84.8	84.8
	PERMANENT FULL-TIME POSITIONS			
	PERMANENT PART-TIME POSITIONS			
	TEMPORARY (FULL-TIME EQUIVALENTS)			
	NUMBER OF MAN MONTHS			

(CURRENT FY)

	FY ____	FY ____	FY ____	FY ____	FY ____	FY ____
EXPENDITURES – TOTAL						
SOURCE OF FUNDS						
FEDERAL						
REQ. G.F. MATCH						
OTHER G. F.						
OTHER (SPECIFY)						

02-1041 (Revised July, 1973)

STATE OF ALASKA
Office of the Governor
Budget & Management Div.

FFY 80 BUDGET AMENDMENT
COST ANALYSIS SUMMARY
by BUDGET COMPONENT

AGENCY	CATEGORY		
	PROGRAM		
DIVISION	SUB PROGRAM		Old Age Assistance
	ELEMENT		
	SUB ELEMENT		

CODE	EXPENDITURE BY OBJECT	FY 80 GOV BUDGET PRESENT AUTHORIZATION	REVISION INCREASE, (DECREASE)	AMENDED AUTHORIZATION FY80
100	PERSONAL SERVICES			
200	TRAVEL			
300	CONTRACTUAL SERVICES			
400	COMMODITIES			
500	EQUIPMENT			
600	LANDS, BUILDINGS, NON STRUCTURAL IMPROVEMENTS			
700	GRANTS, CLAIMS, SHARED REVENUE	3406.1	20.3	3426.4
800	MISCELLANEOUS			
	INTER AGENCY TRANSFERS (INCLUDED ABOVE)			
	TOTAL	3406.1	20.3	3426.4
NEW CODE				
	FEDERAL RECEIPTS			
	REQUIRED GENERAL FUND MATCHING			
	OTHER GENERAL FUND	3406.1	20.3	3426.4
	INTER AGENCY TRANSEERS			
	OTHER			
	TOTAL	3406.1	20.3	3426.4
	PERMANENT FULL-TIME POSITIONS			
	PERMANENT PART-TIME POSITIONS			
	TEMPORARY (FULL-TIME EQUIVALENTS)			
	NUMBER OF MAN MONTHS			

(CURRENT FY)

	FY ____	FY ____	FY ____	FY ____	FY ____	FY ____
EXPENDITURES – TOTAL						
SOURCE OF FUNDS						
FEDERAL						
REQ. G.F. MATCH						
OTHER G. F.						
OTHER (SPECIFY)						

02-1041 (Revised July, 1973)

RESIDENTIAL CARE

Approved By

		(1) # OF PATIENTS ASSESSED AS NEEDING RESIDENTIAL CARE	(2) CURRENT YEARLY RATE PER PATIENT (1)	(3) TOTAL GROSS BILLINGS	(4) LESS 3RD PARTY RECEIPTS (2)	(5) TOTAL NET COST (3)
1	ISLAND VIEW MANOR (KETCH)	11	23725	260975	19800	241175
2						
3	NORTON SOUND (NOME)	3	83403	250209	5400	244809
4						
5	PETERSBURG L.T.C.	5	18725	93625	9000	84625
6						
7	WRANGELL L.T.C.	1	25550	25550	1800	23750
8						
9	CAREAGE NORTH (F-BX)	13	30843	400959	23400	377559
10						
11	CORDOVA L.T.C.	2	26543	53086	3600	49486
12						
13	WESLEYAN N.H. (SEWARD)	22	15440	339680	39600	300080
14						
15	S. PENINSULA L.T.C. (HOMER)	0	39420	-	-	-
16						
17	VALLEY HOSP. L.T.C. (PALMER)	3	34306	102918	5400	97518
18						
19	ST. ANNS (JUNEAU)	4	27375	109500	7200	102300
20						
21	CAREAGE HOUSE (ANCH)	23	24455	562465	41400	521065
22						
23	NAKOYIA (ANCH)	21	37595	789495	37800	751695
24						
25	TOTAL	108		2938462	194400	2794062
26						
27	FUNDING					
28	FEDERAL FUNDS					1397031
29	GENERAL FUNDS					1397031
30						2794062
31						
32						
33	(1) CAREAGE HOUSE RATE ADJUSTED FROM $55 PER DAY TO $67 PER DAY.					
34	ALL OTHERS AT CURRENT RATE					
35						
36	(2) AN AVERAGE OF $150 PER MONTH IS USED FOR EACH PATIENT					
37						
38	(3) THIS DOES NOT INCLUDE COST SETTLING FOR CURRENT YEAR					
39						
40						

Form H555 Buff - Form G555 Green

	Current I.C.F. Rate	Current S.N.F. Rate	Certified Capacity			Current Occupancy			Medicaid
			I.C.F.	S.N.F.	TOTAL	I.C.F.	S.N.F.	TOTAL	% Occup.
Careage House (Anchorage)	55.00		101		101	41		41	41%
Careage North (Fairbanks)	84.50	93.00	101*		101	61	29	90	89%
Cordova Hospital L.T.C.	72.72	80.80	6*		6	4	2	6	100%
Hope Park and Ocean Park ICF/MR	124.36		31		31	31		31	100%
Ketchikan Hospital L.T.C.	65.00		48*		48	43		43	90%
Nakoyia (Anchorage)	103.00	125.00	116	100	216	111	42	153	71%
Norton Sound L.T.C. (Nome)	228.00		6		6	4		4	67%
Petersburg (L.T.C)	51.30	57.00	12*		12	9	2	11	92%
South Peninsula (Homer)	108.00		4		4	1		1	25%
St. Ann's (Juneau)	75.00	82.50	45*		45	18	1	19	42%
Valley Hospital L.T.C. (Palmer)	104.85		6		6	3		3	50%
Wrangell Hospital L.T.C.	70.00	77.00	14*		14	13		13	93%
Weslevan (Seward)	42.30		64		64	54		54	84%
	TOTALS		542	100	654	393	76	469	72%

* All beds certified for both SNF and ICF.

Rod Betit — Feb 23, 19

Rod Betit, Director — Date
Division of Public Assistance

HOME CARE ALTERNATIVES PROJECT

NARRATIVE

The Department of Health and Social Services has determined that the comprehensive, coordinated care necessary to assist individuals in avoiding inappropriate institutionalization is not always readily accessible in Alaska. Often this is largely due to the funding mechanisms available. Existing funding sources are willing to reimburse expensive, highly skilled medical/nursing care. They are less willing to reimburse less expensive, less technical, but often more satisfying preventive and supportive care. This bias toward institutional care is apparent even when institutional admittance is purely for social reasons rather than medical reasons. (Social reasons include such things as: 1) a person being alone and unable to care for themselves; 2) the vacation of the family or friend, thus requiring nursing home admission; 3) personal choice; 4) the family of the person not being able to provide care to the person; 5) the family not willing to provide the necessary care. Medical reasons include such things as: 1) a terminal illness case requiring constant medical attention; 2) 24-hour nursing care requirements; 3) rehabilitation therapy, etc.)

Some 200 persons were admitted to nursing homes or long-term care units of general hospitals in Alaska in 1978. Approximately 100 of the current 469 nursing home residents have been identified as institutionalized for social rather than medical reasons. The Department feels that the high number of placements for social reasons are inappropriate and/or premature.

The state of Alaska has demonstrated a willingness to meet the needs of Senior Alaskans requiring services. The question is whether to provide those services in an instititution (nursing home) or in the individual's community or home.

There is no doubt that nursing homes must be considered as a component in the total service continuum designed to meet the needs of senior Alaskans. But continual increases in Medicaid expenditures and the negative psychological impact of premature and/or inappropriate nursing home placements suggest that alternatives should be developed and tested.

Most of those admitted to nursing homes are recipients of Medicaid assistance which covers their costs of care while institutionalized. Even those few who might pay their own way upon entering a nursing home will likely require Medicaid assistance eventually as personal resources are rapidly exhausted by exorbitant daily nursing home rates. Daily nursing home rates in Alaska run from a low of $42.[illegible] to a high of $228.00. Medicaid assistance costs are shared on a ratio of 50% federal dollars to 50% state dollars. Thus inappropriate or premature placements are very expensive to both the state and federal government.

In order to reduce the inappropriate and/or premature nursing home admissions and to more appropriately utilize state dollars being spent on the care of senior Alaskans, the following pilot project is proposed.

The Department requests that 84.8 general fund monies be diverted from the state share of the Medicaid-Nursing Home FY 80 budget. These monies will be utilized to fund a pilot project to demonstrate that the coordinated intake process and delivery system can provide community-based services to senior Alaskans to prevent inappropriate and/or premature admissions to nursing homes for social reasons. The objectives of the proposed pilot project are:

Objectives:

1. Through community-based supportive services, reduce the number of inappropriate and/or premature admissions of senior Alaskans to nursing homes (for social reasons), to the satisfaction of those being served. (Community-based services include such things as homemaker services, home-delivered or senior center meals, transportation, home health services, companion programs, respite care, etc.)

2. Limit the number of those individuals served by the funding available as a result of the diversion of Medicaid monies stemming from the Residential Care Project (see attached).

3. Prevent an increase in state nursing home expenditures for those senior Alaskans served during the project. (State expenditures refers to state funds required to match federal dollars under the Medicaid program.)

The 84.8 of diverted State Medicaid-Nursing Home monies will be used to purchase services needed to assist senior Alaskans in high risk of social nursing home admission if intervention does not take place.

An existing employee within the Department's Division of Social Services will have primary responsibility for developing a coordinated intake process and service delivery system to offset the premature and/or inappropriate institutionalization of senior Alaskans participating in the project. The Project Director will implement the Home Care Alternatives Project along the lines of the general Standards, Procedures and Guidelines enumerated in Attachment 1.

Predicted Outcomes of the Home Care Alternatives Project:

Should this pilot project be approved, the following positive outcomes will result:

1. There will be an impact on the number of senior Alaskans institutionalized, in that the number of premature and/or inappropriate nursing home placements will be reduced.

2. There will be a greater effort to place individuals in settings where their needs can best be served.

3. There will be better and proper utilization of existing services.

4. There will be a heightened awareness of those services to be phased down or out.

5. There will be reduction in the duplication of services or in the payment for unneeded or dependence-creating services.

6. The freedom of senior Alaskans will be increased as a result of the options offered the participants in the project. As independence is increased, the individual's dignity and sense of self-worth will be heightened, thus improving the quality of life for senior Alaskans.

ATTACHMENT 1

STANDARDS, PROCEDURES AND GUIDELINES

HOME CARE ALTERNATIVES PROGRAM

I. Criteria for Admission to Home Care Alternatives Project:

a. Resident of the State of Alaska.

b. Sixty (60) years of age or older or handicapped or disabled.

c. Client must be in high risk of social nursing home admissions if intervention does not take place (0-90 days). Client determined to be medical crisis candidates will not be accepted.

d. Private physicians must be contacted to determine:

1. high-risk category, and

2. appropriateness of Home Care Alternatives Project in relationship to the client.

e. Initial assessment must be completed on each candidate by an Assessment Team. The Assessment Team will be composed of a Social Worker and a Registered Nurse.

f. If the Assessment Team determines that the client is an appropriate admission to the Home Care Alternatives Project, then the Assessment Team must develop a complete individual case plan for the client. Individual assessments and care plans must be submitted to the Project Director immediately after completion.

g. All informal support systems presently in place must be retained (family, friends, church, etc.). The Home Care Alternatives Project should not replace informal support systems already in place.

h. Alternative services for the family, friends, etc., may be supplied if indicated by the assessment (i.e., respite care).

i. When deemed necessary by the Assessment Team, services may begin immediately. Services to be reimbursed by the Home Care Alternatives Project must be authorized by the Project Director on the basis of the care plan submitted. The Project Director may authorize a care plan by telephone.

j. Follow-up visits must be made within 10 working days after services begin and at least every 30 days from the first follow-up visit. Follow-up visists will include: monitoring of services; appropriateness of services; quality of services; changes in client's condition.

k. Persons who are currently patients in nursing homes may be considered for the Home Care Alternatives Project if the following conditions are met:

1. The client is inappropriately placed at the time of referral to the Assessment Team, and

2. The physician approves of alternative placement.

II. Donations/Fees:

a. Client donations and fees will be accepted and considered Project income. A sliding fee schedule will be devised according to the ability to pay. Fees will be payable to the Project fund to be established within the General Relief BRU.

b. Services Provided with Older Americans Act Funding and Title XX Funding: Services available under Titles III and VII of the Older Americans Act and under Title XX will not be reimbursed by the Home Care Alternatives Project. Such services will be reported by cost of unit service to enable collection of accurate cost data for the project. In the event services normally available under Title III or VII or under Title XX are not available due to over-subscription or lack of resources, similar services may be acquired from other sources and reimbursed by the project. Alternative project clients will be placed in appropriate Title III and VII or Title XX programs when slots become available.

III. Staff Responsibilities:

a. Assessment Team Functions (Social Worker and Registered Nurse):

1. Initial Assessment

2. Case Plan Development

3. Arrangement and coordination of services

4. Follow-up visits

A. First follow-up visit within 10 working days after services have begun.

B. Follow-up visits every 30 days.

5. Reassessment within 90 days of initial assessment and every 90 days thereafter, unless case plan calls for more frequent assessments.

6. Requests for reimbursement filed monthly with Project Director.

b. Project Director Functions:

1. Provide funds to reimburse services provided in support of program activities in accordance with approved case plan.

2. Maintain individual assessment and case plans in a separate file.

3. Review care plans and authorize services as necessary.

4. Monitor clients and services on a random basis each quarter.

5. Provide technical assistance as requested.

IV. Case Plan Management:

Case management is a process to coordinate services for the elderly. With respect to the Home Care Alternatives Project, case management will provide access to the entire services system and insure the coordinated delivery of multiple services to individual clients at high risk of institutionalization. Basic to case management is an initial broad-based assessment of the client's needs. In addition, the case management process involves insuring that a service plan is written which considers all available services solutions, assures that the client is re-examined at regular intervals. Thus the goals of the case management process are: 1) To facilitiate access to a complete continuum of care ranging from home care to institutional care; 2) To facilitate choice of the most appropriate service alternatives for the client's unique conditions and concerns; 3) To ensure the coordinated delivery of services to each clients; and 4) to ensure periodic review of the appropriateness of the service being provided.

Social Services

Scott M. Matheson, Governor, State of Utah
Anthony W. Mitchell, Ph.D., Executive Director

The Alternatives Program For the Elderly

Louise P. Lintz, Model Projects Director

DATE: July 1, 1978 - June 30, 1979

P O M E Summary & Program Goals

BACKGROUND STATEMENT

With the prospect of a thirty-five million dollar expenditure for nursing home care for the fiscal year 1977/78, the Utah State Legislature, in March of 1977, mandated to the Utah State Department of Social Services the responsibility to study Alternative to Nursing Home Care for the Elderly. This responsibility was then charged to the Utah State Division of Aging. A seventy member task force was organized to carry out this mandated study.

In addressing the legislative concerns and as a part of the overall study, the task force conducted a survey of nursing home patients to determine why people entered nursing homes. Of the 168 persons studied in the survey, it was learned that not all admissions were made because of medical needs. Forty of the 168 persons surveyed, or 24%, were admitted to nursing homes for social reasons instead of medical reasons. (Social reasons were defined as and included such things as: 1) a person being alone; 2) the vacation of the family or friend, thus requiring nursing home admission; 3) personal choice; 4) the family of the person not being able to provide care to the person; and 5) the family not willing to provide the necessary care. Medical reasons were defined as and included such things as 1) a broken bone; 2) a terminal illness case; 3) nursing care requirements; 4) rehabilit-

Division of Aging

150 West North Temple, Suite 325
P.O. Box 2500, Salt Lake City, Utah 84110

tion therapy, etc.)

Note: For purposes of this memo, it is important to note that of the forty admits for social reasons, twenty-six were on Title XIX, Medicaid Assistance (a medical program for certain low-income qualifying individuals which pays all medical costs). This study also showed that the comprehensive, coordinated care necessary for avoiding inappropriate institutionalization of the elderly is not readily available. The ease with which a person can be permanently institutionalized contrasts with the difficult negotiation through the complex, fragmented, and uncoordinated system necessary to maintain a person at home. This disparity parallels that between abundant institutional beddage, and sparse social and life-support services in communities; between the willingness of third party payers to reimburse expensive, highly skilled, crisis-oriented medical care, and their reluctance to reimburse less expensive, less technical, preventive and supportive care; between the clear single assessment process to obtain institutional care, and the obscure, multi-agency, multi-assessment process to obtain non-institutional care; and between the concentration on highly skilled medical services and the lack of attention accorded preventive and supportive services such as transportation and nutrition, that are vital to maintenance of good health and independence.

PROBLEM

According to the admission study for the elderly in nursing homes in Utah, there is an average of forty admissions per month to nursing homes for those reasons defined above as social reasons. The task force concluded that these admissions to nursing homes were inappropriate and/or premature. Study results indicate that the reason for these inappropriate and/or premature placements was the result of a lack of available services to deal with the identified needs in the home of the person, or a lack of knowledge of or about the available services in the community. Twenty-s of the forty persons admitted to nursing homes for social reasons were recipients of Medicaid assistance to pay for their nursing home care. (It is important to note

that, according to the Utah Health Care Association, 96% of all long-term care patients will eventually require Medicaid assistance as their own resources are exhausted.) Medicaid assistance costs are shared on a ratio of 69% paid by the Federal Government with 31% State money required as matching funds in order to receive the 69% Federal dollar amount. The cost to the State alone for the 26 new persons (average) per month receiving Medicaid assistance of $535,000 per year (31% of total), not to mention the other 69% of the cost paid by the Federal Government. These inappropriate and/or premature placements are very expensive to the State and to the Federal Government.

In order to reduce the inappropriate and/or premature nursing home admissions and to more appropriately utilize the State dollars being spent on care of the elderly, the following objectives are made.

OBJECTIVES

1) Through community-based in-home services, reduce the number of inappropriate and/or premature admissions of elderly persons to nursing homes (for social reasons) by twelve persons per month, to the satisfaction of those being served. (The number of twelve persons per month was selected for the first year because of the limitation of funding. In-home/community based services include such things as homemaker services, home-delivered meals, transportation, home repair, home-health and nursing services, companion programs, etc.)
2) Prevent any increase in State expenditures for these elderly patients during the first year, and, within the second year, cut the State expenditure by 25%. (By State expenditure, we are referring to the State money that would be required to match the Federal dollars under Medicaid--the 31%. The 69% Federal money would be eliminated entirely.)

METHODS

1) A pre-admittance screening team will be established by the Project Director to explore alternative care with each individual being considered for social

admission to a nursing home.

2) An individual case plan will be developed showing the exact service requirements, providers, and cost, in order to maintain each individual in his/her own home.

3) Purchase of service agreements/vouchers will be prepared to cover the cost for the individual if existing resources are not adequate to cover the need.

4) All case management files will be retained in the Utah Division of Aging, and the Project Director will insure that monthly progress notes are recorded and that monthly reports on the total project are available to the Division, Department of Social Services, and the State Board of Aging.

5) Based on the project results, recommendations will be made to the Utah State Legislature for their further action.

EVALUATION - Recommendations for Program Measurement

The following steps will be accomplished in order to evaluate the project effectiveness;

1) Documentation of 144 individuals (per year) who would have been admitted to nursing homes for social reasons and who, because of the project, have been maintained in their own homes receiving community-based, in-home services.

2) No increase in the projected State fund expenditure (see objective number two).

3) Administration of a service satisfaction questionnaire on the quality of care and satisfaction to the older persons receiving services under the project.

4) Evaluation of the quality and completeness of service rendered, on the service provider, by the project director on a random basis to determine quality of care and whether or not service is adequate. (For example, if the service rendered was homemaker service--is the home kept clean, is there clean linen on th bed, is the client/patient receiving proper skin care, is their any sign of decubitus ulcers, etc.?)

LIMITATIONS OF THE PROPOSED MEASURES AND SPECIAL ATTENTION REQUIREMENTS

Although there are many limitations and difficulties with any attempt at [illegible] the following appear to be among the most significant:

1) In order for the above measures to be truly indicative and useful, the costs of all required services must be taken into account. It needs to be recognized at the outset that different geographical areas will require more or less money for the same service. For example, the wage scales will vary from one location to another. Travel distances may make one service more costly to deliver in one area than another. It may be useful to look at the difference between service provision in urban vs. rural areas.

2) Whenever client satisfaction is measured, care has to be taken in order to produce accurate measurement results. It would not be advisable to have the individual rendering the service administer the client/patient satisfaction questionnaire. This should be done by a different individual, or through a mail-in form, where the client/patient identity is not traceable. (A special telephone number could be given for individual complaints on service satisfaction during the course of the project.) The client/patient should be assured of the confidentiality of his/her response, and that service continuation will not be connected in <u>any</u> way to his response.

3) In the evaluation of the quality of care rendered by the service provider, attention should be given to make sure that this is carried out on a random basis so as not to indicate harassment. Although the main focus of this evaluation will be to assure adequate services, care should be taken to assure that there is not unnecessary service which would create more of a dependency on the part of the client/patient. Finally, the evaluation process should be as complete as is possible and reasonable so that the important considerations are not neglected.

4) Possibly, one of the more significant limitations of the proposed measurements is the multiple criteria problem. Although there is a major advantage in considering multiple variables, sometimes these variables or measures can be in conflict. For example, we have established measurements of client/patient

satisfaction and that of cost containment. What if the costs go up in the provision of community-based, in-home services, but at the same time client/patient satisfaction is significantly improved? Which then becomes the more important measurement--the dollar savings or the client/patient satisfaction, quality of life, independence, etc?

5) There is also a generalizability problem. Even if the various measurement problems can be solved, a problem still arises as to how widely one can generalize the resulting evaluation criteria to other situations and organizations.

6) Whenever one attempts to quantify something for measurement purposes, there arises the measurement precision problem. Quantification or measurement is often made difficult, due to the complexity and magnitude of the concept under study. Also, how consistent are such measures over time? In addition, are we sure that we are making the proper level of analysis? Have we been too broad, or indeed too narrow, in our measurements and evaluation?

For the purposes of the first year of the study, it would appear that the measurements outlined above would be adequate. However, over time, additional measurements should be instituted to take into consideration such things as the increased demands (and resultant increased cost) in home care resulting from project encouragement of the use of community-based in-home services.

PREDICTED POSITIVE OUTCOMES OF THE MEASURES

Several positive outcomes should develop as a result of the above measures. First of all, cost measurements will indicate whether or not project objectives have been accomplished at a higher, lower, or for the same approximate cost, thus enabling better judgments on an economic basis. Client satisfaction and preferences will also be determined as a result of the measures, thus giving the Department and Division a better idea of effective and appropriate service delivery methods. Finally, the measurements proposed should help indicate the kinds of services that need to be developed further (or reduced, as the case may be) and whether or not

in-home community-based service is a viable alternative to institutionalization.

PREDICTED POSITIVE OUTCOMES OF THE PROJECT

It was the consensus of the task force that there is no question but that services should be provided to meet the needs of those requiring such services. The choice is whether to provide these services in an institution (nursing home) or in the individual's community or home. The study, previously referred to, indicates that nursing homes should be considered as a part of the total service continuum to meet certain medical needs; however, continual increases in Medicaid expenditures and the negative psychological impact of premature and inappropriate nursing home placements demand that alternatives be further developed and tested. If this is carried out, the following positive outcomes are predicted:

There will be a tremendous impact on the institutionalization of the State's elderly. There will be a greater effort to place client/patients in settings where their needs can best be serviced. The number of inappropriate and premature nursing home placements will be reduced. There will be a better and proper utilization of existing services. The State Social Services will also have a better idea of those services that need further development or conversely to be phased down or out. It is also anticipated that there will be a reduction in the duplicatio of services or for the paying of unneeded and dependence-creating services.

When services are rendered at the proper level of requirement, and in a manner to allow for a choice on the part of the client/patient, there is obviously an increase in freedom. Independence, which is much too often denied the State's elderly, is increased or maintained as well as the person's dignity and feeling of self-worth. Quality of life then takes on a renewed meaning for those people who, before, were forced to accept fewer choices and options.

/cc

ALTERNATIVES PROGRAM
STANDARDS, PROCEDURES, AND GUIDELINES

A. Criteria for Admission into the Alternatives Program:

1) Resident of the State of Utah

2) 60 years of age or older

3) Client must be in high risk of social nursing home admissions if intervention does not take place (0 - 90 days). Clients determined to be medical crisis candidates will not be accepted.

4) Private physicians must be contacted to determine:

   a) high-risk category, and

   b) appropriateness of Alternatives Program in relationship to the client.

5) Initial assessment must be completed on each candidate by the Assessment Team. The Assessment Team will be composed of an Area Agency on Aging designee and a Registered Nurse.

6) If the Assessment Team determines that client is an appropriate admission to the Alternative Program, then the Assessment Team must develop a complete individual case plan for the client.

7) All informal support systems presently in place must be retained (family, friends, church, etc.). The Alternatives Program should not replace informal support systems presently in place.

8) Alternative Services for the family, friends, etc., may be supplied if indicated by the assessment (e.g., Respite, Payment for care in the home of another, etc.).

9) Individual assessments and case plans must be submitted to the State Division of Aging immediately after completion.

10) When deemed necessary by the Assessment Team, services may begin immediately; however, services to be reimbursed must be authorized by the State Division of Aging within a time period of 14 calendar days from the date of initial assessment. Case plans must be received by the State Division of Aging before they will be approved. The State Division of Aging may authorize a case plan by telephone.

11) Completed case plans must be received by the State within 7 calendar days of the initial assessment.

12) Follow-up visits must be made within 10 working days after services begin and again every 30 days from the first follow-up visit, except when the Assessment Team determines that an emergency exists, a follow-up visit will be made in advance of ten working days.

13) Follow-up Visits must include:

a) monitoring of services (e.g., service connections and coordination),

b) appropriateness of services,

c) quality of services, and

d) changes in client's condition.

14) Persons who are currently patients in nursing homes may be considered for the Alternative Program if the following conditions are met:

a) The client is inappropriately placed at the time of referral to the Assessment Team, and

b) the physician approves of alternative placement.

B. Donations/Fees:

1) Each client should be encouraged to donate to the program. All donations are voluntary.

2) Donations and fees will be considered Project Income and will be transferred to the State Division of Aging or considered as partial payment to the contractee for services provided if they are made directly to a member of the Assessment Team. Donations made to non-alternative funded services will be treated as non-alternative Project Income.

3) Sliding scale fee schedule will be used for those persons whose monthly income exceeds 74% of the state's median income (see attached fee schedule). Fees will be assessed by the Assessment Team to the client. Fees are payable to the Area Agency on Aging and will be treated as alternative Project Income.

4) Fees will be assessed for the entire package of services, not for individual services.

5) Exception to the above #4 will apply when the service is provided by a Title XX program. Fees assessed will then be paid to Title XX (e.g., Division of Family Services, Homemaker Program) when applicable.

6) When a Title XX service is required by the case plan, a signed Title XX group eligibility form must accompany the case plan when it is submitted to the State.

7) Services may be provided for those clients above the allowable sliding scale income level; however, fees assessed will be determined on an individual basis with each individual who is above the sliding scale income level. The Assessment Team will determine what fees should be assessed.

8) Assets will not be considered for eligibility in the program.

C. Services Provided with Older Americans Act Funding:

Services available under Titles III and VII will not be reimbursed by the Alternatives Program. These services must be reported by cost of unit service so that accurate cost data can be developed. In the event services normally available under Title III or VII are not available due to over-subscription of existing programs, then similar services will be acquired from other sources and reimbursed by the State. Alternative clients will be placed in appropriate Title III and VII programs when slots become available.

D. Services Provided with Title XX Funding:

Services available under Title XX will not be reimbursed by the Alternatives Program. These services must be reported by cost of unit so that accurate cost data can be developed. In the event services normally available under Title XX are not available due to over-subscription of existing programs, then similar services will be acquired from other sources and reimbursed by the State. Alternative clients will be placed in appropriate Title XX programs when slots become available.

E. Area Agency Responsibilities:

1) Initial Assessment

2) Case Plan Development

3) Arrangement and Coordination of Services

4) Follow-Up Visit

   a) First Follow-Up Visit within 10 working days after services have begun except when the Assessment Team determines that an emergency exists, a follow-up visit will be made in advance of ten working days.

   b) Follow-Up Visits every 30 days

5) Reassessment within 90 days of initial assessment and every 90 days thereafter, unless case plan calls for more frequent assessments.

6) Requests for Reimbursement filed monthly.

F. State Division of Aging Responsibilities:

1) Provide money (cash assistance) to project in support of project activities in accordance with the State Division of Aging approved case plan services.

2) Individual Assessment and Case Plan will be maintained on each individual in a separate file.

3) Case plans will be reviewed and services authorized, if approved, within 7 days after being received in the State Division of Aging office and returned to the Area Agency on Aging with any changes made by the Project Director.

4) Monitoring of clients and services will be conducted on a random basis quarterly.

5) Technical Assistance will be available as requested.

6) Authorization of requests for reimbursement to the Utah State Finance Department monthly in accordance with the individual approved case plan.

6/30/78

ALTERNATIVES PROGRAM FEE SCHEDULE

FAMILY OF ONE		FAMILY OF TWO		FAMILY OF THREE	
MONTHLY GROSS INCOME	MONTHLY FEE	MONTHLY GROSS INCOME	MONTHLY FEE	MONTHLY GROSS INCOME	MONTHLY FEE
0 - 277	0	0 - 382	0	0 - 484	0
278 - 300	0	383 - 400	0	485 - 500	5
301 - 400	5	401 - 500	5	501 - 600	10
401 - 500	10	501 - 600	10	601 - 700	15
501 - 532	15	601 - 696	15	701 - 800	20
533 - 600	20	697 - 800	20	801 - 860	25
				861 - 900	30

THE ALTERNATIVE PROGRAM

CASE MANAGEMENT

DEFINITION

Case management is a process to coordinate services for the elderly. Done for and with a selected sub-set of clients, it provides access to the entire services system and insures the coordinated delivery of multiple services to individual clients. Basic to case management is an initial broad-based assessment of the client's needs. In addition, the case management process involves insuring that a service plan is written which considers all available service solutions, that the client is actually connected to service, and that the progress of the client is re-examined at regular intervals.

GOALS

The goals of the case management process are: 1) to facilitate access to a complete continuum of care ranging from home care to institutional care; 2) to facilitate choice of the most appropriate service alternatives for the client's unique conditions and concerns; 3) to ensure the coordinated delivery of services to each client; and, 4) to ensure periodic review of the appropriateness of the service being provided.

CASE MANAGEMENT COMPONENTS

DEFINITIONS

Needs Assessment	is the collection of information about a person's situation and functioning which allows identification of the client's problems in the major functional areas.
Service Plan	is an agreement between the client and worker regarding client problems identified, goals to be achieved and services to be pursued in support of goal achievement.
Arranging for Service	is contacting service providers and negotiating with them for the delivery of needed services to the client in the manner prescribed in the service plan.
Reassessment	is the scheduled re-examination of the client's situation and functioning to identify changes which occurred since the initial assessment to measure progress toward the goals outlined in the service plan and to assure that the services are being delivered. In so doing, the case manager determines whether the service plan needs to be updated and the pattern of service delivery changed.
Recording	All pertinent information regarding each client will be recorded in an individual case file, maintained at the State Division of Aging and guaranteeing the confidentiality of each person and file.

THE ALTERNATIVES PROGRAM

MAJOR SERVICE GOALS

Upon completion of assessment, determine which of the following categories or goals are most applicable to the major purpose of the Alternative Program.

Enter this on the bottom of the assessment sheet.

Goal Category I: refers pr' arily to those clients with episodes of illness or conditions in which the major purpose of the Alternatives Program is elimination of the problem or problems (Short term care). Full independence anticipated.

Example of Goal:

a) Complete recovery from illness or disability.

b) Satisfactory adjustment to a major crisis.

c) Adequate learning re: nutrition, health practices and procedures.

Goal Category II: refers to clients with problems that are expected to continue but ultimate objective is to assist the client or family to provide the necessary care without the Alternatives Program.

Example of Goal:

a) Client or family or family substitute competent in total client care.

b) Client or family competent to seek help as indicated.

Goal Category III: refers to clients with conditions or problems in which rehabilitation or improvement can be anticipated.

Example of Goal:

a) Rehabilitation to optimum level of function and activity - physical, social, and emotional.

b) Reduced pain and disability.

c) Disease brought into control.

d) Client referred to and accepted by another agency which is meeting client's needs for rehabilitation.

Goal Category IV: refers to clients who need alternatives assistance in maintenance care.

Example of Goal:

a) Maintenance level of ADL.

b) Prevent regression and complications.

c) Retard disease progression.

d) Detect early signs of deviation from normal or status quo.

Goal Category V: refers to clients in terminal stages of illness.

Example of Goal:

a) Prevent premature institutionalization.

b) Achieve satisfactory level of comfort and dignity at home during terminal stages.

c) Delay hospitalization or nursing home placement until family unable to meet needs.

326 Fourth Street - Apt. 38D
Juneau, Alaska. 99801.
20 March 1979.

The Committee on Health, Education
and Social Services
House of Representatives
State of Alaska.

May I add my strong support of
House Bill No. 374 now before the
Eleventh Legislature of the House?

For an Act entitled: "An Act relating
to equalizing the costs of full-time
residential or nursing care."

I approve completely this far-
sighted and hopeful legislation
to insure the complete care of aged
or aging persons according to the
amendment of Section 1. 47-25, by
adding new sections to qualify
and safeguard the Act:

New Sections 47.25.103
" 47.25.105
and three provisions concerning
eligibility.

As a recipient of Homemaker care
I am encouraged that full care may
be added as needed by many persons
fulfilling State of Alaska requirements.

Sister Trinity B.S.I.
(Sarah Swift-Carter).

LA11 0857 10.45 JA01 0004 12.03 93723/79

TO REPRESENTATIVE THELMA BUCHHOLDT, HOUSE HESS
REPRESENTATIVE RUSS MEEKINS, HOUSE FINANCE
SENATOR JOHN SACKETT, SENATE FINANCE

FROM ROSE PALMQUIST, PRESIDENT, OLDER PERSONS ACTION GROUP 276-4041

HB 374, EQUALIZING COSTS OF RESIDENTIAL OR NURSING CARE, DOES NOT ADDRESS THE REAL PROBLEM WITH PIONEERS HOMES VS. OTHER INSTITUTIONAL CARE. THE BEST FIRST APPROACH IS HOME CARE, AND AFTER THAT, EVALUATION OF OTHER CARE RESOURCES. REGARDING THE PIONEERS HOMES, THE LEGISLATURE SHOULD ADDRESS THE NECESSITY FOR A SLIDING SCALE OF FINANCIAL CONTRIBUTION BY THE RESIDENTS TOWARD THE END THAT THE RESIDENTS PAY WHAT THEY CAN AFFORD BEFORE THE TAXPAYERS PICK UP THE TAB. MANY RESIDENTS OF PIONEERS HOMES AMASS ASSETS FOR THEIR HEIRS WHILE IN THE HOMES. THIS PROBLEM COULD BE CORRECTED BY A CHANGE OHE RULES WITHIN THE DIVISION OF PIONEERS BENEFITS AND WOULD NO DOUBT RESULT IN FEWER APPLICATIONS FOR ADMITTANCE INTO THE HOMES. THUS, THE PROBLEM THAT HB 374 ADDRESSES COULD BE RESOLVED WITHOUT ADDITIONAL LEGISLATION.

JHEOM/

Name	Address	Organization	Bill No.
Margaret C. Cavanaugh	Rt. 3, Box 3003, apt 201, Juneau	Retired Social Worker	HB 374
Dove M. Hull	Mendenhall Apts 1010, Juneau	American Lease Retired Person	HB 374
Thomas F. Landon	1170 Glacier Ave apt 103-11		
Clifford Swaggy	Box 1117 Juneau, Ak.	AARP	HB 374
N. H. Bigger	423 East St., Juneau, AK	AARP	HB 374
Opal C Bigger	423 East St. Juneau, ak	AARP	
Louis LaBeaume	865 West 12th Juneau Ak.	AARP	HB 374
Sister Barbara Hauser	3100 Tongass ave. Ketchikan	Long Term Care Division of Ak State Hosp. com. and Ketch. Gen. Hosp. / Island View Manor	HB 374 HO 96
John R. Pugh	Dept. of H & SS		
Barbara Baker	424 East Street Juneau	Southeast Nutrition Program for the Elderly	HB 374
John W Houser	2321 CANARY court, Anchorage	Valley Is Health Care Ctr	HB 374
George Elgee		Department of Administration	HB 374
Pat Denny	419 6th St, Juneau ak	Catholic Community Service	HB 374
Donna Stephens	SRA - 94T Anch. AK 99507	Carriage House	HB 374
Richard L. Wilson	P.O. Box 847 Fairbanks A99701	Carriage North	HB 374
Emma Y. Ivy	P.O. Box 80 Wrangell, Alaska 99929	Wrangell Gen. Hosp. and Long Term Care Facility	HB 374
Florence LeRoy	Box 589 Petersburg, ALASKA 99833	Petersburg General Hospital and Long Term Care	HB 374

ALTERNATIVES PROGRAM
STANDARDS, PROCEDURES, AND GUIDELINES

A. Criteria for Admission into the Alternatives Program:

1) Resident of the State of Utah

2) 60 years of age or older

3) Client must be in high risk of social nursing home admissions if intervention does not take place (0 - 90 days). Clients determined to be medical crisis candidates will not be accepted.

4) Private physicians must be contacted to determine:

   a) high-risk category, and

   b) appropriateness of Alternatives Program in relationship to the client.

5) Initial assessment must be completed on each candidate by the Assessment Team. The Assessment Team will be composed of an Area Agency on Aging designee and a Registered Nurse.

6) If the Assessment Team determines that client is an appropriate admission to the Alternative Program, then the Assessment Team must develop a complete individual case plan for the client.

7) All informal support systems presently in place must be retained (family, friends, church, etc.). The Alternatives Program should not replace informal support systems presently in place.

8) Alternative Services for the family, friends, etc., may be supplied if indicated by the assessment (e.g., Respite, Payment for care in the home of another, etc.).

9) Individual assessments and case plans must be submitted to the State Division of Aging immediately after completion.

10) When deemed necessary by the Assessment Team, services may begin immediately; however, services to be reimbursed must be authorized by the State Division of Aging within a time period of 14 calendar days from the date of initial assessment. Case plans must be received by the State Division of Aging before they will be approved. The State Division of Aging may authorize a case plan by telephone.

11) Completed case plans must be received by the State within 7 calendar days of the initial assessment.

12) Follow-up visits must be made within 10 working days after services begin and again every 30 days from the first follow-up visit, except when the Assessment Team determines that an emergency exists, a follow-up visit will be made in advance of ten working days.

13) Follow-up Visits must include:

a) monitoring of services (e.g., service connections and coordination),

b) appropriateness of services,

c) quality of services, and

d) changes in client's condition.

14) Persons who are currently patients in nursing homes may be considered for the Alternative Program if the following conditions are met:

a) The client is inappropriately placed at the time of referral to the Assessment Team, and

b) the physician approves of alternative placement.

B. Donations/Fees:

1) Each client should be encouraged to donate to the program. All donations are voluntary.

2) Donations and fees will be considered Project Income and will be transferred to the State Division of Aging or considered as partial payment to the contractee for services provided if they are made directly to a member of the Assessment Team. Donations made to non-alternative funded services will be treated as non-alternative Project Income.

3) Sliding scale fee schedule will be used for those persons whose monthly income exceeds 74% of the state's median income (see attached fee schedule). Fees will be assessed by the Assessment Team to the client. Fees are payable to the Area Agency on Aging and will be treated as alternative Project Income.

4) Fees will be assessed for the entire package of services, not for individual services.

5) Exception to the above #4 will apply when the service is provided by a Title XX program. Fees assessed will then be paid to Title XX (e.g., Division of Family Services, Homemaker Program) when applicable.

6) When a Title XX service is required by the case plan, a signed Title XX group eligibility form must accompany the case plan when it is submitted to the State.

7) Services may be provided for those clients above the allowable sliding scale income level; however, fees assessed will be determined on an individual basis with each individual who is above the sliding scale income level. The Assessment Team will determine what fees should be assessed.

8) Assets will not be considered for eligibility in the program.

C. Services Provided with Older Americans Act Funding:

Services available under Titles III and VII will not be reimbursed by the Alternatives Program. These services must be reported by cost of unit service so that accurate cost data can be developed. In the event services normally available under Title III or VII are not available due to over-subscription of existing programs, then similar services will be acquired from other sources and reimbursed by the State. Alternative clients will be placed in appropriate Title III and VII programs when slots become available.

D. Services Provided with Title XX Funding

Services available under Title XX will not be reimbursed by the Alternatives Program. These service must be reported by cost of unit so that accurate cost data can be developed. In the event services normally available under Title XX are not available due to over-subscription of existing programs, then similar services will be acquired from other sources and reimbursed by the State. Alternative clients will be placed in appropriate Title XX programs when slots become available.

E. Area Agency Responsibilities:

1) Initial Assessment

2) Case Plan Development

3) Arrangement and Coordination of Services

4) Follow-Up Visit

   a) First Follow-Up Visit within 10 working days after services have begun except when the Assessment Team determines that an emergency exists, a follow-up visit will be made in advance of ten working days.

   b) Follow-Up Visits every 30 days

5) Reassessment within 90 days of initial assessment and every 90 days thereafter, unless case plan calls for more frequent assessments.

6) Requests for Reimbursement filed monthly.

F. State Division of Aging Responsibilities:

1) Provide money (cash assistance) to project in support of project activities in accordance with the State Division of Aging approved case plan services.

2) Individual Assessment and Case Plan will be maintained on each individual in a separate file.

3) Case plans will be reviewed and services authorized, if approved, within 7 days after being received in the State Division of Aging office and returned to the Area Agency on Aging with any changes made by the Project Director.

4) Monitoring of clients and services will be conducted on a random basis quarterly.

5) Technical Assistance will be available as requested.

6) Authorization of requests for reimbursement to the Utah State Finance Department monthly in accordance with the individual approved case plan.

6/30/78

ALTERNATIVES PROGRAM FEE SCHEDULE

FAMILY OF ONE		FAMILY OF TWO		FAMILY OF THREE	
MONTHLY GROSS INCOME	MONTHLY FEE	MONTHLY GROSS INCOME	MONTHLY FEE	MONTHLY GROSS INCOME	MONTHLY FEE
0 - 277	0	0 - 382	0	0 - 484	0
278 - 300	0	383 - 400	0	485 - 500	5
301 - 400	5	401 - 500	5	501 - 600	10
401 - 500	10	501 - 600	10	601 - 700	15
501 - 532	15	601 - 696	15	701 - 800	20
533 - 600	20	697 - 800	20	801 - 860	25
				861 - 900	30

THE ALTERNATIVE PROGRAM

CASE MANAGEMENT

DEFINITION

Case management is a process to coordinate services for the elderly. Done for and with a selected sub-set of clients, it provides access to the entire services system and insures the coordinated delivery of multiple services to individual clients. Basic to case management is an initial broad-based assessment of the client's needs. In addition, the case management process involves insuring that a service plan is written which considers all available service solutions, that the client is actually connected to service, and that the progress of the client is re-examined at regular intervals.

GOALS

The goals of the case management process are: 1) to facilitate access to a complete continuum of care ranging from home care to institutional care; 2) to facilitate choice of the most appropriate service alternatives for the client's unique conditions and concerns; 3) to ensure the coordinated delivery of services to each client; and, 4) to ensure periodic review of the appropriateness of the service being provided.

CASE MANAGEMENT COMPONENTS

DEFINITIONS

Needs Assessment	is the collection of information about a person's situation and functioning which allows identification of the client's problems in the major functional areas.
Service Plan	is an agreement between the client and worker regarding client problems identified, goals to be achieved and services to be pursued in support of goal achievement.
Arranging for Service	is contacting service providers and negotiating with them for the delivery of needed services to the client in the manner prescribed in the service plan.
Reassessment	is the scheduled re-examination of the client's situation and functioning to identify changes which occurred since the initial assessment to measure progress toward the goals outlined in the service plan and to assure that the services are being delivered. In so doing, the case manager determines whether the service plan needs to be updated and the pattern of service delivery changed.
Recording	All pertinent information regarding each client will be recorded in an individual case file, maintained at the State Division of Aging and guaranteeing the confidentiality of each person and file.

THE ALTERNATIVES PROGRAM

MAJOR SERVICE GOALS

Upon completion of assessment, determine which of the following categories or goals are most applicable to the major purpose of the Alternative Program.

Enter this on the bottom of the assessment sheet.

Goal Category I: refers primarily to those clients with episodes of illness or conditions in which the major purpose of the Alternatives Program is elimination of the problem or problems (Short term care). Full independence anticipated.

Example of Goal:

a) Complete recovery from illness or disability.

b) Satisfactory adjustment to a major crisis.

c) Adequate learning re: nutrition, health practices and procedures.

Goal Category II: refers to clients with problems that are expected to continue but ultimate objective is to assist the client or family to provide the necessary care without the Alternatives Program.

Example of Goal:

a) Client or family or family substitute competent in total client care.

b) Client or family competent to seek help as indicated.

Goal Category III: refers to clients with conditions or problems in which rehabilitation or improvement can be anticipated.

Example of Goal:

a) Rehabilitation to optimum level of function and activity - physical, social, and emotional.

b) Reduced pain and disability.

c) Disease brought into control.

d) Client referred to and accepted by another agency which is meeting client's needs for rehabilitation.

Goal Category IV: refers to clients who need alternatives assistance in maintenance care.

Example of Goal:

a) Maintenance level of ADL.

b) Prevent regression and complications.

c) Retard disease progression.

d) Detect early signs of deviation from normal or status quo.

Goal Category V: refers to clients in terminal stages of illness.

Example of Goal:

a) Prevent premature institutionalization.

b) Achieve satisfactory level of comfort and dignity at home during terminal stages.

c) Delay hospitalization or nursing home placement until family unable to meet needs.

Honorable Chairperson & Committee members

8 yrs CW Supt
2 yrs Clinical Soc Wk Pt
8 yrs Alex AHHAS
Bd for Comm & Mental Hlth Facilities

Subject: HB 374 Today 1:00 Room 112 Capitol J Rudderow

The passage of this Bill into law will enable many older persons to remain in their own homes as long as possible and help hold families together.

For 8 years, I was Director of Alaska Homemaker-Home Health Aide Service. Our basic funding originally was from the Older Americans Act, Office of Aging. In 1974-75, this agency served statewide 253 older Alaskans. By age groups there were

Age	Number
55-60	12
60-65	20
* 65-70	131
70-75	25
75-80	18
80-85	20
85-90	12
90-95	10
95-100	2
100-113	3
	253

J. Duncan –
H. Biggs – HSS
Elgee – Admin
Sr Bills – Retirement
Finance – Lack –

With a combination of quality homemaker-home health aide service and local nursing homes re-imbursed from the pioneer fund, Senior Alaskans can remain in their own homes & our Communities

as long as possible. This plan would be less beneficial for human beings; and, per person, less expensive for government.

... elderly woman said, "I ... away from my home and family and ... died soon after ... age. Her grand daugh... great grand daughter pleaded unsuccess... ... to keep her at home - we hi... as near as that they could visit. Often ... money in the black or an - home care ... patients & and their agency members ...

Dave M Kull, Chairperson - N.S.U., A.C.S.W.
Juneau Chapter of American Aca of Social Workers
Members on the Chapter

3-20-79

Mrs. Dave M. Kull
Mendenhall Apts. #1010
326 - 4th Street
Juneau, Alaska 99801

Dr. Robt. Butler, Dir. N.I.Agency
In-home care is 80% less expensive

OF ALASKA MEMORANDUM

TO: Janice Gates, Special Assistant
to the Commissioner
Dept. of Health & Social Services

DATE: March 28, 1979

FILE NO:

TELEPHONE NO:

FROM: Harold L. Cosgrove, Jr.
Harold L. Cosgrove, Jr.
Associate Coordinator
Office on Aging

SUBJECT: Elderly Population
(60+, 65+, 75+)
by Region and City.

For: M.D. Plotnick, Coordinator

The following are tabular presentations of your telephone request of March 24, which was further updated in a personal briefing on the morning of March 28.

ere are an estimated 19,749 elderly 60+ (July 1, 1979)
nere are an estimated 10,337 elderly 65+ (July 1, 1979)
There are an estimated 3,200 elderly 75+ (July 1, 1979)

Regions	60+	65+	75+
Northwest	1,185	708	217
Interior	2,765	1,297	405
Southwest	1,580	910	290
Southcentral	8,887	4,362	1,293
Southeast	5,332	3,060	995
Total	19,749	10,337	3,200

Janice Gates, Special Assistant March 28, 1979

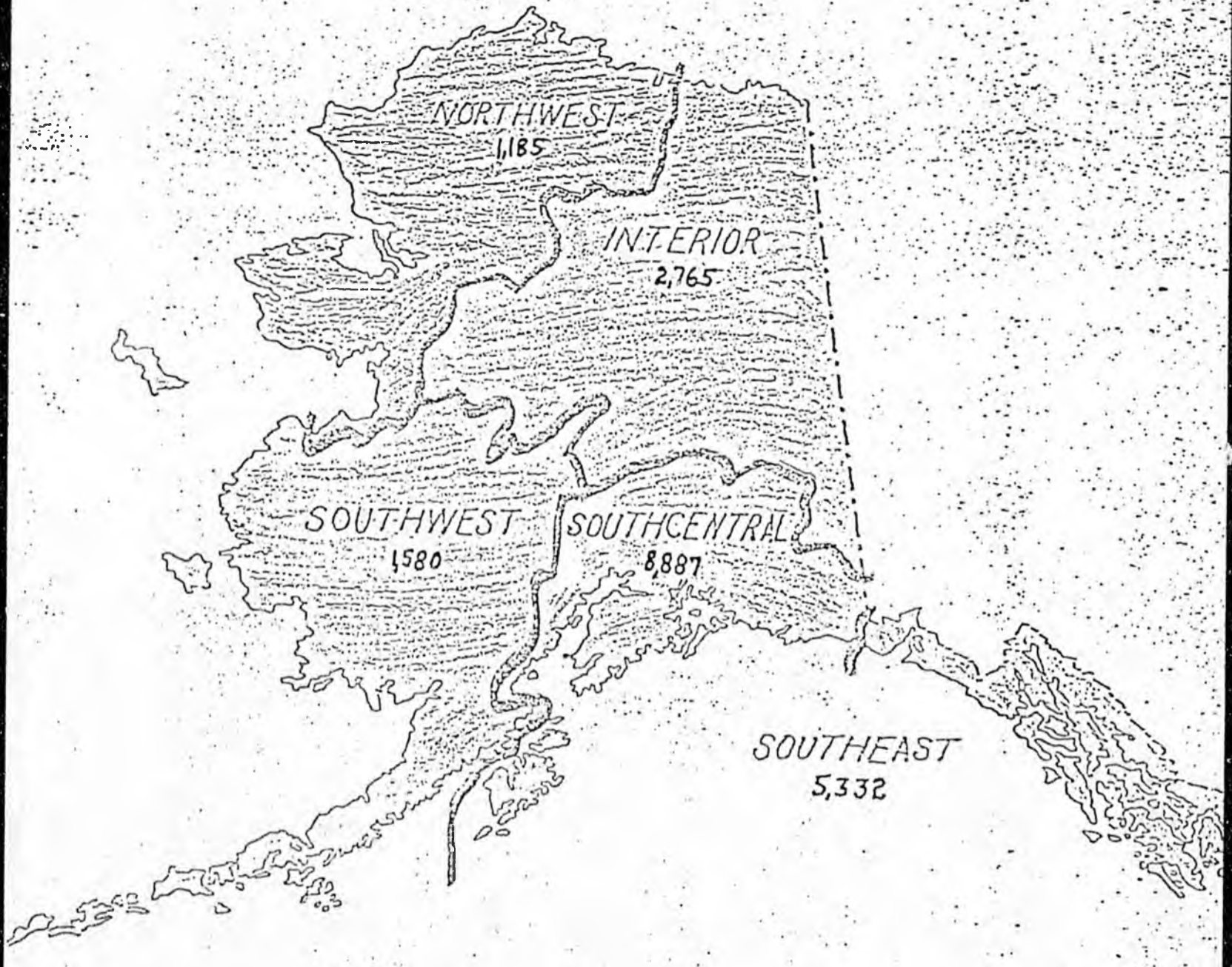
AGE BREAKOUTS BY COMMUNITY WITHIN THE 5 REGIONS

		60+	65+	75+
NORTHWEST	Barrow	174-185	84-113	29
	Nome	247-279	150-198	34-40
	Kotzebue	134-151	78-99	17
INTERIOR	Fairbanks	1,425-2,123	706-1,346	186-211
SOUTHWEST	Bethel	151	105	23
	Dillingham	84-119	41-80	6-19
SOUTHCENTRAL	Anchorage	3,936-6032	1,924-3650	538-597
	Cordova	152-158	84-103	17
	Homer	139-152	83-102	22
	Kenai	129-230	63-129	15
	Kodiak	345-467	197-310	57-65
	Palmer	152-162	87-109	28
	Seward	255-275	170-216	49-51
	Valdez	81-131	42-72	12
SOUTHEAST	Juneau	1,387-1,679	757-1,145	179-209
	Ketchikan	1,006-1,039	632-744	184-193
	Petersburg	312-315	201-224	57
	Wrangell	242-268	138-185	34-41

Attachment

TOTAL 19,74

REGIONAL DISTRIBUTION of ALASKA'S 60+ POPULATION



REGIONAL DISTRIBUTION of ALASKA'S 65+ POPULATION

REGIONAL DISTRIBUTION of ALASKA'S 75+ POPULATION

LA11 0857 10.45 JA01 0004 12.03 93/23/79

TO REPRESENTATIVE THELMA BUCHHOLDT, HOUSE HESS
REPRESENTATIVE RUSS MEEKINS, HOUSE FINANCE
SENATOR JOHN SACKETT, SENATE FINANCE

FROM ROSE PALMQUIST, PRESIDENT, OLDER PERSONS ACTION GROUP 276-4041

HB 374, EQUALIZING COSTS OF RESIDENTIAL OR NURSING CARE, DOES NOT ADDRESS THE REAL PROBLEM WITH PIONEERS HOMES VS. OTHER INSTITUTIONAL CARE. THE BEST FIRST APPROACH IS HOME CARE, AND AFTER THAT, EVALUATION OF OTHER CARE RESOURCES. REGARDING THE PIONEERS HOMES, THE LEGISLATURE SHOULD ADDRESS THE NECESSITY FOR A SLIDING SCALE OF FINANCIAL CONTRIBUTION BY THE RESIDENTS TOWARD THE END THAT THE RESIDENTS PAY WHAT THEY CAN AFFORD BEFORE THE TAXPAYERS PICK UP THE TAB. MANY RESIDENTS OF PIONEERS HOMES AMASS ASSETS FOR THEIR HEIRS WHILE IN THE HOMES. THIS PROBLEM COULD BE CORRECTED BY A CHANGE OHE RULES WITHIN THE DIVISION OF PIONEERS BENEFITS AND WOULD NO DOUBT RESULT IN FEWER APPLICATIONS FOR ADMITTANCE INTO THE HOMES. THUS, THE PROBLEM THAT HB 374 ADDRESSES COULD BE RESOLVED WITHOUT ADDITIONAL LEGISLATION.

JHEO%/

Original

THE LEGISLATURE OF THE STATE OF ALASKA
ELEVENTH LEGISLATURE

FISCAL NOTE

I. REQUEST
Bill/Resolution No. HB 374
Title An act relating to equalizing the cost of full time residential or nursing care *
Requested by Duncan and Miller Date 4/11/79

* for pioneer Alaskan's.

II. FISCAL DETAIL
Agency Affected Div. of Pioneers' Benefits/Department of Administration
Program Category Affected Social Services
Budget Request Unit(s) Affected Alaskan Pioneers' Home

EXPENDITURES (Thousands of Dollars)

	FY 79	FY 80	FY 81	FY 82	FY 83	FY 84
100 PERSONAL SERVICES		185.1	199.9	215.9	(Cost are	assumed to
200 TRAVEL		6.0	6.5	7.0	increase	at the same
300 CONTRACTUAL		7.0	7.6	8.2	rate)	
400 COMMODITIES		3.5	3.8	4.1		
500 EQUIPMENT		2.8	3.0	3.3		
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC.		7,876.0	8,663.6	9,529.9		
TOTAL		8,080.4	8,884.4	9,768.4		

FUNDING (Thousands of Dollars)

GENERAL FUND		8,080.4	8,884.4	9,768.4		
FEDERAL FUNDS						
OTHER (Specify)						

POSITIONS

FULL TIME		3	3	3		
PART TIME		8	8	8		
TEMPORARY						

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

Administrative costs were determined based on the assumption that the Department of Administration would have an RSA with the Department of Health & Social Services to provide the administrative support. (See Attachment A)

Cost for nursing and residential care assumes that the rates for care and the number of people served will remain constant. (See Attachment B)

IV. DATE 4/11/79 PREPARED BY George Elgee
AGENCY Office of the Commissioner/Dept.
PHONE 465-2217

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)

33-001 (Rev. 10/78)

ATTACHMENT A
HB 374
Personal Services

(1) Assumption: The costs are based upon the Department of Administration having an RSA with the Department of Health & Social Services to provide the administrative support. In order to provide this support it will require the following personnel:

Medical Surveillance Officer	(1/4)	$ 11,820 -
Central Office Coordinator	(1/2)	13,116 -
Fiscal Compliance Auditor	(1)	22,656 -
Social Worker	(1/2)	9,774 -
Social Worker	(1/2)	9,774 -
Social Worker	(1/2)	9,774 -
Social Worker	(1/2)	9,774 -
Social Worker	(1/2)	9,774 -
Social Worker	(1/2)	9,774 -
Administrative Assistant II	(1)	19,548 -
Accounting Clerk II	(1)	14,136 -
	Total	$ 139,920
Benefits: .2383 % plus $141.32 per mon/per person		45,211
		$ 185,131
8% FY 81		$ 199,941
8% FY 82		$ 215,936

ATTACHMENT B
HB 374
Schedule of Costs for Residential & Nursing Care

The potential eligible population is estimated to be approximately 10,000 people.

National statistics indicate that 5% of this population will need nursing care and 9% will need some sort of alternative care.

Presently (as of Feb. 1979) 409 people are receiving nursing care statewide and 284 people are receiving residential care at the Pioneers' Homes.

5% of 10,000 equals 500 people. 409 people are receiving nursing care which indicates that 91 people (500-409= 91) need nursing care. 9% of 10,000 equals 900 people. 284 people are receiving residential care which indicates that 616 people (900-284 = 616) need some sort of residential care.

The rates for nursing care and residential care as provided by the Department of Health and Social Services indicates a rate of $88 per day for nursing care and $900 per month for residential care. The Pioneers' Home presently charge $275.00 per month for nursing care and $225.00 per month for residential care. This will reduce the rates for nursing care to $79.00 per day and residential care to $675.00 per month.

Nursing Care Costs

(As of Feb. 1979)	91 people X $79/day X 365/days =	$ 2,623.9
FY 80	10% inflation factor =	$ 2,886.4
FY 81	10% inflation factor =	$ 3,175.0
FY 82	10% inflation factor =	$ 3,492.5

Residential Care Costs

*FY 80	616 people X $675/mo. X 12 mo. =	$ 4,989.6
FY 81	10% inflation factor =	$ 5,488.6
FY 82	10% inflation factor =	$ 6,037.4

Municipality of Anchorage

POUCH 6-650
ANCHORAGE, ALASKA 99502
(907) 264-4431

GEORGE M. SULLIVAN,
MAYOR

OFFICE OF THE MAYOR

March 26, 1979

Thelma Buchholdt
House of Representatives
Pouch V
Juneau, AK 99811

Dear Representative Buchholdt:

Under provisions of Section 504 of the Rehabilitation Act of 1973 the U.S. Congress mandated that no otherwise qualified handicapped individual in the United States shall solely by reason of his or her handicap be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance. The implementation of Section 504 is now being enforced by all Federal Departments. In June of 1978, the U.S. Department of Transportation issued guidelines for enforcement of Section 504 which are predicated on a new definition of a handicapped person. This Federal interpretation is much more liberal than the current definition used by the Municipality of Anchorage for our handicapped program. It will undoubtedly require future expansion of our present program in order for the Municipality to comply with Section 504 guidelines.

Supplemental handicapped transportation (demand responsive, curb to curb service) as set forth by the current Municipality of Anchorage specifications was started January 1, 1977 on a six month contractual trial basis with a budget of $22,000. Completion of this trial program indicated a strong need for continuing this type of supplemental service. As a result of this demonstration project the program was funded by the Municipality of Anchorage for the remainder of 1977. In 1978, $75,000 was budgeted for this program and the same amount likewise was budgeted for 1979. To date all funding for this program has come from the Municipality's general fund as opposed to the Senior Citizen Transportation Program which has been heavily funded by State grants.

Ridership for Transportation of the Handicapped Program in 1978 was 13,223. The present operation is sub-contracted to Far North Transportation, Inc. Each handicapped applicant with a supplemental card (issued by the Municipality of Anchorage) is entitled to the use of this service daily between the hours of 7:00 a.m. and 7:00 p.m. Transportation needed for special occasions such as plays, dinners, etc. are available by special request between the hours of 7:00 p.m. and 11:00 p.m. This is a service demand transportation program with a 24-hour advance call for demand response. There is one unit available with a lift for those patrons with wheelchair needs. During the first part of May the Municipality anticipates the delivery of two additional wheelchair lift units. At present there are approximately 350 handicapped supplemental passes issued in the Anchorage area based on the criteria above.

One of the main elements of the handicapped program has been the Municipality's definition of handicapped eligibility, which has used the following criteria:

1. Non-ambulatory disability requiring the use of wheelchairs;
2. Semi-ambulatory disability requiring the use of braces or crutches or other prosthetic devices;
3. Functional blindness.

The Federal government in effect now will require us to expand our definition. The following is an exerpt from the Federal Register, dated June 8, 1979:

> Under Section 504 the handicapped person means any person who (1) has a physical or mental impairment that substantially limits one or more major life activities, (2) has a record of such an impairment, or (3) is regarded as having such an impairment. As used in this definition (1) "Physical or mental impairment" means any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: neurological, musculoskeletal, special sense organs, respiratory, including speech organs, cardiovascular, reproductive, digestive, genito-urinary, hemic and lymphatic, skin and endocrine, or any mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities. The term "physical or mental impairment" includes, but is not limited to, such diseases and conditions as orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, mental retardation, emotional illness, drug addiction, and alcoholism.
>
> "Major life activities" means functions such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working.
>
> "Has a record of such an impairment" means has a history of, or has been classified, or misclassified, as having a mental or physical impairment that substantially limits one or more major life activities.
>
> "Is regarded as having an impairment" means has a physical or mental impairment that does not substantially limit major life activities but that is treated by a recipient as constituting such a limitation; has a physical or mental impairment that substantially limits major life activity only as a result of the attitudes of others toward such an impairment; or has none of the impairments set forth in the preceding paragraphs of definition, but is treated by a recipient as having such an impairment.

By altering our Transportation of the Handicapped Program to include all handicapped persons meeting the Section 504 definition, the Municipality of Anchorage expects to quadruple our present ridership. Utilizing Section 504 criteria, it is estimated that in the Anchorage area there is in excess of 6,000 potential handicapped riders. Considering the additional equipment on order as well as the projection of available handicapped riders using the new criteria, the Municipality would need a 1980 budget in excess of $260,000 in order to maintain the same level of service. We plan to maximize the load

factor and reduce the cost per passenger, which hopefully would reduce the total 1980 budget to approximately $200,000.

As a result of past discrimination of handicapped persons, and the Federal mandate of Section 504, which requires correction of these discrepancies, the Municipality plans to commit itself to comply with these new regulations and urges the State of Alaska to jointly fund our Transportation of the Handicapped Program with a grant of $100,000. The Municipality will match this amount. This action will help distribute in an equitable manner State and local government's financial obligation to the handicapped and will enable the program to be partially funded by the State similar to the State's current funding of the Transportation of the Elderly Program. Your legislative support of this proposed joint program is requested.

Sincerely,

George M. Sullivan
Mayor

Municipality of Anchorage

MEMORANDUM

DATE: January 2, 1979

TO: Opportunities For The Handicapped Commission

FROM: Douglas Weiford, Municipal Manager

SUBJECT: Proposed Definitions of the term "Handicapped"

Listed below are three definitions of the term "handicapped". Please review and discuss the language of each definition and comment with regard to its suitability to the Municipality's transportation program for the handicapped.

1. "Physical Handicap" means any physical disability, infirmity, malformation, or disfigurement which is caused by bodily injury, birth defect, or illness including epilepsy, and includes any degree of paralysis, amputation, lack of physical coordination, blindness or visual impediment, deafness or hearing impediment, or physical reliance on a guide dog for the blind, wheelchair, or other remedial appliance or device.

   Source: 6 AAC 30.170(B) (current Alaska Human Rights Commission definition.

2. "Handicapped" means any person who is unable to use the mass transportation system without special facilities by reason of a physical or mental impairment or disability and has been so certified by a doctor licensed by the State of Alaska.

   Source: New.

3. "Handicapped Persons" means those individuals who by reason of illness, injury, congenital malfunction, or other permanent or temporary incapacity or disability, including those who are non-ambulatory wheelchair bound and those with semi-ambulatory capabilities, are unable without special facilities or special planning or design to utilize mass transportation facilities and services as effectively as persons who are not so affected.

   Source: 49 USC 609.3 (current UMTA definition).

MUNICIPALITY OF ANCHORAGE

D. J. Weiford

Douglas Weiford
Municipal Manager

DW:JG:ah

Original sponsors: Duncan and Miller

IN THE HOUSE

BY THE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

CS FOR HOUSE BILL NO. 374

IN THE LEGISLATURE OF THE STATE OF ALASKA

ELEVENTH LEGISLATURE - FIRST SESSION

A BILL

For an Act entitled: "An Act relating to equalizing the costs of full-time residential or nursing care."

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

* Section 1. AS 47.25 is amended by adding new sections to read:

Sec. 47.25.103. CONTRACTUAL AGREEMENTS. (a) The commissioner of administration shall enter into contractual agreements with licensed institutions providing full-time residential or nursing care for the elderly to provide care to Alaska residents eligible under AS 47.25.108. A contractual agreement under this section shall provide for payment of the full daily (or monthly equivalent) charges by the institution for each eligible patient, less the amount charged under AS 47.25.030 for the equivalent level of care for a patient at the Alaska Pioneers' Home. The commissioner shall enter into an agreement under this section with the type of institution that is consistent with an individual's treatment needs.

(b) In this section the phrase "institution providing full-time residential care" means an institution

(1) that provides minimum basic care and protective supervision of residents of the institution;

(2) that does not routinely provide nursing or other medical services; and

(3) that is licensed under AS 47.35.020.

Sec. 47.25.108. ELIGIBILITY. A person is eligible to receive contractual services under AS 47.25.103 if

(1) he is eligible for admission into the Alaska Pioneers' Home under AS 47.25.010 - 47.25.110;

(2) he is not eligible for benefits from any source that would pay for the cost of full-time residential or nursing care;

(3) he resides more than 50 miles, by highway, from the Alaska Pioneers' Home, or he cannot be admitted to the Alaska Pioneers' Home because the home is full to capacity; and

(4) he is at risk of being institutionalized outside of his community if care is not provided under AS 47.25.103.

House Health, Education & Social Services Committee Meeting/Hearing on HB374 Date: 3/11/80

	Name	Address and Phone	Organization/Self	For/Against or Observing
1/	Duncan (Joyce ?)			
2/	Com. Helen Bevins		H&SS	
3/	Sue Green		administration	
4/				
5/				
6/				
7/				
8/				
9/				
10/				
11/				
12/				
13/				

THE LEGISLATURE OF THE STATE OF ALASKA
ELEVENTH LEGISLATURE

FISCAL NOTE

I. REQUEST
Bill/Resolution No. H.B. 374
Title An Act relating to providing for full-time residential care for Pioneer Alaskans
Requested by _____ Date _____

II. FISCAL DETAIL
Agency Affected Administration
Program Category Affected Social Services
BRU, Program, or Subprogram(s) Affected Pioneers' Homes
(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

		FY80	FY 81	FY 82	FY 83	FY 84	FY 85
100	PERSONAL SERVICES		0	0	0	(costs are assumed	
200	TRAVEL		6.5	7.2	7.9	to increase at the	
300	CONTRACTUAL		263.1	289.4	318.3	same rate.)	
400	COMMODITIES		3.8	4.1	4.5		
500	EQUIPMENT		7.0	0	0		
600	LAND & STRUCTURES						
700	GRANTS, CLAIMS, ETC.		12,640.3	14,599.6	16,862.5		
	TOTAL		12,920.7	14,900.3	17,193.2		

FUNDING (Thousands of Dollars)

GENERAL FUND		12,920.7	14,900.3	17,193.2		
FEDERAL FUNDS						
OTHER (Specify Fund Source)						

POSITIONS

FULL TIME		4	4	4		
PART TIME		7	7	7		
TEMPORARY						

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)
Administrative costs were determined based on the assumption that the Department of Administration would have an RSA with the Department of Health and Social Services to provide the administrative support (See attachment A).

IV. DATE 3/10/80 PREPARED BY George J. Michael
AGENCY Administration
PHONE 465-4401

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)

33-001 (Rev. 12/78)

ATTACHMENT A
H.B. 374
Personal Services

(1) Assumption: The costs are based upon the Department of Administration having an RSA with the Department of Health and Social Services to provide the administrative support. In order to provide this support it will require the following personnel:

Medical Surveillance Officer	(1/2)	$ 17,503
Central Office Coordinator	(1)	32,538
Fiscal Compliance Auditor	(1)	32,538
Social Worker	(1/2)	12,210
Social Worker	(1/2)	12,210
Social Worker	(1/2)	12,210
Social Worker	(1/2)	12,210
Social Worker	(1/2)	12,210
Social Worker	(1/2)	12,210
Administrative Assistant II	(1)	24,420
Clerk Typist III	(1)	16,856
Subtotal		$197,115
Benefits: 21% plus $127 per month/person		58,158
Total FY 81		$255,273
Total FY 82		$280,800
Total FY 83		$308,880

Inflation of 10% per year is assumed.

ATTACHMENT B
H.B. 374
Schedule of Costs for Residential & Nursing Care

The potential population of people in Alaska over 65 years of age is estimated to be approximately 12,000 people. However, not all these people would qualify under the eligibility requirements of H.B. 374, particularly the 15-year residency. The total number of people which would be eligible is approximately 10,000.

National statistics indicate that 5% of this population will need nursing care and 9% will need some sort of alternative care. Alaskan experience is somewhat higher due to inclement weather and the fact that more elderly Alaskans are not able to benefit from having a family nearby. A figure of 8% is more realistic for nursing care and 12% for residential care.

Presently 644 people are receiving nursing care from privately operated or municipal facilities and 154 are in Pioneers' Homes, for a total of 798 people presently receiving nursing care. Two hundred eighty-eight people are currently receiving residential care in Pioneers' Homes.

Eight percent of 10,000 eligible people equals 800 people. Seven hundred ninety-eight people are presently receiving nursing care, which indicates that substantially all people needing nursing care are receiving that care through some means.

Twelve percent of 10,000 people equals 1,200 people. Two hundred eighty-eight people are presently receiving residential care in the Pioneers' Homes. The number of needy persons receiving residential care in private homes is not known, but it is presumed to be negligible. Therefore, it is believed that 912 eligible people could benefit from residential care in Alaska.

The rates for nursing and residential care as provided by the Department of Health and Social Services averaged $2,670 per month per person for nursing care and $1,000 per month per person for residential care.

The above figures are based on present experience. It is believed that need will grow at approximately 5% per year due to the following:

1. More elderly people will be retiring in Alaska in the future due to improvements in services and benefits to the elderly.

2. H.B. 374 will make it possible to obtain care which has not been available in the past due to economic hardship.

Therefore, a 5% per year growth rate is projected.

Additional Cost of H.B. 374

Residential Care

FY 81 912 people x 105% x $1,000 x 12 + 10% inflation = $12,640,320
FY 82 FY 81 + 5% increased need + 10% inflation = $14,599,569
Fy 83 FY 82 + 5% increased need + 10% inflation = $16,862,501

M9/C

POSITION PAPER/Department of Health & Social Services

POSITION PAPER
ON
HOUSE BILL NO. 374

"An Act relating to equalizing the costs of full time residential or nursing care."

House Bill 374 amends the statutes to allow the Commissioner of Administration to enter into contracts with private residential and nursing care providers to purchase services for certain senior Alaskans who are eligible for Pioneer Home benefits. These eligible persons must meet:

1. All eligibility requirements for admission into the Alaska Pioneer Homes, including being age 65 or over and having at least 15 years of continuous Alaska residency immediately prior to admission;

2. Are not eligible for benefits from any sources (including Medicare, Medicaid or private medical insurance) that would pay for the cost of full-time residential or nursing care; and

3. Do not reside less than 50 highway miles from a Pioneer's Home that has bed space available and could admit the individual.

The Department of Adminis ration would pay for the fees charged by the facility less the monthly contribution of $225-$250 that pioneers are required to contribute if they are able to pay towards their cost of care.

General Overview

Most social scientists, health professionals, and seniors themselves acknowledge the advantage of keeping older persons in their communities and preferably in their own homes. Remaining in the community, even in cases of where the person is in an institution, enhances the senior's morale and provides security of familar settings and being close to family and friends. Too often in Alaska seniors are not given the choice of remaining in their home community when they become in need of medical or social support services, because the services they need are often unavailable or unaffordable. House Bill 374 would increase the access to residential and nursing home care for certain pioneer Alaskans who were unable to receive them from the Pioneer's Home Program due to unavailable bed space in a Pioneer's Home facility within 50 highway miles from the person's home community.

Discussion Items

1. There are many pioneers living in communities outside of the towns where Pioneer's Homes are located. In some cases such as in Juneau and Bethel, there are facilities with available bed capacity which could provide the care that these pioneers need. Presently, the

POSITION PAPER/Department of Health & Social Services

Pioneer's Home Program is limited to the provision of care only on Pioneer Home facilities and the program is not designed to purchase care from local community resources. Relocation of seniors to a Pioneer's Home in a different community at this time in the older person's life may cause a hardship on the patient, as well as his/her family.

2. There are many pioneers, as well as other seniors, who are financially unable to pay for the purchase of care in a local facility. Costs of residential care can sometimes run from $800-$1,200 a month, while nursing home care costs are considerably higher at $1,500-$4,000 a month. Senior pensions of over $625 a month are inadequate to purchase the care, but make the person financially ineligible for coverage by Medicaid or other public assistance programs.

3. Insurance coverage for residential or nursing home coverage is extremely limited. Most policies, if they cover nursing care services, at all limit coverage to 30 days of care. Also, the care generally must be necessary in place of more costly hospital care services. Residential care, since it generally does not include medical services, is not reimburseable by virtually all insurance and assistance programs to our knowledge (including Medicaid and Medicare).

4. The Department of Health and Social Services has experienced a few cases this fiscal year of pioneers who are eligible for Pioneer's Home admission, but are in need for specialized or intensive medical care that is unavailable at the Pioneer's Homes facility. These persons who are determined "too sick" to be appropriately placed in Pioneer's Homes are currently receiving care in private nursing facilities. Often the person's resources are inadequate to cover the nursing home bill, yet they are over income to be eligible for public assistance. The bill would have to be amended to allow coverage of these individuals.

5. House Bill 374 provides for the Department of Administration to base reimbursement rates on the fees charged. Our experience through Medicaid, General Relief-Medical, and Social Services programs has found that providers often charge amounts in excess to their actual allowable costs under the program. Also, allowing fees charged by providers to be reimburseable would provide no incentive for cost containment by the residential and nursing care facilities. We would recommend the Committee consider linking the rates paid under H.B. 374 to the state fees allowed under Medicaid for nursing homes or under the Division of Social Services for residential care.

6. The legislature is currently considering the passage of the Older Alaskan's Commission through H.B. 618 and S.B. 328. This Commission was designed to address these long range aging issues. It may be

POSITION PAPER/Department of Health & Social Services

appropriate, in light of the significant change of direction of H.B. 374, to reserve judgement until such a issue could be formally addressed by the Commission and/or Governor's Advisory Committee on Aging and Pioneer's Home Board.

7. In many areas of Alaska, especially in the remote ones, pioneers may still be required to leave their communities to receive care even if H.B. 374 were passed. Residential care and nursing home services are generally only available in urban areas and rural regional centers. This bill, though, may serve as an important catalyst to encourage private enterprise to develop facilities in those areas in the future by providing an important source of continuing revenue to pay for operating expenses.

Department's Position

The Department of Health and Social Services recognizes the need addressed in House Bill 374 and is supportive of the concept of increasing the availability of services to permit seniors to remain in their local communities.

Approved by: Helen D. Beirne 3/11/80

Helen D. Beirne, Commissioner
Department of Health and Social Services

(DATE)

NURSING HOMES

CENSUS: January 1980

	Current Rate		Certified Capacity			Current Occupancy: Medicaid DPA* Placements		Current Occupancy: Non-DPA Placements		Current Census	Vacant Beds	% Occupancy of Total Beds	
	ICF	SNF	ICF	SNF	Total	ICF	SNF	Medicare	Other***			Overall	Medicaid
areage House (Anchorage)	55.00		101**		101	37	0	0	2	39	62	39%	37%
areage North (Fairbanks)	84.50	93.00	101		101	52	24	0	2	78	23	77%	75%
ordova Hospital L.T.C	— 125.68 —		8		8	4	0	0	1	5	3	63%	50%
etchikan Hospital L.T.C.	73.31		48		48	37	0	0	1	38	10	79%	77%
akoyia (Anchorage)	103.00	125.00	116**	100	216	39	99	0	6	144	72	67%	64%
orton Sound Hosp. L.T.C. (Nome)	100.00		6**		6	6	0	0	0	6	0	100%	100%
etersburg Hosp. L.T.C.	51.30	57.00	12		12	7	1	0	2	10	2	83%	67%
outh Peninsula Hosp. L.T.C. (Homer)	108.00		4		4	3	0	0	0	3	1	75%	75%
St. Ann's (Juneau)	--126.56--		45		45	23	4	1	3	31	14	69%	60%
Valley Hospital L.T.C. (Palmer)	104.85		6		6	3	0	0	0	3	3	50%	50%
Wrangell Hospital L.T.C.	75.00	82.50	14		14	13	0	0	1	14	0	100%	93%
Wesleyan (Seward)	52.00		64		64	49	0	0	5	54	10	84%	77%
Kodiak Hospital L.T.C.	100.00		19**		19	8	0	0	0	8	11	58%	58%
TOTAL			544	100	644	281	128	1	23	433	211	67%	64%

ICF Certified Capacity means that all beds are certified for both SNF and ICF unless otherwise noted.

* includes GR Medical placements
** beds are certified for ICF only

Rod Betit 2/20/80

Rod Betit, Director — Date

Division of Public Assistance

Last year interest in this bill was one of several factors influencing the development of the Interim Committee on Elderly Services. As you are aware, one of the major recommendations of that interim work has been the legislation to establish the Older Alaskans Commission. Because we believe HB 374 to represent a significant change in direction for the Pioneers' Home Program, as originally designed by the Legislature, we believe that it deserves review and recommendation from the Pioneers' Home Board and Commission. Thus we first urge passage of the Older Alaskans Commission bill now in House Finance Committee.

The concept of dollars following the person eligible for entrance to a Pioneers' Home is not altogether undesirable, but it is fraught with several concerns that suggest it should be addressed in a comprehensive approach.

The program for the elderly are all creatures of the Legislature and can, of course, take new directions as desired by the Legislature. We would, however, urge an orderly approach to the new directions of services such as would be more readily available to you through the work of the Pioneers' Home Board and Commission during the next year or two.

A question must be raised regarding priorities when a bill with expensive price tags is addressed. As I read the testimony collected across the State by the Interim Committee on Services to the Elderly, high priority goes to finding a mechanism to assist the elderly and disabled who "fall through the cracks" of existing services and assistance programs, providing more home and health aide services to all elderly citizens, not just those meeting Pioneers' Home Program qualifications.

If there is sufficient need to address the needs of clients for whom HB 374 was designed prior to the establishment of the Commission and a comprehensive review, then we would recommend a less costly and more efficient approach through HB 781. The approach would be more efficient because the administrative framework and expertise exist in Health and Social Services and the Catastrophic Illness statute to which HB 781 applies is a logical vehicle. Further, the benefits would address a broader base of clients, not just pioneers.

Thus, the Department of Administration would urge (1) passage of HB 618 and the establishment of the Commission for planning and recommending the future direction of elderly services (2) involvement of the Pioneer Home Board with the Commission in that review and planning, and (3) if an interim measure is needed, the passage of HB 781 to cover both pioneer and other elderly clients.

from Sue Green

THE LEGISLATURE OF THE STATE OF ALASKA
ELEVENTH LEGISLATURE

FISCAL NOTE

I. REQUEST
Bill/Resolution No. H.B. 374
Title An Act providing for full-time residential care for Pioneer Alaskans
Requested by Representative Buchholdt Date 3/18/80

II. FISCAL DETAIL
Agency Affected Administration
Program Category Affected Social Services
Budget Request Unit(s) Affected Pioneers' Homes

EXPENDITURES (Thousands of Dollars)

	FY80	FY81	FY82	FY 83	FY 84	FY85
100 PERSONAL SERVICES					(costs are assumed to	
200 TRAVEL					increase at the same	
300 CONTRACTUAL		2,983.0	2,857.5	3,285.7	rate)	
400 COMMODITIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC.						
TOTAL		2,983.0	2,857.5	3,285.7		

FUNDING (Thousands of Dollars)

GENERAL FUND		2,983.0	2,857.5	3,285.7		
FEDERAL FUNDS						
OTHER (Specify)						

POSITIONS

FULL TIME		4	4	4		
PART TIME		3	3	3		
TEMPORARY						

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

This fiscal note is based on initiation of a pilot project which would serve Southeastern Alaska only and provide for residential care only. In a recent review of need for skilled nursing care, it became apparent that substantially all of the elderly people in Alaska who need nursing care are receiving that care through some means, although there were a few cases where the person had some sort of difficulty financially in paying for necessary services. These cases generally fell into the category of having too much income to qualify for state or federal assistance, but not enough income to fully cover cost of services where special or intensive care is necessary.

(continued)

IV. DATE 3/17/80 PREPARED BY ~~George~~ T. Michael
AGENCY Administration
PHONE 465-4401

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named) Representative Duncan
Office of the Governor, Keith Specking

33-001 (Rev. 10/78)

Rationale for Determining Costs for Residential Care

The population of people in Southeastern Alaska over 65 years of age is estimated to be approximately 2,207 people. However, not all these people would qualify under the eligibility requirements of H.B. 374, particularly the 15-year residency. The total number of people which would be eligible in Southeastern Alaska is approximately 265.

These figures were arrived at by analyzing the statistics of an existing program for the elderly, the Alaska Longevity Bonus Program. February 1980 recipients of the Longevity Bonus were 2,006 in Southeastern Alaska, and 5,736 for the balance of the state. This gives a baseline of data which indicates that 26% of the state's total population over 65 have resided in Southeastern Alaska continuously for at least 25 years, the minimum for eligibility for the Alaska Longevity Bonus. This is twice the average of the population of all ages, which is 5,400 in Southeastern to 362,000 for all the rest of the state, according to most current statistics of the Department of Labor.

The minimum length of continuous residence in Alaska to be eligible for benefits under H.B. 374 is only 15 years. Therefore, it is assumed that the percentage of eligible population would be approximately 10% higher than the Longevity Bonus statistics, or 36% of the people 65 years of age and older residing in the state because of the lesser residency requirements. This is considered to be a conservative figure, since not all people over 65 and eligible have applied for and receive the Longevity Bonus.

National statistics indicate that 9% of the population 65 and older will need residential or alternative care. Alaskan experience is higher due to more inclement weather and the fact that more elderly Alaskans are not able to benefit from having a family nearby to assist them. A figure of 12% is more realistic.

Ten percent added to 2,006 (Longevity Bonus recipients) equals 2,207 people. Twelve percent of 2,207 elderly people equals 265 people. Sixty-seven residents are presently being cared for in the Sitka Pioneers' Home and a nominal amount in other facilities. Beginning approximately January 1, 1982, fifteen to twenty residents will be cared for at the Ketchikan Pioneers' Home.

Rates for residential care average $1,000 per month per person, according to the Department of Health and Social Services.

The above figures are based on present experience. It is believed that need will grow at approximately 5% per year due to the following:

1. More elderly people will be retiring in Alaska in the future due to improvements in services and benefits to the elderly.

2. H.B. 374 will make it possible to obtain care which has not been available in the past due to economic hardship.

Therefore, a 5% per year growth rate is projected.

Cost of Residential Care

FY 81 — 265 people less 67 people (cared for at Sitka Pioneers' Home) x 105% x $1,000 x 12 months + 10% inflation = $2,744,280

FY 82 — FY 81 less 10 people (20 people cared for at Ketchikan Pioneers' Home for 6 mo.) + 5% increased need x $1,000 x 12 mo. + 10% inflation = $2,605,680

FY 83 — FY 82 + 5% increased need + 10% inflation = $3,009,560

Personal Services Costs

	No. of Positions	
Medical Surveillance Officer (R19)	1/2	$ 16,467
Program Coordinator (R21)	1	37,890
Fiscal Compliance Auditor (R18)	1/2	15,315
Social Worker (Juneau) (R16)	1	26,538
Social Worker (Ketchikan) (R16)	1/2	13,269
Administrative Assistant II (R14)	1	23,070
Clerk Typist III (R8)	1	16,020
Subtotal Salaries		$148,569
Benefits: 21% of salaries plus $127/mo. per person		$ 39,581
Total FY 81 Salaries & Benefits		$188,150
Total FY 82 Salaries & Benefits		$203,876
Total FY 83 Salaries & Benefits		$223,416

Salaries are computed in accordance with the State's new salary schedules (C.S.S.B. 182) for the period July 1, 1980, through December 31, 1981. Inflation of 10% per year is assumed for salaries after December 31, 1981.

Other Program Costs	FY 81 Costs
Travel: This would fund travel for one full-time social worker in Juneau and one half-time social worker in Ketchikan. These workers would travel to all cities and villages with a population of at least twenty-five persons where assistance is needed in relation to this program. Travel is also needed for the program coordinator. Travel between Juneau and the larger cities would be needed at the outset of the program and thereafter once a year (Yakutat, Sitka, Petersburg, Wrangell, Ketchikan) in monitoring the program.	$ 29,872
Contractual Services: Office and program operating expense, such as telephones, postage, copying, printing, etc., for the staff of two full-time and five part-time personnel. Only a small allowance is included for office space under the assumption that most personnel would be operating in already existing state office space.	$ 11,000
Commodities: Office supplies for office and field staff.	$ 2,700
Equipment: Initial outfitting of new positions with office furnishings and equipment.	$ 7,000

If H.B. 374 is approved and the Department of Administration is funded for this pilot project, it is proposed to RSA these funds to the Department of Health and Social Services, for the staff to be their staff, and for them to operate the program. This program fits precisely into the type of social services programs operated by that department.

Ten percent inflation is included in "other" program costs for years beyond FY 81.

M9/L

Honorable Chairperson & Committee members

8 yrs CW Supt. grandpa
3 yrs Clerical Sec. NSPHS
8 yrs Ass A HHAS
Bd in 3 Nursing Homes
Capt 7 Pendelton

Subject: HB 374 Today 1:00 Room 112

The passage of this Bill into law will enable many older persons to remain in their own homes as long as possible and help hold families together.

For 8 years, I was Director of Alaska Homemaker-Home Health Aide Service. Our basic funding originally was from the Older Americans Act, Office of Aging. In 1974-75, this agency served statewide 253 older Alaskans. By age groups there were

Age	Number
55-60	12
60-65	20
* 65-70	131
70-75	25
75-80	18
80-85	20
85-90	12
90-95	10
95-100	2
100-113	3
	253

D. Duncan -
H. Bigne - HB 55
Edge - Admin
Sobocan - Legislative
Hanson - Exec

With a network of quality homemaker-home health aide service and local nursing homes re-instituted from the pioneer fund, Senior Alaskans can remain in their own homes & own communities

[illegible] Juneau and family and dear
[illegible] Mary Jean, Her grandaughter
[illegible] granddaughter pleaded unsuccess-
[illegible] remained to keep her at home - we did
[illegible] what they could afford. Often I
[illegible] in the back room - some have
[illegible] and their agency [illegible]

Dove M Kull, [illegible] Chairperson Mgt. & C.S.W.
[illegible] Chapter of American Assn of Retired
[illegible] on the Chapter

3-24-79

Mrs. Dove M. Kull
Mendenhall Apts. #1010
326 - 4th Street
Juneau, Alaska 99801

Mr. Robt. Butler, Dir. D.H.Agency
Re-Home Care as set to less offensive

as long as possible. This plan would be less traumatic for human beings; and, per person, less expensive for government.

ELEVENTH LEGISLATURE

FISCAL NOTE

I. REQUEST

Bill/Resolution No. House Bill 374

Title "An Act providing for full-time residential care for Pioneer Alaskans."

Requested by Representative Jim Duncan Date March 25, 1980

II. FISCAL DETAIL

Agency Affected Administration

Program Category Affected Social Services

BRU, Program, or Subprogram(s) Affected Pioneers' Homes

(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 80	FY 81	FY 82	FY 83	FY 84	FY 85
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL		674.8	1,323.9	1,518.1	1,738.1	1,987.4
400 COMMODITIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC.						
TOTAL		674.8	1,323.9	1,518.1	1,738.1	1,987.4

FUNDING (Thousands of Dollars)

GENERAL FUND		674.8	1,323.9	1,518.1	1,738.1	1,987.4
FEDERAL FUNDS						
OTHER (Specify Fund Source)						

POSITIONS

FULL TIME		2	2	2	2	2
PART TIME		1	1	1	1	1
TEMPORARY						

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

This fiscal note is based on initiation of a demonstration project which would serve Southeastern Alaska only and provide for residential and nursing care of those who are eligible to enter Pioneer's Homes under AS 47.25.010-110, are not eligible for benefits from any source that would pay for the cost at full-time residential and nursing care, who reside more than 50 miles from the Alaska Pioneer's Home, and do not wish to enter the Pioneers' Home.

The number of elderly Alaskans who would benefit from this bill is unknown at the present time. The Department of Health and Social Services has some indication that some need exists, but cannot quantify that need.

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)

Prepared by: George Michael Date: March 25, 1980
Division/Office: Pioneers' Home PH: 465-4401
Department of Administration

33-001 (Rev. 12/79)

Residential Care

This demonstration project would verify the scope of need, and develop residential care capability in the private sector where virtually none now exists in Southeastern Alaska.

This fiscal note is based on the assumption that only seven (7) slots would be developed during FY 81, that twice that number of slots would be available and utilized during FY 82, and that the number of slots would increase by five (5) per year after FY 82.

Rates for residential care average $1,000 per month per person in FY 80. One thousand dollars, less $225 per month payable by the recipient under AS 47.25.030 would result in a net cost to the State of $775 per month per person.

Inflation at the rate of 10% per year is included throughout this fiscal note.

Cost of Residential Care

FY 81	7 slots X $775 X 12 mo. + 10% inflation	=	$ 71,610
FY 82	14 slots X $853 X 12 mo. + 10% inflation	=	157,634
FY 83	19 slots X $938 X 12 mo. + 10% inflation	=	235,250
FY 84	24 slots X $1,032 X 12 mo. + 10% inflation	=	326,938
FY 85	29 slots X $1,135 X 12 mo. + 10% inflation	=	434,478

Nursing Care

Based on statistics of the Department of Health and Social Services, a total of 23 vacant nursing beds are available in Southeastern Alaska at the present time. It is assumed that one-half of these beds would be filled in FY 81, and all 23 would be filled by FY 82.

The average cost for nursing care in FY 80 is $3,422 per month per person. Three thousand four hundred twenty-two dollars, less $275 per month payable by the recipient under AS 47.25.030 would result in a net cost to the State of $3,147 per month per person for FY 81. It should be noted that overall cost of care in the Pioneers' Homes is $2,110 per month per person for FY 81.

Cost of Nursing Care

FY 81	12 beds X $3,147 X 12 + 10% inflation	=	$ 498,485
FY 82	23 beds X $3,462 X 12 + 10% inflation	=	1,051,063
FY 83	23 beds X $3,808 X 12 + 10% inflation	=	1,156,109
FY 84	23 beds X $4,189 X 12 + 10% inflation	=	1,271,780
FY 85	23 beds X $4,610 X 12 + 10% inflation	=	1,399,596

Administrative Costs

At the outset, a Program Coordinator would be required to develop the program, contact prospective providers of residential and nursing care to encourage development of capacity in existing and/or new facilities, and guide those providers by setting standards, providing information relative to licensing, determining standard operating procedures, etc. When the program is up and running, the Program Coordinator will have the responsibility for successful continuation of the program.

A Social Worker is needed on a half-time basis to advise and assist the eligible elderly persons in obtaining benefits and with personal problems.

A Clerk Typist is needed for clerical support of the Program Coordinator and Social Worker.

		FY 81 Cost
Personal Services		$ 74,413
Salaries - Program Coordinator (R-18)	$29,580	
Social Worker III (R-16)(1/2)	12,792	
Clerk Typist III (R-8)	15,324	
Subtotal	$57,696	
Benefits	16,717	
Total Salaries and Benefits	$74,413	
Travel		14,000
For Program Coordinator and Social Worker		
Contractual Services		10,000
Office and program operating expenses		
Commodities		1,500
Office supplies for office and field staff		
Equipment		4,800
Outfitting of new positions with office furnishings and equipment		
Total Administrative Cost		$104,713

If House Bill 374 is approved and the Department of Administration is funded for this pilot project, it is proposed to RSA these funds to the Department of Health and Social Services to operate the program.

HB
391

OCSO INC. ARCHITECTS, ENGINEERS & PLANNERS

April 6, 1979

Representative Thelma Buchholdt
Pouch V
Juneau, Alaska 99811

Dear Representative Buchholdt:

Enclosed is a copy of my testimony on House Bill 391 which was presented at the hearing this morning. House Bill 391 relates to the topic of AEIDC's competition I wrote to you about earlier. Thank you for your interest in this matter.

Sincerely,

CONSTRUCTION SYSTEMS MANAGEMENT, INC.

Donald E. Slone, PE

bmn
Enclosure

CONSTRUCTION SYSTEMS MANAGEMENT, INC.
902 WEST INTERNATIONAL AIRPORT ROAD ANCHORAGE, ALASKA 99502 (907) 276-3033

April 6, 1979

TESTIMONY ON HOUSE BILL 391

"An Act relating to competition by the University of Alaska with private businesses."

TO: House Committee on Health Educational and Social Services and Judiciary

Mrs. Thelma Buchholdt, Chairperson

BY: Donald E. Slone
902 West International Airport Road
Anchorage, Alaska 99502 (276-3033)

Thank you for this opportunity to testify before your committee on House Bill 391. My name is Don Slone. I'm a professional engineer and a partner in an architectural/engineering firm in Anchorage.

My comments relate primarily to the Arctic Environmental Information and Data Center (AEIDC) and, secondarily, to other governmental agencies. This is not because I'm out to undermine AEIDC but because it is a University agency I'm familiar with. In fact, I feel AEIDC provides an important function, but for reasons they may either control or not control, they find it necessary to do work in areas that compete directly with my business.

The problem is that their ability (or need) to compete with private business is not well defined. Because of this and the legislative authority given to the University of Alaska to be "contract and be contracted with" the State's Ombudsman does not investigate complaints of competition with private businesses.

There is something morally wrong, though, when a public agency is allowed to acquire work on a competitive or even speculative basis. It is even worse when they maintain this is necessary to obtain the funding to support their staff level.

Any time a governmental agency attempts to procure work on a competitive basis, it tells me that my tax dollars are being used improperly. It is especially frustrating when such agencies are directly competing with my livelihood. I am, in those instances, quite literally supporting the competition.

And why? Because they are less costly or more efficient? I don't believe so. I expect other testimony here today will comment directly on the fallacy of governmental efficiency and subsidized rates; so I won't.

Instead, I'd like to state that the proposed House Bill 391, while being a step in the right direction, is inadequate because it attacks the symptom instead of the problem. The 20% cost differential tries to address the symptoms. The problem is that they are allowed to, or even have to, compete in order to function as a viable entity.

In AEIDC's case I feel they are placed in a competitive position by two factors:

First, they are apparently underfunded for the mission they feel they must fulfill.

Secondly, they are frequently asked by other governmental agencies to perform services they were not established to provide.

This creates pressure from both ends. Too much work and not enough dollars. They must then attempt to acquire other funds to keep up the staff level necessary for the inflated work load.

The solutions then seem apparent: remove both the ability and the need to compete.

I encourage you to expand this Bill to be something more than a monetary scale for measuring what is fair and not fair. What is "20% higher"? Is it based on a lump sum price? And if so, out of whose pocket does a cost overrun come? From the employees of the state or the state taxpayers? We know what happens in private industry.

Instead expand it to include:

1. clear legislative definition of agency purpose; and

2. restrictions against any competition with private businesses.

Care must be taken in writing a bill that tries to be a cure-all. There is the possibility of a backlash in trying to be too protective as was the case with the lien law. Perhaps have a statement of total non-competition intent is sufficient. Such action would provide the basis for the State's Ombudsman to investigate complaints.

The executive branch should be asked to establish administrative policy to use private enterprise whenever possible. Regulations must be implemented which delineate when governmental agencies can ask others to provide services and when those agencies should solicit proposals from private businesses. This will go a long way in limiting the "empire building" the State is often accused of.

As I said when I began, these comments relate to all governmental agencies. To AEIDC's credit, they seem to be a cost-conscience organization and try to avoid competition. It does not always happen. Usually pressure must be executed first. What we should do with this Bill is address the problem and not the symptoms. There are better uses for our tax dollars than funding our own demise.

Thank you.

Donald E. Slone, PE

CSO INC. ARCHITECTS, ENGINEERS & PLANNERS

Jl. 14.40.040 (3)

February 9, 1979

Representative Thelma Buchholdt
Pouch V
Juneau, AK 99811

Dear Representative Buchholdt:

I have attached a copy of a letter to Commissioner McAnerney explaining my concern about Arctic Environmental Information and Data Center's (AEIDC) ability to use tax dollars to compete with private enterprise on a project for which the Department of Community and Regional Affairs recently solicited letters of interest.

I objected on the basis that AEIDC uses taxpayer's money to compete for work that can be done by private Alaskan businesses. The State's Ombudsman's Office has informed me that it has no jurisdiction over the situation, and suggested recourse through the legislature.

Apparently when the University created AEIDC it was not their intent for AEIDC to compete with private enterprise. Nor was that the legislature's intent when it funded AEIDC in 1972 for arctic data collection and library services.

Statutory authority allows the University of Alaska to "contract and to be contracted with." It is through this loop hole that AEIDC, as a subpart of the University, has been providing services in areas that Alaskan businesses can and should be fulfilling. In the absence of clear legislative intent and executive authority, AEIDC has been operating under informal University administrative policy. I would like your assistance in clarifying this situation through the legislature.

The State's Ombudsman has a file and list of numerous complaints on this matter that may provide you a greater understanding of the concern by the State's taxpayers and businesses. If I can provide additional information, please contact me. Thank you for your assistance.

Sincerely yours,

CONSTRUCTION SYSTEMS MANAGEMENT, INC.

Donald E. Slone, P.E.

DES/bmn
Enclosure

CONSTRUCTION SYSTEMS MANAGEMENT, INC.
902 WEST INTERNATIONAL AIRPORT ROAD ANCHORAGE, ALASKA 99502 (907) 276-3033

CSM INC. ARCHITECTS, ENGINEERS & PLANNERS

April 6, 1979

Representative Thelma Buchholdt
Pouch V
Juneau, Alaska 99811

Dear Representative Buchholdt:

Enclosed is a copy of my testimony on House Bill 391 which was presented at the hearing this morning. House Bill 391 relates to the topic of AEIDC's competition I wrote to you about earlier. Thank you for your interest in this matter.

Sincerely,

CONSTRUCTION SYSTEMS MANAGEMENT, INC.

Donald E. Slone, PE

bmn
Enclosure

April 6, 1979

TESTIMONY ON HOUSE BILL 391

"An Act relating to competition by the University of Alaska with private businesses."

TO: House Committee on Health Educational and Social Services and Judiciary

Mrs. Thelma Buchholdt, Chairperson

BY: Donald E. Slone
902 West International Airport Road
Anchorage, Alaska 99502 (276-3033)

Thank you for this opportunity to testify before your committee on House Bill 391. My name is Don Slone. I'm a professional engineer and a partner in an architectural/engineering firm in Anchorage.

My comments relate primarily to the Arctic Environmental Information and Data Center (AEIDC) and, secondarily, to other governmental agencies. This is not because I'm out to undermine AEIDC but because it is a University agency I'm familiar with. In fact, I feel AEIDC provides an important function, but for reasons they may either control or not control, they find it necessary to do work in areas that compete directly with my business.

The problem is that their ability (or need) to compete with private business is not well defined. Because of this and the legislative authority given to the University of Alaska to be "contract and be contracted with" the State's Ombudsman does not investigate complaints of competition with private businesses.

There is something morally wrong, though, when a public agency is allowed to acquire work on a competitive or even speculative basis. It is even worse when they maintain this is necessary to obtain the funding to support their staff level.

Any time a governmental agency attempts to procure work on a competitive basis, it tells me that my tax dollars are being used improperly. It is especially frustrating when such agencies are directly competing with my livelihood. I am, in those instances, quite literally supporting the competition.

And why? Because they are less costly or more efficient? I don't believe so. I expect other testimony here today will comment directly on the fallacy of governmental efficiency and subsidized rates; so I won't.

Instead, I'd like to state that the proposed House bill 391, while being a step in the right direction, is inadequate because it attacks the symptom instead of the problem. The 20% cost differential tries to address the symptoms. The problem is that they are allowed to, or even have to, compete in order to function as a viable entity.

In AEIDC's case I feel they are placed in a competitive position by two factors:

First, they are apparently underfunded for the mission they feel they must fulfill.

Secondly, they are frequently asked by other governmental agencies to perform services they were not established to provide.

This creates pressure from both ends. Too much work and not enough dollars. They must then attempt to acquire other funds to keep up the staff level necessary for the inflated work load.

The solutions then seem apparent: remove both the ability and the need to compete.

I encourage you to expand this Bill to be something more than a monetary scale for measuring what is fair and not fair. What is "20% higher"? Is it based on a lump sum price? And if so, out of whose pocket does a cost overrun come? From the employees of the state or the state taxpayers? We know what happens in private industry.

Instead expand it to include:

1. clear legislative definition of agency purpose; and

2. restrictions against any competition with private businesses.

Care must be taken in writing a bill that tries to be a cure-all. There is the possibility of a backlash in trying to be too protective as was the case with the lien law. Perhaps have a statement of total non-competition intent is sufficient. Such action would provide the basis for the State's Ombudsman to investigate complaints.

The executive branch should be asked to establish administrative policy to use private enterprise whenever possible. Regulations must be implemented which delineate when governmental agencies can ask others to provide services and when those agencies should solicit proposals from private businesses. This will go a long way in limiting the "empire building" the State is often accused of.

As I said when I began, these comments relate to all governmental agencies. To AEIDC's credit, they seem to be a cost-conscience organization and try to avoid competition. It does not always happen. Usually pressure must be executed first. What we should do with this Bill is address the problem and not the symptoms. There are better uses for our tax dollars than funding our own demise.

Thank you.

Donald E. Slone, PE

DARBYSHIRE & ASSOCIATES
community planning and management services

January 14, 1980

The Honorable Thelma Buchholdt
House of Representatives
State of Alaska
Pouch V
Juneau, Alaska 99811

Dear Representative Buchholdt:

Thank you for inviting us to express our views on the most desirable relationship between state research projects, the University of Alaska, and the private consulting community. While we acknowledge a need for universtiy-level research, the role of the university should be clearly spelled out if the state and its citizenry, and the university and its students, are to benefit. This letter outlines some of the considerations that we feel should be taken intc account in defining the most effective role for the university's research agencies.

As a starting point, I would like to examine what has transpired to date. Historically, the state has wisely authorized and funded a variety of university research agencies (e.g. ISER, AEIDC, etc.). These actions were founded on good intentions and a need to fill a specific research requirement. Unfortunately, such research organizations don't seem to be able to exist for the sole purpose of accomplishing their initial charge. Once in existence, they become dynamic organizations that must develop credibility. Thus, they move to take on more responsibilities, consulting projects, staff, office space, etc. In the process, the administrators gain recognition, climb up the professional/professorial ladder, justify salary increases, and gain professional mobility.

AEIDC is a prime example of this phenomena. Authorized by the legislature in 1971, AEIDC was initially charged with the responsibility to serve as a repository for arctic environmental information and data. Further, the legislature appropriated $100,000 for the first year's operation of the organization.

420 L street, suite 403 / anchorage, alaska 99501 (907)-272-5443

Since 1971, AEIDC has grown substantially. To quote Mr. Foster F. Diebold in his correspondence of March 22, 1979 (he was then President of the university) to the Honorable Glenn Hackney: "In 1977-78 their appropriation was $520,400. $176,388 was paid for rent. The balance of their budget came from contractual funds received through grants and contracts. Thus, in effect, state monies covered 27% of their budget." In other words, 73 percent of AEIDC's budget ($1,405,000) came from consulting work over and above that which they received directly from the legislature. This made AEIDC one of the largest consulting firms in the state in 1977-78.

Such growth and personal aggrandizement would not be all that bad <u>if</u> the state were to equally gain something. But, does the state save money because the university can do the research cheaper, do it better, or do it faster? No, the university doesn't do its research work for the state or federal government for less than private consulting firms. They do it for the same price or more! This, when their basic existence and core administrative, accounting, bookkeeping, personnel, recruiting, and office space are being completely paid for by the state! In essence, then, the state ends up paying <u>more</u> to use the university research organizations than if they were to use private consulting firms.

As to the question of getting better work from the university, I don't think you will find this to be the case either. Rather than comment on this personally, however, I suggest you contact any of the state agencies who have used the university as consultants in the past for their evaluation of the products they received.

It has been suggested that there is a proposal to set up a system whereby the university would have the first right of refusal on all state contracting/consulting work. If the university decided that they didn't want to, or couldn't do the work, then, and only then, would the request for consulting services be available to the private sector. If this is true, I would strongly caution against the adoption of such a proposal. Oh - the problem of competition between the university and the private sector would certainly be defused. But the negative ramifications would be <u>devastating</u> for the state.

First, with the volume of consulting work that is to be done in the state over the foreseeable future, we would see the growth of a university research bureacracy like you wouldn't believe! Secondly, the state would end up paying far more for its research consulting needs than necessary. For instance, our firm is now completing a community profiles project for the Department of Community and Regional Affairs. Our budget for this project totals $208,000. According to information we have received, AEIDC said they would do the job for $260,000. If the proposed system would have been in existence, we would not have had a chance to bid on the project and the state would have unnecessarily spent $52,000.

Finally, there is one heck of a lot of technical and intellectual capability outside of the university. If the proposed system were activated, it would severely limit the use of this capability.

Frankly, I'm not sure how this problem will ever be resolved. It is our opinion, however, that the following policies should be examined in determining the ultimate role for the university's research organizations:

- Historically, universities have been centers for higher learning; places for the gathering and dissemination of knowledge in advanced fields of study; and have provided facilities for teaching and research.

- The university should involve itself in the research of issues that have statewide interest and concern.

- The university should seek to develop required research capabilities that do not now exist in the state or private sector.

- The university's research capabilities should be directly funded by the state through adequate legislative appropriations. This would give the university the freedom from investigative restriction that exists when research is conducted under contract.

- The university should do research as part of its education system to assist students rather than getting students to fit into a mold that their contractual obligations require.

Maybe a solution to the problem would be for state agencies to publish a notice of intent to request proposals in house and allow private firms an opportunity to demonstrate their ability to provide such services. The state would then reserve it's option to go public if the contracting agency felt that the in-house request for proposal had not resulted in a satisfactory response.

My own suggestion would be to adopt HB 391 by amending Sec. 14.40.045 by deleting the last words of the paragraph that state "at a price no more than 20 per cent higher than that submitted by the university." This should, however, be followed up with an appropriation of funds to permit the university to carry out its necessary and desired research programs.

What has come to pass is a system where the Alaska consulting community finds itself in a situation where they are competing for their livelihood with the state through its university system. Needless to say, competing for one's livelihood against state organizations who are set up, funded and operated with our own tax dollars doesn't make us too happy. Especially when it is remembered that if we don't get the work, we don't make an income and will eventually be forced out of business. However if the university doesn't get the work, they still have a job, get paid, accrue vacation time, and have another shot at securing additional work.

We appreciate this opportunity to be heard on the matter, and we stand ready to provide additional information as required.

Respectfully submitted,

Ralph R. Darbyshire
President

THOMAS DOWELL, JR. PH. D.
13801 JARVI DRIVE
SRA BOX 846
ANCHORAGE, ALASKA 99502

April 9, 1979

907 344-6936

Chairman and Members of the House Committee on Health, Education and Social Services
Pouch V
Juneau, Alaska 99811

Dear Madam Chairman and Committee Members;

I wish to thank the members of the Committee for the opportunity to talk to them on the telecommunication network on April 6, 1979 in reference to H. B. 391.

During the hearing Representative Chatterton commented that the question of constitutionality of the bill being considered may be raised in the Judiciary Committee with, I presume, particular emphasis probably being placed on the propriety of the legislature interfering with the policy-making authority of the Board of Regents and University administrators.

Not being a lawyer, I become uncomfortable when I am told, as I have been in this case, that what the law says and what it means are not necessarily the same. However, I still wonder, as I look at Alaska Statutes, Chapter 40, Section 14.40.040. General powers of the university. This section apparently indicates that the legislature " ..created and established a corporation to be called the University of Alaska. It may in that name

(1) sue and be sued;
(2) receive and hold real property;
(3) contract and be contracted with;
(4) adopt, use and alter a corporate seal;
(5) do and have done all matters necessary for the purpose of any function set forth in this chapter.

If that says to you what it says to me, the Alaska legislature created the University corporation and authorized it to have certain powers. It seems to me that if the legislature created the corporation and authorized it to have certain powers, the legislature can modify that charter and those powers.

This bill would not impinge upon academic freedom, nor would it direct the University in the conduct of its primary goal. The University was created to pursue the gevernmental taks of providing education in accordance with an express mandate of the constitution, Article VII Section 2. State University. The University of Alaska is hereby established as the state university and constituted a body corporate. It shall have title to all real and personal property now orhereafter set aside for or conveyed to it. Its property shall be administered and disposed of according to law.

None of the powers authorized under Section 14.40.040. address education. Curriculum is addressed in Section 14.40.060.

I believe the powers of the corporation can be modified by changing Section 14.40.040, paragraph (3) to read

> (3) contract and be contracted with, provided that such contracts may not permit the University to compete with private business;

Such a change would not prevent the University from contracting with suppliers, faculty, construction contractors working on University property or lands, or other similar contractors. I believe this was the type of contract the legislators had in mind in writing such a clause into Section 14.40.040., and the change I suggest would not limit that authority. It would eliminate the activities this bill addresses while not conflicting with the University's role in education.

In my testimony I said that if research institutes depend upon competition with private business for their survival, then they are not research institutes and should not survive. Mr. Darbyshire indicated the problem these institutes have. They have grown in size as a result of their activities in the private sector and have lost sight of research in order to maintain staff. The solution to this problem is to reduce staff and maintain only their research activities.

This is a problem many universities have faced with declining enrollment. I know first-hand because I worked in pure and applied research in the Center for Advanced Computation, Department of Computer Science, University of Illinois. When our research funds were reduced staff was reduced. We did not market nor compete in the private sector. Although dire threats of extinction were made, the Center still exists and is engaged in education and pure research.

Under the powers now held by the University it can enter into any field it chooses to. If it wanted to it could build an airline for its Aviation Tech program, open a bakery for its Food Technology program or maintain a staff of highly competent graphics specialists to prepare presentation material for industy and academia. Of these three options, so far only the last is on the market.

It is important that the Committee recognize the distinction between interference in the educational and/or policy process and modifying corporate authority. Only the latter need be addressed. I believe it is only a clarification of previous legislative intent. I can't imagine the free-spirited members of the legislature in 1949 creating a corporate entity that would compete with them in business.

If the modifications to the corporate powers are considered in this context, the need for threats of budgetary control or other distasteful situations which serve neither the public nor the University well can be avoided.

Sincerely,

Thomas Dowell

Thomas Dowell, Jr., Ph. D.

were underway this year, there are many aspects of rural Arctic education that may not be fully covered. For this reason, the interim committee worked with the Alaska Native Foundation in the fall to put together a plan consisting in part of the following:

a). Review of programs of teacher training and cultural institutes of other circumpolar nations, and how they have dealt with

(1). materials development;
(2). teacher and administrator training;
(3). scheduling and alternative "tracking" for students;
(4). curriculum and program design, including provision for diverse student interests and career plans; and
(5). delivery systems

b). How all of the above could be used in Alaska as models to upgrade our teacher training and administrator program for Native and non-Native Alaskans.

The work project with the Alaska Native Foundation is much more complicated and has to be continued during the first few months of this legislative session. The interim funds for this project had been set aside, and should be reflected in the budget lapsing into the General Fund.

3). An assessment of what may be unfair competition by the University of Alaska research with private enterprise (HB 391) received an informal commitment from the President of the University that right serve as partial solution to this apparent problem of the private sector; the solution might be that those projects which could not be done by the U. of A. research on its own and are put out to bid by the State of Alaska should be left to be done by private businesses with the lowest bid. Further expression

Alaska State Legislature

TELECONFERENCE HEARINGS

TOPIC: HB 391 - Competition by U of A with private business
HB 412 - Minimum standards for hospital care

COMMITTEE: House HESS (Buchholdt)

DATE: Friday, April 6, 1979 (DATE SCHEDULED: 4/3/79)

TIME: 11 a.m. to 1 p.m. A.S.T.

SITES PARTICIPATING: Anchorage only

CONFERENCE MODE: audio LOCATION: ~~LIO~~ MODERATOR: Hopkins

NOTES:

Contacted
✓Don Sloane 276-3033
✓Mike Brunet, Municipal Human Res. 264-4261
✓Valley Hospital, Palmer
✓Chris Beardsley, Providence
✓Chamber of Commerce 272-2401
✓Women's Club FREE Committee
✓Harry Gray 277-4522

Expect to spend 1 hour on each bill

PUBLICITY:

___ INVITATIONAL

___ Committee making contacts

✓ PSAs 4/3 (date) 27 (quantity)

___ News release ___ (date) ___ (quantity)

___ Summary to be provided
___ Text to be provided
___ Quotes to be provided

___ Direct mail ___ (date) ___ (quantity)

✓ Phone 4/3 (date) 7 (quantity)

xx Posted at Information Office

TELECONFERENCE STARTED 11:12 am

TELECONFERENCE ENDED 1 pm

	391	412	
WITNESSES	6	2 = 8	
OBSERVERS	1	2 = 3	ATTENDANCE
TOTAL	7	4 = 11	

today in anchorage

Public comment on HB 391, competition by the University of Alaska with private business, and HB 412, minimum standards for hospital care, is invited by the House Health, Education and Social Services Committee in an audio teleconference starting at 11 a.m. The teleconference will be held in the legislative information office, 1024 W. Sixth Ave. Area residents wishing to testify should register in advance by calling 278-3668.

Alaska State Legislature

TELECONFERENCE HEARINGS

April 3, 1979
Contact: Judy Hopkins
278-3668

PUBLIC SERVICE ANNOUNCEMENT (run through 4/5/79)

PUBLIC COMMENT ON HB 391, COMPETITION BY THE UNIVERSITY OF ALASKA WITH PRIVATE BUSINESS, AND HB 412, MINIMUM STANDARDS FOR HOSPITAL CARE, IS INVITED BY THE HOUSE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE IN AN AUDIO TELECONFERENCE STARTING AT 11:00 a.m. FRIDAY, APRIL 6, AT THE LEGISLATIVE INFORMATION OFFICE, 1024 WEST SIXTH AVENUE. AREA RESIDENTS WISHING TO TESTIFY SHOULD REGISTER IN ADVANCE BY CALLING 278-3668. OBSERVERS ARE WELCOME.

###

Legislative Affairs Agency
Legislative Teleconferencing Network
State Capitol . Pouch Y . Juneau . 99811

Phone: 465-4980

Name Janet A. Boylan Here to TESTIFY ____

Representing self

Mailing Address 409 E. 23 Zip 99503 Here to OBSERVE X

Phone 276-4495

BROADCAST CONSENT: This proceeding may be broadcast live or recorded for later broadcast by radio or television stations. Please indicate your consent by signing below:

Janet A. Boylan
(signature)

Have you participated in other legislative teleconferences? - How many? 1

Would you have participated in this hearing if the network were available? no

How did you learn about this hearing?

Thelma Buchholdt

If yes, did you use network:
___ instead of travel
___ instead of phone conversations
___ instead of mailed testimony

Date: 4/6/79 Subject: (HB 391) HB 412 - House HESS Location: Anchorage

T

Name Thomas Dowell Ph. D. Here to TESTIFY Yes

Representing SELF

Mailing Address SRA Box 846, Anch Zip 99502 Here to OBSERVE ____

Phone 344-6936

BROADCAST CONSENT: This proceeding may be broadcast live or recorded for later broadcast by radio or television stations. Please indicate your consent by signing below:

Thomas L Dowell Jr
(signature)

Have you participated in other legislative teleconferences? NO How many? ____

How did you learn about this hearing?

From another Consultant

Would you have participated in this hearing if the network were not available? NO

If yes, did you use the network:
___ instead of travel
___ instead of phone conversations
___ instead of mailed testimony

Date: 4/6/79 Subject: HB 391, HB 412 - House HESS Location: Anchorage

T

Name C.A. "Bud" Herschbach

Here to TESTIFY ✓

Representing International Technology Limited

Mailing Address 723 west 6th Ave Zip 99501

Here to OBSERVE ____

Phone (907) 278-1571

BROADCAST CONSENT: This proceeding may be broadcast live or recorded for later broadcast by radio or television stations. Please indicate your consent by signing below:

C. A. Herschbach
(signature)

Have you participated in other legislative teleconferences? No How many? ____

How did you learn about this hearing?

Through other Interested Parties

Would you have participated in this hearing if the network were not available? No

If yes, did you use the network:
___ instead of travel
___ instead of phone conversations
___ instead of mailed testimony

Date: 4/6/79 Subject: HB 391, HB 412 - House HESS Location: Anchorage

7

Name LUREN LEMAN Here to TESTIFY ____

Representing CH2M HILL

Mailing Address 310 K ST Anchorage Zip 99501 Here to OBSERVE ____

Phone 278-2551

BROADCAST CONSENT: This proceeding may be broadcast live or recorded for later broadcast by radio or television stations. Please indicate your consent by signing below:

Loren D. Leman
(signature)

Have you participated in other legislative teleconferences? no How many? ____

Would you have participated in this hearing if the network were not available? NO

How did you learn about this hearing?

word of mouth

If yes, did you use the network:
___ instead of travel
___ instead of phone conversations
___ instead of mailed testimony

Date: 4/6/79 Subject: HB 391, HB 412 - House HESS Location: Anchorage

(T)

Name DONALD B. SLOAN

Here to TESTIFY ✓

Representing CSM ARCHITECTS ENGINEERS & PLANNERS

Mailing Address 902 W. INTERNATIONAL zip 99502

Here to OBSERVE ____

Phone 276 3033

BROADCAST CONSENT: This proceeding may be broadcast live or recorded for later broadcast by radio or television stations. Please indicate your consent by signing below:

(signature)

Have you participated in other legislative teleconferences? No How many? ____

How did you learn about this hearing?

Would you have participated in this hearing if the network were not available? No

If yes, did you use the network:
___ instead of travel
___ instead of phone conversations
___ instead of mailed testimony

Date: 4/6/79 Subject: (HB 391), HB 412 - House HESS Location: Anchorage

(1)

Name Chris Beardsley — Here to TESTIFY ✓

Representing Providence Hospital

Mailing Address 3200 Providence Dr. Zip 99504 — Here to OBSERVE ____

Phone 276-4511

BROADCAST CONSENT: This proceeding may be broadcast live or recorded for later broadcast by radio or television stations. Please indicate your consent by signing below:

Chris Beardsley
(signature)

Have you participated in other legislative teleconferences? ____ How many? ____

How did you learn about this hearing?
~ indirectly ~
House HESS Chairman

Would you have participated in this hearing if the network were not available? Yes

If yes, did you use the network:
___ instead of travel
___ instead of phone conversations
___ instead of mailed testimony

Date: 4/6/79 Subject: HB 391, HB 412 - House HESS Location: Anchorage

(T)

Name George W. Seutfert M.D. Here to TESTIFY ✓

Representing self

Mailing Address SRA Box 616 G - Anch Zip 99507 Here to OBSERVE ____

Phone 349-5630

BROADCAST CONSENT: This proceeding may be broadcast live or recorded for later broadcast by radio or television stations. Please indicate your consent by signing below:

George W Seutfert
(signature)

Have you participated in other legislative teleconferences? No How many? ____

Would you have participated in this hearing if the network were not available? No

How did you learn about this hearing?

am bill 412

If yes, did you use the network:
- ✓ instead of travel
- ___ instead of phone conversations
- ___ instead of mailed testimony

Date: 4/6/79 Subject: HB 391, HB 412 - House HESS Location: Anchorage

Name Ingrid Seuffert

Here to TESTIFY ____

Representing D. Seuffert

Mailing Address SRA Box G1-G Zip 99507

Here to OBSERVE X

Phone 349 5230

BROADCAST CONSENT: This proceeding may be broadcast live or recorded for later broadcast by radio or television stations. Please indicate your consent by signing below:

_____
(signature)

Have you participated in other legislative teleconferences? No How many? _____

Would you have participated in this hearing if the network were not available? _____

How did you learn about this hearing?

Providence Hospital

If yes, did you use the network:
___ instead of travel
___ instead of phone conversations
___ instead of mailed testimony

Date: 4/6/79 Subject: HB 391, HB 412 - House HESS Location: Anchorage

PLEASE PRINT

Name Ron Hammett — Here to TESTIFY ____

Representing SCHPD

Mailing Address 1135 W 4th S.1 Zip 99501 — Here to OBSERVE X

Phone 278-3631

BROADCAST CONSENT: This proceeding may be broadcast live or recorded for later broadcast by radio or television stations. Please indicate your consent by signing below:

Ron Hammett
(signature)

Have you participated in other legislative teleconferences? Yes How many? 1

Would you have participated in this hearing if the network were not available? no

How did you learn about this hearing?

Legis. Info Officer

If yes, did you use the network:
___ instead of travel
___ instead of phone conversations
___ instead of mailed testimony

Date: 4/6/79 Subject: HB 391, HB 412 House HESS Location: Anchorage

(T)

Name MICHAEL E. PLUNKETT Here to TESTIFY K

Representing LANE KNORR PLUNKETT ARCHITECTS

Mailing Address 800 CORDOVA ANCH Zip 99501 Here to OBSERVE ____

Phone 276-4939

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Date: 4/6/79 Subject: (HB 391), HB 412 - House HESS Location: Anchorage

Name Ralph R Darbyshire

Here to TESTIFY (T) ✓

Representing Darbyshire

Mailing Address 229 "D" St. #201 Zip 99501

Here to OBSERVE ____

Phone 279-0703

BROADCAST CONSENT: This proceeding may be broadcast live or recorded for later broadcast by radio or television stations. Please indicate your consent by signing below:

Ralph R Darbyshire
(signature)

Have you participated in other legislative teleconferences? No How many? ____

Would you have participated in this hearing if the network were not available? ____

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___ instead of travel
___ instead of phone conversations
___ instead of mailed testimony

Date: 4/6/79 Subject: HB 391, HB 412 - House HESS Location: Anchorage

House Health, Education & Social Services Committee Meeting/Hearing on HB 391 Date: 2/29/80

	Name	Address and Phone	Organization/Self	For/Against or Observing
1/	Spaziani, Richard L.	RT 4 Bx 4257-35 Juneau	State Dept. Education	AGAINST
2/	Dennis Demmert	Office of the President University of Alaska Fairbanks, Alaska 99701	University of Alaska	AGAINST
3/				
4/				
5/				
6/				
7/				
8/				
9/				
10/				
11/				
12/				
13/				

House Health, Education & Social Services Committee Meeting/Hearing on HB 391 Date: 2/29/80

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3/				
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5/				
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12/				
13/				

Jay Barton
President

UNIVERSITY OF ALASKA
FAIRBANKS ALASKA 99701

February 29, 1980

TO: Representative Thelma Buchholdt

FROM: Jay Barton
President

RE: HB 391: "An Act relating to competition by the University of Alaska with private businesses" - Fiscal Note

At your request, we have made an initial analysis of the potential impact HB 391, "An Act relating to competition by the University of Alaska with private businesses", would have on the University of Alaska. Time constraints mandated that this initial assessment focus on the University of Alaska - Fairbanks, and the Organized Research units in reviewing the magnitude of current State contracts. In analyzing current budgeted Federal receipts (grants and contracts), your requirement for immediate information has mandated that we focus on the University of Alaska - Fairbanks; Organized Research units; and Rural Education. (Please note: Additional Federal Receipts, in the amount of $7,302.4, are budgeted to be received by UAA, UAJ, Community Colleges and the Cooperative Extension Service.) We assume that the figures presented below primarily reflect grants and contracts awarded on a competitive basis; some proportion of funds received through grants and contracts undoubtedly have also been awarded on a sole-source basis. An assessment of which grant and contract funds received by the University were bid upon by private firms, at a price no more than 20% higher than our proposals, would require analysis by the entities awarding such grants and contracts.

STATE-FUNDED CONTRACTS

State contracts awarded UAF and Organized Research in the period of July 1, 1979, through December 31, 1979.

AEIDC	$104.8
ISER	125.0
Institute of Water Resources	60.6
Cooperative Wildlife Research Unit	30.0
Department of Engineering	37.2
Library	2.0
Museum	33.6
Safety	2.0
School of Business & Management	6.0
Agricultural Experiment Station	10.0
Department of Geology	6.5
Sea Grant Program	12.1
Cross Cultural Education	3.0

To: Representative Thelma Buchholdt
From: Jay Barton
Re: HB 391
Date: February 29, 1980

State-Funded Contracts (7/1/79 - 12/31/79) - continued

Cooperative Fisheries Research Unit	$ 19.0
Conferences & Institutes	15.3
College of Arts & Sciences	26.7
Institute of Marine Science	1.0
TOTAL	$494.8
Annualized: $494.8 X 2 =	$989.6

Time constraints have precluded development of a similar breakout of funds for the Division of Community Colleges, Rural Education and Extension; the University of Alaska, Juneau; and the University of Alaska, Anchorage. It is important to note, however, that the Alaska Department of Education currently contracts with many of the Community Colleges to provide Adult Basic Education instruction.

FEDERALLY-FUNDED GRANTS AND CONTRACTS

From FY80 Authorized Budget (FCC).

	Federal Receipts	GFM	Total
Organized Research	$37,134.3	$1,502.1	$38,636.4
REA-Research & Professional Centers	518.9	---	518.9
UAF-Research & Professional Centers	165.0	---	165.0
TOTAL	$37,818.2	$1,502.1	$39,320.3

In summary, two points should be made concerning HB 391 fiscal impact on the University:

1. Normal conduct of business is to award grants and contracts to the lowest responsible and responsive bid. In normal practice, bids are called for to be unconditional. HB 391 in practical effect requires any bid by the University of Alaska to be unresponsive to bid requests by requiring a self-imposed condition on all our bids. The University would effectively be prohibited from bidding on grants and contracts at all, because most parties (i.e. all parties except State of Alaska agencies) seeking bids would not tolerate such a condition.

2. It is accurate to state that virtually all grants-and-contracts' activity of the University of Alaska could be jeopardized by HB 391. Furthermore, the Bill speaks strictly to dollar amounts of competing bids, and does not speak to the scope or qualitative ability of competing bids, an issue of absolutely critical importance to funding sources.

HB

401

TESTIMONY OF PATRICK PLETNIKOFF ON H.B. 728
MOBILE DENTAL CLINIC
April 7, 1978

Throughout the dental feasibility study conducted by APIA for the Aleutian/Pribilof area, it was very early apparent that massive efforts were made by Public Health Dental Units to deliver service to the people of this area over the past few years. However, the records show that these efforts were often uncoordinated, equipment very often arriving days late after the professional staff had arrived and in some cases when the dentist was ready to leave or had already left. One could criticize the Public Health's efforts to deliver dental care in almost the same wording as Dr. Douglas Smole, Chief, Service Unit Dental Program used in his criticism of our plan to use mobile units combined with supervisory professionals and overwhelming numbers of volunteers who want to help free of charge. I quote him here "one shot" programs have no potential for continuing success when they deal with disease processes as multifactorial as dental diseases. Furthermore, one shot programs are usually not cost effective."

The records clearly show that the one shot approach is in fact the approach most often followed by the PHS Dental Program.

In 1974, 1975, 1976, and 1977, the records clearly indicate that the one shot a year plan was the plan used and the same plan is anticipated for 1978.

Let's explain the facts.

ATKA - Village received a total of 9 days dental service with a single dentist from 1974 through 1978 and even at that the dentist waited for his equipment to arrive and in one case decided to talk about good dental health to the children instead because he had no equipment.

FALSE PASS - Received 9 days of dental care from 1974 through 1978. The 1974 trip was aborted due to weather and another attempt was made in March of the following year.

KING COVE - From 1974 through 1978 the average days of service for dental treatment was 10 days a year for a population of over 270 people. 7 evenings were devoted to night emergency treatment of adult teeth in 1974 and the dentist was told by his superiors the program emphasis was for children's teeth, not adults. Even with this increased number of days of service the reports read (rampant cares) decay out of control, and once again the late arrival of equipment needed to treat patients.

BELKOFSKI - Children were transported to King Cove when the dentist was there for emergency care. No opportunity was available for adults or out of school youth beyond grade 8 to have dental assistance.

NIKOLSKI - From 1974 through 1978, 5' days of service was delivered to children. A planned trip for November of 1976 was attempted again the next year in May.

NELSON LAGOON - 1974 to 1978, 9 days of service. An aborted trip in November was attempted again 6 months later.

SAND POINT - 1974 to 1978, almost 20 days a year of dental service was available except for the days equipment was late in coming and the time spent trying to find a place to have a clinic. The dental staff had to clean out an old building in order to set up at all, and the portable equipment arrived 3 days later leaving 4 of the 9 days for treatment. Community response was reported as very poor. Obviously little pre-planning was done to involve the communtiy.

UNALASKA - Public Health reports a population of 104-252. The dentists say 500 year around. An average of 11 days service per year since 1974 with the usual late arrival of equipment reported by the dentists. A flouride program in the water system seems to be helping here.

A private practitioner in May of 1976 delivered emergency care for a 7 day period. The previous October, over 100 adults requested emergency treatment.

ST. PAUL - Reported population, 419. Although this community had more days care per year than all the other villages from 1974 to 1977, reports were of rampant dental disease, high sugar consumption and little or no community dental plan. Lack of coordination with school; 30 children reported as not showing for check ups in one period.

ST. GEORGE - Average of 6.4 days a year since 1974 of dental care by a dentist for a community of 154 people. Emphasis on children's teeth.

We cannot over emphasis our intention in our request for support of this program of dental care for the Aleutian/Pribilof people. We do not have as a goal the embarrassment of PHS, Indian Health Service of private practitioners. We appreciate all past efforts to check dental disease in our islands. The records clearly show that the present system is not working satisfactorily and a new approach is needed. We ask only that the new approach be given the support it deserves. The worst that can happen is the communities will get a little more dental care and the mobile unit can be used by any agency wantint to use it for delivery of service to our area.

The best that can happen is that we will have discovered and tested a new funtional, less expensive way to bring dental health care to bush Alaska and other areas will be using the money they now waste on poor programs to duplicate this method of service.

THE FOLLOWING DOCUMENT(S) MAY NOT FILM LEGIBLY BECAUSE OF POOR QUALITY OF THE ORIGINAL.

South Central District Dental Society

P.O. BOX [illegible] 3-487
ANCHORAGE, ALASKA-99508 99501

March 17, 1978

Representative Alvin Osterback
Alaska State Legislature
Pouch V
Juneau, Alaska 99811

RE: HB 728 - mobile dental clinic

Dear Representative Osterback:

The South Central District Dental Society is deeply concerned that state funds be spent for services to specific, designated, select geographic groups. This would set a precedent of legislating public tax monies to provide health care for a group limited by race and geographical location.

It appears that the Aleut-Pribilof Corporation did not assess rural area resources already available to meet the area's dental needs. Furthermore, it seems no cost effective studies were performed, nor did the Aleut-Pribilof Corp. and the Indian Health Service coordinate in planning the project referred to in the bill.

The proposal of $200,000.00 appropriates $100,000.00 for transportation and $100,000.00 for equipment. We are concerned that no appropriations were made for manpower evaluation and licensing - or continuation of the project in successive years.

If, however, the funds are allocated, fixed facilities and equipment should be used in preference to a mobile unit. This would allow more equipment in more areas for the same dollar amount. As many as 20 communities could be served with permanent equipment.

Federal and state funds are currently being used in cost effective programs which provide services for the dentally needy, further, the continuity of licensed voluntary manpower is available within the state. Services may be provided through a multiplicity of funding sources such as: Indian Health Service, private insurance, Medicaid, General Relief Medical, and native health corporations.

In view of the above information, it seems apparent, that, in the interest of all Alaskans, the proposed legislation be further investigated. Please contact our lobbyist, Mr. Henry Pratt, for any additional information and assistance.

Sincerely,

William F. Pell, D.D.S., President
South Central District Dental Society

cc: Senator Ferguson
Senator Hackney
Senator Sackett
Representative Poor
Representative Cooper
Mr. Henry Pratt

THE PRECEDING DOCUMENT(S) MAY NOT FILM
LEGIBLY BECAUSE OF POOR QUALITY OF THE
ORIGINAL.

Aleutian/Pribilof Islands Association, Inc.

430 "C" Street, Suite 303
Anchorage, Alaska 99501
Phone (907) 278-3567

REPLY TO SOUTHCENTRAL DISTRICT
DENTAL SOCIETY LETTER OF 3-17-78

To: William P. Fell, DDS, President
South Central District Dental Society

The letter signed by Dr. William Fell of the South Central District Dental Society was reviewed with interest and amazement. Why should the South Central Dental Society be concerned with an area of the State they do not serve nor have any intention of serving with dental care?

The statement that this program would provide health care for a group limited by race and geographical location is indeed erroneous by design. Nowhere in the proposed bill is health care limited to any one race. When it comes to geography, of course this demonstration project is designed geographically to demonstrate a solution to a problem of geographic delivery of service. Almost every bill out of the hopper has a geographic area of service or demonstration.

The Aleutian/Pribilof Association did assess rural area resources already available to meet the area's dental needs and found all sources committed, over committed and over spent and underfunded. When it comes to cost effective studies, the Dental Association should be willing to pass over this snake pit. Private dentists from the South Central Region occasionally contracted to deliver service were so far out of reach price wise that cost effectiveness would be a joke.

For instance, one dentist billed us $30,000 for 10 days of service. That's 25% of the total PHS allotment for the entire area for a year.

The system we anticipate with this unit has proven itself over and over again as cost effective. We don't need to study the study anymore. The State of California found it so cost effective even Ronald Reagan made the support of the mobile dental units a part of the regular State budget every year to solve the dental problems of farm workers and their children.

We do not know where Dr. Fell gets his figures on cost of the unit and delivery of service. The correct figures are attached.

So far as continuation of the project over the years, we as a district have applied for self management of dental health care funds allotted to our district and have a long time commitment from the dental school to stick with us over the years ahead. We will not be returning every year for additional funding as some people have suggested.

Most of our communities lack even basic housing at this time for families. To suggest fixed facilities be built by the State for dental care is really uninformed. Does the good doctor know what it costs the State for a 900 sq. ft. building for schools in the bush? He is talking about millions, not thousands for his plan.

What does the doctor mean when he says "The continuity of licensed voluntary manpower is available within the State." Is he suggesting his organization will volunteer dental services? If so, we accept and will make the mobile dental unit available to them for that purpose.

As our program develops we will need all the help we can get and hope we will be able to count on Dr. Fell and his association for consulting and direct service.

Yours Sincerely,

ALEUTIAN/PRIBILOF ISLANDS ASSOCIATION, INC.

Patrick Pletnikoff
Executive Director

PP:alp

SPECIAL NOTE

On the strength of various legislators' commitments to this project and our own faith in the legislature, the University of California has begun work on the dental bus already, so it will be completed in time to be operational this summer. Their students picked up the shell bus in Michigan and drove it back to school on their Easter Vacation.

We are told they have over 80 volunteers wanting to serve Alaska. It would be an embarrassment to have this Bill fail.

Recommendations

It is the recommendation of this consulting agency based on the information gathered to date that there are a number of alternatives to solving the problems of delivery of dental health care to the Aleutian/Pribilof Islands.

It should be understood that this area is the most expansive geographical area in the State covering over 1,000 air miles from Kodiak Island to the Pribilofs and that, although great, efforts have been made under limited budgeting restraints by the Indian Health Service and other agencies to provide care the task was almost impossible. Without a rather dramatic community dental health education program coupled with the availability of a number of practioners, the task may never be accomplished.

Alternative I

Establish a dental unit in each of the 11 villages and bring in a dentist when needed.

Most villages have enough dental problems to require the presence of a dentist 100% of the year. The cost for such a program would be prohibitive due to State regulations and standards for building a dental health clinic coupled with the problem of getting a single dentist to work alone in one of these isolated villages as a life work.

Estimated cost of this plan would be approximately $350,000 for each of the 11 villages served or approximately $4 million without staff or equipment.

Alternative II

Fly in with 3 or 4 dentists with portable equipment, set up a clinic in the school or church and recruit students and townspeople to have their teeth repaired.

(1) Housing would be required for staff of professionals and support staff.

(2) Auxiliary x-ray developing tanks, etc. would be set up in some available building.

(3) Although the equipment for portables is good it does take up badly needed school space and it is more difficult to find things to work with under such conditions. The program is usually viewed as an intrusion because it displaces space and often staff to meet its goals as another extra in an already crowded school program.

(4) The availability of the numbers of staff necessary to complete satisfactorily the work needed is remote - other areas of the State are also in need and would suffer if staff were diverted to the Aleutian area needs.

Alternate III

Is the development of a complete mobile multi-seated and work station dental clinic completely outfitted as a large city facility not dependent on old buildings or the availability of space dedicated to the school program. Such a program has been tried previously and successfully carried out by the University of California Dental School under the direction of Dr. Stark and Dr. Solberg.

Visitation to the University of California Dental School and to its operational unit working in the Sacramento Valley fields for migrant workers' children. The willingness of the Unversity to commit for such a project as this was explored and the possibilities look good for such an arrangement to be made similar to the porject now serving the migrant workers and .

This program operates as follows:

1. Advance staff do surveys of the community to be served.

2. Massive school and community programs of information and education are are initiated prior to the arrival of the mobile unit. Charts, posters and public lectures and films on diet health and tooth care are conducted.

3. Dental mobile unit arrives staffed by 3 University of California staff dentists and dental graduates awaiting their final licensure. Also a part of the team are dental hygienists who assist and work wi h the unit.

4. The complete unit operates steadily often rotating in other volunteers as needed.

5. Volunteers are paid only a per diem subsistence allowance and transportation costs. They would receive additional credit for added clinical experience.

6. A periodontist would also spend time in the unit and a good possibility of a follow up prosthetic unit to work over the year on dentures be good.

At present the Aleutian people have no qualified personnel to deliver dental health needs to their people and the Public Health Service delivers only emergency type care to this area.

Due to the over 1,000 miles one must travel in order to cover the distance of the Aleutian/Pribilof area -- and the isolation of the communities -- there is not adequate space or facilities to do quality dental work and as a result very little restorative work is done. The pattern has been to extract rather than repair.

With the mobile dental unit we are designing, we will be able to move this total working clinic from one place to another and recruit quality personnel to staff it.

The Aleutian/Pribilof Islands people have no funds at this time to develop this unit and provide the service.

Unless we have these facilities we will not be able to recruit the volunteer dentists and hygienists to work on our people.

Our objectives are to design and build a mobile dental vehicle equipped with three chairs -- total service units comparable to any funds in a large city setting; to equip a step van to follow for the x-ray unit and hygienists and records; to staff the vehicles with volunteer dentists supervised by the professional staff of the University of California Dental School; to also staff the vehicles with volunteer hygienists and trained dental assistants; and to deliver full dental health service to all our people and to then make our units available to other Native groups in need in Alaska.

Methods of delivery of dental care to isolated areas have been examined throughout this country as well as in Canada and countries abroad; specialist in California and in British Columbia recommended unanimously a full mobile dental clinic which could be moved about from place to place as needed. All experts also are in agreement a short term summer program will not meet the needs of the Aleutian/Pribilof islands people. Neither the consultants nor officials from A/PIAI have ever contemplated a three to four week program as interpreted by Commissioner Helen Bierne.

Such conclusions are politically motivated and reflect a total lack of research on the part of her unit.

It is clearly the intention of A/PIAI and the volunteer dentist to develop a year round program of delivery of dental care -- beginning with clinical repair and graduating to specialized areas and ultimately using the facilities for a prosthetic follow through.

Children's rotten teeth continue to drain down their throats poisoning their systems and the older folks continue to suffer from swollen tongues and extreme malaclusion and deformity leading ultimately to warped speech patterns and systemic discord while politicians scheme out ways to protect themselves against criticism for non-delivery of service the public has been paying them to deliver.

The mobile dental system tried and tested and proven in the migrant labor areas of California and in refugee camps in Israel are not pursued with the idea of embarassing anyone. What has or

has not been done in the past is history all are willing to forget.

We want to get on with the show. Surely our legislators would not be opposed to seeking alternative methods of solving this old problem.

We are not talking about 200 million dollars worth of service.

We are talking about 200,000 which we believe will deliver 2 million dollars worth of care. Is Alaska so affluent we can afford to pass up such opportunities? We are anxous as Mrs. Bierne to see permanent dental facilities in every village in Alaska -- and some day in the future this may be possible through a subsidized program of building dental facilities in isolated areas and providing incentives to young dentists to practice in these isolated areas. Perhaps some of our young professional volunteers will want to fill these vacancies in the future after a volunteer exposure to this area.

In the meanwhile our people need dental care now.

For answers to the ill informed comments about the impossibility of moving this mobile unit from place to place in the islands one needs only to look at the equipment being moved about in the islands now and since World War II. Oil drills, heavy equipment, portable fish processing equipment and millions of barrels of fuel oil as well as prefabricated homes are moved about as easy as moving a sheel barrel and none has even suggested it was not possible.

All the Doubting Thomas' are welcome to stop by this next year, sit in our new mobile unit and have their teeth cleaned.

SOME QUESTIONS YOU MIGHT HAVE

Question

How long will the dentists use the unit?

Answer

We have a long term commitment from the University of California Mobile Dental Clinic to serve Alaska as long as we want their services.

The unit will be staffed with a dentist year round. This summer a team of three dentists, one supervising professor, two dental technicians and one x-ray technician will work for six weeks -- then throughout the year a licensed dentist will do follow up work The following summer a new team will return for another six weeks time frame.

In addition to the teams from the University of California operating their summer program we have a number of volunteer dentists from around the country who are willing to donate their time and services for two weeks to a month at a time. One association has 180 members all willing to participate.

Question

What kind of unit is it and how will it be transferred to the Chain?

Answer

The unit is a G.M.C. 26' motor home stripped. Then refitted at the University of California as a dental clinic. When completed it will be just like a three chair dental office in a large city complete with cabinetry, overhead lights, delux dental chairs and all of the support equipment needed to do a good job.

It will be transported by sea to St. Paul Islands this summer. Next summer it will be moved to the Aleutians, possibly Unalaska or Sand Point by SeaLand. At this time, moves are contemplated for Unalaska, Sand Point, and Cold Bay as needed.

Question

How will the dentists be licensed?

Answer

There are at least two ways -- (1) they can be employed by PHS for a dollar a year and assigned to the Aleutian/Pribilof Islands Association (The State law permits this); or (2) the State Department of Commerce also can license the dentists in remote areas not presently served by dentists (within a 50 mile radius).

Question

How long will the unit be in the Aleutian area?

Answer

We anticipate that after two years the unit could be moved to other remote areas of the State as requested -- we have long term consultants to staff throughout the State.

The dental program will serve anyone who is identified as in emergency need of dental care regardless of who they are. Our hygienist staff will work closely with village health aides to locate people in greatest need first and to repair on a priority basis, teeth which would be soon lost without immediate treatment.

Question

If you will primarily be serving Native Americans, why doesn't the Indian Health Service fund the program?

Answer

The primary responsibility for ensuring the protection of public health in Alaska is the State of Alaska. While this is not an overwhelming problem in the urban areas of our State where dentists establish their practices, it is almost non-existent in the rural areas.

While the Indian Health Service has a special responsibility for the health care of Native Americans, it is not capable of providing the most basic dental services to Alaska Natives.

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MS PAIRICK PLETNIKOFF

ALEUTIAN PRIBILOFF PROJECT 430 C ST

ANCHORAGE ALASKA 99501

THIS WILL CONFIRM OUR AGREEMENT SET FORTH TO NETTIE PERATROVICH

TO ESTABLISH A MOBILE DENTAL CLINIC IN ALEUTIAN ISLANDS THIS CLINIC WILL BE DESIGNED AND BUILT BY DR MARVIN STARK AND DR KENNETH SOELBERG OF THE UNIVERSITY OF CALIFORNIA SCHOOL OF DENISIRY SAN FRANCISCO MEDICAL CENTER THE CLINIC WILL BE STAFFED BY PROFESSORS OF PEDIATRIC DENTISTRY AND SENIOR DENTAL STUDENTS AND HYGIENISTS. CLINIC OPERATION SAME FORMAT AS MOBILE CLINICS IN SAN FRANCISCO OPERATING FOR 10 YEARS IN MIGRANT FARM WORKER CAMPS. CLINICS WILL ALSO HAVE CAPABILITY OF HEARING TESTING AND EYE TESTING. FUNDS TO BE USED FOR TRANSPORTATION OF FACULTY AND STUDENTS PLUS PER DIEM EXPENSES. YOU HAVE OUR COMMITTMENT TO PROVIDE STAFFING AND SERVICES AND COMPLETED CLINIC. CLINIC WILL BE SHIPPED AS PER DIRECTION OF ALEUTIAN PRIBILOFF PROJECT AND ESTABLISHED ON ISLANDS UNDER THEIR AEGIS. CLINIC WILL BE CONSTRUCTED UNDER THE SUPERVISION AND DIRECTION OF MARVIN M STARK RESEARCH FOUNDATION A NON-PROFIT FOUNDATION LICENSED IN STATE OF CALIFORNIA.

DR MARVIN STARK AND DR KENNETH SOELBERG

0300 EST

of ALASKA MEMORANDUM

TO Commissioner Helen Beirne
Dept. Health & Social Services
Juneau

DATE January 12, 1978

FILE NO

TELEPHONE NO 278-4668

FROM Frederick McGinnis
Deputy Commissioner
Dept. Health & Social Services
Anchorage

SUBJECT Request by Aleutian/Pribilof Islands Association, Inc.: Permit Request--Dental Services for Aleutian Chain

Consistent with numerous other recent activities on the part of the Aleutian/Pribilof Islands Association to improve health and social services to the residents of the Aleutian Islands, information was sought from my office today with regard to our Department's assistance to the citizens of the Aleutian Islands for improved dental services.

Mr. Frank Peratrovich, Deputy Director of the Association, raised the question as to whether our Department is in the position to assist consistent with the applicable Alaska Statute--AS 08.36.271, Permits for Isolated Areas. For convenience a copy of the statute is attached (Attachment No. 1).

It is my understanding that the Aleutian/Pribilof Islands Association's plan is to secure the services of dentists on a voluntary basis mostly, if not entirely, from other states to render the services. The Public Health Service will be asked by the Association to employ the dentists at a nominal salary for technical purposes. The dentists apparently will meet the Alaska statutory requirements provided in AS 08.36.110 with latest amendments (see 1976 Supplement Amendments for 08.36.110).

It is in the knowledge of the A/PIA and their legal counsel that "the Department of Health and Social Services shall designate as isolated areas those specific placesand regions remote...". (AS 08.36.271(a))

It is their impression that "the Board shall, upon recommendation of the Department of Health and Social Services, issue an annual permit authorizing...". (AS 08.36.271(b))

It is my understanding that the Association is considering requesting a slight amendment to AS 08.36.271 if necessary to accomplish certain goals but, at this time, it is not certain if such will be required.

RECOMMENDATION: It is recommended that

(1) the Department officials concerned give strongest support to the proposed plan being developed by the Aleutian/Pribilof Islands Association, Inc. in their goals of addressing this extremely long neglected need to improve the dental health of the citizens of the Aleutian Chain.

(2) the Department of Health and Social Services, after consultation with the Department of Law, release the attached suggested letter (Attachment No. 2) and the attached suggested "Designation of Isolated Areas" (Attachment No. 3).

EMcG/mg

Attachments: as indicated

cc: Catherine M. Lloyd, Deputy Commissioner

gether with the registration fee. The division of occupational licensing shall, as soon as practicable, issue a registration certificate valid for the years for which issued. Each licensee shall keep the registration certificate beside or attached to his license. Failure to receive the registration form does not exempt a dentist from biennial registration. (§ 12 art III ch 186 SLA 1955; am § 9 ch 155 SLA 1968; am § 7 ch 121 SLA 1972)

Effect of amendment. — The 1972 amendment substituted "division of occupational licensing" for "central licensing section" in the first and third sentences.

Sec. 08.36.260. Branch office registration. A licensee who practices in an established office with an address other than that address for which his biennial registration certificate is issued shall obtain a branch office registration certificate for each office. (§ 13 art III ch 186 SLA 1955; am § 10 ch 155 SLA 1968)

Sec. 08.36.270. Permits for isolated areas.

Repealed by § 3 ch 26 SLA 1965; § 5 ch 93 SLA 1965.

Sec. 08.36.271. Permits for isolated areas. (a) The Department of Health and Social Services shall designate as isolated areas those specific places and regions remote from major population centers which are not served by dentists licensed under this chapter and which have a geographical location which works financial hardship, extended loss of time, or arduous and costly travel upon residents needing dental care.

(b) The board shall, upon recommendation of the Department of Health and Social Services, issue an special permit authorizing the treatment of residents in an area designated under (a) of this section, who are not entitled to dental care by the state or federal government, by a dentist employed by the United States Public Health Service or qualified member of the armed services who serves in that area. (§ 1 ch 93 SLA 1965; am § 11 ch 155 SLA 1968; am § 6 ch 104 SLA 1971)

Sec. 08.36.280. Temporary permit. (a) The board may issue a one year temporary permit without examination to an applicant to practice dentistry in a locality requested by the applicant if the locality is of the type specified in (2) of this subsection and the applicant

(1) meets the requirements of § 110 of this chapter;

(2) desires to practice dentistry in a city or rural village which does not have a resident licensed dentist in active general practice;

(3) has a license in good standing to practice dentistry in a state, territory, district or possession of the United States;

(4) tenders and pays the fee prescribed in § 290(6) of this chapter.

Attachment No. 2

STATE OF ALASKA

JAY S. HAMMOND, GOVERNOR

DEPT. OF HEALTH AND SOCIAL SERVICES

OFFICE OF THE COMMISSIONER / POUCH H 01 – JUNEAU 99811

January 16, 1978

Dental Examiners Board
937 Eighth Avenue
Fairbanks, Alaska 99701

Attention: Sydnor L. Stealey, President

Gentlemen:

Re: Designation by Department of Health and Social Services of Aleutian Islands as Isolated Area

It has recently come to the attention of the Department of Health and Social Services that, through the initiatives of certain Alaska Native organizations, improved dental services for citizens of the villages of the Aleutian Islands may be arranged. Such plans envision the utilization of dentists falling under the general coverage of AS 08.36.271(a) and (b).

Consistent with the provisions of AS 08.36.271, the Department of Health and Social Services encloses at this time the appropriate formal designation by the Department for the region involved in the emerging plans.

In line with the specific provision of AS 08.36.271(b), the Department of Health and Social Services hereby recommends to the Board the issuance of annual permits to the dentist applicants meeting the qualifications of applicants contained in AS 08.36.110, with latest amendments. The specific and individual applications related to this recommendation will be filed in accordance with your procedures.

It is our understanding that qualified applicants shall be granted annual permits under the conditions contained in the statutes and consistent with the recommendation contained herein.

Sincerely yours,

Helen Beirne
Commissioner

Attachment No. 3

STATE OF ALASKA
JAY S. HAMMOND, GOVERNOR
DEPT. OF HEALTH AND SOCIAL SERVICES
OFFICE OF THE COMMISSIONER
POUCH H 01 – JUNEAU 99811

January 16, 1978

DESIGNATION OF ISOLATED AREAS

by

STATE OF ALASKA, DEPARTMENT OF HEALTH AND SOCIAL SERVICES

In accordance with the provisions of Alaska Statutes 08.36.271, Permits for Isolated Areas, the Department of Health and Social Services hereby designates as isolated areas the entirety of the Aleutian Islands Chain of the state of Alaska, including any and all specific villages and communities of the Aleutian Chain.

Such designation is made solely for the purposes served by the provisions of the Alaska Statute cited above, and for dental services as provided in the cited statute.

Helen Beirne, Commissioner

Law Offices of
JAMES E. COLLINTINE
805 W. 3rd Avenue
Anchorage, Alaska 99501
Phone. 276-8144

January 11, 1978

Mr. Frank Peratrovich
Deputy Director
Aleutian/Pribilof Islands Association, Inc.
430 C Street, Suite 303
Anchorage, Alaska 99501

Dear Frank:

This responds to your request for my opinion as to whether or not A/PIA, under a contract which it has assumed from the IHS under P.L. 93-638, can employ dentists in the Aleutian area who are not licensed to practice dentistry under Alaska law. Unfortunately, at this point, the answer is not clear. Attached are copies of the relevant Alaska Statutes.

Under A.S. 08.36.271 the State Department of Health and Social Services is to designate isolated areas of the State which are not served by licensed dentists. Then, the Alaska Board of Dental Examiners shall, upon recommendation of the Department of Health and Social Services, issue an annual permit to a dentist employed by the United States Public Health Service. Hence, it appears that dentists need not be licensed to practice in Alaska if they are employed by the Public Health Service. As you suggested, perhaps there is some way that you can arrange to have the dentists under your contract employed by the Public Health Service. This would neatly solve the problem.

Another approach might be to have your dentists apply for a temporary permit from the Board of Dental Examiners to practice dentistry in Alaska. This approach is provided for in A.S. 08.36.280, a copy of which is attached. Basically, this provision provides that the Board may issue a one year temporary permit to a person not licensed in Alaska to practice dentistry in a rural area if:

> (a) the applicant is of good moral character, and is a graduate of a dental college approved by the Council on Dental Education of American Dental Association at the time of graduation, and holds a D.D.S. or D.M.D. degree, or the equivalent; and
>
> (b) the applicant has a license in good standing to practice dentisry in a State, territory, district or possession of the United States.

At first glance it would appear that your dentists could receive a temporary permit from the Board of Dental Examiners. However, I just spoke with Martha Dearborn of the Alaska Dental Society (phone 279-9144), and John Beard (phone 277-3213) who is an attorney who sits on the Board of Dental Examiners. Both persons told me that in December of 1977 the Board of Dental Examiners voted not to issue any further temporary permits. Mr. Beard stated that the Board felt that A.S. 08.36.280 was a "permissive, rather than a "mandatory" statute.

I feel that the determination by the Board of Dental Examiners not to issue temporary permits in Alaska is erroneous. In my opinion, if an applicant meets the legal requirements he is entitled to practice dentistry in Alaska under a temporary permit pursuant to A.S. 08.36.280. We could challenge the Board in Court. However, it will probably be best to have your dentists first apply to the Board of Dental Examiners for a temporary permit and obtain a formal decision from the Board. Note that the attached statute provides that the Board shall grant or deny an application for a temporary permit within sixty (60) days after it is received. After the applications are submitted we can request an oral hearing before the Board whereby we would attempt to put forward a compelling argument to pursuade them to accept the applications. They are free to reverse their December 1977 ruling to the effect that no further temporary permits will be granted in Alaska. If they do not, depending on what A/PIA wants to do, we can then take them to Court.

As you stated, another approach, and possibly the best might be for A/PIA to approach the Alaska Legislature and attempt to have the attached statutes changed. However, we do not know how long this will take. Mr. Milne has just informed me that he will send me a memorandum on what should be included in the amendment to the dentistry laws. I will then draft a proposed bill.

In summary, the quickest approach would probably be for A/PIA to have the dentists employed by the United States Public Health Service. In the alternative, the dentists could apply for a temporary permit pursuant to A.S. 08.36.280. Third, A/PIA should attempt to have the dentistry statutes amended to more realistically conform to the needs of the rural populace.

If you have any questions please do not hesitate to call.

Sincerely,

James F. Vollintine

Health and Social Services shall designate as isolated areas those specific places and regions remote from major population centers which are not served by dentists licensed under this chapter and which have a geographical location which works financial hardship, extended loss of time, or arduous and costly travel upon residents needing dental care.

(b) The board shall, upon recommendation of the Department of Health and Social Services, issue an annual permit authorizing the treatment of residents in an area designated under (a) of this section, who are not entitled to dental care by the state or federal government, by a dentist employed by the United States Public Health Service or qualified member of the armed services who serves in that area. (§ 1 ch 93 SLA 1965; am § 11 ch 155 SLA 1968; am § 6 ch 104 SLA 1971)

Sec. 08.36.280. Temporary permit. (a) The board may issue a one year temporary permit without examination to an applicant to practice dentistry in a locality requested by the applicant if the locality is of the type specified in (2) of this subsection and the applicant graduate of dental college; D.D.S. or D.M.D.

(1) meets the requirements of § 110 of this chapter;

(2) desires to practice dentistry in a city or rural village which does not have a resident licensed dentist in active general practice;

(3) has a license in good standing to practice dentistry in a state, territory, district or possession of the United States;

(4) tenders and pays the fee prescribed in § 290 (6) of this chapter. [125.00].

(b) The board may authorize a temporary permittee to practice dentistry in more than one city or rural village of the type specified in (a) (2) of this section.

(c) The board may annually renew a temporary permit upon written application of an applicant and upon payment of the prescribed fee if the applicant has not committed an act which is a ground for revocation in § 310 of this chapter, but in any case, within two years from issuance of his first temporary permit, the applicant must pass a board exam.

(d) A temporary permit may be revoked, suspended or annulled, or the permittee may be reprimanded, censured or disciplined by the board in the same manner and for the same cause as a licensed dentist under § 310 of this chapter.

(e) The board shall grant or deny an application for a temporary permit within 60 days after it is received. (§ 15 art III ch 186 SLA 1955; am § 4 ch 26 SLA 1965; am §§ 8, 9 ch 121 SLA 1972)

Sec. 08.36.285. Licensing a permittee.
Repealed by § 10 ch 121 SLA 1972.

Editor's note. — The repealed section derived from § 5, ch. 26, SLA 1965.

Sec. 08.36.290. Fees and penalties. The board shall impose and collect the following fees and penalties:

(1) for the issuance of an original license, $30;

(2) for the examination of an applicant, $50;

(3) for re-examination of an applicant, $50;

Sec. 08.36.271. Permits for isolated areas. (a) The Department of Health and Social Services shall designate as isolated areas those specific places and regions remote from major population centers which are not served by dentists licensed under this chapter and which have a geographical location which works financial hardship, extended loss of time, or arduous and costly travel upon residents needing dental care.

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Mobile dental clinics, inside full sized buses, have been bringing much needed dental care to the children of migrant farm laborers in California since 1968. In 1971 the pioneering program was expanded overseas and next month they will go to Israel, Greece, Yugoslavia and Kenya.

A Busload Of Mercy

ONE OF THE most difficult things in the world to do is to try and help people—you're immediately suspect.

But if helping people is what you want to do and your motives and intentions are honest, untinged with a personal gain or greed—then you find a way. Dr. Marvin M. Stark, a Los Altos dentist, is one of those people who finds a way.

Dr. Stark very much believes that the future of the world depends on the welfare and happiness of children. In his own way, with the help of faculty colleagues and students at the University of California, San Francisco, Dr. Stark has been eliminating needless pain in children in California and overseas for several years.

Dr. Stark's way is with a bus—a mobile dental clinic complete with four treatment chairs, the latest equipment for providing complete dental treatment, an auxiliary unit for x-ray equipment and a laboratory. Since 1968 mobile clinics have been traveling the dusty trails of the migrant farm workers, stopping wherever they did to give aid to their children. In 1971 the program was expanded overseas to Israel and then to Greece the following summer. This year it will expand even more to Yugoslavia and Kenya.

A CHILD'S visit to one of the mobile clinics is frequently also his first visit to a dentist. The friendly attitude on the part of the dental students soon allays any apprehension on the part of the children. The mobile clinic operates in each area for several days. The first day a dentist, interpreter and several assistants visit the location to orientate the children and their parents. A puppet show on dental hygiene is followed by the distribution of toothpaste, brushes and mouthwash. The mobile clinic is explained and the people are told it will be coming the following day.

When the bus arrives the children are all examined and given prophylaxis and flouride treatment. Treatments are scheduled based on priorities determined from the examinations and x-rays. If the children require additional treatment, further appointments are made. Many of the dentists participating do not speak the various languages so an interpreter explains such things as Novocain is "a medicine to make your tooth and lip go to sleep. It will go away in a couple of hours."

The story of the mobile clinics is a remarkable one in many ways. It dates back to 1965 when Drs. Stark, Ronald Nicholson, Kenneth Soelberg and Robert Weis, professors of dentistry at the University of California

By Mary Gottschalk

Medical Center in San Francisco, found themselves with a house trailer left over from a UC dental project. They gave the trailer back to UC along with the concept of converting it into a dental clinic to treat children in Head Start schools and institutions for the handicapped.

THE HOUSE trailer was a success and the idea for a mobile clinic in the form of a large bus to provide sorely needed service to the children of migrant farm laborers seemed to be the next step. The buses in California are under the sponsorship of UC and funds for their operation come from the State of California's Bureau of Community Services and Migrant Education. In its first five years of operation alone, the clinic buses, which now number three, treated upwards of 15,000 children in the agricultural valleys of California. It is an on going program that this summer will be in Ventura, the Woodland Davis area, and areas such as Salinas, Soledad and San Joaquin.

With such a successful program underway in California why not just sit back – why branch out? Dr. Stark sees it as a "natural offshoot" of the United States program. But more than that, it is a "20th century covered wagon" filled with pioneers who want to earn friends for their country. In Dr. Stark's own words "There is no better way of making friends with people than by healing their children."

The first overseas bus, in 1971, went to Israel. It was a project that involved more than a year of preparatory work, not the least of which was raising the $100,000 it took to purchase and outfit the first bus and to ship it to Israel.

THE MONEY did not come from any government sources or corporations – it was money donated by individuals who shared in Dr. Stark's vision of the mobile clinic and what it could accomplish. Dr. Nicholson, a friend and faculty colleague for many years, gives the credit for the bus – the concept and the reality – to Dr. Stark.

Along with the charisma necessary to raise large sums of money, Dr. Stark has unbounded determination to see a project of this magnitude through to its fruition. He is also a man of vision. He recently found a helicopter pilot and now he is on the lookout for a helicopter to outfit as a clinic and visit remote areas that are inaccessible to motor vehicles. Some people might think "good luck" but with Dr. Stark nothing is an impossibility.

The overseas experiences are not easy to describe. Different things stand out in the minds of each participant. Gladys Stark, Dr. Stark's wife, perhaps best expresses the emotion and impressions of those who have experienced the trip first hand.

"THE CHALLENGE at first was an adventure into a new land, culture, language and people. There were many unknowns – would we be able to communicate? Where would we live, especially in a country where people wait years for a tiny apartment? Could we adjust to new customs, new foods, extreme hot temperatures? Could we be of service? Would a war torn people appreciate or realize we were trying to help in a new and different way by bringing dental care and education? All of these uncertainties made our first trip a very precarious one.

"Nevertheless we went and in spite of innumerable obstacles, we saw, we did, we accomplished a great deal and came home with many impressions. One in particular was our tremendous admiration for the courage and industriousness of the pioneering Israelis who but a few years ago took this impossible desert wasteland, interspersed with malaria swamplands, and transformed it into beautiful, green, fertile farmlands capable of producing the finest crops in the world.

"Another overwhelming impression was the lilliputian, tiny size of the country. As one drives the length of Israel, which can be done in six to eight hours, on either side of the road Arab lands are visible. Looking at a map the many Arab countries with their huge expanses of vast uninhabited territories which they may never use is quite apparent. However their determination to have these few square miles of land, Israel, is an obsession.

"THE REWARDS were many. We were able to communicate. English is the second language taught in the schools. The diverse cultural backgrounds of the people exposed us to a fascinating mix of customs and languages. Besides Hebrew, we heard French, Russian, Italian, German, Polish, Spanish, Arabic and Yiddish. We were able to start a worthwhile dental health program. The needs were great. Institutions for the handicapped and retarded, kibbutzim, Druze and Arab villages, deprived sectors of Tel Aviv and Jerusalem overflowed with children in need of dental care and education.

"Often the days were long and arduous, the heat unrelenting. Still the rewards predominate. We found friends everywhere – not only because of what we were doing directly, but also because we were a group who came so far specifically to give unselfishly. At first the American dental group was suspect. What were our motives? Later as the word spread through the kibbutzim and villages, the doors opened widely and they remain open today with letters arriving daily requesting our speedy return."

For Dr. Bill Moore, who went to Israel the second year in 1972, the memories include treating a small boy one morning who had arrived at the clinic on his horse. The child spoke only Hebrew so communication was

Dr. Marvin M. Stark of Los Altos treats a woman in need of dental care at a mental institution in Israel. Dr. Stark is the single force behind the idea of a mobile dental clinic and he is the man who made it a reality for over 15,000 California children and people overseas.

A small child receives dental treatment from a senior dental student at a migrant farm workers' camp in the San Joaquin Valley. A faculty member from the University of California Medical Center supervises. Mobile dental clinics have aided over 15,000 children since they began operating.

non verbal. At the lunch break Dr. Moore noticed the boy beckoning him to come out. He did and the boy gave him a ride on his horse to show his appreciation.

OTHER PARTICIPANTS recall their invitation to a Yemenite wedding. The wedding had over a year of preparation in it and the invitation to attend was extended to the entire group of 60 participating in the dental care program.

Dr. Weis had some apprehensions about his family which included a six-month old baby. There are no such things as disposable diapers in Israel, so the family filled their suitcases with them. They found their hosts very concerned about their comfort and welfare.

For Santa Clara dentist Dr. George Mednick, the mobile clinic experience changed his life. While participating in the Israel program the first three summers, Dr. Mednick met his wife Tamar, an Israeli living in a kibbutz. He was further influenced by the program to become a children's specialist. In addition to his private practice, Dr. Mednick is also a part time instructor at the UC Medical Center.

Mark and Marina Bogdan of Palo Alto have also been active volunteers with the project since its inception. Mark started when he was an undergraduate at the University of Santa Clara, where many of the student volunteers come from. Marina volunteered when she was a dental hygiene student at UC. Mark and Marina were married last year and will continue their participation this summer with the program in Yugoslavia.

The mobile clinics are staffed by American students and dental instructors for only five weeks of the year, in late summer. To make sure they do not sit idle at other times, they are affiliated with institutions such as universities or municipalities. While they are there, the American group shares their methodology and skills with the dentists of the host countries. Those countries then operate it the rest of the year and it becomes a lasting goodwill project.

THE STUDENTS come from across the United States, not only from California. Participants have included students from Kentucky, Maryland, Michigan, Texas and Ohio. The host countries provide room and board and tender loving care to the participants, but no salary. Each person is responsible for raising the $1,000 it will cost them in transportation costs overseas.

The project is an expensive one, but the money involved is carefully spent. Drs. Stark and Soelberg, as well as volunteer students, spend many of their weekends at the J. W. Cross Co. in Mountain View working on the buses. Owners Dr. James Cross and Gordon Nelson allow them to store the buses there. Dr. Soelberg is the chief designer of the interiors and a minimum of 2,000 man hours goes into the outfitting of each bus. Bud Heintz and Bob Farry of University Electric in Santa Clara and Hank Heckman of Floorcraft Co. in San Jose have donated much of their time and skills in aiding the project as well.

Even now, buses are being worked on, supplies are being wrapped for shipping and money is being sought. There are still many long hours of preparation work left, to be followed by long hours of service in a foreign land. But as Gladys Stark has said, "I along with our extended family can say as Virgil's Aeneas: 'Many of these things I saw, and some of them I was.' " ◻

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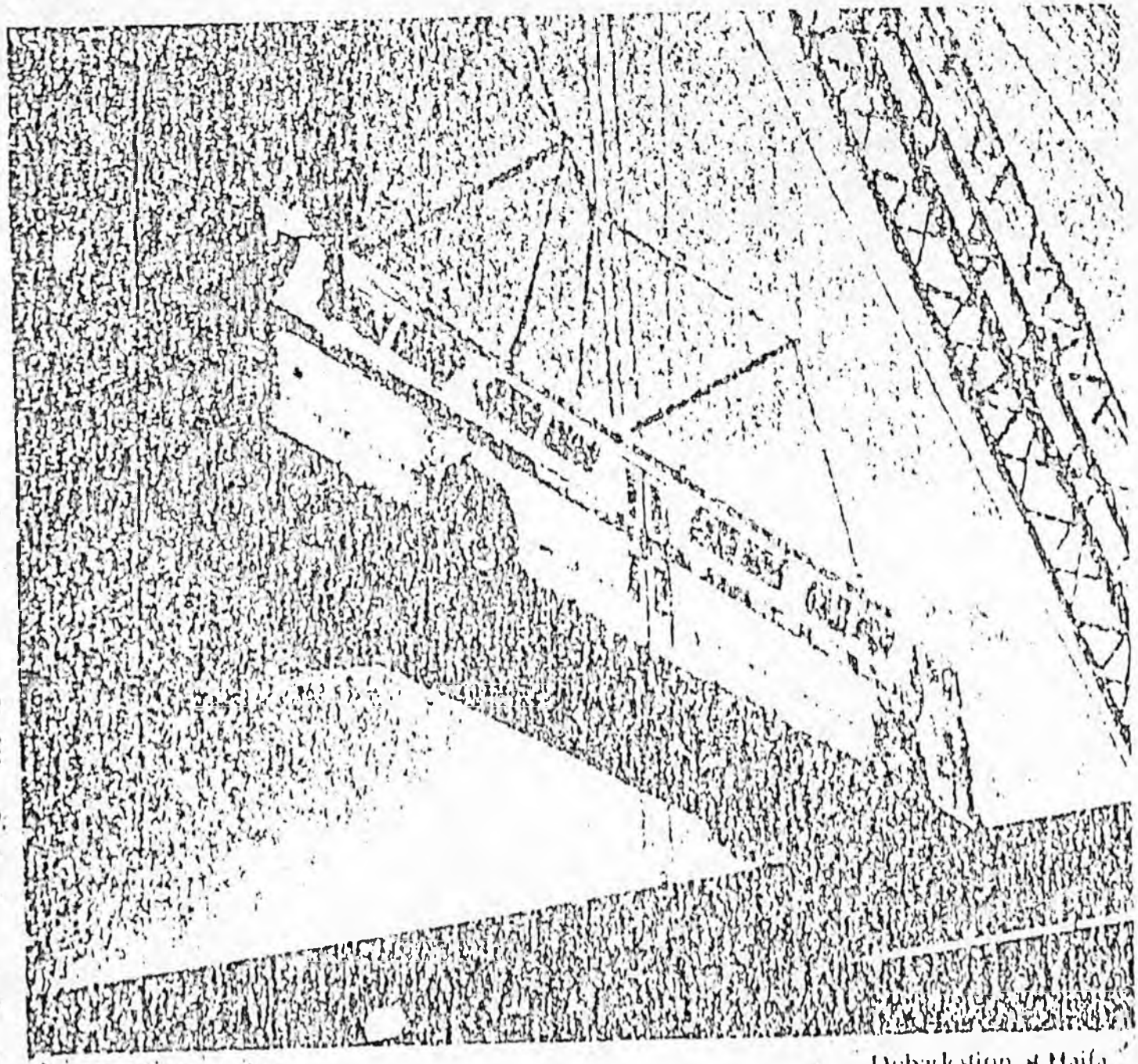
ADA News



Debarkation at Haifa

THE MOBILE CLINIC GOES INTERNATIONAL

PAGE SIX

UNIVERSITY OF CALIFORNIA, SAN FRANCISCO

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SCHOOL OF DENTISTRY SAN FRANCISCO, CALIFORNIA 94143

MARVIN H. STARK, D.D.S.
Date of Birth: March 14, 1921

PRESENT APPOINTMENTS:

Professor of Operative Dentistry and Oral Biology
University of California
School of Dentistry
San Francisco, California

Lecturer
Microbiology
University of California
School of Medicine
San Francisco, California

Consultant to Chief Health Officer, Dept. of Health, State of California.

EDUCATION:

A.B. Microbiology. University of California Los Angeles, 1948

D.D.S. University of California San Francisco, 1952

Research Fellowship, Harvard School of Dental Medicine, 1952-53

PRIVATE PRACTICE:

General Dentistry, 1954 to present

Assistant Director, Dental Clinic, Santa Clara County Hospital

Visiting Staff, O'Connor Hospital, San Jose, California

MEMBERSHIP IN:

International Association for Dental Research
Northern California Academy of Endodontists
Omicron Kappa Upsilon
Fellow, American College of Dentists
American Dental Association
American Association of Dental Schools
American Men of Science
Fellow, International College of Dentists

Marvin M. Stark, D.D.S.

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1. Laser Evaluation of Handpiece Contamination
   Journal of Dental Research, Feb. 1978.

2. "Human Blood Pressure Pulse Rate Responses to Racemic Epinephrine Retraction Cord."
   Journal Prosthetic Dentistry

Abstracts Presented at IADR Meetings

A. Philadelphia-1954: Studies on Recurrent Apthae: Evidence That Herpes Simplex is not the Etiological Agent, with Further Observations on the Immune Responses in Herpetic.

B. Los Angeles-1964: The Localization of Radioactive Calcium Hydroxide Over Exposed Pulps in Rhesus Monkey Teeth.

C. Toronto-1965: The Localization of Radioactive Calcium Hydroxide Over Exposed Pulps in Rhesus Monkey Teeth; and Hemorrhage Control in the Dental Pulp with the Use of Resorbable Oxycellulose.

D. Bal Harbour, Fla.-1966: Autoradiographic Tracings Utilizing Ca45-Labeled Ethylene Diamine Tetra-Acetic Acid; and The Effect of Topically Applied Epinephrine on Blood Pressure and Pulse Rate.

E. Washington D.C.-1967: The Measurement of Systemic Effects In Humans and Animals Following the Use of an Epinephrine Containing Gingival Retraction Agent.

F. Houston, Texas-1969: The Effects of Commonly Used Retraction Procedures on Ginaival Tissue and Blood Pressure; and Marginal Seal Afforded by Polysiloxane As A Cavity Liner.

LECTURES:

Guest Lecturer:	OB-GYN Staff, O'Connor Hospital, San Jose, CA "Dental Problems of Interest to the Obstetrician and Pediatrician"	1961, 1962
Guest Lecturer:	Naval Reserve, Oak Knoll Naval Hospital "Current Concepts in Restorative Dentistry" "Gingival Retraction"	Apr. 1960
Guest Lecturer:	Naval Reserve, Oak Knoll Naval Hospital "Problems Related to Amalgam Restoration" "Cements: Their Use and Abuse"	Apr. 1961
Guest Lecturer:	Naval Reserve, Oak Knoll Naval Hospital "Varnishes, Bases, and Liners" "Current Concepts in Restorative Dentistry"	Apr. 1962
Guest Lecturer:	Naval Reserve, Oak Knoll Naval Hospital "Gingival Retraction" "Problems Related to Amalgam Restoration"	Apr. 1963
Lecture:	Northern California Assn. of Endodontists, Statewide Meeting "Pulp Capping and Histological Effects of Proprietary Compounds"	Apr. 1963
Guest Lecturer:	Naval Reserve, Oak Knoll Naval Hospital "Cements: Their Use and Abuse" "Varnishes, Bases, and Liners"	Apr. 1964
Guest Lecturer:	Naval Reserve, Oak Knoll Naval Hospital "Current Concepts in Restorative Dentistry" "Problems Related to Amalgam Restoration"	Apr. 1965
Essayist:	College of Physicians & Surgeons, Annual Alumni Meeting, San Francisco, CA "Advances in Restorative Dentistry"	1965
Essayist:	Univ. of Calif. Alumni Meeting "Current Concepts in Restorative Dentistry"	1965
Moderator & Participant:	Dental Radio Conference, Graduate Education, Univ. of Calif.	1965
Lecture:	California Teacher's Assn., San Mateo, CA "New Methods of Health Care Delivery"	1965
Lecture:	CAIC Meeting, Pacific Coast Academy of Restorative Dentistry "Gingival Retraction and Related Problems"	1965
Lecture:	University of Maryland, Faculty "Educational Problems of Interest to Restorative Dentists" "Teaching of Operative Dentistry"	1965

Lecture:	Research Symposium, U.C.S.F. "Aerosol Hazards of Interest to the Operative Dentist"	1965
Lecture:	Mid-Peninsula Dental Society "Epinephrine Uptake in Gingival Tissue"	April 1965
Lecture:	Research Symposium, U.C.S.F. "Mercury Leakage in Amalgam Capsules"	1966
Guest Essayist:	American Academy of Restorative Dentistry, Chicago. "Epinephrine Uptake in the Gingivae of Rhesus Monkeys" Film & scientific presentation.	1966
Essayist:	American Academy of Crown & Bridge Pros. "Evaluation of Cements, Bases and Liners"	1966
Participant, Lecture and Discussion:	Career Day Program, Foothill College, Los Altos, CA	Feb. 1966
Lecture:	Dental Society, Nassau, Bahamas "Cavity Liner, Restorative Dentistry"	Mar. 1966
Lecture:	Mendel Society, Research in Dentistry University of Santa Clara.	April 1966
Guest Lecturer:	Naval Reserve, Oak Knoll Naval Hospital "Gingival Retraction" and "Varnishes, Bases, Liners"	April 1966
Essayist:	American Assn. of Endodontists National Meeting, San Francisco "Ca45 Labeled EDTA and Its Effects on Dentistry"	April 1966
Lecture:	Peninsula Component Dental Hygienists	May 1966
Essayist:	American Academy of Crown & Bridge Pros. "Aerosol Hazards of Interest to the Restorative Dentist"	1967
Guest Lecturer:	Naval Reserve, Oak Knoll Naval Hospital "Cements: Their Use and Abuse" and "Problems Related to Amalgam Restoration"	April 1967
Lecture:	Contra Costa County Dental Society. "Epinephrine Uptake in Gingival Tissue"	April 1967
Essayist:	Society de Endodontia, Bogata, Colombia. "Pulp Capping: Clinical & Histological Discussion" and "Teaching Restorative Dentistry in the U.S."	July 1967
Lecture:	Foothill College, Los Altos, California "Dentists' Role in Community Service"	Oct. 1967

Lecture:	Case Western University, Faculty, Students. Cleveland, Ohio. "Teaching Restorative Dentistry" and "Recent Advances in Restorative Dentistry"	Feb. 1968
Lecture:	Peninsula Component Dental Hygienists Palo Alto, California	Mar. 1968
Guest Lecturer:	Naval Reserve, Oak Knoll Naval Hospital "Varnishes, Bases, Liners" and "Current Concepts in Restorative Dentistry"	April 1968
Lecture:	Western Study Group of Combined Therapy "Pulpal Response to Operative Procedures" Los Angeles, California	Dec. 1968
Essayist:	Southern Calif. State Meeting, Los Angeles "Advances in Restorative Dentistry. Discussion of Pulp Protection; Bases, Varnish, Microleakage Around Amalgam Restoration, Research and Clinical Data"	May 1968
Lecture:	Southern Calif. Academy of Endodontists Los Angeles, California	Dec. 1968
Lecture:	Greater New York Dental Meeting. Seminar. "Current Concepts in Restorative Dentistry"	Dec. 1968
Guest Essayist:	Chicago Mid-Winter Meeting "Evaluation of Cavity Varnishes and Bases. Their Clinical Effectiveness and Shortcomings. Research and Clinical Data."	1968
Guest Essayist:	Chicago Mid-Winter Meeting "Recent Advances in Restorative Dentistry"	1969
Lecture:	Southern Calif. Assn. of Endodontists Los Angeles, California	Feb, 1969
Lecture:	Dental Hygienists, Univ. of Calif. S.F.	Mar. 1969
Lecture:	Oak Knoll Naval Hospital, Oakland, Calif.	April 1969
Lecture:	San Gabriel Valley Dental Society. Pasadena, California "Current Concepts in Restorative Dentistry"	April 1969
Participant and Table Clinic:	Santa Clara County Health Fair, De Anza College, San Jose, CA	April 1969
Lecture:	Alpha Omega Dental Alumni Chapter. L.A. "Current Concepts in Restorative Dentistry"	April 1969
Lecture:	Southern Calif. Dental Assn. Los Angeles "Current Concepts in Restorative Dentistry"	May 1969

Lecture:	Foothill College, Los Altos, Calif. "Role of the Hygienist in Community Service"	May 1969
Lecture:	University of Michigan faculty. "Current Research and Clinical Studies in Gingival Retraction"	June 1969
Headline Essayist:	American Academy of Pedodontists. Chicago, Illinois. "Literature Review and Research Data Related to Steroids in Dentistry" "The Pedodontist's Role in a Successful University Community Dental Program"	Aug. 1969
Lecture and Clinic Demonstration:	Deutche Rue Gruppe. Dusseldorf, Germany. "Crown Preparation and Gingival Retraction and Use of Hydrocolloids"	Aug. 1969
Lecture:	Royal Dental School, Faculty & students Copenhagen, Denmark. "Pulp Protection. Cavity Disinfection. Amalgam Restoration. Teaching of Operative Dentistry. Admission Procedures in a U.S. Dental School."	Aug. 1969
Lecture:	Ivoclar Company. Schaan, Liechtenstein. "Cavity Varnishes and Silicates"	Aug. 1969
Lecture:	L'Ecole dentiare de Paris, Paris, France. "Pulp Protection. Cavity Disinfection. Amalgam Restoration. Teaching of Operative Dentistry. Admission Procedures in a U.S. Dental School."	Sept. 1969
Lecture:	Northern California Dental Ass't. Assn.	Sept. 1969
Lecture:	Southwest Dental Assembly, San Antonio, Texas. "Recent Advances in Restorative Dentistry. Research in Varnishes and Bases. Radioactive Tracer in Varnishes."	Dec. 1969
Lecture:	Mexico Dental Association. Mexico City. "Recent Advances in Restorative Dentistry. Research in Varnishes and Bases. Radioactive Tracer in Varnishes."	Dec. 1969
Lecture:	Los Altos Rotary Club. Los Altos, Calif. "Teaching of Operative Dentistry in a Mobile Clinic. Description of a Community Program." Movies and Discussion.	Dec. 1969

Lecture:	Bermuda Dental Association. Bermuda. "Recent Advances in Restorative Dentistry. Research in Varnishes and Bases. Radioactive Tracer in Varnishes."	Dec. 1969
Lecture:	University of Guadalajara, Mexico. "Recent Advances in Restorative Dentistry. Community Mobile Clinic Program."	Jan. 1970
All Day Symposium:	Mid-Winter Meeting, Chicago Dental Society. "Current Research and Clinical Data Related to Gingival Retraction"	Feb. 1970
Lecture:	Northern Calif. State Dental Hygienists Assn.	Feb. 1970
Lecture:	Dental Hygienists, U.C.S.F. "Dentistry and Community Service"	Mar. 1970
Lecture:	Oak Knoll Naval Hospital, Oakland, CA "Research in Restorative Dentistry, Part I and Part II"	Apr. 9, 23, 1970
Participant and Table Clinic:	Santa Clara County Health Fair, De Anza College.	Apr. 1970
Lecture:	Rotary Club, Hayward, CA	Apr. 1970
Lecture:	Berkeley Dental Society. "Current Research and Clinical Data Related to Gingival Retraction"	May 1970
Lecture:	University of Athens, School of Dentistry	Dec. 1970
Lecture:	University of Paris, Faculty and students	Dec. 1970
Lecture:	Tel-Aviv University, Faculty of Continuing Education	Dec. 1970
Lecture:	Denver Dental Society, Denver, CO "Gingival Retraction"	Jan. 1971
Lecture:	Massachusetts Dental Society	May 1971
Postgraduate Course:	Tel-Aviv University, Faculty of Continuing Education, Tel-Aviv, Israel	Aug. 1971
Lecture:	New Orleans Dental Conference	Nov. 1971
Lecture:	University of Athens, Faculty and students	Dec. 1971
Postgraduate Course:	Ohio State University	Jan. 1972
Participant and Table Clinic:	Santa Clara County Health Fair, De Anza College	Apr. 1972

Lecture:	Oak Knoll Naval Hospital, Interns	Apr. 1972
Lecture:	American Dental Association "Sealants"	Nov. 1972
Lecture:	Mexico Dental Association	Jan. 1973
Essay:	American Dental Association, Houston, TX "Recent Advances in Restorative Dentistry"	Oct. 1973
Lecture:	Greater New York Dental Meeting "Concepts in Restorative Dentistry"	Nov. 1973
Lecture:	Oak Knoll Naval Hospital, Interns	Apr. 1974
Lecture:	Oak Knoll Naval Hospital, Interns	Apr. 1975
Mini Lecture:	Univ. of Calif. Alumni Assn. "Gingival Retraction Procedures"	Jan. 1976
Lecture:	Oak Knoll Naval Hospital, Interns	Apr. 1976
Lecture:	Oak Knoll Naval Hospital, Interns	May 1976
Mini Lecture:	American Dental Association "Gingival Retraction Procedures"	Nov. 1976
Lecture:	Brandeis University National Women's Committee, Palo Alto, CA "Mobile Clinics"	Feb. 1977
Lecture:	Oakland Naval Hospital, Interns	Apr. 1977

LECTURES AND CLINICS:

Clinical lectures and Scientific Session participant, American Dental Association annual meetings:

1. "Pulp Protection" Los Angeles, CA 1960
2. "Epinephrine in Gingival Retraction" Las Vegas, NV 1964
3. "Current Restorative Dentistry Procedures" Dallas, TX 1966
4. "Current Research in Restorative Dentistry" Washington, D.C. 1967
5. "Clinical Data Related to Gingival Retraction" Miami, FL 1968
6. "Current Concepts in Restorative Dentistry" New York, NY 1969
7. "Current Concepts in Restorative Dentistry" Las Vegas, NV 1970
8. "Current Concepts in Restorative Dentistry" Atlantic City NJ 1971
9. "Techniques and the Result of Sealant Application" San Francisco, CA 1972

Television Presentation, American Dental Association:

1. "Gingival Retraction Procedures" New York, NY 1969
2. Chaired: Television panel on "Restorative Dentistry Procedures." Other participants: R.J. Nicholson, K.B. Soelberg, R.H. Augsburger, Vern Tueller.

Motion Picture Presentations, American Dental Association:

1. "Abre La Boca": New York, NY Oct. 1969
   Las Vegas, NV 1970
2. "Las Manos Que Ayudan": Las Vegas, NV 1970
   Atlantic City, NJ 1971
3. "Chalutz" Atlantic City, NJ 1971
4. "Aliyah" San Francisco, CA 1972
5. "Sights and Sounds of the International Mobile Clinic" Las Vegas, NV 1976

LECTURES AND CLINICS:

Table Clinics:

1. University of California Alumni Association: 1954, 1956, 1961, 1962, 1963, 1964, 1965, 1966, 1967, 1968, 1969.

2. California Dental Association: 1961, 1962, 1963, 1964, 1965, 1966, 1967, 1968, 1969, 1970.

3. American Dental Association:

   a. "Pulp Protection" Atlantic City, NJ, 1963
   b. "Pulp Capping" Las Vegas, NV, 1965
   c. "Pulp Protection" Dallas, TX, 1966
   d. "Gingival Retraction" Washington, D.C., 1967
   e. "Pulp Capping" Miami, FL, 1968
   f. "Gingival Retraction" New York, NY, 1969
   g. "Pulp Protection" Las Vegas, NV, 1970
   h. "Pulp Protection" Chicago, IL, 1975.

4. Southern California State meetings: 1967, 1968, 1969, 1970.

5. Chicago Mid-Winter meetings: 1963, 1964, 1965, 1966, 1967, 1968, 1969, 1970.

POST GRADUATE COURSES PRESENTED:

A. University of California

1. Stark, M. M.: "Restorative Dentistry." May 1964.

2. Stark, M. M., Nicholson, R.J., and Soelberg, K.B.: "Pulp Therapy." Dec. 1964.

3. Stark, M.M., Morris, M.E., and Nicholson, R.J.: Dental Radio Conference. April, 1965.

4. Nguyen, N., Stark, M.M., and Sapone, J.: "Modern Endodontic Therapy." June, 1965.

5. Stark, M.M.: "Research Symposium." April 1966.

6. Stark, M.M., Nguyen, N., and Sapone, J.: "Modern Endodontic Therapy." Sept. 1966.

7. Stark. M.M., Nicholson, R.J., Soelberg, K.B., Christie, T.M., Morris, M.E., and Sapone, J.: "Pulp Therapy." Oct. 1966.

8. Stark, M.M., Soelberg, K.B., and Nicholson, R.J.: "The Dental Pulp---Protective Procedures." Dec. 1967.

9. Stark, M.M., Christie, T.M., Morris, M.E., Nicholson, R.J., Sapone, J., and Soelberg, KB.: "Pulp Therapy." Jan., 1968.

10. Stark, M.M., Nicholson, R.J.: "Endodontics for the Modern Practitioner." Feb., 1968.

11. Stark, M.M., Nicholson, R.J., Soelberg, K.B., and Augsburger, R.H.: Research Symposium, "Recent Advances in General Practice." June, 1969.

12. Stark, M.M., Soelberg, K.B., and Nicholson, R.J.: "The Dental Pulp--Protective Procedures" Nov., 1971.

13. Stark, M.M., Nicholson, R.J., and Soelberg, K.B.: "Save That Pulp" Jan., 1974.

14. Stark, M.M., Nicholson, R.J. Soelberg, K.B., Pelzner, R.B., Augsburger, R.H., and Barkin, P.R.: "Recent Advances in Restorative Dentistry." Nov. 1975.

15. Stark, M.M, Pelzner, R.B., Augsburger, R.A., Nicholson, R.J., Tueller, V.M., Soelberg, K.B., and Barkin, P.R.:
"Mini Course in Restorative Dentistry"
Jan., 1977

POST GRADUATE COURSES PRESENTED:

B. University of Southern California, Los Angeles

1. Stark, M.M., Christie, T.M., Nicholson, R.J., and Soelberg, K.B.: "Pulp Therapy." June, 1966.

2. Stark, M.M., Nicholson, R.J., Soelberg, K.B.: "The Dental Pulp--Protective Procedures." May, 1967.

3. Stark, M.M., Christie, T.M., Nicholson, R.J., Soelberg, K.B., and Weis, R.W.: "The Dental Pulp--Protective Procedures." Nov., 1968.

4. Stark, M.M., Nicholson, R.J., Augsburger, Christie, T.M., Soelberg, K.B., and Weis, R.W.: "Advanced Concepts in Restorative Dentistry." Nov., 1969.

5. Stark, M.M., Nicholson, R.J., Augsburger, R.H., Soelberg, K.B., Tueller, V.M., and Weis, R.W.: "Advanced Concepts in Restorative Dentistry." April, 1971.

Appointments

A. Visiting Professor, University of Cartegena, Colombia, South America., 1967

B. Member, Board of Director, American Cancer Society. Santa Clara Coutny, 1956-1962.

C. Pre-Dental Advisor, University of California
1. Berkeley, 1950-1954
2. Los Angeles, 1954-1964

D. Member, Health Advisory Committee, State Board of Education.

E. Member, Board of Director, University of California, Santa Cruz Association.

F. Consultant to:
1. Shering Corporation, Special Seminar of Pulp Capping, 1960.
2. Johnson & Johnson, 1964-1967
3. Pascal Company, Seattle, Washington. 1964-present.
4. Barnes Hind Co. Sunnyvale, Calif. 1962-present

G. Project Head Start Program and Peace Corps, July and August, 1965-66, for dental examinations.

H. Consultant, U.S. Naval Hospital Oak Knoll California.1966-67-68

I. Volunteer, S.S.HOPE Ship, Cartagena, Colombia, 1967.

J. Consultant, Tulare County School District, California Migrant Farm Children Program-Dental Project, Summer 1968

K. Chairman, California State Dental Association Research Committee, 1970 to present.

L. Member, Foothil Junior College, Dental Hygiene Advisory Committee-1970

M. Consultant, Vick Chemical Company, Mount Vernon, New York 1969-present.

N. Consultant, State of California Dept. of Education, Bureau of Community Service and Migrant Education.

O. Faculty, Postgraduate Education, University of Southern Calif.

P. Chairman,ProjectedClinics in Color and Sound, U. C. Alumni meeting, January 1970.

Q. Board of Trustess, California College of Podiatric Medicine, 1970-1973

R. Visiting Professor, Tel-Aviv University, Faculty of Continuing Education, Dental Division. Tel-Aviv, Israel, 1971-7

APPOINTMENTS continued

S. Special Consultant, Ministry of Health, Israel, 1973.

T. Consultant on Scientific Material, California Dental Association, 1974-present

U. Special Consultant, Dr. Jerome Lackner, Director of Health, State of California. 1976-77

V. Personal Consultant in Dental Health to Director of Health, Jerome Lackner, State of California. 1977

W. Nominated: For Public Service Award, U.C.S.F awarded by the Chancellor for outstanding community service. 1975, 1976, 1977

COMMITTEES: University of California School of Dentistry

1. Bachelor Science Committee
2. Admissions Committee
3. Curriculum Committee
4. Building Committee
5. Chairman, Welfare and Memoriae, Academic Senate Committee
6. Director, Mobile Clinic Program, U.C. project developed to provide treatment for underprivileged children utilizing a mobile clinic staffed by faculty-supervised dental students.

PATENTS:

1. The use of acridines as caries-disclosing agents
2. Artilk, articulating paper to disclose inequalities in occlusion
3. Dental cavity liner and method of restoring carious teeth

PATENTS APPLIED FOR: 1976

1. New capsule dispenser for amalgam
2. Special digital pulp tester
3. Unique crown remover
4. Pliers for inserting pins
5. Spot-welded band kit
6. Plaque remover and interdental stimulator
7. Dental Amalgam Well; a device to reduce mercury vapor

RESEARCH IN PROGRESS: 1976

1. Evaluation of varying concentrations of epinephrine-saturated cords in the control of hemorrhage. A unique blood pressure device is being used to evaluate changes in blood pressure and heart rate.

2. Evaluation of currently used amalgams in extracted teeth. Effects of polishing and the effects of dilute acid in alkali will be determined with the scanning electron microscope.

3. Effects of finishing and polishing on composites will be evaluated utilizing radioactive materials to determine marginal leakage.

4. Evaluation of currently used die stones and their compatability with hydrocolloid impression materials.

5. Reinforced gutta percha---histological evaluation.

6. Evaluation of currently available high speed handpieces; ease of sterilization and bur removal.

7. Evaluation of mercury leakage from pre-proportioned and conventional amalgam capsules.

8. Clinical, two-year evaluation of modern amalgam and composite restorative materials in deciduous teeth.

9. Evaluation and development of new desensitizing paste.

10. Evaluation of mercury leakage around dental operatories.

11. Special testing on sterility of syringes.

PRODUCER:

1. Abre La Boca - 1969

   28 minute, color and sound, 16 mm documentary movie describing the Mobile Clinic Program in the San Joaquin Valley of California.

   Funds for the film obtained from a grant from the Vick Chemical Company.

   Purchased by the American Dental Association for their film library for national distribution.

2. Las Manos Que Ayudan - 1970

   26 minute, color and sound, 16 mm documentary which graphically portrays U.C.S.F. dental students providing dental care to migrant children, and depicts the social and educational benefits to the students and the children.

   Funds for the film obtained from a grant from the ADA.

   On file in the ADA film library for national distribution.

3. Chalutz - 1971

   15 minute, color and sound, 16 mm documentary describing the free dental care being provided to Israeli children both Arab and Jew in an effort to promote international goodwill through the medium of dentistry.

   Winner of 1971 CINE Golden Eagle Award. Entered as U.S. representative of educational films in international film festivals.

   Funds for the film obtained from grant from the California Dental Association, $8,000.

   On file in the Library of Congress.

   On file in the ADA film library for national distribution.

4. Aliyah - 1972

   10 minute, color and sound, 16 mm documentary showing dental students under faculty supervision treating Israeli children on a mobile clinic in the Gaza Strip, and in the kibbutzim and moshavim of northern Israel as well as in schools for the handicapped.

   Funds for the film were obtained from a $5,000 grant from a private individual.

   Winner of the 1972 CINE Golden Eagle Award.
   On file in the Library of Congress film library.
   On file in the ADA film library for national distribution.

MOBILE CLINICS: (California)

The following grants were obtained from the California State Department of Education to subsidize the Mobile Clinic program in California:

1969	$ 40,835
1970	210,000
1971	113,000
1972	99,000
1973	91,920
1974	98,900
1975	117,210
1976	120,053
1977	78,467

TOTAL TO DATE $969,385.

These clinics have operated in the State of California from as far north as Marysville and south to Santa Barbara.

To date approximately 25,000 children have received restorative care and instruction in prevention in these clinics. Approximately one-third of the students in the senior class serve in the these clinics each year providing dental care to the children of migratory farm workers.

These clinics have motivated a substantial number of students to proceed on to graduate work in Pedodontics.

MOBILE CLINICS: (Overseas)

A non-profit public foundation has been established which has IRS approval as a Charitable Trust 509A classification. The State of California has assigned a non-profit status to this corporation.

To date $590,000 has been contributed to this foundation from private source during the past 5 years.

Two clinics were built by Marvin Stark and his associates and are currently operating in Israel treating both Arab and Israeli children.

One mobile clinic was established in Greece in 1971.

One mobile clinic was established in Yugoslavia in 1975.

To date approximately 100 students have served in the clinics in Israel, Greece, and Yugoslavia, and at least 3,000 children have received restorative treatment in these clinics. Dental students from the Universities of California, Michigan, Southern California, Connecticut, Maryland, Case Western, and University of the Pacific have volunteered their service and provided their own transportation. The foundation provides living accomodations for the students.

MOBILE CLINICS OVERSEAS (continued)

SPECIAL APPOINTMENT: Chief Purchasing Consultant for the Kibbutz Movement. Responsible for assisting with design and equipment for dental clinics for 275 kibbutzim in Israel.

MOBILE CLINICS:

1971: Israel

1972: Israel, Greece

1973: Israel, Greece

1974: Israel, Greece, Yugoslavia

1975: Israel, Yugoslavia

1976: Israel, Greece, Yugoslavia

1977: Israel, Greece

AWARDS:

Myrtle Wreath Award: Presented to H. Stark and family by the San Francisco Chapter of Hadassah for their humanitarian work in providing mobile dental clinics in Israel. Jan. 1977

MOBILE CLINICS: (overseas)

Future Plans

1. Plans are currently underway to develop a program for Ankara, Turkey in conjunction with UNICEF.

2. Another clinic is in the formative stages for Cebu City, Philippines.

All construction and design of the mobile clinics in California and overseas have been accomplished by Kenneth Soelberg, Ronald Nicholson, and Marvin Stark and student volunteers.

As a result of the California mobile clinic grants from the Department of Education, the Regents of the University of California currently own:

1. 40 foot General Motors transit coach outfitted as a complete 4 chair dental clinic.

2. 40 foot General Motors transit coach outfitted as a complete dental clinic.

3. 30 foot General Motors, transit coach outfitted as a complete three-chair dental clinic.

4. Four support vehicles (transport personnel and supplies)
   a. Chevrolet Carryall (2)
   b. GM Rallywagon
   c. Chevrolet Step-Van

5. X-ray equipment, and all other equipment necessary to operate 11 chairs in the field.

ADDITIONAL GRANTS:

From private industry:

1. $26,000, Johnson & Johnson, 1960.
2. $15,000, Vick Chemical Co.
   Kerr Mfg. Co.

STUDENTS SPONSORED: During the past 8 years the following students have recieved financial aid in graduate training:

1. Molly Green---University of Michigan, Pedodontics
2. Ernest Peterson---University of Indiana, Dental Materials
3. George Mednick---University of Michigan, Pedodontics
4. Michael Meyer---University of California, Orthodontics
5. Joseph Schmutz---University of California, Pedodontics
6. William Nielsen---University of California, Pedodontics
7. Ralph Zotovich---University of California, Pedodontics
8. Larry Ford ---Western Reserve University, senior student
9. Mark Bogdan---University of Detroit, dental student
10. Also sponsored---foreign students, all financial arrangements made for the student and provided for 3 years of education for the student.

FACULTY SPONSORED: The following dentists for abroad have received assistance with transportation, room and board while at U.C.S.F.

1. Ljobomir Orlic, Split, Yugoslavia
2. Daniel Kempler, one year post graduate training from Hebrew University, Jerusalem, Israel
3. Herb Judes, Head, Operative Dentistry, Tel Aviv University, Israel
4. David Assif, Tel Aviv University, Israel
5. Amos Buchner, Chairman Oral Pathology and Oral Medicine, Tel Aviv University, Israel

PUBLIC INFORMATION:

News articles related to Mobile Clinic activities have appeared in the following press releases:

1. Berkeley Gazette, June 2, 1965.
2. Synapse, U.C.S.F. campus publication, Sept. 17, 1965.
3. San Jose Mercury, Aug. 6, 1965.
4. Redwood City Tribune, Dec. 2, 1965.
5. Palo Alto Times, Aug. 3, 1966.
6. San Francisco Examiner, July 12, 1965.
7. San Jose News, July 11, 1966.
8. Redwood City Tribune, July 10, 1968.
9. Journal, American Dental Association, May 1969.
10. Journal, American Dental Association, Nov., 1969.
11. San Francisco Examiner Sunday Magazine, "California Living" May 10, 1970.
12. Congressional Record, Monday, June 1, 1970, p. E4995.
13. American Dental Association News, Sept. 14, 1970.
14. Rocky Mountain News, Denver, Colorado, Jan. 12, 1971.
15. News Letter, International College of Dentists, March 1971.
16. U.C. News (University of California Clip Sheet) April 18, 1972.
17. San Francisco Jewish Bulletin, June 30, 1972.
18. San Francisco Examiner, July 27, 1972.
19. The New York Times, Sept. 17, 1972.
20. The Campus Bulletin, (U.C.S.F. bulletin) Sept. 1972.
21. TWA Ambassador (official magazine of TWA Ambassadors Club) November 1972.
22. International College of Dentists, Scientific & Educational Journal, 1973. Vol VI, No. 2.
23. Journal American Dental Association, Feb., 1973.

PUBLIC INFORMATION: (news articles continued)

24. American Dental Association News, June 18, 1973.

25. U.C.S.F. News, June 1973.

26. California Dental Association Journal, Aug. 1973.

27. Congressional Record, June 4, 1974. Vol. 120, No. 79.

28. U.C.S.F. News, June 1974.

29. American Dental Association News. June 3. 1974.

30. Journal American Dental Association, July 1974.

31. The Hellenic Chronicle February 20, 1975

32. American Dental Association News, Oct. 11 1971

33. San Jose Mercury News Sunday Magazine, California Today, June 9, 1974.

34. Jerusalem Post, January 4, 1977. p. 5

PROFESSIONAL LICENSES:

A. Clinical Microbiologist, 1949

B. California State License Dentistry, 1952

C. National Dental Boards, 1952

D. Massachusetts License

Dental Breakthrough
for Bush Alaska

Senior Year dental students pose with their professors in front of the new mobile dental clinic — the first of its kind in Alaska. Paid for by the State of Alaska as the result of H.B. 728 which passed the House then cleared Senate HESS and was ultimately funded through Governor Hammond's discretionary budget.

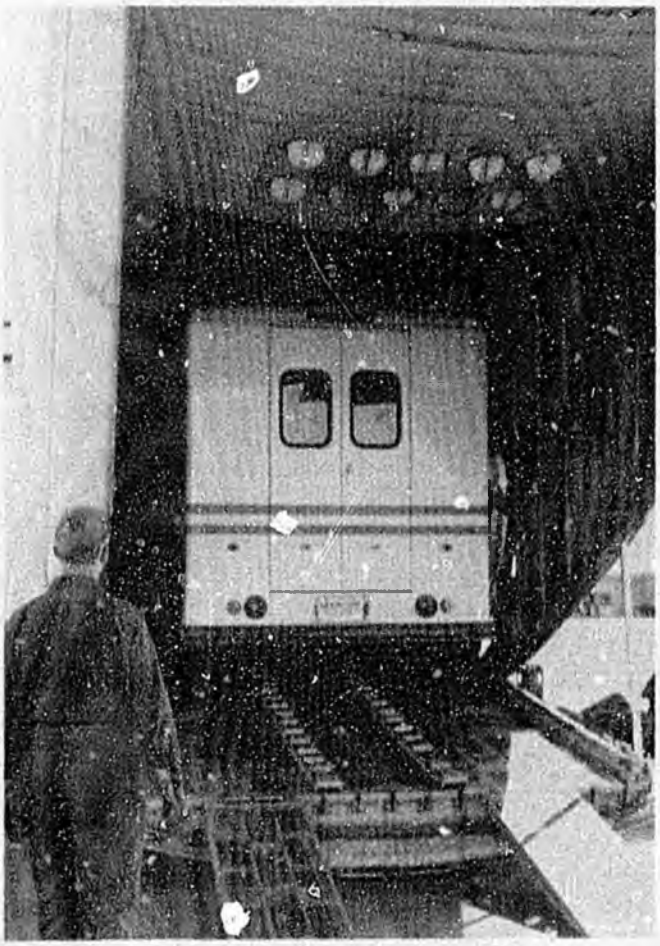
No clinic — mobile or stationery in the world is any better equipped or more modern than the new unit.

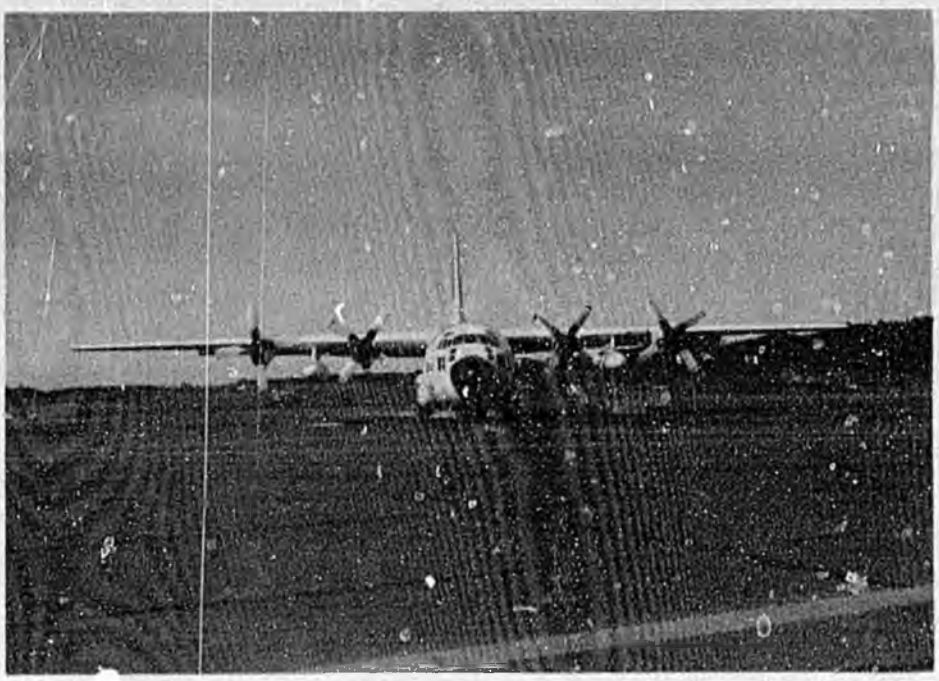
"There is no better feeling of worthwhile accomplishment than to leave a village knowing a whole lot of kids will no longer suffer from tooth aches."

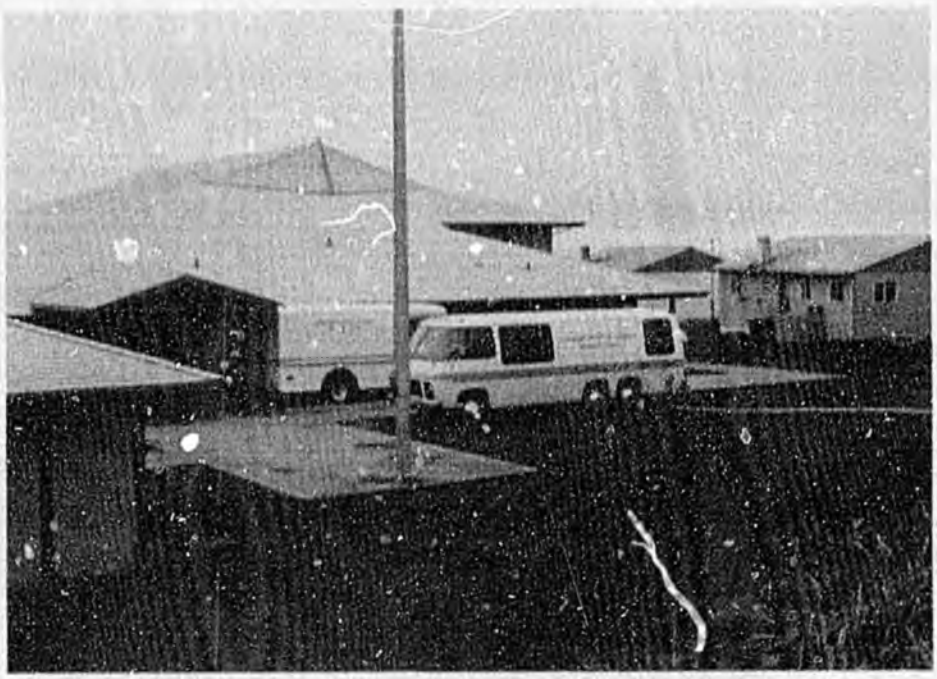
Dr. Kenneth Soelberg of the Stark Foundation joins in for the ribbon cutting ceremony, accompanied by Dr. Stolpe of PHS; Dr. Fred McGinnis, Deputy Commissioner for the State Department of Health and Social Services; Ralph Eluska, Deputy Director of APIA; and Jessie Dodson, Special Assistant to Governor Hammond.

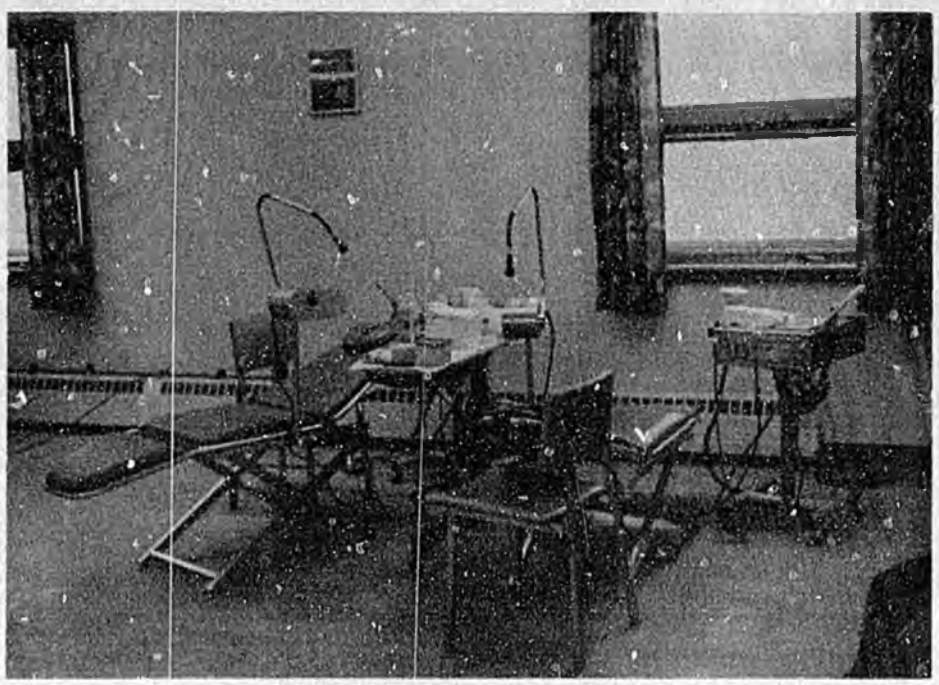
The mobile clini has every feature available for comfort and efficiency — including stereo music to listen to while being treated, air load levelers for bumpy spots in the road and heaters strategically located throughout the unit.

Pressing time and a missed barge bring the Coast Guard to the rescue. They delivered the companion support unit to St. Paul when there was no place else to turn for help.









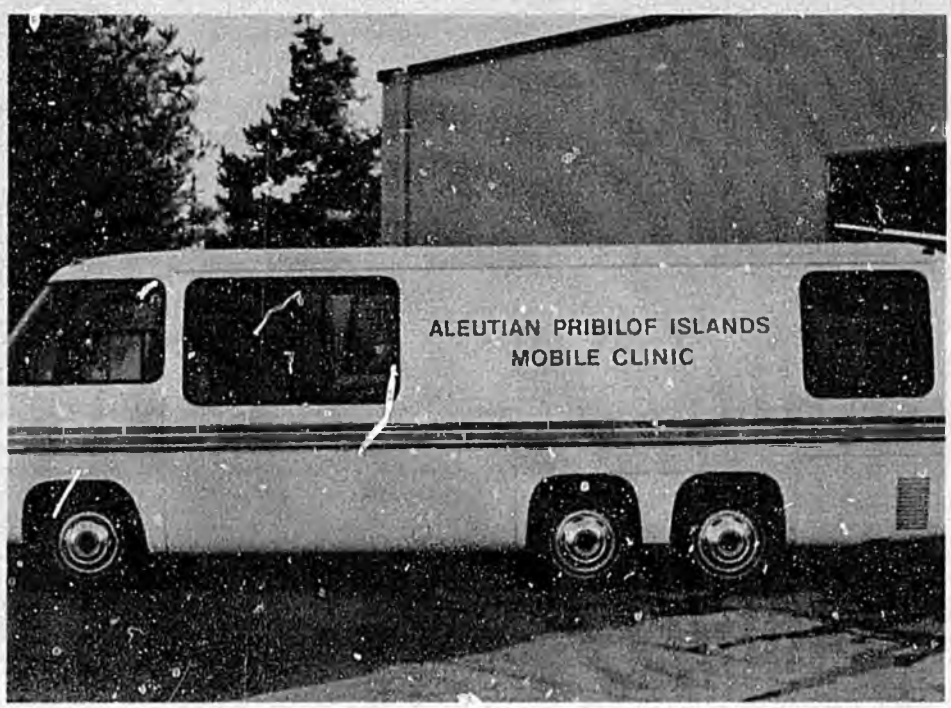
Hygienists outside working at auxilliary units cleaned teeth and did preliminary examinations and screening.

With so many volunteers we were able to set up auxilliary hygiene units outside the mobile clinic which allowed us to serve more peopie.

Every patient had thorough x-ray examinations so as to not miss any hidden cavities.

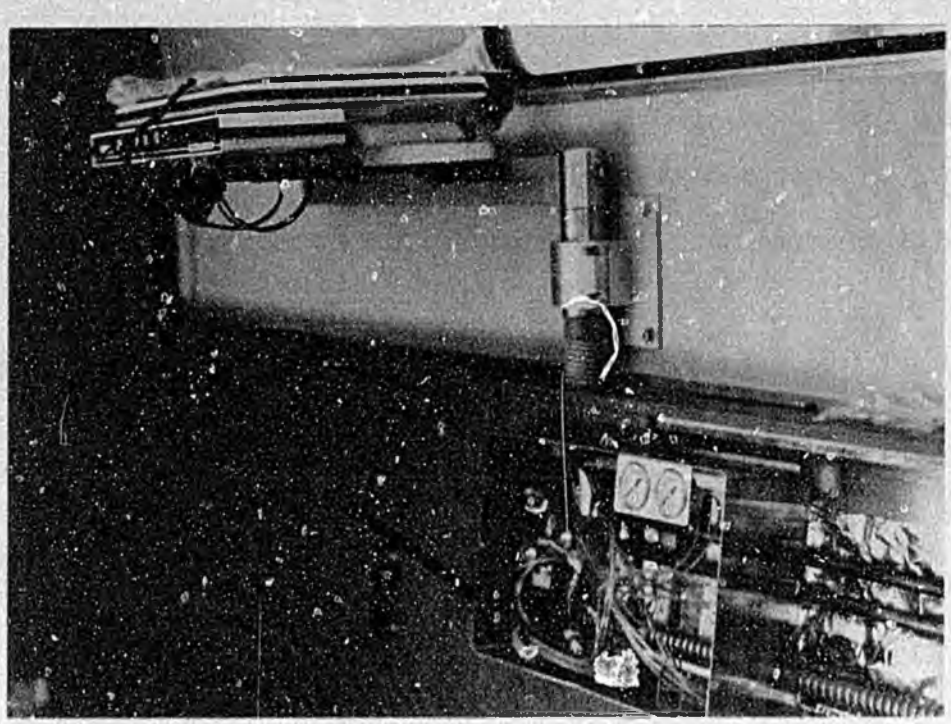
Dental Health is a Family Affair.

First class procedures were the watch word — full dental dams and quality techniques were applied to every patient.

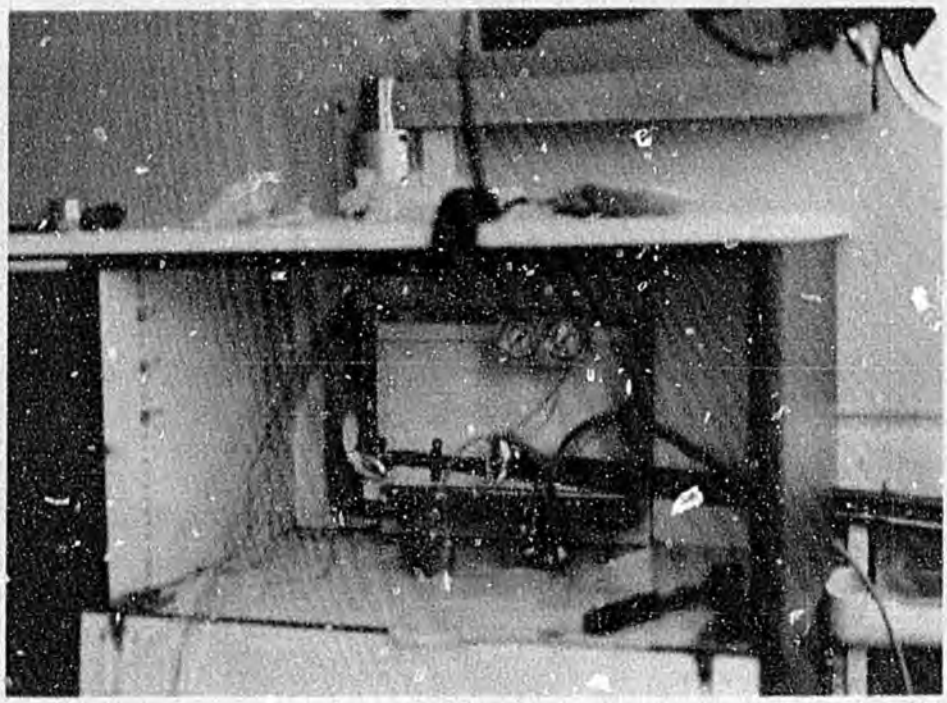


Working together is the only solution to the delivery of health care services to bush Alaska.

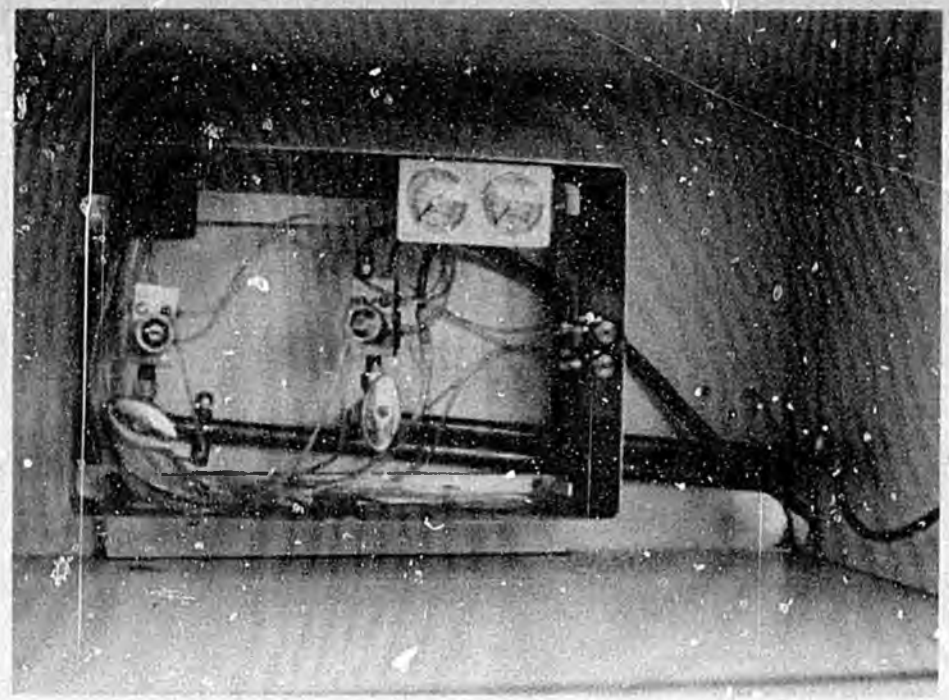
Students and professors built the unit from scratch cutting the cost by at least 25%.



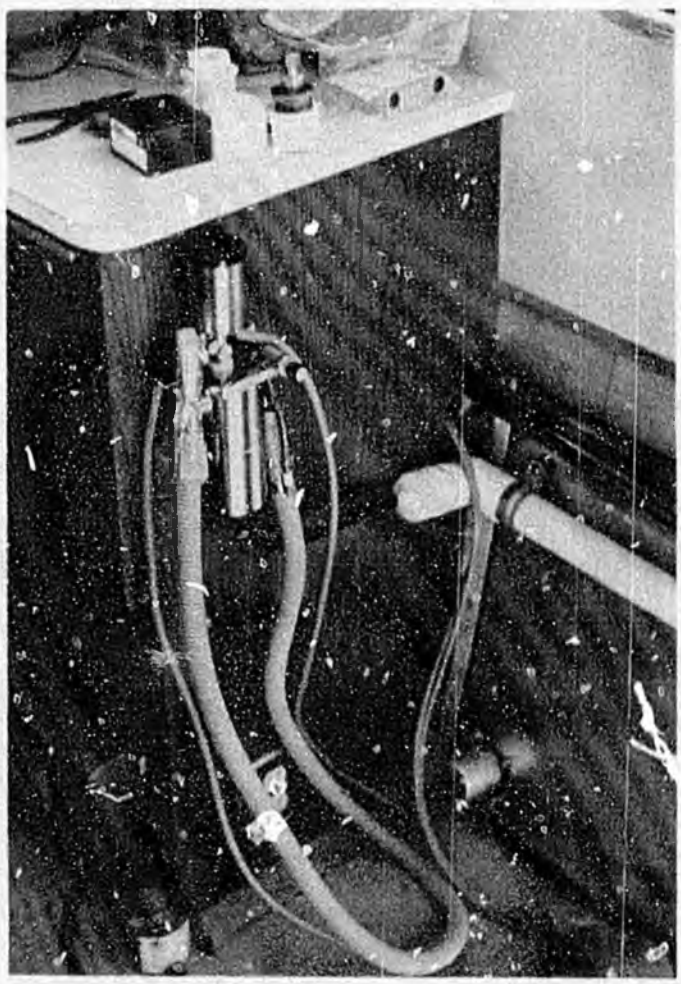
The x-ray system is wall mounted and swings out where needed.

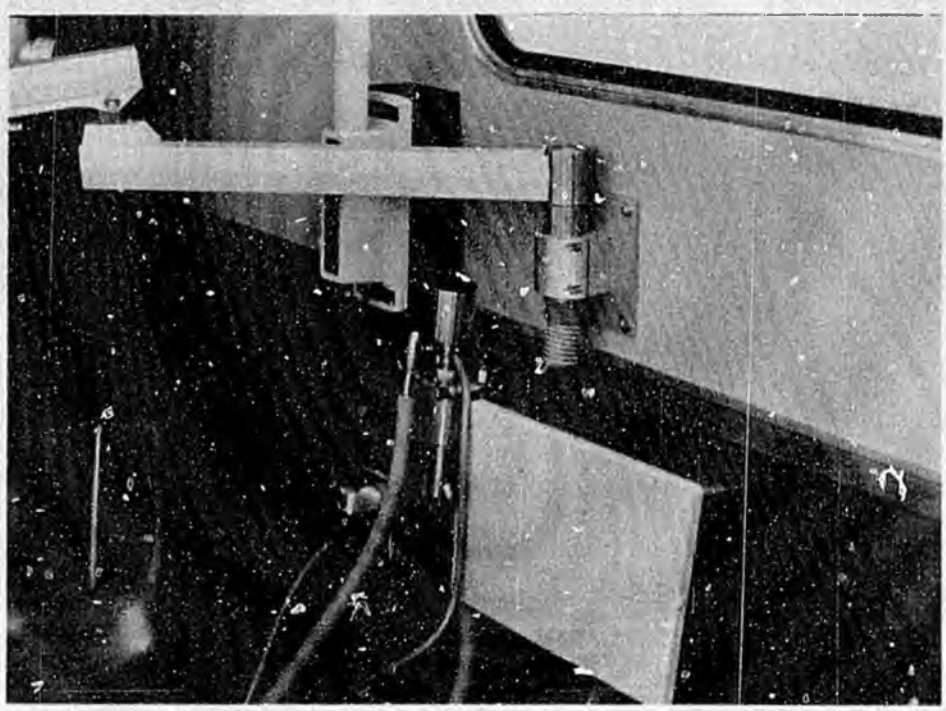


Plumbing and wiring were major undertaking for this modern unit.

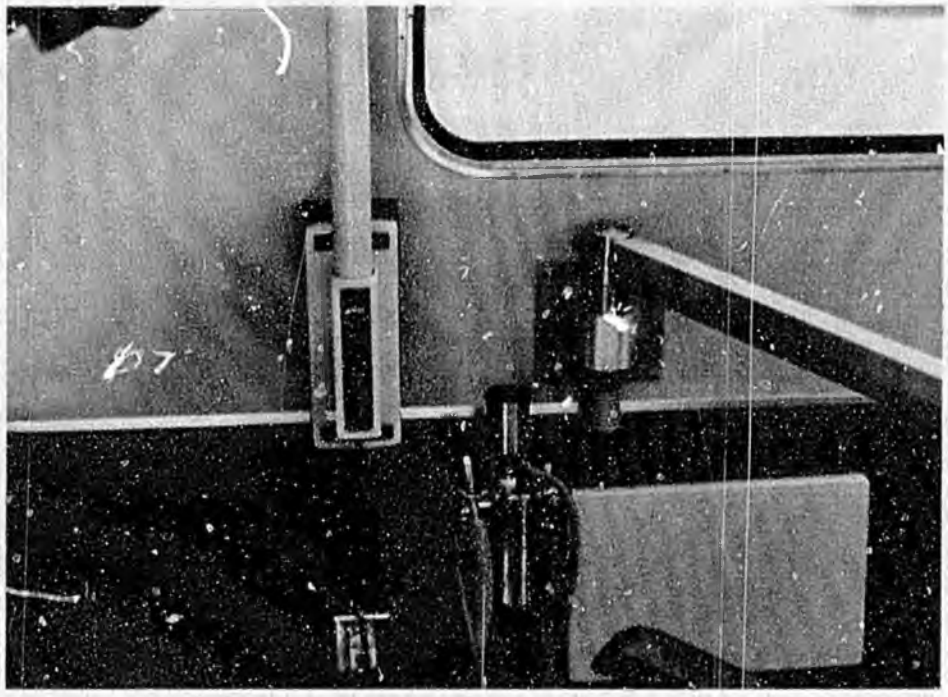


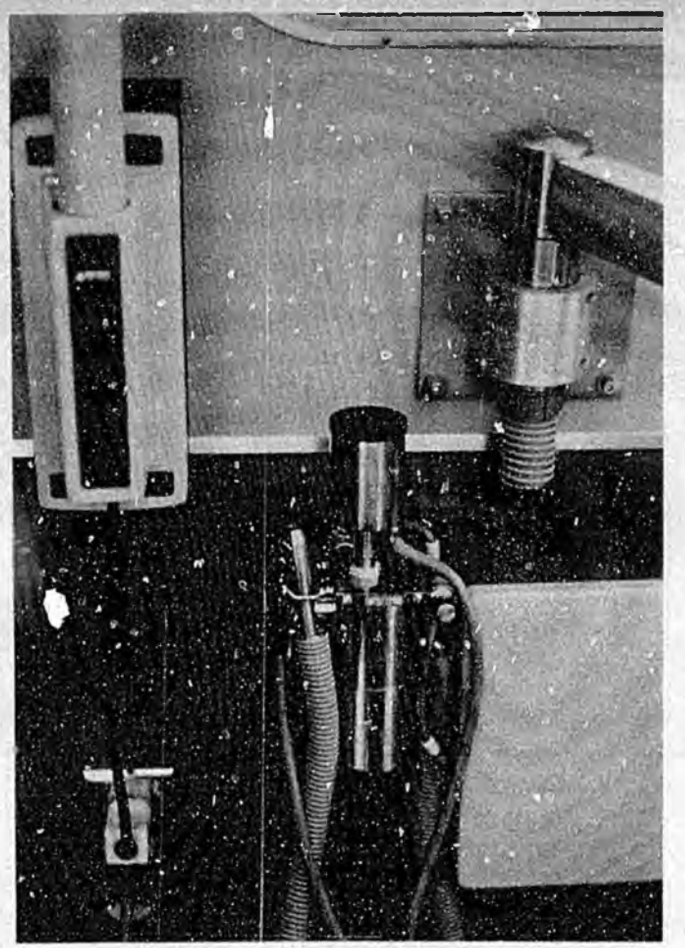
Dental Equipment hookups can be very technical — a challenge to any plumber.



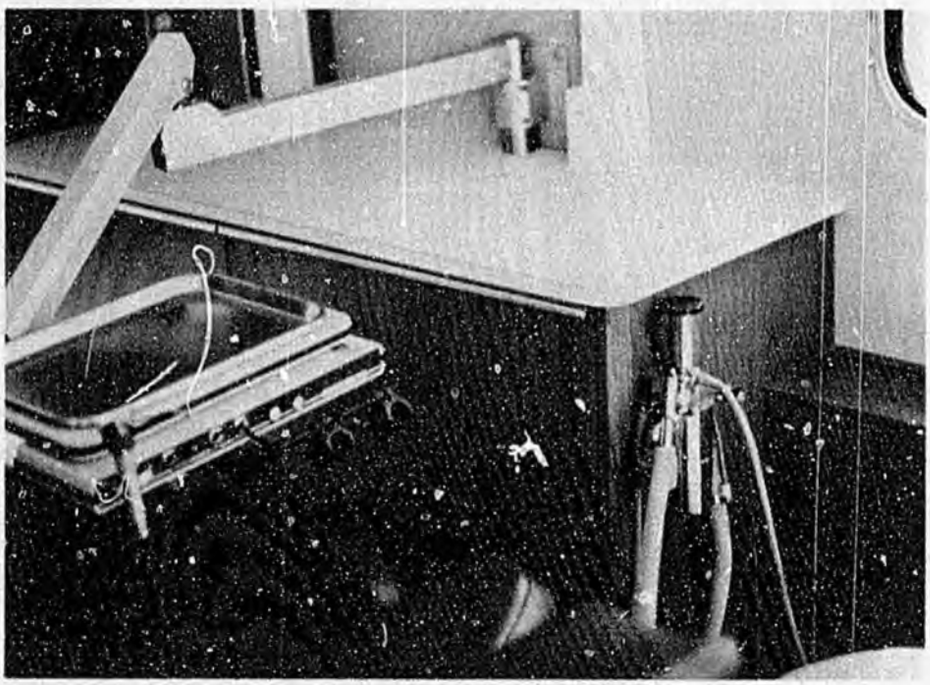


All equipment swings out and can be secured for the road.

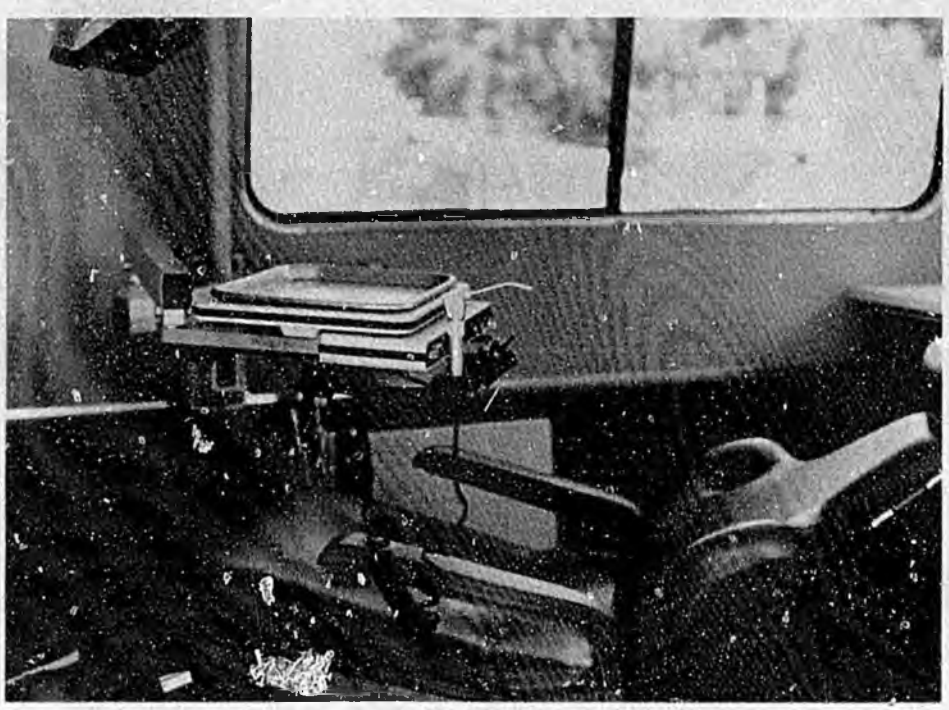




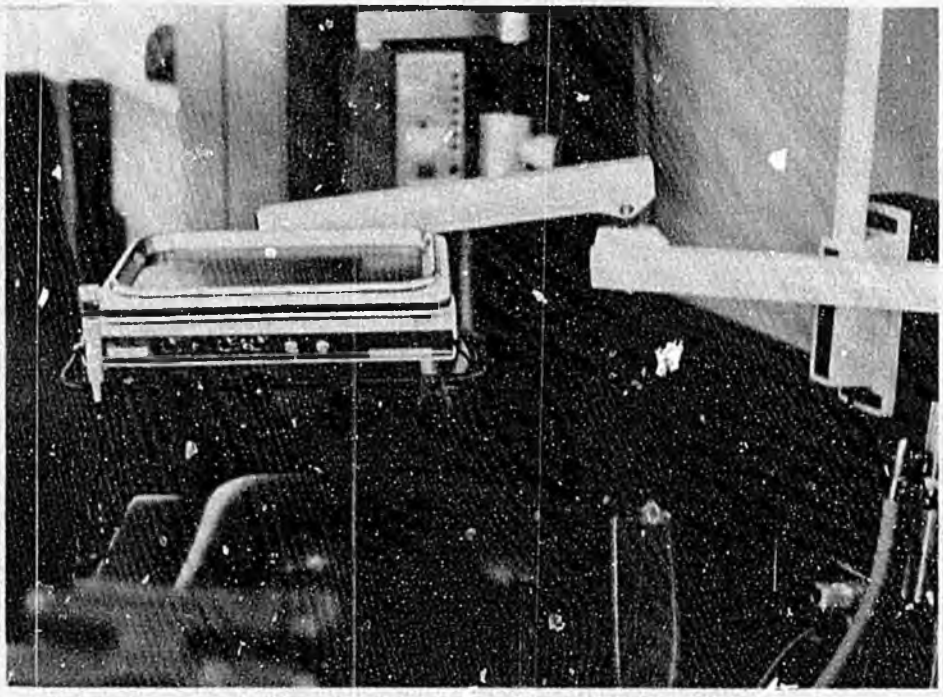
The stereo system and ear phones takes the patients mind off the drill and needles that frighten most patients. The Cukaracha Technique works well with kids.

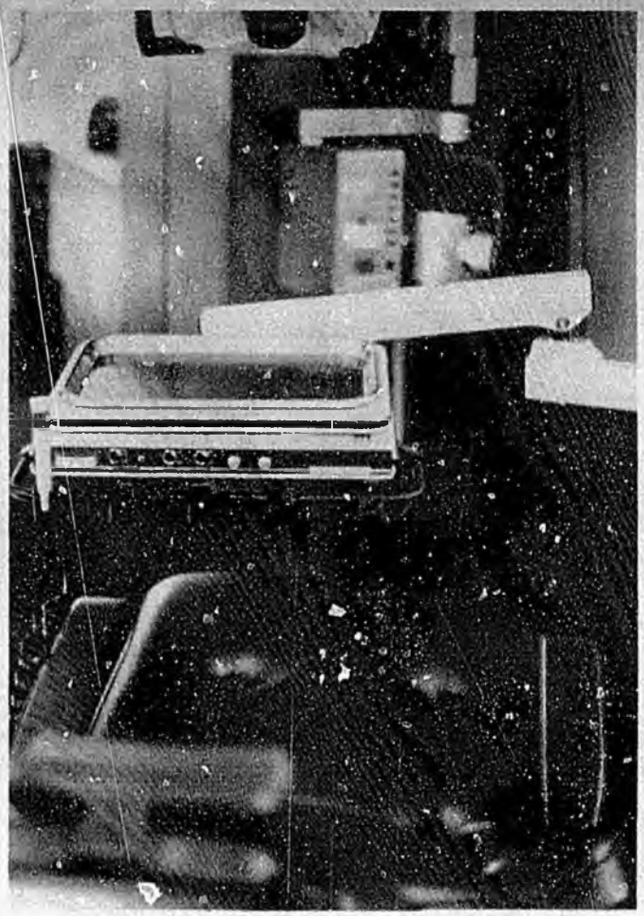


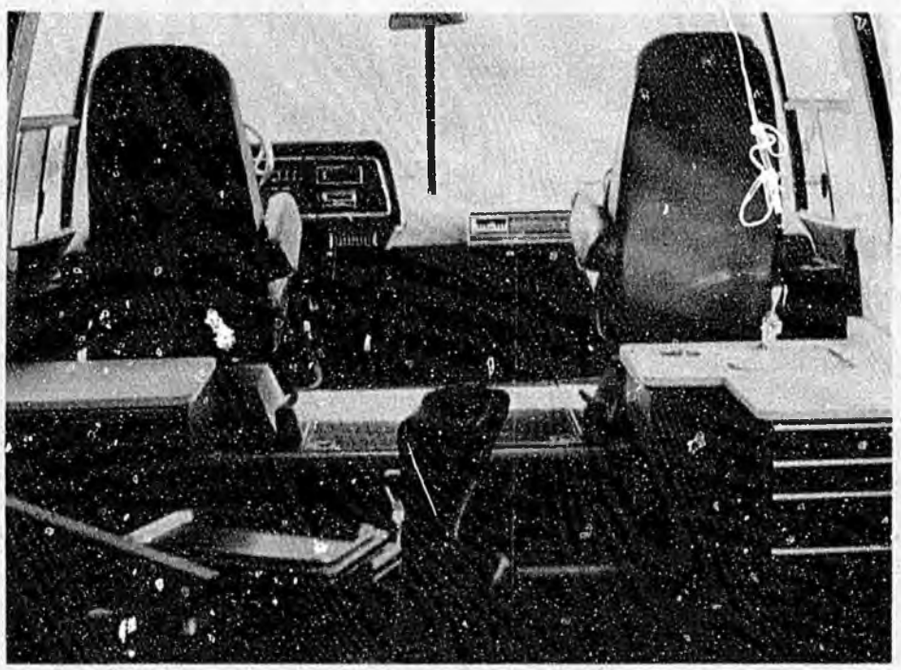
All of the equipment is the very latest and best.



These Siemens chairs are the best in the world — and better than many dental offices now have.

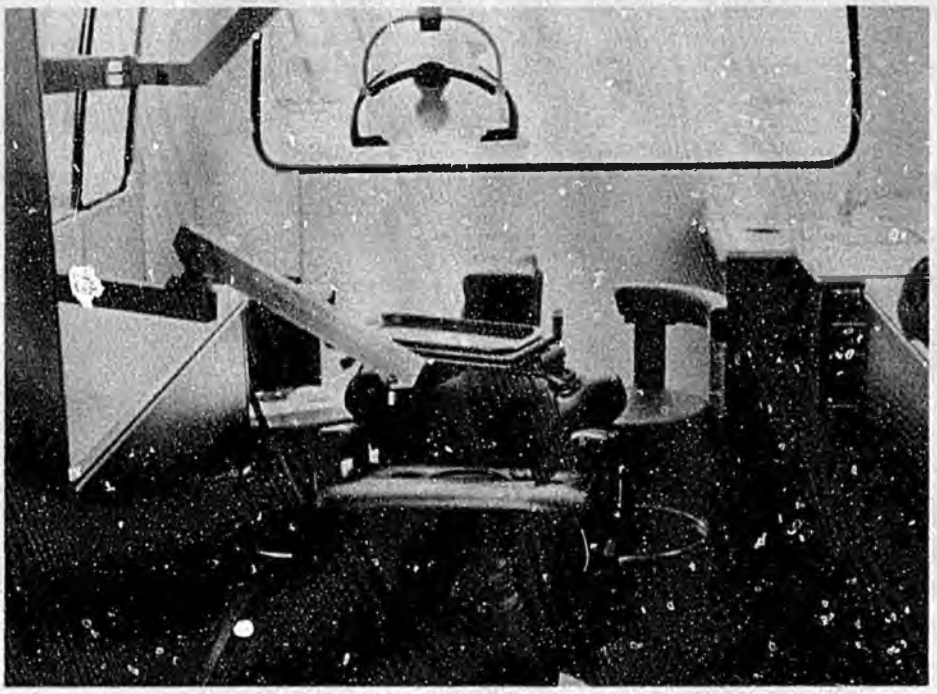






The spaciously designed drivers area allows plenty of room to operate and great viewing advantage through large picture like windows.

All equipment is designed to swing into place when and where needed.



That's it! We're all ready to go. All we need is legislation which allows Volunteer Dentists to give of their time and effort working with students of dentistry and dental hygiene fixing kids teeth in Alaska.

Your help is appreciated.

In Appreciation:

Our special thanks go to the Marvin M. Stark Research Foundation, an International organization dedicated to the health of children everywhere — for their unfailing devotion to the idea of delivery of voluntary health care to Alaska's isolated bush residents. They built the units, they drove them to Alaska and they staffed and operated the clinic as unpaid volunteers. They waded through unbelievable red tape and took a whole lot of bureaucratic abuse just so they could be of service. We apologize for the reception they got from the State Dental Board and other self serving professionals.

Pass H. B. 401
for a
Sane Approach to
Bush Dentistry

TELEGRAM

RCA ALASKA COMMUNICATIONS, INC.
PHONE 586-6442
JUNEAU, ALASKA 99802

#CJ

1979 APR 25 PM 6 05

02281 NL ANCHORAGE ALASKA 91 04-25 120P AST

PMS REP BILL MILES

HOUSE HESS COMMITTEE

JUNEAU AK

WE ARE AMAZED THAT NONE OF THE MATERIAL SENT YOU ON THE MOBILE DENTAL UNIT HAS FOUND ITS WAY TO THE FILES OF THE HESS COMMITTEE. WE ARE AGAIN SENDING A WHOLE PACKAGE WHICH WILL BRING EVERYONE FAIRLY AND HONESTLY UP TO DATE. PLEASE AT LEAST GIVE US THE BENEFIT OF SUBMITTING DOCUMENTATIONS TO THE COMMITTEE MEMBERS NO WONDER IT HASNT MOVED OUT OF YOUR COMMITTEE. FRIDAY WOULD BE A GOOD DATE FOR A PRESENTATION TO THE COMMITTEE BY OUR PEOPLE.

PATRICK PLETNIKOFF EXECUTIVE DIRECTOR ALEUTIAN PRIBILOF ISLANDS ASSN 1689 C ST ANCHORAGE AK 99501

TELEGRAM

RCA ALASKA COMMUNICATIONS, INC.
PHONE: 586-6142
JUNEAU, ALASKA 99802

02272 NL ANCHORAGE ALASKA 270 04-24 0350P AST

PMS REP BILL MILES, HOUSE HESS COMMITTEE

JUN

WHEN SOLOMON AS LEADER OF HIS PEOPLE HAD TO MAKE DECISIONS HE OFTEN LOOKED BEYOND HIS OWN PERSONAL TASTE, BEYOND HIS ENEMIES AND THE DEVISIVE INFLUENCES THAT PLAGUED HIM TO VIEW THE TRUE RECIPEINTS OF HIS ACTIONS, THE LITTLE PEOPLE WHO WOULD BARE THE BRUNT OF HIS DECISIONS. WE HAVE KIDS IN BUSH ALASKA WHO HAVE TOOTHACHES, WHO SUFFER ALL THE TIME WITH SYSTEMIC POSIONING AND MALNUTRITION BECAUSE OF DENTAL HEALTH PROBLEMS. LOOK BEYOND ALL THE RHETORIC OF THE PROFESSIONALS WHO HAVE MADE NO UNPAID EFFORT TO BRING RELIEF TO THESE PEOPLE. WHO BELIEVES THEM NOW WHEN THEY SAY THEY ARE READY TO GO TO WORK FIXING TEETH IN BUSH ELASKA, NOT I AND SURELY NOT YOU. OURS IS A VOICE CRYING OUT OF THE WILDERNESS BUT NOT BY ANY MEANS A LONE VOICE. EVERY SINGLE RURAL COMMUNITY WANTS DENTAL CARE NOW. THEY DONT CARE ABOUT OIL TAXES, FISH TAXES, D-2 OR PORK BARREL LEGISLATION WHEN THEY SUFFER WITH A TOOTH ACHE THEY WANT HELP NOW. WE HAVE A DLRS200,000 MOBILE CLINIC READY TO GO, PAID FOR WITH STATE TAX DOLLARS. IT IS INCONCEIVABLE THAT A SPECIAL INTEREST GROUP COULD BE SUCCESSFUL IN PREVENTING VOLUNTEERS FROM DELIVERING RELIEF TO THE SUFFERING SIMPLY BECAUSE THEY HAVE MONEY AND POWER. IT IS OURHOPE THT EVERY LEGISLATOR WHO VOTES OR ACTS IN OPPOSITION TO THIS EFFORT SUFFERS FROM S SEVERE TOOTH ACHE OR BREAKS HIS BRIDGE IF THE DENTISTS HAVE ALREADY GOTTEN HIS TEETH. OUR BILL IS TIED UP IN THELMA BUCKHOLDTS HESS COMMITTEE. HELP US GET IT OUT FOR A VOTE. THANKS.

PATRICK PLETNIKOFF, EXECUTIVE DIRECTOR, ALEUTIAN PRIBILOF ISLANDS ASSOCIATION 1689 C STREET ANCHORAGE ALASKA 99501

New views for Alaska television

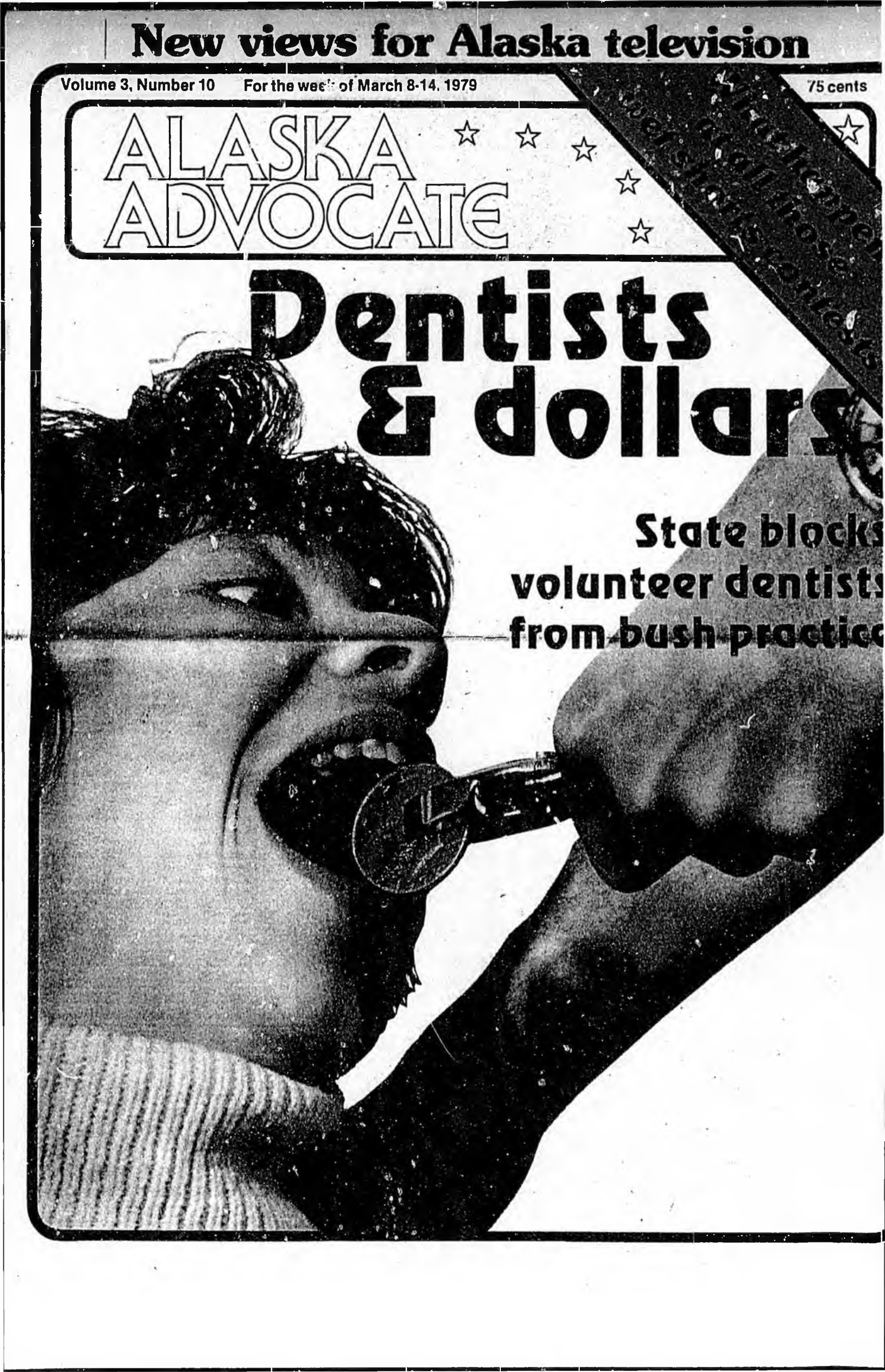
Volume 3, Number 10 For the week of March 8-14, 1979 75 cents

ALASKA ADVOCATE

Alaska's consumer newspaper

Dentists & dollars

State blocks volunteer dentists from bush practice



Examining dollars & dentists

Volunteer dentists who try to help in the bush have been blocked by rules that keep them out

by Bill Lazarus

Anchorage

While Aleuts suffer from a lack of basic dental care, state laws and the state dental board are blocking volunteer efforts to provide needed services.

Professors from reputable dental schools have volunteered to work on the Aleutian Chain for free. Fourth-year dentistry students working with the professors also have offered services, under a program developed by the Aleutian/Pribilof Islands Association.

But the program is floundering because the professors and students apparently can't get permits to practice from the Alaska Board of Dental Examiners. The dentist-dominated board is responsible for licensing dentists to work in the state.

"Professors aren't necessarily competent dentists," says Arthur Hansen, president of the dental board. He says the board is trying to protect Alaskans by insuring that only capable dentists practice in Alaska.

Officials at the Aleutian/Pribilof Islands Association, however, suspect an additional motivation: greed. They say the state board may view volunteer dentistry as undercutting private practice in the Bush.

Many private Alaska dentists contract with the U.S. Public Health Service to work in villages across Alaska. The work days tend to be long, but the pay is excellent. According to a small, random sample of 1978 health service data, individual earnings vary greatly, but on the average a dentist makes more than $1,000 a day while working in the Bush.

One health service official says that on a 10-day stay in Ft. Wainwright five years ago, Dr. Hansen earned some $22,000. Another official suggests the stay was probably 12 days.

Hansen says he doesn't recall how much he made, but he defends the figures. He says that since he worked double time in the village, he really worked about 20 normal days. That's a working month, he adds, pointing out that he makes more money in a month at his Fairbanks office. Generally, "I probably earn 25 percent less when I go to the villages than when I go to my own office," he says.

Public Health Service officials say that Bush fees are essentially the same as the office fees, except that at times money is provided to pay travel and lodging expenses.

The Public Health Service also employs its own dentists to work in the Bush. Between this and the private contracting, health service officials say, most dental needs of Bush children are met. They admit, however, that in many villages basic care for adults is not provided, because the service does not have the money.

"All we're trying to do is to get dental care out to rural Alaska where it's not being provided," says Pat Pletnikoff, executive director of the Aleutian/Pribilof Islands Association. "Right now we're just right in the middle of a pissing match. We have two people who want to come up now (the chairman and assistant chairman of the children's dentistry department at the University of California Dental School at San Francisco) ...but we can't get the permits issued for them to come and practice in Alaska."

"There is no provision in the Alaska statutes to do what they are trying to do," says Hansen. He points out that only dentists licensed in other states—and not students—are legally able to obtain special, one-year permits to work in Bush Alaska without going through the licensing procedure. (In states with dental schools, senior students are able to practice dentistry under supervision of a licensed dentist. But Alaska has no dental school and no such provision).

Besides, Hansen says, the Aleuts and their volunteers "haven't even made an attempt to apply for a permit."

The catch is that in December 1977 the board decided not to issue any more Bush permits. The one person holding a permit "had abused it," says board member John Beard. "He was practicing in an area that he wasn't supposed to be practicing in and he was doing bad work."

Other than obtaining a special permit, there are only two ways a dentist can legally practice in Alaska: he can pass an exam and gain a license from the dental board, or he can work for the Public Health Service. Federally employed dentists do not need to be licensed by the state, but they only earn $30,000 a year.

Passing the licensing exam is no easy task. Although the test is supposed to be simple, 13 of 25 people who took it last year flunked. Eighteen of the would-be Alaska dentists were already licensed in other states, but nearly half of those practicing dentists failed the clinical portion of the exam, which is judged by the dental board. This test is given only once a year.

Hansen says it's "hard to answer" questions about why so many established dentists failed. He suggests that "we have far fewer (malpractice) problems in Alaska...I think this quality has come about because our standards may be a bit higher."

A legislative audit completed earlier this year looks at the situation differently.

"Presently there is a dental manpower shortage noted in several areas of Alaska. Board policies are restricting the entry of qualified dentists and are not in the public's best interests...

"The Board's clinical examination has several deficiencies...first noted several years ago...(which) have not been corrected," the audit report says.

The report also says no instances of "deliberate grading bias" were found. It notes, however, that "a potential conflict of interest...exists when Alaska Board members who are practicing dentists grade the performance of applicants who represent potential competition."

In a written response to the audit, Hansen maintains, "There is no conflict of interest in the grading system. This is a serious charge to make especially by a lay person regarding a profession he knows little or nothing about."

He also says no shortage of dentists exists and "adequate numbers" of dentists are willing to travel to the Bush.

Only four dentists live in Alaska rural areas with a total population approaching 60,000. Alaska has 260 dentists: 200 private practitioners, 28 military dentists and 32 with the Public Health Service. Although very few dentists live in the Bush, the dentist population ratio in Alaska beats the national average of one dentist for every 2,186 people.

In its own response to the legislative audit, the House Commerce Committee voted recently to put the dental board on two years probation and urged the board to make it easier for dentists to practice in the state. The committee opted to dismantle several professional boards under Alaska's "sunset" law, but a final decision awaits a full vote of the legislature.

Despite the legislative recommendation, Hansen says he is not certain he would support legislation allowing student dentists to work under their professors in Alaska. He also says he is not sure he would support issuing permits to the

[continued on page 16]

Dentists

[continued from page 5]

dentistry professors who want to work with the Aleuts.

"I don't know whether we feel that we would have enough control over the situation...to insure quality work. In remote areas anything can go on and nobody's going to see it," he says. He adds that he is speaking for himself, not the board.

The predicament facing the Aleuts is not new. Last spring their association applied for a $200,000 state grant to buy a mobile dental clinic and to pay for the transportation and housing of volunteer dental students and professors. Representatives of the Alaska Dental Association unsuccessfully lobbied against the proposal.

Then last summer, in conjunction with the proposal, a group of four professors, six dental students and four dental hygienists came from California to work on the Pribilof Islands. But because of licensing problems, the group spent about 10 days in Anchorage doing nothing.

"They forced (the volunteer program) on people...They never cleared it through normal channels," says Hansen.

Jim Milne, a consultant through the Public Health Service after learning that the board had decided not to issue any permits. As volunteers for the federal government, the professors and students would not need approval from the state board.

Milne says the Public Health Service earlier agreed to take the volunteers under its wing, but later balked. Only after pressure was applied in Washington, D.C., he says, did the service agree to accept the volunteers, who then left Anchorage and spend about two and a half weeks treating 220 islanders.

Dr. John Stolpe, chief of dentistry for Public Health Service in Alaska, says the service did not flip-flop on the matter. He says the Aleuts approached the service about the matter only shortly before the volunteers arrived in Alaska.

Whatever the case, the health service now says it won't accept the dental volunteers.

According to Stolpe, who worked with the volunteers last summer, the problem is not the quality of the service. "From a technical standpoint, I found their services to be totally satisfactory...They are a young, enthusiastic group of people. They established a very good rapport with people in the (Pribilof) Public Health Service takes the volunteers, it will be in charge of the program. Instead, he says, it's better for the Aleutian/Pribilof Islands Association to keep control of the program and to obtain permits from the dental board.

Stolpe also says some paperwork requirements have not been met by the association and that, despite the volunteer help, the program cost more than the services provided.

Milne says the volunteer program saved money. He charges that the Public Health Service is just responding to pressures from Alaska dentists not to take the volunteers.

In light of the recent legislative recommendations, Milne says the association now will apply to the dental board for a temporary Bush permit for the volunteer dentists. He says it doesn't make sense for a dentist who might work here for only part of one summer, to go through the cost and burden of taking the licensing examination.

Even if application is made, the outlook doesn't look good for issuance of the permits.

The legislative audit itself criticizes the "double standard" of allowing unlicensed dentists to work under special permit in the Bush but not in urban areas. It recommends that either Hansen says the board is studying the possibility of reciprocal license agreements with other states but suggests it is likely to recommend that it judge some applicants on the basis of their credentials. This would "allow for close Board scrutiny of an applicant, thus assuring the same degree of quality," he says.

Board member John F. Kobylarz, a Soldotna dentist, disagrees with the primary recommendation of the audit. "Nowhere in (Alaska law)...is the Board charged with encouraging dentists to practice in Alaska. I think the State in its powers should protect the consumer, not try to coddle the citizen from birth to death," he writes.

The dental board is made up of five dentists, one dental hygienist and one person not associated with the dental profession, a mix Hansen claims "adequately represents the public interest."

John Beard, the one public member of the board, says licensing is "protectionist" and the board ought to be dismantled. An Anchorage lawyer with Libertarian leanings, Beard suggests that judging of dentists should be left to the marketplace and that even graduation more traditional point of view. She says she understands why the public might view the dental board as protecting the state's dentists from competition. But, she insists, the state exam is necessary. "Come to the next clinical dental examination. I think you would have your eyes opened. Just having a certificate from a dental school does not mean that you are competent," she says.

Varrati questions the wisdom of allowing students and professors to practice in Alaska. "Let them come up and take the board (exam)," she says. "I don't think we have remarkably high standards...We have one of the simpler exams...I wouldn't like to see someone who fail[ed] practice in the state."

"Either something is wrong with the dental schools or we have the best dental program in the entire world. I have the feeling that (the high failure rate) is related to the economics of competition," says Bob Worl, who served as health director of the North Slope Borough for three years.

Alaska dentists, he says, have volunteered work in the Bush and "it's very tough to say it's all black or white in terms of altruism or the economics involved. It's a real mixed bag."

New views for Alaska television

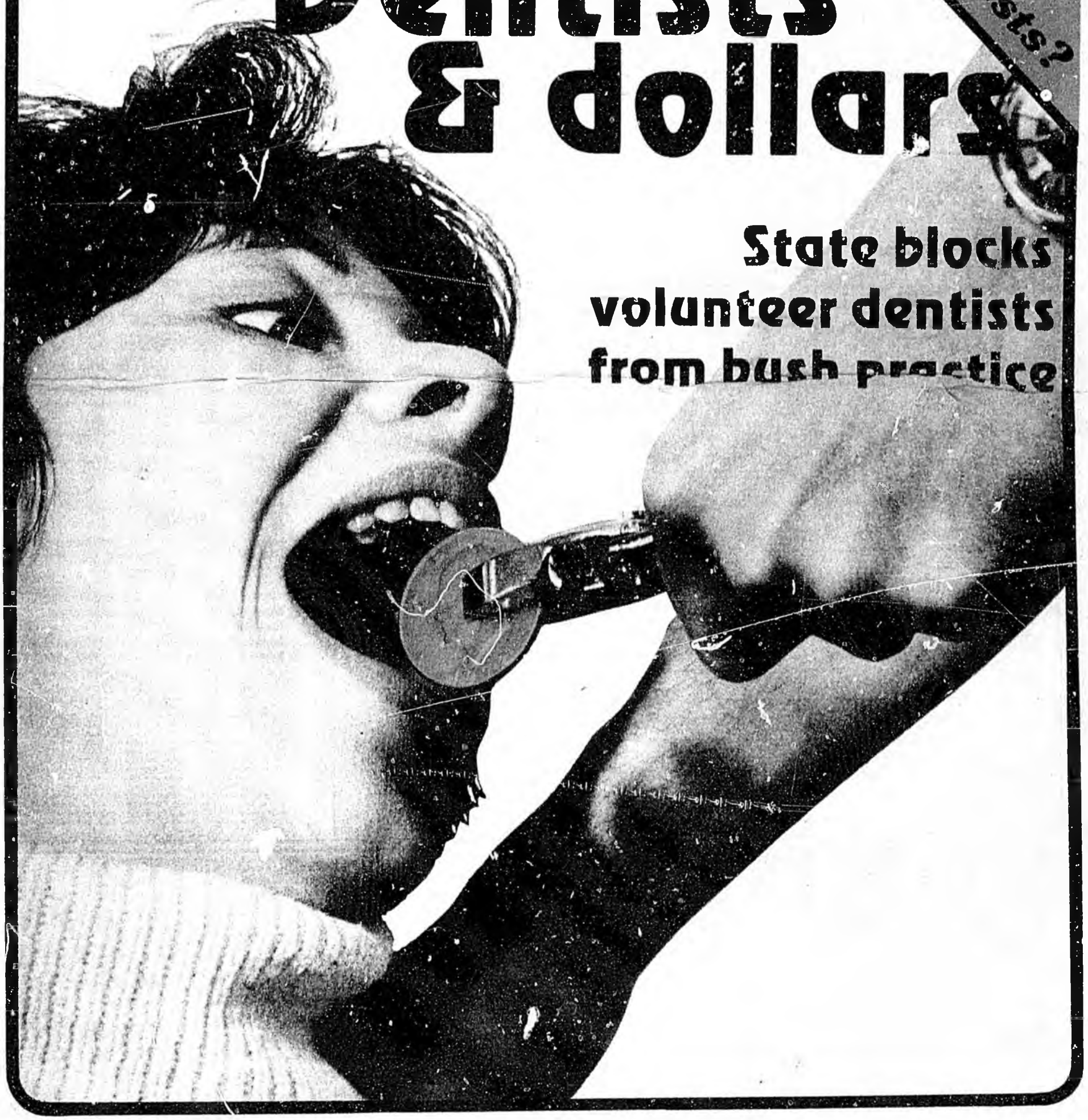
Volume 3, Number 10 For the week of March 8-14, 1979

75 cents

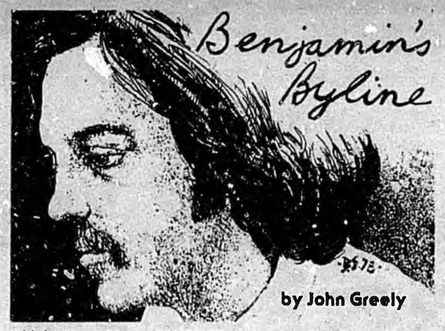
ALASKA ADVOCATE

What happens at all those wet shorts contests?

Dentists & dollars



State blocks volunteer dentists from bush practice



Juneau

Perhaps it's cabin fever. Maybe it's just a hangover from the eclipse. But a lot of people have been getting unset lately over Alaska's image.

If you've been reading Vogue Business Week or any number of newspaper reports from Washington, D.C., you might get the idea that the composite Alaskan in 1979 drives a bulldozer to work, climbs glaciers in the nude, slays multinational oil companies in the morning and shoots wolves in the afternoon.

Now that's one hell of an image. If my folks didn't know me better, they might think their son had gone out with the sun.

So for the sake of the image-conscious (if not the relatives) let's take a few lines to examine this composite:

Bulldozers—I've always been fascinated by bulldozers, ever since they came through my childhood neighborhood to build the freeway. They returned a few years ago to make the freeway bigger and the old neighborhood smaller, but now I live in Juneau and there isn't a freeway in sight.

However, as we've been told by Ron. Morris Udall of Arizona and others, bulldozers are "poised on the border" waiting to invade the state.

Udall's right, of course, but for Alaskans living 100 miles from the nearest road, it's nothing to get hysterical about. In fact, most of the bulldozers on the border are really pointed the other way, waiting to build the gas pipeline through Canada. So, if there's anybody who should be concerned about bulldozers in Alaska, it's the Canadians.

Beating Big Oil—An image dredged up by developers to counteract the bulldozer hysteria portrays the oil industry as Alaska's whipping boy. *Business Week* magazine (Feb. 26) is the latest organ to grind out this tune.

Business Week even went so far as to suggest that because of state tax increases in recent years, the oil industry might be cool to taking on our government as a partner in some ventures. Of course, the magazine could find no one from Northwest Alaska Pipeline Co. or the Alaska Petrochemical Corp. to back up that notion.

Northwest, for example, wants the state to cough up a bundle to help build the gas pipeline. The consortium might have found a willing partner, except state officials are holding back while they study the feasibility of the project. In turn, the feasibility of the project hinges on decisions by the gas owners, who aren't budging.

So, the question seems to be, who is whipping whom? Alaskans may take a lash to the big boys now and then, but the beating is certainly returned. Any bets that the first $1 gallon of gasoline was sold in Alaska five years ago?

Sex on Ice—A $150,000 ad placed in *Vogue Magazine* last month raised some ire because it attempted to entice tourists to Alaska with full-color shots of lots of female skin displayed in such unlikely places as Ruth Glacier ("Lovely name for an icedream.")

For state officials pondering the Northwest partnership, the Vogue ad might have been pause for thought; it was the product of another deal jointly financed by industry (the Alaska Visitors Association) and government.

Instead, the protests generally revolved around the idea of using sex to sell Alaska.

What those protests ignore, of course, is that the tourist industry has been using sex to sell Alaskans for years now. No, not to take off our clothes at home, but in some place like Tahiti.

So, the Vogue ad might be viewed as something of a boost for Alaskans to spend their vacation money in Alaska. If not, we at least will have another way to tell who the tourists are this season—they'll be the ones with no clothes on.

Wolf Killers—So much has been written about this image in the last few years that I hesitate to add any more. So whenever somebody asks me about the state's plan to knock off another 170 wolves to save the moose of Western Alaska, I just point to Gov. Jay Hammond (a veteran wolf hunter in those areas in the 1950s) and say, "Oh, that's just the start of the 1998 campaign."

To... joke, a lot of people nod knowingly because, somehow, that's the only image that makes sense.

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ALASKA ADVOCATE

DOLLARS

State laws and the dental board are blocking efforts to bring volunteer dentists to Bush Alaska. Dental board members say they are only trying to protect the public. But some people suspect the dental board is trying to protect lucrative Bush contracts in which Alaska dentists earn more than $1,000 daily.
by Bill Lazarus
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(Cover photo by Ken Roberts)

WILD, WET & WILLING

In a unisex change of pace, several Anchorage-area clubs have begun to feature male dancers along with traditionally topless and bottomless females.
by Jim Erickson
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TV CHANGES

What do you want on TV tonight? Opera? Children's programming without commercials? How about Don Young, live and in color direct from Capitol Hill in Washington? All of this is possible when cable television comes to Alaska's big cities. The fast-changing medium could multiply the goodies available on the tube, but also may hurt the state's conventional TV stations and movie theaters.
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STAFF

EDITORIAL

Howard Weaver, Editor — John Greely, Reporter, Juneau
Ken Roberts, Art Director — Clifford John Groh, Reporter, Anchorage
W.P. Dougherty, Managing Editor — Bill Lazarus, Reporter, Anchorage

Contributors
Ed Bennett, Chip Brown, Satch Carlson, Michael I. Carey, Dennis Cowals, Richard Finsberg, Elliot Friedman, Tom Kizzia, Karen L. Lew, Rodger Painter, Laury Roberts, Brad Stockwell, Betsi Woodman, Gordon Wright.

ADVERTISING

Diana Doyle, Manager — Mark R. Sutherlin, Representative, Anchorage

BUSINESS

Mark H. Hamilton..... General Manager
Mark Weaver..... Production Manager
Jim Erickson..... Circulation Manager
Jeanette Humphrey..... Accounting
Jolene Hillestad..... Typesetter

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'Mikado'

[continued from page 10]

quarterfinalist competition and will be teaching music, opera specifically, when he returns to Anchorage in June to settle permanently.

Only when you have a large enough skilled musical population can you skim off a cream experienced enough to produce a good show. But enthusiasm does not automatically make quality, a fact Lee Salisbury knows. He calls it a luxury to be able to choose from many qualified singers here rather than having to work with whatever you've got.

During their own time Gilbert & Sullivan were so popular that they were always fighting "pirated" versions of their works produced without royalty or permission. To avoid this happening in the U.S., they spirited the company here secretly, complete with aliases, a midnight ship boarding, and concealment of their destination from family and friends. To prevent the rival producer from furnishing his production, they pursuaded Liberty's store not to sell Japanese silks to him, and Carte himself bought all the Japanese costumes in Paris. They succeeded in opening two days before the "pirate" and ran for 430 performances in New York City.

Gilbert and Sullivan were sometimes a reluctant team. Separately they were failures—Sullivan eternally yearning for recognition in the "serious" musical world and Gilbert never finding another partner as stimulating (or as difficult) as Sullivan. Gilbert wrote the lyrics first, giving them to Sullivan only a few months before opening date. The collaborative tradition in light operas has continued, with bread-and-butter teams like Rogers and Hammerstein, and Lerner and Lowe carrying on.

Operetta is a diminutive term and Gilbert and Sullivan light operas are not diminutive forms. They are exciting as music, captivating as social commentary, enthralling in their humanistic themes. Better yet they are simply fun. Gilbert might have been talking seriously about himself when Pooh-Bah says, "I am a particularly haughty and exclusive person, of pre-Adamite ancestral descent...I can trace my ancestry back to a protoplasmal primordial atomic globule. Consequently, my family pride is something inconceivable."

The production plays in Anchorage March 8 through 11.

If you're going to be in Haines April 25-28, take a look at what's happening at ASCTA's festival. It's a great way to see nine Alaska theater performances in short order. Since the theater holds only 200 people, I recommend contacting Mimi Gregg, Box 75, Haines 99827, phone 766-2116 (work) or 766-2425 (home) about tickets.

If you can't get to Haines, check out the local performances. But don't stop at being part of the audience...see what it's like to participate in community theater.

Virtu

[continued from page 9]

competition will be Ella Gerber of New York. She has considerable theater experience as an actress, director and playwright, and is listed in *Who's Who in the American Theatre*.

The first festival competition in 1973 was won by the Juneau-Douglas Little Theatre for its performance of Edward Albee's "In A Chicago Abyss." The Fairbanks Drama Association won in 1975 with cuttings from a James Thurber production. In 1977 "The Audition," a play written and directed by Gerry Wilson, brought winning honors to the Kodiak Community Theatre.

Winner of the Alaska festival competition goes on to regional competition in Portland, Ore., against Washington and Oregon. Alaska has always come in second in regional competition. The regional winner goes on to Memphis, Tenn., for national competition. Both regional and national competitions are sponsored by American Community Theatre.

Each group has only two hours stage rehearsal time in Haines. This year, ASCTA requires that the competing productions be performed at least once before a local audience prior to the festival. Local arts calendars for recent months indicate the nine community theater groups are doing just that.

Only eight persons from each group are funded to participate in the festival. Half is paid by ASCA, half by theater match. Additionally, each group must sell at least a full page of advertising for the festival program.

During the festival, ASCTA's board of directors meets and elects a seven-member executive board. The 11-member general board has delegates from each of the ASCTA community theater organizations. Any adult amateur community theater, or a university or college theater with a community governing board, is eligible to join ASCTA. Actors and actresses who are active members of Actors Equity, or who receive more than half their income from acting may not participate in the festival.

Cable

[continued from page 4]

many people assume that cable's pay-to-watch status makes advertising unnecessary, commercials will be included on at least four of the 14 channels initially planned for the Fairbanks system. A similar proportion probably will be included in the Anchorage system selected by the APUC.

By law, over-the-air commercial stations distributed by cable will run with advertising spots intact. As for programming generated specifically for cable TV, industry sources say first-run movies and entertainment specials offered as parts of extra-cost, premium packages are inviolate and will run uninterrupted.

On the basic service, cable industry sources say advertising in addition to the commercials already on the regular over-the-air stations will be light and unobtrusive.

John McCaw, vice-president of Frontier ColorCable, Inc., winner of an APUC certificate to build a Fairbanks cable system, says his company will reserve one channel for advertising that it will sell itself. Some of the prospective Anchorage operators expect to put commercials on more than one channel, but all predict the ads will be few because of little demand by advertisers.

Dark clouds have peeked over the horizon for those who oppose commercials on cable, however. A widely quoted study predicts advertisers "will start becoming interested on a broad scale" when cable reaches 30 percent of all American homes with television sets. The report says the benchmark will occur within two years (the medium already reaches 20 percent of all TV homes, or more than 18 percent of all homes).

Perhaps an ominous portent is found in the experience of actor Dan Aykroyd, who as a cast member on NBC's "Saturday Night Live" regularly parodies the hard-sell electronic huckster. Aykroyd learned his pitchman act as a real-life salesman for a cable TV station in his native Canada.

Over-the-air commercial broadcasters are concerned as well. A recent report by their national association claims cable will transmit "deceptive and irresponsible advertising" as well as "borderline pornography...subversive propaganda...the outpourings of the lunatic fringe." Broadcasters clearly are worried about loss of advertising dollars.

Recently the management of Juneau's KINY-TV, the capital city's lone commercial broadcast television station, cut back programming by 40 hours a week. KINY management cited ad revenue competition from the local cable operation as a reason for the reduction.

In Anchorage, commercial broadcasters formally opposed a 1973 bid to bring cable to town. They claimed the proposed system would duplicate their services and jeopardize free TV; the plan later died after a newspaper investigation revealed its ties to a reputed organized crime figure.

The three local TV stations also have been reluctant to sell advertising to Visions, the local pay-TV station, after it began over-the-air service in late 1977.

The local broadcasters have not come out against the new round of Anchorage cable proposals, opting instead to wait and see.

Cable industry sources insist that the new service will tend to increase all kinds of TV viewing. One local observer says the mass appeal of over-the-air broadcasting will continue to hold a large market share: "People will watch 'Laverne and Shirley' no matter what else is on." However, this experienced Anchorage broadcaster also predicts the competition provided by cable will force the commercial telecasters to improve, and in the long run could force one of the three Anchorage stations out of business.

The record shows that competition does spur the improvement of the commercial broadcasters' performance. Improvements last year in the programming and operations of the Anchorage TV stations coincided with the arrival of Visions, although several other factors probably had more impact.

Broadcasters agree that the introduction of cable TV likely will produce an intensified scramble for viewers that will further the trend toward beefed-up local programming and generally tightened operations.

Anchorage movie theaters also have been upgraded in recent months. Their traditionally poor treatment of customers seems to have run headlong into Visions' widely praised efforts in programming first-run movies.

The dominant Wometco-Lathrop chain frequently waited six months or longer after a film's initial release before putting it—sometimes in a very poor-quality copy—on one of its nine Anchorage screens. Although the company still receives complaints about its selection of films, the lag on several major releases has been eliminated.

Wometco-Lathrop vice-president Hugh McCauley of Anchorage denies that the arrival of Visions has speeded up the chain's film-buying process, saying he ordered the switch 18 months ago without knowing the pay-TV station soon would begin operations.

McCauley also dismissed as "far-fetched" any predictions that cable TV will make theaters unprofitable. A well-known study concludes that by 1985 cable and other innovations will combine to do just that. Other observers say the neighborhood movie house will survive, if only to give teenagers a place to meet and neck.

What worries broadcasters and theater operators is cable TV's capacity to entertain, but the medium is able to do much more than that. McCaw says the Fairbanks system will be capable of bi-directional cable or "two-way television." The intense competition for the right to build the Anchorage system virtually insures that the winner will boast even more state-of-the-art features.

Subscribers can use a bi-directionally equipped television to protect their residences with security systems, to purchase commodities from their living rooms and even to vote from their easy chairs—in short, to talk back to their TV sets.

An experimental system boasting all these features now operates in Columbus, Ohio.

Although the capacity for such futuristic services will be engineered into both Anchorage and Fairbanks systems, they still are at least a few years away from operation. Still farther down the road—perhaps 10 or 15 years—is direct satellite-to-home transmission by use of special antennas, which could threaten cable the way cable threatens over-the-air broadcasting.

Whatever the next stage in this technological revolution, TV's role in American life is expected to grow. The average household operates its set six hours, 17 minutes a day, the latest Nielsen survey shows, and that figure is sure to rise. Not only will people watch more television, but the expanded choice of programming probably will have them watching it alone as each viewer finds a congenial show. This implies a continuing growth in sales of TV sets as typical households buy two or three rather than one.

The future of cable TV is uncertain for more reasons than the impending advances of satellite transmission. Capital-intensive and heavily regulated, the industry is likely to be affected greatly by turns in the economy and the outcome of current congressional consideration of communications legislation. However, one bet is sure: Alaskans interested in money could do worse than to jump into the tube business.

Examining dollars & dentists

Volunteer dentists who try to help in the bush have been blocked by rules that keep them out

by Bill Lazarus

Anchorage

While Aleuts suffer from a lack of basic dental care, state laws and the state dental board are blocking volunteer efforts to provide needed services.

Professors from reputable dental schools have volunteered to work on the Aleutian Chain for free. Fourth-year dentistry students working with the professors also have offered services, under a program developed by the Aleutian/Pribilof Islands Association.

But the program is floundering because the professors and students apparently can't get permits to practice from the Alaska Board of Dental Examiners. The dentist-dominated board is responsible for licensing dentists to work in the state.

"Professors aren't necessarily competent dentists," says Arthur Hansen, president of the dental board. He says the board is trying to protect Alaskans by insuring that only capable dentists practice in Alaska.

Officials at the Aleutian/Pribilof Islands Association, however, suspect an additional motivation: greed. They say the state board may view volunteer dentistry as undercutting private practice in the Bush.

Many private Alaska dentists contract with the U.S. Public Health Service to work in villages across Alaska. The work days tend to be long, but the pay is excellent. According to a small, random sample of 1978 health service data, individual earnings vary greatly, but on the average a dentist makes more than $1,00[illegible] a day while working in the Bush.

One health service official says that on a 10-day stay in Ft. Wainwright five years ago, Dr. Hansen earned some $22,000. Another official suggests the stay was probably 12 days.

Hansen says he doesn't recall how much he made, but he defends the figures. He says that since he worked double time in the village, he really worked about 20 normal days. That's a working month, he adds, pointing out that he makes more money in a month at his Fairbanks office. Generally, "I probably earn 25 percent le s when I go to the villages than when I go to my own office," he says.

Public Health Service officials say that Bush fees are essentially the same as the office fees, except that at times money is provided to pay travel and lodging expenses.

The Public Health Service also employs its own dentists to work in the Bush. Between this and the private contracting, health service officials say, most dental needs of Bush children are met. They admit, however, that in many villages basic care for adults is not provided, because the service does not have the money.

"All we're trying to do is to get dental care out to rural Alaska where it's not being provided," says Pat Pletnikoff, executive director of the Aleutian/Pribilof Islands Association. "Right now we're just right in the middle of a pissing match. We have two people who want to come up now (the chairman and assistant chairman of the children's dentistry department at the University of California Dental School at San Francisco) ...but we can't get the permits issued for them to come and practice in Alaska."

"There is no provision in the Alaska statutes to do what they are trying to do," says Hansen. He points out that only dentists licensed in other states—and not students—are legally able to o[illegible] in special, one-year permits t[illegible] work in Bush Alaska [illegible]ithout going through the licensing procedure. (In states with dental schools, senior students are able to practice dentistry under supervision of a licensed dentist. But Alaska has no dental school and no such provision).

Besides, Hansen says, the Aleuts and their volunteers "haven't even made an attempt to apply for a permit."

The catch is that in December 1977 the board decided not to issue any more Bush permits. The one person holding a permit "had abused it," says board member John Beard. "He was practicing in an area that he wasn't supposed to be practicing in and he was doing bad work."

Other than obtaining a special permit, there are only two ways a dentist can legally practice in Alaska: he can pass an exam and gain a license from the dental board, or he can work for the Public Health Service. Federally employed dentists do not need to be lic[illegible]sed by the state, but they c[illegible]y earn $30,000 a year.

Passing the licensing exam is no easy task. Although the test is supposed to be simple, 13 of 25 people who took it last year flunked. Eighteen of the would-be Alaska dentists were already licensed in other states, but nearly half of those practicing dentists failed the clinical portion of the exam, which is judged by the dental board. This test is given only once a year.

Hansen says it's "hard to answer" questions about why so many established dentists failed. He suggests that "we have far fewer (malpractice) problems in Alaska...I think this quality has come about because our standards may be a bit higher."

A legislative audit completed earlier this year looks at the situation differently.

"Presently there is a dental manpower shortage noted in several areas of Alaska. Board policies are restricting the entry of qualified dentists and are not in the public's best interests...

"The Board's clinical examination has several deficiencies...first noted several years ago...(which) have not been corrected," the audit report says.

The report also says no instances of "deliberate grading bias" were found. It notes, however, that "a potential conflict of interest...exists when Alaska Board members who are practicing dentists grade the performance of applicants who represent potential competition."

In a written response to the audit, Hansen maintains, "There is no conflict of interest in the grading system. This is a serious charge to make especially by a lay person regarding a profession he knows little or nothing about."

He also says no shortage of dentists exists and "adequate numbers" of dentists are willing to travel to the Bush.

Only four dentists live in Alaska rural areas with a total population approaching 60,000. Alaska has 260 dentists: 200 private practitioners, 20 military dentists and 32 with the Public Health Service. Although very few dentists live in the Bush, the dentist population ratio in Alaska beats the national average of one dentist for every 2,186 people.

In its own response to the legislative audit, the House Commerce Committee voted recently to put the dental board on two years probation and urged the board to make it easier for dentists to practice in the state. The committee opted to dismantle several professional boards under Alaska's "sunset" law, but a final decision awaits a full vote of the legislature.

Despite the legislative recommendation, Hansen says he is not certain he would support legislation allowing student dentists to work under their professors in Alaska. He also says he is not sure he would support issuing permits to the

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Alaska news and tidbits from across the state

by Clifford John Groh, with staff reports

Anchorage:

Educational executives from Missoula, Miami and Buffalo are among the five finalists for the presidency of the University of Alaska.

The five were chosen from a list of 90 original candidates for a job that has turned over twice in the past two years.

Named as finalists by the university's Board of Regents were Jay Barton, vice-president and provost for academic affairs at West Virginia University; William Carlson, president of the University of Wyoming; Lawrence Pettit, former commissioner of higher education with the Montana University system; Albert Somit, executive vice-president and president of political science at State University of New York at Buffalo; and Clyde Wingfield, executive vice-president for academic affairs and provost, University of Miami.

The regents voted at a special meeting in Anchorage to bring the finalists to Alaska soon for a six-day look at the system.

UA President Foster Diebold will end his term by previous agreement early this summer.

Fairbanks:

The Fairbanks police union is suing to force reinstatement of six employees laid off by the city in an economy drive.

The Fairbanks Police Department Employees Association lawsuit charges that the layoffs of five patrolmen and a secretary violated the union's contract. The suit, filed in state superior court, also complains that the city took the action without consulting the union or attempting to find another cost-cutting move that would avoid layoffs.

City Manager Bob Wolting said the layoffs were necessary to cut the police department's budget by $245,000, a move mandated by an ordinance passed last May that requires this year's city spending be held to last year's levels.

Wolting told the *Fairbanks Daily News-Miner* that nothing in the contract prevents reducing the police force.

Ketchikan:

The second of three unions striking the First City's pulp mill has settled on a contract and returned to work.

Members of the International Brotherhood of Electrical Workers have accepted a three-year pact with the Louisiana-Pacific mill. The new pact provides 15 members of the IBEW with terms similar to those earlier approved by the 40-member Union of Operating Engineers.

The IBEW contract provides for a 10 percent wage hike during the first year, retroactive to June 1, 1978, a 9 percent increase in the second year, and 8 percent in the third year.

Meanwhile, members of the Association of Western Pulp and Paper Workers, the 400-member union that has been striking since Sept. 15, said talks would not take place until later this month. The union said its representatives were tied up in other negotiations in Washington.

Shorts

[continued from page 8]

it all off while playing bagpipes, most participants at this Amateur Night forego any elaborate talent show. Constant cries of "Fluff that muff" from a juiced-up cross-section of GIs, tourists and run-of-the-mill locals appears to deter the nudeniks from doing much more than jiggling their flesh.

The crowds overlap at the "Wet Shorts" contest held at the other end of town, but the atmosphere is decidedly less sadistic than the scene at PJ's. Instead of a jeering, pressure-filled degradation ritual, every Monday night the Roadhouse puts on a raunchy version of a high-school popularity contest. In this "Splash for Cash" competition, well-formed young men go offstage to strip down to baby blue trunks with "WET SHORTS" imprinted on the back. (Women get their own chance for the $101 prize the next night, when the Muldoon tavern sponsors a "Wet T-Shirt" contest.)

When the men return to the dance floor that doubles as a stage, eager women with bottles of cold water spray the stretchy material until it clings tightly to the contestants' genitals.

The guys then do their stuff, dancing to the repetitive disco lyric, "Push, push in the bush." The most popular entrants are obvious—they garner not only cheers and applause, but also ice cubes and dollar bills stuffed down their flimsy undies by admiring women who approach from the audience.

Roadhouse manager Dennis Smith says the contest is judged by the announcer's reading of crowd reaction. No independent evaluators are used, he said, because, "They'd kill the judges."

Dentists

[continued from page 5]

dentistry professors who want to work with the Aleuts.

"I don't know whether we feel that we would have enough control over the situation...to insure quality work. In remote areas anything can go on and nobody's going to see it," he says. He adds that he is speaking for himself, not the board.

The predicament facing the Aleuts is not new. Last spring their association applied for a $200,000 state grant to buy a mobile dental clinic and to pay for the transportation and housing of volunteer dental students and professors. Representatives of the Alaska Dental Association unsuccessfully lobbied against the proposal.

Then last summer, in conjunction with the proposal, a group of four professors, six dental students and four dental hygienists came from California to work on the Pribilof Islands. But because of licensing problems, the group spent about 10 days in Anchorage doing nothing.

"They forced (the volunteer program) on people...They never cleared it through normal channels," says Hansen.

Jim Milne, a consultant for the Aleuts, admits the association had not applied to the dental board for special permits for the volunteers. He says the association decided to work through the Public Health Service after learning that the board had decided not to issue any permits. As volunteers for the federal government, the professors and students would not need approval from the state board.

Milne says the Public Health Service earlier agreed to take the volunteers under its wing, but later balked. Only after pressure was applied in Washington, D.C., he says, did the service agree to accept the volunteers, who then left Anchorage and spend about two and a half weeks treating 220 islanders.

Dr. John Stolpe, chief of dentistry for Public Health Service in Alaska, says the service did not flip-flop on the matter. He says the Aleuts approached the service about the matter only shortly before the volunteers arrived in Alaska.

Whatever the case, the health service now says it won't accept the dental volunteers.

According to Stolpe, who worked with the volunteers last summer, the problem is not the quality of the service. "From a technical standpoint, I found their services to be totally satisfactory...They are a young, enthusiastic group of people. They established a very good rapport with people in the (Pribilof) community...I enjoyed working with them. I thought they were sincere and worked quite hard," he says.

But Stolpe says if the Public Health Service takes the volunteers, it will be in charge of the program. Instead, he says, it's better for the Aleutian/Pribilof Islands Association to keep control of the program and to obtain permits from the dental board.

Stolpe also says some paperwork requirements have not been met by the association and that, despite the volunteer help, the program cost more than the services provided.

Milne says the volunteer program saved money. He charges that the Public Health Service is just responding to pressures from Alaska dentists not to take the volunteers.

In light of the recent legislative recommendations, Milne says the association now will apply to the dental board for a temporary Bush permit for the volunteer dentists. He says it doesn't make sense for a dentist who might work here for only part of one summer, to go through the cost and burden of taking the licensing examination.

Even if application is made, the outlook doesn't look good for issuance of the permits.

The legislative audit itself criticizes the "double standard" of allowing unlicensed dentists to work under special permit in the Bush but not in urban areas. It recommends that either the permit system be done away with (and licensing made easier) or that it be applied statewide.

In his audit response, Hansen says the dental board recommends the permit system be eliminated. He says the board is studying the possibility of reciprocal license agreements with other states but suggests it is likely to recommend that it judge some applicants on the basis of their credentials. This would "allow for close Board scrutiny of an applicant, thus assuring the same degree of quality," he says.

Board member John F. Kobylarz, a Soldotna dentist, disagrees with the primary recommendation of the audit. "Nowhere in (Alaska law)...is the Board charged with encouraging dentists to practice in Alaska. I think the State in its powers should protect the consumer, not try to coddle the citizen from birth to death," he writes.

The dental board is made up of five dentists, one dental hygienist and one person not associated with the dental profession, a mix Hansen claims "adequately represents the public interest."

John Beard, the one public member of the board, says licensing is "protectionist" and the board ought to be dismantled. An Anchorage lawyer with Libertarian leanings, Beard suggests that judging of dentists should be left to the marketplace and that even graduation from dental school should not be required to practice dentistry in Alaska.

Jana Varrati, a dental hygienist on the board, has a more traditional point of view. She says she understands why the public might view the dental board as protecting the state's dentists from competition. But, she insists, the state exam is necessary. "Come to the next clinical dental examination. I think you would have your eyes opened. Just having a certificate from a dental school does not mean that you are competent," she says.

Varrati questions the wisdom of allowing students and professors to practice in Alaska. "Let them come up and take the board (exam)," she says. "I don't think we have remarkably high standards...We have one of the simpler exams...I wouldn't like to see someone who failed practice in the state."

"Either something is wrong with the dental schools or we have the best dental program in the entire world. I have the feeling that (the high failure rate) is related to the economics of competition," says Bob Worl, who served as health director of the North Slope Borough for three years.

Alaska dentists, he says, have volunteered work in the Bush and "it's very tough to say it's all black or white in terms of altruism or the economics involved. It's a real mixed bag."

However, taking a broad perspective, he says, "The problem is that the system is set up so that a guy is a fool if he doesn't make a killing."

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Enclosed for your information and files are materials relating to the teleconference on HB 401 held March 29, 1979, including a copy of the witness and observer list.

Judy Hopkins
Anchorage Moderator

LAA 11
(Rev. 4-29-77 M)

TELECONFERENCE HEARINGS

TOPIC: HB 401 - exempting certain persons practicing dentistry and dental hygiene from licensing requirements

COMMITTEE: House HESS (Buchholdt)

DATE: Thursday, March 29, 1979 (DATE SCHEDULED: 3/28/79)

TIME: 11 - 12:30 A.S.T.

SITES PARTICIPATING: Anchorage, Fairbanks, Ketchikan, Nome

CONFERENCE MODE: audio LOCATION: LIO MODERATOR: Hopkins

NOTES:

expect: Josh Wright - Jane
Dr. Hanson - Jane
Dr. Redmond - Jane

How about Jana? Claudia will advise.
Jana will be in Juneau.

PUBLICITY:

x INVITATIONAL

x Committee making contacts

___ PSAs (date) (quantity)

___ News release (date) (quantity)

___ Summary to be provided
___ Text to be provided
___ Quotes to be provided

___ Direct mail (date) (quantity)

___ Phone (date) (quantity)

x Posted at Information Office

TELECONFERENCE STARTED 11:10 AM

TELECONFERENCE ENDED 1:00 pm

WITNESSES ___
OBSERVERS 7 ATTENDANCE
TOTAL 7

(2 Tel Legal to Juneau, one home rec'd)

Name Ralph Elusha Here to TESTIFY ____

Representing API A Inc

Mailing Address 1689 C St Zip 99504 Here to OBSERVE V

Phone 276-2700

BROADCAST CONSENT: This proceeding may be broadcast live or recorded for later broadcast by radio or television stations. Please indicate your consent by signing below:

Ralph I Elusha
(signature)

PLEASE PRINT

Name Mike Dolimont Here to TESTIFY ____

Representing A.P.I.A.

Mailing Address 1689 'C' Street Zip 99501 Here to OBSERVE X

Phone 276-2700

BROADCAST CONSENT: This proceeding may be broadcast live or recorded for later broadcast by radio or television stations. Please indicate your consent by signing below:

(signature)

Have you participated in other legislative teleconferences? No How many? ____ Would you have participated in this hearing if the network were not available? No

How did you learn about this hearing? If yes, did you use the network: ____

PLEASE PRINT

Name Dorothy E. Morrison Here to TESTIFY ____

Representing ____

Mailing Address 1306 S Zip 99503 Here to OBSERVE ____

Phone ____

BROADCAST CONSENT: This proceeding may be broadcast live or recorded for later broadcast by radio or television stations. Please indicate your consent by signing below:

(signature)

PLEASE PRINT

Name GERALD M. STRANIK DDS. Here to TESTIFY V

Representing SELF

Mailing Address 2601 BONIFACE PKWY Zip 99504 Here to OBSERVE

Phone 337-9474

BROADCAST CONSENT: This proceeding may be broadcast live or recorded for later broadcast by radio or television stations. Please indicate your consent by signing below:

(signature)

Have you participated in other legislative teleconferences? How many? Would you have participated in this hearing if the network were not available?

PLEASE PRINT

Name Michael A. Martin Here to TESTIFY

Representing Aleutian/Pribilof Islands Assoc.

Mailing Address 1689C St. Anch. Zip 99501 Here to OBSERVE X

Phone 276-2700

BROADCAST CONSENT: This proceeding may be broadcast live or recorded for later broadcast by radio or television stations. Please indicate your consent by signing below:

(signature)

Have you participated in other legislative teleconferences? No How many? Would you have participated in this hearing if the network were not available?

PLEASE PRINT

Name Anthony Philemonoff Here to TESTIFY

Representing API A

Mailing Address St. Paul ISLAND, AK Zip 99660 Here to OBSERVE V

Phone 546-8001

BROADCAST CONSENT: This proceeding may be broadcast live or recorded for later broadcast by radio or television stations. Please indicate your consent by signing below:

(signature)

Have you participated in other legislative Would you have participated in this hearing

PLEASE PRINT

Name N. Fredenberg — Here to TESTIFY X

Representing self

Mailing Address 121 W. Fireweed Zip 99505 — Here to OBSERVE ____

Phone 278-4665

BROADCAST CONSENT: This proceeding may be broadcast live or recorded for later broadcast by radio or television stations. Please indicate your consent by signing below:

N. Fredenberg
(signature)

Have you participated in other legislative teleconferences? ____ How many? ____

Would you have participated in this hearing if the network were not available? ____

How did you learn about this hearing?

If yes, did you use the network:
- X instead of travel
- ___ instead of phone conversations
- ___ instead of mailed testimony

Date: 3/29/79 Subject: HB 401 Location: Anchorage

Name	Address	Organization	Bill No.
Pat Pietnikoff	1689 'C' St. Anch. AK	Aleutian/Pribilof Islands Assoc.	401
Roseann Reeder	SEA, Box 49-D, Anchorage 99507	Alaska State Dental Hygienists Assn.	401
Irene Vassati	7030 Foothill Dr Anchorage 99504	Alaska Health Coalition	401
Wayne Putman	RR5 Box 5107 Juneau	Alaskan Board of Dental Examiners	401
Elizabeth Nickerson	POUCH 1105	Department of Health & Social Servs	130
David O. Osterbeck	Box 144 Sand Point, Ak	Ak Comm. Marketing assoc.	401
Thomas. S. Redmind	3606 Rhone Cir. Anch. AK.	AK. Dental Society	401
Joshua J. Wright	3401 Denali, Anch, AK	" " "	401

Pat Pletnikoff - Ex. Director

Says the program was working last summer in Pribilof Island - was very cost effective. They took care of everyones teeth.

Problem: they're trying to modify the regulations - change the statutes so that they can bring practitioners from out-of-State. These people are volunteers. Pat says this program has been implemented in California, Isreal & Greece. People donate their services. The Board of Examiners (dental) & local practitioners aren't going for it. They feel threatened economically.

Aleut Corp. wants 1 yr. temporary permits (would rather have permanent) So that they can convince the program.

Spec. Approp. DHSS
Mobile Dental Clinic
HB-728 — SB-466

Was funded. Client Corp. received funds. Was put in Free Conference Committee.
Pat Pletnikoff - asked for funds.
278-3567
Dept. Health & S.S. 6-2700
Dr. Robert Fraser - Div. Public Health (3090)
Sam Granato - Div. S.S. - 3170

Lowell Swartz - 3015 acct.

$200,000 - last year.
Supposed to be down Friday.
Dick Reniger — discussed duties of Changes in Contractual Agreement Auditor problems.
Made Recom. & Commissioners deals w/ how to apply grant.
Intended for Capital Construction only. Used for operational activities Negotiated contract Aug. '78 allowed only for purchase ; Equipping - Want alteration of agreement.
Have equipment.

Pat
- No scheduled meetings - modifications of regulations 16th Jan. Emery Johnson
- Problem - bringing practitioners from out of State. Volunteers not being paid.
- DH. has no reciprocal agreement
- 1 yr. temporary permits.

Aleutian Pribilof Island Assoc.

Tim Milne
APIA 1689 'C' St.
Anch 99501

Al. Island Assoc.

APIE

3 Anch. dentists

Call Dr. McGinnis —
Dept H & SS All

Ralph Pluska

Alaska State Legislature

House of Representatives

Committee on

Health, Education & Social Services

Official Business

Pouch V
State Capitol
Juneau, Alaska 99811

March 22, 1979

Dr. Jim Milme
APIA
1689 "C" Street
Anchorage, Alaska 99501

Dear Jim:

Enclosed you will find two copies of Rep. Osterback's bill on dentistry.

I have just spoken with Rep. Osterback and he was wondering if you were planning to come down to testify on this bill, or planning to send down any written information as back up. I told him I did not know. You might want to call him at his office: 465-3715.

Thanks for calling.

Sincerely,

Cynthia L. Hill

CYNTHIA L. HILL for
THELMA BUCHHOLDT
Chairman
House HESS Committee

Enclosure

3/8/80

HB 40

CHESTER VALLEY ANIMAL HOSPITAL

1571 MULDOON ROAD
ANCHORAGE, ALASKA 99504
(907) 333-6591

Dear Member of House HESS;

I would like to express my support for the Dental Board in their endorsement of the concept of "licensure by endorsement."

I am familiar with this type of licensure thru the veterinary licensure system. We have a similar provision in our practice act whereby a veterinarian can become licensed by providing proof of licensure in another state of the US having licensure requirements substantially similar to the Alaska requirements, and also providing proof of having been an active practitioner for at least 5 of the last 7 years.

To me this is an effective method allowing experienced candidates to be readily licensed. To my knowledge this provision has not been abused in the veterinary field.

I think it is important that the law read "has practiced for 5 of the last 7 years." This avoids blanket licensure of candidates who have 5 years of practice time but who may not have practiced in the last 10 years and thus would be out of date.

Please let me know if I can be of service.

Sincerely,

Jon Thomas, DVM

1D

MEDIOCRITY A SUBSTITUTE FOR QUALITY?*

Gentlemen, here in my hands I hold some recent news releases and editorials referring to the current problem of defective, substandard merchandise and services as well as the prevalent trend of ignoring the basic fundamental requirements for character.

Let me take time to read one or two.

Under the headline, "Apparel Industry Feeling Pinch of Defective Goods," we read that "Industry officials attribute the problem to a chain of failures that stretches from the fabric mill at one end through the dyeing and finishing industry and the garment maker to the retail shop."

Here is another. The U. S. Chamber of Commerce Chief, Winton M. Blount, warns of "A rising tide of consumer dissatisfaction with shoddy merchandise and services and with advertising and merchandising techniques will result in increasing government restraints unless businesses learn to police themselves."

From an editorial in the Texaco Star, I read the following: "Those suspected of violating the basic tenets of loyalty, honesty and ethics have been prosecuted to the fullest extent of the law." "There have been those who have criticized such a policy on the basis that 'permissiveness' is rampant in our society, and that such wrongdoing should be dismissed or treated lightly as simply a sign of the times."

We are all aware of the number of new model automobiles with defective parts that had to be recalled by the factories in the last two or three years.

Now, let me read you the conclusion of a survey made by D. L. Moore and J. L. Stewart and published in the Journal of Prosthetic Dentistry, April, 1967, under the title "Prevalence of Defective Dental Restorations."

"More than one-third of the operative effort was consumed in replacing defective restorations."

What does this mean? It means that no business today is immune to the philosophical disease of "Acceptable Mediocrity" which has us all writhing with the fear and fever of a full scale epidemic. It means that dentistry too has been caught up in the fearful tide.

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*Presented by Roy A. Fetterman, D. D. S. at the Eighty-fifth Annual Meeting of the American Association of Dental Examiners, October 25-26, 1968, Miami Beach, Florida.

It means that we, the public, which is complaining about the defective goods and below-standard services, is that same public producing the defective goods and below-standard services. It is time we the public start the cure for this debilitating disease before we become so weak we cannot stand. The prevention for this disease is no mystery. It is a three part vaccine called "Basic tenets of Loyalty, Honesty and Ethics." For some strange reason, man has, over the centuries, fought the use of this vaccine with more vigor than he has the use of fluorine in his water.

Because of the public complaints of the misuse of the fee scale by many of our profession in conjunction with a flagrant lack of ethics and poor services, the affairs of our profession and its services are gradually slipping from the hands of those most qualified with dental knowledge to handle them and into the hands and control of political arsonists. Unfortunately, the public hears little of the ethical sincere members of our profession.

"The evil that men do lives afterthem;
The good is oft interred with their bones;"
So said Anthony at the funeral of Caesar.

It behooves these sincere and loyal members of the profession to seriously start a cure for those among us who are affected by the disease of "Acceptable or Permissive Mediocrity." In addition, we need the development of some sound preventive program aimed at those not yet infected as well as the students soon to join our ranks.

But first, we must each put our own professional house in order lest we be not qualified to judge another.

With all honesty and sincerity, I wish to say that I consider this opportunity to speak to you today as a singular honor, for you gentlemen are looked upon by the rest of the members of the profession, as well as by a large segment of the balance of the populace, as the ultimate in dental wisdom, dental ability and dental ethics. You are the supreme court of the Dental Profession.

Upon your shoulders rests the responsibility of judging whether or not our dental schools have properly prepared a man to represent our profession. Upon your shoulders rests the responsibility of deciding whether or not these graduates will be of service to the public. You, gentlemen, are the highest tribunal of a fairly new and very necessary profession.

If I should tread upon the toes of an individual or a school, I say "If the shoe fits, put it on." I have nothing to gain politically nor financially by this appearance before you. I seek only help from the members of our profession to restrengthen the foundations upon which our profession has been based; to shore up the walls which have been weakened by the philosophies of speed and mediocrity; and restore the roof of dedication to dentistry and its service to mankind.

I feel it is reasonable to expect to find all the categories of dental education amalgamed into a harmonious and efficient medium of services offered the public by honest and enthusiastic men loyal to their profession as well as to their patients, offering the best services their ability and dental training can produce. This is our Ideal. The target is perfection which seems always just a little out of range. We must keep our sights upon it lest it slip from view over the horizon. We must keep this idea on the horizon and encourage our young people, as part of their training, to push on towards it. Enthusiasm and hope for the future will be their motivation and only we, by our example, can give them this.

I have many thoughts on the subject of our young people as who does not, so many ideas for improvements I feel could be beneficial in the teaching programs for those we are preparing to send out to practice dentistry, but of course time today does not permit me to say all I wish to say on this subject. Sufficient time will be used if I do as it was suggested that I do and give you my evaluation of the average Dental graduate in Operative Dentistry; his attitude, ability and training as based upon my experiences teaching failing senior students and men who have been unable to pass the California State Board.

Several years ago, I had the responsibility and rewarding experience of diagnosing and correcting the problems of seniors of U.S.C. Dental School who were in danger of not graduating because of their weaknesses in Operative Dentistry. It was here with my "Goon Squads" as the members affectionately called themselves, that I acquired the nickname, "Whispering Roy."

This experience became the foundation upon which I later based my instruction for the refresher course I have taught for the last nine years. This course, which is offered by the University of California Extension Division, is held twice a year for nine weeks in the spring and nine weeks in the fall, and the classes average from 10 to 20 students.

Over the last nine years, I have instructed 285 men. These men have ranged in age from 24 to 68 years and their graduating dates have ranged from 1924 to 1967. They represent 44 schools of the United States, Canada and Europe. Among them are OKU men, members of the Dean's list and of the specialities. Some have failed the California Board once, some twice, or even more. Some come for help before even attempting to take the Board.

All of these men and women, including those of my goon squads, suffered from the same thing, the lack of knowledge of the Basic Fundamental Principles of Cavity Preparation.

Those who fail the board have a long list of reasons why they failed the operative portion but not one of which even suggests that it was because of their lack of knowledge on this subject.

In 1961, I had the honor of being asked to audit the California Board and I can honestly say that the complaints of discrimination of school or race can be dismissed. I agree that a man who has been practicing one of the specialties for years and then attempts to take an operative exam is going to have difficulties and a man unaccustomed to doing foils is going to have a tough time putting in a foil, and I'll not argue that it is possible to have a bad break, a bad patient or a bad cavity, etc. on any examination, but these are the exceptions.

After observing silently, by request, for a whole day, I agree wholeheartedly with the board member who said to me, "We do not fail these men, they fail themselves." It was obvious here. So many lacking the knowledge of these important Basic Fundamentals and the ability to apply them properly.

Nine years ago, with no other magic than the desire to share the best of what I had learned in school and, in subsequent years, from men such as Ernie Jones, George Hollenbeck and Dave Shoeshone; as charter members and director of the Jones Gold Foil Study Club of U.S.C.; 25 of the last 33 years on the staff at U.S.C.; many years of association with Dr. Rex Ingraham; many years of practical experience and Rex Ingraham's Atlas of Gold Foil and Rubber Dam Procecures, I set to work. I know I had my work cut out for me because I was expected to teach these men in nine days of instruction what they had missed along the road of four years in dental school or had forgotten in years of practice. Teach them enough to enable them to pass the board.

To me, however, just trying to teach them enough to pass the board seemed as futile an effort as that made by the hunter just shooting at the spot on the

hill where the four point buck stood before he vanished over the horizon.

I'm not "Whispering Roy" any more. I'm now the "Ogre," but at the end of the course they almost all tell me they learned more in nine weeks about Operative Procedures than they did in four years of dental school. I sincerely hope I have sent each on his way with the word Operative Dentistry wrapped and tied securely with enthusiasm and quality.

Of the 17 classes, only two have passed 100% on the first try. The remaining classes have averaged about 85% passage of the board on the first try following the refresher course. Most pass it on the second try. I say most because there are some I never hear from after their completion of the course.

My first class was rather a flub since I had no one with whom to confer on a course of teaching, but it was not long before I was quite aware of the needs of these men. At the end of the class, some of the men said they did not think they had improved too much, in fact they did not think they were too bad to start with. I had to find some way to measure their improvement, so I started a procedure with the fourth class which I have continued to this time.

Each student is asked to prepare a Cl. II on the distal of the upper right second bicuspid on his typodont and bring it to class the first evening. Before I start to lecture, I collect and keep these prepared teeth until the end of the course, at which time each man makes another preparation and turns it in.

The operative shortcomings of these men I feel can pretty well represent those of many others as well and help to explain why so many of us spend a large percentage of our operative time doing over work at the expense and comfort of the patient, to say nothing of the time wasted for both dentist and patient.

No doubt you wonder why I teach only the Cl. II in a bicuspid. Nine teaching days is not enough time to make finished operators on all types of preparations. With minor modifications, the Gold Foil preparation becomes an alloy preparation. Then, too, I must remember that most of these men are primarily interested, when they come, in learning just enough to pass the board. Concentrating on one preparation seems to be the answer.

Before I show you my slides of these prepared teeth, let us refresh our memories on the definition of a cavity preparation from the book entitled

"Operative Dentistry" by G. V. Black, the acknowledged "granddad" of Operative Procedures.

> "The mechanical treatment of the injuries to the teeth produced by dental caries as will best fit the remaining part of the tooth to receive a filling, restoring original form, giving it strength, and preventing recurrence of decay in the same surface."

Now let us have a little review of the seven fundamental principles that are general to the "mechanical treatment of the injuries of teeth produced by dental caries."

1. Outline Form. This may be defined as the form of the area of the tooth surface to be included within the outline or enamel margins of the finished cavity. This would include all pits and fissures on the occlusal surface.

   On proximal cavities, this means that the whole of the habitually unclean areas should be included within the outline of the cavity. This will often require that sound enamel and dentine be cut away to obtain correct outline form and is known as extension for prevention of the recurrence of the decay.

2. Resistance Form. This is that shape given to a cavity intended to afford such a seat for the filling as will best enable it to withstand the stress brought upon it by mastication. The resistance form consists of a flat seat for the filling, cut at right angles with the long axis of the tooth. In proximo-occlusal cavities the gingival wall of the proximal portion is cut flat and in the horizontal plane with definite angles. The step is also given a flat horizontal seat.

3. Retention Form. This is the provision for preventing the filling from being displaced. A large part of this is provided for by the Resistance Form, but it is further required that provision be made that will prevent the filling from being thrown out of the cavity by such lateral or tipping force as may be brought against it. This is accomplished by making the occlusal step in the form of a dove tail, and by shaping certain of the opposing walls that they will be strictly parallel or slightly undercut.

4. Convenience Form. This may require certain modifications in the general form of the cavity to render the form more convenient for placing the filling material.

   A second order of convenience form consists of sharpening the internal line and point angles. These are necessary for starting gold foil and assist in starting and securing the first portions of an alloy filling.

5. Remove remaining carious decay.

6. Finish the enamel wall.

7. Make the toilet of the cavity.

Now, let us look at the "before and after" pictures and see if you agree with me when I say the men who made the preparations did not understand the rules we just finished reviewing.

First, I will show slides of my class of November 1961 and those teeth with red dots represent the work of students who graduated from dental school in June, 1961.

(show slides)

By 1967, the California State Board approved the Cl. V restoration as an acceptable Gold Foil procedure, so now I have them cut a Cl. V as well as a Cl. II before class starts. In the fall of 1967 and the spring of 1968, I had 31 students in my two classes and there were 12 1967 graduates in this group. I would like to show you slides of the work of these 1967 graduates and see if you agree with me in my contention that they are no better operators than the 1961 students.

(show slides)

Some of you gentlemen passed these men when they took the board in your state.

Just for emphasis, let me enumerate a few of the major problems which beset these men:

1. Cutting the cavity square in the tooth.

2. Getting the gingival seats flat and at right angles to the long axis of the tooth.

3. Recognizing the proper buccal and lingual extension.

4. Recognizing decay.

5. Recognizing the difference between dentine and enamel.

6. Visualizing the finished preparation in advance.

There are other problems too, some of which are particular to individuals and others general to all.

1. Do not know how to sharpen hand instruments.

2. Lack complete knowledge of Finger Rest Position.

3. Have no understanding of the names of the hand instruments as they relate to their use.

4. One 1962 graduate had never prepared a MOD alloy. (It took him five hours to prepare and fill his first cavity for my course.)

5. Lack of knowledge of the use of and practice of using rubber dam.

6. Double jointed men have great difficulty holding and controlling handpiece and hand instruments.

7. One student had been practicing for 23 years and had never used a hand instrument.

8. One student was using the palm thumb grasp on his contra-angle trying to prepare an upper tooth.

At the opening of this paper, I made mention of a report on a survey made by D. L. Moore and J. L. Stewart on the "Prevalence of Defective Dental Restorations." In the same article was also the result of a similar survey made in 1936 by P. J. Brekhus and printed under the title, "Your Teeth" and published by the University of Minnesota Press. These two reports suggest that there has been no improvement in the failure rate of restorations in the last thirty years.

In other words, the percentage of poor operators has remained about static be they past or recent graduates in spite of the high speed handpieces, visual aids, closed circuit T. V., four-handed dentistry, etc.

I believe that my findings from teaching my refresher course might well be used to contribute evidence to this fact.

Now I submit to you my evaluation of the recent graduates, as well as all the others whom I have taught the operative portion of the Refresher Course in Dentistry offered by the University of California Extension Division during the 1960-1968 period.

They are inadequately prepared with an understanding of the basic Fundamental Principles of Operative Dentistry and insufficiently trained in the application of these principles. In addition, I feel that the lack of demonstrative pride in the profession made manifest by many instructors in addition to their permissive attitude toward the students have combined with the weak training to produce too many dentists who substitute Mediocrity for Quality either by accident or intent.

Before I move on to suggested teaching procedures which I feel could help to take better advantage of the potential of each student, I wish to enumerate a few complaints of recent graduates.

1. Some schools issue hand instruments which are too large and cumbersome.

2. Students resent smart and irrelevant remarks made by instructors.

3. Several said they had received the lectures on the basic principles but no one had insisted they produce them on the clinic floor.

4. One student had been an instructor in the operative department of an Eastern school for two years and was told by the head of the department that they do not use Rex Ingraham's book because it just can't be done the way Rex says it should be done.

5. All recent graduates complain they do not get enough help from the instructors.

6. Lack of interest in the student, especially in the freshman and sophomore years. Seem to resent interruptions by students.

Would you care to guess what pertinent question is often asked me? "Can the State Board examiners do what they ask of the students?" Can you, gentlemen? Are you qualified to judge whether or not a man knows the basic principles of Operative Dentistry or are you just someone's political favorite for the appointment? These are the frank questions asked by our young people and, in many cases, for good reason.

Now that we have aired the shortcomings and complaints of the members of our profession and those about to become a part of the profession, let us turn our thoughts to how we can begin to correct these problems. How are we going to improve our service to our students so that they, upon graduation, can more efficiently fulfill their social obligations to the public?

I believe that our dental education, like the garment industry, will often find that the cause of the defective merchandise, in this case the poor dentist, began back at the "fabric mill" so to speak. Inasmuch as we cannot return the poor graduate for a refund, we are stuck with him and, only too often, his practicing of the 8th Fundamental of Cavity Preparation or the "Stickum Form" as this technique is so aptly named by my good friend and fellow teacher, Dr. Rene Eidson. In case some of you are not familiar with this form, here is the recipe. Take one large burr, use it sparingly and stickum full of filling material.

It would seem, then, that we should be more critical of our selection of students.

Right now, I wish to make it clear that I am not overlooking the fact that there are two branches of dentistry - the medical and the mechanical. In spite of the current practice of de-emphasizing the mechanics of dentistry even to the point of speaking of us as "dental physicians" just as though there is some kind of stigma connected with being a mechanic or engineer, I still say that dentistry is primarily a mechanical profession. In the same breath, I might add that I feel that a fine surgeon doing transplants is a mechanic also.

However, regardless of the present philosophy, the fact remains that most dental practitioners spend the greatest amount of their time doing Restorative Dentistry. If you remember Black says, in his definition of a Cavity Preparation, "The mechanical treatment of...." etc.

So, since we now know that the graduate dentist is going to spend most of his time doing operative, which is a mechanical procedure, then logically the candidate for dental school should be selected on his mechanical interests

and experience as well as scholastic standing. Did he ever have a Hot Rod to keep running? Has he had any art, mechanical drawing, machine shop or wood shop? I would choose a man with a lower grade average but who had enthusiasm for the profession and a background in some mechanical skills over a man with high academic scholastic record but no background of any mechanical training.

Only one man in my last class of twenty knew what I was talking about when I suggested that each one should look upon his hand and the handpiece it holds as a "milling machine."

Another point which I wish to make on the selection of these students is a closer check on the useability of the hands. Some of my students seemed to be having great difficulty in developing good control of their instruments and I discovered that these men are double jointed. Their knowledge of the subject was adequate but their attempts at applying this knowledge was very frustrating to them. I have devised a very simple test to determine whether or not this condition is present in a candidate. If it is, I feel he should be advised of it and warned of the difficulties which lie ahead. Perhaps consultation as to entering one of the less mechanical specialty fields after graduation might be considered as beneficial to the man as well as the public and the profession.

What good is the theory if you cannot put it into practice?

Another point I feel very strongly about is that teachers should have that long lost "right" to "flunk" a student restored to them. The instructor working with the student is the one most likely to know his strengths and weaknesses, not the head of the department nor the Dean. There is nothing but good to be gained by repetition of an operation, a course, a semester or a year.

The new concept of teaching operative by preparing an area in a tooth in the typodont once and then going right to the mouth of a patient is a frightening thought to me. One of the schools which teaches this theory graduated its first class this year. I have one of the students enrolled in my fall class at this moment. It will be most interesting to observe this graduate work. How will he compare with the 1963 graduate who had never put in a MOD alloy? It took him five hours to make and fill his first preparation in my class.

I feel there should be a national re-evaluation of the teaching staffs of our dental schools. True, the dental education program is also suffering from

a shortage of teachers so it is than all the more important that each one be performing to his or her maximum performance. This then means teaching the teacher to teach. Faculty study groups taught by someone from another section of the nation, such as UCLA is now doing, could be a great help in standardizing the instruction in our dental schools throughout the nation.

With few exceptions, in my opinion, the average graduate student is not qualified to go right into teaching on the operative floor. He lacks the experience of solving problems that arise that do not look like those pictured in the book. An instructor should be able to quickly appraise a preparation or filling, or whatever, and aid the student in making any corrections necessary. If the instructor is a recent graduate, he is likely to teach students the same mistakes he is making, as indeed of course any other instructor is likely to do.

A teacher must be flexible, creative and enthusiastic and be aware that the methods to teach some students will not work on others. The trick is to find out why some are not doing well and correct the cause. This takes time, of course, but results are usually gratifying to student, teacher, educational institution and the public.

Too often, I have found that my students do not see or understand the relationship of an instrument to its use. For instance - the pulling action of the hoe or the chopping action of the hatchet, etc. So often we who know these things so well forget to pass these seemingly unimportant bits of information on to our students. A recent letter from my nephew who is a sophomore at one of the dental schools advises me, "the amount you taught me really put me ahead. We received an instrument case this year chucked full of stuff. They (the other students) have no idea what that stuff is. Here we are rolling into the third week and they are really having a time of it."

During the ADA meeting in Dallas, I had about a dozen senior students ask me what I mean by hollow grinding a gold knife. I reciprocated with a question. How many of them knew the difference between a splitting axe and a chopping axe. Not one did. The difference between these two axes are mechanical necessities for improving the ease and efficiency of their use for a specific job.

To know terms but not their meanings is like reciting the Lord's Prayer and not understanding the meaning of the words.

Almost all of my students have been unable to sharpen their hand instruments. If a man cannot sharpen his own insturments, I feel he is truly handicapped. How often as I work I step into my lab to sharpen up the edge of a chisel or a hoe or of what have you. You can't work with dull instruments - which brings up a point. I have found that many of my operators do not know that part of their difficulties in cavity preparation are the result of dull instruments. Some have told me they used the same instruments for the two years in school without having to sharpen them.

A real puzzler is the lack of understanding of the Finger Rest Position. Recently, I asked instructors from U.S.C., U.C.L.A. and Loma Linda if they teach Finger Rest Position, per se, and their answers were all the same. No. They say they assume that anyone who can hold a pen or a pencil can hold a handpiece. I feel that in teaching there is no room for assumption except for the assumption that the student knows nothing about the subject or portion of the subject you plan to teach him.

One day, I observed a student using the palm thumb grasp on his contra-angle handpiece preparing an upper tooth. When I suggested he try the pen grasp he said he never had. Before he completed the course, he made the change and commented on how much easier it was to use a handpiece properly. An alert and interested instructor should have corrected this for him years ago.

Unfamiliarity with the use of the rubber dam is a very serious problem. I found one of my students, a recent graduate, struggling with a rubber dam which kept buckling over the tooth he was trying to work on. He could not recognize his problem which was simply that he had put the dam to place and then turned it a quarter of a turn, thus placing the top and bottom of the dam to the sides. Try it some time. You'll have a hell-of-a-time working on the tooth.

I have been told by many of my students that they were never made to use the rubber dam.. My experiences with these students does much to substantiate a report by Dr. Robert E. Going entitled "Study Finds GP's Avoid Rubber Dam Technique." This report in turn confirms an earlier observation by Dr. Leon Ireland that "probably no other technique, treatment or instrument used in dentistry is so universally accepted and advocated by the recognized authorities and so universally ignored by the practicing dentists."

From the same article just referred to, Dr. Going states "Frequently,

the student's concepts relate entirely to the instructor's enthusiasm for or against the procedure. The quantity and quality of teaching the technique varies greatly among schools and among individual instructors within schools."

On these findings, then, we might surmise that in spite of all their weak excuses for not using rubber dam, the real reason so many men to not is becuase they were never thoroughly convinced by their instructors of the true importance of its use. This, then, brings us to one of the complaints of many of my students. They would like to have had more explanation and help from the instructors. They feel they waste time having to find out too many things by themselves. At one school, it is assumed that the seniors know all there is to know and that the instructor's role is only to act as a checker.

There is nothing that irritates an elder more than a smart-aleckyounster. If you are one of these irritated elders, just don't forget that that smart-aleck youngster learned his "smartness" from some smart - aleckadult. I find that many of my students have remarked about senseless smart - remarks made by an instructor on a serious subject. The student in question asked the instructor to check his cavity preparation which the instructor did, punctuating his observation with the remark, "It looks like a chicken with its head cut off." The student said this left no doubt in his mind that the cavity was bad but he was not told how to correct it.

All I have said this afternoon adds up to a need. A need for more carefully selected students and better prepared instructors with a more uniform teaching program on a national basis. A staunch stand by our state boards against the lowering of their standards, no matter how much the political pressure piles up, is needed.

When I was going to dental school 36 years ago, all that was required for entrance was a "C" average and $300.00. In fact, the $300.00 was of more importance than the "C." U.S.C. Dental School had "Little Caesar" as we called Dean Louie Ford. We feared him, made snide remarks about him behind his back, but held him in awe and respected him as being the man at the helm. On the scene as part of his crew, either full time or part time, to prod us, coerce us and inspire us were men like Ernie Jones, George Hollenbeck, Don Smith, Jim Hickson, Doug Dyer, and others. These men were our idols and they were all men of experience and able to practice what they preached. They were unwavering in their belief in the truth of the importance of the fundamentals as the foundation for future improvements in techniques.

Most of you know I am a member of The American Academy of Gold Foil Operators and, naturally, a great advocate of foils. I am aware that the subject of Gold Foils is treated very lightly by many of the dental schools and this grieves me. I am in firm agreement with the philosophy of Ernie Jones which is that doing Gold Foil work is one of the best dental exercises there is for a dentist.

For foil to be a success, strict attention to the application of the fundamentals is an absolute must. This is not so of many other filling materials we use. It was his contention that the good habits formed in doing foil work would carry over into all other fields of the profession.

One of the currently stressed concepts of education today is that of "Continuing Education." Of course, this is nothing new but just being stressed anew. G. V. Black once said, "The professional man has no right to be other than a continuous student." Percy T. Phillips also made a similar statement when he said, "To protect the quality of dental service, the professional man must be a lifelong student of dental science and dental technology. His education must never stop."

Unfortunately, the type of continuing education in which the average dentist is most interested today is some new technique - a way to do it faster, easier, so he can make more money at it. Often the glamour of a new slant on an old subject influences us at the expense of attention to the underlying principles upon which these new concepts are based. I am in favor of continuing education 100%, but I feel we are terribly in need for some Continuing Review as a part of the program.

No matter how many new concepts there may be on the subject of castings, alloys, endontia, etc., the basic principles remain the same. For the new alloys or the improved castings to be successful, the underlying preparation of the tooth must be right. The basic concept of root canals has not changed; the opening of the canal, its reaming out, sterilization and the filling clear to the apex. The new medicaments have undoubtedly been a wonderful aid, especially to the careless operator. Without a thorough understanding of the old and proven knowledge, one cannot well understand and apply the new.

Many of these courses in new techniques in Operative presuppose that the operator knows how to make a proper cavity preparation, but from my observation of the recent graduates as well as men who have been in practice and I have taught in my refresher course, this is far from being a fact. Ask a lab man about the quality of the preparations sent to him - the finish

lines and tapers - the quality of impressions.

It grieves me greatly to see the pressures, political and otherwise, our boards are currently experiencing on the subjects of Reciprocity, changing of the Dental Practice Act, and licensing of Lesser Trained Personnel.

I feel that total reciprocity would be disastrous. No serious thought is needed to foresee what would happen if this were to take place. There would be a mad move of practitioners into the western states - the supposed land of "milk and honey," where the action and the money is, leaving less desirable areas devoid of dental care. Soon, some other kind of control or distribution of practitioners would be initiated and my guess is it would be Federal control. That would be one more step down the road away from the control of our own lives and of that of our profession.

California has been plagued with requests for Reciprocity time and time again. One of the members of the California Board recently told me that they require only the minimum to pass the board now. How far down are we supposed to go with our standards to meet those less qualified? How much better it would be to help those unqualified ones to either climb up and join the rest or be eliminated.

I see no wrong with dental teams as long as they function within the Dental Practice Act, but the suggestions that there be a change in this Act is the most frightening threat we have had yet. I fear that once we have opened the lid and released the "plagues" from the "Pandora's Box" we will close the lid and shut away forever the "hope" for quality. If we cannot turn out uniformly trained quality operators in four years of schooling, what hope do we have for those turned out in two or less?

Once again I say if a greater effort were made to properly select, train and motivate our men to produce quality restorations of maximum serviceability, we could better serve society by reducing the necessity of having to do over work improperly done and thus reduce the seeming need for Lesser Trained Personnel.

I, as a representative of the majority of the ethical Dental Practitioners of this glorious country, urge you to hold firmly to a positive line and do not let yourselves become "Permissive," taking the easy way out by allowing the few weak, incapable and incompatible ones to control the majority who are hard-working and dedicated.

While on the subject of relaxing standards, I wish to read you two letters.

One is addressed to a Dr. Rengstorff, a former student of one of my classes. It is from the House of Representatives, Alaska State Legislature. The second is Dr. Rengstorff's reply.

"Dr. P. V. Rengstorff
2321 West Lawn Avenue
Madison, Wisconsin 53711

Dear Doctor Rengstorff:

I am making a study of Professional Licensing Board procedures in support of my legislation to liberalize and simplify licensure in this state. I hope you will assist me.

It appears from the skimpy files available in the newly established central licensing section of our Department of Commerce (1966 legislation) that you applied for licensure in this state and were denied.

Please tell me your side of the story. It is my contention that the Board is limiting the number of dentists permitted to enter the state on an arbitrary basis, rather than for substantial cause. The law authorizes the Board to determine qualifications of the applicants and to pass everyone who is qualified, who in effect would not endanger the public. Under the cloak of high quality many are refused licensure we believe.

Therefore we wish to make a test case, in the courts if necessary, and to simplify and liberalize the licensing procedures. For example, the practical examination could be given by any American Dental Association approved dental school, etc.

The State Legislative Council is also studying this area. Further, more, the Department of Commerce is in the process of completing a study of its own, coupled with an audit by the Legislative Audit Committee, the results of this becoming available in January of this coming year.

Trusting you can be helpful to us in this most important work, I am

Sincerely yours,

Dr. Mike Beirne, Member
House of Representatives
Alaska State Legislature"

"Alaska State Legislature
Representative
Michael F. Beirne, M. D.
P. O. Box 4-1539
Anchorage, Alaska

Dear Doctor Beirne:

Upon graduating from Marquette School of Dentistry in 1964 I drove to Anchorage for the purpose of taking the dental board. I failed the dental board held in July of that year. In September of 1964 I joined the United States Public Health Service with which organization I served until September of 1966. In July of 1965 I failed the board for a second time. The Board advised me to take a refresher course in operative dentistry as the quality of my work fell below that of the other applicants. Many of the applicants each year come from the West Coast dental schools, e.g. Oregon, Washington, and the California dental schools. It is generally acknowledged in dentistry that the most proficient dental operators in the country are graduates of West Coast dental schools. These dental schools work with good equipment, hire excellent instructors, and demand their students to produce a high quality restoration. Because I was committed to PHS duties I did not at that time take the Board's advice concerning a refresher course. I took the dental board in Alaska for the third time in 1966, and again failed. In the Spring of 1967 I enrolled in a nine-week postgraduate, dental refresher course given by the University of California at Los Angeles. This course is given to help the non-West Coast dental school graduate pass the California Dental Board. In July of 1967 I took the Alaskan Dental Board for the fourth time. This time I earned by Alaskan license.

I have prefaced my remarks about the Alaskan dental board by tracing my board experiences because if anyone has a right to harbor bitterness towards the Alaskan Board it is I. But, on the contrary, I feel a deep gratitude towards the Alaskan Dental Board. They indirectly compelled me to become a competent dental operator. The nine weeks at U. C. L. A. taught me things that four years at Marquette never did.

At the beginning of the U. C. L. A. course each dentist was asked to prepare two dentiform teeth, one for placement of a gold foil and another for an amalgam. These were collected and held by the instructor. At the termination of the course we were asked to prepare two dentiform teeth again, one for a foil and one for an amalgam. We were then presented with both sets. The results of nine weeks training were remarkable. The first attempts might have been done with my pocket knife. The second preparations were beautiful.

My contention is that Marquette failed in teaching me the basic rules of operative dentistry. I don't understand why the Alaskan Dental Board should be punished for the failings of the applicant's school. Through four Alaskan dental boards I was able to compare my work with the work of graduates of other dental schools. Only this year was I able to point with pride at my gold foil, or gold inlay, or silver amalgam when a graduate of, say, Southern California or Oregon asked to see it.

The statement that the Alaskan Board limits the number of licenses on an arbitrary basis, rather than for substantial cause, simply is not true. As I recall, each year perhaps 70% of the applicants received licenses. This percentage of success compares favorably with other Western state dental boards. In fact, this year three applicants were allowed to take another one-half day to recast their faulty gold inlays, as their first casting just didn't fit. If anything, the Alaskan Board is more than fair in their examination. If the applicant can do the work he will receive a license.

Alaska is unique in that it is able to profit by the past [illegible] of other states. This is true in conservation, commercial fishing, and forestry as well as in dentistry. In Wisconsin and in California, both states which I have lived in and am licensed in, I have seen some horrible examples of dentistry. The people of Alaska deserve high quality dentistry. I am in full agreement with the Alaskan Board of Dental Examiner's licensing procedures. They are doing the people of Alaska a fine service. It is not the fault of the Board that Nome or Big Delta cannot retain a full time resident dentist.

The burning college liberal too often defends the status quo once he is out of school and enjoying financial solvency. Lest you might think my success in this year's board has blunted any previous crusading spirit, let me assure you this is not the case. Never after my three failures did I blame the Alaskan Board. Marquette was unable to teach me the principles of sound dentistry. Only after I was drilled in these principles last Spring was I able to pass the Alaskan Board.

In your letter you say that you are "making a study," yet as I read further it seems like your conclusions have already been established. You state in your letter you are out to abolish the Alaskan Dental Boards. I hope the time I have taken to write this letter has not been wasted, and that is used in your study, rather than dismissed. Perhaps because you lead me to doubt your objectiveness I have taken the liberty to send courtesy copies of this letter to the State Legislative Council and to the Alaskan

Board of Dental Examiners.

I thank you for allowing an expert in the field of recent Alaskan dental boards the opportunity to tell his side of the story.

Sincerely

Peter V. Rengstorff, D.D.S."

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With the support of strong young men such as Dr. Rengstorff to back me up, I say that Mediocrity is not a substitute for Quality any time nor anywhere. As the pendulum begins its swing away from the current philosophies, I would like to see dentistry as the first island of Quality rising from the modern sea of Mediocrity. I, as an individual, am trying hard to do all I can to help this come about. When the going is made difficult by those with attitudes such as that advanced by one of my students who stated that if he were to do dentistry the way I teach it he would have to double his prices or live lower on the hog. I re-read letters such as this one from Dr. Hashimoto, one of my students,

> "We really received a good stimulus to reviewing our concept of operative dentistry. I think it should be done periodically to keep us humble and alert. In this era of ultra high-speed, stress on the fundamentals is especially important and valuable before we go 'hogwild' zipping out mediocre preparations and restorations. I think your efforts were particularly meaningful to those of us going into general practice and I am sure we will pay even more attention to quality, particularly after receiving a clear insight on how to do it."

To those who have escaped that insidious disease "Acceptable Mediocrity," I say "cheers." Keep up your small preventive booster doses of that all important vaccine, the Basic Tenets of Loyalty, Honesty and Ethics, combined with continuous learning or reviewing.

To those who have willingly or unwillingly succumbed to the disease, I say "we pit you" but there is still hope for you providing you want to be healed. We need you, too, to help us shore up the sagging walls of our dental "houses."

It is never too late and it is not later than you think. Today, everyone has almost twice as much time in a lifetime to attempt to realize his desires than did those of not too long ago. For most, the drudgeries of life have been erased, sickness reduced to a minimum, and we have been given an opportunity to pick and choose from an endless number of topics about which to learn, things to do and places to go that we have become, as F. Scott Fitzgerald once said, "That most limited of all specialists, the 'well rounded man.'"

However, if you look at the philosophies on time there is much truth in these words I read some place recently:

> "If you don't have time to do it right,
> When will you have time to do it over?"

Thank you, gentlemen, for your time and respectful attention. I wish to leave you with these words of wisdom entitled "Horse Sense." This has nothing to do with dentistry but might well be applied by many of our dissenters of today; those who would willfully destroy the basic tenets of Loyalty, Honesty and Ethics rather than build upon them.

Horse Sense

A horse can't pull while kicking.
This fact I merely mention.
And he can't kick while pulling,
Which is my chief contention.

Let's imitate the good old horse
And lead a life that's fitting
Just pull an honest load, and then
There'll be no time for kicking.

MEDIOCRITY A SUBSTITUTE FOR QUALITY?

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FAILURES ON CLINICAL EXAMINATIONS - REMEDIATION

Roy A. Fetterman, D.D.S. F.A.C.D.
Instructor of Operative Dentistry - General Refresher Course
University of California Extension Division

Ten years ago I had the pleasure of addressing those attending the Eighty-Fifth Annual Meeting of the American Association of Dental Examiners in Miami, Florida. The title of my paper at that time was "Mediocrity, a Substitute for Quality." I have granted your association permission to re-print that paper and copies will be available at the conclusion of this session.

The substance of that paper was based on my experiences years ago while helping to correct the problems of senior students of U.S.C. Dental School who were in danger of not graduating because of their weakness in Operative Dentistry, subsequent years on the Operative Department Staff of U.S.C., and my more current experiences teaching the Operative Dentistry portion of a refresher course offered by the University of California Extension Division.

I doubt that many of you were present in the audience that day ten years ago but if you were, will you please raise your hand? I just wish to congratulate you on your continued contribution of time and energy in the interest of our profession.

This past July I addressed the meeting of the Western Conference of Dental Examiners and Dental School Deans on the subject of whether or not specialists should be required to submit to a General Dental State Board Examination for Licensure. Believe me when I say that the study involved for that paper increased my respect for, and understanding of, the problems of state boards tenfold.

I have now been teaching the Refresher Course for 18 years and in addition have tutored dentists for the states of Alaska, Nevada, and Arizona. All of these dentists were prospective clinical failures or had already achieved that status. I was once invited to audit the California State Board after which the President remarked to me, "We do not fail these men. They fail themselves."

Presented at 95th Annual Meeting of the American Association of Dental Examiners. October 19, 1978 aboard the Queen Mary Hyatt Hotel in Long Beach, California.

Since my last appearance before you, I have had the very special experience of having been a guest of the South African Prosthedontics Society with the opportunity to lecture on Operative Dentistry for a week at each of the three Dental Schools of that country. I also demonstrated the preparation and completion of a Gold Foil at two of the schools. Delivering the Fifth Fred Hossack Lecture on "Principles and Problems of Dentistry" was one of the greatest honors I have ever received. Professor Hossack has been associated with the South African Dental Schools for close to sixty years.

Speaking of honoring men from our profession, many of you have by now received your new ADA Journal and read the article which reminds us that 1978 marks the 60th year since the dedication of a statue to G. V. Black in Lincoln Park, Chicago. In South Africa I was pleasantly surprised to see Dr. Black honored with his name over the door to the Operative Clinic of the University of Witwatersrand in Johannesburg.

Last, but far from the least of my credits, is my association with the Jones Gold Foil Study Club. I am proud to remind you that I am the only remaining active Charter Member, my membership years now totaling 42. With Rex Ingraham and Jack Seymour I share the honor of teaching the club.

As you can gather from my varied experiences, I have had the opportunity to see and analyze many clinical failures.

In my 41 years as a General Practitioner and Instructor of Operative Dentistry, I note that the problems of the dentist remain the same. Namely, people still get holes in their teeth and still develop periodontal diseases. No new permanent or everlasting filling materials have as yet been developed and those materials we have are still only as good or equal to the ability and the workmanship of the dentist who prepares the cavity and places the restoration, plus the degree of care the Oral Cavity receives from the patient.

Working in close association with state boards, I am aware that the majority of the failures on the clinical examinations are those Operative procedures performed upon patients. These failing dentists often become the students I have to teach and, without exception, be they newly graduated, members of the armed forces, foreign educated, out of state educated or instructors in a dental school, they have one common problem. That is their lack of knowledge and understanding of the Basic Fundamentals of Cavity Preparation as outlined by G. V. Black.

In a few minutes I shall show you slides of Class II preparations, made by students before they had received my first lecture, and those prepared at the conclusion of the

refresher course. You will note that improvement is commensurate to each man's ability to learn and perform.

The subject of clinical failure is one of concern to many people. The failing dentist, the public, the school, the instructors, the profession, the state board and the Government. Since this is a national meeting, I assume the topic of this paper, which was suggested by B. J. Crawford, your Secretary Treasurer, is one of national concern. Articles on this subject may be found throughout the various publications of our profession but as yet no writer has printed a solution to the problem of Failures on Clinical Examinations.

I have already stated that I believe the major cause of clinical failures to be the operator's lack of knowledge of the Basic Fundamentals as well as his inability to demonstrate and use these principles. There is no doubt that there are other contributing causes for these failures as well as for the weak performances of the "near" failures.

I list six catagories which I believe are more or less contributory to failures on clinical examinations and which we might reasonably expect to alter and thus reduce the incidence of these failures.

1. Government Involvement
2. School Attitude
3. Student Selection
4. Student Attitude
5. State Boards
6. Public Attitude

Please note that I place Government Involvement in the number one position, for in recent years the dictates of the Government have really determined the attitude of the schools and the students as well as the selection of freshmen students and the performance of the State Board. The Public knows little about our profession and its problems but demands a finger in the pie because it is the Public's money which is used to educate and examine dentists. However, the Public is more concerned with possible racial discrimination and the "rights" of the candidates than with their ability or the quality of their work, thus interfering with the educational process and the true purpose of the State Board, which is to protect the people from unethical and unqualified dentists by means of "admission to licensure, renewal of licensure, and discipline."[1]

Let us just briefly study these catagories.

Government Involvement is based on money. Both State and Federal funds provide a significant portion of typical dental school finances today but with this financial aid comes a long

list of attached "strings" or controls. True, the Federal funds do aid with research grants and numerous other special programs common to dental schools, but there has also been an establishment of dictatorial "goals such as shorter (three year) programs, increased production of new dentists (larger classes), and the creation of more socially sensitive dentists (off campus training programs)." [2] These are all priorities which have been established by the Federal Government and pursued through its agencies.

There are many less obvious pressures such as affirmative action policies, the 1974 Federal "open records law," etc. No doubt many of these changes have improved the performance of some schools but they have also added administrative burdens to schools, consuming important money and time resources which I feel could be better used to improve educational programs.

Federal Legislation requires curriculum changes in all schools seeking basic grants and the selection of faculty too may be influenced by the Government, but unfortunately funds for salaries to attract experienced and qualified instructors seems not forthcoming, forcing the schools to use recent graduates or prevail upon unpaid part time instructors such as members of study clubs, etc. Just this summer members of the Jones Gold Foil Study Club gave time teaching at U.S.C.

Dental education has become so sophisticated compared to the days when I was taking my training that the schools can seemingly no longer survive on tuition and clinical income and are forced to accept the State and Federal funds with all the strings. It is very understandable that the schools often find themselves literally in "bondage" to the Government.

"As the scope of the modern dental practice changes, so does that of the schools. In recent years, schools have added time to their programs for Oral Medicine, Behavioral Sciences, Patient (and Auxiliary) Management, Hospital Dentistry, Physical Diagnosis, Periodontology, Community Dentistry, Clinical Orthodontics, Oral Biology, and many other disciplines which were not taught at all nor as extensively in the past. Naturally, these additions have almost universally produced a concomitant decrease in the percentage of time and effort allocated to the traditional dental courses." [3] Operative Dentistry and its Basic Fundamentals in particular have suffered.

In an attempt to up-grade the "image" of dentistry and remove it from the "cottage industry" catagory, some schools are stressing the medical aspect of the curriculum, also at the expense of the mechanical aspect. I think this very shortsighted philosophy on the part of those schools.

Let me quote from my paper which I delivered in South Africa. "We always have been a very important segment of the medical field entrusted with the responsibility of caring for a rather small area of the body called the Oral Cavity. We are learned in the art of prevention, healing and the relationship of the health of this cavity to the health of the whole body. We are engineers with the technical knowledge of a Civil Engineer and the Mechanical Skills of a fine Watch Maker. We are Artists able to sculpt in wax, cast in metals, and create functional appliances to replace lost natural dentition. We are salesmen teachers, educating our patients in their roll of prevention. We are researchers constantly looking for new ways to eradicate the problems of caries and periodontal involvement so as to spare man the painful dental experience."

We have truly come a great distance since powdered bones, hoofs, crabs and eggshells were mixed with honey and used as a dentifrice.

One very, very important fact to be considered in explaining clinical failures is the method of selecting freshmen students.

"Due to the lack of any better means of ranking applicants, many schools still rely far too heavily upon pre-dental grade point averages and Dental Admissions Test scores."[4] These high grade point averages may indicate that the student concentrated upon intellectual development, which is important, but dentistry is a mechanical procedure whether or not one likes the term mechanical, so, in addition to a high I.Q. and 4.0 grade point average, the dental student absolutely must have considerable mechanical skill and problem solving ability.

Regardless of what the Government says, we are not all equal in learning ability or speed or mechanical ability. How can we be when we do not even all walk, talk, or cut our teeth at the same age? A patient recently expressed "equality" in this manner: "We are all born with an equal opportunity to prove our inequality."

From an article by Dr. Robert Barkley entitled "The Dilemma of Dental School Admissions," come the following revelations. "Early indications from testing senior dental students from several schools with the new selection vehicle reveal that a sizeable percentage is below average and probably should never have been selected to study dentistry, regardless of how high their GPA was."[5] Once more from the same article: "With all of the people they have tested, four years of teachers college has never yet made an effective teacher from a freshman whose 'profile' was that of an ineffective teacher."[6]

It is reasonable to believe this would be true in the case of dental freshmen, too.

How well I remember the oft' repeated remark one of my instructors used to make: "We spoil a lot of shoe salesmen trying to make dentists of them" There is no doubt that student attitude is a contributing factor in clinical failures. However, I dislike placing the blame for this entirely upon the shoulders of the student. I recently read the following quote some place: "Members of the younger generation are alike in many disrespects."

We have been hearing complaints for many years regarding student open criticism of authority, insistance on determining curriculum, complaints about quality of instructors, lack of respect for peers, etc.

What else would one expect from a product of a permissive society which advocates base and violent entertainment, refuses to obey such a simple law as a proven safer speed limit, expects the medical profession to keep it alive for free, preserve its teeth for free, has little respect for others, lacks refinement and good manners, and generally feels that any discipline of its so-called "freedoms" is a violation of its human rights?

While lecturing on Operative Dentistry before a senior class at UCLA a few years ago, I felt that the time I took from my office to give to these students was wasted. Not only did the students show their disrespect by just sauntering in during my lecture, but they brought with them coffee and doughnuts to eat and drink while I lectured. Evidence that they really thought there was nothing more they needed to learn. Reminded me of the man who once said, "Don't bother me with the facts. My mind is already made up."

In recent years, the seniors at U.S.C. decided they had had all of the Prosthetics instruction they needed and rebelled against the remainder of the course. The sequel to this action was the failure of the Prosthetics portion of the state examination by a number of them.

Continued attitudes such as these are certainly not conducive to a professional image or production of quality clinical dentistry on either a board examination or within a practice.

No doubt you wonder why I have included the State Board in the listed categories. I feel that the boards, too, must shoulder their share of the responsibility for clinical failures.

We expect a graduate to have "gained knowledge, clinical skills, a level of professional judgment, an appreciation of the role of the dentist in the community, a concern for the oral health of all people and a level of professional maturity."[7] The only subject from this list on which the dentist will be judged by the board is Clinical Skills, and this without benefit of ever seeing the candidate at work.

Unfortunately, at this date, there has been no standardization for the teaching of clinical skills among the dental schools or for the judging on state board examinations. In other words, no agreement has ever been made within these bodies as to just what specifically constitutes a good or just acceptable preparation and completed procedure. Without a relatively standard model of the ideal to refer to either mentally or in actuality, how can one man make a fair assessment of another man's work? Only a grade of 75%, a very average grade, is required to pass a board examination, but the question is - 75% of what?

Almost all of the dentists I have worked with have passed a board examination in some state prior to their trying the California, Arizona, Nevada or Alaska examination and may take two of the western boards, thus assuring themselves more than one place to practice. These men and women, you can understand, are well qualified to make the statement that there is a difference in the quality of work accepted by the various state boards. If this is so, then this lack of standardization causes unjust criticism of the boards.

I repeatedly hear it argued that it is the responsibility of the state board to keep the incompetent out of the profession but I disagree with this thinking. Keeping the incompetent out of the profession is the duty of the schools. It is they who decide who may graduate and receive that DDS or DMD degree. A state board can only, hopefully, keep the incompetent out of its own state.

Let me cite an example of what can happen under the present system. Several years ago, a middle-aged, out-of-state dentist took the refresher course after having failed the California board several times. He made little improvement during the course and continued to fail the board until his total was twelve. The cause of his failure was mechanical exposure. You wonder what happened to this man? I have been told he returned to the state from which he had come and continued on in practice. Are not the people of his state entitled to the same protection from practitioners such as he as are the people of California?

Actually, the responsibility of the state board today is two-fold. As already mentioned, the protection of the Public

from the incompetent and unreputable dentist, and now the protection of the dentist from the public.

I refer you to the top of the cover of the October 9th issue of People Magazine where you will read these words: "Malpractice: When and How to Sue Your Doctor."

Now, board members must be concerned about what the dentist can be held accountable for by the public. In other words, what can he be sued for? Certainly not on his knowledge of the use of Auxiliaries nor his knowledge of Patient Management, Community Dentistry and other such programs but - on his Oral Diagnosis, Treatment Planning and Clinical Skills. All the more reason why you board members must be very sure of those you pass.

In listing the six catagories referred to earlier, I had great difficulty deciding whether Government Involvement or Public Attitude should be in the #1 position. To be a "Public," and I use the word facetiously, is very confusing because each of us is a seller as well as a buyer, a plaintiff as well as a defendant, and a voter who influences the Government Policies. Are we then the cause of our own ills and seeking a cure?

Incongruous as it is, it is the Government-Public which pressures the schools to admit lesser qualified students, while in the same breath saying we are all equal; which pressures you gentlemen to drop the minimum passing grade for all of those so-called "equal" dentists and license some of them, regardless of the quality of their work, thus flooding the market and reducing dental costs. It is this same Government-Public which is so quick to accuse members of the medical profession for neglect, poor judgment, poor workmanship, and high costs yet it, itself, produces all manner of inferior services and materials under the philosophy or attitude of "It's good enough."

As the number of malpractice suits increase, there has been a corresponding increase in the use of Peer Review board effort trying to mediate between dissatisfied patients and those members of our profession who are being accused, thus reducing the number of cases reaching the courts. The malpractice lawyer responsible for the article in the October 9th issue of People Magazine states, "They (the Drs.) should police themselves."[9] We might say in return, Plumbers, mechanics, etc. police yourselves.

The public has advocated the lowering of entrance requirements to accommodate below average freshmen who graduate as below average dentists and who, more often than not, fail the state clinical examination. Eventually, these poorer students will pass a board and then the public will complain about his inferior quality of dentistry and sue him for malpractice.

The same public who joyously accepts the prepaid dental programs with its impersonal and assembly-line approach to dental programs may also be affecting clinical failures in a sense since fewer patients visit the dental school clinics and thus each student finds it more and more difficult to find patients and perfect his clinical skills.

SHOW SLIDES HERE

In remediation, I cannot pretend to give you solutions to the various influencing causes of Failures on Clinical examinations and I doubt that anyone else can either or it would have been done before now. Through lack of personal experience within the schools and boards, most of us must depend upon reading the published papers and reports of those closely involved.

I am most qualified from experience to discuss the inadequacies of clinical skills as the major cause of failures, but I have done considerable reading and given much thought to bringing you what I hope you find acceptable discussion on the six contributing catagories I have listed.

The following information from the July 1978 issue of the Journal of American College of Dentists indicates that schools, like so many businesses, seem no longer able to survive without either State of Federal financial aid.

"We have found that neither the N.Y.U. dental school nor the one at Columbia - the two under private auspices in the State - can attract adequate amounts of gifts and grants to cover operating deficits, meaning special treatment must be accorded to those institutions by the State."[10]

As we read the report on N.Y.U., etc.,we learn that U.S.C. dental school is going to receive over a million dollars less aid in the coming year. I assume this unequal distribution of funds is happening across the country. Time will soon show just how capable the administrators are at the schools which are to receive less.

It seems that less aid from the Government with a corresponding reduction of attached "strings" is our only hope to bring about the return of more of the responsibility of administration of the schools to those members of the profession, educators, state board, etc. who are familiar with the needs of the profession and the needs of dental education. These people must not compromise their principles and they must continue to try to hold the line against any increased encroachment by the Government into the territory of Dental Education.

Certainly, it is time to reverse the trend of the "permissive" attitude in all schools and the philosophy of "It's good enough." I believe that people in general yearn to be able to say "It is good" and I am sure that in their hearts most of the students wish to excel, be they able or not. The opposite of permissive is dictatorial, I am told, but there must be a workable and happy medium some place in-between where the transfer of that wonderful, indestructible and never-ending supply of knowledge from instructor to student can be accomplished with a minimum of stress and resentment.

To achieve this is, to my thinking, a mark of a good teacher.

In 1975 Dr Rex Ingraham circulated among deans, representatives of the restorative disciplies of the west coast dental schools, as well as state board members of the western states, an Opinion survey regarding clinical failures. Many of us here today have had for years the same complaints as those listed in the survey. Now that the shortcomings of the clinical training of dental students is a reality, recognized by the deans, heads of departments, etc., perhaps constructive action to correct some of the obvious problems will finally be taken.

From the Ingraham report we read the following: "Inadequate inservice training of the technique and clinical teaching staffs is probably one of the greatest failures of the undergraduate educational system." "To this date, a truly successful approach to this universal problem has not been developed by dental education."[11]

Since most instructors in the dental schools have not had any teaching training and only a DDS or DMD degree is required, I feel they should all belong to participating study clubs relative to their particular fields. G. V. Black believed that "no man has a right to be other than a continuous student."

From my paper delivered in South Africa three years ago, I quote the following taken from a report by C. C. Alpert entitled, "A Dental Examiner's View of Dental Education." "...new and very logical concepts in teaching are taking place at the University of Kentucky College of Dentistry. It is now required that all courses be reviewed periodically and that all faculty members submit to some form of evaluation."[12]

Dr. Ingraham has personally told me of the inservice training meetings he is having with his faculty members, an obvious indication of the desire of Dr. Ingraham and the faculty to provide the students of U.S.C. Dental School with the best training possible.

The schools keep trying. This phrase reminds me of my admonition to my students during their struggle to master a procedure. "Keep stirring." This refers to the story of our first astronaut to land on the moon where he was met by the beautiful Moon Maiden, etc., etc.

Since time does not allow me to read the whole report by Dr. Ingraham, I shall only read you a small portion and recommend that each of you make an effort to read the entire article which may be found in the April 1977 issue of the Journal of The American College of Dentists and is entitled "Is Clinical Preparation Adequate?"

One of the questions of this important survey asks -

"According to your observation, have there been changes between the years 1960 and 1975 in the level of competency of dental graduates in those clinical skills traditionally evaluated by state board examiners?" 83% agreed there have been changes.

Also, according to the survey, 76% agree the highest standard of performance was in the early 1960's and the lowest in 1972 to 1974. An uptrend was noted, starting in 1974, continuing into 1975.

65% of the educators polled agree there is a correlation between levels demonstrated by undergraduate students and performance of the graduates on the state boards.

In 1960 and 1962, 100% of the class from U.S.C. passed the California State Board. By the years 1972 and 1973, those passing the board totaled 90% of the classes. By 1974 an uptrend was observed and in 1975, 96% passed.

Dr. Ingraham lists the following factors which he considers to be contributory to the decline over the 15 year period just referred to, and includes the percentage of those questioned who agree.

1.	General administrative leniency	81%
2.	Lenient attitude of clinical teachers	81%
3.	Poor student attitude	90%
4.	Less clinical demonstration by highly skilled staff	63%
5.	Accelerated three year program	89%

In an article entitled, "Responsibility of Educators," S. P.Hazen questions: "Today, educators are told that our graduates are not as competent as those in the past. What standards of comparison are being used? What perspective is being taken on what a graduate should be today as compared to that of the past?"[13]

Dr. Hazen's question regarding the standard of comparison is a good one and one that I doubt anyone can answer. However, Dr. Ingraham's report certainly substantiates the current feeling that many of our graduates are not as competent as they should be and he now has statistics to prove this point.

The following is another small portion from the same survey listed under Open-ended Comments, etc. and lists reasons for clinical failures.

1. Lack of attention to detail by the daily clinical staff.
2. Lack of sufficient competent clinical staff members.
3. Younger, inexperienced clinical staff members.
4. Use of high speed; less use of hand instrumentation.
5. Lack of clinical judgment by the student.
6. Student's time divided into too many sub-requirements: team preventive dentistry, mini clinics, DAU, etc.
7. Too much emphasis on biological;not enough on clinical applications.
8. All schools seem to be in a trend to put less emphasis on clinical teaching; end result is an inferior clinical operator.
9. Lowering the student grade point admission level to accept the minority and then the faculty are requested to bring these students up to the average of the class which is next to impossible. End result - inferior training of students all the way through school and inferior practitioners after graduation.

I have a number of my own ideas for suggested changes in the school attitude within the realm of instruction, discipline having been mentioned already. That every student should have to achieve a certain level of proficiency before being allowed to graduate is, in my mind, very important. Regardless of the amount of extra time required, if the student needs it let him have it, and this does not infer that the slow learner cannot achieve. It takes him a little longer,

Two very successful dentists who were my freshmen classmates did not graduate with me. One repeated his Junior year and the other repeated every year with the exception of the senior one.

Entry to dental school at the time of my schooling required a "C" GPA and $300.00 plus one year of pre-dental training. The failure rate between the freshman and senior years was 50%. Today, the entering freshman more often than not has four years of pre-dental. He has been seasoned in the learning process, has maturity, travel experience, and a great diversity of knowledge to his credit. Note that I say knowledge and not education. I like the following quote from Ralph Waldo

Emerson: "The things taught in colleges and schools are not an education but the means of education."

Among my students I have found evidence of an abundant amount of enriching knowledge but a lack of very important information pertinent to their chosen profession, such as Finger Rest Position, Instrument and Handpiece Grasp, all of which I must correct. When inquiring of local dental schools if they teach these techniques per se, the answer has generally been "no." The men whom I questioned say they assume anyone who can hold a pen can hold a handpiece correctly, and yet we all know that the handpiece and hand instruments are not held in the same manner in which we hold a pen or pencil to write. No instructor has a right to assume anything where the student is concerned except that he comes to the school knowing nothing about dentistry.

Most of those I have taught do not understand when I say they should learn to think of their hand and handpiece as a "milling machine" as I explain the proper movement of the handpiece. They do not understand the significance of the names of their hand instruments nor the meaning of the identifying numbers of the hand instrument nor how to sharpen these instruments. In fact, most state that they were not taught how to sharpen their hand instruments and some even say they never sharpened them during four years of dental school. Some have told me they never use a hand instrument! Rather appalling revelations,don't you think? Why did these dentists fail the clinical portion of the state board? Not hard to understand.

To see Gold Foil becoming an endangered species makes me very sad as you may guess. This is due almost directly to the attitude of schools since someone decided that Gold Foil should be replaced with the easier to master and cheaper composite with its cosmetic beauty.

Dr. Ernest Jones, the first Dean of the University of Washington Dental School and former head of the Operative Department at U.S.C., was a Foil man and he made Foil men of many students during his teaching years. It was his opinion that the mastery of that procedure is the greatest disciplinary training for the dentist and he could prove that to the student. There is no cement nor any other crutch upon which to rely for the successful Foil. It all depends upon the skill of the operator.

I would like to see the Gold Foil restored to its rightful place in the dental school curriculum in place of some of the extraneous courses which might be moved to the Continuing Education Program.

Unfortunately, students are now told that the Foil is no longer a practical restoration, is too time consuming, and too difficult a procedure. It is a fact that the prepaid dental plans refuse to pay for Gold Foils because of the cost, unaware, apparently, that the properly placed and cared for Foil will outlast the alternate composite filling many times, preserve the tooth and save money. Isn't that what dentistry is all about?

Ten years ago, I made use of the following comment from a Gold Foil survey made by the Medical University of South Carolina. "The time needed to develop the necessary clinical skills and the asset of good judgment simply rules out the waste of the clinical hours required to develop a competent skill in the use of the 'least' useful of dental materials."[14]

At the death of my mother, age 88, two anterior teeth held Gold Foils placed there by a traveling dentist when she was 18 years of age. My wife has 8 clearly visible Foils in her anterior teeth, ranging in age from 12-39 years. Can you beat that for economy and service?

I have a question for you. If a traveling practitioner of so long ago with, at most, one year of dental training, could master the Basics and the use of the compacted gold filling, why should we ask any less of the student of today with his very superior pre-dental education and four times as much dental education?

Other than the reinstatement of the Gold Foil in the dental education program throughout the United States, nothing would make me happier to hear that the schools were adapting a standard of quality for a good, not just acceptable, cavity preparation and completed filling. How much easier this would make the student's lot, the instructor's teaching, and the state board's judging.

Ten years ago, I stated my thought on student selection and I have not changed my thinking on that subject. Dr. G. V. Black's definition of a Cavity Preparation begins with these words: "The mechanical treatment of ...., etc." Since the Generalist will spend most of his time doing Operative Dentistry which is a mechanical procedure, then logically the selection of the freshman should be partially predicated on his mechanical interests and experiences as well as his scholastic standing. Has he ever had a Hot Rod to keep running, or has he had any mechanical drawing, machine shop, wood shop, or art courses would be questions asked of him.

I have noticed some of my students having great difficulty developing good control of their instruments and I discovered that in some cases these men are double jointed. Usability of

the hands is vital in the selection of a freshman student. A very simple test will reveal if this condition is present and I think it should be a part of the freshman selection criteria.

Yesterday and today's dissatisfaction with the present admissions test is finally leading to new and elaborate experiments in seeking a better way of screening freshmen for entry to dental school. Dr. Ingraham tells me that U.S.C. has returned to the use of the carving test as part of the selection criteria.

If you have not read Dr. Robert Barkley's paper entitled, "The Dilemma of Dental School Admissions," you should. It may be found in the April 1976 issue of the Journal of the American College of Dentists.[15] The following quote is from that article:

> "A major breakthrough may be approaching. A handful of innovative U.S. Dental Schools are currently evaluating a revolutionary new selection process that may not only help solve the admissions dilemma, but may actually take a major step toward remaking the dental profession."

All good news and action which should in time reduce the incidence of Failures on Clinical examinations.

Every time I prepare a new paper from a requested Topic I rediscover my "inadequacies" and this paper has been no exception. As usual, my wife and I have spent many hours in discussion and analyzation of the subject matter, but this category of Student Attitude has proven to be the most demanding in thought and the most illusive in "remediation."

Just a page or two ago I read from the Ingraham report that 90% of those polled felt that Student Attitude was a contributing factor in the decline of clinical competency. Whenever, and wherever, dentists involved with education or state boards gather sooner or later the subject of student attitude and selection comes up and much time is spent in discussion and general complaints of these "misguided and mis-selected folk." These discussions so often infer that every student is obnoxious and unwilling to accept discipline, etc. This cannot be so for even in a barrel of apples there are only a very few "rotten" ones.

I asked Dr. Ingraham if he could give me an estimate of the number of disturbing students in a class. He gave an answer of 15-20%. The importance of his answer is that more than 80% are really trying to "receive" the knowledge they came to get.

Earlier, I quoted from a report on a new method for selecting students which mentioned that it had been determined

that a large number of students of a senior class tested were way below the average and should never have been selected for dental school. Could this group be part of those who cause the inharmony? Are their own inadequacies and frustrations the cause of their rebellion?

Dr. Ingraham now thinks so. He feels that the reinstating of the carving test added to other new ideas for selection of freshmen may reduce the number of poor performers and thus decrease the number of students with the so-called poor attitude.

A resentful and rebellious attitude is not the exclusive property of the undergraduate student. Many of my refresher students are lax in attendance and some are very resentful as they do not understand why, since a school did grant them degrees and a state board did issue them licenses, they cannot pass the California board examination. It is my unpleasant duty to tell them the painful truth, which is that the quality of their work does not meet the standards set by the boards of the western states. Many argue with me about the techniques I teach, telling how they were previously taught and how they would do the procedure, etc. I have a stock answer. "You have already tried your way and failed." One older man told me that if he had to practice dentistry the way I advocate he would have to double his prices or live lower on the "hog." I must add that most of those I have tutored on a private basis are usually receptive and hard working.

Over the years, my students, too, have complained of instructors they have had. So what's new? They complain about incompetent instructors, obnoxious instructors, unavailability of instructors when they are needed to help on the clinic floor plus the fact that a lecturer may advocate a certain procedure in the classroom but the same procedure may not be followed in the clinic. Now, hold onto your hats. I have even had complaints in reverse about discipline with the comment that they had heard about certain procedures but were never "made" to use them!

To my point of view, the proper "first day" could make all the difference in the world in the future attitude of a student. I asked Dr. Ingraham if U.S.C. has an orientation period for the entering freshmen and he says they do. I assume that this then is the practice of most dental schools.

My first day in dental school so many years ago is just a blur with the exception of the following statement made by Dean Ford: "Gentlemen, take a look at your neighbor because next year one of you will not be here." Attitudes were certainly formed at that moment.

Judging by the problems with students just reviewed and

the new and positive steps being taken to correct these problems, 1979 should bear witness to tremendous strides made by students in the field of clinical skills and the harmonious giving and taking of knowledge between competent instructors and eager students.

Board members will not believe how many times I have been asked if the members of the boards can produce the same quality work expected of the candidates taking the boards. How would you men and women answer that question?

Once again we come up against the Government, for, of course, members of the state board are appointed by the Governor. As in the case of one of my colleagues who is an Orthodontist, members who have not actually practiced any Operative Dentistry for years may be appointed to the board. Unfortunately, few are as conscientious as my neighbor, willing to admit their inadequacies and ask for aid. My neighbor asked me to give him some "refreshing" and I did. Now I understand that there are complaints that he is too tough a grader.

Some of the boards are taking interesting steps to improve the system of evaluating the candidates. The Nevada and Hawaii boards are considering having me give their members a participating review course in Operative Dentistry. If this comes about, the students will not have to wonder if board members can produce what they require from the board candidates.

The California Board and the Central Regional Boards have held workshops and each member has been asked to evaluate pre-prepared teeth and defend his reasoning.

It is tragic that no way has ever been devised to test a man on his ethics. One of my students once asked me, "How do you give a man a conscience?" If any of you have an answer to that question, I shall be glad to hear it.

"The measure of a man's character is what he would do if he knew he would never be found out." (Thomas MacCaulay)

From an article in the September-October CDS Newsletter comes the following: "Mr. Gilbert Laws of the United Rubber Workers stated that essentially labor wants quality dental treatment at a fair price."[16]

There is nothing new nor profound in the statement from United Rubber Workers. The desire for quality service in all realms has ever been the sentiment of us all and there is no good reason why we should not expect quality service for our money. If each of us gave quality service while earning our wages, this philosophy would travel the proverbial "full circle" and in time return quality to each of us.

It is my personal opinion that quality dentistry cannot be found in the prepaid clinic and never will be as long as "speed" is the rule and the operator required to produce 10.8 surfaces of alloy per hour and rewarded with a bonus if he does more than that. If this be the desire of the people, then perhaps we should train dentists for quality private practice and others for the prepaid clinic.

To be assured the possibility of quality dentistry, the Government-Public must learn to accept the judgment of those who are knowledgeable of and involved with the dental education process and return to them and the schools the responsibility of training dentists whom the state boards can reasonably expect to pass and license. This means, then, that the schools must be allowed to set the admissions criteria, graduation standards, etc. without public interference.

In addition, this same Government-Public must believe that the responsibility of the state board is to protect the public. It must give the boards free reign to once again pass or fail board candidates on the merit of their skill, without public intervention such as they have now.

To this date, the Government-Public's forcing of the admittance of unqualified freshmen to the schools and the school policy of "all pass" has not been a success. Once again, I refer to Dr. Ingraham's report and the statement concerning the lowering of the student GPA level to accommodate the minority student and the futile request that the faculty bring these students up to class average. "End result - inferior training of students all the way through school and inferior practitioners after graduation."[17]

These inferior practitioners have no doubt been among those who have failed the clinical examinations and their failing is due directly to the current philosophy of the public that changes the rules to accommodate everyone.

CONCLUSION

Now, in conclusion we agree that clinical failures on the state board are still an unpalatable reality. Whether or not the incidence of these failures will diminish in the future remains to be seen.

As this paper goes to print, I have received calls from two out-of-state students wishing to be tutored. One tells me that eleven graduates of one school took the California and Arizona boards and all failed but one.

It is still my opinion that the main cause of these failures is the lack of proficiency in the clinical skills. The student does not know nor does he understand the application of the Basic Fundamental Principles of Cavity Preparation.

In this paper we have explored six factors which I feel are contributory to the above stated main cause of the clinical failures, namely, Government Involvement, School Attitude, Student Selection, Student Attitude, State Board and Public Attitude, and discussed their relationship to the problem.

I think the future looks promising in its relationship to the reduction of failures on the dental state board examinations. We have learned much from our involvement with the Government. We enjoyed the money to spend but not the string attached and we found that the Government way is not the better way.

We now see some of our schools with a new attitude enthusiastically accepting the challenge of creating a better learning institution with less money to spend; the selection of students based upon their abilities as related to the needs of the dental profession in addition to their GPA; new philosophies developing pertaining to the control of students attitudes and training of instructors; state board members searching out ways to make their judging fair and protection of public and dentists effective.

Hopefully, the attitude of the Public will mellow to a less accusing, more receptive and understanding one.

May there be less need for Malpractice suits or even the enforcing of the "ordinance in South Foster, Rhode Island which provides that a dentist who extracts the wrong tooth must have a corresponding tooth pulled by the village blacksmith, or pay a fine."[17]

When all is said and done, let us remember ".... the truth is that more and better medical care is available for the sick in the United States than anywhere else in the world."[18]

And, "The fact is that for two hundred years we have had for the most part a unified profession. We have achieved the finest dental health care for most people at the most reasonable cost. The American people have the finest oral health in the world."[19]

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RURAL ALASKA

Partners for Progress with Alaska Communities

COMMUNITY ACTION PROGRAM, INC.

ROUTE SLIP

TO: JANA VERATI
AK Health Coalition

____ ACTION	____ NOTE & RETURN
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____ CONTACT ME	____ PREPARE REPLY
____ DISCUSSION	____ SIGNATURE REQUIRED
____ DISTRIBUTE TO	____ SUBMIT TO
____ FILE — PER REMARKS	X FOR YOUR INFORMATION

FROM PHIL SMITH
RURAL CAP

REMARKS

MOORE BUSINESS FORMS, INC. 14

Thelma - This is a copy of the grant Abadian - Dias & N. got to lobby HB 401 through the legislature. (There is some question about the legality of Rural CAP doing this.) Regardless, we are in favor of extending the dental statute to allow students to work outside their school setting. If this bill (401) doesn't →

12/22/78

Grant/Contract Documents:

Approval & Routing Sheet

Funding Source CSA - '79 "221" grant

Brief description of attached document HESS Dental Advocacy Contract with Aleutian/Pribilof Is. Association for $15,060

Grant/Contract # (if any) _____
Grant/Contract period Mar. 12, 1979 to June 30, 1979

Approval Required:

Department Head [signature] Date 3/19/79

Controller/Ch Acct [signature] Date 3/19/79

Executive Director [signature] Date 7-19-79

This form shall be completed prior to final approval by the Executive Director.

The completed form will be released to the Chief Accountant by the Dept. Head after all signatures are affixed by the Executive Director.

OBJECTIVE: Have legislation enacted which will allow for volunteer dental service in Alaska.

STRATEGY:

1. Compile and distribute at least 100 informational kits explaining the concept and advantages of the Mobile Dental Unit and utilization of qualified volunteer services. Kit to consist of pertinent documents, articles, pamphlets, photographs, etc.
2. Draft and distribute press releases based on (1) above.
3. Organize and conduct at least 8 meetings with groups involved with rural health services, i.e. - educators in health training, Native organization staffs, state employees. Show "Open Your Mouth" film and provide information on the advantages of the Mobile Dental Unit and utilization of qualified volunteers.
4. Make contact with legislators and explain need for amendments to Alaska Statutes which will enable volunteers to practice in Alaska. Testify as appropriate.

OBJECTIVE: Complete preparations for resumption of services this summer utilizing Mobile Dental Unit.

STRATEGY:

1. Travel twice to San Francisco and meet with representatives of the Stark Foundation; negotiate '79 schedule, etc. Also meet with at least one other volunteer group during these trips to ascertain if they can provide help.
2. Make detailed plans for volunteer manpower during summer '79. Seek additional private foundation funds for transportation and for per diem support of volunteers traveling to the Aleutians.
3. Coordinate plans with PHS/IHS, to include:
   a) Travel once to Washington DC to explain the program and elicit support.
   b) Advise the Anchorage IHS service unit of the ongoing status of the project.
   c) Arrange with Anchorage IHS service unit appropriate format for gathering data -- undergo orientation with PHS on forms, records, documentation so as to generate data which will facilitate proper tracking of clients.

4. The APIA shall organize at least one meeting involving representatives of State of Alaska-DHSS, Indian Health Service, Dental Examiners Board, and other appropriate individuals in order to refine the strategy and logistics of resuming services this summer.

12/22/78

Grant/Contract Documents:

Approval & Routing Sheet

Funding Source CSA - '79 "221" grant

Brief description of attached document HESS Dental Advocacy Contract with Aleutian / Pribilof Is. Association for $15,060

Grant/Contract # (if any) _____

Grant/Contract period Mar. 12, 1979 to June 30, 1979

Approval Required:

Department Head [signature] Date 3/19/79

Controller/Ch Acct [signature] Date 3/19/79

Executive Director [signature] Date 7-19-79

This form shall be completed prior to final approval by the Executive Director.

The completed form will be released to the Chief Accountant by the Dept. Head after all signatures are affixed by the Executive Director.

DENTAL SERVICES ADVOCACY PROGRAM

CONTRACT FOR SERVICES

THIS AGREEMENT made and executed the day and year hereinafter last written, by and between the RURAL ALASKA COMMUNITY ACTION PROGRAM, INC., an Alaska corporation, hereinafter called "Grantee," and Aleutian/Pribilof Islands Association, hereinafter called "Contractor," consistent with RurAL CAP Grant 00919-T-79/02 effective January 1, 1979, as modified.

W I T N E S S E T H:

The parties come in consideration of the mutual covenants herein contained agree as follows:

1. Contractor Responsibilities. The Contractor shall perform all duties and liablilties under this agreement in a satisfactory and proper manner as determined by the Grantee.

2. Board of Directors. Contractor shall maintain a Board of Directors whose members shall represent the respective communities or subregional areas from which they are elected or designated by a representative community body. The Board of Directors shall speak for and communicate with the respective communities or subregional areas they represent. Contractor agrees that it will conduct at least one full board meeting during program year 1979 (January 1, 1979 to September 30, 1979) and at least three additional meetings of either the full Board of Directors, or the Executive Board, or any combination thereof. Contractor agrees to notify Grantee in writing of all meetings of Contractors full Board of Directors at least fourteen (14) days prior to such Board meeting. Contractor further agrees to notify Grantee in writing of any and all Executive Committee meetings with said notification being provided to Grantee

at the same time as notice is provided to Executive Committee members. Minutes of all meetings of Contractor's Board and/or Executive Committee shall be submitted to Grantee not later than twenty-one (21) days after adjournment of such meeting.

3. Target Area Reports and Representation to the Grantee.

(a) Where the Bylaws of the Grantee provide for the Contractor to fill one seat on the Grantee's Board of Directors then, pursuant to Grantee's Bylaws, the Contractor shall ensure that one person (local to the region, and preferably a member of the Contractor's Board) will be designated to serve on Grantee's Board and attend Grantee's Board meetings. The Contractor shall also designate one alternate (also local to the region and preferably a member of the Contractor's Board) to fill said seat on the Grantee Board when the regular representative is unable to do so. At any regular meeting of the Grantee's Board the Contractor's representative to that Board shall be prepared to present a Target Area Report which shall, at a minimum, explain the following:

(i) The progress the Contractor is making and problems encountered in fulfilling the goals of the work program as outlined in Appendix A attached.

(ii) The progress the Contractor is making and problems encountered in fulfilling the goals of any other program Contractor is operating with Grantee funds.

(iii) Public issues which significantly affect the low-income population in the region.

The report shall be specific and shall convey a clear understanding to the Grantee's Board of the status of the Contractor's program,

with associated accomplishments and problems.

(b) The Contractor's designee to the Grantee's Board of Directors shall submit a subsequent report to the Contractor's Board of Directors and Executive Committee at the earliest available time after any meeting of the Grantee's Board of Directors. The report shall inform Contractor's Board and Executive Committee members of issues discussed and actions taken by the Grantee Board.

4. Approved Work Program and Period of Performance. Contractor shall perform all activities described in the approved work program and budget which are attached hereto and made a part hereof as Appendix A (Work Program) and Appendix B (Budget). Such activities are embodied in RurAL CAP Grant 00919-T-79/02, as modified, and shall be performed between March 12, 1979 and June 30, 1979, according to the timetable in Appendix A.

5. Payment and Reimbursement Procedure. Of the funds available for Contractor's program, Grantee shall advance to Contractor the sum of Nine thousand three hundred and xx/100 _____ DOLLARS ($ 9,300.00 _____), within 5 days of contract execution, which amount shall be used by Contractor to initiate the program described herein. All subsequent sums payable to Contractor shall be paid on the reimbursement method and must be substantiated by submitting the following documents:

(a) Copies of all checks disbursed for reimbursable expenses;

(b) Copies of all invoices, time sheets and other supporting documents substantiating each disbursement.

(c) Other documentation required by the Grantee or specified in the "Rural Cap/CSA Contractors Notebook.

Contractor agrees to furnish Grantee with copies of all such documents supportive of a reimbursement request on or before the 10th calendar day of each month, which documents shall reflect all costs incurred by Contractor during the preceding calendar month. Grantee shall reimburse Contractor for all allowable expenditures substantiated by the foregoing documentation within ten (10) days after receipt of such documentation from Contractor, but in no event shall Grantee pay to Contractor, during any single calendar month an amount greater than N/A DOLLARS ($_____), (or _____%) of the total sum designated for Contractor's budget, unless expressly approved by Grantee's Controller.

The Grantee is not liable for Contractor incurred costs which conflict with CSA or Grantee regulations or policies. It is the responsibility of the Contractor to make obligations and spend funds consistent with such regulations and policies.

The Contractor will in no case exceed in expenditure or in commitment the total obligation dollar amount agreed upon with the Grantee, as outlined in Appendix B. The Contractor is fully responsible for any and all overexpenditures and for any disallowable and disallowed costs which it may incur.

6. Progress Reports. Contractor shall be required to prepare and submit two (2) written work program progress reports. Such reports shall detail Contractor's progress toward accomplishing the goals stated in the work program. All information contained in such reports shall be specific and will quantify data wherever possible. Reports shall be submitted according to the following schedule:

1) First Report - due May 4, 1979	Covering period March 12 through May 4.
2) Second Report - due July 6, 1979	Covering period May 7 through June 30.

Grantee may provide report forms to the Contractor in advance of each report due date, and if this occurs the report shall be submitted on such forms. Contractor shall maintain a filing system which contains documentation of progress made toward the accomplishment of goals stated in the work program.

7. Monitoring. It is agreed that Grantee, its agents and employees shall have the right to enter program areas and offices of Contractor at any reasonable time for the purpose of examining work in progress and administrative records in order to conduct such monitoring as is necessary for providing technical and administrative assistance and to insure compliance with this agreement. Where such monitoring by the Grantee necessitates the active involvement of the Contractor's staff, Grantee shall provide reasonable notice to the Contractor in order that the Contractor may fully participate in the monitoring activities.

8. Non-Federal Share. Contractor, its agents, or employees shall provide One thousand six hundred seventy three and xx/100 DOLLARS ($1,673) or the equivalent thereto, as its non-federal share requirement and shall document such contributions on forms approved by the Grantee. For purposes of this agreement, this non-federal share requirement shall be provided in accordance with the non-federal share budget attached hereto and incorporated herein as Appendix B.

9. Modification of Work Program and Budget.

(a) Work Program. A modification of the Contractor's work program (Appendix A) requiring written amendment is defined as any major change, including additions, deletions, or substantive rewriting of one or more goal statements. A work program amendment shall require approval by Contractor's Board or Executive Committee and submission in writing of an amended work program form to Grantee with attached narrative justification. Grantee retains the right to approve or disapprove any modification of the work program. Grantee Executive Director shall review and process any proposed work program amendment within 14 days of receipt and shall notify Contractor of said approval or disapproval. If Grantee disapproves a work program amendment, Grantee shall provide written justification for such disapproval.

(b) Budget. A budget change requiring written amendment is defined as any change which increases or decreases the amount in any cost category, as outlined in Appendix B, by an amount greater than $1,000. Grantee specifically reserves the right to render final approval of all proposed budget modifications. Grantee Executive Director shall review and process any proposed budget amendment within 14 days of receipt of such and shall notify Contractor of approval or disapproval. In the event Grantee disapproves a budget amendment, Contractor shall be provided written justification from Grantee.

(c) Fixed Budget Total. The total amount of federal funding available under this agreement is Fifteen thousand sixty and xx/100 Dollars ($15, 060). The parties to this contract understand and agree that in no case shall Contractor increase the approved total federal share, or decrease the approved total non-federal share for the budget year.

10. Delegate Agency Status. For purposes of CSA statutes, regulations, and directives the Contractor shall be considered a Delegate Agency of the Grantee as defined in CSA regulation.

11. Compliance with Approved Program and Laws. Contractor and Grantee agree to comply with all laws, rules, and regulations, federal, state and municipal, which are now, or in the future may be applicable to their businesses, equipment and employees engaged in or in any manner connected with Contractor's performance hereunder. All activities authorized by this contract shall be performed by Contractor in accordance with the approved work program (Appendix A) and approved budget (Appendix B), the Grant conditions and relevant Community Services Administration (CSA) directives.

12. Nondiscrimination. Contractor and Grantee hereby agree that no person shall, on the ground of race, color, religion, sex, age, handicap or national origin by excluded from pa ticipation in, be denied the benefits of, or be otherwise subject to discrimination in determining eligibility to participate in the program, as required by General Conditions Governing Grants under Titles II, III - B and VII of the Economic Opportunity Act of 1964, as amended.

13. Assignment or Subleasing. Contractor may not assign or sublease its interest hereunder to any other party without the prior written consent of Grantee, and Contractor agrees that any violation of this covenant will, at the option of Grantee, work immediate forfeiture of Contractor's interest hereunder.

14. Default or Termination. The Grantee may, by giving at least fifteen (15) days written notice specifying the effective date, terminate this contract in whole or in part for cause, which shall include: (1) failure, for any reason, of the Contractor to fulfill in a timely and proper manner its obligations under this contract,

including compliance with the approved program and attached conditions, and such statutes, Executive Orders, and CSA directives as may become generally applicable at any time; (2) submission by the Contractor to CSA or to the Grantee of reports that are incorrect or incomplete in any material respect; (3) ineffective because of inadequate program activity, or improper use of funds provided under this contract; and (4) suspension or termination by CSA of the grant to the Grantee under which this contract is made, or the portion thereof delegated by this contract when required by CSA direction. If the Contractor is unable or unwilling to comply with such additional conditions as may be lawfully applied by CSA to the grant or to the Grantee, the Contractor shall terminate the contract by giving reasonable written notice notice to the Grantee, signifying the effective date thereof. In such event the Grantee may require the Contractor to ensure that adequate arrangements have been made for the transfer of the delegated activities to another Contractor or to the Grantee. In the event of any termination, all property and finished or unfinished documents, data, studies, and reports purchased or prepared by the Contractor under this contract shall be disposed of according to CSA directives, and the Contractor shall be entitled to compensation for any unreimbursed expenses reasonable and necessarily incurred in satisfactory performance of the contract. Notwithstanding above, the Contractor shall not be relieved of liability to the Grantee for damages sustained by the Grantee by virtue of any breach of the contract by the Contractor and the Grantee may withhold any reimbursement to the Contractor for the purpose of set-off until such time as the exact amount of damages due the Grantee from the Contractor is agreed upon or otherwise determined.

It is further understood by the parties to this agreement that when written notification of termination for cause is given by the Grantee's Board, the Contractor shall have the opportunity, within the 15-day time limit, to take such corrective action as may be necessary. If such action that Contractor may take is deemed adequate by the Grantee for correcting the cause of termination, then the Grantee shall not terminate the agreement. It is the policy of the Grantee to terminate an agreement only as a last resort.

In the case where action to terminate this agreement occurs, the Contractor reserves the right to appeal such action, consistent with CSA Notice 6441-1.

15. Covenant Against Contingent Fees. The Contractor warrants that no person or selling agency or other organization has been employed or retained to solicit or secure this contract upon an agreement or understanding for a commission, percentage, brokerage, or contingent fee. For breach or violation of this warrant the Grantee shall have the right to annul this contract without liability or, in its discretion, to deduct from the contract or otherwise recover full amount of such commission, percentage, brokerage, or contingent fee, or seek such other remedies as legally may be available.

16. Waiver. The failure of either party in one or more instances to insist upon strict performance of any of the covenants or conditions of this agreement, or to exercise any privilege conferred, shall not be construed as a waiver or relinquishment of the effect of any such covenant, conditions or privilege, but the same shall be and remain in full force and effect.

17. Prior Agreement. This agreement supercedes all contracts arrangements, commitments and offers of every kind or nature, oral or written, at any time heretofore made by the parties.

18. Modification. No modification or amendment hereto shall be binding upon either of the parties unless in writing, signed by both parties.

19. Indemnification. Contractor agrees that it will save harmless and indemnify the Grantee from and against all liability and claims for damages and/or suits arising out of Contractor's performance of this agreement.

20. Applicable Laws. This agreement and the relationship of the parties hereto shall be governed by and interpreted in accordance with the laws of the State of Alaska and of the United States.

21. Status of Contractor. Contractor represents that it is a duly registered non-profit corporation incorporated under the laws of the State of Alaska and in all ways is in good standing in accordance with State law.

22. Independent Contractor. It is expressly understood that Contractor is an independent Contractor and neither it nor its agents or employees are employees of the Grantee. The actual performance and supervision of performance hereunder shall be under the control and direction of the Contractor; provided, however, that Grantee being interested in results to be obtained, is to be kept at all times fully informed of Contractor's activities in this regard. Contractor warrants that Contractor is an employer, as that term is defined in the Federal Insurance Contributions Act and the Unemployment Compensation laws of the state or states in which the work is to be performed and Contractor's identification account numbers are as follows:

Federal_____ State_____

23. Insurance Requirement. Contractor agrees to carry and maintain at all times during the time of this contract, general

liability insurance, in an amount not less than Three Hundred Thousand Dollars ($300,000).

24. This agreement incorporates all terms of Appendices A and B.

IN WITNESS WHEREOF, this Agreement has been executed and delivered this _____ day of _____, 1979.

RURAL ALASKA COMMUNITY ACTION PROGRAM, INC.

By: signed 3/19

Position: _____

CONTRACTOR:

ALEUTIAN/PRIBILOF ISLANDS ASSOCIATION

By: signed / Pat P. 3/20

Position: _____

ALASKA STATE DENTAL HYGIENISTS ASSOCIATION

TESTIMONY OF LOISANN G. REEDER
Given at Legislative Hearings on HB 401
March 29, 1979

I am presenting testimony on behalf of the Alaska State Dental Hygienists' Association. My testimony pertains only to Lines 13 - 29 on Page 1, and Lines 1 - 5 on Page 2, of HB 401. This is the portion of the bill relating to dental hygiene licensing requirements. My association is aware of, and in sympathy with, the problems which have developed due to the gap in policy in the statutes which presently does not allow dental hygiene students and their supervising faculty to perform in clinical dental school study programs in remote areas of our state. As such, we are in support of HB 401, amended to read as follows:

- SEE ATTACHMENT -

Respectfully submitted,

Loisann G. Reeder

Loisann G. Reeder, Chairperson
Legislative Committee

ALASKA STATE DENTAL HYGIENISTS' ASSOCIATION

SUGGESTED AMENDMENTS TO HB 401

Sec. 08.32.010. LICENSE REQUIRED. No person may practice, offer or attempt to practice, or advertise or announce oneself as prepared or qualified to practice dental hygiene without a license except

(1) bona fide, full-time students of dental hygiene who have completed one year of clinical study at a dental hygiene school which requires at least a two-year course and is accredited by the Commission on Accreditation of Dental and Dental Auxiliary Education Programs of the American Dental Association who are

(A) enrolled in a clinical program sponsored by, and forming a part of, the course of study at the school, and which has been registered with, and awknowledged by, the board;

(B) practicing dental hygiene in an area designated as "remote" by the Department of Health and Social Services, on an unpaid basis under the direct supervision of a dentist member of the faculty of the school, or the direct supervision of a dental hygienist member of the faculty in conjunction with the indirect supervision of a dentist member of the faculty; and

(C) (SAME - no changes)

(2) dental hygienist members of the full-time faculty at a dental hygiene school which requires at least a two-year course and is accredited by the Commission on Accreditation of Dental and Dental Auxiliary Education Programs of the American Dental Association who are

(A) engaged in a clinical program sponsored by, and forming a part of, the course of study of the college, and which has been registered with, and awknowledged by, the board; and

(B) supervising and/or practicing dental hygiene in an area designated as "remote" by the Department of Health and Social Services, on an unpaid basis under the indirect supervision of a dentist member of the faculty.

(3) A person practicing dental hygiene under the licensing exemptions as stated in (1) and (2) of this section shall be subject to all provisions of this act and other applicable laws which govern the practice of dental hygiene by licensed practitioners.

TELEGRAM

RCA ALASKA COMMUNICATIONS, INC.
PHONE: 586-6412
JUNEAU, ALASKA 99802

1979 APR 24 PM 11 39

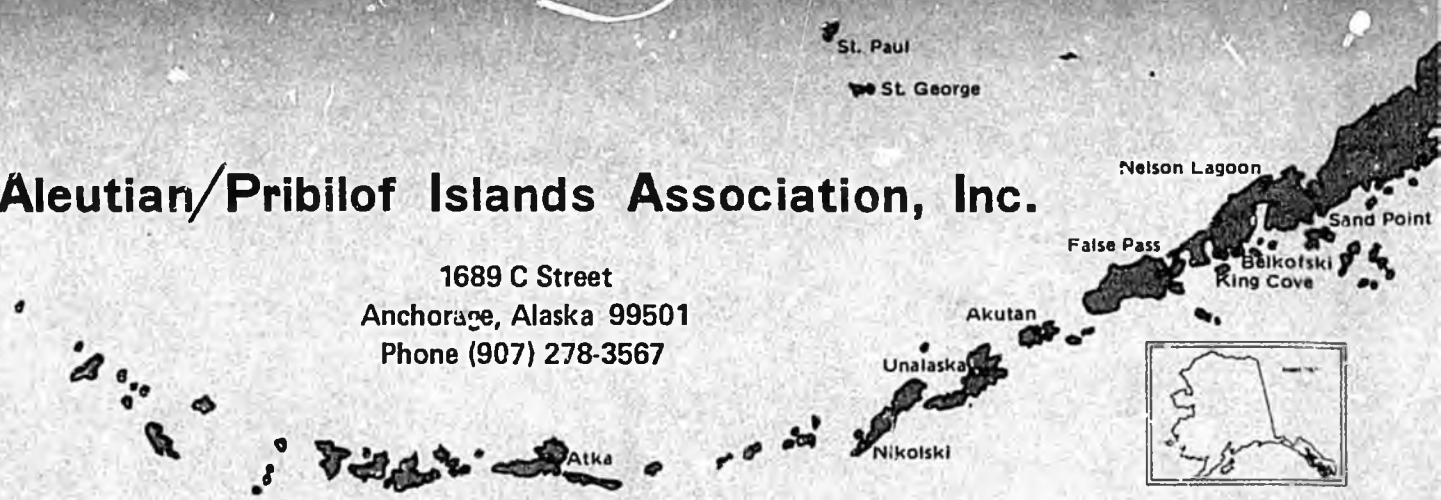
02269 NL ANCHORAGE ALASKA 270 04-24 0350P AST

PMS THELMA BUCHHOLDT,CHAIRMAN,HOUSE HESS COMMITTEE

JUN

WHEN SOLOMON AS LEADER OF HIS PEOPLE HAD TO MAKE DECISIONS HE OFTEN LOOKED BEYOND HIS OWN PERSONAL TASTE, BEYOND HIS ENEMIES AND THE DEVISIVE INFLUENCES THAT PLAGUED HIM TO VIEW THE TRUE RECIPEINTS OF HIS ACTIONS, THE LITTLE PEOPLE WHO WOULD BARE THE BRUNT OF HIS DECISIONS. WE HAVE KIDS IN BUSH ALASKA WHO HAVE TOOTHACHES, WHO SUFFER ALL THE TIME WITH SYSTEMIC POSIONING AND MALNUTRITION BECAUSE OF DENTAL HEALTH PROBLEMS. LOOK BEYOND ALL THE RHETORIC OF THE PROFESSIONALS WHO HAVE MADE NO UNPAID EFFORT TO BRING RELIEF TO THESE PEOPLE. WHO BELIEVES THEM NOW WHEN THEY SAY THEY ARE READY TO GO TO WORK FIXING TEETH IN BUSH ALASKA, NOT I AND SURELY NOT YOU. OURS IS A VOICE CRYING OUT OF THE WILDERNESS BUT NOT BY ANY MEANS A LONE VOICE. EVERY SINGLE RURAL COMMUNITY WANTS DENTAL CARE NOW. THEY DONT CARE ABOUT OIL TAXES, FISH TAXES, D-2 OR PORK BARREL LEGISLATION WHEN THEY SUFFER WITH A TOOTH ACHE THEY WANT HELP NOW. WE HAVE A DLRS200,000 MOBILE CLINIC READY TO GO, PAID FOR WITH STATE TAX DOLLARS. IT IS INCONCEIVABLE THAT A SPECIAL INTEREST GROUP COULD BE SUCCESSFUL IN PREVENTING VOLUNTEERS FROM DELIVERING RELIEF TO THE SUFFERING SIMPLY BECAUSE THEY HAVE MONEY AND POWER. IT IS OURHOPE THT EVERY LEGISLATOR WHO VOTES OR ACTS IN OPPOSITION TO THIS EFFORT SUFFERS FROM S SEVERE TOOTH ACHE OR BREAKS HIS BRIDGE IF THE DENTISTS HAVE ALREADY GOTTEN HIS TEETH. OUR BILL IS TIED UP IN THELMA BUCHHOLDTS HESS COMMITTEE. HELP US GET IT OUT FOR A VOTE. THANKS.

PATRICK PLETNIKOFF, EXECUTIVE DIRECTOR, ALEUTIAN PRIBILOF ISLANDS ASSOCIATION 1689 C STREET ANCHORAGE ALASKA 99501



Aleutian/Pribilof Islands Association, Inc.

1689 C Street
Anchorage, Alaska 99501
Phone (907) 278-3567

February 6, 1979

Thelma Buchholdt
House of Representatives
Pouch V
Juneau, Alaska 99811

Dear Mrs. Buchholdt:

Pursuant to our discussion concerning our need for legislation to allow volunteer dentists to serve in our remote areas under permits issued by the State Department of Health and Social Services, we are sending you a packet of materials to bring you up to date and also on the cover a suggested Statute change which will take away the right to issue permits from the self serving dentists and put that authority with the Health Department instead

Sincerely yours,

Pat Pletnikoff

Patrick Pletnikoff
Executive Director

PP:alp
Enclosures

An Act

Providing for the Practice of Dentistry by Certain Students

Be it enacted by the Legislature of the State of Alaska,

Section 1. A.S.08.36.350 is amended by adding at the end thereof:

(7) Bona fide students of dentistry in pursuit of clinical studies as provided by A.S.08.36.275.

Section 2. Title 8, Chapter 36, of the Alaska Statutes is amended by adding thereto, the following new section:

Section 08.36.275. Practice of Den istry by Certain Students. A license is not required of a bona fide full time dentistry student who, during the period of his enrollment and as part of his course of study, engages in a clinical program which is:

1. Performed under the direct supervision of a:
   A. Member of the faculty of the institution offering the program who is either a professor, associate professor, assistant professor or instructor, or,
   B. A dentist holding a permit or license from the State of Alaska pursuant to A.S.08.36.220, 240, 280, or 285.
2. Sponsored by an institution which files with the board on forms to be provided for this purpose:
   A. Evidence of full insurance coverage and protection afforded all participants in the program from claims under A.S.09.55.535, et seq.

B. A waiver of venue and consent to submit to the jurisdiction of the Alaska State Courts in any suit arising from the practice of dentistry by any participant in such program.

3. Offered by a dental college approved by the Council on Dental Education of the American Dental Association, and the American Association of Dental Examiners.

Off - File - Dental files

Aleutian/Pribilof Islands Association, Inc.

1689 C Street
Anchorage, Alaska 99501
Phone (907) 278-3567

November 17, 1978

Phil Smith, Executive Director
Rural Alaska Community Action Program
P. O. Box 3-3908
Anchorage, Alaska 99501

Dear Phil:

We were pleased to be invited to submit an application for an Advocacy Network Contract since we had been left out of your last funding cycle.

This dental program is really badly needed and I think we can swing it through the legislature with a little of this kind of help.

Hopefully you will be able to see your way to fund this little package.

Sincerely yours,

Patrick Pletnikoff
Executive Director

PP:alp
Enclosure

Application for a Network Advocacy
Contract for the Aleutian/Pribilof Islands Association

Anyone who has worked more than even a few weeks in rural Alaska becomes aware of the tremendous dental health problems of the people who live there. PHS and the Native Health Service are responsible only for Native dental health problems and they are unable under their present structure and budget to meet the growing need for care.

Alaska is not alone with its problems of delivery of adequate dental service to pockets of poverty - isolated communities and disadvantaged groups. Nor are they alone in their attempts to solve these problems through conventional channels only to be crushed by insecure schizophrenic professional organizations who fear public programs and volunteer services threaten their livlihood. Even Native adults living in Anchorage have a five year waiting list to sit out before they can get dental care.

Frustrated, angry and desperate for help, APIA staff began l-oking around the country to see how others were solving their rural dental health problems. The most impressive program was operated by the University of California Dental School out of San Francisco, particularly aimed at solving the dental health problems of the migrant farm laborers of California. They have an impressive record of 8 years of service and are now a permanent part of the State health budget. The program is quite simple - socially conscious dentists on staff work with students of the U of C dental school in their senior year of dental school aboard mobile clinics which bring dental health care to the people where they live and

work. It is true they had a head on collision with the dental societies of California, local, regional and state who were worried about their personal income being threatened by these units offering free services, however time and performance healed the breaches and the units continue to fill a tremendous need.

Not only does this operation not threaten private dentistry, but it complements private practice. People become more aware of dental health - prevention and care and as a result whole generations of people choose a private dentist when they can afford one and make room in their lives and budgets for dental health care services.

Hundreds of bush Alaskans are now going to a private dentist when they can as a result of the dental health awareness that has taken place over the years through the public service units like PHS and Indian Health Service.

Alaska's Rural Problems of Dental Health Care Delivery

1. The need is there and demonstrated by at least 2 organizations as intolerable: (a) APIA, (b) Cook Inlet Native Association, (c) North Slope Natives.

APIA - developed a plan with the University of California in San Francisco Dental School for delivery of health care through a mobile clinic approach. The same as was used in California. This mobile clinic became operational this summer and accomplished more than the PHS program over a 5 year period and at no cost to PHS.

Cook Inlet Native Association - hired a full time dentist right under the nose of PHS in the city of Anchorage, ordered equipment and supplies and built a dental clinic. Surely they did

not do this if there was not need for it as the dental society claims.

What are the Problems?

The problems are PHS and the Alaska Dental Society who are in bed together massaging each other's ego.

Facts

Alaska has no dental school.

Alaska has no provision for licensing or allowing volunteers in training to practice dentistry in Alaska without being in violation of the laws the Dental Society fostered.

The State Public Health Service designated the Aleutian area a distressed isolated area in order to qualify the area for issuance of emergency permits for outside dentists to practice dentistry.

The Dental Society over rode the State health services, ruling that no dentist from outside the State could practice dentistry, even free.

Federal law allowed that the APIA dental program could operate under the umbrella of the PHS or the Armed Forces, but PHS refused to allow us to operate.

This summer the dental volunteer team of 22 people arrived ready to work all summer on kids' teeth under the supervision of the U. C. Dental professors only to be told they would be arrested if they tried to deliver service. The Dental Society refused to allow temporary permits to be issued and the PHS only after pressure from Washington allowed us to operate under their wing for the limited summer program.

Facts (continued)

We have 200,000 worth of mobile dental equipment we are willing to share with the rest of rural Alaska once we get through all the legal hurdles and roadblocks put in our way by the Alaska Dental Society and the Public Health Service.

PHS dentists anticipating retirement soon from PHS intend to obtain Alaskan licenses from their cooperative bedfellows in the Dntal Society and then contract with PHS for delivery of dental services at the outrageous prices contract dentists get for their services in bush Alaska.

The head of the bush dentistry program for the State Dental Society contracted last year at Wainright, Alaska for $45,000 for two-week long sessions.

The same fellow wants to kill off our mobile dental clinic.

We need legislation now to allow volunteer licensed dentists and students supervised by their professors in quality dental schools to practice dentistry in the State of Alaska without violating any laws and without going through the self serving dental society.

We want to design such legislation, generate support for passage early in the session and get our mobile clinic back on the road fixing people's teeth this winter. We feel the $15,000 advocacy grant would be of tremendous assistance in our efforts to improve the dental health of rural Alaska.

Newwork Advocacy Program

Budget

Personnel	
Primary advocate - ½ time for 3 mo.	3,500
Secretary	1,000
Travel and per diem	
Per diem - 20 days @ $50	1,000
Travel - 4 round trips to Juneau	684
Limo and cab service	250
Rental of space for advocating in an appropriate setting - 18 meetings @ 150 each	2,700
Printing, type set and production support flyers and booklet printing	2,200
Telephone	1,200
Mobile clinic pictures and replicas of units	700
	13,235
Administrative overhead	2,000
	$15,234

UNIVERSITY OF CALIFORNIA, SAN FRANCISCO

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SCHOOL OF DENTISTRY
Department of Restorative

SAN FRANCISCO, CALIFORNIA 94143

October 5, 1978

Ms. Anna Philemonoff
c/o Aleutian/Pribilof Islands Association
1689 "C" Street
Anchorage, Alaska

Dear Anna,

Enclosed please find all of the addresses, phone numbers, and times at which I can be reached, as per your request.

Please feel free to call or write at any time.

Looking forward to seeing you soon.

Sincerely,

Marvin M. Stark, D.D.S.
Professor of Operative
Dentistry and Oral Biology

RECEIVED
OCT 12 1978
Aleutian/Pribilof Islands
Assn., Inc.

MMS/sf
Enc.

Marvin M. Stark, D.D.S.
Professor of Operative
Dentistry and Oral Biology
532 Parnassus St.
Room 104
San Francisco, CA 94143

(this is the address at the University)

Marvin M. Stark, D.D.S.
23480 Ravensbury
Los Altos Hills, CA 94022

(home address)

Marvin M. Stark, D.D.S.
1150 Scott Blvd
Santa Clara, CA 95050

(private practice)

On Mondays and Fridays, Dr. Stark can be reached at the University at (415) 666-2048 or 2030, between the hours of 8:30 and 5:30.

On Tuesdays, Wednesdays, and Thursdays, Dr. Stark is at his private practice. The phone numbers are (408) 246-6588 or 243-4216

Evenings and weekends, his home phone number is (415) 948-6881 or 948-9334.

Aleutian/Pribilof Islands Association, Inc.

1689 C Street
Anchorage, Alaska 99501
Phone (907) 278-3567

September 26, 1978

Mr. Herb Rhodes, Publisher
The Great Lander
3110 Spenard Road
Anchorage, Alaska 99503

Dear Mr. Rhodes:

Your editorial outlining the abuses of the State Bid System was frankly unfair and inaccurate with reference to the Mobile Dental Lab for serving the unmet needs of the Aleutian/Pribilof area.

1. Both the House and Senate approved of the Dental Measure. You claimed they defeated the measure. The House had a floor vote in which it passed unanimously and the Senate Finance Committee gave it a "do pass" vote.

2. The money was intended by the legislature to be appropriated however more programs were approved than the Governor had money for so he was put in the position of making a choice of the best programs approved. He approved this one because it had merit and would bring to the State many times more value than the $200,000 appropriated in volunteer services helping the Native people who needed dental care the PHS was not able or willing to deliver.

3. The Mobile Dental Unit was designed by the staff of the University of California Dental School and built by them, a task only they could accomplish - no other vendor has the capability of building and delivering the unit except the Siemens Company in West Germany and their unit, not half as good as what we got, costs twice as much.

The Department of Health and Social Services did not ever order anything nine months ahead of the time money was appropriated for the unit or even afterwards. The Aleutian/Pribilof Islands

Association, Inc., a non-profit corporation, was given a contract for the development of the units and delivery of them. They made the purchase of the base unit through an Alaskan auto dealer, Alaska Sales & Service, who gave the unit to them "at cost" with no profit whatever, which could never have happened on a bid.

The size of the unit does not limit their versatility at all. They were carefully planned and are near perfect - far superior to anything ever before developed. The reason a Hercules aircraft was used to move a unit to the Pribilofs was because a jealous, hypocritical money grabbing group prevented the delivery of "free" dental services for personal reasons, refusing to issue the permit to practice causing the units to miss the pre-arranged transportation donated by SeaLand to the islands.

The staff was very adequately housed and transported as planned. AFIU housed the volunteers while in Anchorage and they were efficiently delivered by Reeve Aleutian to their destination. Your reporting was prejudiced, biased and irresponsible. If you are really interested in what services are or are not provided to the Natives of this State, do a little honest research before you print. The Chairman of the Bush Dentistry Committee of the Dental Association was paid $44,000 for two stints to a bush community by the Indian Health Service last year - could this be a clue as to why they did not want to license volunteers? There is a really good story here, but you missed it completely.

As to the adequacy of dental services to bush Alaska, tell that to the toddlers, the people with swollen tongues from poor dental care and those whose decay causes drainage down their throats all their lives. Forty-five Alaskans out of 100 must conduct their business, work or study enduring dental pain or with essential teeth missing because it's cheaper to fly to Europe for dental care than to stay home and mortgage life and limb to pay for treatment.

Do you think the Aleutian/Pribilof Islands Association would have sought out dental assistance from out of State if their people were receiving adequate care? Do you think for a minute the Cook Inlet Native Association would have hired their own dentist and invested in a dental office right under the nose of PHS if the service was adequate? Do you think for a moment that we would have had requests for service from our volunteer mobile unit from five areas of the State if their needs were being met? Thank God Governor Hammond is not the kind of person to give in to the political pressures that were brought to bear on him by the PHS personnel and the Alaskan Dental Association and their lobbyists in Juneau - he's got guts and our people are getting their teeth fixed. Can that garbage you are peddling and send

it to a more appreciative audience. You may or may not have a legitimate beef on your loss of a printing job, but attacking our dental project is sure not the way to correct it. We would give serious consideration to supporting legislation which takes government at all levels out of the printing business and puts it back with private enterprise because we feel the taxpayer should not be put in th position of competing with his own money for work.

Sincerely yours,

ALEUTIAN/PRIBILOF ISLANDS ASSOCIATION, INC.

Patrick Pletnikoff
Executive Director

PP:alp
Enclosure

cc: Governor Jay Hammond
Bob Atwood, Anchorage Times
Dr. Frederick McGinnis
Senator Glenn Hackney
Senator W. E. Bradley
Senator Ed Willis
Senator Bob Ziegler
Senator Pat Rodey
Senator John Sackett
Senator Bill Sumner
Rep. Alvin Osterback
Rep. Frank Ferguson

...Alaska. By 1907, it had become a ... Katalla had become a ghost town -- a vestige of a ...d coal and oil center, but by the mid-forties, ... bygone era in Alaska's history.

nboots

...d it; the kids understood ...ed it, but I sensed it was

... these people were former ...esidents of Katalla, where ...fined till the mid-thirties ... refinery burned. Now ...e just winter residents, ... the trapping. This was ...e '40's when fur trapping ...orable profession even to ...onists, with no overtones ...gered species" and all ...es, the price of fur was ... good. The permanent ...of Katalla was about two ...sen and "Wolf" Larsen. ...ber all kinds of odds and ... gathering around the big ...e at Bill Hansen's cabin. ...s gathered around the ...e very practical reason -- ...re the light was. One gas ...p hung on a nail above ...nd we all sat at the table ...d, or eat. The gas mantle ...he big round table were ..., in my opinion, that ...e so close in the old days. ... of course, was the main ... the two-room cabin.

... one time, early in the ...e of the men brought in 30 ... remember my sense of ...at in the world would we ...0 ducks? But the whole ... pitched in, cleaned and ...e whole smear of them; ... roasted up and a grand ...had by all, there at that ...e in Bill Hansen's cabin. I ...he ducks were actually ... to other households for ...and all that. I don't ... the details after all these ... I do remember sitting ...at round table eating ...d I remember the tin on

...l Hansen's cabin at one ...ass in the door but it had ...roken and been replaced ...ece of tin. Whenever ... into a bee-bee in his ...rew it against the tin --

...nda fun, and the sort of

...tinued on page 6)

The Great Lander FREE
SHOPPING NEWS & SOURDOUGH SAVER CLASSIFIEDS

Volume 10, No. 37 Anchorage, Alaska September 13, 1978

State Purchasing Scandal --

'Tis Your Money...And Here's How the State Wastes It!

Two weeks ago the Great Lander went to war with the state of Alaska on its bid and purchase procedures. We declared that the state was ignoring the low award bid procedure as prescribed by law -- worse yet that thousands and even millions were going out with no bids at all -- many to Outside firms leaving Alaskan vendors and taxpayers holding the bag.

As one prime example, the court system admitted to 49 violations amounting to $62,000 in form buying alone. An appeal for public information has kept our telephone ringing. And we hope it continues, through the day and into the Arctic night.

Here are some of the incidents brought to light in a single week:

Radio Equipment. Fred Jones of General Electric, in Anchorage, says the state has purchased approximately $1,500,000 worth of mobile radio equipment since 1973 without bid. He says a contract held by Motorola expired that year and that pleas to Don Harris, head of state transportation, and to Mel Holverston, of the division of communications, for a bid procedure have gone unheeded. "They pay lip service to us and that is all," Jones declares. He says that the state without a bid system has been getting only a 15 percent discount from list price on the radios. Normally, a contract discount would allow 20 to 40 percent off the standard price. He estimates the state in four years has paid $300,000 more for mobile radios than it should have under a formally bid contract. He says he and other suppliers can list 53 violations of state purchasing laws that require competitive bid during the past four years.

Mailing Contract. A contract for approximately $117,000 was placed with a Hawaiian firm for the January through July period. The contract was originally placed in Seattle, but later changed to Hawaii. Bids were asked on this but Ken O'Brien of the American Mailing Equipment Co. of Anchorage says state officials felt no one in Alaska could do this work. O'Brien says his firm advised the state it could be ready in a week. When he inquired into the expiration of the Hawaiian contract, which was to end in July, state officials said a call would be made for new bids. It is now September and O'Brien reports he has never been notified by the state of a call for bids as promised.

Rehabilitation Project. A registered engineer named Louie Overstreet reports he bid $56,000 to conduct a feasibility study on rehabilitating Lynden Arms apartments for the state. He says the contract was awarded to a firm that bid $65,000 -- $8,000 more than his own bid. Overstreet was told by state officials that the other firm offered more "expertise" than his organization.

Floor Covering. Jerry Willis, who has been here since 1955, says he was the only bidder on a state contract to re-carpet the International Airport. The ... Forms, an Outside firm, who entered a higher bid.

Regular Prnting. The Anchorage Printing Co. with a bid of $128,000 was low bidder on a state call to print its elections pamphlets. The state went into negotiation with Craftsmen Press of Seattle the following day and awarded that firm the job. Formal bids were never cancelled and re-advertised as required by law. Anchorage Printing was also low bidder by $9,000 on the Capital Site Commission tabloid, but the work went to Craftsmen Press after the state changed the required paper shortly before bid openings, thus eliminating sufficient time to ship the newly called for paper stock north.

School Bus Contract. Bud Goodyear of the Susitna Sentinel says that in May of this year the State Department of Education at Palmer considered accepting a school bus contract that was not the lowest offer. Goodyear reports that the Mat Su Borough officials quickly rectified the system and demanded that new bids be requested.

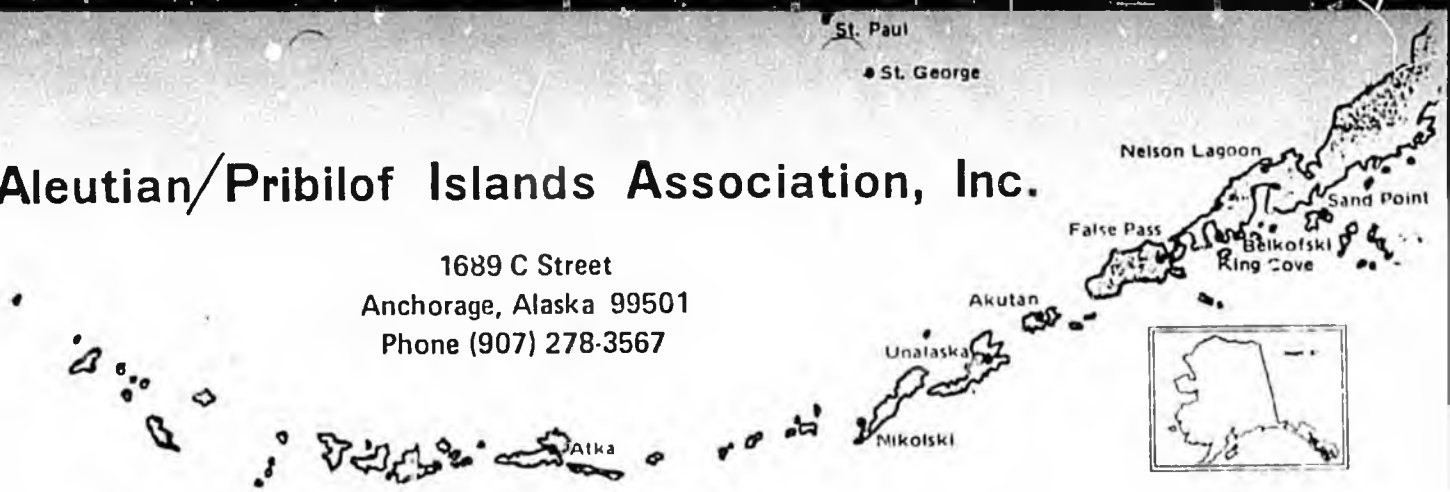
Mobile Dental Lab. When both the Senate and House defeated a measure for a $200,000 mobile dental lab for the Aleutians, the appropriation was slipped through in the governor's capital budget. The two units were purchased without bid as required by state law and are reportedly so large they can only be moved to the Aleutians in a Hercules cargo plane at $1750 an hour. Indications are the units had to be ordered by the Alaska Department of Health and Social Services at least nine months before the money was ever okayed.

The size of the units limits their versatility and insiders say dental care was already being provided Alaskan natives to the westward. No provision was made for a staff and their lodgings or transportation. A team came from the Stark Foundation in California to serve with the units, but Outside dentists are not allowed to practice in Alaska.

Form Printing. K and R Printing, now called Printmore, says it has fought the state for years to get form printing out on bid in the court system. The state ...

Aleutian/Pribilof Islands Association, Inc.

1689 C Street
Anchorage, Alaska 99501
Phone (907) 278-3567



September 20, 1978

G. H. Ivey, Director
Alaska Area Native Health Service
Anchorage, Alaska

Dear Mr. Ivey:

Thank you for your letter of September 12, 1978 in which you point out what appeared to you to be inaccuracies in my letter of August 7th.

It was our impression PHS was in some way associated with the U of A Dental Hygiene Program which was why I specifically asked how this training activity was covered legally, thinking that if they had found a way to square with the Statutes we might use the same route. I don't recall anyone at our meeting ever saying that PHS was not in fact a sponsor so I just assumed they were. I apologize for the misinterpretation. In any case, how are they covered?

The statement about covering the expenses of PHS supervisor of our program was in fact made by Dr. Smole. At least that's the way we heard it.

On Page 2 you call our attention to the fact that the Aleutian Islands area had been declared a remote area under the State Statutes and that there would be no difficulty for volunteer dentists and hygienists to receive permits to practice in Alaska. As you know that was the intention of the legislation but this intention was by-passed by the State Dental Board when their board met on December 16th and decided to stop issuing any temporary permits to practice in Alaska. We did not know of this decision by the Alaska Dental Board until May of this year and we are certain the legislators did not know of this short circuit either.

It is difficult to understand why the Alaska Dental Society an the Alaska State Board of Dentistry would be upset with PHS because they cooperated with us on this project. We very much appreciate your strength of conviction and dedication to servic which prompted you to help us out when we had no place else to turn.

The reason we have contacted other health organizations in regai to this project was to ascertain if there was sufficient need ar interest for establishing a health support training program at AMU, since we would not alone have students in sufficient number to make up a class or a program.

We were told by the Dentist at Cook Inlet they might want to train several for their new unit, and we have also spoken with the Chugach group. There is not anything confidential or secretive about our inquiries nor has there ever been. As a matter of fact, I would think your service unit might want to be involved in not only the planning of such a program but in the hands on clinical experience as well since we expect many of those who complete the program to seek employment in the bush areas when the demand is sufficient to employ them.

As to future planning of mobile dentistry project, we are now ready to sit down and talk with you and your staff concerning where we want to function next, record keeping and cooperation. If we are to function to everyone's advantage, we will not want to be operating in competition with your schedule; rather, we would like to complement your efforts and you likewise.

As to a full time coordinator being hired this is not yet the case. However, we have asked Terry Buterin, a young Aleut man from St. Paul to spend some time with the unit, learn what he can and to then decide if he wants to pursue a training program at UCF Dental School, leading to a special certificate in mobile dentistry. He seems very excited about the potential for such a program and we will attempt to get it off the ground. It is possible at that time we might want to petition for a budgeting change to reflect this change of scope of our previously designed program and activities.

We are very pleased with your expressed willingness to work with us further this year.

Our hope is that we can move the unit from the Pribilofs this month and become operational with the following staffing by November 1st.

The UCSF Dental School has agreed to furnish us with a graduate periodontist who will supervise two dental students and a hygienist in training to be rotated each month until the summer program begins again. The cost of this phase of the program would be about $24,000 for the rest of the year including air fare and per diem.

We would appreciate having your thoughts on this and meeting with you and your staff to discuss the details at your earliest convenience.

Thanks again for your help on the Pribilofs project this summer. We look forward to meeting with you soon.

I talked with Dr. Soelberg and he says all the records were left in the stap van. If you want them sent to your office we can arrange this when we move the unit.

Sincerely yours,

ALEUTIAN/PRIBILOF ISLANDS ASSOCIATION, INC.

J. D. Milne
Consultant

JDM:alp

cc: Dr. Arthur Hansen, President, Alaska Board of Dentistry
Ms. Beverly Long, Senator Gravel's Office
Dr. Thomas Redmond, President, Alaska Dental Society
Mr. Watson, Chief, Office of Personnel, ANHS
Dr. Morrow, Director, Dental Hygiene Program, UAA
Dr. Smole, Chief, Service Unit Dental Program, ANMC
Dr. Glen Olds, President, AMU
Dr. Marvin Stark, UCSF

Dr. Smole
Chief, Service Unit Dental Program
Alaska Native Medical Center
Box 7741
Anchorage, Ak

Dr. Glen Olds
President, AMU
Grant Hall
Anchorage, Ak

Beverly Long
Fed. Building
Office of Senator Gravel
Anchorage, AK

Dr. Author Hansen
President, Ak Board of Dentistry
Alaska Dental Society
Statewide
1400 W 31st. Ave
Anchorage, Ak

Dr. Marvin Stark
Univ. of CA Dental School
Mobil Clinic
San Francisco, CA

Dr. Thomas Redmond
Pres. Alaska Dental Society
3606 Phone Circle
Anchorage, AK

Mr. Watson
Chief, Office of Personnel
ANMC
Box 7741
Anchorage, AK

Dr. Morrow
Director, Dental Hygiene Program
2651 Providence Dr. UAA
Anchorage, Ak

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

September 12, 1978

Refer to A-D (A-DE)

ALASKA AREA NATIVE HEALTH SERVICE
BOX 7-741
ANCHORAGE, ALASKA 99510

Dr. Fredrick McGinnis
Deputy Director
Alaska Department of Health
and Social Services
McKay Building
Anchorage, Alaska 99501

Dear Dr. McGinnis:

This agency has received a copy of a memorandum dated August 7, 1978, from Dr. J. D. Milne, Dental Project Consultant, Aleutian Pribilof Island, Assn. The memorandum was in relation to a meeting between Aleutian Pribilof Island, Assn., the Alaska Native Health Service and Senator Gravel's office. I would like to take the opportunity to point out to you the inaccuracy of some statements in Dr. Milne's memorandum.

The U. S. Public Health Service is not associated with the University of Alaska Dental Hygiene program, nor do the students in this program practice under the auspices or the federal government. In the past, the Alaska Native Health Service, has trained persons in dental assisting in association with Sheldon Jackson College.

Dr. Milne also stated, "they will consider allowing us to operate under this direct supervision... and added that we would have to pay for their supervision". The Alaska Native Health Service is always interested in supporting individuals and organizations committed to the improvement of the health of the Alaska Native people. We do not, nor have we in the past required payment for our support. In fact, in most instances we provide financial assistance. In this project we were not included in the planning or arrangements for what we were assured was a State of Alaska Program.

Dr. Milne implied the Alaska Native Health Service was not willing to employ volunteers. Persons providing volunteer services within the federal health system must meet all the requirements of federal employees performing the same health care. Having met those requirements, volunteer employees are entitled to all of the benefits of the federal government, save those relating to compensation (salary, retirement etc). We must accept responsibility for the individuals themselves as well as the services they provide. We cannot place individuals in "nominal employment", in order to circumvent state statutes as we were requested by Aleutian Pribilof Island, Assn.

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SEP 19 1978
Aleutian/Pribilof Islands
Assn., Inc.

Further, it was our understanding that the State Department of Health and Social Services had declared the Aleutian Pribilof Islands a remote area under State Statutes and there would be no difficulty for volunteer dentists and hygienists to receive permits to practice in Alaska. We were assured the Aleutian Pribilof Island, Assn Mobile Dental Project did not involve the Alaska Native Health Service. It was a project authorized by the legislature of the State of Alaska to be carried out under applicable state statutes and with the support of appropriate state agencies.

As you know, this did not occur. My reasons to reverse an earlier decision to not become involved and to employ the volunteers under federal regulations authorizing volunteer employment were:

1. The Alaska Native Health Service has a committment to support Alaska Native Health organizations such as the Aleutian Pribilof Island Assn.

2. We have a responsibility for the health of Alaska Native people. If this project failed because of licensing problems, the persons to suffer would be potential recipients of care..

3. Considerable State of Alaska funds had been expended for the purchase of equipment and the expenses of the several volunteers from California. If we did not employ the individuals in our program these expenditures would have been wasted entirely.

4. The dentists, dental hygienists and other volunteers were found to be well qualified, sincere and concerned individuals. Their efforts and time would have been similarily wasted.

5. The people of St. Paul and St. George supported this program and requested our assistance.

Even though my decision has resulted in a serious breach in our relations with the Alaska Dental Society and the Alaska State Board of Dentistry,

I feel the care being provided compensates for the expenditure of federal funds and the use of federal authority. It is my request that your office provide assistance to the Aleutian Pribilof Island Assn., in securing proper licensure and/or permits for volunteer personnel to practice in Alaska in the future. I would also appreciate being kept advised by your office of future plans and operations of this project.

Sincerely,

G. H. Ivey
Director
Alaska Area Native Health Service

Enclosure (1)

cc: Dr. Arthur Hansen, President, Alaska Board of Dentistry
Ms. Beverly Long, Senator Gravel's Office
Dr. Thomas Redmond, President, Alaska Dental Society
Mr. Watson, Chief, Office of Personnel, ANHS
Mr. Pletnikoff, Director, APIA
Dr. J. D. Milne, Consultant, APIA
Dr. Morrow, Director, Dental Hygiene Program, UAA
Dr. Smole, Chief, Service Unit Dental Program, ANMC

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Department of Restorative

SAN FRANCISCO, CALIFORNIA 941[illegible]

September 11, 1978

Dr. James Milne
Aleutian/Pribilof Islands Association, Inc.
430 "C" Street
Suite 303
Anchorage, Alaska 99501

Dear Jim,

Enclosed please find brochure and price list for Siemens equipment. The items we purchased were encircled on pages 21 and 27. The price listed is retail and we get 35% discount.

The cost of the bus is approximately 150-170 thousand dollars, depending on the equipment. You will note that the chair featured in the brochure is not as new as the one we used in our bus.

I trust this is what you needed.

Best wishes.

Sincerely,

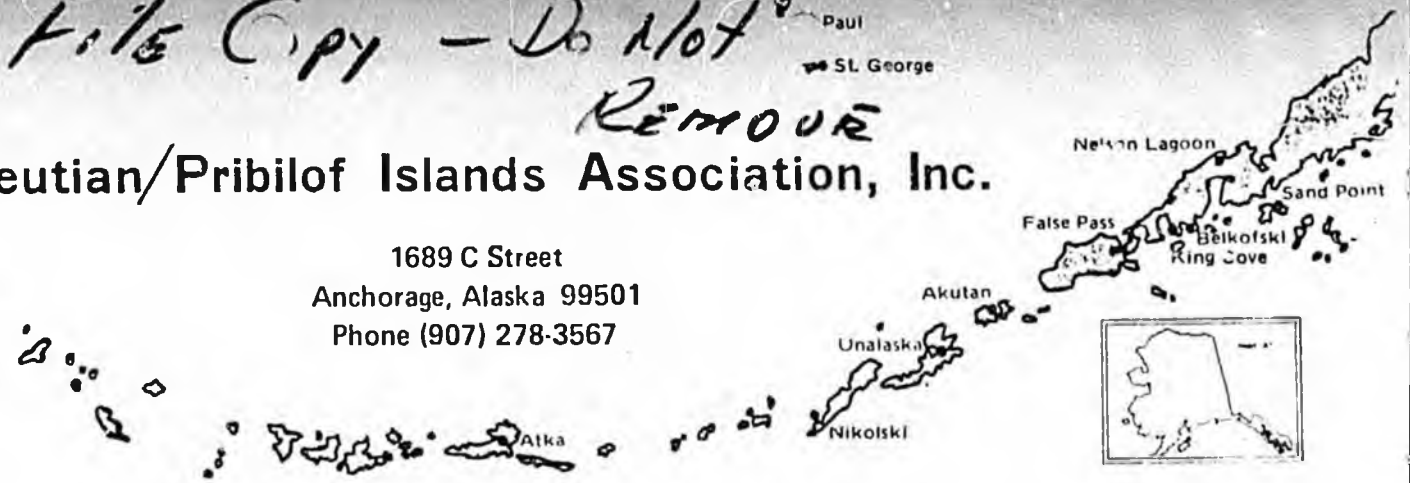
Marvin M. Stark, D.D.S.
Professor of Operative
Dentistry and Oral Biology

MMS/sf
Enc.

File Copy – Do not Remove

Aleutian/Pribilof Islands Association, Inc.

1689 C Street
Anchorage, Alaska 99501
Phone (907) 278-3567



September 5, 1978

Dr. Glen Olds
President
Alaska Methodist University
Anchorage, Alaska

Subject: APIA Dental Program

Dear Dr. Olds:

We would like to propose the following program be developed at AMU to serve the health support requirements of bush Alaska. We feel we could furnish a number of students from the Aleutian as well as from other native organizations such as Chugach and Cook Inlet.

Cook Inlet is planning a dental facility designed to accommodate 3 chairs with a demand for at least 2 assistants and perhaps 2 hygienists. The APIA facility could easily use 6 such persons for the summer months and one in each village during the year.

We would be happy to assist AMU in a search for funding of such a project should you be interested in pursuing it further.

Naturally, such students would need an operational facility available for training. For this purpose our mobile clinic would be available as well as the new Cook Inlet Dental Unit. Our mobile unit then would become an important element of your training program and essential to your operation. As an institution of higher learning you would be legally able to operate the mobile clinic either alone or in consort with the University of California Dental School of U.S.C. or any other school you might be comfortable with. Emery was suggested as a possibility at one time and the Stark Foundation would have no objection to this whatever.

Please find enclosed the Alaska Statutes which were obviously designed to meet the bush needs for dentistry. However, since

that time steps have been taken by the dental association and the examining board to circumvent this intention. As an example the board decided last year in its December meeting to abolish temporary permit issuance totally.

We are also sending you a fairly complete run down on what has taken place with this program and the bases touched since its inception. You will readily see that it has been an uphill vested interest battle politically as volatile as the AMI Program. It is only fitting and proper that we join forces to combat these anti social groups who are more worried about lining their pockets than delivery of service.

Sincerely yours,

ALEUTIAN/PRIBILOF ISLANDS ASSOCIATION, INC.

Patrick Pletnikoff
Executive Director

PP:alp
Enclosures

Article 3. General Provisions.

Section
190. "Board" defined

Sec. 08.32.190. "Board" defined. Board means the Board of Dental Examiners.

Chapter 36. Dentistry.

Article
1. Board of Dental Examiners (§§ 08.36.010—08.36.091)
2. Examination and Licensing (§§ 08.36.100—08.36.300)
3. Unlawful Acts (§§ 08.36.310—08.36.340)
4. General Provisions (§§ 08.36.350—08.36.360)

Article 1. Board of Dental Examiners.

Section
10. Creation and membership of board
20. Appointment and term of service of members
30. Election of officers
40. Meetings
50. Quorum
60. [Repealed]
70. General powers
80. Applicability of Administrative Procedure Act
90. [Repealed]
91. Records and reports

Sec. 08.36.010. Creation and membership of board. There is created the Board of Dental Examiners, referred to in this chapter as the board, consisting of seven members. Five members shall be qualified resident dentists who have been engaged in the practice of dentistry in the state for five years immediately preceding appointment, one member shall be a dental hygienist licensed under AS 08.32, and one member with no direct financial interest in the health care industry. (§ 1 art II ch 186 SLA 1955; am § 2 ch 155 SLA 1968; am § 8 ch 102 SLA 1976)

Effect of amendment. — The 1976 amendment substituted "seven members" for "five members" at the end of the first sentence and rewrote the second sentence.

Editor's note. — Section 1, ch. 155, SLA 1968, provides: "Purposes. The practice of dentistry in the state is hereby declared to affect the public health, safety and welfare and to be subject to regulation and control in the public interest. It is further declared to be a matter of public interest and concern that the dental profession merit and receive the confidence of the public and that only qualified dentists be permitted to practice dentistry in the state. All provisions of this chapter relating to the practice of dentistry and dental hygiene and to the registration of dental laboratories shall be liberally construed to carry out these objects and purposes."

Am. Jur., ALR and C.J.S. references. — 41 Am. Jur., Physicians and Surgeons, §§ 13, 23.

Dentist as within statutes pertaining to physician or surgeon, 115 ALR 261.

70 C.J.S. Physicians and Surgeons §§ 1 to 5.

Sec. 08.36.020. Appointment and term of service of members. Members of the board are appointed by the governor, subject to confirmation by the legislature in joint session. Each board member serves for a term of five years, and until his successor is appointed and qualified. The term begins on February 1. An appointment to a vacancy

is for the unexpired term. (§ 2 art II ch 186 SLA 1955; am § 1 ch 59 SLA 1964; am § 9 ch 102 SLA 1976)

Effect of amendment. — The 1976 amendment deleted "assembled" from the end of the first sentence and deleted the former fifth through eighth sentences, which related to a list of names from which appointments were to be made.

Sec. 08.36.030. Election of officers. The board shall elect a president and a secretary from among its members, each to serve for a term not to exceed two years. (§ 3 art II ch 186 SLA 1955; am § 1 ch 121 SLA 1972)

Sec. 08.36.040. Meetings. The board shall meet as often as, and at the times and places, necessary to conduct its business. (§ 3 art II ch 186 SLA 1955)

Sec. 08.36.050. Quorum. A majority of the board constitutes a quorum for the transaction of business. (§ 4 art II ch 186 SLA 1955)

Sec. 08.36.060. Expenses and salary.
Repealed by § 3 ch 59 SLA 1966.

Sec. 08.36.070. General powers. The board shall have, but not by way of limitation, the following powers and duties:

(1) to examine and issue licenses to applicants;

(2) to register licensed dentists in good standing;

(3) to submit an annual report of its proceedings to the governor and to members of the Alaska Dental Society, containing a statement of money received and disbursed;

(4) to affiliate with the American Association of Dental Examiners, and pay annual dues to the association;

(5) to hold hearings, revoke, annul, or suspend the license of a person who violates this chapter or the rules and regulations of the board;

(6) to supply forms for applications, licenses, permits, certificates, and other papers and records;

(7) to enforce the provisions of this chapter and make, alter, or amend the rules and regulations necessary or desirable to make the provisions of this chapter effective. (§ 5 art II ch 186 SLA 1955; am § 6 ch 69 SLA 1970)

Legislative committee report. — For report on ch. 69, SLA 1970 (HB 564), see 1970 House Journal Supplement No. 2, p. 7.

Sec. 08.36.080. Applicability of Administrative Procedure Act. The board shall comply with the Administrative Procedure Act (AS 44.62).

Sec. 08.36.090. Records and reports.
Repealed by § 3 ch 59 SLA 1966.

Sec. 08.36.091. Records and reports. The board shall maintain

(1) a record of its proceedings;

(2) a register containing the name, office and home addresses, and other information considered necessary by the board, of each person licensed as a dentist or dental hygienist, and a register of the licenses revoked by the board, and information on the status of each licensee. (§ 3 ch 155 SLA 1968)

Article 2. Examination and Licensing.

Section
100. License required
110. Qualifications of applicants
115. Malpractice insurance
120. Photograph and filing date of application
130. Examination
140. Out-of-state examination
150. Examination in out-of-state dental schools
160. Contents of examination
170. Partial examination
180. Re-examination
190. Grading of examination
200. Waiver of written examination
210. Waiver of examination by reciprocity
220. Issuance of license by reciprocity
230. Practice outside the state
240. Issuance of license; recordation; display
244. License to practice as specialist required
246. Qualification for a specialist license
247. Limitation of special practice
248. Suspension or revocation of specialty licenses
250. Biennial registration
260. Branch office registration
270. [Repealed]
271. Permits for isolated areas
280. Temporary permit
285. [Repealed]
290. Fees and penalties
300. [Repealed]

Sec. 08.36.100. License required. No person, except those specifically exempted from the application of this chapter, may practice, or attempt to practice, dentistry without a license or permit, and a current certificate of registration. (§ 1 art III ch 186 SLA 1955; am § 4 ch 155 SLA 1968)

ALR and C.J.S. references. — Unlicensed dentist's right to recover for services, 30 ALR 860; 118 ALR 661.

Right of corporation or individual not himself licensed, to practice dentistry rough licensed employees, 103 ALR 1240.

Constitutionality and construction of statutes or regulations prohibiting one who has no license to practice dentistry from owning, maintaining, or operating an office therefor, 20 ALR2d 808.

70 C.J.S. Physicians and Surgeons §§ 6 to 23.

Sec. 08.36.110. Qualifications of applicants. An applicant for a license to practice dentistry may apply to the board for an examination and license by submitting information that he is

(1) Repealed by § 25 ch 245 SLA 1970.

(2) of good moral character;

(3) Repealed by § 10 ch 127 SLA 1974.

(4) a graduate of a dental college approved by the Council on Dental Education of the American Dental Association at the time of graduation, and holds a D.D.S. or D.M.D. degree or the equivalent;

(5) Repealed by § 1 ch 36 SLA 1970. (§ 2 art III ch 186 SLA 1955; am § 1 ch 26 SLA 1965; am § 1 ch 36 SLA 1970; am § 7 ch 69 SLA 1970; am § 25 ch 245 SLA 1970; am § 10 ch 127 SLA 1974)

Effect of amendment. — The 1974 amendment repealed paragraph (3).

Legislative committee reports. — For report on ch. 69, SLA 1970 (HB 564), see 1970 House Journal Supplement No. 2, p. 7. Chapter 245, SLA 1970 (HCSSB 399 am H), was identical to CSHB 406 (Jud.). For report on CSHB 406 (Jud.), see 1970 House Journal Supplement No. 6.

For report on ch. 127, SLA 1974 (SCSHB 817 am S), see 1974 House Journal, p. 657.

Sec. 08.36.115. Malpractice insurance. If medical malpractice insurance for dentists becomes unavailable on the voluntary market and the director of insurance finds, after public hearing, that the unavailability is impairing the delivery of dental services to the public, the director of insurance may require all persons licensed under this chapter to carry medical malpractice insurance and to purchase their insurance from the Medical Indemnity Corporation of Alaska established under AS 21.88. If a finding of unavailability of insurance on the voluntary market and impairment of services has been made under this section, purchase of medical malpractice insurance from the Medical Indemnity Corporation of Alaska is a condition of licensure under this chapter. The provisions of this section are satisfied if the licensee's employer maintains insurance for him from the Medical Indemnity Corporation of Alaska. (§ 10 ch 102 SLA 1976)

Sec. 08.36.120. Photograph and filing; date of application. Each applicant shall submit a recent unmounted, autographed photograph of himself. Applications shall be filed at least 30 days before the date scheduled for an examination. (§ 2 art III ch 186 SLA 1955)

Sec. 08.36.130. Examination. An examination shall be given at times and places determined by the board to be convenient and economical for the applicants and the state. At least once each year the board shall appoint from its membership an examination committee of at least three persons. The examination committee shall conduct an examination at least once a year and report the results to the board for official action. (§ 3 art III ch 186 SLA 1955; am § 5 ch 155 SLA 1968)

Sec. 08.36.140. Out-of-state examination. If an applicant requests the board to hold an examination outside the state, the board may require the applicant to pay the transportation costs to the members of the committee conducting the examination. (§ 3 art III ch 186 SLA 1955)

Sec. 08.36.150. Examination in out-of-state dental schools. The examination committee, with the approval of the board, may conduct an examination in the clinic of an approved dental school within the continental limits of the United States and admit to the examination a dental student in his last year of school who would otherwise be eligible

for admission to examination and licensing in the state upon completion of his education. (§ 3 art III ch 186 SLA 1955)

Sec. 08.36.160. Contents of examination. The examination shall be clinical and written and of such a character as to test in a satisfactory manner the qualifications of the applicant to practice dentistry. The examination shall consist of the following:

(1) The subjects of the written examination shall be selected in accordance with the trend of dental education as determined by the Council of Dental Education of the American Dental Association.

(2) The applicant shall give demonstration of his skill in operative and the prosthetic dentistry or any procedures as recommended by the American Association of Dental Examiners. (§ 4 art III ch 186 SLA 1955; am § 6 ch 155 SLA 1968)

Sec. 08.36.170. Partial examination. A student at least 19 years of age who has satisfactorily completed regular courses of instruction in dentistry in at least two different school years at an approved dental school, and who is certified by the dean of the college as having satisfactorily completed the subjects included in section 1 of the examination may take section 1 of the examination. If the student passes section 1 and subsequently takes the full examination, the requirements of section 1 are waived. (§ 5 art III ch 186 SLA 1955)

Sec. 08.36.180. Re-examination. An applicant shall pass each subject of each section of the examination with a score of at least 75 per cent. If an applicant fails in one subject in each section, he may be re-examined in that subject. If an applicant fails in more than one subject in any section, he shall be re-examined in the whole section. If an applicant fails the examination or any section of it on two separate occasions, the board shall refuse to examine him further until he produces evidence satisfactory to the board that he has pursued further study in preparation for the examination. (§ 6 art III ch 186 SLA 1955)

Sec. 08.36.190. Grading of examination. Upon the conclusion of the written examination and as soon as practicable, the papers shall be rated by an examiner. The examiner shall prepare a report in duplicate on each written examination and a report in duplicate on each practical examination. The examiner shall forward one copy of each report on each candidate to the secretary of the board and one copy to the division of occupational licensing. The secretary shall prepare a composite report on each applicant and file one copy of his report with the division of occupational licensing. As soon as practicable the division of occupational licensing shall notify each candidate of the results of the examination. (§ 7 art III ch 186 SLA 1955; am § 2 ch 121 SLA 1972)

Sec. 08.36.200. Waiver of written examination. The board may waive the requirement for written examination for an applicant who holds a certificate from the National Board of Dental Examiners that

he has passed the theoretical or written examination given by the national board. (§ 8(a) art III ch 186 SLA 1955)

Sec. 08.36.210. Waiver of examination by reciprocity. The board may waive the requirement for written examination for a graduate of an approved dental school who has been licensed, and has been in legal and reputable practice of dentistry in a state, territory, district or possession of the United States which has requirements for licensing, and give reciprocal rights, equivalent to those of this state, if the applicant meets the requirements of § 110 of this chapter. (§ 8(b) ar' III ch 186 SLA 1955; am § 3 ch 121 SLA 1972)

Sec. 08.36.220. Issuance of license by reciprocity. If an applicant having the qualifications contained in §§ 110 and 210 of this chapter has been engaged in the practice of dentistry for a period of five years in the state, territory, district or possession of the United States, immediately preceding his application to practice in the state, the board may license the applicant without examination. (§ 9 art III ch 186 SLA 1955; am § 2 ch 26 SLA 1965; am § 7 ch 155 SLA 1968; am § 4 ch 121 SLA 1972)

Sec. 08.36.230. Practice outside the state. A dentist licensed to practice in this state and residing and practicing dentistry outside of this state, may maintain his eligibility to practice in this state by biennially registering his name and place of residence with the division of occupational licensing. If the dentist fails to register, the board may reinstate his license without examination upon payment of a penalty of $25, payment of all delinquent registration fees, and presentation of proof of active practice at his place of residence, certified by the dental board having jurisdiction at his place of residence, or, if there is no board, by evidence satisfactory to the board. (§ 10 art III ch 186 SLA 1955; am § 5 ch 121 SLA 1972)

Sec. 08.36.240. Issuance of license; recordation; display. The board shall issue a license to each successful applicant who has paid the required fees. The holder of a license shall register it in the office of the clerk of the superior court in the judicial district of his place of residence. The licensee shall display the license in a conspicuous place where he practices. (§ 11 art III ch 186 SLA 1955; am § 6 ch 121 SLA 1972)

Sec. 08.36.244. License to practice as specialist required. No licensed dentist may hold himself out to the public as being especially qualified in a branch of dentistry by announcing through the press, sign, card, letterhead or printed matter, or any means of public advertising, using such terms as "specialist," or inserting the name of the specialty, or using other phrases customarily used by qualified specialists that would imply to the public that he is so qualified, without first securing a specialist's license as provided in this chapter. (§ 8 ch 155 SLA 1968)

Sec. 08.36.246. Qua cation for a specialist license. (An applicant for a specialty license must

(1) possess a license to practice dentistry in the state, and

(2) have completed two or more academic years of advanced education in the specialty.

(b) The provision of (a) (2) of this section does not apply to dentists who have limited their practice exclusively and who ethically announced limitation of practice in accordance with American Dental Association policy before July 23, 1968. (§ 8 ch 155 SLA 1968)

Sec. 08.36.247. Limitation of special practice. (a) No specialty license may be issued unless the applicant presents proof satisfactory to the board that he is qualified to practice that specialty.

(b) This section may not be construed as limiting or preventing a licensed and qualified dentist from performing, without a specialty license, dental acts or services to the public in any of the branches of dentistry, except that no dentist may administer a general anesthetic to a patient without a valid permit as required by regulations of the dental examiners board. (§ 8 ch 155 SLA 1968)

Sec. 08.36.248. Suspension or revocation of specialty licenses. The board may suspend or revoke a specialty license upon any grounds set out in § 310 of this chapter, and the procedure for suspensions and revocations shall be the same as for the revocation or suspension of a regular license to practice dentistry. (§ 8 ch 155 SLA 1968)

Sec. 08.36.250. Biennial registration. At least 60 days before January 1 of every other year, the division of occupational licensing shall mail a form for biennial registration to each licensed dentist. Each licensee shall complete the form and return it together with the registration fee. The division of occupational licensing shall, as soon as practicable, issue a registration certificate valid for the years for which issued. Each licensee shall keep the registration certificate beside or attached to his license. Failure to receive the registration form does not exempt a dentist from biennial registration. (§ 12 art III ch 186 SLA 1955; am § 9 ch 155 SLA 1968; am § 7 ch 121 SLA 1972)

Sec. 08.36.260. Branch office registration. A licensee who practices in an established office with an address other than that address for which his biennial registration certificate is issued shall obtain a branch office registration certificate for each office. (§ 13 art III ch 186 SLA 1955; am § 10 ch 155 SLA 1968)

Sec. 08.36.270. Permits for isolated areas.

Repealed by § 3 ch 26 SLA 1965; § 5 ch 93 SLA 1965.

Sec. 08.36.271. Permits for isolated areas. (a) The Department of Health and Social Services shall designate as isolated areas those specific places and regions remote from major population centers which

are not served by dentists licensed under this chapter and which have a geographical location which works financial hardship, extended loss of time, or arduous and costly travel upon residents needing dental care.

(b) The board shall, upon recommendation of the Department of Health and Social Services, issue an annual permit authorizing the treatment of residents in an area designated under (a) of this section, who are not entitled to dental care by the state or federal government, by a dentist employed by the United States Public Health Service or qualified member of the armed services who serves in that area. (§ 1 ch 93 SLA 1965; am § 11 ch 155 SLA 1968; am § 6 ch 104 SLA 1971)

Sec. 08.36.280. Temporary permit. (a) The board may issue a one year temporary permit without examination to an applicant to practice dentistry in a locality requested by the applicant if the locality is of the type specified in (2) of this subsection and the applicant

(1) meets the requirements of § 110 of this chapter;

(2) desires to practice dentistry in a city or rural village which does not have a resident licensed dentist in active general practice;

(3) has a license in good standing to practice dentistry in a state, territory, district or possession of the United States;

(4) tenders and pays the fee prescribed in § 290 (6) of this chapter.

(b) The board may authorize a temporary permittee to practice dentistry in more than one city or rural village of the type specified in (a) (2) of this section.

(c) The board may annually renew a temporary permit upon written application of an applicant and upon payment of the prescribed fee if the applicant has not committed an act which is a ground for revocation in § 310 of this chapter, but in any case, within two years from issuance of his first temporary permit, the applicant must pass a board exam.

(d) A temporary permit may be revoked, suspended or annulled, or the permittee may be reprimanded, censured or disciplined by the board in the same manner and for the same cause as a licensed dentist under § 310 of this chapter.

(e) The board shall grant or deny an application for a temporary permit within 60 days after it is received. (§ 15 art III ch 186 SLA 1955; am § 4 ch 26 SLA 1965; am §§ 8, 9 ch 121 SLA 1972)

Sec. 08.36.285. Licensing a permittee.
Repealed by § 10 ch 121 SLA 1972.

Editor's note. — The repealed section derived from § 5, ch. 26, SLA 1965.

Sec. 08.36.290. Fees and penalties. The board shall impose and collect the following fees and penalties:

(1) for the issuance of an original license, $30;

(2) for the examination of an applicant, $50;

(3) for re-examination of an applicant, $50;

(4) for biennial registration, $40;
(5) for each branch office biennial registration, $40;
(6) for a temporary permit, $25;
(7) Repealed by § 7 ch 94 SLA 1968.
(8) for re-instatement as provided in § 230 of this chapter a penalty of $10;
(9) for a specialty license, $30;
(10) for a duplicate license, $10. (§ 16 art III ch 186 SLA 1955; am § 7 ch 94 SLA 1968; am § 12 ch 155 SLA 1968)

For history of taxation of profession of dentistry, see United States v. Dasher, 9 Alaska 719 (1940).

C.J.S. references. — 53 C.J.S. Licenses § 34; 70 C.J.S. Physicians and Surgeons §§ 2 to 4, 6 to 8.

Sec. 08.36.300. Deposit of fees and payment of expenses. Repealed by § 3 ch 59 SLA 1966.

Article 3. Unlawful Acts.

Section
310. Grounds for revocation of license
320. Order of reprimand, suspension and revocation
325. Limits or conditions on license; discipline
330. Injunction
340. Penalties

Sec. 08.36.310. Grounds for revocation of license. A license and registration may be revoked, suspended, or annulled, or the licensee may be reprimanded, censured, or disciplined by the board after hearing when he

(1) secures a license through deceit, fraud, or wilful misrepresentation of a material fact;
(2) is convicted of a crime involving moral turpitude;
(3) has a chronic or persistent inebriety or addiction to habit-forming drugs which renders him incompetent to continue the practice of dentistry;
(4) commits wilful or gross malpractice or wilful or gross neglect in the practice of dentistry;
(5) hires, supervises, permits or aids unlicensed persons to practice dentistry;
(6) is insane or has a contagious or infectious disease making him an improper person to continue in the practice of dentistry;
(7) practices or offers to practice dentistry under a name other than the name in which the license is issued;
(8) uses the name of a company, association, corporation, trade name, dental clinic, or business name in connection with the practice of dentistry;
(9) knowingly practices in the employment of or in association with a person who is practicing in an unlawful manner;

(10) uses an advertising solicitor or free-publicity press agent;

(11) wilfully deceives or attempts to deceive the board with reference to any matter under investigation by it;

(12) advertises professional superiority;

(13) advertises free dental work or free examination;

(14) advertises prices for professional service;

(15) advertises to perform any dental operation painlessly;

(16) advertises by means of a large display, glaring light sign, or sign containing as a part of it the representation of a tooth, bridgework, or any portion of the human head;

(17) advertises by a medium other than the carrying or publishing of a modest professional card or the display of a modest window or street sign at the licensee's office containing the name, address, profession, office hours, telephone number and specialty;

(18). permits the use of his name as a dentist by others in the sale or advertisement of products;

(19) violates a provision of this chapter or a regulation of the board promulgated under authority of this chapter;

(20) advertises as a specialist in any branch of dentistry, unless he devotes a major portion of his practice to that branch;

(21) engages in the practice of fee-splitting;

(22) engages in unprofessional conduct;

(23) obtains a fee by fraud;

(24) directly or indirectly advertises or solicits for dental hygiene business;

(25) advertises as a specialist in a branch of dentistry without first obtaining a specialty license;

(26) fails to report a death that occurred on premises used for the practice of dentistry to the office of the secretary-treasurer of the board within 72 hours;

(27) administers a general anesthetic without a valid permit required by regulations of the dental board. (§ 1 art IV ch 186 SLA 1955; am §§ 13—15 ch 155 SLA 1968)

Cross reference. — As to malpractice actions, see AS 09.55.530—09.55.560.

ALR references. — Ground for revocation, 54 ALR 1504; 82 ALR 1184.

What amounts to conviction within statute making conviction ground for cancelling license, 113 ALR 1179.

Revocability of license for fraud or other misconduct before or at the time of its issuance, 165 ALR 1138.

Admissibility and necessity of expert evidence in proceeding for revocation of license, 6 ALR2d 675.

Sec. 08.36.320. Order of reprimand, suspension and revocation. The board may, by a majority vote, evidenced by the signatures of the members on the order, reprimand a licensee or revoke or suspend a license. (§ 5 art IV ch 186 SLA 1955)

Sec. 08.36.325. Limits or conditions on license; discipline. (a) In addition to actions under §§ 310 and 320 of this chapter, upon a finding that by reason of demonstrated problems of competence, experience, education, or health, the authority to practice dentistry should be limited or conditioned or the practitioner disciplined, the board may censure, place on probation, restrict practice by specialty, procedure or facility, require additional education or training, or revoke or suspend a license.

(b) The Administrative Procedure Act (AS 44.62) applies to any action take by the board under this section. (§ 10 ch 102 SLA 1976)

Sec. 08.36.330. Injunction. The board may sue in its own name in a competent court to enjoin any person from doing an act consituting a violation of this chapter. (§ 7 art IV ch 186 SLA 1955)

Sec. 08.36.340. Penalties. A person who violates any provision of this chapter for which no specific penalty is provided, is guilty of a misdemeanor and is punishable by a fine of not more than $500, or by imprisonment for not more than six months, or by both. (§ 8 art IV ch 186 SLA 1955)

Article 4. General Provisions.

Section
350. Application of chapter
360. Practice of dentistry defined

Sec. 08.36.350. Application of chapter. This chapter applies to a person who practices, offers or attempts to practice dentistry in the state except

(1) dental surgeons or dentists in the military service in the discharge of official duties;

(2) licensed dental hygienists in the performance of duties authorized by law;

(3) dentists in the employ of the United States Public Health Service, United States Veterans' Administration, Alaska Native Service, or Department of Health and Social Services, in the discharge of official duties;

(4) clinicians demonstrating at meetings of dentists approved by the board;

(5) physicians and surgeons;

(6) dentists in the employ of the United States Public Health Service providing care by authority of a permit issued under § 271 of this chapter. (§ 2 art I ch 186 SLA 1955; am § 2 ch 93 SLA 1965; am § 6 ch 104 SLA 1971)

Sec. 08.36.360. Practice of dentistry defined. A person engages in the practice of dentistry who

(1) performs or holds himself out to the public as being able to perform dental operations;

(2) diagnoses, treats, operates on, corrects or attempts to correct, or prescribes for, a disease, lesion, pain, injury, deficiency, deformity, or physical condition, malocclusion or malposition of the human teeth, alveolar process, gums or jaws and adjacent tissues;

(3) performs or attempts to perform an operation incident to the replacement of teeth;

(4) furnishes, supplies, constructs, reproduces, or repairs prosthetic dentures, bridges, appliances or other structures to be used and worn as substitutes for natural teeth, except on prescription of a duly licensed and registered dentist and by the use of impressions or casts made by a duly licensed and registered dentist;

(5) uses the word "dentist" or "dental surgeon" or the letters D.D.S. or D.M.D. or other letter or title which represents him as engaging in the practice of dentistry;

(6) extracts or attempts to extract human teeth;

(7) owns, manages or operates a place where the acts and things described in this section are performed or done. (§ 1 art I ch 186 SLA 1955)

Chapter 40. Electrical Administrators.

Article
1. Board of Electrical Examiners (§§ 08.40.005—08.40.080)
2. Licensing (§§ 08.40.090—08.40.180)
3. General Provisions (§§ 08.40.190—08.40.200)

Cross reference. — As to electrical contractors, see AS 08.18.026.

Article 1. Board of Electrical Examiners.

Section
05. Purpose of chapter
10. Creation and membership of board
20. Appointment and term of office
30. Chairman of board
40. Board meetings
45. Categories of licenses
50. Regulations
60. Examinations
70. Inspection or investigation by board
80. Compensation of board members

Sec. 08.40.005. Purpose of chapter. The purpose of this chapter is to protect the safety of people and property in the state from the danger of improperly installed electrical wiring and equipment, by providing a procedure to assure

(1) the public that persons responsible for making electrical installations in this state are qualified; and

(2) a sufficient number of persons are so qualified. (§ 2 ch 53 SLA 1977)

Sec. 08.40.010. Creation and membership of board. There is hereby created a Board of Electrical Examiners consisting of three members

STATE
of ALASKA

MEMORANDUM

DATE: January 12, 1978

FILE NO:

TELEPHONE NO: 278-4668

TO: Commissioner Helen Beirne
Dept. Health & Social Services
Juneau

THRU: Frederick McGinnis
Deputy Commissioner
Dept. Health & Social Services
Anchorage

SUBJECT: Request by Aleutian/Pribilof Islands Association, Inc.: Permit Request--Dental Services for Aleutian Chain

Consistent with numerous other recent activities on the part of the Aleutian/Pribilof Islands Association to improve health and social services to the residents of the Aleutian Islands, information was sought from my office today with regard to our Department's assistance to the citizens of the Aleutian Islands for improved dental services.

Mr. Frank Peratrovich, Deputy Director of the Association, raised the question as to whether our Department is in the position to assist consistent with the applicable Alaska Statute--AS 08.36.271, Permits for Isolated Areas. For convenience a copy of the statute is attached (Attachment No: 1).

It is my understanding that the Aleutian/Pribilof Islands Association's plan is to secure the services of dentists on a voluntary basis mostly, if not entirely, from other states to render the services. The Public Health Service will be asked by the Association to employ the dentists at a nominal salary for technical purposes. The dentists apparently will meet the Alaska statutory requirements provided in AS 08.36.110 with latest amendments (see 1976 Supplement Amendments for 08.36.110).

It is in the knowledge of the A/PIA andtheirlegal counsel that "the Department of Health and Social Services shall designate as isolated areas those specific places and regions remote...". (AS 08.36.271(a))

It is their impression that "the Board shall, upon recommendation of the Department of Health and Social Services, issue an annual permit authorizing...". (AS 08.36.271(b))

It is my understanding that the Association is considering requesting a slight amendment to AS 08.36.271 if necessary to accomplish certain goals but, at this time, it is not certain if such will be required.

RECOMMENDATION: It is recommended that

(1) the Department officials concerned give strongest support to the proposed plan being developed by the Aleutian/Pribilof Islands Association, Inc. in their goals of addressing this extremely long neglected need to improve the dental health of the citizens of the Aleutian Chain.

(2) the Department of Health and Social Services, after consultation with the Department of Law, release the attached suggested letter (Attachment No. 2) and the attached suggested "Designation of Isolated Areas" (Attachment No. 3).

EJcG/mag

Attachments: as indicated

cc: Catherine M. Lloyd, Deputy Commissioner

STATE OF ALASKA
JAY S. HAMMOND, GOVERNOR
DEPT. OF HEALTH AND SOCIAL SERVICES
OFFICE OF THE COMMISSIONER
POUCH H 01 – JUNEAU 99811

January 16, 1978

Dental Examiners Board
937 Eighth Avenue
Fairbanks, Alaska 99701

Attention: Sydnor L. Stealey, President

Gentlemen:

Re: Designation by Department of Health and Social Services of Aleutian Islands as Isolated Area

It has recently come to the attention of the Department of Health and Social Services that, through the initiatives of certain Alaska Native organizations, improved dental services for citizens of the villages of the Aleutian Islands may be arranged. Such plans envision the utilization of dentists falling under the general coverage of AS 08.36.271(a) and (b).

Consistent with the provisions of AS 08.36.271, the Department of Health and Social Services encloses at this time the appropriate formal designation by the Department for the region involved in the emerging plans.

In line with the specific provision of AS 08.36.271(b), the Department of Health and Social Services hereby recommends to the Board the issuance of annual permits to the dentist applicants meeting the qualifications of applicants contained in AS 08.36.110, with latest amendments. The specific and individual applications related to this recommendation will be filed in accordance with your procedures.

It is our understanding that qualified applicants shall be granted annual permits under the conditions contained in the statutes and consistent with the recommendation contained herein.

Sincerely yours,

Helen Beirne
Commissioner

Attachment No. 3

STATE OF ALASKA

JAY S. HAMMOND, GOVERNOR

DEPT. OF HEALTH AND SOCIAL SERVICES

OFFICE OF THE COMMISSIONER / POUCH H 01 – JUNEAU 99811

January 16, 1978

DESIGNATION OF ISOLATED AREAS

by

STATE OF ALASKA, DEPARTMENT OF HEALTH AND SOCIAL SERVICES

In accordance with the provisions of Alaska Statutes 08.36.271, Permits for Isolated Areas, the Department of Health and Social Services hereby designates as isolated areas the entirety of the Aleutian Islands Chain of the state of Alaska, including any and all specific villages and communities of the Aleutian Chain.

Such designation is made solely for the purposes served by the provisions of the Alaska Statute cited above, and for dental services as provided in the cited statute.

Helen Beirne, Commissioner

MIDDLETOWN, VA. 22645

RCA Mailgram

UNITED SERVICE AIR MAIL

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4156663018 MGM TDRN SAN FRANCISCO CA 100 08-17 0432P EST

PAT PLEINIKOFF
CARE ALEUTION PRIBOFF ISLAND ASSN
430 C ST
ANKORAGE AK 99500

WAS PLEASED TO LEARN OF YOUR ACQUISITION OF A MOBILE DENTAL UNIT. PEDODONTIC SPECIALTY TRAINING PROGRAM AT UCSF AND USC HAVE BEEN LOOKING FOR SUCH A FACILITY TO STAFF WITH SPECIALTY STUDENTS AND INSTRUCTORS ON A ROTATING BASIS. WOULD LIKE TO DISCUSS THIS WITH YOU.

MERLE E MORRIS, DDS PROFESSOR AND HEAD PEDODONTICS
DEPT OF GROWTH AND DEVELOPMENT
UNIVERSITY OF CALIFORNIA AT SAN FRANCISCO
SAN FRANCISCO CA 94143

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Aleutian/Pribilof Islands Assn., Inc.

University of California - San Francisco

Ray Wong	Dental student
Dan Fong	Dental student
Glenda Fong	Dental Assistant
Diane Perez	Dental Assistant
Carolyn Stark	Dental Assistant
Evon Mitchell	Dental Hygienist
Sandro Fong	Dental Hygienist
Carmen Romo	Dental Hygienist
Sigrid Jennings	Coordinator
Kenneth Moore	Coordinator/student
Dr. K. Solberg	Dentist
Dr. R. Pelznen	Dentist
Dr. Marvin Stark	Director, Mobile Dentistry

Univeristy of Southern California

Tony Perez	Dental student
Tami Haroldson	Dental Hygienist Student
Judy Salter	Dental Hygienist Student
Dr. Chris Thanos	Faculty Member

UCLA

Dave Kolegraff	Dental Assistant

San Francisco State University

Debbie Jacobson	Dental Assistant

Mr. Bob Singke
Area Executive Officer
Alaska Area Native Health Service
P. O. Box 7-741
Anchorage, Alaska 99510

TELEGRAM

THE RESIDENTS OF ST. PAUL ISLAND HAVE A DESIRE TO RECEIVE DENTAL TREATMENT AS PROVIDED BY THE ALEUTIAN PRIBILOF ISLANDS MOBILE DENTAL UNIT AND THE UNIVERSITY OF CALIFORNIA SCHOOL OF DENTISTRY, DENTAL STUDENTS IN THEIR LAST CLINICAL YEAR UNDER THE DIRECT SUPERVISION OF THE PROFESSORS OF DENTISTRY.

WE APPRECIATE THE COOPERATION OF THE PUBLIC HEALTH SERVICE IN WORKING WITH THE ALEUTIAN PRIBILOF ISLANDS ASSOCIATION IN MAKING THIS PROGRAM POSSIBLE AND PERHAPS RELIEVING SOMEWHAT THE PRESSURE FOR SERVICE.

MICHAEL ZACHAROF, PRESIDENT
TANADGUSIX CORPORATION

8/16/78 called in by J. Linda Merculief

NIGHTLETTER - May 4, 1978

Sent to:

Glen Hackney, Chairman, Senate HESS Committee
Rep. Alvin Osterback
Rep. Frank Ferguson

PLEASE BE ADVISED THAT ALL OPPOSITION TO OUR DENTAL PROJECT, H.B. 728 HAS BEEN WITHDRAWN BY THE ALASKA NATIVE HEALTH SERVICES. FOLLOWING IS A COPY OF THEIR LETTER:

Dear Mr. Pletnikoff:

The project description of your Mobile Dental Project has been received and reviewed by the Alaska Native Health Service. The review was done by four experienced professionals within and without the dental field. Upon completion of the individual reviews, an Ad Hoc Committee of Area Office and Service Unit personnel considered carefully all of the information available about your project. It is our conclusion the Aleutian Pribilof Island Association Mobile Dental Project does not constitute a project proposal for Alaska Native Health Service participation. At the present time the Aleutian Pribilof Island Association Mobile Dental Project involves only the State of Alaska and the U. S. Bureau of Indian Affairs.

As an Indian health agency, I would be remiss in not supporting a program aimed at the improvement of the general health and dental health of the Alaska Native people. The Aleutian Pribilof Island Association Mobile Dental Project has my support subject to the following conditions and recommendations:

1. My support does not constitute any future commitment by the Alaska Native Health Service for additional expenditures of funds or personnel.

2. The medical (or dental) services provided carries no threat of detriment to the health of the recipients of care.

3. The project is accepted and desired by the people in the communities of the Aleutian chain and the Pribilof Islands.

4. The Aleutian Pribilof Island Association coordinate the services provided by this project with the dental program of the Anchorage Service Unit.

It is my sincere wish that this project will result in improved dental care to the Alaska Native people in the Aleutian Pribilof Region. I urge you to take advantage of the experience and knowledge of members of my staff in completing the planning of the project and your dental feasibility study. I will look forward to a successful cooperative program.

Sincerely,

G. H. Ivey
Director
Alaska Area Native Health Service

UNITED STATES GOVERNMENT

memorandum

DATE: March 17, 1978

REPLY TO ATTN OF: Chief, Service Unit Dental Program - ANMC

SUBJECT: APIA Dental Feasibility Studies

TO: Community Relations Officer, ANMC

The attached information should enable you to answer APIA questions about dental activities in this Service Unit.

1. COSTS: (Attachments # 1)

a) Costs of field trips, by village, are listed. This includes dates, duration of trip, costs of freight and names of dental personnel traveling. This should serve to show typical costs of Aleutian trips.

b) In a usual fiscal year our dental teams have been providing 29-32 team weeks in the APIA region including overtime. An exception to this was F.Y. 1977. Less time was spent as a result of two mid-year dentist resignations resulting in trip delays to bring replacements on duty. Copies of our F.Y. 1978 field trip schedules have been provided APIA previously. A revised version is attached. See attachment # 2.

c) Teams traveling usually consist of a Commissioned Officer grade O-4 and a dental assistant GS-4. The APIA proportion can be calculated from team work weeks spent in the APIA region and the following information. Average Annual Salaries for those IHS dental team employees including Base Pay, COLA, SHA, incentive pay, quarters and subsistence are :

CO-4- $25,750
GS-4- $14,645

Overtime costs are currently averaging $6.89/hr for the dental assistants. No overtime is paid to salaried Commissioned Officers. Current overtime experience averages 16 hours per field trip week for each team member.

d) The Anchorage Service Unit dental supply budget for F.Y. 1978 is $29,600 . We have no way of identifying what portion of that amount is used in the Aleutian-Pribilof region. Based upon a porportion population a "guesstimate" would be in the $1500-$2000 range.

e) Our teams use portable field equipment that costs about $4500 per set-up at Gov. prices. Portable x-ray units, when available, in safe portable form, cost another $2000-$3000. Hand instruments cost another estimated $1000 per portable unit. This equipment weighs about 700 lbs and does not include lab support equipment and complete instrumentation and supply for specialty services.

Buy U.S. Savings Bonds Regularly on the Payroll Savings Plan

OPTIONAL FORM NO. 10
(REV. 7-76)
GSA FPMR (41 CFR) 101-11.6
5010-112

2. The level of care provided and frequency of visits by dental teams for the past three years are shown on attachment # 3. These data also include references to level of specific preventive programs, community efforts, travel difficulties etc.

   Basic care consists of routine services with the exception of specialty care like prosthetics and orthodontics and periodontal surgery. Examinations, fluoride treatments, prophylaxsis and oral hygiene instructions, fillings, stainless steel crowns, extractions, pulpotomies, minor surgical procedures and palliative treatments make up the bulk of basic care provided.

3. All age groups are treated. The main emphasis is on pre-schoolers and students. In some instances available dental-team time has exceeded adult demand for care. Complete prosthetic and orthodontic treatment of high quality cannot be provided during visits of short duration due to lack of lab support, time and equipment. Considerable prosthetic care has been provided however during longer trips such as to St. Paul and St. George. More manpower to allow more frequent visits by the same dentist would be desirable.

   Computer printouts are attached which show services provided by age group and village during Fiscal Years 76 and 77. F.Y. 77 printouts for King Cove, Nikolski, False Pass and Belkofski are missing. A retabulation and separate computer run has been requested to recapture that data. Individual patient exam records could be used as an interim source of information. I'll be available to explain the printouts if necessary.

   Computer printouts are also available that reflect epidemiological data and services required by patients examined. It is important to note that these data are probably under-reported since the large sample of examinations are for younger age groups. In addition clinicians tend to under-report specialty service requirements that they are unable to provide in portable-intermittant clinics. The net result in my opinion is that the report of level of services required is not 100% accurate for older age groups. Disease rates and services requirements of patients seen at ANMC may provide a more accurate picture. This is because a larger sample of adult patients is seen and a broader scope of services is provided at the ANMC fixed facility. Such information can be duplicated from printouts or microfiche. I believe that personal explanation of the data would be beneficial and less confusing.

4. Other sources of funding would include :

   a) Dental benefits for those under age 21 in families who are eligible for Medicaide.

   b) Employees benefit plans that include dental coverage, ~~Dental~~ Dental Plan etc.

   c) Veterans benefit for those who have been recently discharged or who have service connected disabilites.

   d) Personal dental insurance coverage.

   e) Private funds.

   f) Corporation funds for contract dental care.

   g) State grants for community programs, such as H_2^O Fluoridation.

   h) Grants from private foundations.

   i) Volunteer programs.

   j) National Health Service Corps.✓

5. The greatest un-met dental needs are :

   a) The need for consistent effective community involvement in meaningful preventive programs such as :

      - Community H_2^O fluoridation.

      - School centered fluoride rinse and fluoride tablet programs.

      - Periodic topical fluoride gel programs by Health Aides et.als.

      - Community and family attention to nutrition and limitation of refined carbohydrate consumption.

      - Continuing integration of dental health information into school curriculum.

   b) Increased corrective services for adults especially in larger villages.

   c) Increased specialty services for younger patients.

d) Continuing evaluation of quality of care at clinical and community levels.

6. To accomplish the above the expertise and resources of several agencies need to be coordinated. The needs can be best met by co-operative efforts to overcome travel obstacles and the lack of adequate facilities and manpower. The more frequent presence of familiar dental personnel, working in facilities equipped to provide a broader range of service, has the greatest potential for overcoming disease backlogs and most importantly has the best chance of getting communities involved in preventing disease. One shot programs have no potential for continuing success when they deal with disease processess as multifactorial as dental disease. Furthermore one shot programs are usually not cost effective.

I hope these thoughts contribute to the APIA efforts. I look forward to cooperative efforts toward total program improvement.

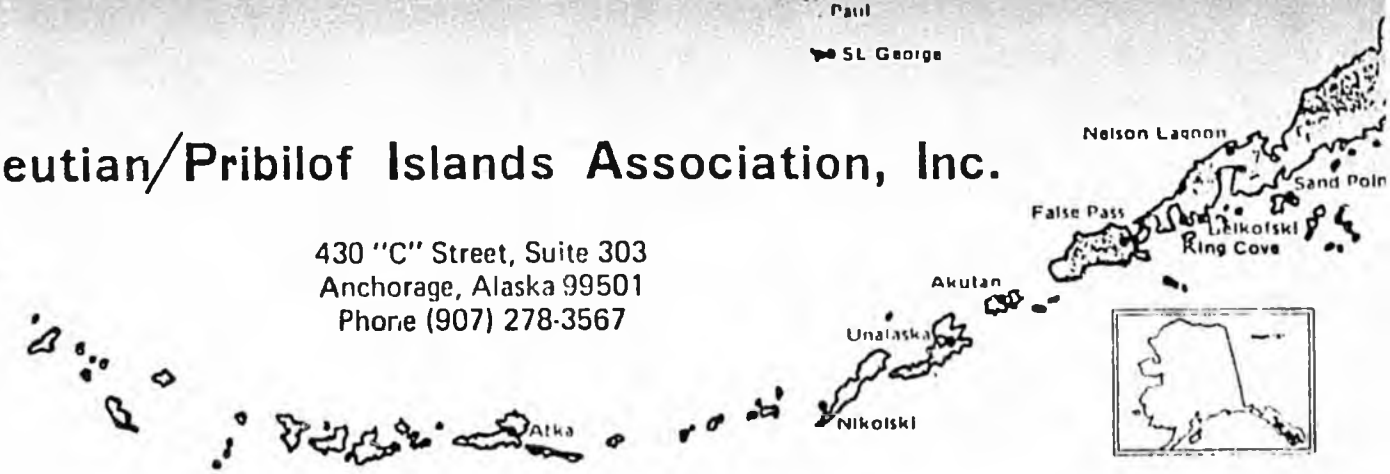
H. Douglas Smole, DDS

CC: ANC-ACH
C,ADSB

Attachments (4)

Aleutian/Pribilof Islands Association, Inc.

430 "C" Street, Suite 303
Anchorage, Alaska 99501
Phone (907) 278-3567



Memorandum

To: Dental Feasibility File

From: Patrick Pletnikoff, Executive Director

Date: April 10, 1978

Subject: Meeting with IHS Personnel Regarding Dental Project

A meeting was held this date with the following to discuss the Dental Project:

1. Dr. Nielsen
2. Dr. Douglas Smole
3. Dr. John Stope
4. Mr. Ken Isaac
5. Mr. Elmo Strickland
6. Mr. Jeff Trenton
7. Mr. Perry Smith, BIA Area Office

The purpose of this meeting was to discuss the problems, concerns, and progress made to date regarding our dental feasibility study as well as our proposed programs in the dental field. We also discussed the lack of information being provided IHS in the total project. Mr. Perry Smith represented the Area Office of the BIA and discussed the proposal we submitted requesting funding from BIA.

In essence, BIA will fund our proposal request when IHS does the following:

1. Agree to monitor and provide technical assistance to our dental project.

2. Agree with the scope of work that we propose in our mobile dental project.

Information is being provided IHS to Dr. Smole for review concerning our mobile dental program. We have set a date of 4/18/78 as a final review date. At this time, IHS should provide a letter to BIA indicating that they will support our program in all aspects.

The meeting ended with all agreeing to support a program we wish to develop and implement.

Information will be provided IHS this date to Dr. Smole.

PP:alp

TESTIMONY IN SUPPORT OF THE MOBILE DENTAL HEALTH SERVICE FOR THE ALEUTIAN/PRIBILOF AREA OF ALASKA PRESENTED BY PATRICK PLETNIKOFF, EXECUTIVE DIRECTOR

When I was a child and my father before me, statistical surveys were being conducted concerning the conditions of the children's teeth. The studies go on and the teeth fall out before the final report is in. Last year's cavities are this year's candidates for false teeth. We don't want money for another study of what needs to be done. Anyone living in bush Alaska knows the deplorable conditions of the dental health of these people. Many people find it less expensive to fly to Switzerland to have their teeth fixed and easier than getting care at home. Unfortunately, most of us are not able to afford the trip or to be away from our families long enough to get our teeth fixed in that way.

One thing we don't want this project to be is a threat or an attack on any one group of professionals. We know most everyone is doing the best they can with what they have to work with given the vast area they must serve. What we do want to do is provide a pilot project demonstration of still another way of dealing with the problem. It has worked in other places and we believe it will work here. Once we have things under control in the Aleutian/Pribilof area we will be happy to move the equipment to other parts of the State where the need is great -- we have that kind of long term commitment also from Dr. Stark and the University of California Dental School in San Francisco.

At present the Aleutian people have no qualified personnel to deliver dental health needs to their people and the Public Health Service delivers only emergency type care to this area.

Due to the over 1,000 miles one must travel in order to cover the distance of the Aleutian/Pribilof area -- and the isolation of the communities -- there is not adequate space or facilities to do quality dental work and as a result very little restorative work is done. The pattern has been to extract rather than repair.

With the mobile dental unit we are designing, we will be able to move this total working clinic from one place to another and recruit quality personnel to staff it.

The Aleutian/Pribilof Islands people have no funds at this time to develop this unit and provide the service.

Unless we have these facilities we will not be able to recruit the volunteer dentists and hygienists to work on our people.

Our objectives are to design and build a mobile dental vehicle equipped with three chairs -- total service units comparable to any funds in a large city setting; to equip a step van to follow for the x-ray unit and hygienists and records; to staff the vehicles with volunteer dentists supervised by the professional staff of the University of California Dental School; to also staff the vehicles with volunteer hygienists and trained dental assistants; and to deliver full dental health service to all our people and to then make our units available to other Native groups in need in Alaska.

Methods of delivery of dental care to isolated areas have been examined throughout this country as well as in Canada and countries abroad; specialist in California and in British Columbia recommended unanimously a full mobile dental clinic which could be moved about from place to place as needed. All experts also are in agreement a short term summer program will not meet the needs of the Aleutian/Pribilof islands people. Neither the consultants nor officials from A/PIAI have ever contemplated a three to four week program as interpreted by Commissioner Helen Bierne.

Such conclusions are politically motivated and reflect a total lack of research on the part of her unit.

It is clearly the intention of A/PIAI and the volunteer dentist to develop a year round program of delivery of dental care -- beginning with clinical repair and graduating to specialized areas and ultimately using the facilities for a prosthetic follow through.

Children's rotten teeth continue to drain down their throats poisoning their systems and the older folks continue to suffer from swollen tongues and extreme malaclusion and deformity leading ultimately to warped speech patterns and systemic discord while politicians scheme out ways to protect themselves against criticism for non-delivery of service the public has been paying them to deliver.

The mobile dental system tried and tested and proven in the migrant labor areas of California and in refugee camps in Israel are not pursued with the idea of embarassing anyone. What has or

has not been done in the past is history all are willing to forget.

We want to get on with the show. Surely our legislators would not be opposed to seeking alternative methods of solving this old problem.

We are not talking about 200 million dollars worth of service.

We are talking about 200,000 which we believe will deliver 2 million dollars worth of care. Is Alaska so affluent we can afford to pass up such opportunities? We are anxous as Mrs. Bierne to see permanent dental facilities in every village in Alaska -- and some day in the future this may be possible through a subsidized program of building dental facilities in isolated areas and providing incentives to young dentists to practice in these isolated areas. Perhaps some of our young professional volunteers will want to fill these vacancies in the future after a volunteer exposure to this area.

In the meanwhile our people need dental care now.

For answers to the ill informed comments about the impossibility of moving this mobile unit from place to place in the islands one needs only to look at the equipment being moved about in the islands now and since World War II. Oil drills, heavy equipment, portable fish processing equipment and millions of barrels of fuel oil as well as prefabricated homes are moved about as easy as moving a sheel barrel and none has even suggested it was not possible.

All the Doubting Thomas' are welcome to stop by this next year, sit in our new mobile unit and have their teeth cleaned.

SOME QUESTIONS YOU MIGHT HAVE

Question

How long will the dentists use the unit?

Answer

We have a long term commitment from the University of California Mobile Dental Clinic to serve Alaska as long as we want their services.

The unit will be staffed with a dentist year round. This summer a team of three dentists, one supervising professor, two dental technicians and one x-ray technician will work for six weeks -- then throughout the year a licensed dentist will do follow up work. The following summer a new team will return for another six weeks time frame.

In addition to the teams from the University of California operating their summer program we have a number of volunteer dentists from around the country who are willing to donate their time and services for two weeks to a month at a time. One association has 180 members all willing to participate.

Question

What kind of unit is it and how will it be transferred to the Chain?

Answer

The unit is a G.M.C. 26' motor home stripped. Then refitted at the University of California as a dental clinic. When completed it will be just like a three chair dental office in a large city complete with cabinetry, overhead lights, delux dental chairs and all of the support equipment needed to do a good job.

It will be transported by sea to St. Paul Islands this summer. Next summer it will be moved to the Aleutians, possibly Unalaska or Sand Point by SeaLand. At this time, moves are contemplated for Unalaska, Sand Point, and Cold Bay as needed.

Question

How will the dentists be licensed?

Answer

There are at least two ways -- (1) they can be employed by PHS for a dollar a year and assigned to the Aleutian/Pribilof Islands Association (The State law permits this); or (2) the State Department of Commerce also can license the dentists in remote areas not presently served by dentists (within a 50 mile radius).

Question

How long will the unit be in the Aleutian area?

Answer

We anticipate that after two years the unit could be moved to other remote areas of the State as requested -- we have long term consultants to staff throughout the State.

The dental program will serve anyone who is identified as in emergency need of dental care regardless of who they are. Our hygienist staff will work closely with village health aides to locate people in greatest need first and to repair on a priority basis, teeth which would be soon lost without immediate treatment.

Question

If you will primarily be serving Native Americans, why doesn't the Indian Health Service fund the program?

Answer

The primary responsibility for ensuring the protection of public health in Alaska is the State of Alaska. While this is not an overwhelming problem in the urban areas of our State where dentists establish their practices, it is almost non-existent in the rural areas.

While the Indian Health Service has a special responsibility for the health care of Native Americans, it is not capable of providing the most basic dental services to Alaska Natives.

Law Office of
JAMES F. VOLLINTINE
805 W. 3rd Avenue
Anchorage, Alaska 99501
Phone: 276-8144

January 11, 1978

Mr. Frank Peratrovich
Deputy Director
Aleutian/Pribilof Islands Association, Inc.
430 C Street, Suite 303
Anchorage, Alaska 99501

Dear Frank:

This responds to your request for my opinion as to whether or not A/PIA, under a contract which it has assumed from the IHS under P.L. 93-638, can employ dentists in the Aleutian area who are not licensed to practice dentistry under Alaska law. Unfortunately, at this point, the answer is not clear. Attached are copies of the relevant Alaska Statutes.

Under A.S. 08.36.271 the State Department of Health and Social Services is to designate isolated areas of the State which are not served by licensed dentists. Then, the Alaska Board of Dental Examiners shall, upon recommendation of the Department of Health and Social Services, issue an annual permit to a dentist employed by the United States Public Health Service. Hence, it appears that dentists need not be licensed to practice in Alaska if they are employed by the Public Health Service. As you suggested, perhaps there is some way that you can arrange to have the dentists under your contract employed by the Public Health Service. This would neatly solve the problem.

Another approach might be to have your dentists apply for a temporary permit from the Board of Dental Examiners to practice dentistry in Alaska. This approach is provided for in A.S. 08.36.280, a copy of which is attached. Basically, this provision provides that the Board may issue a one year temporary permit to a person not licensed in Alaska to practice dentistry in a rural area if:

> (a) the applicant is of good moral character, and is a graduate of a dental college approved by the Council on Dental Education of American Dental Association at the time of graduation, and holds a D.D.S. or D.M.D. degree, or the equivalent; and
>
> (b) the applicant has a license in good standing to practice dentisry in a State, territory, district or possession of the United States.

At first glance it would appear that your dentists could receive a temporary permit from the Board of Dental Examiners. However, I just spoke with Martha Dearborn of the Alaska Dental Society (phone 279-9144), and John Beard (phone 277-3213) who is an attorney who sits on the Board of Dental Examiners. Both persons told me that in December of 1977 the Board of Dental Examiners voted not to issue any further temporary permits. Mr. Beard stated that the Board felt that A.S. 08.36.280 was a "permissive, rather than a "mandatory" statute.

I feel that the determination by the Board of Dental Examiners not to issue temporary permits in Alaska is erroneous. In my opinion, if an applicant meets the legal requirements he is entitled to practice dentistry in Alaska under a temporary permit pursuant to A.S. 08.36.280. We could challenge the Board in Court. However, it will probably be best to have your dentists first apply to the Board of Dental Examiners for a temporary permit and obtain a formal decision from the Board. Note that the attached statute provides that the Board shall grant or deny an application for a temporary permit within sixty (60) days after it is received. After the applications are submitted we can request an oral hearing before the Board whereby we would attempt to put forward a compelling argument to pursuade them to accept the applications. They are free to reverse their December 1977 ruling to the effect that no further temporary permits will be granted in Alaska. If they do not, depending on what A/PIA wants to do, we can then take them to Court.

As you stated, another approach, and possibly the best might be for A/PIA to approach the Alaska Legislature and attempt to have the attached statutes changed. However, we do not know how long this will take. Mr. Milne has just informed me that he will send me a memorandum on what should be included in the amendment to the dentistry laws. I will then draft a proposed bill.

In summary, the quickest approach would probably be for A/PIA to have the dentists employed by the United States Public Health Service. In the alternative, the dentists could apply for a temporary permit pursuant to A.S. 08.36.280. Third, A/PIA should attempt to have the dentistry statutes amended to more realistically conform to the needs of the rural populace.

If you have any questions please do not hesitate to call.

Sincerely,

James F. Vollintine

REPORT OF NATIVE EDUCATION CONSULTING & TRAINING ASSOCIATE
ON DENTAL FEASIBILITY STUDY FOR THE ALEUTIAN/PRIBILOF AREA

Consultants for the Aleutian/Pribilof Islands Association have spent many hours visiting with dentists interested in donating some of their valuable time to work with the people of the Aleutian/Pribilof Islands on their dental problems.

One particular group visited and planned with is the University of California Dental School at San Francisco - Mobile Dental Lab Unit headed by Dr. Marvin Stark and by Dr. Kenneth Soelberg his associate.

Films on the entire mobile dental program were reviewed and an on site visit to a migratory farm workers camp where children were being treated was made. Particularly impressive was the quality of care delivered. No Park Avenue Dental office would be more conscientious, kind and caring no matter what was paid yet their volunteer dentists, hygienist and support staff worked deligently and painstakingly with no payment whatsoever. Full dental dams were used, full sterile technique and leaded aprons for X-ray for both patients and operator were mandatory and every child was treated with flouride. The hygienists gave instructions concerning dental health, tooth care and diet.

After several days of exploring the needs of the Aleutian/Pribilof Islands and the Dr. Stark Mobile Dental Program, we finally arrived at a consensus.

1. The dental team agreed to serve the Aleutian/Pribilof Islands area. Three senior staff dentists expressed a willingness to be a part of the project - supervising graduate and senior year dental students as they volunteered services to the people of the Aleutians area.

2. An examination of the area to be served resulted in our selecting St. Paul and St. George as our first target area. The units would start there and spend the entire summer bringing the entire community up to standard care level. It was planned to do follow up on this period with a periodontics and a prosthetic unit which would take care of the prosthetic needs identified by the clinic team. While the clinic was operational the local health aides would be given comprehensive instruction by the dental hygienists on tooth and mouth care and help them design a year round dental health program for the schools.

Both St. Paul and St. George would be treated in St. Paul. St. George people would be transported to St. Paul for ease of delivery of service.

3. Prior to clinic time publicity would go out to the communities to be served. Plenty of notice would be available in order to give people time to plan and be ready for treatment. When the unit arrives people will be examined and given prophylaxis and flouride treatment. Treatments are scheduled based on priorities determined from examinations and X-rays. For those requiring additional treatment, further appointments are made.

4. If proper arrangements can be made a follow up periodontist (child specialist) will spend 3-6 months at the unit along with a crew of prosthetic technicians who will manufacture teeth prescribed by the clinic team.

Housing

Housing and board will need to be furnished for the entire team (usually seven at a time).

Transportation

All volunteers would be furnished round trip transportation and a per diem payment large enough to cover food and living expenses.

Facilities

It is possible to set up an entire unit in a school room, hall or church but it would be far batter to have a mobile unit much like the bus they have been working with since it is compact and so efficient to work with. The recommendation made by the team is that we purchase a G.M.C. motorhome unit stripped - which the team will equip themselves with special chairs, suction, X-ray, lights, etc. Cabinet work would be done under their supervision in Palo Alto. When the entire unit is complete it will be shipped to our summer clinic site at St. Paul in the Pribilof Islands.

It is our recommendation the unit be moved next to Sand Point and then to Cold Bay and Unalaska and the patients be transported

to the central site for treatment.

Once the Aleutian/Pribilof Islands have been worked thoroughly, the unit could be made available for other parts of the State where needed.

IN THE HOUSE

HOUSE BILL NO.

IN THE LEGISLATURE OF THE STATE OF ALASKA

TENTH LEGISLATURE - SECOND SESSION

A BILL

For an Act entitled: "A mobile dental clinic for isolated Alaskans."

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

Section 1. The sum of $200,000 is appropriated from the general fund to the Department of Health and Social Services to be allocated as follows:

FY 78 (1) To the Aleutian/Pribilof Islands Assoc., Inc., for purchase of a mobile dental clinic (a GMC motor home, equipped with three complete dental work units - cabinets and fixtures) $100,000

(2) Funding for supplies movement and operation of the dental unit for a period of one (1) year $100,000

Said dental unit to be made available to other areas of the State through the Aleutian/Pribilof Islands Association, Inc., as it becomes available after meeting the crisis need of the Aleutian/Pribilof area.

Section 2. The unexpended and unobligated portion of this appropriation lapses into the general fund June 30, 1979.

Section 3. This act takes effect immediately in accordance with AS-01-10-070(c).

UNIVERSITY OF CALIFORNIA, SAN FRANCISCO

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SCHOOL OF DENTISTRY
Department of Growth and Development

SAN FRANCISCO, CALIFORNIA 94143

August 23, 1978

Pat Pletnikoff
Alention Priboff Island Association
430 C Street
Anchorage, Alaska

Dear Pat:

I was very pleased to learn of your acquisition of a mobile dental unit. The pedodontic specialty training programs at U.C.S.F. and U.S.C. have been looking for such a facility to staf with specialty students and instructors on a rotating basis. I would like to discuss this with you.

Sincerely,

Merle E. Morris

Merle E. Morris, D.D.S., M.S.
Professor & Head of Pedodontics
Department of Growth & Development

MEM/jag

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

August 10, 1978

Refer to A-DE

ALASKA AREA NATIVE HEALTH SERVICE
BOX 7-741
ANCHORAGE, ALASKA 99510

Mr. Ralph Eluska
Deputy Director
Aleutian Pribilof Island, Assn.
430 C Street Suite 303
Anchorage, Alaska 99510

Dear Mr. Eluska:

The purpose of this letter is to report to you the substance and conclusions of the meeting held on Monday, August 7, 1978. In addition, I will list for your information the conditions of Alaska Native Health Service participation in health corporation health care programs. Participating in the meeting were:

Representing Aleutian Pribilof Island, Association:

Mr. Ralph Eluska, Deputy Director
Dr. James Milne, Consultant to APIA

Representing Senator Gravel's office:

Ms. Beverly Long, Special Assistant

Representing the Alaska Native Health Service:

Mr. Robert Singyke, Executive Officer
Mr. Charles Watson, Chief, Office of Personnel
Dr. John Stolpe, Chief, Area Dental Services Branch
Dr. David Jones, Ass't Chief, Area Dental Services Branch
Dr. Douglas Smole, Chief, Service Unit Dental Program, Anchorage

The request to nominally "hire" Aleutian Pribilof Island, Assn., volunteer personnel to staff a Mobile Dental project presented to the Alaska Native Health Service by Mr. Marc Grober on June 5, 1978, was not accepted. The reasons for this decision were presented and are the subject of a separate letter to Aleutian Pribilof Island, Assn., dated August 4, 1978. Briefly the reasons can be stated as follows:

1. The government must assume liability for the acts of its employees including employees under a Volunteer Service Agreement. In order to assume this liability, day to day supervision must exist.

2. Volunteers are considered employees of the Federal government

for the purposes of the benefits provided by 5 U.S.C 8101, for work related injuries and diseases.

3. Volunteers are covered by the Tort Claims provisions of Title 23 U.S.C.

4. The circumstances proposed by Aleutian Pribilof Island, Assn., do not meet the definition of a Federal employee.

5. "Nominal hire", by the government would result in circumvention of the Alaska statutes relating to the licensing and dental practice.

6. The coordination and personnel workload required to qualify and place on volunteer agreements as many as 25 - 40 individual volunteers would be unreasonable.

The Alaska Native Health Service would be remiss in not supporting a dental program aimed at the improvement of the general health of the Alaska Native people. In a previous letter to Aleutian Pribilof Island, Assn., based upon the circumstances outlined in the information provided in your proposal titled, Aleutian Pribilof Islands, Association Mobile Dental Project, it was concluded the project does not constitute a project for our participation. Health care programs must meet specific conditions to assure the support and participation of the Indian Health Service. These conditions can be summarized as general conditions and personnel requirements. These conditions and requirements are found in Federal laws, Federal regulations and Indian Health Service policies and are listed below:

General Conditions:

1. Support of a program by the Alaska Native Health Service does not constitute any future committment of additional expenditures of funds or personnel.

2. Medical (or dental) services provided carries no threat or detriment to the health of the recipients of care.

3. The project is accepted and desired by the people in the communities involved. Evidence of this acceptance must be provided in writing from the appropriate village council or governing body.

4. The services are planned and coordinated with the dental program in the Service Unit having responsibility for the health of the community.

5. Where specific Service Unit resources are requested, the program

be approved by resolution of the Service Unit Health Board and/or Regional Health Corporation Board of Directors.

6. The personnel appointed as Federal employees meet the definition of a government employee which includes:

   a. Intent to become a Federal employee.
   b. Work under the direct supervision and control of Department (HEW) officials.
   c. Work under a formal appointment.
   d. Work in a Department facility.
   e. Volunteers may supplement, but not take the place of personnel employed through usual procedures.
   f. In accordance with the provision of an established volunteer service program.
   g. Selection of individual volunteers will be the responsibility of Department officials.
   h. Records of actual service performed by each volunteer must be maintained.

Personnel Requirements for Appointment: In general the personnel requirements for the appointment of a volunteer employee are similar to those for permanent employment, and are:

1. U.S. citizenship, volunteers are not required to be U.S. citizens.

2. Dentists must be graduates of an accredited dental school and submit evidence of graduation.

3. Dentists must be licensed in one of the states or District of Columbia and submit evidence of licensure.

4. The individual must intend to become a Federal employee.

5. An application or request should be submitted.

6. A resume' of training and experience is required.

7. Evidence of satisfactory medical condition may be required.

8. The term of appointment must be determined.

Aleutian Pribilof Island Assn., representatives stated that the immediate problem they face is the fact that the Mobile Dental Unit will be arriving in Alaska on or about August 14, 1978. Volunteer dentists and

students from the University of California San Francisco School of Dentistry will arrive with the unit. A method must be sought which will allow them to work for the period August 15 to September 30, 1978.

In summary, the recommendations agreed upon at the meeting, in general, encompassed both the long range solution to the problems of licensing and a short range solution to the immediate problem.

1. The Aleutian Pribilof Island Assn., will arrange a meeting with the Alaska Board of Dental Examiners and IHS representatives to explore the possibility of receiving some type of licensure by the State of Alaska for the dental personnel of the Aleutian Pribilof Island Assn. project.

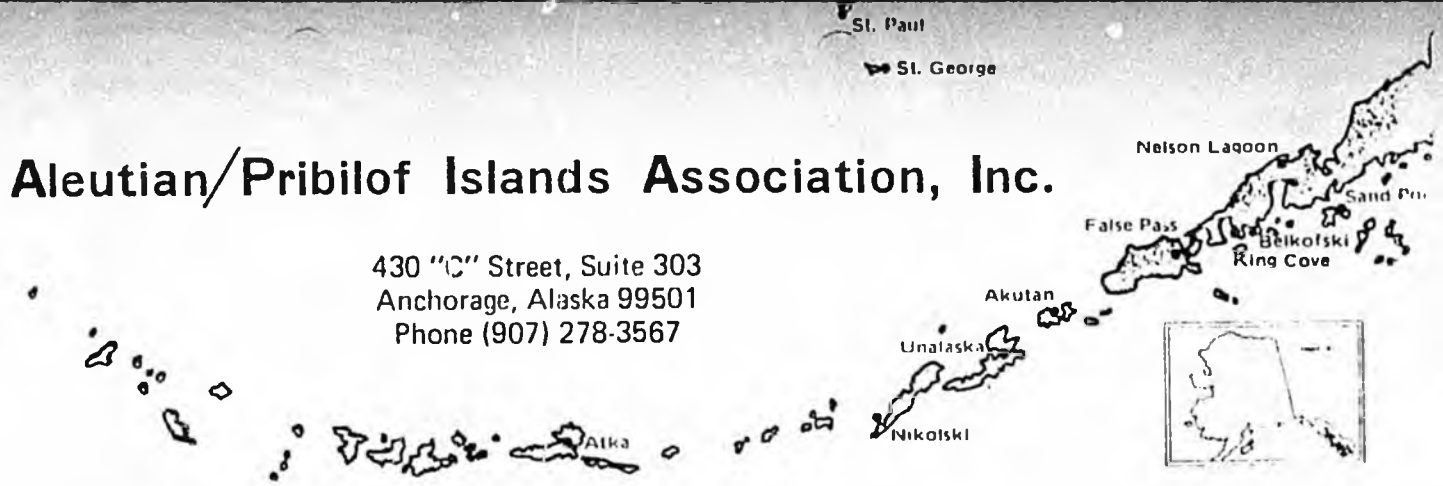
2. Depending on the results of the above meeting, IHS will attempt to provide support for the immediate operation of the Aleutian Pribilof Island Assn. project as available personnel and scheduled activities permit.

3. The Alaska State Board of Dental Examiners and Alaska Dental Society shall be made aware of any arrangements which IHS makes to provide interim supervision of the Aleutian Pribilof Island Assn. project.

Sincerely,

John R. Stolpe, D. D. S. M. P. H.
Chief, Area Dental Services Branch

cc: Dr. Milne, APIA Dental Consultant
Ms. Long, Special Ass't, Senator Gravel
Mr. Singyke, Area Executive Officer
Mr. Watson, Chief, Area Personnel
Dr. Jones, Ass't Ch, Area Dental
Dr. Smole, Ch, ANMC Dental
Dr. Hansen, President, Alaska State Board of Dental Examiners



Aleutian/Pribilof Islands Association, Inc.

430 "C" Street, Suite 303
Anchorage, Alaska 99501
Phone (907) 278-3567

June 5, 1978

David Jones, DDS
Assistant Chief
Area Dental Services Branch
Box 7-741
Anchorage, Alaska 99510

Dear Dr. Jones:

As you are aware, we are now approaching the fruition of a dream I think we all share, intensive remedial and prophylactic dental care in the Aleutians, through the use of our mobile dental unit.

In our earlier discussions you offered that IHS might consider "hiring" our instructor and student dentists so that they might be able to practice in the bush.

To my knowledge, the best way in which these personnel can practice with the mobile dental unit project, under the current statutes, is to be in the employ of IHS (see AS 08.36.350.(3)). Though we have prepared legislation to alter the statutory scheme, enactment is far beyond the time at which the project will be ready to roll.

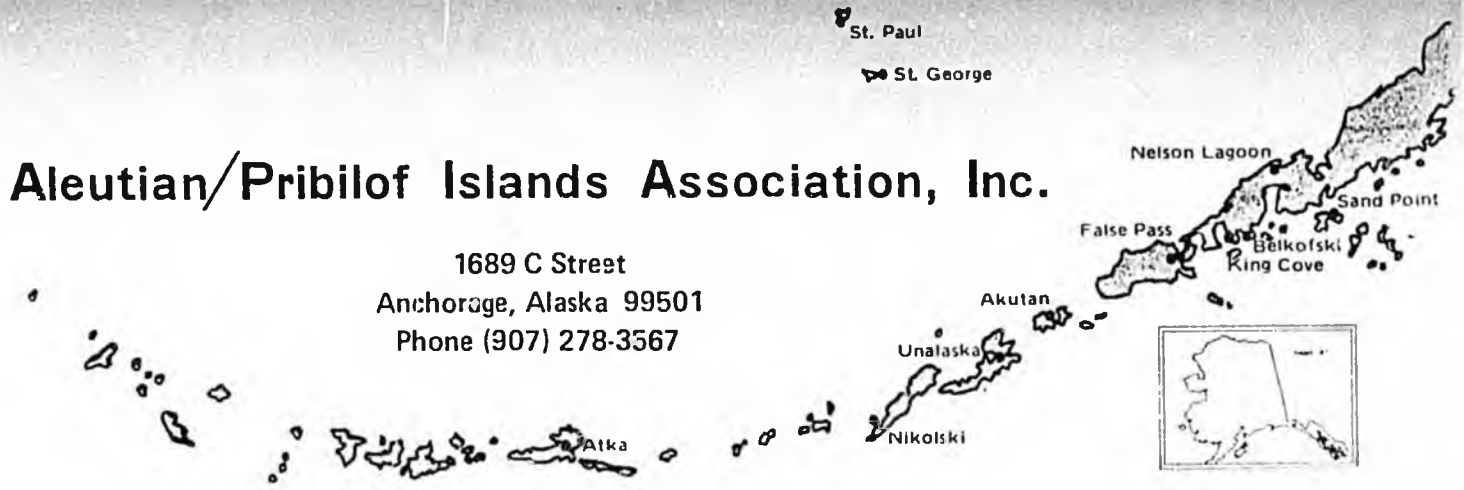
We are asking that you nominally "hire" our personnel for the term of their tour of duty with the unit. As I am sure there is a maze of paper work that would be required before we could begin such a program, I'd like you to put me in touch with the proper person to work out the necessary details. I, of course, am at your disposal.

I hope in this way we can provide "dentists" to bush communities at no cost to IHS or ANS. As I think that is a common goal I look forward to your affirmative response.

Please, let's get together at your earliest convenience.

Sincerely yours,

Marc Grober
Counsel



Aleutian/Pribilof Islands Association, Inc.

1689 C Street
Anchorage, Alaska 99501
Phone (907) 278-3567

To: Gerald H. Ivey, Director
Alaska Area Native Health Services

From: Patrick Pletnikoff, Executive Director

Date: February 6, 1979

Subject: Letter of Commitment to Plan

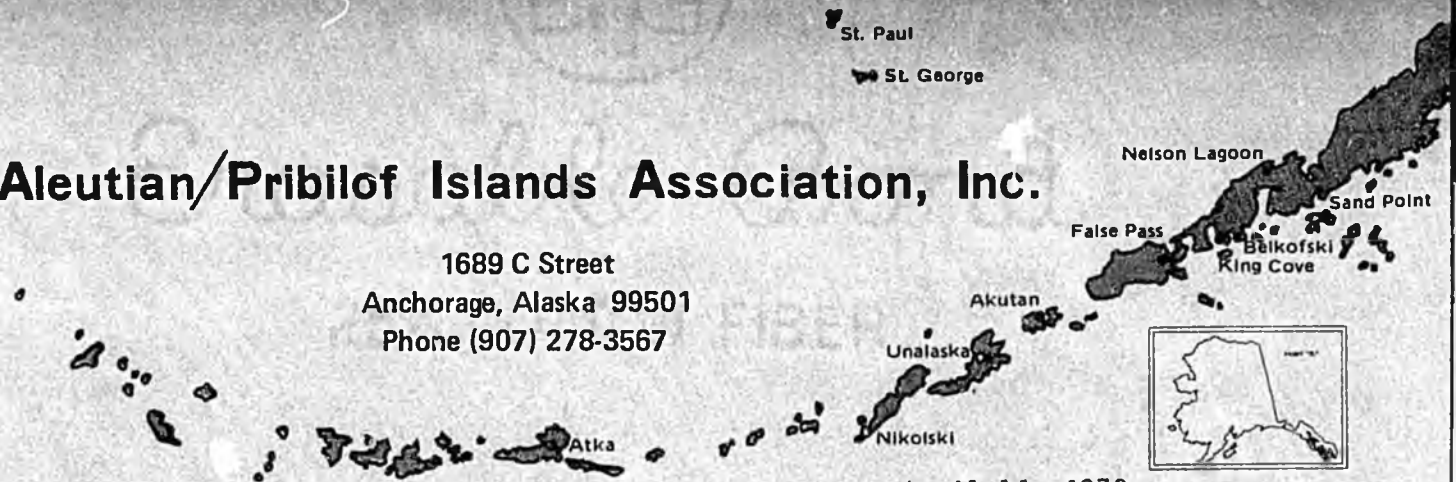
This is a letter of commitment to plan and implement any future operations of the mobile dental clinic with the Service Unit Director of the Anchorage Service Unit of IHS.

This letter will serve to inform you that we are ready and waiting to talk to you and your staff about our plans for use of the dental clinic in the months ahead. We really should have a meeting soon to discover what areas of coverage need immediate attention and what our priorities will be.

Although efforts will be made to obtain licensure through the State Legislature we want to be sure our people will be allowed to work this summer.

An early meeting would be appropriate for all concerned.

PP:alp



Aleutian/Pribilof Islands Association, Inc.

1689 C Street
Anchorage, Alaska 99501
Phone (907) 278-3567

April 11, 1979

Thelma Buchholdt
Pouch V
Juneau, Alaska 99811

Subject: Support H.B. 401

Dear Ms. Buchholdt:

You may already be aware of the efforts of the Aleutian/Pribilof Island Association to bring adequate dental health care to the people of the Aleutian Islands, but we want you to know more about our mobile dental clinic and the problems we have had in getting authorization from the State Dental Board needed to allow our volunteer dentists and dental students in training to offer their services in Alaska. The Dental Board wants no permits to practice issued even though the present law specifies they are to issue permits - as a matter of fact, they refuse to issue any permits at all.

Last summer we had 22 volunteers standing by waiting to get permission to volunteer their services - we finally ran the program through the United States Public Health Service. The present law and contrived conditions which exist in Alaska prevent any volunteer who would fix kids teeth without charge from practicing.

Representative Osterback has submitted a bill this session which will exempt volunteer dental personnel from permit requirements thus paving the way for a new summer program of dental health care aboard the mobile unit. Your support of H.B. 401 is essential to the health care of all bush Alaskans. Your Yes vote on this measure is essential this session.

Thousands of Alaskans go to work every day of their lives with a tooth ache or in need of dental care because the cost of dentistry is prohibitive. Some fly to Europe for dental work because it's cheaper than staying home and having the work done by an Alaskan dentist.

Eventually of course, over pricing, indifference and greed will move the citizenry to action - and dentistry will become a publicly supported element of our society. In the meanwhile we need your support now of H.B. 401 so we can bring in the sensitive socially conscious volunteers who want to come to Alaska for a few weeks to improve the overall dental health of our people.

Sincerely yours,

Patrick Pletnikoff
Executive Director

alp

Aleutian/Pribilof Islands Association, Inc.

1689 C Street
Anchorage, Alaska 99501
Phone (907) 278-3567

September 26, 1978

Mr. Herb Rhodes, Publisher
The Great Lander
3110 Spenard Road
Anchorage, Alaska 99503

Dear Mr. Rhodes:

Your editorial outlining the abuses of the State Bid System was frankly unfair and inaccurate with reference to the Mobile Dental Lab for serving the unmet needs of the Aleutian/Pribilof area.

1. Both the House and Senate approved of the Dental Measure. You claimed they defeated the measure. The House had a floor vote in which it passed unanimously and the Senate Finance Committee gave it a "do pass" vote.

2. The money was intended by the legislature to be appropriated however more programs were approved than the Governor had money for so he was put in the position of making a choice of the best programs approved. He approved this one because it had merit and would bring to the State many times more value than the $200,000 appropriated in volunteer services helping the Native people who needed dental care the PHS was not able or willing to deliver.

3. The Mobile Dental Unit was designed by the staff of the University of California Dental School and built by them, a task only they could accomplish - no other vendor has the capability of building and delivering the unit except the Siemens Company in West Germany and their unit, not half as good as what we got, costs twice as much.

The Department of Health and Social Services did not ever order anything nine months ahead of the time money was appropriated for the unit or even afterwards. The Aleutian/Pribilof Islands

Association, Inc., a non-profit corporation, was given a contract for the development of the units and delivery of them. They made the purchase of the base unit through an Alaskan auto dealer, Alaska Sales & Service, who gave the unit to them "at cost" with no profit whatever, which could never have happened on a bid.

The size of the unit does not limit their versatility at all. They were carefully planned and are near perfect - far superior to anything ever before developed. The reason a Hercules aircraft was used to move a unit to the Pribilofs was because a jealous, hypocritical money grabbing group prevented the delivery of "free" dental services for personal reasons, refusing to issue the permit to practice causing the units to miss the pre-arranged transportation donated by Sealand to the islands.

The staff was very adequately housed and transported as planned. AMU housed the volunteers while in Anchorage and they were efficiently delivered by Reeve Aleutian to their destination. Your reporting was prejudiced, biased and irresponsible. If you are really interested in what services are or are not provided to the Natives of this State, do a little honest research before you print. The Chairman of the Bush Dentistry Committee of the Dental Association was paid $44,000 for two stints to a bush community by the Indian Health Service last year - could this be a clue as to why they did not want to license volunteers? There is a really good story here, but you missed it completely.

As to the adequacy of dental services to bush Alaska, tell that to the toddlers, the people with swollen tongues from poor dental care and those whose decay causes drainage down their throats all their lives. Forty-five Alaskans out of 100 must conduct their business, work or study enduring dental pain or with essential teeth missing because it's cheaper to fly to Europe for dental care than to stay home and mortgage life and limb to pay for treatment.

Do you think the Aleutian/Pribilof Islands Association would have sought out dental assistance from out of State if their people were receiving adequate care? Do you think for a minute the Cook Inlet Native Association would have hired their own dentist and invested in a dental office right under the nose of PHS if the service was adequate? Do you think for a moment that we would have had requests for service from our volunteer mobile unit from five areas of the State if their needs were being met? Thank God Governor Hammond is not the kind of person to give in to the political pressures that were brought to bear on him by the PHS personnel and the Alaskan Dental Association and their lobbyists in Juneau - he's got guts and our people are getting their teeth fixed. Can that garbage you are peddling and send

it to a more appreciative audience. You may or may not have a legitimate beef on your loss of a printing job, but attacking our dental project is sure not the way to correct it. We would give serious consideration to supporting legislation which takes government at all levels out of the printing business and puts it back with private enterprise because we feel the taxpayer should not be put in the position of competing with his own money for work.

Sincerely yours,

ALEUTIAN/PRIBILOF ISLANDS ASSOCIATION, INC.

Patrick Pletnikoff
Executive Director

PP:alp
Enclosure

cc: Governor Jay Hammond
Bob Atwood, Anchorage Times
Dr. Frederick McGinnis
Senator Glenn Hackney
Senator W. E. Bradley
Senator Ed Willis
Senator Bob Ziegler
Senator Pat Rodey
Senator John Sackett
Senator Bill Sumner
Rep. Alvin Osterback
Rep. Frank Ferguson

...Alaska. By 1907, it had become a ...d coal and oil center, but by the mid-forties, Katalla had become a ghost town -- a vestige of a bygone era in Alaska's history.

...nboots

...d it; the kids understood ...sed it, but I sensed it was

these people were former ...esidents of Katalla, wh...e ...fined till the mid-thirties ... refinery burned. Now ...e just winter residents, the trapping. This was ...e '40's when fur trapping ...orable profession even to ...onists, with no overtones ...gers species" and all ...les, the price of fur was ...y good. The permanent ... of Katalla was about two ...sen and "Wolf" Larsen. ...ber all kinds of odds and ... gathering around the big ...e at Bill Hansen's cabin. ...s gathered around the ...e very practical reason -- ...re the light was. One gas ...p hung on a nail above ...nd we all sat at the table ...d, or eat. The gas mantle ...he big round table were ..., in my opinion, that ...e so close in the old days. ... of course, was the main ... the two room cabin.

... one time, early in the ...e of the men brought in 30 ... remember my ...ense of ...t in the world would we ...0 ducks? But the whole ... pitched in, cleaned and ...e whole smear of them; ... roasted up and a grand ...had by all, there at that ...e in Bill Hansen's cabin. I ...he ducks were actually

The Great Lander

FREE

SHOPPING NEWS & SOURDOUGH SAVER CLASSIFIEDS

Volume 10, No. 37 Anchorage, Alaska September 13, 1978

State Purchasing Scandal --

'Tis Your Money...And Here's How the State Wastes It!

Two weeks ago the Great Lander went to war with the state of Alaska on its bid and purchase procedures. We declared that the state was ignoring the low award bid procedure as prescribed by law -- worse yet that thousands and even millions were going out with no bids at all -- many to Outside firms leaving Alaskan vendors and taxpayers holding the bag.

As one prime example, the court system admitted to 49 violations amounting to $62,000 in form buying alone. An appeal for public information has kept our telephone ringing. And we hope it continues, through the day and into the Arctic night.

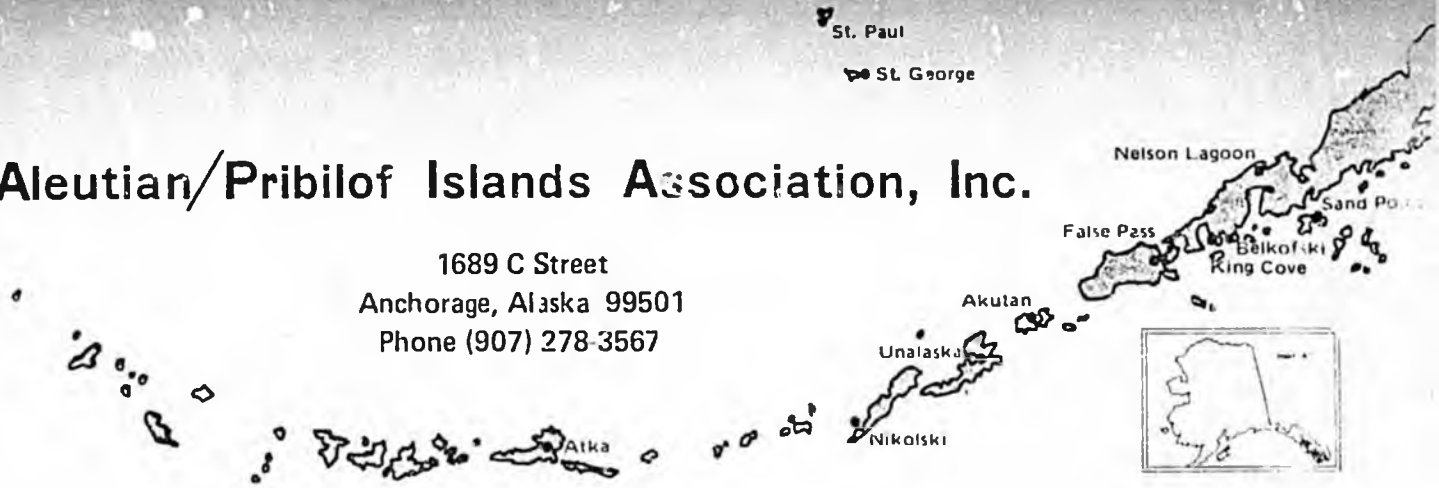
Here are some of the incidents brought to light in a single week:

Radio Equipment. Fred Jones of General Electric, in Anchorage, says the state has purchased approximately $1,500,000 worth of mobile radio equipment since 1973 without bid. He says a contract held by Motorola expired that year and that pleas to Don Harris, head of state transportation, and to Mel Holverston, of the division of communications, for a bid procedure have gone unheeded. "They pay lip ... Forms, an Outside firm, who entered a higher bid.

Regular Printing. The Anchorage Printing Co. with a bid of $128,000 was low bidder on a state call to print its elections pamphlets. The state went into negotiation with Craftsmen Press of Seattle the following day and awarded that firm the job. Formal bids were never cancelled and re-advertised as required by law.

Aleutian/Pribilof Islands Association, Inc.

1689 C Street
Anchorage, Alaska 99501
Phone (907) 278-3567



QUESTIONS AND HONEST ANSWERS ON THE MOBILE CLINIC

1. Why was the unit stuck out on St. Paul all winter?

   Answer Because we were told by the State enforcement people we would be arrested if we operated it. They took down the license number of the vehicles and names and addressed of all volunteers then threatened them with arrest.

2. Why was most of the work done outside the Van?

   Answer It was not. Though large numbers were examined outside the parent van, some cleaning was also done in this manner on portable units which were an integral part of an operating system. Without the parent operative units outside van service would not have been practical. Our system allowed 7 chairs to operate all at the same time saving time and allowing for a flow of screened patients to the operative unit.

3. Was the mobile concept cost effective?

   Answer No it was not because we had to feed and house all of the volunteers for 14 days while we went through all the red tape getting started.

   As it turned out we accomplished over $100,000 worth of dental services. It could have been $200,000 without all the interference.

4. Did APIA apply for licenses or permits?

   Answer We were prevented from applying for anything by the dental board. We were informed that there was no application procedure or way to apply since the board had met in December and decided not to issue any permits to anyone no matter what the legislation says.

   Dr. Hanson and Dr. Wright re-stated this information in the APIA offices. Dr. Hanson said there would never be any permits issued to anyone as long as he had anything to say about

it no matter what the Legislature decided nor how the present law read.

5. Is there any other way to qualify?

   Answer No!

6. How do the present hygienists in training qualify for permits?

   Answer They do not qualify. They operate illegally but are not bothered by the dental board for some unknown reason.

7. Is there a record of what was accomplished before the unit arrived in St. Paul?

   Answer Yes there is. It was a buck shot hit and miss attempt.

   St. Paul: Reported population of 419. Although this community had more dental days care per year than all the other villages from 1974 - 1977, reports from visiting dentists were of rampant dental disease, high suger consumption and little or no community dental plan. Lack of coordination with the school program. 30 children reported as not showing for check ups in one period. Floridation system broken down for 3 years.

   St. George: Average of 6.4 days of care a year since 1974. For a community of 154 people - emphasis on children's teeth only.

AFTER THE UNIT OPERATED

1. New health attitude about dental care. Everyone in town was served. Mothers brought their children. Relatives brought their friends. The floridation unit was repaired. A total community dental health program was started. All examinations were documented together with x-rays and completed charts furnished by the PHS Dental Service Unit. Records left behind for the next visiting PHS dentist were so complete the next group of PHS dentists were able to pick up where the volunteers left off. This was indeed a good demonstration of how effective the 2 agencies could work together without the outside interference of the Dental Union and the State Dental Board. As a result of this joint venture, St. Paul has the best dental health in all of bush Alaska.

With the elimination of red tape, delays and political pressures, every $20,000 spent for transportation and room and board for volunteers will produce $100,000 worth of excellent dental treatment and care.

We cannot over emphasize our intention in our request for support of this program of dental care for the Aleutian/Pribilof people. We do not have as a goal the embarassment of PHS, Indian Health Service or private practitioners. We appreciate all past efforts to check dental disease in our islands. The records clearly show that the present system is not working satisfactorily and a new approach is needed. We ask only that the new approach be given the support it deserves. The worst that can happen is the communities will get a little more dental care and the mobile unit can be used by any agency wanting to use it for delivery of service to our area.

The best that can happen is that we will have discovered and tested a new functional, less expensive way to bring dental health care to bush Alaska and other areas will be using the money they now waste on poor programs to duplicate this method of service.

When the units were here for inspection by the dentists, Dr. Hanson walked right past the units refusing to even look inside. Let's not depend on this kind of open mind to make a decision on this service.

Reprinted from American Psychologist, Vol. 33, No. 11, November 1978
Printed in U. S. A.

The Myth of Professional Licensing

STANLEY J. GROSS *Indiana State University*

ABSTRACT: *The public and most professionals believe that occupational licensing protects service consumers against charlatans and incompetents. This review of historical, economic, and sociological research indicates a specious association between licensing and the competence of practitioners. Rather, the evidence reveals licensing to be a mystifying arrangement that promises protection of the public but that actually institutionalizes a lack of accountability to the public. The collusion between the state and the professions is maintained by myth. Acknowledging the failure of licensing is preparatory to defining the problem of how to protect the public.*

Licensing is presently a "hot" issue for psychologists, social workers, and counselors (Forster, 1977; Hardcastle 1977; Matarazzo, 1977; Prest, 1976; Swain, 1975). The helping professions are following in the footsteps of the health and legal professions in attempting to gain legal sanction for autonomous practice, expecting to gain similar status for these professions as well as the approval of third-party payers. Though the several helping professions are at different points in their progress from registration to certification to licensing[1] in each of the 50 states, there is an almost universal assumption that licensing is a "good thing." This myth is most often expressed as a belief that "licensing protects the public against incompetent practitioners." This largely uncritical stance appears to be the attitude of the vast majority of the public and professionals alike. Even highly critical consumer-oriented groups (Adams, 1975) appear mystified by the licensing notion, believing it to be an initial screening device for determining quality service.

This article examines the research and scholarly opinion related to the incredibly varied licensing system that results from the collaboration between the state and the professions. Licensing is used in the literature to refer both to the arrangement whereby practice is restricted as well as to all collaboration between a state and a profession, including registration and title certifications. This article is not concerned with professionally controlled credentialing arrangements that do not benefit from association with restrictive legislation. It focuses on those occupations that have gained autonomy as the result of licensing statutes. Excluded from this analysis are occupations for which autonomy is precluded either by statutes that write in a subservient role for the professional (e.g., as in nursing) or by institutions that maintain control of the service setting (e.g., as in school teaching).

A great deal of the research on which this article is based focuses on the medical profession, but this is appropriate. Medical licensure is the model that other professions aspire to, so experience with that model is instructive. Unfortunately, there is little research referring specifically to psychologists or other helping professionals, the history of such arrangements being so recent. It is possible, though not likely, that some of the conclusions might be different for them.

The history of licensing in the health professions centers on the attempts of special interests to impose or to sabotage a monopoly on the practice of healing. Licensing has been the instrument used to restrict practice to professionals, who have claimed it was in the public interest to do so. There is no good evidence to support these claims. Of the evidence found, some is inconclusive or insufficient on some points, but mainly the research refutes the claim that licensing protects the public. This knowledge is crucial to the current debate yet

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Requests for reprints should be sent to Stanley J. Gross, Graduate Studies in Education, Indiana State University, Terre Haute, Indiana 47809.

[1] Friedman (1962) defines them as follows: *Registration*—"individuals are required to list their names in some official register if they engage in certain kinds of activities. There is no provision for denying the right to engage in the activity to anyone who is willing to list his name" (p. 144). *Certification*—"the governmental agency may certify that an individual has certain skills but may not prevent, in any way, the practice of an occupation using these skills by people who do not have such a certificate" (p. 144). *Licensing*—"requires some demonstration of competence . . . and anyone who does not have a license is not authorized to practice and is subject to a fine or a jail sentence if he does engage in practice" (p. 145).

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0003-066X/78/3311-1009$00.75

is almost completely ignored outside of the scholarly disciplines used in this investigation which are devoted to the study of such phenomena.

Though reference is made in this article to professional self-interest and lack of accountability to the public, no implication that individual practitioners or professional associations are deliberately or intentionally self-serving is intended. In fact, one reason for this article is that practitioners as well as the public are mystified, such mystification being an important contribution to and evidence for the existence of a system of thinking, feeling, and behaving that maintains licensing. The difference between what people believe to be true about licensing and what is cited in this article indicates that the belief is maintained by myth and argues for the necessity of the consciousness raising attempted herein. The article reviews the historical antecedents of current licensing arrangements, relates the guild-like structure of professions to the licensing charter, examines the effectiveness of state licensing boards—particularly their actions to maintain professional self-interest, considers the centrality of the license to the entire system, and explores the supposed link between licensing and quality service.

Historical Antecedents

In the 13th century, Frederick II, Emperor of the Holy Roman Empire, wrote the first medical practice law. Its provisions included (a) examination by a teacher of medicine, (b) punishment for offenders by confiscation of goods and a year in prison, (c) three years devoted to the study of logic, (d) one year of practice under the direction of an experienced physician after five years of study, (e) the setting of fees, (f) free care of the poor, and (g) a prohibition on a physician owning an apothecary shop (Derbyshire, 1959).

Krause (1977) points to a pattern, dating from ancient Egypt and Greece, of a medical practice hierarchy that differentiated the curers of the masses and the curers of the elite. At the top of this hierarchy was temple medicine with its priests serving the aristocracy. At the next level were the community practitioners who practiced a fee-for-service medicine for those who could afford it, which served as the model for practice today. At the bottom was folk medicine practiced in an oral tradition, often by women. Ehrenreich and English (1973) described these practitioners:

> Women have always been healers. They were the unlicensed doctors and anatomists of western history. They were abortionists, nurses and counsellors. They were pharmacists, cultivating healing herbs and exchanging the secrets of their uses. They were midwives, travelling from home to home and village to village. For centuries women were doctors without degrees, barred from books and lectures, learning from each other, and passing on experience from neighbor to neighbor and mother to daughter. They were called "wise women" by the people, witches or charlatans by the authorities. (p. 3)

Ehrenreich and English (1973) also noted the dichotomy in medical practice that emerged in 13th-century Europe, where "witches" practiced among the people while the ruling classes were served by university-trained physicians. Licensing laws came into vogue as the means "to prohibit all but university-trained doctors from practice" (Ehrenreich & English, 1973, p. 17). Though the effectiveness of these laws was limited because of the great need for service and the inability and unwillingness of university-trained physicians to serve the masses, it is important to note this early reliance on the authority of the state to legitimate an occupation. This attempt to monopolize medical practice in situations of imbalance between need and available service was unrealistic given the large number of unlicensed medical advisors and would eventually lead to a temporary abandonment of licensing in the 19th century in the United States (Kett, 1968).

Licensing laws were used as an exclusionary technique in France during the 14th century (Ehrenreich & English, 1973). As the result of the requirement for university training, the practice of healing was restricted to the upper classes, to men, and to those in the favor of the Church (which controlled the universities), most of whom were ecclesiastics (Spector & Frederick, 1952). By the 16th century as the universities became more secularized, the university-trained professionals no longer were compelled to take religious orders. Emerging from the grip of the church, the associations of physicians became similar to craft guilds. These, however, were not destroyed by the impact of commercialism, centralized governments, and laissez-faire economics, as the craft guilds and the feudal system were to be (Spector & Frederick, 1952).

As occupations, professions were a special case, first in serving the social elite and later in being populated by the elite. Professions, like land, broke the direct connection between work and income for the English gentleman, permitting him to make a considerable sum of money without engaging in a "despised" trade. Gerstle and Jacobs (1976) concluded, "One could carry on commerce

by sleight of hand while donning the vestments of professional altruism" (p. 3).

In the United States, a flood of legislation prior to 1800 gave the power to regulate medical practice to the guildlike associations of professionals, the state medical societies (Spector & Frederick, 1952). The development of medical schools at about the same time instituted a two-tiered hierarchy of regular medical practice that included those trained through apprenticeship only and those who added medical school to their qualifications. Both categories were licensed, though Shryock (1967) has observed that legislatures were more impressed with the latter group. Three parallels with the present day were evident prior to the 19th century. First, licensing was associated with the interests of the dominant elite—the Church and aristocracy in Europe and the commercial class in America (Reiff, 1974). Second, sanctioning power was given to guildlike professional organizations as the means by which these interests were to be maintained. Third, admission to the guild maintained the profession's upper-class identification by requiring where it could and otherwise preferring a period of prolonged university training unavailable to the lower classes.

The second quarter of the 19th century brought about surprising changes in these developments in the United States. In response to the egalitarian sentiment of the times, there was a wholesale deregulation of the professions of law and medicine. By the time of the Civil War, "no effective state licensing system was in operation" (Spector & Frederick, 1952, p. 191). The popular rhetoric explaining this eventuality has a modern sound. It included complaints that the professions (a) made things so complicated that intelligent persons who ordinarily could be expected to take responsibility for themselves could not argue in a court of law or obtain the information needed to properly take care of themselves, (b) were monopolies in restraint of trade, (c) maintained a subordinating class system that hoarded privileges and blocked the entry of the lower classes, and (d) retarded developments and blocked talent in nonorthodox realms of practice (Tabachnik, 1976). More fundamentally, the demands of a growing population and an expanding frontier ushered in a wave of democracy and individualism (Spector & Frederick, 1952) and a popular health movement (Ehrenreich & English, 1973) that upset the machinery by which professional practice was controlled. The professions then became more socially inclusive as the society became more egalitarian.

Beginning in the 1870s, however, the bar associations and the medical societies began promoting a relationship between competence and licensing that culminated in our present complex system (Tabachnik, 1976). In effect, the professions, no longer able to call upon the class system to maintain their privileged status, turned toward government to secure public confidence and a monopoly of skill (Gerstle & Jacobs, 1976). In the 20th century, the trends have been (a) for licensing to include an ever greater number of occupations, (b) for the type of licensing to go from title certifications to compulsory licensing of practice, and (c) for the raising and tightening of standards—including moving from an apprentice system to one centering training in educational institutions, lengthening the period of training, and adding internships after training (Spector & Frederick, 1952). Though there have been some reactions to professional dominance expressed during the last decade by client revolts and by pressures toward community control, the present strength of professional power makes "threats to established patterns of dominance appear minimal" (Gerstle & Jacobs, 1976, p. 18).

Profession as Guild

Gerstle and Jacobs (1976) described a craft guild as follows:

> They restricted competition, set prices, defined the quality of raw materials and craftsmanship, controlled entrance and training, and enacted detailed ordinances touching on the craftsman's relations with fellow members, non-members, members of other guilds, future members, dependent workers, and consumers. (p. 2)

Though professionals may wish to deny any similarity between their associations and guilds because of the crass commercialism or the association with unionism suggested by the guild label, the analogy is helpful in understanding the centrality of licensing to professional practice. The charter of autonomy is given to the professional via the licensing arrangement on the basis of public acceptance of the idea of professional expertise and altruism (Haug & Sussman, 1969). The charter is essential. Without it, professionals would not be able to control the potentially shorable knowledge that is the basis of their expertise, nor would they bother to guide practitioners to make the costly pretense of the altruistic ideal (Haug & Sussman, 1969; Reiff, 1974). To maintain the charter,

the professional must mystify the public by making the service appear to be expert and difficult.

Modern professionals conceal their economic interests, but these are nonetheless apparent in professional procedures. Reif (1974) describes the professional as an entrepreneur dealing with knowledge as a commodity, "supplying man with holding for a price service as a form of labor" (p. 455). According to Krause (1977), for physicians "the key variable is power gained through possession of the medical skill. The power is legitimized —made official—through licensing laws which prohibit others from practicing medicine" (p. 35). Controlling the knowledge, making it a commodity, creates a scarcity economy over which the professionals have monopolistic control. Though there is talk about a free market, "Health care providers themselves are not responsive to market pressures exerted by consumers, because demand levels are not determined by consumers but by physicians" (Carlson, 1979, p. 857). By having absolute control over the spigot, professionals can arrange things so that they themselves are benefited rather than their clients. For example, Carlson (1970) points to the choice of a fee-for-service system as opposed to a prepayment system. In a fee-for-service system, services, "the need for which is determined by the providers of those services, are continuously bought by users" (p. 858). According to Carlson (1970), this induces inelasticity in demand by restricting user choice and leads to increases in costs. The alternative, prepayment, gives providers and consumers a common goal—maintenance of health. Krause (1977) points out that in a fee-for-service system it is to the physicians' economic advantage to overtreat who is ill, while in a prepayment system it is to their advantage to underdefine this group.

The charter of autonomy includes the necessity to define the terms of practice and "legal, moral, and intellectual mandate to determine for the individual and society at large what is bodily, moral, ethical, deviant, normal or abnormal" (Reif, 1974, p. 452). Thus, a system of logic and perception may be erected which organizes ethics and rationalization to protect professionals from the effects of their decisions. Those dependent on them suffer from their mistakes, ignorance, self-deception, and bias, since professionals have the right (indeed the mandate) to define when a mistake has been made. In this way a situation is created in which feedback from experience is so limited that self-corrective action is unlikely. These trappings of power led Gerstle and Jacobs (1976) to observe the "shift of emphasis on the part of professionals from control over the quality of the product or service to control of price" (p. 9). Such power is widely emulated, so much so that many want their occupations to become professions. Gerstle and Jacobs (1976) observed that the mystique of the professional is considered so socially useful for so many purposes that there is no consideration that it could be a liability.

The Boards

The mechanism by which monopolistic control is maintained is the state licensing board. The charter is, in effect, given to a public body by a state legislature, and its members are generally appointed by the state's governor. On the surface it appears that these boards would act in the public interest, but in fact, they are "captured" by the profession they are supposed to regulate. In most cases, particular professions proposed the licensing law establishing the board, their representatives negotiated with the legislators during its passage, and their representatives fill a majority, if not all, of the seats on the board (Cohen, 1975). Shimberg (1976), in reviewing the effect of "sunset" laws, indicates that even when public members are included they often become coopted. Using "umbrella" agencies to supervise a number of professional boards in a state has not made these boards more accountable. Pfeifer (1974) also found inclusion of the lay public on boards to have little observable effect on their accountability.

"If there is a tie between competence and licensing, there ought to be some evidence of that tie in the work of licensing boards. Unfortunately, there is not. As Cohen and Mirke (1974) have suggested, in addition to assessing initial competence, the boards should monitor continuing competence and should discipline errant practitioners. A related public interest matter is the availability of licensed professionals. Boards ought to be active, according to Cohen and Mirke (1974), in affecting the redistribution of practitioners and in developing new patterns of utilization of related professionals. Referring to health care personnel supply and demand, Krause (1977) concludes, "Self-interest of the crudest sort still plays a role in the way these issues are handled. As usual, the needs of the consumer are pushed aside" (p. 193). Licensing boards do very little in these areas and instead restrict themselves to the administration of

entry examinations. Even in this role they do poorly, measuring minimal competence only (Cohen & Miike, 1974).

So, what do licensing boards do? Pfeffer (1974), reviewing the limited research, concluded, "Occupational licensing operates to restrict entry and enhance occupational incomes" (p. 104). He reported observed relationships (a) between the enactment of licensing laws and the decline in the numbers of training institutions and trainees, (b) between the control of competitive behavior among professionals and an oversupply of professionals (to maintain the illusion of professional dominance), and (c) between the restrictiveness of a profession and its independence from local economic conditions. In this regard, Krause (1977) reports that the number of medical school graduates was held constant from the 1930s to the 1960s despite rapid population growth. Moore (1961) found that restrictions on entry benefit the practitioners in the field at the time the restrictions are imposed. He reported the imposition of citizenship requirements for regulated occupations in Illinois in 1939, at a time when there was a large influx of trained practitioners from Europe.

The particular means of controlling entry is the manipulation of the examination pass rate. Maurizi's (1974) study of 18 occupations indicated that

> a 10 percent increase in excess demand (applications) generates a decrease in the pass rate varying, primarily from 1 percent to 10 percent depending on the occupation, and that a 10 percent increase in average practitioner incomes produces up to a 10 percent decrease in the pass rate . . . . The power of the licensing boards is often used to prolong the period of higher incomes resulting from increases in excess demand for the services of the occupation in question. (p. 412)

Maurizi (1974) suggested that over the long run the increase in income at the time restrictions were imposed would attract more new entrants, which in turn would result in a decline in income for members of a profession if entry restrictions were not manipulated. The relationship between restriction imposition and income is apparently not all that certain. Maurizi (1974) said his data had no power to explain the relationship for half of the occupations he studied. Pfefier (1974), studying three occupations, found no evidence of a relationship between the licensing of an occupation per se and the incomes of its practitioners. He did find, however, a relationship between examination failure rates and incomes—the higher the proportion of successful applicants, the lower the income (Pfeffer, 1974). Cohen and Miike (1974) and Krause (1977) report the practice of permitting foreign physicians to practice in chronic-disease hospitals and mental hospitals—either ignoring citizenship requirements or lowering passing examination grades for those who will work in less desirable settings or in geographical areas of high need.

Licensing Is the Key

It has been observed that licensing has rarely been sought by the public; rather, it has been sought by the professionals who wished to be licensed (Cohen, 1975; Friedman, 1962). In effect, the legal mechanisms of the state legitimize the occupation. Freidson (1970) observed,

> The foundation on which the analysis of a profession must be based is its relationship to the ultimate source of power and authority in modern society—the state. In the case of medicine, much, though by no means all, of the profession's strength is based on legally supported monopoly over practice. This monopoly operates through a system of licensing that bears on the privilege to hospitalize patients and the right to prescribe drugs and order laboratory procedures that are otherwise virtually inaccessible. (p. 83)

Hardcastle (1977) calls the need for legal protection an "expedient of an occupation on the make" (p. 14). The occupation becomes "made," ironically, as a profession through the use of public institutions and in opposition to the public interest. Friedman (1962) called the results of licensing "unendurable" even in medicine where the case for licensing was the strongest.

Though there is no evidence of any relationship whatsoever between licensing and the quality of care, the likelihood of licensing laws being removed is remote. Carlson (1970) describes licensing as going from a presumed remedy to a problem: "Licensure would likely fall of its own weight except for a reverence for professionalism" (p. 860). Licensure statutes are defended vigorously because their loss to the professions means (a) the loss of a captured board that acts in their interest free of the influence of outsiders and (b) the loss of the power given to the profession as the result of making the violation of the professional monopoly punishable as a crime (Pfeffer, 1974). So licensure is terribly important to the professionals, and yet the public is gullible (Moore, 1961), loosely organized, and lacking expertise when compared to the highly motivated trade and professional groups (Shimberg, 1976). The result is the maintenance of self-serving licensing systems regardless of their justice or usefulness.

The existence of licensing laws indicates a shift of opinion in the last century from the notion that people know what is best for themselves to the notion that "society" is the best judge (Moore, 1961). In this regard, Krause (1977) observes that the public does not judge expertise. Technically incompetent general practitioners have as many patients as competent ones. The conclusion is thus made by many that the public cannot protect itself and that licensing is, therefore, a necessity. However, the control of information by professionals does not permit a testing of the capacity of consumers to take care of themselves. The belief that information is the key to quality care is supported by the necessity, even with licensing statutes, for individuals to gain a considerable amount of information in order to effectively choose a therapist (Gross, 1977).

This complex structure surrounding licensing permits professionals to hide from the public's view their dependence on the licensing statute. Fortunately, it isn't really that necessary for the integrity of the profession, but it is for monopolistic economic control. There are several professions (e.g., university professors, dietitians, librarians, engineers) that are generally unlicensed partly because they practice in institutions. Goode (1960) suggests that pressure for licensing is greatest for occupations that deal with clients as individuals and where competence cannot be easily demonstrated. Reviews of licensing suggest that certification and registration arrangements would accomplish the protection of the public as well as the compulsory licensing of practice would (Friedman, 1962; Moore, 1961). Professional associations credential practitioners and accredit training programs without dependence on state law. More than 100 years ago it was recognized that the licensing laws had provided the professions with their power, so it was these laws that became the target for attack (Tabachnik, 1976). This may not happen in this century, but it is useful and important to note that the problem of licensing is brought about through the complicity of state governments (Gerstle & Jacobs, 1976; Tabachnik, 1976).

There is a rather strong push currently to reform licensing laws (e.g., national credentialing, institutional licensure; Cohen, 1970; Roemer, 1973). Though it is appealing to believe that there is hope for the system, the fact that professionals would remain in control in the alternatives suggested is discouraging. The crucial aspects of the problem, the absence of accountability and the maintenance of the monopoly, would not change (Illich, 1976). Further, the underlying reason for reform is obscured by the hope of reform. According to Krause (1977), the grip of physicians on maintaining control of their work is weakening under pressure from new technology and new specialty occupations. The old craft-guild model is not up to controlling it all without some help from the state legislature. The help might follow the pattern of nurse licensing laws in which the nurse's subservience to the physician is written into the law (Krause, 1977), or new laws may be suggested that institutionalize the physician as the manager of a system of health service delivery. In these ways, then, "reform" aids the physician to adapt to the problem of role obsolescence. Still, licensing is the key.

Licensing and Quality

The link between licensing and competence is the basis for societal support for licensing arrangements. I have questioned that link. It is instructive to add the evidence that licensing does not seem to be effective in preventing incompetent practice, and in the specific case of medicine with which we are most concerned, there isn't much interest in the discipline of incompetent practitioners. Derbyshire (1969), a former president of the Federation of State Medical Boards, intensively studied the problem of discipline and estimated that 5% of America's doctors are unfit to practice. He also reported that 38 states do not even specify professional incompetence as a reason for disciplinary action.

The political nature of this problem is revealed by the contrasting views of the action of the state boards in the area of discipline. Derbyshire (1969) apparently conducted two studies of state board disciplinary actions. Referring to the first study, he is vague about the number of incompetents, but of the 1,000 disciplinary actions taken over a 5-year period, he says *many* were because of incompetence. He goes on to say,

> Critics have said this is not a significantly high number. But if one makes a modest estimate that each of these physicians treats an average of 800 new patients every year, this means that 800,000 people have fallen into the hands of unscrupulous or incompetent physicians during the five year period. Viewed in this light the "insignificant" figure assumes important proportions. (Derbyshire, 1969, p. vii)

Shryock (1967), also referring to the first study,

thinks the number is *not large* and wonders how effective the board actions were but concludes that "the medical members of the boards were making *some* effort at professional self-discipline in the public interest" (p. 114; emphasis added). Cohen (1973), on the other hand, referring to Derbyshire's (1969) later study of 938 board actions over a 4-year period says "*only* 400 were based upon some form of incompetence" (p. 3; emphasis added). Krause (1977), having reviewed studies of discipline, is not specific, but he takes a stronger stand: "The most striking finding of all studies is the near total avoidance of any policing of peers by the licensing board members even in cases of extreme malfeasance" (p. 284). Since physicians are autonomous, they can and do determine the extent to which professional incompetence is defined as a social problem. The lack of action on this problem indicates that it is to their self-interest to obscure the problem.

Board staffs, according to Cohen (1973), are inadequate to carry out investigations, and the statutory provisions for such investigations are marked by ambiguity and a lack of precision. Malpractice suits appear to be the only effective feedback technique available that is likely to affect the physicians' willingness to consult and to refrain from procedures for which they are unqualified (Klaw, 1975). Krause (1977) reports that one half of all surgical operations are performed by physicians untrained or inadequately trained in surgery. Since physicians are permitted under licensing laws to use procedures for which they have not been trained, the likelihood is that economic motives (earning higher fees, losing a patient to another doctor) will maintain the threat posed by the incompetent physician. Federally mandated Peers Standards Review Organizations pose more problems than prospects for change (Laptzin, 1974; Newman & Luft, 1974; Zitrin & Klein, 1976). Israel (1973) has commented, "Among the features hindering effective implementation (of the review process) is the tradition of autonomy in private practice, and the associated reluctance of physicians to interfere in each others' practices and to be publicly critical of each other" (p. 130).

There are some who see licensing as the determiner of incompetence. Illich (1973, 1976) has been articulate about health delivery systems creating dependency on physicians. This dependency, which reduces the ability of people to care for themselves, is joined with a mystification by which people ignore the possibility that they could care for themselves. Iatrogenic disease is a major factor in iatrogenic (physician-caused) illness, which is variously estimated (a) to include from 50% of all illness (Illich, 1976) to 20% of medical patients (Stuart, 1970), (b) to jeopardize one third of hospitalized patients (Walker, 1973), and (c) to more than double the length of hospital stays (Stuart, 1970). Those who want to see licensing laws changed to permit "paraprofessionals" to perform licensed medical functions describe licensing laws as restricting the productivity of personnel (Roemer, 1973), locking practitioners into activities prescribed by statute which are not in accord with their abilities (paraprofessionals can do many tasks better than physicians but are not permitted to), and escalating health care costs (Carlson, 1970).

The experience with deprofessionalization in the second quarter of the 19th century is viewed differently in different quarters. Tabachnik (1976) reports that in America, deprofessionalization stimulated the growth of medical schools, increased the number of doctors, raised average standards, and was not as bad as the then-leaders of American medicine expected it to be. Shryock (1967), on the other hand, treats it as a calamity—a time of rampant quackery and deterioration in the quality of practice. It is never clear in his analysis if quality is related to incompetence or to the social class and educational background of the physicians.

In summary, licensing arrangements do not seem to be providing the structure for effective solutions to the problems of delivering quality care in the health and helping services. Instead, the evidence overwhelmingly supports the conclusion that licensing maintains a structure that is in the self-interest of the service giver and in opposition to the public interest. Licensing actually results in the institutionalization of a lack of accountability to the public. This information may cause some to question a collusion between the state and the professions which is justified in altruistic terms but which appears not to merit public confidence. This information has not been introduced into any of the debates about licensing in the professional literature. Acknowledging this information can be the first step toward a clearer definition of the problem of how to protect the public and maintain professional integrity.

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HB

419

John Adcox
Newhalen CSC Chairman
Box # 6
Iliamna, Alaska 99606

Ms. Thelma Buckholdt
Chairman- Health, Education, Social Services
Alaska State Legislature
Pouch V Room 112
Capital Building
Juneau, Alaska 99811

Dear Ms. Buckholdt,

I would like to impress upon you, the importance of the passage of House Bill # 419.

At this time, Newhalen School is inadequately operating with the number of students enrolled. There are not enough classrooms, no library, inadequate gym, less than one half the size of a regular gym, shop too small to operate power tools already on hand and the kitchen for this number of students is entirely too small.

Ms. Buckholdt, we are not just saying this to try to get something that we don't really need. The things I've mentioned are real and urgently needed. House Bill # 419 would really make an improvement on the quality of education that our children could get. Just having MORE SPACE for a Science Lab, Library and Special Ed. facilities would really be a big help.

Presently, we're threatened with a law suit, because one Special Ed. Student doesn't have adequate space in which to be instructed. House Bill # 419 would help eliminate this problem.

So Ms. Buckholdt, I strongly and sincerely ask your help. Please help us with our problem. I am also calling on Rep. Nels Anderson and Gov. Jay Hammond for their support on this request.

I know this letter is brief, but I'm sure you're busy and this is why I've come right to the point.

SOUTHWORTH CO. U.S.A.
25% COTTON FIBER

Please feel free to call me at any t me. I also invite you to come to Newhalen and see for yourself the condition of our school. Our school needs help and H.B. would give us alot of help.

Thanks so much for your time and consideration Ms. Buckholdt and we'll look forward to hearing from you soon.

I Remain,
John Adcox
Newhalen CSC Chairman
Box # 6
Iliamna, Alaska 99606

RAGTRADE BOND
SOUTHWORTH CO. U.S.A.

April 17, 1979

HB 419

Ms. Thelma Buckholdt, Chairperson
Health, Education and Social Services
Alaska State Legislature
Pouch V
Room 112 Capitol Building
Juneau, Alaska 99811

Dear Ms. Buckholdt:

Due to the fact that the Newhalen/Iliamna Communities are growing quite rapidly at the present time we wish to express our complete support of House Bill 419. The additional financial support is a realistic need for the Newhalen/Iliamna High School.

We would certainly hope that the children in the bush are considered important enough to get this House Bill 419 and Senate Bill 199 approved. The monies would be well spent for a worthwhile cause.

Your support for HB 419 and SB 199 would be greatly appreciated.

Thank you for your consideration in this matter!

Respectfully,

Roy F. Erhart
Katherine S. Erhart

Roy F. and Katherine S. Erhart
Box 14
Iliamna, Alaska 99606
571-1234

HB 419

Bristol Bay Native Corporation
445 E. 5TH AVENUE / P.O. BOX 220 / ANCHORAGE, ALASKA 99510 / PH (907) 278-3602

March 9, 197[illegible]

The Honorable Thelma Buchholdt
Alaska State House of Representatives
Pouch V
State Capitol Building
Juneau, AK 99811

Dear Ms. Buchholdt:

The Bristol Bay Native Corporation supports Dillingham's efforts in getting a new elementary school building and remodeling of the high school. These facilities are badly needed in light of the present run-down conditions.

We urge that you make every effort to resolve these conditions.

Should you have any questions of me, please don't hesitate to contact me at 842-5261 in Dillingham.

Best regards,

Harold H. Samuelsen

Harold H. Samuelsen
President

cc: Mr. Oba
Gov. Hammond
Mr. Gardiner
Sen. Tillion
Sen. Sackett

file w/ HB 419

Alaska State Legislature

REPRESENTATIVE
NELS A. ANDERSON, JR.
BOX 234
DILLINGHAM, ALASKA 99576
HOME PHONE 842-5302

WHILE IN JUNEAU
POUCH V
JUNEAU, ALASKA 99811
PHONE 465-3738 OR 3739
HOME PHONE 789-7297

House of Representatives

March 12, 1979

MEMORANDUM

TO: HOUSE HESS

FROM: Representative Nels A. Anderson, Jr.

SUBJECT: Village School Concern

Enclosed are copies of letters I've received from the Iliamna-Newhaler communities on their concerns for their school.

Community School Committee
Newhalen, Alaska 99606

Representative Nels A. Anderson, Jr.
Alaska State Legislature
Pouch V
Juneau, Alaska 99811

Dear Nels,

We, the people of the Iliamna-Newhalen Communities, are writing to you expressing concern for our school.

We have alloted to us, from our school district, $930,000.00 for a new addition. After Architectual fees, soil samples and the many other expenses that come off the top, we will be working with approximately $730,000.00 for our new school. This would not permit us to have a regulation sized gym and this is one thing that we desperately need. Many sporting events composed of all the schools in our district are held here in Newhalen and there just isn't enough room. We also need more classroom space than what they're trying to give us, as many good courses can't be offered due to lack of space. This would not even be enough space so that we could havw a Library.

The concern is justified Mr. Anderson. Why build a building that you know is too small to begin with. Nondalton was given a 2½ to 3 Million Dollar school this past year and next year Newhalen will have more students enrolled than Nondalton. There are at least six new families moving into our immediate area this summer, and most of them have school age children.

Nels, there must be a way that you could help us obtain more funding for a bigger school. We have seen the educational bills that you've run through the Legislature, and you've really done an excellent job.

Nels, thanks for your time and concern while reviewing this letter, and I hope that there is some way that you can find to help our school out. Please feel free to visit our villages when you have the time.

Thanks again for your concern,

I Remain,

John Adcox
President--Newhalen Local C.S.C.

John Adcox

New people coming in
F. & G.

Iliamna Village Council
Iliamna, Alaska 99606
February 28, 1979

Representative Nels A. Anderson, Jr.
Alaska State Legislature
Pouch V
Juneau, Alaska 99811

Dear Mr. Anderson:

We, the Village Council of Iliamna, are asking for your support to acquire more funds for a school project in our area. We have been informed by our school district that we have available $930,000 for a gymnasium. After architectual fees are subtracted, we will have approximately $700,000. The square foot will cost about $145, giving us a gym three-quarter of the normal size.

Since our school has grown so fast (doubled in five years) and to all indications, will continue to grow as fast, we feel if we are going to have a gym built, it should be built to the proper size now.

As you know, village life can be pretty hard on our young people. With no other facilities to go to in the evenings and on week-ends for recreation, they have nothing but leisure time on their hands. This, many times, gives them more opportunities to get into drugs, alcohol, or other undesirable behavioral problems. Therefore, we strongly feel that a gym is not only a necessity during school, but after school as well.

Nondalton is a good example. The gym is used every night. The older people love going down just to sit and watch the younger people play ball.

There is so much we need here. A larger kitchen, a library, and more classrooms. We invite you to come and look over our school complex! You will see for yourself the future needs of this area.

Thank you for your good representation. We have looked over carefully all the bills you have sponsored, and feel confident you will be our greatest asset in acquiring the matching or supplemental funding that will be needed.

We are hoping to hear from you.

Sincerely,

Iliamna Village Council

President----------Trig Olsen

Vice-President---------Elia Anelon

Secretary----------Ethel Adcox

March 2,1979
Box 8
Iliamna,Ak 99606

Representative Nels A. Anderson
Alaska State Legislature
Pouch, State Capitol
Juneau, Alaska 99811

Dear Mr.Anderson:

I am writing you to express a concern I have about the Newhalen,Iliamna new high school. It is my understanting that approximately $1,300,000 was allocated for this project. It seems that the Lake & Peninsula School District has taken some of this money to use at a different site. Leaving us here in Newhalen,Iliamna with $930,000. This amount will not meet our present and future needs.

To my knowledge the Lake and Peninsula District has not made a needs assessment for our communities. The Community School Committee has tried in every way to let the School District know what the needs are but the District dosen*t seem to want to listen. The Superintendent was present during one meeting with the project director and the community.

Last year the School District put in a new 16* x 20* shop to serve 18 high school students and the district knew before they built it that it wouldn*t meet the studerts needs. At the same time they also put in a Multi-Purpose room for the total school which also didn*t meet the needs of the students. These two projects cost approximately $95,000.

Now they are trying to cut the budget for the new high school and put in something that won*t meet the needs of the students. I have always felt that the objective of the School District is to provide students with an education and facilities to accommodate a curriculum that will prepare our young people for later life.

It is my sincere hope that you can help us here in Newhalen, Iliamna recover the total money that was appropriated for the High School or help us locate additional money from another source so we can build a facility to meet the needs of the students rather than trying to piece mistakes together which never will meet their needs.

I am a member of the Newhalen, Iliamna Community School Committee and also a concerned parent. Any and all help you can give us will be appreciated. Thank you.

Sincerely,

F.C. Avril

F.C. Avril

HB
453

House Health, Education & Social Services Committee Meeting/Hearing on _____ Date: _____

	Name	Address and Phone	Organization/Self	For/Against or Observing
1/	Cherie Shelley	340 N Franklin Juneau 586-2334	APEA	HB 453
2/				
3/				
4/				
5/				
6/				
7/	Bob Munnerlyn	207 Seward Bldg Juneau 586-3090	NEA - Alaska	
8/	Bob Van Houten	207 Seward Bldg - JNU	NEA - AK	
9/	Bois Greene	204 No. FRANKLIN	AASIS	
10/	Ken Spray	114 2nd ST	Local 71	HB453 FOR
11/	Dale Cheek	Dept of Labor	BX 630 Juneau Ak 99811	HB 453
12/	Gayle Schoepflin	2970 Douglas Highway Juneau AK 99801	Seventh-day Adventist Church	HB 453 amend
13/				

STATE OF ALASKA
THE LEGISLATURE

LEGISLATIVE AFFAIRS AGENCY

POUCH Y - STATE CAPITOL
JUNEAU, ALASKA 99811
907-465-3800

M E M O R A N D U M January 30, 1980

SUBJECT: Analysis of certain school collective bargaining cases.

TO: Representative Thelma Buchholdt
Chairman, House HESS Committee

FROM: Billy G. Berrier
Director
Division of Legal Services

You have requested an analysis of Kenai Peninsula Borough v. Kenai Peninsula Ed, 572 P.2d 416 (Alaska 1977) and Kenai Peninsula Borough Sch. Dist. Etc, 590 P.2d 437 (Alaska 1979).

I am enclosing an analysis of the 1977 case from the Report of Examinations of Court Decisions, 1978 prepared by the Legislative Affairs Agency.

As an added note on the case, the Court expressed some dissatisfaction with AS 14.20.550 and AS 14.20.610 saying:

> "An examination of the other specific items listed above yields equally indefinite answers. We are confronted, then, with a situation in which the legislature has not spoken with clarity and concerning which we possess no expertise. We can only conclude that salaries, fringe benefits, the number of hours worked, and the amount of leave time are negotiable. In view of the concerns expressed on pages 419, 420 supra, we conclude that the other specific items listed on page 422 are, under the existing statutory language, non-negotiable.
>
> "It would be helpful if the legislature, through future enactments, provided more specific guidance on a number of the items which the unions seek to negotiate. Lacking that guidance, however, we cannot confidently say that the legislature intended any of these items to be bargainable. We cannot, therefore, read the statutes expansively as to the scope of what is negotiable."

The 1979 case involved the labor relations policy adopted by the Kenai Peninsula Borough School Board which included a provision that the District would not negotiate (1) with any individual who was not an employee of the School District nor (2) with an employee organization affiliated with any state or national labor union.

Two questions were involved. The first question was whether the restriction violated the rights of the employees under the first amendment to the United States Constitution.

The Court held that these restrictions on affiliation and choice of bargaining representative were unconstitutional. After examination of the facts and case law, the court stated:

> "As we read these decisions they posit a constitutional framework in which employees are free to organize and select an advocate, and from that guarantee of collective strength then lobby their various legislatures for particular rights in the employer/employee relationship. See, e.g., Atkins v. Charlotte, 296 F.Supp. 1068, 1077 (W.D.N.C. 1968). The virtue of that view is its consistent emphasis on freedom of action, and its antagonism to coercion. And within that perspective it does not follow at all, that once bargaining rights are successfully secured, as in the instant case, the constitutional rights disappear.
>
> "We affirm the superior court's judgment that the School District's policy restrictions on affiliation and choice of bargaining representative are violative of first amendment freedoms guaranteed to the non-certificated school employees."

The second question was whether these portions of the policy were severable, that is whether the remaining parts are so independent that it may be presumed that the district would have enacted the valid parts without regard to the invalid parts. The majority found the provision severable in context. Justice Rabinowitz dissented from this part of the decision finding the provisions "a paramount part of the structure upon which the Board's labor policy rested."

Copies of the decisions are enclosed.

BGB:jdn

Enclosures

KENAI PENINSULA BOROUGH SCHOOL DISTRICT, Appellant,

v.

KENAI PENINSULA BOROUGH SCHOOL DISTRICT CLASSIFIED ASSOCIATION, Appellee.

No. 3800.

Supreme Court of Alaska.

Feb. 16, 1979.

An association recognized by a school district as the employee bargaining agent brought suit to compel the district to resume negotiations. The State of Alaska Superior Court, Third Judicial District, Peter J. Kalamarides, J., granted summary judgment to the association, finding restrictive provisions on the school board's labor policy unconstitutional but severable. The school district appealed. The Supreme Court, Matthews, J., held that: (1) the school district's asserted interest in needing to exercise prospective control over vigor with which its noncertificated employees would be represented at the bargaining table was not a paramount interest which would override the fundamental right of employees to freely choose their representative, and the district's policy restrictions on affiliation and choice of bargaining representative were violative of the Fifth Amendment freedoms guaranteed to such employees, and (2) the unconstitutional restrictions were severable, leaving remainder of the policy intact and enforceable.

Affirmed.

Rabinowitz, J., dissented in part and filed opinion.

1. Constitutional Law ⇐91

Right of employees to self-organization and to select representatives of their own choosing without restraint or coercion by employer emanates from protections afforded by First Amendment. AS 23.40.250(5); National Labor Relations Act, § 2(2) as amended 29 U.S.C.A. § 152(2); U.S.C.A. Const. Amend. 1.

2. Labor Relations ⇐86, 88

Right to affiliate with union of one's choice is right of public employee as well as private employee. AS 23.40.070, 23.40.250(5); National Labor Relations Act, § 2(2) as amended 29 U.S.C.A. § 152(2); U.S.C.A. Const. Amend. 1.

3. Labor Relations ⇐88

Public employees are free to join national as well as local unions, and such freedom has been covered by state Public Employment Relations Act. AS 23.40.070, 23.40.250(5); National Labor Relations Act, § 2(2) as amended 29 U.S.C.A. § 152(2); U.S.C.A.Const. Amend. 1.

4. Labor Relations ⇐86

Employee's freedom in affiliation and his right to freely choose his or her representative at bargaining table are inseparable under National Labor Relations Act. AS 23.40.250(5); National Labor Relations Act, § 2(2) as amended 29 U.S.C.A. § 152(2).

5. Constitutional Law ⇐91
Labor Relations ⇐88

Right of school district's noncertificated employees to select representatives of their own choosing for collective bargaining, whether from local or national organizations, without restraint or coercion by the employer was grounded firmly in First Amendment. AS 23.40.070, 23.40.250(5); National Labor Relations Act, § 2(2) as amended 29 U.S.C.A. § 152(2); U.S.C.A. Const. Amend. 1.

6. Constitutional Law ⇐82(1)

Government may not confer statutory right or benefit and withdraw it when beneficiary exercises constitutional prerogative, nor may government confer right and condition it unconstitutionally in same breath. U.S.C.A.Const. Amend. 1.

7. Constitutional Law ⇐82(11)

Government may not require individual to relinquish rights guaranteed him by First Amendment as condition of public employment. AS 23.40.070, 23.40.250(5); National Labor Relations Act, § 2(2) as amended 29

U.S.C.A. § 152(2); U.S.C.A.Const. Amend. 1.

8. Labor Relations ⇐177

Test of constitutionality of school district's labor policy's restrictions was not rational relationship test, but, rather, to override presumpt. e First Amendment right, it was necessary that school district's interest be paramount interest of vital importance, and burden was on school district to show existence of such paramount interest. AS 23.40.070, 23.40.250(5); National Labor Relations Act, § 2(2) as amended 29 U.S.C.A. § 152(2); U.S.C.A.Const. Amend. 1.

9. Constitutional Law ⇐275(5)
Labor Relations ⇐88

School district's asserted interest in needing to exercise prospective control over vigor with which its noncertificated employees would be represented at bargaining table was not paramount interest which would override fundamental right of employees to freely choose their representative, and district's policy restrictions on affiliation and choice of bargaining representative were violative of First Amendment freedoms guaranteed to such employees. AS 23.40.070, 23.40.250(5); National Labor Relations Act, § 2(2) as amended 29 U.S.C.A. § 152(2); U.S.C.A.Const. Amend. 1.

10. Labor Relations ⇐364

In determining severability of school district's labor policy, portions of which had been found unconstitutional, it was necessary first to determine whether constitutional portions, standing alone, could be given legal effect, and secondly to identify primary purpose and determine whether such purpose could be achieved with invalid provisions stricken. AS 23.40.250(5).

11. Labor Relations ⇐364

Unconstitutional restrictions in school district's labor policy were severable, leaving remainder of policy intact and enforceable. AS 23.40.250(5).

Stephen C. Hillard, Allen McGrath, and Chris J. Rigos, of Graham & James, Anchorage, for appellant.

William Jermain, of Jermain, Dunnagan & Owens, Anchorage, for appellee.

OPINION

Before BOOCHEVER, C. J., and RABINOWITZ, CONNOR, BURKE and MATTHEWS, JJ.

MATTHEWS, Justice.

On February 17, 1975, the Kenai Peninsula Borough School Board adopted a comprehensive labor relations policy by which it bound itself to recognize and bargain collectively with an organization to be formed by a majority of the non-certificated school employees of the District, *e. g.*, secretarial, custodial, and cafeteria personnel. The policy stipulated that the District would not negotiate (1) with any individual who was not an employee of the School District, nor (2) with an employee organization affiliated with any state or national labor union.[1]

The appellee Association was duly organized and subsequently recognized by the District on February 21, 1977, as the employee bargaining agent. One month later, after negotiations had not progressed to its satisfaction, in part because the School District would not permit an employee consultant into the negotiating room, the Association affiliated with the Kenai Peninsula

1. The recognition paragraph of the policy reads:

> The Kenai Peninsula Borough School District will recognize, for the purpose of discussing and negotiating mutually satisfactory agreements on specified matters pertaining to their employment, the Kenai Peninsula Borough School District classified employee group which on a certain date has, as bona fide members, a majority of the total classified staff employed by the district on that date and which files a certified list of such members with the Superintendent of Schools. The Kenai Peninsula Borough School District will negotiate only with employees of the district. The Board will not recognize for the purpose of negotiations, any union or association which is not made up exclusively of Kenai Peninsula Borough School District employees nor will the Board negotiate with a local association affiliated with a state or national union.

Federation of Teachers, itself an affiliate of the American Federation of Teachers. The District then refused to negotiate further, demanding that the Association disaffiliate from the Kenai Peninsula Federation. The Association brought suit, seeking to compel the District to resume negotiations.

On September 19, 1977, Judge Peter J. Kalamarides granted summary judgment to the Association, finding the aforementioned restrictive provisions both unconstitutional and severable from the rest of the labor policy, and ordered the District to resume negotiations. The School District appeals from both judgments. We affirm.

I

It is conceded for purposes of this litigation that the right of the non-certificated school employees to compel their employer to bargain collectively arises solely out of the labor relations policy enacted by the District. These employees are not among those within the ambit of the National Labor Relations Act, 29 U.S.C. § 152(2) (1970), or the Alaska Public Employment Relations Act, AS 23.40.250(5), and the Association, in the face of much contrary authority, does not seek to establish such a right in the federal constitution. *See, e. g., University of New Hampshire Chap. of Am. Ass'n. of Univ. Profs. v. Haselton*, 397 F.Supp. 107, 109 (D.N.H.1975); *Atkins v. Charlotte*, 296 F.Supp. 1068, 1077 (W.D.N.C.1969).

The first question that confronts us then, is whether the School District can grant non-certificated employees the right to bargain collectively and simultaneously decree whom the employees may send to the bargaining table as their representative, and with whom they may affiliate to effectuate their right under the labor policy. We hold that the first amendment prohibits such restrictions.

[1] Forty-two years ago, the Supreme Court asserted that:

> [In] safeguard[ing] the right of employees to self-organization and to select representatives of their own choosing for collective bargaining or other mutual protection without restraint or coercion by their employer. . . . [the National Labor Relations Act goes no further than to safeguard] a fundamental right. . . . Hence the prohibition by Congress of interference with the selection of representatives for the purpose of negotiation and conference between employers and employees, 'instead of being an invasion of the constitutional right of either, was based on the recognition of the rights of both.'

NLRB v. Jones & Laughlin Steel Corp., 301 U.S. 1, 33–4, 57 S.Ct. 615, 622–623, 81 L.Ed. 893, 909–10 (1937) (citations omitted). The associational right so identified emanates from the protections afforded by the first amendment. *See Brotherhood of Railroad Trainmen v. Virginia*, 377 U.S. 1, 5, 84 S.Ct. 1113, 1116, 12 L.Ed.2d 89, 93 (1964).

[2, 3] It can no longer be disputed that the right to affiliate with the union of one's choice is the right of the public employee as well as the private employee. *Lontine v. VanCleave*, 483 F.2d 966, 967 (10th Cir. 1973); *Orr v. Thorpe*, 427 F.2d 1129, 1131 (5th Cir. 1970); *American Federation of State, County, & Munic. Employees v. Woodward*, 406 F.2d 137, 139 (8th Cir. 1969); *McLaughlin v. Tilendis*, 398 F.2d 287, 288 (7th Cir. 1968); *O'Brien v. Leidinger*, 452 F.Supp. 720 (E.D.Va.1978). *See Thomas v. Younglove*, 545 F.2d 1171, 1172 (9th Cir. 1976); *Lodge 1858, American Federation of Gov't. Employees v. Paine*, 141 U.S. App.D.C. 152, 164, 436 F.2d 882, 894 n.72 (1970). It is implicit in the cases just cited, that public employees are free to join a national as well as a local union, for in each case the petitioning employees had, in one manner or another, in fact affiliated with a national organization. *Accord, Atkins v. Charlotte*, 296 F.Supp. 1068 (W.D.N.C.1968). We have recognized that same freedom for employees covered by the Alaska Public Employment Relations Act, AS 23.40.070. *State v. Petersburg*, 538 P.2d 263, 267 (Alaska 1975).

[4, 5] We can find no sound basis for distinguishing an employee's freedom in affiliation from the right to freely choose his

or her representative at the bargaining table. The two are inseparable under the National Labor Relations Act, *see General Electric Co. v. NLRB*, 412 F.2d 512, 517 (2d Cir. 1969), in the Supreme Court's identification of fundamental rights in *NLRB v. Jones, supra*, and would seem to be similarly inseparable in fact. A powerful incentive in affiliating with a national union is the effective advocacy thereby secured. Governmental interference with a labor organization's ability to effectively assert its members' legal rights has been held to be an unconstitutional impairment of associational freedoms. *United Mine Workers v. Illinois State Bar Ass'n.*, 389 U.S. 217, 221–222, 88 S.Ct. 353, 355–356, 19 L.Ed.2d 426, 430–1 (1967); *Brotherhood of Railroad Trainmen*, 377 U.S. at 6, 84 S.Ct. 1113, 12 L.Ed.2d at 93. We thus find the conclusion inescapable that the right of the District's non-certificated employees to "select representatives of their own choosing for collective bargaining," be they from local or national organizations, "without restraint or coercion by their employer," is grounded firmly in the first amendment. *NLRB v. Jones, supra.*

[6, 7] The School District does not dispute this conclusion. Instead it argues that the employees represented by the Association are still quite free to join the Kenai Federation. All they cannot do is both affiliate and retain the "privilege" to bargain collectively.

Essentially the District is reiterating Holmes' observation that "[t]he petitioner may have a constitutional right to talk politics, but he has no constitutional right to be a policeman." *McAuliffe v. Mayor of New Bedford*, 155 Mass. 216, 29 N.E. 517 (1892). In the first amendment area the distinction between right and benefit has long been dead. A government may not confer a statutory right or benefit and withdraw it when the beneficiary exercises a constitutional prerogative. Neither may it confer a right and condition it unconstitutionally in the same breath. Numerous cases in the past twenty-five years have made these propositions irrebuttable. *See, e. g. Elrod v. Burns*, 427 U.S. 347, 361, 96 S.Ct. 2673, 2683, 49 L.Ed.2d 547, 558 (1976), and the cases cited therein. *Accord, State v. Wylie*, 516 P.2d 142, 146 (Alaska 1973). As the Supreme Court recently stated in *Abood v. Detroit Board of Education*, 431 U.S. 209, 234, 97 S.Ct. 1782, 1799, 52 L.Ed.2d 261, 283 (1977):

> [A] government may not require an individual to relinquish rights guaranteed him by the First Amendment as a condition of public employment.

[8] The District is thus left with the task of persuading us that the interests embodied in the labor policy's restrictions outweigh the value of the associational freedoms impinged. The School District would have this court scrutinize its restrictive provisions only for a "rational relationship" to the interests it asserts are at stake here. But a "rational connection . . . will not suffice." *Thomas v. Collins*, 323 U.S. 516, 530, 65 S.Ct. 315, 322, 89 L.Ed. 430, 440 (1945). To override a presumptive first amendment right the School District's interest must be "paramount, one of vital importance." *Elrod*, 427 U.S. at 362, 96 S.Ct. at 2684, 49 L.Ed.2d at 559; *Woodward*, 406 F.2d at 140; *McLaughlin*, 398 F.2d at 290. And even if the School District's "purpose be legitimate and substantial, that purpose cannot be pursued by means that broadly stifle fundamental personal liberties when the end can be more narrowly achieved." *Shelton v. Tucker*, 364 U.S. 479, 488, 81 S.Ct. 247, 252, 5 L.Ed.2d 231, 237 (1960).

The burden is on the School District to show the existence of such a paramount interest. *See Elrod*, 427 U.S. at 362, 96 S.Ct. 2673, and the cases cited therein. In its argument below the School District justified the non-affiliation provision by its interest in avoiding negotiations "conducted by outsiders." In this court it has added others: avoiding the 'rigidity in demands," the escalation of "employee relations tensions," and the "test cases" mind-set allegedly characteristic of national unions. Since "uniquely local interests" are involved, the District desires "negotiations

[that] are uniquely local in character." Finally, it argues that as a public employer it must be allowed to recognize that "[s]trong union demands may either exceed the capacity of the democratically-controlled budget process . . . or they may overwhelm a management negotiator not constrained by ordinary 'profit' motivations."

[9] The essence of the District's asserted interest is that it needs to exercise prospective control over the vigor with which its non-certificated employees will be represented at the bargaining table. We can see in this no more than a bald assertion that will lead to too much labor unrest if public employees are permitted to exercise their first amendment rights. We rejected such a contention with regard to public employees covered by the Public Employment Relations Act, *State v. Petersburg, supra*, and we reject the contention here. To construe the School District's interest here as so paramount as to override the fundamental right to freely choose one's representatives, would render the latter right illusory, for it is difficult to imagine a context in which public employees could then successfully assert it.[2]

In contending that it should be permitted to constrict the Association's effectiveness as it sees fit, the School District points to the many decisions finding that public employees cannot compel collective bargaining without statutory authority, and to those permitting restraints on the right to strike. However, those cases which uphold the aforementioned restraints take great pains to distinguish the rights in issue here.

> The right to strike, because of its more serious impact upon the public interest, is more vulnerable to regulation than the right to organize and select representatives for lawful purposes of collective bargaining which this Court has characterized as a 'fundamental right' and which, as the Court has pointed out, was recognized as such in its decisions long before it was given protection by the Labor Relations Act.

International Union Local 232 v. Wisconsin Employment Relations Board, 336 U.S. 245, 259, 69 S.Ct. 516, 52[illegible], 93 L.Ed. 651, 666 (1948) (citations omitted). *See also United Federation of Postal Clerks v. Blount*, 325 F.Supp. 879, 883 (D.D.C.), *aff'd mem.*, 404 U.S. 802, 92 S.Ct. 80, 30 L.Ed.2d 38 (1971).

As we read these decisions they posit a constitutional framework in which employees are free to organize and select an advocate, and from that guarantee of collective strength then lobby their various legislatures for particular rights in the employer/employee relationship. *See, e. g., Atkins v. Charlotte*, 296 F.Supp. 1068, 1077 (W.D. N.C.1968). The virtue of that view is its consistent emphasis on freedom of action, and its antagonism to coercion. And within that perspective it does not follow at all, that once bargaining rights are successfully secured, as in the instant case, the constitutional rights disappear.

We affirm the superior court's judgment that the School District's policy restrictions on affiliation and choice of bargaining representative are violative of first amendment freedoms guaranteed to the non-certificated school employees.

II

[10] Having decided that portions of the School District's labor policy are unconstitutional, we must now decide whether these may be severed, leaving the remainder of the policy intact and enforceable.

In determining questions of severability, we make two inquiries. *Lynden Transport, Inc. v. State*, 532 P.2d 700 (Alaska 1975). First we must determine whether the unconstitutional portions of the policy, standing alone, can be given legal effect. *Id.* at 713. The School District concedes that they can, and no further discussion is necessary.

2. We note that the District has incorporated in its labor policy other means of dealing with the problems it fears a strong union will create, means which do not impinge on associational freedoms. For example, the labor policy forbids all forms of work stoppages, significantly constricts the scope of mandatory bargaining subjects, and stipulates that any agreement reached by the negotiators will only be advisory to the school board.

Second, we must identify the primary purpose of the labor policy, and determine whether this purpose can be achieved with the invalid provisions stricken. *Id.* at 714–15. "The test . . . is whether the remaining parts are so independent and complete that it may be presumed that the [School District] would have enacted the valid parts without regard to the invalid part." *Jefferson v. State*, 527 P.2d 37, 41 (Alaska 1974). It is not dispositive that the stricken portions constitute a fragment of a paragraph. *Lynden Transport, supra; Speidel v. State*, 460 P.2d 77 (Alaska 1969).

[11] We find that the primary purpose of the labor policy is stated in its preamble:

> [T]he Board wishes to maintain its long tradition of fair play with its employees by enacting a policy which will set the stage for harmonious and cooperative relations between the Board and its classified employees and to protect the public by assuring orderly and uninterrupted operations of the district.

After striking only the unconstitutional restrictions of the policy, the superior court concluded that the purpose articulated in the preamble could still be fulfilled. We concur.

The policy adopted by the school board contains more than just the language authorizing collective bargaining and limiting affiliation rights. The recognition paragraph states that the association may not limit membership on the basis of race, religion, creed, sex, or marital status. It prohibits making membership in the association or payment of dues a condition of employment. It prohibits strikes or slowdowns by association members and requires that the association assist in preventing these where possible. Beyond the recognition section, other sections of the labor policy lay down the conditions an association must meet before it will be deemed by the school board to have been authorized by the school employees to represent them. The section titled "Scope of Bargaining" narrowly limits what the association can discuss in negotiations, and prohibits negotiations on "inherent managerial policy", which includes but is not limited to

> the functions and programs of the Board, standards of services, the district budget, utilization of technology, the organizational structure of the schools and the selection and direction of personnel, including work hours, assignments, transfers, job descriptions, promotions based on merit with seniority a secondary factor, the determination of other hiring and dismissal or demotion procedures.

Other sections of the policy cover, among other things, what will happen if the parties cannot agree in negotiations, disputes procedures, and the duration of any labor agreement. All of these provisions of the labor policy apply regardless of whether the association is affiliated with a non-local organization or not.

Given the detailed nature of the labor relations policy when read as a whole, we conclude that the superior court properly found that the non-affiliation clause is severable. The primary purpose of the policy is clearly stated in the preamble. There the school board said that it wished to preserve "harmonious relations" with its classified employees and assure smooth operation of the school district. Although the non-affiliation clause may be considered an important part of the structure the board created to achieve these goals, deleting the clause will leave virtually all of the labor policy intact. Since the school board obviously considered collective bargaining important to the maintaining of good relations with its classified employees, we cannot assume that it would not have enacted the constitutional portions, had it known that two restrictions would be found unconstitutional.

AFFIRMED.

RABINOWITZ, Justice, dissenting in part.

I am in agreement with the court's holding that those portions of the School District's labor policy which place restrictions on affiliation and choice of bargaining representative are violative of the first amendment rights of non-certificated school em-

ployees. My disagreement with the court's opinion centers on the majority's conclusion that the non-affiliation clause is severable.

In discussing presumptions of separability and inseparability in *Lynden Transport, Inc. v. State*, 532 P.2d 700, 711–12 (Alaska 1975), we quoted, with approval from *Carter v. Carter Coal Co.*, 298 U.S. 238, 312, 56 S.Ct. 855, 873, 80 L.Ed. 1160, 1189 (1936), where the Supreme Court said in part:

> Under the statutory rule, the presumption must be overcome by considerations which establish 'the clear probability that the invalid part being eliminated the Legislature would not have been satisfied with what remains.'

In my view, non-affiliation is a paramount part of the structure upon which the Board's labor policy rested. Before the remainder of the policy had any applicability, the employees' organization had to meet the recognition requirement. I think it apparent that the non-affiliation clause was intended as a mandatory requirement for it embodies one of the two explicit requirements found in the recognition paragraph—the other being proof of majority representation. Thus, I conclude that it cannot be fairly said that the Board viewed the non-affiliation requirement as severable, "independent," or "non-essential." [1]

1. In short, I have concluded that the burden of proof adopted in *Lynden Transport, Inc. v. State*, 532 P.2d 700, 711–12 (Alaska 1975), as applied in the instant case, leads to the result that the non-affiliation clause was not severable. In reaching this conclusion, I assume arguendo that there is a statutory presumption of severability with regard to the Board's labor policy, but find that the record establishes the "clear probability" that the Board "would not have been satisfied" with the labor policy without the non-affiliation clause.

KENAI PENINSULA BOROUGH SCHOOL DISTRICT and Kenai Peninsula Borough, Appellants,

v.

KENAI PENINSULA EDUCATION ASSOCIATION, Appellee.

ANCHORAGE BOROUGH EDUCATION ASSOCIATION, Appellant,

v.

GREATER ANCHORAGE AREA BOROUGH, ANCHORAGE BOROUGH SCHOOL DISTRICT, Appellee.

MATANUSKA-SUSITNA SCHOOL DISTRICT, Appellant,

v.

MATANUSKA-SUSITNA EDUCATION ASSOCIATION, Appellee.

Nos. 2470, 2492 and 2563.

Supreme Court of Alaska.

Dec. 9, 1977.

In two separate actions, teachers' associations sued school district and boroughs to compel collective bargaining in good faith. In third action, school board sought declaratory judgment that certain issues were not bargainable. Appeals were taken from judgments of the Supreme Court, Third Judicial District, Kenai and Anchorage District, James A. Hanson, Victor D. Carlson and C. J. Occhipinti, JJ., ruling in favor of school boards in one action, in favor of teachers' union in another, and in third action, in favor of board on some issues and union on others. The Supreme Court, Connor, J., held that: (1) salaries, fringe benefits, number of hours worked and amount of leave time are negotiable and (2) relief from nonprofessional chores, elementary planning time, paraprofessional tutors, teacher specialists, teacher's aides, class size, pupil-teacher ratio, teacher ombudsman, teacher evaluation of administrators, school calendar, election of instructional materials, use of secondary department heads, secondary teacher preparation and planning time and teacher representation on school board advisory committees are nonnegotiable.

Affirmed in part, reversed in part.

1. Labor Relations ⇐178

Questions concerning public school teachers' salaries, number of hours to be worked and amount of leave time are all so closely connected with economic well-being of individual teacher that they are negotiable and subject to collective bargaining under statutes governing negotiation with certificated employees and legal responsibilities of school board. AS 14.20.550, 14.20.610.

2. Labor Relations ⇐178

Following specific items pertaining to public school teachers are, under existing statutory language, nonnegotiable: relief from nonprofessional chores; elementary planning time; paraprofessional tutors; teacher specialists; teacher's aides; class size; pupil-teacher ratio; teacher ombudsman; teacher evaluation of administrators; school calendar; selection of instructional materials; use of secondary department heads; secondary teacher preparation and planning time, and teacher representation on school board advisory committees. AS 14.20.550, 14.20.610.

3. Labor Relations ⇐179

As to matters which affect educational policy and are therefore not negotiable, there is implicit in statutes governing negotiation with certificated employees and legal responsibilities of school board intention that school boards meet and confer with union and it is desirable that boards consider teacher proposals on such questions. AS 14.20.550, 14.20.610.

4. Statutes ⇐216

Even if it were placed in evidence, reliance upon privately expressed opinion is

letter of a former legislator in construing statutes governing negotiation with certificated employees and legal responsibilities of school board would be impermissible, and therefore resort to letter as means of legal interpretation was therefore error in action in which collective bargaining requirements for public school teachers was in issue. AS 14.20.550, 14.20.610.

Allen McGrath and John R. Snodgrass, Jr., of Graham & James, Anchorage, for School Districts.

John R. Strachan, Anchorage, for Education Associations.

Before BOOCHEVER, Chief Justice, and RABINOWITZ, CONNOR, ERWIN and BURKE, Justices.

CONNOR, Justice.

These cases present important questions of labor law and constitutional law concerning the collective bargaining requirements for teachers in the public schools. Two of these cases are before us because the teachers' associations (the unions) have sued school districts and boroughs (the school boards) to compel collective bargaining in good faith under AS 14.20.550. In the third, a school board seeks a declaratory judgment that certain issues are not bargainable. The school boards, while not disputing the unions' right to collective bargaining on a number of employment-related issues, contend that they should not be forced to bargain collectively on various items which they regard as affecting educational policy. Educational policy, the school boards contend, must be determined only by the public through the legislature and, by delegation, through the school boards. We will examine the more specific issues later in this opinion. They include such items as class size and the use of teacher specialists and para-professionals. Of the three trial courts which passed on the matter, one ruled in favor of the school boards,[1] one ruled in favor of the teachers' union,[2] and one split the various items, ruling for the board on some and the unions on others.[3]

I. *Introduction*

To facilitate the understanding of our more detailed legal discussion later in this opinion, we will summarize at the outset the contentions of the parties. The statutes at issue in this litigation are AS 14.20.550 and .610, which provide:

"Sec. 14.20.550. *Negotiation with certificated employees.* Each city, borough and regional school board, shall negotiate with its certificated employees in good faith on matters pertaining to their employment and the fulfillment of their professional duties. (§ 1 ch 18 SLA 1970; am § 3 ch 71 SLA 1972; am § 21 ch 124 SLA 1975)."

"Sec. 14.20.610. *Legal responsibilities of boards.* Nothing in §§ 550–600 of this chapter may be construed as an abrogation or delegation of the legal responsibilities, powers, and duties of the school board including its right to make final decisions on policies. (§ 1 ch 18 SLA 1970)."

The boards contend, using labor cases from the private sector, that the requirement of collective bargaining in good faith is a term of art in labor law. Unlike a simple "meet and confer" requirement, to negotiate in "good faith" entails a duty to make concessions. Thus, management does

1. *Anchorage Borough Ed. Ass'n v. GAAB. Anchorage Borough School Dist.*, No. 2492 (hereinafter Anchorage).

2. *Kenai Pen. Borough Sch. Dist. and Kenai Pen. Borough v. Kenai Pen. Ed. Ass'n*, No. 2470 (hereinafter Kenai).

3. *Matanuska-Susitna Sch. Dist. v. Matanuska-Susitna Ed. Ass'n*, No. 2563 (hereinafter Mat-Su).

not have the final decisions on matters subject to good faith collective bargaining, since if management adheres to its determined policies, it violates the law.

The school boards contend that the submission of educational policies to a good faith collective bargaining requirement would remove the final decisions on such matters from the boards, contrary to the intent of the legislature expressed in AS 14.20.610. The boards contend that to require bargaining on questions of educational policy would also contravene the Alaska Constitution, art. VII, § 1, which makes education the exclusive domain of the legislature.[4] *See Macauley v. Hildebrand*, 491 P.2d 120 (Alaska 1971). Delegation of part of the decision-making power on educational policy to labor unions is unconstitutional, they urge, because the union is a private organization, unaccountable to the public. The union can use the power for its own ends, and is under no duty to foster educational policies which are in the general public interest.

The unions argue that such delegation is perfectly proper, and that there is no delegation of decision-making power inherent in a labor negotiations requirement. They further argue that they represent professional employees, and that their participation in good faith collective bargaining labor negotiations is an attempt by the legislature to provide professional advice to school boards on the management of the schools. They assert that this is a legislative policy judgment, in no way inimical to the Alaska Constitution. Also relying on labor cases, they discount the importance of any "management prerogative" to determine educational policy under AS 14.20.610, and assert that labor's concerns with working conditions override any management prerogative as to basic policy.

The unions argue that the Alaska teachers' collective bargaining statutes are more comprehensive than those found elsewhere, and hence the scope of bargaining should be interpreted broadly. The school boards assert that the Alaska Constitution as interpreted in *Macauley v. Hildebrand, supra*, is more adamant than provisions in other states in placing education firmly within the legislative prerogative. Therefore, collective bargaining must yield across a wide range of issues affecting educational policy.

II. *Scope of the Duty to Bargain*

If we were to look to the law concerning bargaining between labor unions and private employers, we would conclude that the scope of negotiable issues is broad. The law relating to the private sector has always contained, and still does contain, uncertainties. But the general trend has been to require that employers bargain in good faith on a wide range of items with respect to wages, hours, and other conditions of employment, without regard to whether the employers consider the items bargained for to be within the prerogatives of management.[5] Moreover, some cases hold that for an employer or a union to avoid being found to have bargained in bad faith, the parties must make some reasonable effort to compose their differences. While the good faith standard of collective bargaining

4. Alaska Constitution, art. VII, § 1 states:
"The legislature shall by general law establish and maintain a system of public schools open to all children of the State, and may provide for other public educational institutions. Schools and institutions so established shall be free from sectarian control. No money shall be paid from public funds for the direct benefit of any religious or other private educational institution."

5. *Fibreboard Paper Products Corp. v. N. L. R. B.*, 379 U.S. 203, 85 S.Ct. 398, 13 L.Ed.2d 233 (1964) (management decision to subcontract out the work of some employees must be bargained); *International Ladies' Garment Workers Union v. N. L. R. B.*, 150 U.S.App.D.C. 71, 463 F.2d 907 (1972) (decision to relocate the business to another state subject to bargaining); *Royal Typewriter Co.*, 209 N.L.R.B. 1006, 1012 (1974) (decision to close a plant subject to bargaining). *But see General Motors Corp.*, 191 N.L.R.B. 951 (1971), *aff'd sub nom., International Union, United Auto. A. & A. Imp. Wkrs. v. N. L. R. B.*, 152 U.S.App.D.C. 274, 277, 470 F.2d 422, 425 (1972) (decision to sell part of business not bargainable).

does not compel either party to make concessions, intransigent positions, adopted in an effort to avoid any agreement, are disfavored.[6] Thus a legal determination that a matter is subject to good faith collective bargaining may narrow the policy-making powers of an employer by curtailing any absolute directives on his part.

When we turn to employment in the public sector, and particularly in education, the question of what is properly bargainable is thrown into more doubt. If teachers' unions are permitted to bargain on matters of educational policy, it is conceivable that through successive contracts the autonomy of the school boards could be severely eroded, and the effective control of educational policy shifted from the school boards to the teachers' unions. Such a result could threaten the ability of elective government officials and appointive officers subject to their authority, in this case the school boards and administrators, to perform their functions in the broad public interest.[7]

Recently the United States Supreme Court had occasion to comment upon the differences between collective bargaining in the public and private sectors. In *Abood v. Detroit Board of Education*, 431 U.S. 209, 227–28, 97 S.Ct. 1782, 1795–96, 52 L.Ed.2d 261, 279–80 (1977), the Court, speaking through Mr. Justice Stewart, observed:

> "A public employer, unlike his private counterpart, is not guided by the profit motive and constrained by the normal operation of the market. Municipal services are typically not priced, and where they are they tend to be regarded as in some sense 'essential' and therefore are often price inelastic. Although a public employer, like a private one, will wish to keep costs down, he lacks an important discipline against agreeing to increases in labor costs that in a market system would require price increases. A public-sector union is correspondently less concerned that high prices due to costly wage demands will decrease output and hence employment.
>
> The government officials making decisions as the public 'employer' are less likely to act as a cohesive unit than are managers in private industry, in part because different levels of public authority—department managers, budgetary officials, and legislative bodies—are involved, and in part because each official may respond to a distinctive political constituency. And the ease of negotiating a final agreement with the union may be severely limited by statutory restrictions, by the need for the approval of a higher executive authority or a legislative body, or by the commitment of budgetary decisions of critical importance to others.
>
> Finally, decisionmaking by a public employer is above all a political process. The officials who represent the public employer are ultimately responsible to the electorate, which for this purpose can be viewed as comprising three overlapping classes of voters—taxpayers, users of particular government services, and government employees. Through exercise of their political influence as part of the electorate, the employees have the opportunity to affect the decisions of government representatives who sit on the other side of the bargaining table. Whether these representatives accede to

6. *Sign and Pictorial Union Local 1175 v. N. L. R. B.*, 136 U.S.App.D.C. 144, 149, 419 F.2d 726, 731 (D.C.Cir. 1969); *N. L. R. B. v. General Electric Co.*, 418 F.2d 736, 756–62 (2d Cir. 1969), *cert. denied*, 397 U.S. 965, 90 S.Ct. 995, 25 L.Ed.2d 257 (1970); *N. L. R. B. v. McLane Co.*, 405 F.2d 483, 484 (5th Cir. 1968); *N. L. R. B. v. Reed & Prince Mfg. Co.*, 205 F.2d 131, 134–35 (1st Cir. 1953), *cert. denied*, 346 U.S. 887, 74 S.Ct. 139, 98 L.Ed. 391 (1953) ("the employer is obliged to make *some* reasonable effort in *some* direction to compose his differences with the union"; emphasis in original); *Majure v. N. L. R. B.* 196 F.2d 735 (5th Cir. 1952). *See generally* Swerdlow, Freedom of Contract in Labor Law, 51 *Tex.L.Rev.* 1 (1972).

7. As one commentator has noted, "what is in the best interest of the students and the community is not always in the best interests of teachers." Rund, Symposium on Teacher Bargaining: Commentary, 50 *Ind.L.J.* 344, 350 (1975).

a union's demands will depend upon a blend of political ingredients, including community sentiment about unionism generally and the involved union in particular, the degree of taxpayer resistance, and the views of voters as to the importance of the service involved and the relation between the demands and the quality of service."

In a concurring opinion in that case Mr. Justice Powell noted the similarity between a public sector union and a conventional political party:

"The ultimate objective of a union in the public sector, like that of a political party, is to influence public decisionmaking in accordance with the views and perceived interests of its membership. Whether a teachers' union is concerned with salaries and fringe benefits, teacher qualifications and in-service training, pupil-teacher ratios, length of the school day, student discipline, or the content of the high school curriculum, its objective is to bring school board policy and decisions into harmony with its own views. Similarly, to the extent that school board expenditures and policy are guided by decisions made by the municipal, state and federal governments, the union's objective is to obtain favorable decisions—and to place persons in positions of power who will be receptive to the union's viewpoint. In these respects, the public sector union is indistinguishable from the traditional political party in this country."

431 U.S. at 256, 97 S.Ct. at 1810, 52 L.Ed.2d at 298.[8]

The legislature was evidently cognizant of this concern when it enacted AS 14.20.550 and .610, stating two goals which apparently conflict. We must now proceed to interpret what we believe the legislature meant by these provisions.

The school boards initially argue that to make matters of school operation and educational policy subject to collective bargaining amounts to an unconstitutional delegation of governmental power to the unions.

While courts in an earlier era often held laws unconstitutional on the ground that they delegated legislative power to private persons or groups, *e. g., Carter v. Carter Coal Co.*, 298 U.S. 238, 311, 56 S.Ct. 855, 80 L.Ed. 1160 (1936), the trend has been to uphold such delegations, even when the power is delegated to a group with an economic interest in the decisions to be made. *E. g., United States v. Rock Royal Cooperative, Inc.*, 307 U.S. 533, 577–78, 59 S.Ct. 993, 83 L.Ed. 1446 (1939) (cooperative marketing program from agricultural products); *Agricultural Prorate Comm'n v. Superior Court*, 5 Cal.2d 550, 55 P.2d 495, 504–06 (Cal.1936) (same); *Potter v. New Jersey Supreme Court*, 403 F.Supp. 1036, 1039–40 (D.N.J. 1975), *aff'd*, 546 F.2d 418 (3d Cir. 1976) (requirement that attorneys have graduated from law schools accredited by the American Bar Association). *See generally*,

8. The holding of the majority in *Abood* was that a union shop or agency shop agreement for public employees, requiring all employees in the bargaining unit to make financial contributions to the union, did not violate the first amendment rights of employees who objected to the union. The same rule obtains for unions in the private sector. Although Justice Powell concurred in the majority's decision to remand the case for further proceedings, he disagreed with this constitutional holding. Unlike the majority, he felt that the differences between public and private employment compelled a holding that agency shop or union shop agreements in the public sector are forbidden by the first amendment.

See generally Rehmus, Constraints on Local Governments in Public Employee Bargaining, 67 *Mich.L.Rev.* 919 (1969); Shaw and Clark, The Practical Differences Between Public and Private Sector Collective Bargaining, 19 *U.C.L.A.L.Rev.* 867 (1972); Summers, Public Sector Bargaining: Problems of Government Decisionmaking, 44 *U.Cinn.L.Rev.* 669 (1975); Summers, Public Employee Bargaining: A Political Perspective, 83 *Yale L.J.* 1156 (1974); Wellington & Winter, The Limits of Collective Bargaining in Public Employment, 78 *Yale L.J.* 1107 (1969); Project, Collective Bargaining and Politics in Public Employment, 19 *U.C.L.A.L.Rev.* 887, 1010-51 (1972).

1 K. Davis, Administrative Law Treatise § 2.14 (Supp.1970) (collecting cases). *See also* 1 *Id.* § 2.15 (1958).

Furthermore, the statute merely requires the school board to negotiate with the union. It does not require the board to accept any particular proposal the union might offer. It does not require, and probably does not permit, the board to delegate to the union the sole power to make any decision. Therefore, cited cases invalidating outright grants of governmental power to private groups, *e. g., Hetherington v. McHale*, 458 Pa. 479, 329 A.2d 250 (1974), and *Bayside Timber Co. v. Bd. of Supervisors*, 20 Cal.App.3d 1, 97 Cal.Rptr. 431 (1971), are not apposite.

The cases in other states rejecting the argument that collective bargaining with teachers' unions is an unconstitutional delegation of power, all involve statutes which fairly narrowly constrict either the scope of bargainable issues, or the school boards' duty to accede to union proposals, or both. *Chicago Div. of Ill. Ed. Ass'n v. Board of Ed.*, 76 Ill.App.2d 456, 222 N.E.2d 243, 251 (1966); *Joint School Dist. No. 8 v. Wisc. Emp. Rel. Bd.*, 37 Wis.2d 483, 155 N.W.2d 78, 83 (1967); *State v. City of Laramie*, 437 P.2d 295, 300 (Wyo.1968) (firemen). In this opinion, we similarly construe the Alaska statute. A statute defining the scope of collective bargaining as broadly as the union would have us do, might well present a more troubling constitutional question. But we find no constitutional infirmity in AS 14.20.550 and .610. The delegation of power problem still bears upon our task of statutory interpretation, however, for in interpreting the relevant statutes we will not readily assume that the legislature intended to divest the school boards of their power to determine matters of educational policy and school system management.

Courts in other jurisdictions have considered problems similar to those which we confront here. It is instructive, though not determinative, to look to the case law of other jurisdictions as an aid to interpretation.

The court in *Dunellen Bd. of Education v. Dunellen Ed. Ass'n*, 64 N.J. 17, 311 A.2d 737 (1973), dealt with a conflict between a requirement to bargain about "terms and conditions" of employment (without further definition) and the broad managerial power over schools entrusted to local school boards. The court noted that "terms and conditions" of employment without further definition does not furnish a dispositive guideline. It held that the decision whether to consolidate chairmanships of the social studies department and English department was not a subject of mandatory bargaining. It was a matter predominately of educational policy and thereby fell within the exclusive prerogative of management.[9]

National Ed. Ass'n of Shawnee Mission, Inc. v. Board of Ed., 212 Kan. 741, 512 P.2d 426 (1973), is closely analogous to the case at bar. There the teachers' association negotiated under a statute which permitted it to "participate in professional negotiation with boards of education . . . for the purpose of establishing, maintaining, protecting or improving terms and conditions of professional service." The state constitution, like Alaska's, gave the legislature the power to provide for public schools. The negotiations reached an impasse after the board took the position that all matters, whether negotiable under the statute or not, were of a policy nature subject to unilateral change by the board and could not be incorporated into a contract, while the teachers asserted that nearly everything pertaining to school operations was negotiable.

9. The teachers' unions in the case at bar argue that *Dunellen* was overruled by later legislation. The statute in question dealt with only a limited aspect of bargaining; and *Dunellen* has been followed by the courts despite the statutory amendment. *See, e. g., Galloway Tp. Bd. of Ed. v. Galloway Tp. Ed. Ass'n*, 135 N.J.Super. 269, 343 A.2d 133 (1975).

On appeal the Kansas Supreme Court was confronted with the same problem that we are: how to frame a test which would delimit those matters which are bargainable from those which are not. The Kansas court held that salaries, vacations, and sick leave are negotiable. In so doing it pointed out that the term "policy" is not helpful, because even salaries are a matter of policy. It drew the following distinction:

> "The key, as we see it, is how direct the impact of an issue is on the well-being of the individual teacher, as opposed to its effect on the operation of the school system as a whole." 512 P.2d at 435.

While the *Shawnee Mission* case represents a commendable attempt to balance competing claims, it does not provide a test which is useful in determining the negotiability of specific subjects. In other words, it does not provide any comforting guidance in determining how, in the last analysis, the balance should be weighed between the school boards and the teachers.

Put another way, a matter is more susceptible to bargaining the more it deals with the economic interests of employees and the less it concerns professional goals and methods. Bargaining over the latter topics presents particular problems because there is less likely to be any politically organized interest group other than the union concerned with these issues. The salaries of public employees have a direct financial effect on the taxpayers; on the other hand, a question such as teacher evaluation of administrators is unlikely to have any impact sufficiently direct to be discernible by laymen. Furthermore, it is such an abstract and abstruse subject that it is unlikely that any appreciable portion of the public will either understand it or care greatly about it. In such circumstances, the risk that effective power over the governmental decision will come to rest with the union is significantly greater. Moreover, it is more likely that there will be disagreements among union members on questions of this nature than on "bread and butter" issues; the risk that minority viewpoints within the union will not be meaningfully represented in the bargaining is a real one. *See* Summers, *supra*, 83 *Yale L.J.* at 1181–82, 1194–95. *But see* Wollett, The Coming Revolution in Public School Management, 67 *Mich. L.Rev.* 1017 (1969) (argues that these subjects should be bargainable).

III. *Specific Issues*

[1] We will now consider the Alaska situation in more detail. At the outset it appears to us that questions concerning salaries, the number of hours to be worked, and amount of leave time are all so closely connected with the economic well-being of the individual teacher that they must be held negotiable under our statutes. The troubling question is what other items are bargainable.

[2] The various trial courts in these cases considered such items as (1) relief from non-professional chores, (2) elementary planning time, (3) para-professional tutors, (4) teacher specialists, (5) teacher's aides, (6) class size, (7) pupil-teacher ratio, (8) a teacher ombudsman, (9) teacher evaluation of administrators, (10) school calendar, (11) selection of instructional materials, (12) the use of secondary department heads, (13) secondary teacher preparation and planning time, and (14) teacher representation on school board advisory committees.

The testimony adduced in the trial courts does not provide us with much enlightenment as to why any of these items should fall on one side of the line or another. Realistically the two areas, i. e., (1) educational policy, and (2) matters pertaining to employment and professional duties, merge into and blend with each other at many points. Logically and semantically it is nearly impossible to assign specific items to one category and not the other. Certain examples may make this point more clearly.

In the *Mat-Su* case the teachers have asked for a planning period of 45 minutes "to be taken during the academic portion of the day." Were this merely a request for planning time, it might be considered negotiable. The demand that it be during the academic portion of the day, however, presents an additional complication: whether, as a matter of educational policy, elementary school children should have one teacher with them throughout the day or whether they are old enough to be taught by different people. This presents a basic educational decision. While the amount of paid time available to a teacher for preparation of lesson plans affects the teacher directly, the demand that such time be available "during the academic portion of the day" presents a policy question.

Similarly, the question of class size affects directly the amount of work a teacher must perform. But the determination of optimum class size is quite basic to school policy and management, and potentially has a substantial impact on the school district's personnel expenditures. A number of courts have found this to be clearly non-negotiable. *See National Ed. Ass'n of Shawnee Mission, Inc. v. Board of Ed.*, 512 P.2d 426, 435 (Kan.1973); *West Irondequoit Teachers Ass'n v. Helsby*, 35 N.Y.2d 46, 358 N.Y.S.2d 720, 315 N.E.2d 775, 777–78 (N.Y. App.1974); *School Dist. of Seward Ed. Ass'n v. School Dist. of Seward*, 188 Neb. 772, 199 N.W.2d 752, 759 (1972); *City of Biddeford v. Biddeford Teachers Ass'n*, 304 A.2d 387, 403 (Me.1973).

An examination of the other specific items listed above yields equally indefinite answers. We are confronted, then, with a situation in which the legislature has not spoken with clarity and concerning which we possess no expertise. We can only conclude that salaries, fringe benefits, the number of hours worked, and the amount of leave time are negotiable.[10] In view of the concerns expressed on pages 419, 420 *supra*, we conclude that the other specific items listed on page 422 are, under the existing statutory language, non-negotiable.

It would be helpful if the legislature, through future enactments, provided more specific guidance on a number of the items which the unions seek to negotiate. Lacking that guidance, however, we cannot confidently say that the legislature intended any of these items to be bargainable. We cannot, therefore, read the statutes expansively as to the scope of what is negotiable.

[3] As to matters which affect educational policy and are, therefore, not negotiable, we believe that there is nevertheless implicit in our statutes the intention that the school boards meet and confer with the unions. It is desirable that the boards consider teacher proposals on such questions. This will encourage teachers to give the boards the benefit of their expertise, and to make their positions known for the board's use in establishing educational policy.

[4] One minor question remains. In the *Kenai* case the trial court, in construing the statutes, relied upon the privately expressed opinion, by means of a letter, of a former legislator. The legislator's opinion was not a matter of public record, subject to judicial notice, nor was it introduced in evidence. Even if it were placed in evidence, reliance upon it would be impermissible under *Alaska Public Employees Ass'n v. State*, 525 P.2d 12, 16 (Alaska 1974). Resort to the letter as a means of legal interpretation was, therefore, error.

AFFIRMED IN PART, REVERSED IN PART.

10. In the list of proposals submitted in the *Kenai* case, for example, it appears that some 38 of the 47 proposals would come within the categories of items we have concluded are negotiable. These items are set forth in the appendix to this opinion.

APPENDIX

LIST OF NEGOTIABLE AND NON-NEGOTIABLE ITEMS

Those items which are non-negotiable are as follows:

1. Relief from Non-Professional Chores [11]
2. Class Size and Teacher Load
3. Ombudsman
4. Evaluation of Administrators
5. Teacher Aides
6. Para-Professionals
7. PTR Formula
8. Specialists
9. Calendar

Those items which are negotiable are:

1. Recognition
2. Negotiation Procedures
3. Grievance Procedures
4. Salary Schedule Conditions
5. Salary Schedule
6. Automatic Cost of Living
7. Extra Curricular and Extra Duty
8. Extended Contract
9. Additional Educational Employment
10. Life Insurance
11. Health Insurance
12. Liability Insurance
13. Automobile Allowance
14. Tuition/In-Service Workshops
15. Reimbursement for Physical Examinations
16. Sabbatical Leave
17. Career Development
18. Administrative Leave
19. Personal Leave
20. Sick Leave and Bereavement
21. Personal and Sick Leave for Half-Time Employees
22. Unpaid Leave of Absence
23. Maternity Leave
24. Political Leave
25. Duty-Free Lunch
26. Teacher Preparation Periods
27. Monthly Planning Time
28. In-Service Days
29. Discretional Materials
30. Personnel Files
31. Teacher Transfer
32. Teacher Retention
33. Job Openings
34. Reduction of Staff
35. Teacher Contracts
36. Association Rights and Privileges
    (a) Information
    (b) Release Time for Meetings
    (c) Use of School Buildings
    (d) Use of School Equipment
    (e) Supplies
    (f) Mail Facilities
    (g) Subcontracting
    (h) Non jeopardy
    (i) Exclusive Rights
    (j) KPEA Professional Leave
    (k) Dues Deduction/Continuing Membership
    (l) Other Deductions
    (m) Conformity to Law
    (n) School Board Agenda
    (o) Preliminary Draft of Budget
37. Agreement Print-up and Dissemination
38. Duration on Contract

11. In the *Kenai* case this item was described in the negotiating document as follows:

"RELIEF FROM NON-PROFESSIONAL CHORES

The Board and Association acknowledge that a teacher's primary responsibility is to teach and that his energies should be utilized to this end, therefore, they agree as follows: Teachers shall not be required to perform the following duties:

A. Non-instructional assignments, including but not limited to, supervising of cafeterias, sidewalks, bus loading, or unloading, or playgrounds of more than fifteen (15) minutes daily.

B. Collecting money from students.

C. Cumulative record cards and other clerical and/or custodial functions."

These matters seem so closely related to school board policy as to be non-negotiable. We do not pass upon other conceivable non-professional functions. We also do not know what is specifically meant by "custodial" functions, and do not, therefore, pass upon that aspect of this item.

AS 14.20.550

NEGOTIATION WITH CERTIFICATED EMPLOYEES. Each city, borough and regional school board, shall negotiate with its certificated employees in good faith on matters pertaining to their employment and the fulfillment of their professional duties.

AS 14.20.610

LEGAL RESPONSIBILITIES OF BOARDS. Nothing in §§ 550 - 600 of this chapter may be construed as an abrogation or delegation of the legal responsibilities, powers, and duties of the school board including its right to make final decisions on policies.

The court was asked to declare what issues pertaining to public school teachers are, under existing statutory language, subject to negotiation under collective bargaining and what matters are educational policy and thus non-negotiable. The court noted that educational policy and matters pertaining to employment and professional duties merge into and blend with each other at many points. The court took into account the many factors which figure into the balance of power between public employee unions and public employers in finding that a matter is more susceptible to bargaining the more it deals with the economic interests of employees and the less it concerns professional goals and methods. The court noted that bargaining over the latter topics presents particular problems because there is less likely to be any politically organized interest group other than the union concerned with these issues. Utilizing this standard, the court felt it could conclude that salaries, fringe benefits, the amount of hours worked, and the amount of leave time are negotiable, but that other issues, such as (1) relief from non-professional chores, (2) elementary planning time, (3) para-professional tutors, (4) teacher specialists, (5) teacher's aides, (6) class size, (7) pupil-teacher ratio, (8) a teacher ombudsman, (9) teacher evaluation of administrators, (10) school calendar, (11) selection of instructional materials, (12) the use of secondary department heads, (13) secondary teacher preparation and planning time, and (14) teacher representation on school board advisory committees were non-negotiable in light of the necessity of preserving the school board's effective control of educational policy.

(Kenai Peninsula Borough v. Kenai Peninsula Ed., Alaska, 572 P.2d 416)

1/28/79

Name	Address & Phone #	Organization	Bill No.
Judy DuBois	P.O. Box 1149 Juneau AK 99811	Dept. of LABOR	H.B. 453
Robert Smathers			
Ron Lorensen	210 N. Franklin, Juneau 99801 586-6994	for Lower Kuskokwim School Dist.	HB 453
Charlie Arteaga	1411 W 33rd Anc.	NEA-Alaska	HB 453
Jim Mannens			
Charles L. D'Amelle	207 Second Bldg - Juneau	NEA-Alaska	HB 453
Bob Van Houte	9851 Basher Dr. - Anc. 99507	NEA-Alaska	HB 453
Bob Greene	3146-48th one NE SALEM, OR	C.P.O. - NEA	HB 453
Hugo Olson	204 No. FRANKLIN St.	Assn Alaska School Bds	H.B 453
Bob McHenry			
[illegible]	Box 63 Nunik Alaska	Kuspuk School Board	HB 453
Cherie Shelley	P.O. Box 108 ANIAK	Kuspuk Sch. Dist	HB 453
CLIFF HARTMAN	P.O. Box 101 ANIAK	Kuspuk Sch. Dist.	H.B 453
	340 N. Franklin - Juneau		
	1433 W. 13th Anch AK 586 2334	APEA	HB 453
		586-9707	

M.M.H.
W.B.P.
L.T.F.
C.N.D.
T.G.B.
A.M.S.
J.R.W.
T.J.B.

THE SUPREME COURT OF THE STATE OF ALASKA

KENAI PENINSULA BOROUGH SCHOOL DISTRICT,

Appellant,

v.

KENAI PENINSULA BOROUGH SCHOOL DISTRICT CLASSIFIED ASSOCIATION,

Appellee.

File No. 3800

O P I N I O N

[No. 1802 - February 16, 1979]

Appeal from the Superior Court of the State of Alaska, Third Judicial District, Anchorage, Peter J. Kalamarides, Judge.

Appearances: Stephen C. Hillard, Allen McGrath, Chris J. Rigos, Graham & James, Anchorage, for Appellant. William K. Jermain, Jermain, Dunnagan & Owens, Anchorage, for Appellee.

Before: Boochever, Chief Justice, Rabinowitz, Connor, Burke and Matthews, Justices.

MATTHEWS, Justice.
RABINOWITZ, Justice, dissenting in part.

On February 17, 1975, the Kenai Peninsula Borough School Board adopted a comprehensive labor relations policy by which it bound itself to recognize and bargain collectively with an organization to be formed by a majority of the non-certificated school employees of the District, e.g., secretarial, custodial, and cafeteria personnel. The policy stipulated that the District would not negotiate (1) with

any individual who was not an employee of the School District, nor (2) with an employee organization affiliated with any state or national labor union.[1]

The appellee Association was duly organized and subsequently recognized by the District on February 21, 1977, as the employee bargaining agent. One month later, after negotiations had not progressed to its satisfaction, in part because the School District would not permit an employee consultant into the negotiating room, the Association affiliated with the Kenai Peninsula Federation of Teachers, itself an affiliate of the American Federation of Teachers. The District then refused to negotiate further,

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1. The recognition paragraph of the policy reads:

> The Kenai Peninsula Borough School District will recognize, for the purpose of discussing and negotiating mutually satisfactory agreements on specified matters pertaining to their employment, the Kenai Peninsula Borough School District classified employee group which on a certain date has, as bona fide members, a majority of the total classified staff employed by the district on that date and which files a certified list of such members with the Superintendent of Schools. The Kenai Peninsula Borough School District will negotiate only with employees of the district. The Board will not recognize for the purpose of negotiations, any union or association which is not made up exclusively of Kenai Peninsula Borough School District employees nor will the Board negotiate with a local association affiliated with a state or national union.

demanding that the Association disaffiliate from the Kenai Peninsula Federation. The Association brought suit, seeking to compel the District to resume negotiations.

On September 19, 1977, Judge Peter J. Kalamarides granted summary judgment to the Association, finding the aforementioned restrictive provisions both unconstitutional and severable from the rest of the labor policy, and ordered the District to resume negotiations. The School District appeals from both judgments. We affirm.

I

* It is conceded for purposes of this litigation that the right of the non-certificated school employees to compel their employer to bargain collectively arises solely out of the labor relations policy enacted by the District. These employees are not among those within the ambit of the National Labor Relations Act, 29 U.S.C. §152(7) (1970), or the Alaska Public Employment Relations Act, AS 23.40.250(5), and the Association, in the face of much contrary authority, does not seek to establish such a right in the federal constitution. See, e.g., University of New Hampshire Chap. of Am. Ass'n. of Univ. Profs. v. Haselton, 39 F.Supp. 107, 109 (D.N.H. 1975); Atkins v. Charlotte, 296 F.Supp. 1068, 1077 (W.D.N.C. 1969).

"The first question that confronts us then, is whether the School District can grant non-certificated employees the right to bargain collectively and simultaneously decree whom the employees may send to the bargaining table as their representative, and with whom they may affiliate to effectuate their right under the labor policy. We hold that the first amendment prohibits such restrictions.

Forty-two years ago, the Supreme Court asserted that:

> [In] safeguard[ing] the right of employees to self-organization and to select representatives of their own choosing for collective bargaining or other mutual protection without restraint or coercion by their employer. . . . [the National Labor Relations Act goes no further than to safeguard] a fundamental right. . . . Hence the prohibition by Congress of interference with the selection of representatives for the purpose of negotiation and conference between employers and employees, 'instead of being an invasion of the constitutional right of either, was based on the recognition of the rights of both.'

NLRB v. Jones & Laughlin Steel Corp., 301 U.S. 1, 33-4, 81 L.Ed. 893, 909-10 (1937)(citations omitted). The associational right so identified emanates from the protections afforded by the first amendment. See Brotherhood of Railroad Trainmen v. Virginia, 377 U.S. 1, 5, 12 L.Ed.2d 89, 93 (1964).

** It can no longer be disputed that the right to affiliate with the union of one's choice is the right of the public employee as well as the private employee. Lontine v. VanCleave, 483 F.2d 966, 967 (10th Cir. 1973); Orr v. Thorpe, 427 F.2d 1129, 1131 (5th Cir. 1970); American Federation of State, County, & Munic. Employees v. Woodward, 406 F.2d 137, 139 (8th Cir. 1969); McLaughlin v. Tilendis, 398 F.2d 287, 288 (7th Cir. 1968); O'Brien v. Leidinger, 452 F.Supp. 720 (E.D.Va. 1978). See Thomas v. Younglove, 545 F.2d 1171, 1172 (9th Cir. 1976); Lodge 1858, American Federation of Gov't. Employees v. Paine, 436 F.2d 882, 894 n.72 (D.C. Cir. 1970). It is implicit in the cases just cited, that public employees are free to join a national as well as a local union, for in each case the petitioning employees had, in one manner or another, in fact affiliated with a national organization. Accord, Atkins v. Charlotte, 296 F.Supp. 1068 (W.D.N.C. 1968). We have recognized that same freedom for employees covered by the Alaska Public Employment Relations Act, AS 23.40.070. State v. Petersburg, 538 P.2d 263, 267 (Alaska 1975).

We can find no sound basis for distinguishing an employee's freedom in affiliation from the right to freely choose his or her representative at the bargaining table. The two are inseparable under the National Labor Relations Act, see General Electric Co. v. NLRB, 412 F.2d 512, 517 (2d

Cir. 1969), in the Supreme Court's identification of fundamental rights in NLRB v. Jones, supra, and would seem to be similarly inseparable in fact. A powerful incentive in affiliating with a national union is the effective advocacy thereby secured. Governmental interference with a labor organization's ability to effectively assert its members' legal rights has been held to be an unconstitutional impairment of associational freedoms. United Mine Workers v. Illinois State Bar Ass'n., 389 U.S. 217, 221-222, 19 L.Ed 2d 426, 430-1 (1967); Brotherhood of Railroad Trainmen, 377 U.S. at 6, 12 L.Ed.2d at 93.* We thus find the conclusion inescapable that the right of the District's non-certificated employees to "select representatives of their own choosing for collective bargaining," be they from local or national organizations, "without restraint or coercion by their employer," is grounded firmly in the first amendment. NLRB v. Jones, supra.

The School District does not dispute this conclusion. Instead it argues that the employees represented by the Association are still quite free to join the Kenai Federation. All they cannot do is both affiliate and retain the "privilege" to bargain collectively.

Essentially the District is reiterating Holmes' observation that "[t]he petitioner may have a constitutional

right to talk politics, but he has no constitutional right to be a policeman." McAuliffe v. Mayor of New Bedford, 29 N.E. 517 (Mass. 1892). In the first amendment area the distinction between right and benefit has long been dead. A government may not confer a statutory right or benefit and withdraw it when the beneficiary exercises a constitutional prerogative. Neither may it confer a right and condition it unconstitutionally in the same breath. Numerous cases in the past twenty-five years have made these propositions irrebuttable. See, e.g. Elrod v. Burns, 427 U.S. 347, 361, 49 L.Ed.2d 547, 558 (1976), and the cases cited therein. Accord, State v. Wylie, 516 P.2d 142, 146 (Alaska 1973). As the Supreme Court recently stated in Abood v. Detroit Board of Education, 431 U.S. 209, 234, 52 L.Ed.2d 261, 283 (1977):

> [A] government may not require an individual to relinquish rights granted him by the First Amendment as a condition of public employment.

The District is thus left with the task of persuading us that the interests embodied in the labor policy's restrictions outweigh the value of the associational freedoms impinged. The School District would have this court scrutinize its restrictive provisions only for a "rational relationship" to the interests it asserts are at stake here. But a "rational connection . . . will not suffice." Thomas v. Collins, 323 U.S. 516, 530, 89 L.Ed. 430, 440 (1945). To

override a presumptive first amendment right the School District's interest must be "paramount, one of vital importance." Elrod, 427 U.S. at 362, 49 L.Ed.2d at 559; Woodward, 406 F.2d at 140; McLaughlin, 398 F.2d at 290. And even if the School District's 'purpose be legitimate and substantial, that purpose cannot be pursued by means that broadly stifle fundamental personal liberties when the end can be more narrowly achieved." Shelton v. Tucker, 364 U.S. 479, 488, 5 L.Ed.2d 231, 237 (1960).

The burden is on the School District to show the existence of such a paramount interest. See Elrod, 427 U.S. at 362, and the cases cited therein. In its argument below the School District justified the non-affiliation provision by its interest in avoiding negotiations "conducted by outsiders." In this court it has added others: avoiding the "rigidity in demands," the escalation of "employee relations tensions," and the "test cases" mind-set allegedly characteristic of national unions. Since "uniquely local interests" are involved, the District desires "negotiations [that] are uniquely local in character." Finally, it argues that as a public employer it must be allowed to recognize that "[s]trong union demands may either exceed the capacity of the democratically-controlled budget process . . . or they may overwhelm a management negotiator not constrained by ordinary 'profit' motivations."

The essence of the District's asserted interest is that it needs to exercise prospective control over the vigor with which its non-certificated employees will be represented at the bargaining table. We can see in this no more than a bald assertion that it will lead to too much labor unrest if public employees are permitted to exercise their first amendment rights. We rejected such a contention with regard to public employees covered by the Public Employment Relations Act, State v. Petersburg, supra, and we reject the contention here. To construe the School District's interest here as so paramount as to override the fundamental right to freely choose one's representatives, would render the latter right illusory, for it is difficult to imagine a context in which public employees could then successfully assert it.[2]

In contending that it should be permitted to constrict the Association's effectiveness as it sees fit, the School District points to the many decisions finding that public employees cannot compel collective bargaining

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2. We note that the District has incorporated in its labor policy other means of dealing with the problems it fears a strong union will create, means which do not impinge on associational freedoms. For example, the labor policy forbids all forms of work stoppages, significantly constricts the scope of mandatory bargaining subjects, and stipulates that any agreement reached by the negotiators will only be advisory to the school board.

without statutory authority, and to those permitting restraints on the right to strike. However, those cases which uphold the aforementioned restraints take great pains to distinguish the rights in issue here.

> The right to strike, because of its more serious impact upon the public interest, is more vulnerable to regulation than the right to organize and select representatives for lawful purposes of collective bargaining which this Court has characterized as a 'fundamental right' and which, as the Court has pointed out, was recognized as such in its decisions long before it was given protection by the Labor Relations Act.

International Union Local 232 v. Wisconsin Employment Relations Board, 336 U.S. 245, 259, 93 L.Ed. 651, 666 (1948)(citations omitted). See also United Federation of Postal Clerks v. Blount, 325 F.Supp. 879, 883 (D.D.C.), aff'd mem., 404 U.S. 802, 30 L.Ed.2d 38 (1971).

As we read these decisions they posit a constitutional framework in which employees are free to organize and select an advocate, and from that guarantee of collective strength then lobby their various legislatures for particular rights in the employer/employee relationship. See, e.g., Atkins v. Charlotte, 296 F.Supp. 1068, 1077 (W.D.N.C. 1968). The virtue of that view is its consistent emphasis on freedom of action, and its antagonism to coercion. And within that perspective it does not follow at

all, that once bargaining rights are successfully secured, as in the instant case, the constitutional rights disappear.

** We affirm the superior court's judgment that the School District's policy restrictions on affiliation and choice of bargaining representative are violative of first amendment freedoms guaranteed to the non-certificated school employees.

f

Having decide that portions of the School District's labor policy are unconstitutional, we must now decide whether these may be severed, leaving the remainder of the policy intact and enforceable.

In determining questions of severability, we make two inquiries. Lynden Transport, Inc. v. State, 532 P.2d 700 (Alaska 1975). First we must determine whether the constitutional portions of the policy, standing alone, can be given legal effect. Id. at 713. The School District concedes that they can, and no further discussion is necessary.

Second, we must identify the primary purpose of the labor policy, and determine whether this purpose can be achieved with the invalid provisions stricken. Id. at 714-15. "The test . . . is whether the remaining parts are so independent and complete that it may be presumed that the

[School District] would have enacted the valid parts without regard to the invalid part." Jefferson v. State, 527 P.2d 37, 41 (Alaska 1974). It is not dispositive that the stricken portions constitute a fragment of a paragraph. Lynden Transport, supra; Speidel v. State, 460 P.2d 77 (Alaska 1969).

We find that the primary purpose of the labor policy is stated in its preamble:

> [T]he Board wishes to maintain its long tradition of fair play with its employees by enacting a policy which will set the stage for harmonious and cooperative relations between the Board and its classified employees and to protect the public by assuring orderly and uninterrupted operations of the district.

After striking only the unconstitutional restrictions of the policy, the superior court concluded that the purpose articulated in the preamble could still be fulfilled. We concur.

The policy adopted by the school board contains more than just the language authorizing collective bargaining and limiting affiliation rights. The recognition paragraph states that the association may not limit membership on the basis of race, religion, creed, sex, or marital status. It prohibits making membership in the association or payment of dues a condition of employment. It prohibits strikes or slow-downs by association members and requires

that the association assist in preventing these where possible. Beyond the recognition section, other sections of the labor policy lay down the conditions an association must meet before it will be deemed by the school board to have been authorized by the school employees to represent them. The section titled "Scope of Bargaining" narrowly limits what the association can discuss in negotiations, and prohibits negotiations on "inherent managerial policy", which includes but is not limited to

> the functions and programs of the Board, standards of services, the district budget, utilization of technology, the organizational structure of the schools and the selection and direction of personnel, including work hours, assignments, transfers, job descriptions, promotions based on merit with seniority a secondary factor, the determination of other hiring and dismissal or demotion procedures.

Other sections of the policy cover, among other things, what will happen if the parties cannot agree in negotiations, disputes procedures, and the duration of any labor agreement. All of these provisions of the labor policy apply regardless of whether the association is affiliated with a non-local organization or not.

Given the detailed nature of the labor relations policy when read as a whole, we conclude that the superior court properly found that the non-affiliation clause is severable. The primary purpose of the policy is clearly

stated in the preamble. There the school board said that it wished to preserve "harmonious relations" with its classified employees and assure smooth operation of the school district. Although the non-affiliation clause may be considered an important part of the structure the board created to achieve these goals, deleting the clause will leave virtually all of the labor policy intact. Since the school board obviously considered collective bargaining important to the maintaining of good relations with its classified employees, we cannot assume that it would not have enacted the constitutional portions, had it known that two restrictions would be found unconstitutional.

AFFIRMED.

RABINOWITZ, Justice, dissenting in part.

I am in agreement with the court's holding that those portions of the School District's labor policy which place restrictions on affiliation and choice of bargaining representative are violative of the first amendment rights of non-certificated school employees. My disagreement with the court's opinion centers on the majority's conclusion that the non-affiliation clause is severable.

In discussing presumptions of separability and inseparability in Lynden Transport, Inc. v. State, 532 P.2d 700, 711-12 (Alaska 1975), we quoted, with approval from Carter v. Carter Coal Co., 298 U.S. 238, 312, 80 L. Ed. 1160, 1189 (1936), where the Supreme Court said in part:

> Under the statutory rule, the presumption must be overcome by considerations which establish 'the clear probability that the invalid part being eliminated the legislature would not have been satisfied with what remains.'

In my view, non-affiliation is a paramount part of the structure upon which the Board's labor policy rested. Before the remainder of the policy had any applicability, the employees' organization had to meet the recognition requirement. I think it apparent that the non-affiliation clause was intended as a mandatory requirement for it embodies one of the two explicit requirements found in the recognition paragraph -- the other being proof of majority representation.

Thus, I conclude that it cannot be fairly said that the Board viewed the non-affiliation requirement as severable, "independent," or "non-essential."[1]

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1. In short, I have concluded that the burden of proof adopted in Lynden Transport, Inc. v. State, 532 P.2d 700, 711-12 (Alaska 1975), as applied in the instant case, leads to the result that the non-affiliation clause was not severable. In reaching this conclusion, I assume arguendo that there is a statutory presumption of severability with regard to the Board's labor policy, but find that the record establishes the "clear probability" that the Board "would not have been satisfied" with the labor policy without the non-affiliation clause.

Alaska Supreme Court Decision on Scope of Negotiations Under Teacher Bargaining Law

IN THE SUPREME COURT
OF THE STATE OF ALASKA

KENAI PENINSULA BOROUGH
SCHOOL DISTRICT and KENAI
PENINSULA BOROUGH

v.

KENAI PENINSULA EDUCATION
ASSOCIATION,
Appellee.

File No. 2470

ANCHORAGE BOROUGH EDUCATION
ASSOCIATION,
Appellant,

v.

GREATER ANCHORAGE AREA BOROUGH,
ANCHORAGE BOROUGH SCHOOL DISTRICT,
Appellee.

File No. 2492

MATANUSKA-SUSITNA SCHOOL DISTRICT,
Appellant,

v.

MATANUSKA-SUSITNA EDUCATION
ASSOCIATION,
Appellee.

File No. 2563

(No. 1537 - December 9, 1977)

Appeals from the Superior Court of the State of Alaska, Third Judicial District, at Kenai, No. 2470, James A. Hanson, Judge; at Anchorage, No. 2492, Victor D. Carlson, Judge; at Anchorage, No. 2563, C.J. Occhipinti, Judge.

Appearances: Allen McGrath and John R. Snodgrass, Jr., of Graham and James, Anchorage, for School Districts. John R. Strachan, Anchorage, for Education Associations.

Before: Boochever, Chief Justice, Rabinowitz, Connor, Erwin, and Burke, Justices.

CONNOR, Justice.

These cases present important questions of labor law and constitutional law concerning the collective bargaining requirements for teachers in the public schools. Two of these cases are before us because the teachers' associations (the unions) have sued school districts and boroughs (the school boards) to compel collective bargaining in good faith under AS 14.20.550. In the third, a school board seeks a declaratory judgment that certain issues are not bargainable. The school boards, while not disputing the unions' right to collective bargaining on a number of employment-related issues, contend that they should not be forced to bargain collectively on various items which they regard as affecting educational policy. Educational policy, the school boards contend, must be determined only by the public through the legislature and, by delegation, through the school boards. We will examine the more specific issues later in this opinion. They include such items as class size and the use of teacher specialists and paraprofessionals. Of the three trial courts which passed on the matter, one ruled in favor of the school boards,[1] one ruled in favor of the teachers' union,[2] and one split the various items, ruling for the board on some and the unions on other.[3]

I. Introduction

To facilitate the understanding of our more detailed legal discussion later in this opinion, we will summarize at the outset the contentions of the parties. The statutes at issue in this litigation are AS 14.20.550 and .610, which provide:

"Sec. 14.20.550. Negotiation with certificated employees. Each city, borough and regional school board, shall negotiate with its certificated employees in good faith on matters pertaining to their employment and the fulfillment of their professional duties. (§1 ch 18 SLA 1970; am §3 ch 71 SLA 1972; am §21 ch 124 SLA 1975)."

"Sec. 14.20.610. Legal responsibilities of boards. Nothing in §§550-600 of this chapter may be construed as an abrogation or delegation of the legal responsibilities, powers, and duties of the school board including its right to make final decisions on policies. (§1 ch 18 SLA 1970)."

The boards contend, using labor cases from the private sector, that the requirement of collective bargaining in good faith is a term of art in labor law. Unlike a simple "meet and confer" requirement, to negotiate in "good faith" entails a duty to make concessions. Thus, management does not have the final decisions on matters subject to good faith collective bargaining, since if management adheres

to its determined policies, it violates the law.

The school boards contend that the submission of educational policies to a good faith collective bargaining requirement would remove the final decisions on such matters from the boards, contrary to the intent of the legislature expressed in AS 14.20.610. The boards contend that to require bargaining on questions of educational policy would also contravene the Alaska Constitution, art. VII, §1, which makes education the exclusive domain of the legislature.[4] See Macauley v. Hildebrand, 491 P.2d 120 (Alaska 1971). Delegation of part of the decision making power on educational policy to labor unions is unconstitutional, they urge, because the union is a private organization, unaccountable to the public. The union can use the power for its own ends, and is under no duty to foster educational policies which are in the general public interest.

The unions argue that such delegation is perfectly proper, and that there is no delegation of decision making power inherent in a labor negotiations' requirement. They further argue that they represent professional employees, and that their participation in good faith collective bargaining labor negotiations is an attempt by the legislature to provide professional advice to school boards on the management of the schools. They assert that this is a legislative policy judgment, in no way inimical to the Alaska Constitution. Also relying on labor cases, they discount the importance of any "management prerogative" to determine educational policy under AS 14.20.610, and assert that labor's concerns with working conditions override any management prerogative as to basic policy.

The unions argue that the Alaska teachers' collective bargaining statutes are more comprehensive than those found elsewhere, and hence the scope of bargaining should be interpreted broadly. The school boards assert that the Alaska Constitution as interpreted in Macauley v. Hildebrand, supra, is more adamant than provisions in other states in placing education firmly within the legislative prerogative. Therefore, collective bargaining must yield across a wide range of issues affecting educational policy.

II. Scope of Duty to Bargain

If we were to look to the law concerning bargaining between labor unions and private employers, we would conclude that the scope of negotiable issues is broad. The law relating to the private sector has always contained, and still does contain, uncertainties. But the general trend has been to require that employers bargain in good faith on a wide range of items with respect to wages, hours, and other conditions of employment, without regard to whether the employers consider the items bargained for to be within the prerogatives of management.[5] Moreover, some cases hold that for an employer or a union to avoid being found to have bargained in bad faith, the parties must make some reasonable effort to compose their differences. While the good faith standard of collective bargaining does not compel either party to make concessions, intransigent positions, adopted in an effort to avoid any agreement, are disfavored.[6] Thus a legal determination that a matter is subject to good faith collective bargaining may narrow the policy making powers of an employer by curtailing any absolute directives on his part.

When we turn to employment in the public sector, and particularly in education, the question of what is properly bargainable is thrown into more doubt. If teachers' unions are permitted to bargain on matters of educational policy, it is conceivable that through successive contracts the autonomy of the school boards could be severely eroded, and the effective control of educational policy shifted from the school boards to the teachers' unions. Such a result could threaten the ability of elective government officials and appointive officers subject to their authority, in this case the school boards and administrators, to perform their functions in the board public interest.[7]

Recently the United States Supreme Court had occasion to comment upon the differences between collective bargaining in the public and private sectors. In Abood v. Detroit Board of Education, ___U.S.___, 52 L.Ed.2d 261, 279-80 (1977), the Court, speaking through Mr. Justice Stewart, observed:

"A public employer, unlike his private counterpart, is not guided by the profit motive and constrained by the normal operation of the market. Municipal services are typically not priced, and where they are they tend to be regarded as in some sense 'essential' and therefore are often price inelastic. Although a public employer, like a private one, will wish to keep costs down, he lacks an important discipline against agreeing to increases in labor costs that in a market system would require price increases. A public sector union is correspondently less concerned that high prices due to costly wage demands will decrease output and hence employment.

The government officials making decisions as the public 'employer' are less likely to act as a cohesive unit than are managers in private industry, in part because different levels of public authority - department managers, budgetary officials, and legislative bodies - are involved, and in part because each official may respond to a distinctive political constituency. And the ease of negotiating a final agreement with the union may be severely limited by statutory restrictions, by the need for the approval of a higher executive authority or a legislative body, or by the commitment of budgetary decisions of critical importance to others.

Finally, decision making by a public employer is above all a political process. The officials who represent the public employer are ultimately responsible to the electorate, which for this purpose can be viewed as comprising three overlapping classes of voters - taxpayers, users of particular government

services, and government employees. Through exercise of their political influence as part of the electorate, the employees have the opportunity to affect the decisions of government representatives who sit on the other side of the bargaining table. Whether these representatives accede to a union's demands will depend upon a blend of political ingredients, including community sentiment about unionism generally and the involved union in particular, the degree of taxpayer resistance, and the views of voters as to the importance of the service involved and the relation between the demands and the quality of service."

In a concurring opinion in that case Mr. Justice Powell noted the similarity between a public sector union and a conventional political party:

"The ultimate objective of a union in the public sector, like that of a political party, is to influence public decision making in accordance with the views and perceived interests of its membership. Whether a teachers' union is concerned with salaries and fringe benefits, teacher qualifications and in-service training, pupil-teacher ratios, length of the school day, student discipline, or the content of the high school curriculum, its objective is to bring school board policy and decisions into harmony with its own views. Similarly, to the extent that school board expenditures and policy are guided by decisions made by the municipal state and federal governments, the union's objective is to obtain favorable decisions - and to place persons in positions of power who will be receptive to the union's viewpoint. In these respects, the public sector union is indistinguishable from the traditional political party in this country." 52 L.Ed.2d at 298.[8]

The legislature was evidently cognizant of this concern when it enacted AS 14.20.550 and .610, stating two goals which apparently conflict. We must now proceed to interpret what we believe the legislature meant by these provisions.

The school boards initially argue that to make matters of school operation and educational policy subject to collective bargaining amounts to an unconstitutional delegation of governmental power to the unions.

While courts in an earlier era often held laws unconstitutional on the ground that they delegated legislative power to private persons or groups, e.g., Carter v. Carter Coal Co., 298 U.S. 238, 311 (1936), the trend has been to uphold such delegations, even when the power is delegated to a group with an economic interest in the decisions to be made. E.G., United States v. Rock Royal Cooperative, Inc., 307 U.S. 533, 577-78 (1939)(cooperative marketing program from agricultural products); Agricultural Prorate Comm'n v. Superior Court, 55 P.2d 495, 504-06 (Cal. 1936)(same); Potter v. New Jersey Supreme Court, 403 F. Supp. 1036, 1039-40 (D.N.J. 1975), aff'd, 546 F.2d 418 (3d Cir. 1976) (requirement that attorneys have graduated from law schools accredited by the American Bar Association). See generally, 1 K. Davis, Administrative Law Treatise §2.14 (Supp. 1970) (collecting cases). See also 1 Id. §2.15 (1958).

Furthermore, the statute merely requires the school board to negotiate with the union. It does not require the board to accept any particular proposal the union might offer. It does not require, and probably does not permit, the board to delegate to the union the sole power to make any decision. Therefore, cited cases invalidating outright grants of governmental power to private groups, e.g., Hetherington v. McHale, 329 A.2d 250 (Pa. 1974), and Bayside Timber Co. v. Bd. of Supervisors, 97 Cal. Rptr. 431 (App. 1971), are not apposite.

The cases in other states rejecting the argument that collective bargaining with teachers' unions is an unconstitutional delegation of power, all involve statutes which fairly narrowly constrict either the scope of bargainable issues, or the school boards' duty to accede to union proposals, or both. Chicago Div. of Ill. Ed. Ass'n v. Board of Ed., 222 N.E.2d 243, 251 (Ill. App. 1966); Joint School Dist. No. 8 v. Wisc. Emp. Rel. Bd., 155 N.W.2d 78, 83 (Wisc. 1967); State v. City of Laramie, 437 P.2d 295, 300 (Wyo. 1968) (firemen).

In this opinion, we similarly construe the Alaska statute. A statute defining the scope of collective bargaining as broadly as the union would have us do, might well present a more troubling constitutional question. But we find no constitutional infirmity in AS 14.20.550 and .610. The delegation of power problem still bears upon our task of statutory interpretation, however, for in interpreting the relevant statutes we will not readily assume that the legislature intended to divest the school boards of their power to determine matters of educational policy and school system management.

Courts in other jurisdictions have considered problems similar to those which we confront here. It is instructive, though not determinative, to look to the case law of other jurisdictions as an aid to interpretation.

The court in Dunellen Bd. of Education v. Dunellen Ed. Ass'n., 311 A.2d 737 (N.J. 1973), dealt with a conflict between a requirement to bargain about "terms and conditions" of employment (without further definition) and the broad managerial power over schools entrusted to local school boards. The court noted that "terms and conditions" of employment without further definition does not furnish a dispositive guideline. It held that the decision whether to consolidate chairmanships of the social studies department and English department was not a subject of mandatory bargaining. It was a matter predominately of educational policy and thereby fell within the exclusive prerogative of management.[9]

National Ed. Assn'n of Shawnee Mission, Inc. v. Board of Ed., 512 P.2d 426 (Kansas 1973), is closely analogous to the case at bar. There the teachers' association negotiated under a statute which permitted it to "participate in professional negotiation with boards of

education . . . for the purpose of establishing, maintaining, protecting or improving terms and conditions of professional service." The state constitution, like Alaska's, gave the legislature the power to provide for public schools. The negotiations reached an impasse after the board took the position that all matters, whether negotiable under the statute or not, were of a policy nature subject to unilateral change by the board and could not be incorporated into a contract, while the teachers asserted that nearly everything pertaining to school operations was negotiable.

On appeal the Kansas Supreme Court was confronted with the same problem that we are: how to frame a test which would delimit those matters which are bargainable from those which are not. The Kansas court held that salaries, vacations, and sick leave are negotiable. In so doing it pointed out that the term "policy" is not helpful, because even salaries are a matter of policy. It drew the following distinction:

"The key, as we see it, is how direct the impact of an issue is on the well-being of the individual teacher, as opposed to its effect on the operation of the school system as a whole." 512 P.2d at 435.

While the Shawnee Mission case represents a commendable attempt to balance competing claims, it does not provide a test which is useful in determining the negotiability of specific subjects. In other words, it does not provide any comforting guidance in determining how, in the last analysis, the balance should be weighed between the school boards and teachers.

Put another way, a matter is more susceptible to bargaining the more it deals with the economic interests of employees and the less it concerns professional goals and methods. Bargaining over the latter topics presents particular problems because there is less likely to be any politically organized interest group other than the union concerned with these issues. The salaries of public employees have a direct financial effect on the taxpayers; on the other hand, a question such as teacher evaluation of administrators is unlikely to have any impact sufficiently direct to be discernible by laymen. Furthermore, it is such an abstract and abstruse subject that it is unlikely that any appreciable portion of the public will either understand it or care greatly about it. In such circumstances, the risk that effective power over the governmental decision will come to rest with the union is significantly greater. Moreover, it is more likely that there will be disagreements among union members on questions of this nature than on "bread and butter" issues; the risk that minority viewpoints within the union will not be meaningfully represented in the bargaining is a real one. See Summers, supra, 83 Yale L.J. at 1181-82, 1194-95. But see Wollett, The Coming Revolution in Public School Management, 67 Mich. L. Rev. 1017 (1969) (argues that these subjects should be bargainable).

III. Specific Issues

We will now consider the Alaska situation in more detail. At the outset it appears to us that questions concerning salaries, the number of hours to be worked, and amount of leave time are all so closely connected with the economic well-being of the individual teacher that they must be held negotiable under our statutes. The troubling question is what other items are bargainable.

The various trial courts in these cases considered such items as (1) relief from non-professional chores, (2) elementary planning time, (3) paraprofessional tutors, (4) teacher specialists, (5) teacher's aides, (6) class size, (7) pupil-teacher ratio, (8) a teacher ombudsman, (9) teacher evaluation of administrators, (10) school calendar, (11) selection of instructional materials, (12) the use of secondary department heads, (13) secondary teacher preparation and planning time, and (14) teacher representation on school board advisory committees.

The testimony adduced in the trial courts does not provide us with much enlightenment as to why any of these items should fall on one side of the line or another. Realistically the two areas, i.e., (1) educational policy, and (2) matters pertaining to employment and professional duties, merge into and blend with each other at many points. Logically and semantically it is nearly impossible to assign specific items to one category and not the other. Certain examples may make this point more clearly.

In the Mat-Su case the teachers have asked for a planning period of 45 minutes "to be taken during the academic portion of the day." Were this merely a request for planning time, it might be considered negotiable. The demand that it be during the academic portion of the day, however, presents an additional complication: whether, as a matter of educational policy, elementary school children should have one teacher with them throughout the day or whether they are old enough to be taught by different people. This presents a basic educational decision. While the amount of paid time available to a teacher for preparation of lesson plans affects the teacher directly, the demand that such time be available "during the academic portion of the day" presents a policy question.

Similarly, the question of class size affects directly the amount of work a teacher must perform. But the determination of optimum class size is quite basic to school policy and management, and potentially has a substantial impact on the school district's personnel expenditures. A number of courts have found this to be clearly non-negotiable. See National Ed. Ass'n. of Shawnee Mission, Inc. v. Board of Ed., 512 P.2d 426, 435 (Kan. 1973); West Irondequoit Teachers Ass'n v. Helsby, 315 N.E.2d 775, 777-78 (N.Y. App. 1974); School Dist. of Seward Ed. Ass'n v. School Dist. of Seward, 199 N.W.2d 752, 759 (Neb. 1972); City

of Biddeford v. Biddeford Teachers Ass'n, 304 A.2d 387, 403 (Maine 1973).

An examination of the other specific items listed above yields equally indefinite answers. We are confronted, then, with a situation in which the legislature has not spoken with clarity and concerning which we possess no expertise. We can only conclude that salaries, fringe benefits, the number of hours worked, and the amount of leave time are negotiable.[10] In view of the concerns expressed on page 7-10 supra, we conclude that the other items listed on page 17 are, under the existing statutory language, non-negotiable.

It would be helpful if the legislature, through future enactments, provided more specific guidance on a number of the items which the unions seek to negotiate. Lacking that guidance, however, we cannot confidently say that the legislature intended any of these items to be bargainable. We cannot, therefore, read the statutes expansively as to the scope of what is negotiable.

As to matters which affect educational policy and are, therefore, not negotiable, we believe that there is nevertheless implicit in our statutes the intention that the school boards meet and confer with the unions. It is desirable that the boards consider teacher proposals on such questions. This will encourage teachers to give the boards the benefit of their expertise, and to make their positions known for the board's use in establishing educational policy.

One minor question remains. In the Kenai case the trial court, in construing the statutes, relied upon the privately expressed opinion, by means of a letter, of a former legislator. The legislator's opinion was not a matter of public record, subject to judicial notice, nor was it introduced in evidence. Even if it were placed in evidence, reliance upon it would be impermissible under Alaska Public Employees Ass'n v. State, 525 P.2d 12, 16 (Alaska 1974). Resort to the letter as a means of legal interpretation was, therefore, error.

AFFIRMED IN PART, REVERSED IN PART.

APPENDIX

LIST OF NEGOTIABLE
AND NON-NEGOTIABLE ITEMS

Those items which are non-negotiable are as follows:

1. Relief from Non-Professional Chores
2. Class Size and Teacher Load
3. Ombudsman
4. Evaluation of Administrators
5. Teacher Aides
6. Para-Professionals
7. FTE Formula
8. Specialists
9. Calendar

Those items which are negotiable are:

1. Recognition
2. Negotiation Procedures
3. Grievance Procedures
4. Salary Schedule Conditions
5. Salary Schedule
6. Automatic Cost of Living
7. Extra Curricular and Extra Duty
8. Extended Contract
9. Additional Educational Employment
10. Life Insurance
11. Health Insurance
12. Liability Insurance
13. Automobile Allowance
14. Tuition/In-Service Workshops
15. Reimbursement for Physical Examinations
16. Sabbatical Leave
17. Career Development
18. Administrative Leave
19. Personal Leave
20. Sick Leave and Bereavement
21. Personal and Sick Leave for Half-Time Employees
22. Unpaid Leave of Absence
23. Maternity Leave
24. Political Leave
25. Duty-Free Lunch
26. Teacher Preparation Periods
27. Monthly Planning Time
28. In-Service Days
29. Discretional Materials
30. Personnel Files
31. Teacher Transfer
32. Teacher Retention
33. Job Openings
34. Reduction of Staff
35. Teacher Contracts
36. Association Rights and Privileges
    (a) Information
    (b) Release Time for Meetings
    (c) Use of School Buildings
    (d) Use of School Equipment
    (e) Supplies
    (f) Mail Facilities
    (g) Subcontracting
    (h) Non Jeopardy
    (i) Exclusive Rights
    (j) KPEA Professional Leave
    (k) Dues Deduction/Continuing Membership
    (l) Other Deductions
    (m) Conformity to Law
    (n) School Board Agenda
    (o) Preliminary Draft of Budget
37. Agreement Print-up and Dissemination
38. Duration of Contract

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[1]Anchorage Borough Ed. Ass'n v. GAAB, Anchorage Borough School Dist., No. 2492 (hereinafter Anchorage).

[2]Kenai Pen. Borough Sch. Dist. and Kenai Pen. Borough v. Kenai Pen. Ed. Ass'n, No. 2470 (hereinafter Kenai).

[3]Matanuska-Susitna Sch. Dist. v. Matanus-

ka-Susitna Ed. Ass'n, No. 2563 (hereinafter Mat-Su).

[4]Alaska Constitution, art. VII, §1 states: "The legislature shall by general law establish and maintain a system of public schools open to all children of the State, and may provide for other public educational institutions. Schools and institutions so established shall be free from sectarian control. No money shall be paid from public funds for the direct benefit of any religious or other private educational institution."

[5]Fibreboard Paper Products Corp. v. N.L.R.B., 379 U.S. 203 (1964) (management decision to subcontract out the work of some employees must be bargained); International Ladies' Garment Workers Union v. N.L.R.B., 463 F.2d 907 (D.C. Cir. 1972) (decision to relocate the business to another state subject to bargaining); Royal Typewriter Co., 209 N.L.R.B. 1006, 1012 (1974) (decision to close a plant subject to bargaining). But see General Motors Corp., 191 N.L.R.B. 951 (1971), aff'd sub nom. International Union, United Auto. A. & A. Imp. Wkrs. v. N.L.R.B., 470 F.2d 422, 425 (D.C. Cir. 1972) (decision to sell part of business not bargainable).

[6]Sign and Pictorial Union Local 1175 v. N.L.R.B., 419 F.2d 726, 731 (D.C. Cir. 1969); N.L.R.B. v. General Electric Co., 418 F.2d 736, 756-62 (2d Cir. 1969), cert. denied, 397 U.S. 965 (1970); N.L.R.B. v. McLane Co., 405 F.2d 483, 484 (5th Cir. 1968); N.L.R.B. v. Reed & Prince Mfg. Co., 205 F.2d 131, 134-35 (1st Cir. 1953), cert. denied, 346 U.S. 887 (1953) ("the employer is obliged to make some reasonable effort in some direction to compose his differences with the union"; emphasis in original); Majure v. N.L.R.B., 198 F.2d 735 (5th Cir. 1952). See generally Swordlow, Freedom of Contract in Labor Law, 51 Tex. L. Rev. 1 (1972).

[7]As one commentator has noted, "what is in the best interest of the students and the community is not always in the best interests of teachers." Rand, Symposium on Teacher Bargaining: Commentary, 50 Ind. L.J. 344, 350 (1975).

[8]The holding of the majority in Abood was that a union shop or agency shop agreement for public employees, requiring all employees in the bargaining unit to make financial contributions to the union, did not violate the first amendment rights of employees who objected to the union. The same rule obtains for unions in the private sector. Although Justice Powell concurred in the majority's decision to remand the case for further proceedings, he disagreed with this constitutional holding. Unlike the majority, he felt that the differences between public and private employment compelled a holding that agency shop or union shop agreements in the public sector are forbidden by the first amendment.

See generally Rehmus, Constraints on Local Governments in Public Employee Bargaining, 67 Mich. L. Rev. 919 (1969); Shaw and Clark, The Practical Differences Between Public and Private Sector Collective Bargaining, 19 U.C.L.A. L. Rev. 867 (1972); Summers, Public Sector Bargaining: Problems of Government Decisionmaking, 44 U. Cinn. L. Rev. 669 (1975); Summers, Public Employee Bargaining: A Political Perspective, 83 Yale L.J. 1156 (1974); Wellington & Winter, The Limits of Collective Bargaining in Public Employment, 78 Yale L.J. 1107 (1969); Project, Collective Bargaining and Politics in Public Employment, 19 U.C.L.A. L. Rev. 887, 1010-51 (1972). Supp. 1036, 1039-40 (D.N.J. 1975), aff'd, 546 F.2d 418 (3d Cir. 1976) (requirement that attorneys have graduated from law schools accredited by the American Bar Association). See generally, 1 K. Davis, Administrative Law Treatise §2.14 (Supp. 1970) (collecting cases). See also 1 Id. §2.15 (1958).

[9]The teachers' unions in the case at bar argue that Dunnellen was overruled by later legislation. The statute in question dealt with only a limited aspect of bargaining; and Dunnellen has been followed by the courts despite the statutory amendment. See, e.g., Galloway Tp. Bd. of Ed. v. Galloway Tp. Ed. Ass'n, 343 A.2d 133 (N.J. Super. 1975).

[10]Or 5 U.S.C. §7512(a) under the Veterans Preference Act.

FISCAL NOTE

I. REQUEST

Bill/Resolution No. House Bill 453 "An Act relating to Labor Relations between School
Title Boards and other public employers and their employees."

Requested by HESS Committee Date 4/18/79

II. FISCAL DETAIL

Agency Affected Department of Labor

Program Category Affected Public Protection

BRU, Program, or Subprogram(s) Affected Wage and Hour Administration

(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

		FY 80	FY 81	FY 82	FY 83	FY 84	FY 85
100	PERSONAL SERVICES		28.8	28.8	28.8	28.8	28.8
200	TRAVEL		16.1	17.2	18.4	19.7	21.0
300	CONTRACTUAL		10.7	11.4	12.3	13.1	14.0
400	COMMODITIES		.2	.2	.2	.3	.3
500	EQUIPMENT		0	0	0	0	0
600	LAND & STRUCTURES		0	0	0	0	0
700	GRANTS, CLAIMS, ETC.		0	0	0	0	0
	TOTAL		55.8	57.6	59.7	61.9	64.1

FUNDING (Thousands of Dollars)

GENERAL FUND	55.8	57.6	59.7	61.9	64.1	
FEDERAL FUNDS						
OTHER (Specify Fund Source)						

POSITIONS

FULL TIME	1	1	1	1	1	
PART TIME						
TEMPORARY						

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

1. Personal Services cost of current salary schedule cost (1/28/80), does not reflect any outstanding salary increases not yet approved by Legislature.

2. Travel to remote areas, $15,000 - Wage & Hour Investigator I, Range 16, Juneau.

3. Contractual Services, $10,000, includes Legal Services cost for Attorney General's Office.

4. Equipment, $1,000 - Desk, Chair, Bookcase, Calculator and recorder.

5. Inflation factor used - 7% for all items, except Personal Services.

6. Assumes effective date of July 1, 1980.

IV. DATE January 28, 1980 PREPARED BY James Souby III

AGENCY Labor

PHONE 465-2720

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)

33-001 (Rev. 12/79)

TOTEM ASSOCIATION OF EDUCATIONAL SUPPORT PERSONNEL

3205 East 17th Anchorage, AK 99504
w-278-9531, h-276-7585

January 23, 1980

Representative Thelma Buchholdt
Pouch V
Juneau, Alaska 99811

Dear Representative Buchholdt

It is our understanding that House Bill 453 is scheduled for a hearing before the Health, Education & Social Services Committee, which you chair, on January 28, 1980.

H.B. 453 is very important to every non-certificated school district employee throughout the state. As we explained to you in our letter of November 1979, we strongly support legislation which would bring classified employees under the protection of the Public Employment Relations Act, which H.B. 453 does.

Thank you for scheduling a hearing for this bill. We will be closely monitoring the progress of H.B. 453 and stand ready to provide you with any information you may need.

Sincerely

TOTEM ASSOCIATION OF EDUCATIONAL
SUPPORT PERSONNEL

Patricia M. Gold

Patricia M. Gold, President

pmg/js

CLASSIFIED PERSONNEL ORGANIZATION
Fairbanks North Star Borough School District
958 Cowles—Room 261
Fairbanks, Alaska 99701 (907) 452-2023

January 18, 1980

Representative Thelma Buchholdt, Chairperson
House Committee on Health, Education and Social Services
Pouch V
Juneau, Alaska 99811

Dear Representative Buchholdt:

Our organization has been informed that H.B. 453 is scheduled for committee hearing on January 28, 1980.

H.B. 453 is very important to our organization and to all non-certificated employees of school districts throughout the State of Alaska. Therefore we support H.B. 453 most vigorously, and urge its passage.

The intent of the legislature when the Public Employment Relations Act was enacted was to create an orderly process by which public employees could collectively resolve problems. The law provides for a problem-solving mechanism which results in acceptable agreement. The law also defines unfair labor practices and provides that mechanism for resolving such charges. Under PERA, finality to the collective bargaining process and related concerns is provided either through binding arbitration or the right to strike. Non-certificated school district employees do not have the above provisions of law available to them. Equity requires that this small group of public employees also be afforded recognition as provided by the Public Employment Relations Act.

We would like to take this opportunity to thank you for your concern in this matter. If we can assist you in gaining passage of this legislation, please so advise.

Sincerely

Iola Harris,
President

THE LEGISLATURE OF THE STATE OF ALASKA
ELEVENTH LEGISLATURE

FISCAL NOTE

I. REQUEST

Bill/Resolution No. HB 453

Title An Act relating to labor relations between school boards and other public employers and their employees

Requested by House HESS Date 1/24/80

II. FISCAL DETAIL

Agency Affected Department of Education

Program Category Affected Education

BRU, Program, or Subprogram(s) Affected

(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 80	FY 81	FY 82	FY 83	FY 84	FY 85
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL						
400 COMMODITIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC.						
TOTAL		0	0	0	0	0

FUNDING (Thousands of Dollars)

GENERAL FUND		0	0	0	0	0
FEDERAL FUNDS						
OTHER (Specify Fund Source)						

POSITIONS

FULL TIME						
PART TIME						
TEMPORARY						

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

Fiscal impact cannot be quantified

IV. DATE 1/28/80 PREPARED BY William D. Thomson, Deputy Commissioner

AGENCY Department of Education

PHONE 465-2800

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)

33-001 (Rev. 12/79)

February 1, 1980

SHARON J. DOWELL
5703 STERLING WAY
ANCHORAGE, ALASKA 99504

Hon. Mike Miller
Alaska House of Representatives
State Capitol
Juneau, Alaska 99811

Dear Representative:

Like most Alaska voters, I believe that a worker should not be forced to join or support a union in order to get or keep a job.

Please cast your every vote against H.B. 453 - or any other bill that would force teachers and education employees to pay a union in order to work.

I'll be very interested to hear from you on your stand concerning this issue.

Sincerely yours,

Sharon Dowell

February 1, 1980

Hon. Mike Miller
Alaska House of Representatives
State Capitol
Juneau, Alaska 99811

Dear Representative:

Like most Alaska voters, I believe that a worker should not be forced to join or support a union in order to get or keep a job.

Please cast your every vote against H.B. 453 - or any other bill that would force teachers and education employees to pay a union in order to work.

I'll be very interested to hear from you on your stand concerning this issue.

Sincerely yours,

Tawana John

ST RT BOX 1783-J
Anch 99502

Hon. Mike
AK House o
State Capi
Juneau, Ak

February 1, 1980

Hon. Mike Miller
Alaska House of Representatives
State Capitol
Juneau, Alaska 99811

Dear Representative:

Like most Alaska voters, I believe that a worker should not be forced to join or suppor' a union in order to get or keep a job.

Please cast your every vote against H.B. 453 - or any other bill that would force teachers and education employees to pay a union in order to work.

I'll be very interested to hear from you on your stand concerning this issue.

Sincerely yours,

Mary L. Cook

Mary L. Cook
Box 1557, Star Route A
Anchorage, AK 99507

Hon. Mike Miller
Alaska House of Representatives
State Capitol
Juneau, AK 99811

February 1, 1980

Hon. Mike Miller
Alaska House of Representatives
State Capitol
Juneau, Alaska 99811

Dear Representative:

Like most Alaska voters, I believe that a worker should not be forced to join or support a union in order to get or keep a job.

Please cast your every vote against H.B. 453 - or any other bill that would force teachers and education employees to pay a union in order to work.

I'll be very interested to hear from you on your stand concerning this issue.

Sincerely yours,

M Sanders

M Sanders
1503-B East 40th
Anchorage, AK 99504

Hon. Mike Miller
Alaska House of Representatives
State Capitol
Juneau, AK 99811

P.O. Box 406
Haines, Alaska 99827
September 31, 1980

Representative Mike Miller
Alaska House of Representatives
State Capitol
Juneau, Alaska 99811

Dear Representative Miller:

Like most Alaskan voters, I believe that a worker should not be forced to join or support a union in order to get or keep a job.

Please cast your vote against H. B. 453--or any other bill that would force teachers and education employees to pay a union in order to work.

I'll be interested to hear from you on your stand concerning this issue.

Thank you very much for your kind attention to this matter.

Yours truly,

Alan W. Heinrich

ALan W. Heinrich

The National Right to Work Agency in Virginia

called 1/17/80

Against HB 453

contact person
Ruth Ann Hoel
703- 573-8550

(6) For the purposes of This Section The arbitrators shall be selected in This manner. The Teachers shall apoint one of the Panel of arbitrators. The school board shall apoint One of The arbitrators and One shall be elected From the school district boundrys on an at large basis. All Three members shall be Resedences of The district.

PROPOSED AMENDMENT TO HB 453
Offered by the Seventh Day Adventist Church

On page 1, line 17, after " . . . agreement.", insert the following:

However, agreement involving union security including an all union agreement or agency agreement must safeguard the rights of non-association employees, based on bona fide religious tenents or teachings of a church or religious body of which such employee is a member. Such employee must pay an amount of money equivalent to regular union dues and initiation fees and assessment, if any, to a non-religious, non-union charity mutually agreed upon by the employee affected and the representative of the employee's bargaining organization to which such employee would otherwise pay dues. The employee shall furnish written proof that this has been done.

TESTIMONY OF LORI SEARS, NEA-ALASKA BEFORE THE JOINT MEETING OF THE HESS COMMITTEE - April 7, 1979

Working Conditions for Teachers

As a result of the narrow view School Boards are taking on items that are negotiable and the 1977 Supreme Court decision, we are seeking the inclusion of working conditions as negotiable items between teachers and their school boards.

The recent DOE Task Force report on Regional High Schools cited the high teacher turnover, among other things, as an interruption in the educational process of rural children. We believe that that high turnover, in part, is due to teachers not being properly informed of the demands placed upon them that are beyond the normal duties of a classroom teacher.

Many accept a teaching position and then discover their duties include additional non-instructional duties that have not been spelled out in the teaching contract or the negotiated agreement. Some of the activities required of teachers by districts are:

- Repair and maintain the school's generators
- Be present at all Community School Committee meetings, Parent advisory meetings for: Indian Education, Johnson O'Malley, Title I and Special Ed
- Supervise and handle paperwork (tends to be massive) for: janitors, cooks, and aides
- Supervise lunch hours
- Provide/supervise community recreation and/or activities like: town movies, dances, PE activities in the gym
- Emergency repairs to schools (if the roof leaks, fix it)
- Haul freight to school from airport or river

In our urban areas, the greatest working condition is the number of students one is required to teach without regard for the type of student who is to be instructed. With mainstreaming of the exceptional child being an intregal part of our classrooms, teachers are finding classloads to be excessive when three or four severely handicapped youngsters are placed in already crowded classrooms. We support the education of all exceptional children in the least restrictive environment, but we do not feel proper attention has been given to the problems the classroom teacher faces when mainstreaming is done without regard to class size.

We feel that the negotiations table is a proper setting to discuss these duties and requirements placed upon teachers that have been narrowly construed to be policy matters rather than conditions pertaining to the fulfillment of our professional duties.

ANALYSIS OF HOUSE BILL 453

Department of Labor
Office of the Commissioner
Phone: 465-2700

April 19, 1979

Title: "An Act relating to labor relations between school boards and other public employers and their employees."

This legislation would make it mandatory for all school boards to permit their non-certificated employees to enter into collective bargaining and they would be covered by the Public Employment Relations Act. This bill would cover persons that have been barred form entering into collective bargaining under present law. The Department of Labor acts as the Labor Relations Agency for all public employees except State employees and would have to take on the added duties for these employees to conduct elections, hold hearings and settle grievances throughout the state.

Section 1. AS 14.20.550 sets out what the school board must negotiate with the certified teachers on, and (b) gives the Department of Labor the authority to settle any disagreements over working conditions if the certificated employees and school boards cannot agree.

Section 2. AS 23.40.100(b) makes it mandatory that no representation be placed on the initial election ballots, for elections conducted under the Public Employment Relations Act.

Section 3. AS 23.40.200(c) prohibits non-certificated employees of school boards from engaging in a strike.

Section 4. AS 23.40.250(5) and (6): (5) takes away the exemption for non-certificated school board employees. (6) makes a school board a public employer under PERA.

Section 5. AS 23.40.250 defines school board for PERA.

Section 6. makes it mandatory for school boards to permit their non-certificated employees to enter into collective bargaining covered by the Public Employment Relations Act.

Section 7. Any collective bargaining agreement already entered into are not covered by these laws.

Fiscal Impact - The bill would require one new position with adequate funding for additional travel and other non-personal services expenses.

Conflicting Bills - Senate Bill 213

Departmental Position - Neutral

CITY AND BOROUGH OF JUNEAU SCHOOL DISTRICT
P.O. BOX 808 • DOUGLAS, ALASKA 99824

February 5, 1980

The Honorable Mike Miller
Alaska State House of Representatives
Pouch V
Juneau, Alaska 99811

Dear Representative Miller:

The Juneau School Board wishes to go on record as being opposed to House Bill 453 and House Bill 487 for the following reasons and respectfully request that you do not support them.

House Bill 453 provides the right to strike to all employees of the School District, and in addition, provides mandatory bargaining to all employees with broad interpretations to what must be bargained. At the present time the Juneau School District negotiates with their classified employees so the legislation is not necessary, and above all, should not include the right for any employees to strike. Please remember that school boards in Alaska cannot raise money on their own, but must come to the Borough Assembly or Legislature for additional revenue. A striking action against the Board allows them no additional revenue with which to resolve the strike. Therefore, educational programs are cut back.

House Bill 487 on binding arbitration removes the decision making authority from the elcted representatives of the people. Instead of leading to a solution of the problem by serious negotiations by both parties to avoid arbitration, often one or the other parties will hold out for arbitration. Historically arbitrators split the difference and everyone holds out with extreme offers as tactical maneuvers.

It is our opinion that the State Board of Education request to the Governor to form a Blue Ribbon Committee to seek the best alternative to the serious problems of negotiation should be honored. Passage of legislation before the study would be premature.

With the legislatures having second thoughts over the collective bargaining of State employees and contemplating some modifications, it seems appropriate to allow a study of the problems to take place before enacting legislation that may not serve any useful purpose.

THE LEGISLATURE OF THE STATE OF ALASKA
ELEVENTH LEGISLATURE

FISCAL NOTE

I. REQUEST
Bill/Resolution No. House Bill 453
Title "An act relating to labor relations between school boards and other public employees and their employees"
Requested by Parr Date 4/18/79

II. FISCAL DETAIL
Agency Affected Department of Labor
Program Category Affected Public Protection
BRU, Program, or Subprogram(s) Affected Wage and Hour Administration
(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 79	FY 80	FY 81	FY 82	FY 83	FY 84
100 PERSONAL SERVICES		29.5	31.3	33.2	35.2	37.3
200 TRAVEL		15.0	15.9	16.9	17.9	19.0
300 CONTRACTUAL		10.0	10.6	11.2	11.9	12.6
400 COMMODITIES		.2	.2	.2	.2	.3
500 EQUIPMENT		1.0	0	0	0	0
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC.						
TOTAL		55.7	58.0	61.5	65.2	69.2

FUNDING (Thousands of Dollars)

GENERAL FUND		55.7	58.0	61.5	65.2	69.2
FEDERAL FUNDS						
OTHER (Specify Fund Source)						

POSITIONS

FULL TIME		1	1	1	1	1
PART TIME						
TEMPORARY						

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

The Department must assume that all non-certificated employees of school boards will enter into collective bargaining. It would require travel to all areas of the state to conduct elections, hold hearings, resolve grievances and unfair labor practices.

It would require the addition of one W/H Investigator I, Range 16, stationed in Juneau. $15,000.00 in additional travel funds to travel to all of the remote areas, $10,000.00 contractual for legal services for the Attorney General's Office, and additional printing costs. $200.00 for commodities and $1,000.00 for equipment; this would include a desk at $329.71, chair $135.63, bookcase $102.04, calculator $209.50 and recorder $223.00.
6% inflation factor used in expenditure analysis.

IV. DATE 4/18/79 PREPARED BY James M. Bouby III
AGENCY Labor
PHONE 465-2720

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)

33-001 (Rev. 12/78)

THE LEGISLATURE OF THE STATE OF ALASKA
ELEVENTH LEGISLATURE

HB 453 Original bill

FISCAL NOTE

I. REQUEST
Bill/Resolution No. House Bill 453
Title "An act relating to labor relations between school [illegible] and other public employees and their employees"
Requested by Rep. Date 4/18/79

II. FISCAL DETAIL
Agency Affected Department of Labor
Program Category Affected Public Protection
BRU, Program, or Subprogram(s) Affected Wage and Hour Administration
(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

		FY 79	FY 80	FY 81	FY 82	FY 83	FY 84
100	PERSONAL SERVICES		29.5	31.3	33.2	35.2	37.3
200	TRAVEL		15.0	15.9	16.9	17.9	19.0
300	CONTRACTUAL		10.0	10.6	11.2	11.9	12.6
400	COMMODITIES		.2	.2	.2	.2	.3
500	EQUIPMENT		1.0	0	0	0	0
600	LAND & STRUCTURES						
700	GRANTS, CLAIMS, ETC.						
	TOTAL		55.7	58.0	61.5	65.2	69.2

FUNDING (Thousands of Dollars)

GENERAL FUND		55.7	58.0	61.5	65.2	69.2
FEDERAL FUNDS						
OTHER (Specify Fund Source)						

POSITIONS

FULL TIME		1	1	1	1	1
PART TIME						
TEMPORARY						

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

The Department must assume that all non-certificated employees of school districts will enter into collective bargaining. It would require travel to remote areas of the state to conduct elections, hold hearings, resolve representation disputes and unfair labor practices.

It would require the addition of one W/H Investigator I, Range 16, stationed in Juneau. $15,000.00 in additional travel funds to travel to all of the remote areas, $10,000.00 contractual for legal services for the Attorney General's Office, and additional printing costs. $200.00 for commodities and $1,000.00 for equipment; this would include a desk at $329.71, chair $135.63, bookcase $102.04, calculator $109.50 and recorder $223.00.
6% inflation factor used in expenditure analysis.

IV. DATE 4/18/79 PREPARED BY James M. Baxley III
AGENCY Labor
PHONE 465-2720

Original: Legislative Finance
cc: Budget and Management
✓Prime Sponsor (First Legislator Named) Rep Charlie Parr

23-001 (Rev. 12/78)

TELEGRAM

RCA ALASKA COMMUNICATIONS, INC.
PHONE: 586-6440
JUNEAU, ALASKA 99801

#

02166 NL ANCHORAGE AK 50 03-07 810P AST

PMS REP THELMA BUCHHOLDT

JUN

WE ARE APPALLED BY THE COMPROMISING POSITION IN WHICH HB489 PLACES LOCAL SCHOOL BOARDS. WE WILL LOSE LOCAL CONTROL ENTIRELY

PLEASE VOTE NO

HEATHER FLYNN

ANCHORAGE SCHOOL BOARD

HFSS coming up on Com. on Friday

TELEGRAM

ACA ALASKA COMMUNICATIONS, INC.
PHONE: 586-6440
JUNEAU, ALASKA 99801

#

02098 POM ANCHORAGE ALASKA 15 02-01 750P AST

PMS REP BUCHHOLDT

JUN

I SINCERELY URGE THE PASSAGE OF HB489 TO STOP THE

DISCRIMINATION AGAINST THE NONCERTIFIED SCHOOL EMPLOYEES

CARL W JONES PO BOX 684 HOMER AK 99603

FEB 1 1978

TELEGRAM

ALASKA COMMUNICATIONS, INC.
PHONE: 586-6440
JUNEAU, ALASKA 99801

#

02078 NL ANCHORAGE ALASKA 50 02-01 810P AST

PMS REP BUCHHOLDT

JUN

I URGE FULL SUPPORT OF HB489 FOR PASSAGE THIS LEGISLATIVE SESSION.

MARGO KALVA BOX 1262 SOLDOTNA AK

1978 FEB 1 PM 11 48

TELEGRAM

...CA ALASKA COMMUNICATIONS, IN...
PHONE: 586-6440
JUNEAU, ALASKA 99801

#

02088 NL ANCHORAGE ALASKA 50 02-01 810P AST

PMS REP BUCHHOLDT

JUN

I URGE FULL SUPPORT OF HB489 FOR PASSAGE THIS LEGISLATIVE SESSION.

DORIS B BAXLEY BOX 335 SOLDOTNA AK

FEB 1 PM 11

TELEGRAM

RCA ALASKA COMMUNICATIONS, INC.
PHONE: 586-6440
JUNEAU, ALASKA 99801

#

02107 NL ANCHORAGE ALASKA 50 02-01 730P AST

PMS REP BUCHHOLD:

JUN

ONGLY URGE YOUR COMMITTEE TO PASS HB489

IN THE BEST INTEREST OF THE NONCERTIFIED PUBLIC EMPLOYEES

OF ALASKA.

DARLENE TACHICK BOX 1506 SOLDOTNA AK 99669

1978 FEB 1 PM 8 03

TELEGRAM

ALASKA COMMUNICATIONS, INC.
PHONE 586-6440
JUNEAU, ALASKA 99801

#

02116 NL ANCHORAGE ALASKA 50 02-01 830P AST

PMS REP BUCHHOLDT

JUN

I URGE FULL SUPPORT OF HB489 FOR PASSAGE THIS LEGISLATIVE SESSION.

DARWIN AND KAYE WALDSMITH BOX 154 NINILCHIK AK 99639

1978 FEB 1 PM 8

TELEGRAM

DBA ALASKA COMMUNICATIONS, INC
PHONE: 586-6440
JUNEAU, ALASKA 99801

1978 FEB 1 PM 11

#

02145 POM ANCHORAGE ALASKA 15 02-01 925P AST

PMS REP BUCHHOLDT

JUN

IM IN FULL SUPPORT OF HB489.

ROY E BROWN JR TEACHER KENAI CENTRAL HIGH SCHOOL

BOX 762 SOLDOTNA AK

TELEGRAM

ACA ALASKA COMMUNICATIONS, INC
PHONE: 586-6440
JUNEAU, ALASKA 99801

FEB 2 PM 1978

02155 POM ANCHORAGE ALASKA 15 02-01 938P AST

PMS REP THELMA BUCHHOLDT

JUN

UURGE YOU SUPPORT HB489 TO END NEGOTIATION DISCRIMINATION

AGAINST CLASSIFIED EMPLOYEES.

GARY AND GEORGIA ALEXANDER

ROUTE 2 BOX 745 SOLDOTNA AK

TELEGRAM

ACA ALASKA COMMUNICATIONS, INC
PHONE: 586-6140
JUNEAU, ALASKA 99801

02068 NL TDA KENAI ALASKA 56 02-01 0605P AST

PMS REP THELMA BUCHHOLDT

JUN

I SINCERELY URGE THE PASSING OF HB489 TO STOP THE DISCRIMINATION AGAINST THE NON-CERTIFICATED SCHOOL EMPLOYEES. RECOGNITION MUST BE GIVEN TO THESE EMPLOYEES TO INSURE THAT THEY DO IN FACT HAVE THE SAME BARGAINING RIGHTS AS ANY OTHER PUBLIC EMPLOYEES.

GAIL M SIBSON PRESIDENT KENAI PENINSULA BOROUGH SCHOOL DISTRUCT CLASSIFIED ASSOTION LOCAL 3255 AFT PO BOX 1221 HOMER AK 99603

RECEIVED
FEB 6 1978

ST. MARY'S SCHOOL DISTRICT

BOX 71
ST. MARYS. ALASKA
99658

LICAUVICUAG ELEMENTARY

ANDREAFSKY HIGH

Feb. 13, 1978

Representative William Akers
Pouch V-State Capitol
Juneau, Alaska 99811

Dear Billy:

I have heard about HB 489 which would require School Boards to bargain with classified employees.

We here do this already. Every year our certified and classified staffs negotiate an annual agreement with the Shcool Board. Obviously we are in favor of both classified and certified employees negotiating with the School Board.

Our negotiations with both groups is held within the parameters of the recent Alaska Supreme Court decision which outlines negotiable and non-negotiable items for certified public school teachers in Alaska.

We would very definitely oppose any legislation which would give our certified staff the right to strike. I understand this is what some of the House HESS Committee would like to see happen since they are talking about placing these employees under the State Public Employees Relations Act.

With every best wish, I remain,

Yours sincerely,

Walter E. Brown

Walter E. Brown
Superintendent

xc: Senator John Sackett
Representative Thelma Buckholdt ✓
William D. Overstreet, Association of Alaska School Boards

WEB:deb

Signed and today,
DoPass - Friano

KODIAK ISLAND BOROUGH SCHOOL DISTRICT
P.O. BOX 886
KODIAK, ALASKA 99615
TELEPHONE: (907) 486-3131

February 4, 1980

The Honorable Thelma Buchholdt
Alaska State House of Representatives
Pouch V, State Capitol Building
Juneau, Alaska 99811

Dear Representative Buchholdt:

The Kodiak Island Borough School District opposes the passage of HB 487 providing for binding arbitration in teacher negotiations. Neither binding arbitration or right to strike laws are the only solution to solving collective bargaining issues. It has been proven that good faith negotiations, presently provided for in State law, do work. Salaries for teachers in Alaska are comparable with other states that provide for both more restrictive and more liberal solutions to collective bargaining. In fact, we question that binding arbitration or the right to strike is a solution at all. They both create problems for local citizens by removing the right to locally determine the fate of their schools, and in the case of a strike, cause an unnecessary division in the parents, students and other constituents of the local district. The point is--education is a local responsibility. State law should not provide for outside third-parties to mandate local outcomes and remove the control of schools from local citizens.

As we stated earlier, the collective bargaining process (good faith negotiations) as it exists now, works. Currently, elected board representatives and representatives of teacher groups can and do sit down to work out mutually acceptable agreements. The give and take of negotiations provides an acceptable process which does function adequately. Can teachers honestly say that the negotiations process, as provided in Alaska State law, does not give them with a wage commensurate with teachers throughout the nation, and in keeping with other Alaskan professionals? We think not.

The law protects the teacher's right to a job by provisions for continuing the contract. The law protects the citizen's rights by mandating local control. Teachers and elected Boards have the responsibility to negotiate. Providing for binding arbitration or the right to strike will erode and eventually destroy that process.

We urge you to reject any proposals that provide for State laws which result in the abdication by local boards and teacher associations of their collective responsibility to negotiate.

Sincerely,

John E. Anttonen

John E. Anttonen
Superintendent

CITY AND BOROUGH OF JUNEAU SCHOOL DISTRICT
P.O. BOX 808 • DOUGLAS, ALASKA 99824

February 5, 1980

The Honorable Thelma Buchholdt
Alaska State House of Representatives
Pouch V
Juneau, Alaska 99811

Dear Representative Buchholdt:

The Juneau School Board wishes to go on record as being opposed to House Bill 453 and House Bill 487 for the following reasons and respectfully request that you do not support them.

House Bill 453 provides the right to strike to all employees of the School District, and in addition, provides mandatory bargaining to all employees with broad interpretations to what must be bargained. At the present time the Juneau School District negotiates with their classified employees so the legislation is not necessary, and above all, should not include the right for any employees to strike. Please remember that school boards in Alaska cannot raise money on their own, but must come to the Borough Assembly or Legislature for additional revenue. A striking action against the Board allows them no additional revenue with which to resolve the strike. Therefore, educational programs are cut back.

House Bill 487 on binding arbitration removes the decision making authority from the elected representatives of the people. Instead of leading to a sclution of the problem by serious negotiations by both parties to avoid arbitration, often one or the other parties will hold out for arbitration. Historically arbitrators split the difference and everyone holds out with extreme offers as tactical maneuvers.

It is our opinion that the State Board of Education request to the Governor to form a Blue Ribbon Committee to seek the best alternative to the serious problems of negotiation should be honored. Passage of legislation before the study would be premature.

With the legislatures having second thoughts over the collective bargaining of State employees and contemplating some modifications, it seems appropriate to allow a study of the problems to take place before enacting legislation that may not serve any useful purpose.

The Juneau School District would appreciate your support on these two matters.

Sincerely,

Carole Burger

Carole Burger, President
Juneau School Board

DLMK/CB:m

cc: Mr. Robert Greene, Executive Secretary, Association of Alaska School Boards

GREATER SITKA BOROUGH SCHOOL DISTRICT
ACCREDITED BY THE NORTHWEST ASSOCIATION OF SECONDARY SCHOOLS & COLLEGES

P. O. BOX 179 SITKA, ALASKA 99835

JOHN E. COFFEE
SUPERINTENDENT

January 30, 1980

Representative Thelma Buchholdt
AK State House of Representatives
Pouch V, State Capitol Building
Juneau, AK 99811

Dear Representative Buchholdt:

I am writing because of my concern about two pieces of legislation that are before your H. E. S. S. Committee at this time. They are H.B. 487 and H.B. 453. The passage of these bills would result in the following:

(1) give teachers the right to strike
(2) allow school district classified employees the right to organize and strike
(3) expand what is bargainable
(4) provide binding arbitration in teacher bargaining

I believe that these bills together constitute a tremendous threat to local decision making and the local school board's right to operate a district responsibly and make some final decisions.

Binding arbitration would effectively place decision making authority in the hands of an entity outside the school district. This would be in direct contradiction to the local control theory of government. School boards are elected by law to manage the affairs of the district. They are, further, required by law to bargain in good faith on various items. This is currently done throughout the State. The result has been, generally, the highest paid teachers in the nation, working, in my view, in some of the best working conditions in the nation. I would refer you to the 1978-79 Alaska Association of School Boards publication entitled Survey of School District Budgeted Revenues, Expenditures, and Employee Benefits. It is my view that teacher unions are doing very well without having further advantages of binding arbitration, expanded bargainable items, and the right to strike.

In Sitka, we have recently received an advisory arbitrator's report that the Board has approved and that the teacher's union will vote on

soon. Hopefully, this will be the culmination of negotiations that began in November of 1978. If the report is accepted we will have a beginning teacher salary here of over $20,000. and a top salary of over $36,000.

The school boards I have worked for in Juneau and Sitka have been made up of reasonable people whose main motives have been to serve the community they represent. Final decision making authority on items that are bargainable must not be taken away from such local officials and given to an outside arbitrator.

I am hopeful that the representative of the Alaska School Board's Association, Mr. Robert Greene, and the respresentative of the Alaska Association of School Administrators, Dr. Cliff Hartman, will be listened to carefully by the H. E. S. S. Committee when they discuss the ramifications of these proposed bills. It is vital that such legislation not become law.

Sincerely,

John E. Coffee, Superintendent
Sitka Borough School District

cc: Senator Pete Meland
Representative Richard Eliason
Mr. Robert Greene, A. A. S. B.
Dr. Cliff Hartman, A. A. S. A.
Sitka School Board

JEC:vhv

LAW OFFICES

JOSEPHSON, TRICKEY & LORENSEN, INC.

210 NORTH FRANKLIN STREET
JUNEAU, ALASKA 99801
907 586-6994, 586-6997

JOE P. JOSEPHSON
HOWARD S. TRICKEY
RONALD W. LORENSEN*
NANCY R. GORDON
TIM MacMILLAN

*Juneau

ANCHORAGE:
425 "G" STREET
SUITE 930
ANCHORAGE, ALASKA 99501
907 276-7133

January 28, 1980

The Honorable Thelma Buchholdt
Chairman
House Health, Education and Social
Services Committee
State Capitol
Pouch V
Juneau, Alaska 99811

Re: HB 487, Relating to Arbitration and Teacher Negotiations

Dear Representative Buchholdt:

The following comments regarding HB 487 (Arbitration and Teacher Negotiations) are submitted on behalf of the Lower Kuskokwim School District.

HB 487 would mandate that binding arbitration be utilized as the final step in employment contract negotiations between teacher bargaining groups and local school boards. The issue of binding arbitration, of course, has been fervently (and often emotionally) debated over the last few years, with the Anchorage teachers' strike of last Fall serving to punctuate emphatically the need for some orderly and reasoned approach to the problems of collective bargaining impasse. In fact, the path of resolution followed by the Superior Court in Anchorage in responding to that strike seems to indicate that, in the absence of a legislative framework for resolution of bargaining impasses, the courts will take it upon themselves to act as binding arbitrators, rather than permit the civil disobedience and disruption which can arise in teacher strikes. The task, therefore, becomes one of identifying alternative solutions to the impasse problem and analyzing their respective merits in the light of the various policy considerations which impact upon labor relations between public schools and their teacher employees.

Binding arbitration as proposed in HB 487 is one possible solution. However, until this approach can be examined and analyzed in comparison with other approaches to bargaining impasse, there is no assurance that this impasse resolution mechanism is the most appropriate one for education in Alaska. The state Board of Education recently adopted a resolution requesting the Governor to appoint a panel to study and develop alternative solutions to the bargaining impasse problem, and we understand that this panel will be appointed in the very near future. Consequently, we would suggest that further consideration on HB 487 be delayed until the Governor's panel has had an opportunity to

carry out its tasks and report back with its findings and recommendations. Once this has been accomplished, your committee could review the available alternatives and decide which of them most closely fits within the various policy considerations which are important to it in the area of education.

With respect to the particular approach to bargaining impasse proposed by HB 487, we have a couple of comments. First of all, it is not clear from the bill precisely what elements of the collective bargaining process are intended to be subject to binding arbitration. For instance, while it seems clear that binding arbitration would apply to disputes concerning salary and other financial benefits of teachers, it is not clear whether items regarding working conditions which do not directly involve financial considerations would also be subject to binding arbitration. Further, would the bill require that those items of negotiations which are not mandatory subjects of bargaining nonetheless be subject to binding arbitration? We would certainly hope not. Similarly, we also wonder whether the bill would require that disputes over questions of precise contract language be subject to binding arbitration, rather than just the general outlines of disputed proposals. Clarification of these kinds of questions seems vital if the impasse resolution procedure adopted by the Legislature, whatever its form, is to have any hope of achieving its desired effect.

Our second main point with respect to HB 487 deals with subparagraph (c) of proposed AS 14.20.585. That provision is apparently intended to preclude arbitrators from making awards which would result in increased costs to a school district. That goal, of course, has much to recommend it. However, from a practical point of view, it would be very difficult, if not impossible, to establish that a particular award would actually increase the cost of school district operations so as to require a municipality to increase its local tax rate or to require increased state funding for a regional educational attendance area, since the argument can always be made that additional costs in one area of operations can always be absorbed by reducing planned expenditures in some other area of the budget.

Sincerely yours,

LOWER KUSKOKWIM SCHOOL DISTRICT

Carl A. Peterson

Carl Peterson, Superintendent

JOSEPHSON, TRICKEY & LORENSEN, INC.

By: Ronald W. Lorensen

RWL:jf

KODIAK ISLAND BOROUGH SCHOOL DISTRICT
P.O. BOX 886
KODIAK, ALASKA 99615
TELEPHONE: (907) 486-3131

February 4, 1980

The Honorable Thelma Buchholdt
Alaska State House of Representatives
Pouch V, State Capitol Building
Juneau, Alaska 99811

Dear Representative Buchholdt:

The Kodiak Island Borough School District opposes the passage of HB 487 providing for binding arbitration in teacher negotiations. Neither binding arbitration or right to strike laws are the only solution to solving collective bargaining issues. It has been proven that good faith negotiations, presently provided for in State law, do work. Salaries for teachers in Alaska are comparable with other states that provide for both more restrictive and more liberal solutions to collective bargaining. In fact, we question that binding arbitration or the right to strike is a solution at all. They both create problems for local citizens by removing the right to locally determine the fate of their schools, and in the case of a strike, cause an unnecessary division in the parents, students and other constituents of the local district. The point is--education is a local responsibility. State law should not provide for outside third-parties to mandate local outcomes and remove the control of schools from local citizens.

As we stated earlier, the collective bargaining process (good faith negotiations) as it exists now, works. Currently, elected board representatives and representatives of teacher groups can and do sit down to work out mutually acceptable agreements. The give and take of negotiations provides an acceptable process which does function adequately. Can teachers honestly say that the negotiations process, as provided in Alaska State law, does not give them with a wage commensurate with teachers throughout the nation, and in keeping with other Alaskan professionals? We think not.

The law protects the teacher's right to a job by provisions for continuing the contract. The law protects the citizen's rights by mandating local control. Teachers and elected Boards have the responsibility to negotiate. Providing for binding arbitration or the right to strike will erode and eventually destroy that process.

We urge you to reject any proposals that provide for State laws which result in the abdication by local boards and teacher associations of their collective responsibility to negotiate.

Sincerely,

John E. Anttonen

John E. Anttonen
Superintendent

TESTIMONY OF LORI SEARS, NEA-ALASKA BEFORE THE JOINT MEETING OF THE HESS COMMITTEE - April 7, 1979

Working Conditions for Teachers

As a result of the narrow view School Boards are taking on items that are negotiable and the 1977 Supreme Court decision, we are seeking the inclusion of working conditions as negotiable items between teachers and their school boards.

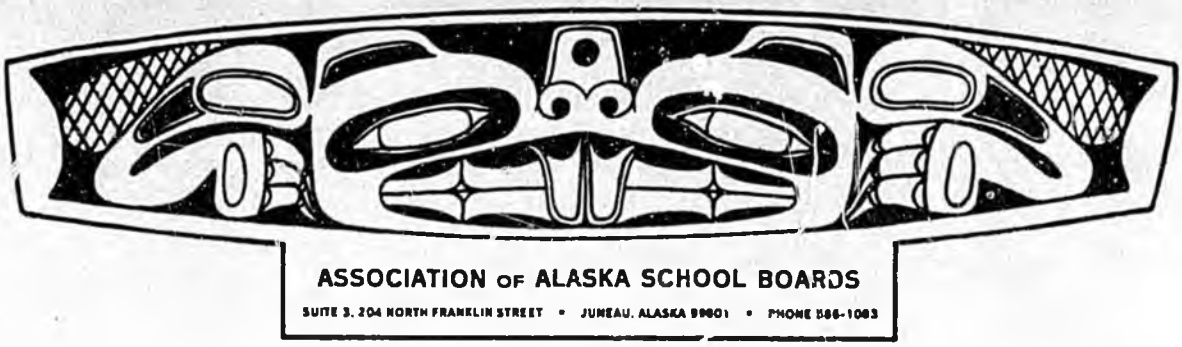
The recent DOE Task Force report on Regional High Schools cited the high teacher turnover, among other things, as an interruption in the educational process of rural children. We believe that that high turnover, in part, is due to teachers not being properly informed of the demands placed upon them that are beyond the normal duties of a classroom teacher.

Many accept a teaching position and then discover their duties include additional non-instructional duties that have not been spelled out in the teaching contract or the negotiated agreement. Some of the activities required of teachers by districts are:

- Repair and maintain the school's generators
- Be present at all Community School Committee meetings, Parent advisory meetings for: Indian Education, Johnson O'Malley, Title I and Special Ed
- Supervise and handle paperwork (tends to be massive) for: janitors, cooks, and aides
- Supervise lunch hours
- Provide/supervise community recreation and/or activities like: town movies, dances, PE activities in the gym
- Emergency repairs to schools (if the roof leaks, fix it)
- Haul freight to school from airport or river

In our urban areas, the greatest working condition is the number of students one is required to teach without regard for the type of student who is to be instructed. With mainstreaming of the exceptional child being an intregal part of our classrooms, teachers are finding classloads to be excessive when three or four severely handicapped youngsters are placed in already crowded classrooms. We support the education of all exceptional children in the least restrictive environment, but we do not feel proper attention has been given to the problems the classroom teacher faces when mainstreaming is done without regard to class size.

We feel that the negotiations table is a proper setting to discuss these duties and requirements placed upon teachers that have been narrowly construed to be policy matters rather than conditions pertaining to the fulfillment of our professional duties.



ASSOCIATION OF ALASKA SCHOOL BOARDS
SUITE 3, 204 NORTH FRANKLIN STREET • JUNEAU, ALASKA 99801 • PHONE 586-1083

FOUR BARGAINING PRINCIPLES

1. Collective bargaining is not a process whereby the general form, quantity or quality of publicservices are to be, or should be, determined. It is not a process for the management of public services.

2. Collective bargaining is not a device to determine public policy except as it may be used to determine the wages and economic benefits that are to be provided for public employees.

3. Collective bargaining is not, nor should it be, a substitute for the proper functioning of a representative government.

4. Collective bargaining should not be permitted to constrain the proper functioning of representative government.

THE RIGHTS OF PUBLIC EMPLOYEES TO STRIKE Vs. THE RIGHTS OF THE PUBLIC.

Because of the basic nature of public services wherein there is no real alternative choice to the established public service, special consideration must be afforded to the protection of both the interests of the general public and the interests of the public employees.

The interests of the general public dictate that any accommodation for collective bargaining and strikes in the public services... ..especially in the public schools... must carefully weigh, and balance, the desire of the employees to organize, bargain and strike against the rights of the public to expect the continued and uninterrupted provision of the public services that public policy has determined should exist. For example, permitting legalized strikes by public employees so upsets the process that the general public cannot withstand the imbalance of power that so results.

IOWA—

Personnel of the board shall be employed pursuant to the provisions of chapter 19A.

5. Members of the board and other employees of the board shall be allowed their actual and necessary expenses incurred in the performance of their duties. All expenses and salaries shall be paid from appropriations for such purposes and the board shall be subject to the budget requirements of chapter 8.

Referred to in sec. 20.3(5)

20.6 General powers and duties of the board. The board shall:

1. Administer the provisions of this chapter.

2. Collect, for public employers other than the state and its boards, commissions, departments, and agencies, data and conduct studies relating to wages, hours, benefits and other terms and conditions of public employment and make the same available to any interested person or organization.

3. Maintain, after consulting with employee organizations and public employers, a list of qualified persons representative of the public to be available to serve as mediators and arbitrators and establish their compensation rates.

4. Hold hearings and administer oaths, examine witnesses and documents, take testimony and receive evidence, issue subpoenas to compel the attendance of witnesses and the production of records, and delegate such power to a member of the board, or persons appointed or employed by the board, including hearing officers for the performance of its functions. The board may petition the district court at the seat of government or of the county wherein any hearing is held to enforce a board order compelling the attendance of witnesses and production of records.

5. Adopt rules in accordance with the provisions of chapter 17A as it may deem necessary to carry out the purposes of this chapter.

20.7 Public employer rights. Public employers shall have, in addition to all powers, duties, and rights established by constitutional provision, statute, ordinance, charter, or special act, the exclusive power, duty and the right to:

1. Direct the work of its public employees.

2. Hire, promote, demote, transfer, assign and retain public employees in positions within the public agency.

3. Suspend or discharge public employees for proper cause.

4. Maintain the efficiency of governmental operations.

5. Relieve public employees from duties because of lack of work or for other legitimate reasons.

6. Determine and implement methods, means, assignments and personnel by which the public employer's operations are to be conducted.

7. Take such actions as may be necessary to carry out the mission of the public employer.

8. Initiate, prepare, certify and administer its budget.

9. Exercise all powers and duties granted to the public employer by law.

20.8 Public employee rights. Public employees shall have the right to:

1. Organize, or form, join, or assist any employee organization.

2. Negotiate collectively through representatives of their own choosing.

3. Engage in other concerted activites for the purpose of collective bargaining or other mutual aid or protection insofar as any such activity is not prohibited by this chapter or any other law of the state.

4. Refuse to join or participate in the activities of employee organizations, including the payment of any dues, fees or assessments or service fees of any type.

Referred to in sec. 20.10

20.9 Scope of negotiations. The public employer and the employee organization shall meet at reasonable times, including meetings reasonably in advance of the public employer's budget-making process, to negotiate in good faith with respect to wages, hours, vacations, insurance, holidays, leaves of absence, shift differentials, overtime compensation, supplemental pay, seniority, transfer procedures, job classifications, health and safety matters, evaluation procedures, procedures for staff reductions, in-service training and other matters mutually agreed upon. Negotiations shall also include terms authorizing dues checkoff for members of the employee organization and grievance procedures for resolving any questions arising under the agreement, which shall be embodied in a written agreement and signed by the parties. If an agreement provides for dues checkoff, a member's dues may be checked off only upon the member's written request and the member may terminate the dues checkoff at any time by giving thirty days' written notice. Such obligation to negotiate in good faith does not compel either party to agree to a proposal or make a concession.

Nothing in this section shall diminish the authority and power of the merit employment department, board of regents' merit system, educational radio and television facility board's merit system, or any civil service commission established by constitutional provision, statute, charter or special act to recruit employees, prepare, conduct and grade examinations, rate candidates in order of their relative scores for certification for appointment or promotion or for other matters of classification, reclassification, or appeal rights in the classified service of the public employer served.

All retirement systems shall be excluded from the scope of negotiations.

Referred to in secs. 20.10, 20.17

20.10 Prohibited practices.

1. It shall be a prohibited practice for any public employer, public employee or employee organization to willfully refuse to negotiate in good faith with respect to the scope of negotiations as defined in section 20.9.

HB
455

THE LEGISLATURE OF THE STATE OF ALASKA
ELEVENTH LEGISLATURE

FISCAL NOTE

I. REQUEST

Bill/Resolution No. HB-455 (Revised 5/16/80 to reflect Ch. 26, SLA 1980)

Title An Act relating to state aid to school districts and REAAs which provide spec. ed. instruction year round.

Requested by House HESS 5/16/80 Date

II. FISCAL DETAIL

Agency Affected Department of Education

Program Category Affected Elementary and Secondary Education

BRU, Program, or Subprogram(s) Affected Foundation Support Programs

(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 80	FY 81	FY 82	FY 83	FY 84	FY 85
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL						
400 COMMODITIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC.		7,914.4	8,705.8*	9,576.4	10,534.1	11,587.5
TOTAL						

FUNDING (Thousands of Dollars)

GENERAL FUND		7,914.4	8,705.8	9,576.4	10,534.1	11,587.5
FEDERAL FUNDS						
OTHER (Specify Fund Source)						

POSITIONS

FULL TIME	N/A					
PART TIME						
TEMPORARY						

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

FY-81 Impact:

REAAs 1,711.7 (.33 x 103 special education FY-81 I.U. x 50,359 average unit cost)

C & B
Districts 6,202.7 (.33 x 507 special education FY-81 I.U. x 37,073 average unit cost)

This impact is based upon the assumption that all districts will participate.

*Fiscal years subsequent to FY-81 inflated at 10% per year.

IV. DATE 5/16/80 PREPARED BY

AGENCY Department of Education

PHONE 465-2800

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)

33-001 (Rev. 12/79)

ALASKA DEPARTMENT OF EDUCATION
POSITION STATEMENT
HOUSE BILL 455

Although the Department has not had the opportunity to discuss the bill with the State Board of Education, we believe the effect of the legislation to be in the best interests of students, and therefore, support it.

5/5/80
Date

Approved by: William D. Thomson
William D. Thomson
Deputy Commissioner
May 2, 1980

House Health, Education & Social Services Committee

Meeting/Hearing on HB 455 Spec ed.

Date: 5/16/80

	Name	Address and Phone	Organization/Self	For/Against or Observing
1/	Joe McKinnon		Sponsor	
2/	Steve Hale		Dept of Ed	
3/	Dr Gregorich	(available for questions)	Dept of HRSS	
4/				
5/				
6/				
7/				
8/				
9/				
10/				
11/				
12/				
13/				

POSITION PAPER/Department of Health & Social Services

POSITION PAPER
ON
HOUSE BILL NO. 455

"An Act relating to state aid to school districts and regional educational attendance areas which provide instruction in special education on a year-round basis; and providing for an effective date."

Like regular education programs, special education programs are of approximately nine (9) months duration. This bill would allow additional State funds to school districts that provide year-round special education services.

It is widely known that many children (and in particular handicapped children) regress in their development during the three-month period when services are not provided. Even though the Department of Health and Social Services (Handicapped Children's Program in the Division of Public Health) currently provides selected services during the summer months, there are usually gaps or breaks in the continuity of services under the present makeshift approach.

The Department recognizes the need for year-round special educational services and recommends that the priority for services should be directed toward the more severely handicapped students. In addition, the Department recommends that year-round education be provided for a student only when the service is written into the student's individual education plan.

The Department supports the passage of House Bill #455.

Recommended by: _____ 5-2-80
Verner Stillner, M.D., M.P.H. (DATE)
Director, Division of Mental Health
and Developmental Disabilities

Recommended by: _____ 5/2/80
Dean F. Tirador, M.D. (DATE)
Director, Division of Public Health

Approved by: _____ 5/5/80
Helen D. Beirne, Commissioner (DATE)
Department of Health and Social Services

THE LEGISLATURE OF THE STATE OF ALASKA
ELEVENTH LEGISLATURE

FISCAL NOTE

I. REQUEST
Bill/Resolution No. House Bill No. 455
Title An Act relating to special education
Requested by House HESS Committee Date 5/2/80

II. FISCAL DETAIL
Agency Affected Department of Health and Social Sevices
Program Category Affected Health
BRU, Program, or Subprogram(s) Affected Mental Health & Developmental Disabilities
(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 80	FY 81	FY 82	FY 83	FY 84	FY 85
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL						
400 COMMODITIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC.						
TOTAL	-0-	-0-				

FUNDING (Thousands of Dollars)

GENERAL FUND						
FEDERAL FUNDS						
OTHER (Specify Fund Source)						

POSITIONS

FULL TIME						
PART TIME						
TEMPORARY						

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

No cost impact is foreseen to the Department of Health & Social Services as a result of this legislation.

TKB for

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)

Prepared by: Verner Stillner Date: 4/30/80
Division/Office: Mental Health & DD PH: 465-3370
Department of Health & Social Services

Approval DHSS Mgt. & Bdgt: Date: 2 May 80

33-001 (Rev. 12/79)
Modify by DHSS (11-28-79)

THE LEGISLATURE OF THE STATE OF ALASKA
ELEVENTH LEGISLATURE

FISCAL NOTE

I. REQUEST

Bill/Resolution No. HB-455 (Revised 5/16/80 to reflect Ch. 26, SLA 1980)

Title An Act relating to state aid to school districts and REAAs which provide spec. ed. instruction year round.

Requested by House HESS 5/16/80 Date

II. FISCAL DETAIL

Agency Affected Department of Education

Program Category Affected Elementary and Secondary Education

BRU, Program, or Subprogram(s) Affected Foundation Support Programs

(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 80	FY 81	FY 82	FY 83	FY 84	FY 85
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL						
400 COMMODITIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC.		7,914.4	8,705.8*	9,576.4	10,534.1	11,587.5
TOTAL						

FUNDING (Thousands of Dollars)

GENERAL FUND		7,914.4	8,705.8	9,576.4	10,534.1	11,587.5
FEDERAL FUNDS						
OTHER (Specify Fund Source)						

POSITIONS

FULL TIME	N/A					
PART TIME						
TEMPORARY						

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

FY-81 Impact:

REAAs 1,711.7 (.33 x 103 special education FY-81 I.U. x 50,359 average unit cost)

C & B
Districts 6,202.7 (.33 x 507 special education FY-81 I.U. x 37,073 average unit cost)

This impact is based upon the assumption that all districts will participate.

*Fiscal years subsequent to FY-81 inflated at 10% per year.

IV. DATE 5/16/80 PREPARED BY

AGENCY Department of Education

PHONE 465-2800

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)

33-001 (Rev. 12/79)

ALASKA DEPARTMENT OF EDUCATION
POSITION STATEMENT
HOUSE BILL 455

Although the Department has not had the opportunity to discuss the bill with the State Board of Education, we believe the effect of the legislation to be in the best interests of students, and therefore, support it.

5/5/80
Date

Approved by: [signature]
William D. Thomson
Deputy Commissioner
May 2, 1980

HB
479

Rural Alaska
Community Action Program, Inc.

February 1, 1980

Thelma Buchholdt, Chairperson
House Health, Education &
Social Services Committee
Pouch V
Juneau, AK 99811

Dear Representative Buchholdt:

We have reviewed with interest two bills pertaining to alcohol and drugs that have or will be coming before your committee: namely, HB 479 and the bill drafted by Governor Hammond's office (draft dated 8/27/79). We have also followed the testimony before the House HESS Committee and find ourselves in agreement with much of what was said about the seriousness of drug and alcohol problems, and the need to establish stiffer penalties for those who participate in illegal traffic and/or use of these substances.

Rather than comment on the pharmacological classification and the method by which substances have been classified and penalties proposed, we want to make some general statements concerning this problem.

1. For several years RurAL CAP has advocated enforcement of existing laws against illegal drug/alcohol traffic yet so far no legal or effective means has been established to support those villages whose Councils vote "dry" in enforcing their communities decision.

2. We support Governor Hammond in his classification of alcohol as a controlled substance equivalent to marjiuana.

3. Proposed legislation speaks to the need to "prevent and deter abuse", but makes no statement as to how such education will be carried out or how it will be funded. There is little point in paying lip service to education. Neither bill speaks to the need for alternatives to imprisonment. We see real need for legislation to provide a means to educate the convicted offender in a positive alternative lifestyle rather than simply sentencing him/her to jail.

Administration • P.O. Box 3-3908, Anchorage, Alaska 99501 • (907) 279-2511

5. Both bills propose to set up controlled Substances Committees, but these committees seem to be mainly designed to hold public hearings and decide on classification or re-classification of abused substances. The Parr bill specifically excludes alcohol from the considerations of this committee, yet alcohol for many people is as addictive and abused as the opium derivatives.

We would like to see your committee and other legislative committees consider these points and, if they do not seem to belong in this type of legislation, work towards some sort of legislation (including funding) which will. It will do little good to mount a massive criminal detection and prosecution program against substance abuse unless some provision is made for realistic statewide education, treatment, and enforcement, especially in rural areas, and for rehabilitation of convicted offenders. By the time most substance abuses reach this point, they are no longer using alcohol and other drugs because they want to but because they are dependent on them. Mere enforced abstinence during incarceration is not enough to change their way of dealing with problems.

Sincerely,

Robert A. Lohr

for Phil Smith
Executive Director

City of Kenai
BOX 580
KENAI, ALASKA 99611
telephone: 283-7535

January 2, 1980

Honorable Thelma Buchholdt, Chairwoman
Health, Education & Social Services Committee
Pouch V
Juneau, Alaska 99811

Dear Representative Buchholdt,

On 1-17-80, I had the privilege of attending a teleconference conducted by your committee on HB 479. It was very encouraging to hear the testimony and the obvious interest with which it was received by yourself and your committee.

As I was unable to testify because of prior scheduling commitments, the following comments are made for your consideration:

1) The designation of possession quantity differentiations, for most substances, other than marijuana, is unrealistic. An example would be that 1/4 ounce of cocaine 50-60% pure would be equivalent to 1 ounce in normal street usage purity. This also applies to other chemical drugs versus marijuana where a quantity designation in Statute may be appropriate. The amount of a chemical drug in possession, purity, and intended use (sale versus individual use) are matters more readily addressed at sentencing than by Statutory proscription.

2) The attempt to address this type of issue, reducing possessions in samll quantities of the narcotic drugs to misdemeanors, by Statute, also created the expressions of "liberalism" that was heard throughout the conference on this Bill.

While your committee is faced with hard decisions in addressing this area of social policy enforcement in face of considerable social change, further studies of this and other proposed bills are necessary. I do not feel this Bill, in the area just discussed, reflects the mainstream of citizen opinion on the issues.

Having reveiwed, at some length, this Bill, Senate Bill 65, and the Governor's proposed legislation, in light of my experience in dealing with this issue in the Kenai area, I believe the proposed legislation of the Governor's to be more reflective of the majority of public opinion on the issues while still giving recognition to social realities.

Thank you for your time and consideration of these remarks.

Respectfully,

Chief Richard A. Ross
Kenai Police Department
Box 3173
Kenai, Alaska

RAR/cd

HOUSE RESEARCH AGENCY
Pouch Y - State Capitol
Juneau, Alaska 99811
465-3991

MEMORANDUM January 28, 1980

TO: Representative Charles Parr

FROM: Jack Fargnoli, Issues Analyst
House Research Agency

RE: Research Request No. 23
(Drug Possession and Sales: Hawaii)

Prosecutor Lee Nakamura of the Prosecutor's Office, Department of the Attorney General in Honolulu, confirmed in a January 25 telephone conversation that the purity or concentration of controlled substances is not addressed specifically in Hawaii statutes and that, further, it is not considered as a factor in enforcement or in judicial proceedings. The purity or concentration of a drug is not used as the basis for determining the "amount" of a drug held in possession, as described in the Hawaii statutes; nor is it used as a basis in decisions to prosecute or in setting criminal sentences. However, occasionally a decision not to proceed with prosecution is reached in cases where extremely small, i.e., "trace," amounts of a controlled substance have been found in a mixture.

Mr. Nakamura informed us that all decisions to prosecute in Hawaii drug cases are made on a case by case basis, and that to date the question of drug purity has not produced any problems (or even been raised as an issue) in the federal courts. Should the courts object in the future, he said, adjustments would be made in the statutes; he did not view this as likely to occur, however.

Please let us know if you have any additional questions.

/dp

BAR MEMBERS
RICHARD L. BRADY
JOHN E. LONGWORTH
ROBERT M. MOSS

LAY MEMBERS
MARCUS R. CLARK
MICHAELA. HOLMES
JOSEPH L. YOUNG

CHAIRMAN EX OFFICIO
JAY A. RABINOWITZ
CHIEF JUSTICE
SUPREME COURT

Alaska Judicial Council

420 L Street, Suite 502
ANCHORAGE, ALASKA
99501
(907) 279-2526

EXECUTIVE DIRECTOR
MICHAEL A. RUBINSTEIN

January 11, 1980

M E M O R A N D U M

TO: Michael Rubinstein

FROM: Nick Maroules

RE: Relationship of Drug and Alcohol Use to Crime

Our new felony sentencing data, which includes most felony convictions in all ten Superior Court locations from July, 1976 to July, 1979, contains information from presentence reports about drug and alcohol use. The information includes (1) indications of past (or ongoing) drug and/or alcohol addiction, (2) drug and/or alcohol use at the time of the offense, and (3) the defendant's record of previous (or current) treatment for drug and/or alcohol problems. This memorandum outlines some preliminary findings regarding relationships between drug and alcohol use and crime.

Table I below indicates that a significant positive relationship exists between drug or alcohol addiction and severity of the defendant's prior record. Specifically, those defendants identified by the presentence reporter as having had alcohol or drug problems also had substantially more serious criminal histories than those without such problems.

TABLE I

Severity of Prior Record By Drug/Alcohol Addiction (N=1669)

	Drug Addiction History	Alcohol Addiction History	Neither	
No Prior Record	12.8%	14.0%	49.6%	
Misdem. Only	37.6%	52.0%	30.7%	
One Prior Felony	35.2%	21.1%	13.7%	significant at .001
Two/more Felonies	24.3%	12.9%	6.1%	(missing cases=232)
	100.0% (218)	100.0% (450)	100.0% (1001)	

The above contingency distributions indicate that defendants with no histories of drug or alcohol problems were four times more likely to have been first offenders than those with a history of drug/alcohol abuse. Nearly half (49.6%) of those with no histories of substance abuse were first offenders, compared to 12.8% and 14.0%, respectively, for those with drug and alcohol problems. At the other end of the scale, those with a drug or alcohol problem were substantially more likley to have prior felony convictions than those with no such history. These observed differences are statistically significant at the .001 level which means that there is only one chance in a thousand that the differences were due to chance.

Table I indicates the overall relationship between prior record and drug/alcohol use for all defendants without regard to the type (or class) of their offense. Table A, in the appendix to this memorandum sets forth the relationship between these two variables for each of five broad classes of offense -- violent felonies, property felonies (burglary, larceny, etc.), frauds/forgeries/embezzlements, drug crimes, and "morals" offenses. An examination of these tables reveals that the relationship observed in Table I persists among all offense classes.

As noted above, our data also includes information on drug or alcohol use at the time of the offense. Table II, below, indicates the proportion of cases in which the defendant was reported to have used drugs, drugs in combination with alcohol, or alcohol alone at the time of his offense, for each of four classes of offenses (drug offenses are eliminated from this aspect of the analysis).

TABLE II

Frequency of Use of Drugs and Alcohol
At Time of Offense for Four Offense Classes

	Used Drugs	Used Drugs & Alcohol	Used Alcohol
Violent Offenses	3.2% (19)	4.9% (29)	56.3% (330)
Property Offenses	4.0% (29)	4.4% (32)	39.2% (286)
Forgery/Fraud Offenses	2.7% (7)	0.6% (2)	9.1% (24)
"Morals" Offenses	1.1% (1,	9.9% (9)	46.2% (42)

Table II shows that a defendant was much more likely to have been under the influence of alcohol than drugs at the time of the offense. The magnitude of alcohol use is staggering in comparison with drugs. It should be mentioned, however, that the relative difficulty in detecting drug intoxication as compared with alcohol use probably accounts for at least a portion of the difference.

APPENDIX

TABLE A

SEVERITY OF PRIOR RECORD BY PAST
DRUG/ALCOHOL USE FOR EACH OFFENSE CLASS

I. Violent Felonies (N=586)

	Past Drug Problem	Past Alcohol Problem	Neither
No Priors	9.3%	16.0%	47.1%
Misdmrs. Only	40.0%	53.1%	28.6%
One Felony	16.0%	17.8%	16.8%
Two/More Felonies	34.7%	13.1%	7.6%
	100.0%	100.0%	100.0%
	(75)	(213)	(238)

(60 Missing Cases)*
Significant at .001

II. Burglary, Larceny Offenses (N=729)

	Past Drug Problem	Past Alcohol Problem	Neither
No Priors	7.1%	10.9%	54.8%
Misdmrs. Only	27.1%	52.4%	28.5%
One Felony	40.0%	23.8%	11.4%
Two/More Felonies	25.7%	12.9%	5.3%
	100.0%	100.0%	100.0%
	(70)	(147)	(376)

(136 Missing Cases)*
Significant at .001

TABLE A, (Cont.)

III. Fraud, Forgery, Embezzlement Offenses (N=264)

	Past Drug Problem	Past Alcohol Problem	Neither
No Priors	26.1%	10.3%	49.2%
Misdmrs. Only	39.1%	35.9%	26.0%
One Felony	26.1%	35.9%	17.7%
Two/More Felonies	8.7%	17.9%	7.2%
	100.0%	100.0%	100.0%
	(23)	(39)	(181)

(21 Missing Cases)*
Significant at .001

IV. Drug Offenses (N=231)

	Past Drug Problem	Past Alcohol Problem	Neither
No Priors	23.8%	7.1%	41.3%
Misdmrs. Only	50.0%	64.3%	41.9%
One Felony	11.9%	21.4%	12.0%
Two/More Felonies	14.3%	7.1%	4.8%
	100.0%	100.0%	100.0%
	(42)	(14)	(167)

(8 Missing Cases)*
Significant at .05

TABLE A, (Cont.)

V. "Morals" Offenses (N=91)

	Past Drug Problem	Past Alcohol Problem	Neither
No Priors	0%	21.6%	51.3%
Misdmrs. Only	37.5%	56.8%	38.5%
One Felony	50.0%	13.5%	5.1%
Two/More Felonies	12.5%	8.1%	5.1%
	100.0%	100.0%	100.0%
	(8)	(37)	(39)

Significant at .01

* Cases noted as missing from the breakdown analysis concern theft for which past drug/alcohol histories or prior record information was unascertainable.

from PARR

Treatment of Marijuana

	Parr Bill	Existing Law
Delivery to Minors - Class C Felony (0-5 yrs.)		0-life, $25,000
Sale of Marijuana -	2 and 2/10 lbs or more (class C Felony) 1/2 lb or more (3 yrs unclassified) less than above amounts (Class A Misdemeanor) one oz. or less for nonremuneration (Class B Misdemeanor)	0-25, $20,000 1st. 0-life, $25,000 2nd.
Mfg. (cultivating) for other than personal use - Class C Felony		would probably fall under possession with intent to sell; see distribution penalties
Possession	2 and 2/10 lbs or more (3 yr., unclassified)	would probably fall under possession with intent to distribute; see distribution penalti
	one lb. or more (class A misdemeanor)	might possibly """.
	display or use in public (violation)	guilty of misdemean and is punishable by fine of $1000.
	in immediate control while operating a motor vehile, airplane, watercraft. (class B misdemeanor)	""" """
	minor in possession (violation)	""" """

Penalties Under the New Criminal Code:

Class A Felony -$50,000 or 0- 20 years or both.

Class B Felony -$50,000 or 0- 10 years or both.

Class C Felony - $50,000 or 0-5 years or both.

Class A Misdemeanor - $5000 or 0-1 year or both.

Class B Misdemeanor - $1000 or 0 - 90 days or both.

Violation - $300 (no possible prison sentence)

Analysis of Penalty Scheme submitted to Legislative Affairs for Your Drug Bill

1. Delivery to Minors:

	Parr Draft	Gov Draft	Fed. Law	Hawaii Law
Schedule I	0-20 yrs. $50,000	5-99, $75,000	0-30 yrs. $50,000	0-20 yrs. $10,000
Schedule II	0-20 yrs. $50,000	6-20 $50,000	0-10 yrs $30,000	0-20 yrs. $10,000
Schedule III	0-20 yrs. $50,000	0-20 $50,000	0-10 yrs. $30,000	0-20 yrs. $10,000
Schedule IV	0-10 yrs. $50,000	0-10 $50,000	0 to 6 yrs. $20,000	0-20 yrs. $10,000
Schedule V	0-5 yrs. $50,000	0-10 $25,000	0-2 yrs. $10,000	0-5 yrs. $10,000
Schedule VI	0-5 yrs. $50,000	0-10 $5c,ccc	0-2 yrs.* $10,000	0-5 yrs.** $10,000

*Note: Feds don't have a Schedule VI, but this is their penalty for pot, which is the only substance in our Schedule VI. ** The same is true for Hawaii statutes.

TO: Charlie
From: Peggy Berck
Date: April 17, 1979

Analysis of Penalty Scheme submitted to Legislative Affairs for Your Drug Bill

2. Manufacturing of Drugs.

	Parr Draft	Gov Or	Fed. Law*	Hawaii Law**
Schedule I	0-20 yrs. $50,000	0-20	0-15 yrs $25,000	
Schedule II	0-20 yrs. $50,000	0-10 $50,000	0-5 yrs. $15,000	
Schedule III	0-10 yrs. $50,000	0-10 $50,000	0-5 yrs. $15,000	
Schedule IV	0-10 yrs. $50,000	0-5 $50,000	0-3 yrs. $1 ,000	
Schedule V	0-5 yrs. $50,000	0-5 $50,000	0-1 yr. $5000	
Schedule VI	0-5 yrs. $50,000	0-5 $50,000		

*Note: Fed. law makes no distinction between mfg., distribution, or possession with intent to mfg. or distribute.

**Note: Hawaii law only provides criminal penalties for distribution and possession.

TO: Charlie
From: Peggy
Date: April 18, 1979

Analysis of Penalty Scheme submitted to Legislative Affairs for Your Drug Bill

3. Distribution of Drugs.

	Parr Draft	Fed. Law Gov D.	Hawaii Law
SCHEDULE I ------- ------- ------- (opium, opiates)	50 or more caps; or 1/8 oz. or more of heroin or morphine; or 1/2 oz. or more of other Sched. I drugs= 0-20 yrs. $50,000 If less than above= 0-10 yrs. $50,000	0-15 yrs, 0-20 $25,000 $50,000	same amounts and same penalties as Parr Draft. (But fines in each case are $10,000.)
Schedule II------- ------- ------- (cocaine, amphetamines)	50 or more caps; or 1/2 oz. or more = 0-20 yrs. $50,000 If less than above= 0-10 yrs. $50,000	If cocaine= Gov 0-10 0-15 $50,000 $25,000 ..... If other drugs= 0-5 yrs. $15,000	same amounts and same penalties, but for cocaine. Hawaii law treats cocaine like heroin and morphine, ie, if 1/8 oz. or more= 0-20 yrs $10,000; if less = 0-10 yrs. $10,000
Schedule III ------ ------ ------	50 or more caps; or 1/2 oz. or more = 0-10 yrs. $50,000 If less than above = 0-5 yrs. $50,000	0-5 yrs. 0-10 $15,000 $50,000	50 or more caps; or 1/8 oz. or more= 0-20 yrs. $10,000 If less than above = 0-10. $10,000

	Parr Draft	Fed. Law	Hawaii Law
Schedule IV ----- ----- -----	50 or more caps;or 1/2 oz. or more= 0- 5 yrs. $50,000 If less than above= 3 yrs. $10,000	0-3 yrs. 0-5 $10,000 $50,000	50 or more caps; or 1/8 oz. or more = 0-20 yrs. $10,000 If less than above= 0-10 yrs. $10,000
Schedule V ------ ------ ------	50 or more caps; or 1/2 oz. or more = 3 yrs. $10,000 If less than above= 0-1 yr. $5000	0-1 yr, 0-5 $5000 $50,000	50 or more caps; or 1/8 oz. or more = 0-5 yrs. $5000 If less than above= 0-1 yr. $1000
Schedule VI ----- ----- -----	2 and 2/10 lbs.or more= 0-5 yrs. $50,000 1/2 lb. or more= 0-3 yrs. $10,000 If less than above = 0-1 yr. $5000 Notwithstanding above, if nonremuneration distribution of one oz. or less= 0-90 days $1000	0-5 yrs. 0-5 15,000 $50,000 If distribution is for small amount and for nonremuneration= 0-1 vr. $5000	two ounces or more= 0-5 yrs. $5000 If less than above = 0-1 yr. $1000

TO: Charlie
From: Peggy
Date: April 17, 1979

Analysis of Penalty Scheme submitted to Legislative Affairs for Your Drug Bill

4. Possession of Drugs.

	Parr Draft	Fed. Law (Gov)	Hawaii Law
Schedule I ------ ------ ------	100 or more caps; or 1 oz. or more heroin or morphine; or 2 oz. or more other Sched. I drug = 0-20 yrs. $50,000 50 or more caps; or 1/4 oz. or more of heroin or morphine; or 1/2 oz. or more other Sched. I drug = 0-10 yrs. $50,000 25 or more caps; or 1/8 oz. or more of heroin or morphine; or 1/4 oz. or more other Sched. I drug = 0-5 yrs. $50,000 If less than above = 0-1 yr. $5000	0-1 yr. 0-5 $50,000 $5000 (If evidence of intent to distribute, ie, scales, packaging equipment, etc., = 0-15 yrs. $25,000)	1 oz. or more heroin or morphine; 2 oz. or more other Sched. I drug = 0-20 yrs. $10,000 50 caps or more; or 1/8 oz. or more heroin or morphine; or 1/2 oz. or more other Sched. I drug = 0-10 yrs. $10,000 If less than above = 0-5 yrs. $5000

	Parr Draft	Fed. Law	Hawaii Law
hedule II ----- ----- -----	200 or more caps;or 2 oz. or more = 0-20 yrs. $50,000 100 or more caps;or 1/2 oz. or more = 0-10 yrs. $50,000 50 or more caps; or 1/4 oz. or more = 0-5 yrs. $50,000 If less than above specified amounts = 0-1 yr. $5000	0-1 yr. $5000 (If evidence of intent to distribute, ie, packaging equipment, scales, etc., the penalties are: if, cocaine = 0-15 yrs. $25,000 if, other drugs = 0-5 yrs. $15,000)	1 oz. or more of cocaine; or 2 oz. or more of the other Sched. II drugs= 0-20 yrs. $10,000 50 caps or more; or 1/8 oz. or more of cocaine; or 1/2 oz. or more of other Sched. II drugs= 0-10 yrs. $10,000 If less than above specified amounts = 0-5 yrs. $5000
Schedule III ----- ----- HA.-Hash) -----	400 or more caps; or 2 oz. or more = 0-10 yrs. $50,000 100 or more caps; or 1/2 oz. or more = 0-5 yrs. $50,000 If less than the above specified amounts = 0-1 yr. $5000	0-1 yr. $5000 (If evidence of intent to distribute, ie, scales, packaging equipment, tec., the penalties are: 0-5 yrs. $15,000.)	400 or more caps= 0-20 yrs. $10,000. 50 or more caps;or 1/8 of oz. or more = 0-10 yrs. $10,000. If less than the above specified amounts = 0-1 yr. $1000

	Parr Draft	Fed. Law	Hawaii Law
Schedule IV ------			
------	400 or more caps; or 2 oz. or more = 0-5 yrs. $50,000	0-1 yr. $5000 (If evidence of intent to distribute, ie, scales, packaging equipment, etc., penalty is: 0-3 yrs. $10,000.)	400 or more caps= 0-20 yrs. $10,000.
------	100 or more caps; or 1/2 oz. or more = 0-3 yrs. $10,000		50 or more caps; or 1/8 oz. or more = 0-10 yrs. $10,000.
	If less than the above specified amounts = 0-1 yr. $5000		If less than the above specified amounts= 0-1 yr. $1000.
Schedule V -------	400 or more caps; or	0-1 yr. $5000 (If evidence of intent to distribute = 0-1 yr. $5000.)	400 or more caps; or 1 oz. or more= 0-5 yrs. $5000.
-------	1 oz. or more = 0-3 yrs. $10,000		50 or more caps; or 1/8 oz. or more = 0-1 yr. $1000.
	If less than the above specified amounts = 0-1 yr. $5000.		If less than the above specified amounts = petty misdemeanor = 0-30 days $500.

Schedule VI	Parr Draft	Fed. Law	Gov's	Hawaii Law
	2 and 2/10 lbs. or more = 6-3 yrs. $10,000.	0-1 yr. $5000. (If evidence of intent to distribute= 0-5 yrs. $15,000.)	1 lb. or more = 5 yrs 50,000	2 and 2/10 lbs. or more = 5 yrs. $5000.
	1 lb. or more= 0-1 yr. $5000.			1 oz. or more = 0-1 yr. $1000.
	Any amount while operating conveyance = 0-90 days $1000.	<---->	0-90 days $1000	If less than the above specified amounts = petty misdemeanor = 0-30 days $500.
	Display or use in public = $300	<---->	0-90 days $1000	
	Any amount if minor= $300.	<---->	0-90 days $1000	

FROM: Margaret W. Berck, Staff
Date: Jan. 21, 1980

Existing Alaska Drug Law--Penalites for certain offenses.

1. Delivery to Minors.

   A. Heroin (Schedule I)*-- first: 10-30 years; $5000 to $10,000.
   second: 15-30 years; up to $25,000.
   third:life

   B. Cocaine (Schedule II) -- same as heroin

   C. Marijuana (Schedule VI) -- 0-life; $25,000.

   D. Amphetamines(Schedule II) -- 0-life; $25,000

   E. Hallucinogens (Schedule II) -- 0-life; $25,000

---

2. Distribution of Controlled Substances.

   A. Heroin (Schedule I) -- first: 2-10 years; $5000
   second: 10-20 years; $7500
   third: 20-40 years; $10,000

   (note: these are the same penalties as provided for the possession of heroin.)

   B. Cocaine (Schedule II) -- first: 2-10 years; $5000
   second: 10-20 years; $7500
   third: 20-40 years; $10,000

   (note: these are the same penalties as provided for the possession of heroin or cocaine and also the same as the penalties as provided for the sale of heroin.)

   C. Marijuana (Schedule VI) -- first: 0-25 years; $20,000.
   second: 0-life; $25,000.

   (these are the same penalties as provided for the sale of hallucinogens.)

   D. Amphetamines (Schedule II) -- first: 0-25 years; $20,000
   second: 0-life; $ 25,000

   E. Hallucinogens (Schedule II) -- first: 0-25 years; $20,000
   second: 0-life; $25,000

*Note: Existing Alaska law does not break out various drugs into schedules. Schedule notations on this memo are denoted for purposes of comparing penalties under existing law with those proposed in HB 479.

3. Possession of Controlled Substances.

A. Heroin (Schedule I) -- first: 2-10 years; $5000
second: 10-20 years; $7500
third: 20-40 years; $10,000

B. Cocaine (Schedule II) -- first: 2-10 years; $5000
second: 10-20 years; $7500
third: 20-40 years; $10,000

C. Hallucinogens (Schedule II) -- Misdemeanor
0-1 year; $1000

D. Amphetamines (Schedule II) -- Misdemeanor
0-1 year; $1000

3. Possession of Controlled Substances.

A. Heroin (Schedule I) -- first: 2-10 years; $5000
second: 10-20 years; $7500
third: 20-40 years; $10,000

B. Cocaine (Schedule II) -- first: 2-10 years; $5000
second: 10-20 years; $7500
third: 20-40 years; $10,000

C. Hallucinogens (Schedule II) -- Misdemeanor
0-1 year; $1000

D. Amphetamines (Schedule II) -- Misdemeanor
0-1 year; $1000

ELEVENTH LEGISLATURE

FISCAL NOTE

I. REQUEST

Bill/Resolution No. House Bill 479

Title An act revising the drug laws of the state.

Requested by House HESS Date 1/21/80

II. FISCAL DETAIL

Agency Affected Department of Health and Social Services

Program Category Affected Justice, Social Services

BRU, Program, or Subprogram(s) Affected Adult Confinement; Office of Alcoholism & Drug Abuse

(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 80	FY 81	FY 82	FY 83	FY 84	FY 85
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL						
400 COMMODITIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC.						
TOTAL	-0-	-0-	-0-	-0-	-0-	-0-

FUNDING (Thousands of Dollars)

GENERAL FUND	-0-	-0-	-0-	-0-	-0-	-0-
FEDERAL FUNDS	-0-	-0-	-0-	-0-	-0-	-0-
OTHER (Specify Fund Source)	-0-	-0-	-0-	-0-	-0-	-0-

POSITIONS

FULL TIME	-0-	-0-	-0-	-0-	-0-	-0-
PART TIME	-0-	-0-	-0-	-0-	-0-	-0-
TEMPORARY	-0-	-0-	-0-	-0-	-0-	-0-

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

The bill as presently written does not address public health concerns. Therefore, we see minimal impact on our Department. Also our Division of Corrections reports that there is little likelihood of serious impact on prison population in the State apart from the more general impact of the presumptive provisions of the Criminal Code revision. The Department believes it would be extremely difficult to predict the effects of these provisions with any degree of reliability. If the bill were amended in line with the recommendations set forth in the attached department position paper, there would be a fiscal impact on our department and a revised fiscal note would be prepared and submitted.

Charles Campbell, Director
Division of Corrections 465-3376

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)

Prepared by: Robert Cole Date: 1/21/80
Division/Office: Alco. & Drug Abuse PH: 586-6201
Department of Health & Social Services

Approval DHSS Mgt. & Bdgt. [signature] Date: 1/21/80

33-001 (Rev. 12/79)
Modify by DHSS (11-28-79)

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420 L Street, Suite 502
ANCHORAGE, ALASKA
99501
(907) 279-2526

EXECUTIVE DIRECTOR
MICHAEL L. RUBINSTEIN

January 11, 1980

M E M O R A N D U M

TO: Michael Rubinstein

FROM: Nick Maroules

RE: Relationship of Drug and Alcohol Use to Crime

Our new felony sentencing data, which includes most felony convictions in all ten Superior Court locations from July, 1976 to July, 1979, contains information from presentence reports about drug and alcohol use. The information includes (1) indications of past (or ongoing) drug and/or alcohol addiction, (2) drug and/or alcohol use at the time of the offense, and (3) the defendant's record of previous (or current) treatment for drug and/or alcohol problems. This memorandum outlines some preliminary findings regarding relationships between drug and alcohol use and crime.

Table I below indicates that a significant positive relationship exists between drug or alcohol addiction and severity of the defendant's prior record. Specifically, those defendants identified by the presentence reporter as having had alcohol or drug problems also had substantially more serious criminal histories than those without such problems.

TABLE I

Severity of Prior Record By Drug/Alcohol Addiction (N=1669)

	Drug Addiction History	Alcohol Addiction History	Neither	
No Prior Record	12.8%	14.0%	49.6%	
Misdem. Only	37.6%	52.0%	30.7%	
One Prior Felony	25.2%	21.1%	13.7%	significant at .001
Two/more Felonies	24.3%	12.9%	6.1%	(missing cases=232)
	100.0% (218)	100.0% (450)	100.0% (1001)	

The above contingency distributions indicate that defendants with no histories of drug or alcohol problems were four times more likely to have been first offenders than those with a history of drug/alcohol abuse. Nearly half (49.6%) of those with no histories of substance abuse were first offenders, compared to 12.8% and 14.0%, respectively, for those with drug and alcohol problems. At the other end of the scale, those with a drug or alcohol problem were substantially more likley to have prior felony convictions than those with no such history. These observed differences are statistically significant at the .001 level which means that there is only one chance in a thousand that the differences were due to chance.

Table I indicates the overall relationship between prior record and drug/alcohol use for all defendants without regard to the type (or class) of their offense. Table A, in the appendix to this memorandum sets forth the relationship between these two variables for each of five broad classes of offense -- violent felonies, property felonies (burglary, larceny, etc.), frauds/forgeries/embezzlements, drug crimes, and "morals" offenses. An examination of these tables reveals that the relationship observed in Table I persists among all offense classes.

As noted above, our data also includes information on drug or alcohol use at the time of the offense. Table II, below, indicates the proportion of cases in which the defendant was reported to have used drugs, drugs in combination with alcohol, or alcohol alone at the time of his offense, for each of four classes of offenses (drug offenses are eliminated from this aspect of the analysis).

TABLE II

Frequency of Use of Drugs and Alcohol
At Time of Offense for Four Offense Classes

	Used Drugs	Used Drugs & Alcohol	Used Alcohol
Violent Offenses	3.2% (19)	4.9%(29)	56.3% (330)
Property Offenses	4.0%(29)	4.4%(32)	39.2%(286)
Forgery/Fraud Offenses	2.7%(7)	0.8%(2)	9.1%(24)
"Morals" Offenses	1.1%(1)	9.9%(9)	46.2%(42)

Table II shows that a defendant was much more likely to have been under the influence of alcohol than drugs at the time of the offense. The magnitude of alcohol use is staggering in comparison with drugs. It should be mentioned, however, that the relative difficulty in detecting drug intoxication as compared with alcohol use probably accounts for at least a portion of the difference.

APPENDIX

TABLE A

SEVERITY OF PRIOR RECORD BY PAST
DRUG/ALCOHOL USE FOR EACH OFFENSE CLASS

I. Violent Felonies (N=586)

	Past Drug Problem	Past Alcohol Problem	Neither
No Priors	9.3%	16.0%	47.1%
Misdmrs. Only	40.0%	53.1%	28.6%
One Felony	16.0%	17.8%	16.8%
Two/More Felonies	34.7%	13.1%	7.6%
	100.0%	100.0%	100.0%
	(75)	(213)	(238)

(60 Missing Cases)*
Significant at .001

II. Burglary, Larceny Offenses (N=729)

	Past Drug Problem	Past Alcohol Problem	Neither
No Priors	7.1%	10.9%	54.6%
Misdmrs. Only	27.1%	52.4%	28.5%
One Felony	40.0%	23.8%	11.4%
Two/More Felonies	25.7%	12.9%	5.3%
	100.0%	100.0%	100.0%
	(70)	(147)	(376)

(136 Missing Cases)*
Significant at .001

TABLE A, (Cont.)

III. Fraud, Forgery, Embezzlement Offenses (N=264)

	Past Drug Problem	Past Alcohol Problem	Neither
No Priors	26.1%	10.3%	49.2%
Misdmrs. Only	39.1%	35.9%	26.0%
One Felony	26.1%	35.9%	17.7%
Two/More Felonies	8.7%	17.9%	7.2%
	100.0%	100.0%	100.0%
	(23)	(39)	(181)

(21 Missing Cases)*
Significant at .001

IV. Drug Offenses (N=231)

	Past Drug Problem	Past Alcohol Problem	Neither
No Priors	23.8%	7.1%	41.3%
Misdmrs. Only	50.0%	64.3%	41.9%
One Felony	11.9%	21.4%	12.0%
Two/More Felonies	14.3%	7.1%	4.8%
	100.0%	100.0%	100.0%
	(42)	(14)	(167)

(8 Missing Cases)*
Significant at .05

TABLE A, (Cont.)

V. "Morals" Offenses (N=91)

	Past Drug Problem	Past Alcohol Problem	Neither
No Priors	0%	21.6%	51.3%
Misdmrs. Only	37.5%	56.8%	38.5%
One Felony	50.0%	13.5%	5.1%
Two/More Felonies	12.5%	8.1%	5.1%
	100.0%	100.0%	100.0%
	(8)	(37)	(39)

Significant at .01

* Cases noted as missing from the breakdown analysis concern theft for which past drug/alcohol histories or prior record information was unascertainable.

THE FOLLOWING DOCUMENT(S) MAY NOT FILM LEGIBLY BECAUSE OF POOR QUALITY OF THE ORIGINAL.

To: Charles [illegible]
From: Margaret W. Berck, Staff
Date: April, 1979

Matrix - Drug Bills

	HB 65 (1979)	Federal Controlled Substances Act	HB 549 (1978)	Recommendation of Criminal Code Revision Commission	Existing Law	Uniform Act	Hawaii
Responsibility for rescheduling, deleting, and adding controlled substances.	Legislature	Attorney General upon recommendation of Secretary of HEW.	Commissioner of Health and Social Services upon advice of Controlled Substances Advisory Committee.	Commissioner of Health and Social Services consistent with advice of Controlled Substances Advisory Committee.	Legislature and Commissioner of Health & Social Services.	Recommends that classification be made by "appropriate person or agency."	Legislature upon advice of state advisory committee on drug abuse.
Criteria for deciding whether drug should be controlled.	Not specified.	Eight factors, including: (1) potential for abuse (2) pharmacological effect (3) risk to public health (4) risk of psychic or physiological dependence.	Factors listed are basically identical to federal act but also include: (1) probable physical and impact of widespread abuse of substance (2) susceptibility of segments of population	Factors listed are basically identical to HB 549.	Not specified.	Factors listed are similar to Federal Act, HB 549, and recommendation of Criminal Code Revision Commission.	Factors listed are similar to Federal Act, HB 549, and recommendation of Criminal Code Revision Commission.
Criteria for deciding in which schedule drug should be classified.	Not specified.	Five schedule tests are specified - factors are: (1) potential for abuse; (2) accepted medical use; and (3) psychological or physical dependence.	Criteria for deciding whether drug should be controlled are examined in determining "danger or probable danger of the substance." Drugs with highest danger are classified in most serious schedule. Drugs with less danger are classified in successively less serious schedules.	Adopts approach identical to HB 549.	Not specified.	Schedule tests similar to Federal Act.	Schedule tests similar to Federal Act.

	SB 65 (1979)	Federal Controlled Substances Act	HB 542 (1978)	Recommendation of Criminal Code Revision Commission	Existing Law	Uniform Act	Hawaii
Increased penalties for large scale drug trafficking.	"Continuing criminal enterprise" provision provides for increased penalties for defendant convicted of drug felony involving five or more persons if defendant is an organizer and obtains substantial income from activity.	SB 65 provision is taken from 10 USC §848.	Presumptive sentencing in criminal code provides that presumptive sentence may be increased if defendant is part of an organization which brings controlled substances into state or defendant has brought large amounts of controlled substances into state.	Did not consider. However, criminal code provides that if defendant was a member of a group of five or more persons and offense was committed to further goals of group, presumptive sentence may be increased to statutory maximum.	None	Not specifically, but second and subsequent offenses result in authorized sentences being doubled.	Not specifically, but increased sentences are authorized for second and subsequent offenses.
Authorization of unannounced entries into buildings pursuant to warrant.	"No-knock" allowed if probable cause shown that if notice is given (1) drugs will be easily destroyed; or (2) safety of officer in danger; and (3) court has authorized "no-knock" entry.	SB 65 provision is taken from 18 USC §879.	None	None	None	None	None

PENALTIES	SB 65 (1979)	Federal Controlled Substances Act	HB 549 (1978)	Recommendation of Criminal Code Revision Commission	Existing Law	Uniform Act	Hawaii
Delivery of heroin to minor	0-life/$25,000	0-30/$50,000 - first 0-45/$75,000- second	0-20/$20,000 7 years presumptive for first 10-1/2 years presumptive for second 14 years presumptive for third.	Sale to minor is an aggravating factor at sentencing which increases the presumptive sentence up to the statutory maximum for an ordinary sale.	10-30/$5,000-$10,000 - first 15-30/$25,000-second life - third	If defendant is 18 or older and minor is 16 or under and three years his junior, authorized penalties are doubled.	If minor is three years defendant's junior - 20 years/ $10,000.
Delivery of cocaine to minor	0-life/$25,000	0-30/$50,000 - first 0-45/$75,000- second	0-15/$20,000 5 year presumptive for first 7-1/2 year presumptive for second 10 year presumptive for third	Sale to minor is an aggravating factor at sentencing which increases the presumptive sentence up to the statutory maximum for an ordinary sale.	Same as heroin.	If defendant is 18 or older and minor is 16 or under and three years his junior, authorized penalties are doubled.	If minor is three years defendant's junior - 20 years/ $10,000.
Delivery of marijuana to minor	0-life/$25,000	0-2/$10,000 - first 0-4/$20,000- second	0-1-1/2/$5,000 6 month presumptive for first 9 month presumptive for second 12 month presumptive for third	Sale to minor is an aggravating factor at sentencing which increases the presumptive sentence up to the statutory maximum for an ordinary sale.	0-life/$25,000	If defendant is 18 or older and minor is 16 or under and three years his junior, authorized penalties are doubled.	If minor is three years defendant's junior - 5 years/ $5,000.

PENALTIES	SB 65 (1979)	Federal Controlled Substances Act	HB 549 (1978)	Recommendation of Criminal Code Revision Commission	Existing Law	Uniform Act	Hawaii
Cocaine sale	2-25/$20,000 - first 4-life/$25,000 - second	0-15/$25,000 - first 0-30/$50,000 - second	0-5/$30,000 1-1/2 year presumptive for first. 2-1/4 year presumptive for second. 3 year presumptive for third. Higher penalties provided for "ongoing commercial enterprise." Presumptive sentences doubled.	0-10/$50,000 4 year presumptive for second. 6 year presumptive for third.	Same penalties as possession of heroin.	Penalty not specified.	If one-eighth or more 20 years/$10,000 If less than one-eighth ounce - 10 years/$10,0
Marijuana sale	0-5/$5,000 - first 0-10/$10,000 - second	0-5/$15,000 - first 0-10/$10,000 - second if distribution is without remuneration 0-1/$5,000 0-2/$10,000	0-6 months/$1,000 Presumptive $1,000-first 1,500-second 2,000-third 0-2/$10,000 for "ongoing commercial enterprise." No penalty for distribution of one ounce or less to person 19 or older for no remuneration.	0-6 months/$1,000 No penalty for distribution of one ounce or less to person 18 or older for no remuneration.	0-25/$20,000 - first 0-life/$25,000 - second	No penalty for distribution of small amounts not involving a profit. Penalty not otherwise specified.	2 oz. or more = 0-5 yrs. $5000 If less than Above = 0-1 yr. $1000

Penalties	SB 65 (1979)	Federal Controlled Substances Act	HB 549 (1970)	Recommendation of Criminal Code Revision Commission	Existing Law	Uniform Act	Hawaii
HEROIN possession	0-5/$5,000	0-1/$5,000 - first 0-2/$10,000 - second	0-1/$20,000 6 month presumptive for first, 9 month presumptive for second, 1 year presumptive for third.	0-5/$50,000 1 year presumptive for second, 1 year presumptive for third.	2-10/$5,000 - first 10-20/$7,500 - second 20-40/$10,000 - third	Misdemeanor	If one ounce or more 20 years/$10,000. If one-eighth ounce or more - 10 years/$10,000. If less than one-eighth ounce - 5 years/$5,000.
COCAINE possession	0-5/$5,000	0-1/$5,000 - first 0-2/$10,000 - second	0-1/$10,000 - first 0-2/$10,000 - second $2,000 presumptive for first, 3 month presumptive for second.	0-1/$5,000 for first 0-5/$50,000 for second	Same penalties as possession of heroin.	Misdemeanor	Same penalties as possession of heroin.
HEROIN sale	2-25/$20,000 - first 4-life/$25,000 - second	0-15/$25,000 - first 0-30/$50,000 - second	0-10/$20,000 3 year presumptive for first, 4-1/2 year presumptive for second, 6 year presumptive for third. Higher penalties provided for "ongoing commercial enterprises"	0-20/$50,000 10 year presumptive for second, 15 year presumptive for third.	Same penalties as possession of heroin.	Penalty not specified.	If one eighth ounce or more - 20 years/$10,000. If less than one-eighth ounce - 10 yrs/$10,000.

	SB 65 (1979)	Federal Controlled Substances Act	HB 549 (1978)	Recommendation of Criminal Code Revision Commission	Existing Law	Uniform Act	Hawaii
PENALTIES Marijuana possession	Does not change existing law.	0-1/$5,000 - first 0-2/$10,000 - second	Display or smoking in motor vehicle, vessel or airplane - misdemeanor - $500. Possession of marijuana for personal use is not unlawful.	Same as HB 549	(1) Use of marijuana in public places (2) possession of one ounce or more in public places (3) possession of any amount while operating motor vehicle or airplane (4) while under 18 possess any marijuana - misdemeanor - $1,000. Possession for own use in other than public place or possession of one ounce or less in public place - civil fine $100.	Misdemeanor unless possession for own use.	2.2 lbs. OR MORE = 5 yrs. $5000 1 oz. or more 1 yr. $1000 If less than above = 0-30 days $500.00

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Penalties	S.B. 65 (1979)	Federal Controlled Substances Act	H.B. 549 (1978)	Existing AK. LAW	Uniform Act	Hawaii Law
SALE of Amphetamines (Parr Sch. II)	0-15yrs/$15,000-first. 0-30yrs/$30,000-second.	0-5yrs./$15,000-first. 0-10yrs./$30,000-second.	If ongoing commercial enterprize: 0-8yrs/$50,000 presumptive sentence-3yrs. 0-5yrs/$20,000 presumptive sentence-18 months	0-25yrs/$20,000-first. 0-Life/$25,000-second.	Penalty not specified	$50 or more caps = 20yrs/$10,000 If 1/2 oz or more = 20yrs./$10,000 If less than above = $10,000/10yrs.
SALE of Hallucinogens (Parr Sch. II)	0-15yrs./$15,000-first. 0-30yrs./$30,000-second.	0-5yrs/$15,000-first. 0-10yrs./$30,000-second.	If ongoing commercial enterprize: 0-5yrs/$20,000 presumptive sentence-2yrs. 0-3yrs./$5000 presumptive sentence-1 yr.	0-25yrs./$20,000-first. 0-Life/$25,000 second.	Penalty not specified	If 50 or more caps = 20yrs/$10,000 If 1/2 oz or more = 20yrs./$10,000 If Less than above = 10yrs/$10,000
SALE of Methaqulones (Parr Sch. II)	0-15yrs./$15,000-first. 0-30yrs./$30,000-second	0-5yrs./$15,000-first. 0-10yrs./$30,000-second.			Penalty not specified	If 50 or more caps = 20yrs/$10,000 If 1/2 oz or more = 20yrs./$10,000 If less than above = 10yrs./$10,000

Penalties	S.B. 65 (1979)	Federal Controlled Substances Act	H.B. 549 (1978)	Existing AK. LAW	Uniform Act	Hawaii LAW
SALE of VALIUM (Parr Sch. IV)	0-5yrs./$5000-first. 0-10yrs./$10,000-second.	0-3yrs./$10,000-first. 0-6yrs./$20,000-second.			Penalty not specified	If 50 CAPS or more = 20 yrs/ $10,000 If 1/8 OZ OR more = 20 yrs/ $10,000 If less THAN Above: 10 yrs/ $10,000
SALE of HASH, HASH OIL (Parr Sch. IV) (Hawaii-Sch. III.)		0-5yrs./$15,000-first. 0-10yrs./$30,000-second.	If ongoing commercial enterprize: 0-5 yrs./$20,000 presumptive sentence-2 yrs. 0-3yrs./$5000 presumptive sentence-1yr.		Penalty not specified	If 50 OR more CAPS = 20 yrs/ $10,000 If 1/8 oz. OR more = 20 yrs. / $15,000 If less THAN above: 10 yrs. / $10,000

Penalties	SB 65 (1979)	Federal Controlled Substances Act	HB 549 (1978)	Existing AK. LAW	Uniform Act	HAWAII LAW
Delivery of Amphetmines to MINORS (Parr Sch. II)	0 – life / $25,000	0 – 10 yrs. / $30,000 } 1st. 0 – 15 yrs. / $45,000 } 2ND.	0 – 15 yrs / $20,000 5 yr. presumptive sentence for 1st.	0 – Life / $25,000	If defendant is 18 or older and MINOR is 18 or under and 3 yrs. his junior, authorized prison penalties are doubled.	If MINOR is three yrs. Defendant's junior = 20 yrs / $10,000
Delivery of Hallucinogens to MINORS (Parr Sch. II)	0 – life / $25,000	0 – 10 yrs. / $30,000 } 1st. 0 – 15 yrs. / $45,000 } 2ND.	0 – 7 yrs. / $10,000 2 yr. presumptive sentence for 1st.	0 – Life / $25,000	If defendant is 18 or older AND MINOR is 18 or under and 3 yrs. his junior, Authorized imprisonment penalties ARE doubled.	If MINOR is Three yrs. Defendant's junior = 20 yrs / $10,000
Delivery of methaqulones to MINORS (Parr Sch. II)	0 – life $25,000	0 – 10 yrs. / $30,000 } 1st. 0 – 15 yrs. / $45,000 } 2nd.			If defendant is 18 or older AND MINOR is 18 or under and 3 yrs. his junior, Authorized imprisonment penalties ARE doubled.	If MINOR is Three yrs. Defendant's junior = 20 yrs. / $10,000

Penalties	SB 65 (1979)	Federal Controlled Substances Act	HB 549 (1978)	Existing AK. Law	Uniform Act	Hawaii Law
Delivery of Valium to Minors Parr Sch. IV)	0 – life / $25,000	0-6yrs. / $20,000 } 1st. 0-9yrs. / $30,000 } 2nd.			If defendant is 18yrs. or older AND minor is 18 or under AND 3yrs. his junior, authorized imprisonment penalties are doubled.	If minor is three yrs. Defendant's junior = 20 yrs. / $10,000
Delivery of Hash, Hash oil to Minors Parr Sch. IV) Hawaii-Sch. III)			0-7yrs. / $10,000 2yr. presumptive sentence 1st.		If defendant is 18 yrs. or older AND minor is 17 or under AND 3yrs. his junior authorized imprisonment penalties are doubled.	If minor is three yrs. Defendant's junior = 20 yrs. / $10,000

Penalties	SB 65 (1979)	Federal Controlled Substances Act	H.B. 549 (1978)	Existing AK. LAW	Uniform Act	Hawaii LAW
Possession of Amphetamines (Parr Sch. II)	0-1 yr. / $1000	0-1 yr. / $5000 1st. 0-2 yr. / $10,000 2nd. If no prior convictions conditional discharge is permitted.	0-1 yr. / $10,000 - 1st. 0-2 yr. / $10,000 - 2nd. $2,000 presumptive for 1st. 3 months presumptive for 2nd.	0-1 yr. / $1000	Misdemeanor	If 2 oz. or more: 20 yrs. / $10,000 If 50 caps or more or 1/2 oz. or more: 10 yrs. / $10,000 If less than Above: 5 yrs. / $5000
Possession of Hallucinogens (Parr Sch. II)	0-1 yr. / $1000	0-1 yr. / $5000 1st. 0-2 yr. / $10,000 2nd. If no prior convictions conditional discharge is permitted.	0-1 yr. / $2000 $1,000 presumptive sentence	0-1 yr. / $1000	Misdemeanor	same as Amphetamines
Possession of Methaqulones (Parr Sch. II)	0-1 yr. / $1000	0-1 yr. / $5000 1st. 0-2 yr. / $10,000 2nd. If no prior convictions conditional discharge is permitted.			Misdemeanor	same as Amphetamines
Possession of Valium (Parr Sch. IV)	0-1 yr. / $1000	0-1 yr. / $5000 1st. 0-2 yr. / $10,000 2nd. If no prior convictions conditional discharge is permitted.			Misdemeanor	If 400 caps or more: 20 yrs / $10,000 If 50 caps. or more: 10 yrs. / $10,000 If less than above: 1 yr. / $1000

Penalties	SB 65 (1974)	Federal Controlled Substances Act	H.B. 549 (1978)	Existing AK. LAW	Uniform Act	Hawaii Law
Possession of Hash, Hash oil (Parr Sch. IV) (Hawaii-Sch. III)		0-1 yr. / $5000 1st. 0-2 yr. / $10,000 2nd. If no prior convictions conditional discharge is permitted.	0-1 yr. / $2000 $1,000 presumptive sentence		Misdemeanor	If 400 or more gms. OR 1 oz or more: 20 yrs / $ If 50 or more gms or 1/8 oz or more: 10 yrs / $10,000 If less than above: 1 yr. / $1,000

STATE OF CALIFORNIA

DEPARTMENT OF JUSTICE

UNIFORM CONTROLLED SUBSTANCES ACT

1978

DIVISION 10

HEALTH AND SAFETY CODE

EVELLE J. YOUNGER

Attorney General

ENFORCEMENT AND INVESTIGATION BRANCH

Headquarters Office

3301 C St. (P.O. Box 13397)

Sacramento, California 95813

Act includes Amendments through 1977

ADDRESSES OF AREA NARCOTIC ENFORCEMENT OFFICES

2550 Mariposa Street
Fresno 93721
488-5451

107 South Broadway
Los Angeles 90012
Telephone: 620-3444

1800 I Street
Sacramento 95814
Telephone: 322-7111

2720 Taylor Street, Rm. 301
San Francisco, 94133
Telephone: 557-2955

1301 State Street
San Diego, 92101
Telephone: 236-7361

874 Town & Country Rd., Rm. 110
Orange 92668
Telephone: 558-4183

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DIVISION 10. UNIFORM CONTROLLED SUBSTANCES ACT

CHAPTER 1. GENERAL PROVISIONS AND DEFINITIONS

11000. This division shall be known as the "California Uniform Controlled Substances Act."

11001. Unless the context otherwise requires, the definitions in this chapter govern the construction of this division.

11002. "Administer" means the direct application of a controlled substance, whether by injection, inhalation, ingestion, or any other means to the body of a patient for his immediate needs or to the body of a research subject by any of the following:

(a) A practitioner or, in his presence, by his authorized agent.

(b) The patient or research subject at the direction and in the presence of the practitioner.

11003. "Agent" means an authorized person who acts on behalf of or at the direction of a manufacturer, distributor, or dispenser. It does not include a common or contract carrier, public warehouseman, or employee of the carrier or warehouseman.

11004. "Attorney General" means the Attorney General of the State of California.

11005. "Board of Pharmacy" means the California State Board of Pharmacy.

11006. "Chief" means the Chief of the Bureau of Narcotic Enforcement of the State Department of Justice.

11006.5. "Concentrated cannabis" means the separated resin, whether crude or purified, obtained from marijuana.

11007. (a) Except for the purposes of Chapter 4 (commencing with Section 11150) of this division, "controlled substance" means a drug, substance, or immediate precursor which are included in Schedules I through V, inclusive, pursuant to Chapter 2 (commencing with Section 11053).

(b) As used in Chapter 4 (commencing with Section 11150) of this division and any provisions of this division specifying penalties for offenses defined in Chapter 4 (commencing with Section 11150), except for those offenses which are punishable under Section 11371, "controlled substance" means any drug, substance, or immediate precursor which is included in one of the five schedules contained in the Federal Controlled Substances Act (Title II, P.L. 91-513), as such schedules may be revised from time to time to add, delete, or transfer substances from one schedule to another, whether by congressional enactment or by administrative rule of the United States Attorney General adopted pursuant to Section 201 of such act. Whenever reference is made in Chapter 4 (commencing with Section 11150) of this division to a controlled substance classified in a particular schedule, the reference shall be deemed to be to a federal

controlled substance classified in the designated federal schedule, as such schedules may be so revised from time to time.

11008. "Customs broker" means a person in this state who is authorized to act as a broker for any of the following:

(a) A person in this state who is licensed to sell, distribute, or otherwise possess any controlled substance.

(b) A person in any other state who ships any controlled substance into this state.

(c) A person in this state or any other state who ships or transfers any controlled substance through this state.

11009. "Deliver" or "delivery" means the actual, constructive, or attempted transfer from one person to another of a controlled substance, whether or not there is an agency relationship.

11010. "Dispense" means to deliver a controlled substance to an ultimate user or research subject by or pursuant to the lawful order of a practitioner, including the prescribing, furnishing, packaging, labeling, or compounding necessary to prepare the substance for that delivery.

11011. "Dispenser" means a practitioner who dispenses.

11012. "Distribute" means to deliver other than by administering or dispensing a controlled substance.

11013. "Distributor" means a person who distributes. The term distributor also includes warehousemen handling or storing controlled substances and customs brokers.

11014. "Drug" means (a) substances recognized as drugs in the official United States Pharmacopoeia, official Homeopathic Pharmacopoeia of the United States, or official National Formulary, or any supplement to any of them; (b) substances intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease in man or animals; (c) substances (other than food) intended to affect the structure or any function of the body of man or animals; and (d) substances intended for use as a component of any article specified in subdivision (a), (b), or (c) of this section. It does not include devices or their components, parts, or accessories.

11015. "Federal bureau" means the bureau of Narcotics and Dangerous Drugs of the United States Department of Justice, or its successor agency.

11016. "Furnish" has the same meaning as provided in Section 4048.5 of the Business and Professions Code.

11017. "Manufacturer" has the same meaning as provided in Section 4034 of the Business and Professions Code.

11018. "Marijuana" means all parts of the plant Cannabis sativa L., whether growing or not; the seeds thereof; the resin extracted from any part of the plant; and every compound, manufacture, salt, derivative, mixture, or preparation of the plant, its seeds or resin. It does not include the mature stalks of the plant, fiber produced from the stalks, oil or cake made from the seeds of the plant, any other compound, manufacture, salt, derivative, mixture, or preparation of the mature stalks (except the resin extracted therefrom), fiber, oil, or cake, or the sterilized seed of the plant which is incapable of germination.

11019. "Narcotic drug" means any of the following, whether produced directly or indirectly by extraction from substances of vegetable origin, or independently by means of chemical synthesis, or by a combination of extraction and chemical synthesis:

(a) Opium and opiate, and any salt, compound, derivative, or preparation of opium or opiate.

(b) Any salt, compound, isomer, derivative, or preparation thereof which is chemically equivalent or identical with any of the substances referred to in subdivision (a), but not including the isoquinoline alkaloids of opium.

(c) Opium poppy and poppy straw.

(d) Coca leaves and any salt, compound, derivative, or preparation of coca leaves, and any salt, compound, isomer, derivative, or preparation thereof which is chemically equivalent or identical with any of these substances, but not including decocainized coca leaves or extractions of coca leaves which do not contain cocaine or ecgonine.

11020. "Opiate" means any substance having an addiction-forming or addiction-sustaining liability similar to morphine or being capable of conversion into a drug having addiction-forming or addiction-sustaining liability. It does not include, unless specifically designated as controlled under Chapter 2 (commencing with Section 11053) of this division, the dextrorotatory isomer of 3-methoxy-n-methylmorphinan and its salts (dextromethorphan). It does include its racemic and levorotatory forms.

11021. "Opium poppy" means the plant of the species Papaver somniferum L., except its seeds.

11022. "Person" means individual, corporation, government or governmental subdivision or agency, business trust, estate, trust, partnership, or association, or any other legal entity.

11023. "Pharmacy" has the same meaning as provided in Section 4035 of the Business and Professions Code.

11024. "Physician," "dentist," "podiatrist," "pharmacist," and "veterinarian" mean persons who are licensed to practice their respective professions in this state.

11025. "Poppy straw" means all parts, except the seeds, of the opium poppy, after mowing.

11026. "Practitioner" means any of the following:

(a) A physician, dentist, veterinarian, podiatrist, or pharmacist acting within the scope of a project authorized under Article 18 (commencing with Section 429.70) of Chapter 2 of Part 1, of Division 1, or registered

nurse acting within the scope of a project authorized under Article 18 (commencing with Section 429.70) of Chapter 2 of Part 1 of Division 1, or physician's assistant acting within the scope of a project authorized under Article 18 (commencing with Section 429.70) of Chapter 2 of Part 1 of Division 1, scientific investigator, or other person licensed, registered or otherwise permitted to distribute, dispense, conduct research with respect to or to administer a controlled substance in the course of professional practice or research in this state.

(b) A pharmacy, hospital, or other institution licensed, registered, or otherwise permitted to distribute, dispense, conduct research with respect to or to administer a controlled substance in the course of professional practice or research in this state.

11027. "Prescription" means an oral order for a controlled substance given individually for the person for whom prescribed, directly from the prescriber to the furnisher or indirectly by means of a written order of the prescriber.

11028. "State bureau" means the Bureau of Narcotic Enforcement of the State Department of Justice.

11029. "Production" includes the manufacture, planting, cultivation, growing, or harvesting of a controlled substance.

11030. "Ultimate user" means a person who lawfully possesses a controlled substance for his own use or for the use of a member of his household or for administering to an animal owned by him or by a member of his household.

11031. "Wholesaler" has the same meaning as provided in Section 4038 of the Business and Professions Code.

11032. Whenever reference is made to the term "narcotics" in any provision of law outside of this division, unless otherwise expressly provided, it shall be construed to mean controlled substances classified in Schedules I and II, as defined in this division. Whenever reference is made to "restricted dangerous drugs" outside of this division, unless otherwise expressly provided, it shall be construed to mean controlled substances classified in Schedules III and IV. Whenever reference is made to the term "marijuana" in any provision of law outside of this division, unless otherwise expressly provided, it shall be construed to mean marijuana as defined in this division.

Chapter 2. Standards and Schedules

11053. The controlled substances listed or to be listed in the schedules in this chapter are included by whatever official, common, usual, chemical, or trade name designated.

SCHEDULE I

11054. (a) Except for purposes of Chapter 4 (commencing with

Section 11150) of this division, the controlled substances listed in this section are included in Schedule I.

(b) Any of the following opiates, including their isomers, esters, ethers, salts, and salts of isomers, esters, and ethers, unless specifically excepted, whenever the existence of these isomers, esters, ethers and salts is possible within the specific chemical designation:

(1) Acetylmethadol.
(2) Allylprodine.
(3) Alphacetylmethadol.
(4) Alphameprodine.
(5) Alphamethadol.
(6) Benzethidine.
(7) Betacetylmethadol.
(8) Betameprodine.
(9) Betamethadol.
(10) Betaprodine.
(11) Clonitazene.
(12) Dextromoramide.
(13) Dextrorphan.
(14) Diampromide.
(15) Diethylthiambutene.
(16) Dimenoxadol.
(17) Dimepheptanol.
(18) Dimethylthiambutene.
(19) Dioxaphetyl butyrate.
(20) Dipipanone.
(21) Ethylmethylthiambutene.
(22) Etonitazene.
(23) Etoxeridine.
(24) Furethidine.
(25) Hydroxypethidine.
(26) Ketobemidone.
(27) Levomoramide.
(28) Levophenacylmorphan.
(29) Morpheridine.
(30) Noracymethadol.
(31) Norlevorphanol.
(32) Normethadone.
(33) Norpipanone.
(34) Phenadoxone.
(35) Phenampromide.
(36) Phenomorphan.
(37) Phenoperidine.
(38) Piritramide.
(39) Proheptazine.
(40) Properidine.
(41) Propiram.
(42) [illegible]oramide.
(43) [illegible]ridine.

(c) Any of the following opium derivatives, their salts, isomers and salts of isomers, unless specifically excepted, whenever the existence of these salts, isomers and salts of isomers is possible within the specific chemical designation:

(1) Acetorphine.
(2) Acetyldihydrocodeine.
(3) Benzylmorphine.
(4) Codeine methylbromide.
(5) Codeine-N-oxide.
(6) Cyprenorphine.
(7) Desomorphine.
(8) Dihydromorphine.
(9) Etorphine.
(10) Heroin.
(11) Hydromorphinol.
(12) Methyldesorphine.
(13) Methyldihydromorphine.
(14) Morphine methylbromide.
(15) Morphine methylsulfonate.
(16) Morphine-N-oxide.
(17) Myrophine.
(18) Nicocodeine.
(19) Nicomorphine.
(20) Normorphine.
(21) Phoclodine.
(22) Thebacon.

(d) Any material, compound, mixture, or preparation which contains any quantity of the following hallucinogenic substances, their salts, isomers and salts of isomers, unless specifically excepted, whenever the existence of these salts, isomers, and salts of isomers is possible within the specific chemical designation:

(1) 3,4-methylenedioxy amphetamine.
(2) 5-methoxy-3,4-methylenedioxy amphetamine.
(3) 3,4,5-trimethoxy amphetamine.
(4) Bufotenine.
(5) Diethyltryptamine.
(6) Dimethyltryptamine.
(7) 4-methyl-2,5-dimethoxyamphetamine.
(8) Ibogaine.
(9) Lysergic acid diethylamide.
(10) Marijuana.
(11) Mescaline.
(12) Peyote.
(13) N-ethyl-3-piperidyl benzilate.
(14) N-methyl-3-piperidyl benzilate.
(15) Psilocybin.
(16) Psilocyn.
(17) Tetranydrocannabinols.

SCHEDULE II

11055. (a) Except for purposes of Chapter 4 (commencing with Section 11150) of this division, the controlled substances listed in this section are included in Schedule II.

(b) Any of the following substances, except those narcotic drugs listed in other schedules, whether produced directly or indirectly by extraction from substances of vegetable origin, or independently by means of chemical synthesis, or by combination of extraction and chemical synthesis:

(1) Opium and opiate, and any salt, compound, derivative, or preparation of opium or opiate, with the exception of naloxone hydrochloride (N-allyl- 14-hydroxy-nordihydromorphinone hydrochloride), but including the following:

(i) Raw opium.
(ii) Opium extracts.
(iii) Opium fluid extracts.
(iv) Powdered opium.
(v) Granulated opium.
(vi) Tincture of opium.
(vii) Apomorphine.
(viii) Codeine.
(ix) Ethylmorphine.
(x) Hydrocodone.
(xi) Hydromorphone.
(xii) Metopon.
(xiii) Morphine.
(xiv) Oxycodone.
(xv) Oxymorphone.
(xvi) Thebaine.

(2) Any salt, compound, isomer, derivative, or preparation thereof which is chemically equivalent or identical with any of the substances referred to in paragraph (1), but not including the isoquinoline alkaloids of opium.

(3) Opium poppy and poppy straw.

(4) Coca leaves and any salt, compound, derivative, or preparation of coca leaves, and any salt, compound, derivative, or preparation thereof which is chemically equivalent or identical with any of these substances, but not including decocainized coca leaves or extractions which do not contain cocaine or ecgonine.

(c) Any of the following opiates, including their isomers, esters, ethers, salts, and salts of isomers, whenever the existence of these isomers, esters, ethers and salts is possible within the specific chemical designation:

(1) Alphaprodine.
(2) Anileridine.
(3) Bezitramide.
(4) Dihydrocodeine.
(5) Diphenoxylate.
(6) Fentanyl.

(7) Isomethadone.
(8) Levomethorphon.
(9) Levorphanol.
(10) Metazocine.
(11) Methadone.
(12) Methadone—intermediate, 4-cyano-2-dimethyl-amino-4,4-diphenyl butane.
(13) Moramide—intermediate, 2-methyl-3-morpho-lino-1,1-diphenyl-propane-carboxylic acid.
(14) Pethidine.
(15) Pethidine—intermediate—A, 4-cyano-1-methyl-4-phenyl-piperidine.
(16) Pethidine—intermediate—B, ethyl-4-phenylpi-peridine-4-carboxylate.
(17) Pethidine—intermediate—C, 1-methyl-4-phenylpiperidine-4-carboxylic acid.
(18) Phenazocine.
(19) Piminodine.
(20) Racemethorphan.
(21) Racemorphan.
(d) Any material, compound, mixture, or preparation which contains any quantity of the following substances having a potential for abuse associated with a stimulant effect on the central nervous system:
(1) Amphetamine, its salts, optical isomers, and salts of its optical isomers.
(2) Phenmetrazine and its salts.
(3) Any substance which contains any quantity of methamphetamine, including its salts, isomers, and salts of isomers.
(4) Methylphenidate.

SCHEDULE III

11056. (a) Except for purposes of Chapter 4 (commencing with Section 11150) of this division, the controlled substances listed in this section are included in Schedule III.
(b) Unless listed in another schedule, any material, compound, mixture, or preparation which contains any quantity of the following substances having a potential for abuse associated with a depressant effect on the central nervous system:
(1) Any substance which contains any quantity of a derivative of barbituric acid, or any salt of a derivative of barbituric acid, except those substances which are specifically listed in other schedules.
(2) Chlorhexadol.
(3) Glutethimide.
(4) Lysergic acid.
(5) Lysergic acid amide.
(6) Methaqualone and its salts.
(7) Methyprylon.
(8) Phencyclidine.

(9) Sulfondiethylmethane.
(10) Sulfonethylmethane.
(11) Sulfonmethane.
(c) Nalorphine.
(d) Any material, compound, mixture, or preparation containing limited quantities of any of the following narcotic drugs, or any salts thereof:
(1) Not more than 1.8 grams of codeine, or any of its salts, per 100 milliliters or not more than 90 milligrams per dosage unit, with an equal or greater quantity of an isoquinoline alkaloid of opium.
(2) Not more than 1.8 grams of codeine, or any of its salts, per 100 milliliters or not more than 90 milligrams per dosage unit, with one or more active, nonnarcotic ingredients in recognized therapeutic amounts.
(3) Not more than 300 milligrams of dihydrocodeinone, or any of its salts, per 100 milliliters or not more than 15 milligrams per dosage unit, with a fourfold or greater quantity of an isoquinoline alkaloid of opium.
(4) Not more than 300 milligrams of dihydrocodeinone, or any of its salts, per 100 milliliters or not more than 15 milligrams per dosage unit, with one or more active, nonnarcotic ingredients in recognized therapeutic amounts.
(5) Not more than 1.8 grams of dihydrocodeine, or any of its salts, per 100 milliliters or not more than 90 milligrams per dosage unit, with one or more active, nonnarcotic ingredients in recognized therapeutic amounts.
(6) Not more than 300 milligrams of ethylmorphine, or any of its salts, per 100 milliliters or not more than 15 milligrams per dosage unit, with one or more ingredients in recognized therapeutic amounts.
(7) Not more than 500 milligrams of opium per 100 milliliters or per 100 grams, or not more than 25 milligrams per dosage unit, with one or more active, nonnarcotic ingredients in recognized therapeutic amounts.
(8) Not more than 50 milligrams of morphine, or any of its salts, per 100 milliliters or per 100 grams with one or more active, nonnarcotic ingredients in recognized therapeutic amounts.

SCHEDULE IV

11057. (a) Except for purposes of Chapter 4 (commencing with Section 11150) of this division, the controlled substances listed in this section are included in Schedule IV.
(b) Any material, compound, mixture, or preparation which contains any quantity of the following substances having a potential for abuse associated with a depressant effect on the central nervous system:
(1) Barbital.
(2) Chloral betaine.
(3) Chloral hydrate.
(4) Ethchlorvynol.
(5) Ethinamate.
(6) Methohexital.
(7) Meprobamate.

(8) Methylphenobarbital.
(9) Paraldehyde.
(10) Petrichloral.
(11) Phenobarbital.

SCHEDULE V

11058. (a) Except for purposes of Chapter 4 (commencing with Section 11150) of this division, the controlled substances listed in this section are included in Schedule V.

(b) Any compound, mixture, or preparation containing limited quantities of any of the following narcotic drugs, which also contains one or more nonnarcotic active medicinal ingredients in sufficient proportion to confer upon the compound, mixture, or preparation, valuable medicinal qualities other than those possessed by the narcotic drug alone:

(1) Not more than 200 milligrams of codeine, or any of its salts, per 100 milliliters or per 100 grams.

(2) Not more than 100 milligrams of dihydrocodeine, or any of its salts, per 100 milliliters or per 100 grams.

(3) Not more than 100 milligrams of ethylmorphine, or any of its salts, per 100 milliliters or per 100 grams.

(4) Not more than 2.5 milligrams of diphenoxylate and not less than 25 micrograms of atrophine sulfate per dosage unit.

(5) Not more than 100 milligrams of opium per 100 milliliters or per 100 grams.

CHAPTER 3. REGULATION AND CONTROL

Article 1. Reporting

11100. (a) Any manufacturer, wholesaler, retailer, or other person who sells, transfers, or otherwise furnishes any of the following substances to any person in this state shall submit a report to the State Department of Justice of all such transactions.

(1) Phenyl-2-propanone
(2) Methylamine
(3) D-lysergic acid
(4) Ergotamine Tartrate
(5) Diethyl malonate
(6) Malonic acid
(7) Ethyl malonate
(8) Barbituric acid
(9) Piperidine

(b) The Department of Justice may adopt rules and regulations in accordance with Chapter 4.5 (commencing with Section 11371) of Division 3 of Title 2 of the Government Code that add substances to subdivision (a) if the substance is a precursor to a controlled substance and delete substances from subdivision (a). However, no regulation adding or deleting a substance shall have any effect beyond March 1 of the year following the calendar year during which the regulation was adopted.

(c) This section shall not apply to any of the following:

(1) Any pharmacist or other authorized person who sells or furnishes such substance upon the prescription of a physician, dentist, podiatrist, or veterinarian.

(2) Any physician, dentist, podiatrist, or veterinarian who administers or furnishes such substance to his patients.

(3) Any manufacturer or wholesaler licensed by the Board of Pharmacy who sells, transfers, or otherwise furnishes such substance to a licensed pharmacy, physician, dentist, podiatrist, or veterinarian.

(d) Any manufacturer, wholesaler, retailer, or other person who sells, transfers, or otherwise furnishes any substance listed in subdivision (a) to a person in this state shall, within 72 hours thereafter, submit a report of such transaction to the Department of Justice. However, the Department of Justice may authorize the submission of such reports on a monthly basis with respect to repeated, regular transactions between the furnisher and the recipient involving the same substance if the Department of Justice determines that; (1) a pattern of regular supply of such substance exists as between the manufacturer, wholesaler, retailer, or other person who sells, transfers, or otherwise furnishes such substance and the recipient of the substance, and (2) the recipient has established a record of utilization of such substance for lawful purposes.

11101. The State Department of Justice shall provide a common reporting form for the substances in Section 11100 which contains at least the following information:

(a) Name of the substance.
(b) Quantity of the substance sold, transferred, or furnished.
(c) The date the substance was sold, transferred, or furnished.
(d) The name and address of the person buying or receiving such substance.
(e) The name and address of the manufacturer, wholesaler.

11102. The Department of Justice may adopt all regulations necessary to carry out the provisions of this part.

11103. The theft or loss of any substance regulated pursuant to Section 11100 discovered by any licensee or any person regulated by the provisions of this chapter shall be reported to the Department of Justice within three days after such discovery.

Any difference between the quantity of any substance regulated pursuant to Section 11100 received and the quantity shipped shall be reported to the Department of Justice within three days of the receipt of actual knowledge of the discrepancy.

Any report made pursuant to this section shall also include the name of the common carrier or person who transports the substance and date of shipment of the substance.

Article 2. Licenses: Customs Brokers and Warehouses

11120. Upon application, the Board of Pharmacy may issue a customs broker's license. Such license authorizes the transfer of a controlled substance to persons who are licensed to sell, distribute, or otherwise possess such controlled substance. The holder of such a license may receive, possess, export, and transfer such controlled substances to such persons.

11121. A customs broker in this state shall not ship or transfer any controlled substance to any of the following persons:

(a) Any person in this state who is not licensed or authorized to sell, distribute, or otherwise possess the controlled substance.

(b) Any person in any other state who is not licensed or authorized by such state to sell, distribute, or otherwise possess the controlled substance.

(c) Any person in a foreign jurisdiction who does not have a legitimate reason to possess the controlled substance.

11122. (a) A controlled substance shall be stored only in a warehouse which is licensed by the Board of Pharmacy.

(b) This section shall not apply to any of the following persons:

(1) Any pharmacy or other person who is licensed or authorized by this state to sell or furnish the controlled substance upon the written prescription of a physician, dentist, podiatrist, or veterinarian, or pharmacist acting within the scope of a project authorized under Article 18 (commencing with Section 429.70) of Chapter 2 of Part 1 of Division 1, or registered nurse acting within the scope of a project authorized under Article 18 (commencing with Section 429.70) of Chapter 2 of Part 1 of Division 1, or physician's assistant acting within the scope of a project authorized under Article 18 (commencing with Section 429.70) of Chapter 2 of Part 1 of Division 1.

(2) Any physician, dentist, podiatrist, or veterinarian, or pharmacist acting within the scope of a project authorized under Article 18 (commencing with Section 429.70) of Chapter 2 of Part 1 of Division 1, or registered nurse acting within the scope of a project authorized under Article 18 (commencing with Section 429.70) of Chapter 2 of Part 1 of Division 1, or physician's assistant acting within the scope of a project authorized under Article 18 (commencing with Section 429.70) of Chapter 2 of Part 1 of Division 1 who possesses a controlled substance for administration to his patients.

(3) Any licensed laboratory in this state which is authorized to receive and use the controlled substance.

(4) Any licensed hospital in this state.

(5) Any person who obtains the controlled substance upon the prescription of a physician, dentist, podiatrist, or veterinarian, or pharmacist acting within the scope of a project authorized under Article 18 (commencing with Section 429.70) of Chapter 2 of Part 1 of Division 1, or registered nurse acting within the scope of a project authorized under Article 18 (commencing with Section 429.70) of Chapter 2 of Part 1 of Division 1, or physician's assistant acting within the scope of a project authorized under Article 18 (commencing with Section 429.70) of Chapter 2 of Part 1 of Division 1 for his personal use.

(6) Any agent or employee of any licensed manufacturer or wholesaler who possesses the controlled substance for display purposes or furnishes such controlled substances as a sample at no cost to a licensed pharmacist, physician, dentist, podiatrist, or veterinarian, or registered nurse acting within the scope of a project authorized under Article 18 (commencing with Section 429.70) of Chapter 2 of Part 1 of Division 1, or physician's assistant acting within the scope of a project authorized under Article 18 (commencing with Section 429.70) of Chapter 2 of Part 1 of Division 1.

(7) A manufacturer licensed pursuant to Section 26685 of this code or Section 4084 or 4084.6 of the Business and Professions Code.

(8) A wholesaler licensed pursuant to Section 4084 or 4084.6 of the Business and Professions Code.

11123. (a) Upon application, the Board of Pharmacy may issue a license to store controlled substances to a warehouseman who maintains a warehouse suitable for the proper storage of the controlled substances.

(b) The Board of Pharmacy shall by regulation establish security measures in order to prevent unauthorized persons from gaining access to any area, place or premises in which controlled substances are stored, kept or maintained. Prior to the issuance of a license under this article, the Board of Pharmacy shall inspect an applicant's establishment to determine compliance with security regulations adopted by the Board of Pharmacy.

(c) As a condition to the granting of the license, the warehouseman shall agree to comply with the provisions of this division and any rules and regulations which are adopted by the Board of Pharmacy.

11124. On or before the effective date of this chapter, each licensed warehouseman shall make a complete and accurate record of all stocks of such controlled substances on hand. Thereafter, a current inventory shall be kept and preserved for at least two years from the date of making such inventory. Records and inventories shall contain such information as shall be provided by the rules and regulations promulgated by the Board of Pharmacy.

Such records shall be submitted in summary form to the Board of Pharmacy on or before July 1, 1973, and every two years thereafter.

The Board of Pharmacy shall have the right to inspect such records at the business office of the licensee at any time during business hours.

11125. Each warehouseman who applies for a license to store a controlled substance shall execute and file with the Board of Pharmacy a bond to the state as a condition to the granting of the license. The bond shall secure the faithful performance of the warehouseman of his obligations under the laws of the state and the rules and regulations which are adopted pursuant to this division and such additional obligations which he may assume under a contract with the depositor of the drug. The Board of Pharmacy may prescribe the form, amount, terms, and conditions of the bond.

11126. Any person who is injured by the breach of any obligation secured by the bond which is executed and filed pursuant to Section 11125 may sue on the bond in his own name in any court of competent jurisdiction to recover any damages he may have sustained by such breach.

11127. (a) The provisions of this article shall apply only to licenses issued by the Board of Pharmacy for customs brokers and warehouses which store controlled substances.

(b) The Board of Pharmacy shall have authority to issue licenses for customs brokers and warehouses which store controlled substances. Such licenses shall be issued in accordance with the provisions of this chapter and regulations adopted by the board pursuant thereto. All licenses issued by the Board of Pharmacy shall expire one year from the date of issue. Licenses may be renewed upon application and payment of the renewal fees if the application for renewal is made within the 30-day period prior to the date of expiration. Persons whose licenses have expired shall immediately cease the activity requiring a license, but the Board of Pharmacy shall accept applications for renewal during the 30-day period following the date of expiration if they are accompanied by the new license fee. In no case shall a license be renewed where the application is received more than 30 days after the date of expiration.

(c) Each application for a new or renewal license shall be accompanied by a fee which shall be fixed by the Board of Pharmacy at an amount not to exceed two hundred dollars ($200). The application shall be made upon a form furnished by the Board of Pharmacy. It shall contain such information concerning the background of the applicant and his experience which the Board of Pharmacy may prescribe, in addition to any other information required by law.

11128. (a) Licenses issued by the Board of Pharmacy shall not be transferable.

(b) In the event of a change of name, not involving a change of ownership, or a change of address of the licensee, the license shall be returned to the board for cancellation, and a new license application form shall be submitted. The Board of Pharmacy shall cancel the returned license and issue a new license for the unexpired term without fee.

11129. (a) Any license issued may be suspended or revoked by the Board of Pharmacy. The Board of Pharmacy may refuse to issue a license to any applicant for the reasons set forth in subdivision (b).

The proceedings under this chapter shall be conducted in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code, and the Board of Pharmacy shall have all the powers granted therein.

(b) The Board of Pharmacy may deny a license if the applicant does or has done any of the following:

(1) Fails to meet the qualifications established by the Board of Pharmacy pursuant to this chapter for the issuance of the license applied for.

(2) Was previously the holder of a license issued under this chapter which has been revoked and never reissued or was suspended and the terms of the suspension have not been fulfilled.

(3) Has committed any act which, if committed by any licensee, would be grounds for the suspension or revocation of a license issued pursuant to this chapter.

(4) Has committed any act involving dishonesty, fraud, or deceit whereby another is injured or the applicant has benefited.

(5) Has acted in the capacity of a licensed person under this division without having a license therefor.

(6) Has entered a plea of guilty or nolo contendere to, or been found guilty or convicted of, a felony or a crime involving moral turpitude and the time for appeal has elapsed or the judgment of conviction has been affirmed on appeal, irrespective of an order granting probation following the conviction or suspending the imposition of sentence, or of a subsequent order under the provisions of Section 1203.4 of the Penal Code allowing the person to withdraw his plea of guilty and to enter a plea of not guilty, setting aside the plea or verdict of guilty, or dismissing the accusation, information, or indictment.

(7) Violated any of the provisions of this division.

11130. The Board of Pharmacy may suspend, revoke, or take other disciplinary action against a license as provided in this chapter if the licensee does any of the following:

(a) Violates any section of this division which relates to his licensed activities.

(b) Is convicted of any felony.

(c) Violates any of the regulations promulgated by the Board of Pharmacy pursuant to this chapter.

(d) Has misrepresented a material fact in obtaining a license.

(e) Aids or abets an unlicensed person to evade the provisions of this division.

(f) Fails to make and keep records showing his transactions as a licensee, or fails to have such records available for inspection by the Board of Pharmacy for a period of not less than three years after completion of any transaction to which the records refer, or refuses to comply with a written request of the Board of Pharmacy to make such records available for inspection.

(g) Violates or attempts to violate the provisions of this division relating to the particular activity for which he is licensed.

(h) Fails to send a copy of the monthly reporting form to the Board of Pharmacy as required by the provisions of this chapter.

11131. A plea or verdict of guilty or a conviction following a plea of nolo contendere is deemed to be a conviction within the meaning of this chapter. The Board of Pharmacy may order the license suspended or revoked, or may decline to issue a license, when the time for appeal has elapsed, the judgment of conviction has been affirmed on appeal, or an order granting probation is made suspending the imposition of sentence, irrespective of a subsequent order under the provisions of Section 1203.4

of the Penal Code allowing such person to withdraw his plea of guilty and to enter a plea of not guilty, setting aside the verdict of guilty, or dismissing the accusation, information, or indictment.

11132. The Board of Pharmacy may take disciplinary action against any licensee, after a hearing as provided in this chapter, by any of the following:

(a) Imposing probation upon terms and conditions to be set forth by the Board of Pharmacy.

(b) Suspending the license.

(c) Revoking the license.

11133. The expiration or suspension of a license by operation of law or by order or decision of the board or a court, or the voluntary surrender of a license by a licensee, shall not deprive the Board of Pharmacy of jurisdiction to proceed with any investigation of, or action or disciplinary proceedings against, the licensee, or to render a decision suspending or revoking the license.

11134. All accusations against licensees shall be filed within three years after the act or omission alleged as the ground for disciplinary action.

11135. When any license has been revoked or suspended following a hearing under the provisions of this chapter, any additional license issued under this chapter in the name of the licensee may also be revoked or suspended by the Board of Pharmacy.

11136. After suspension of the license upon any of the grounds set forth in this chapter, the Board of Pharmacy may reinstate the license upon proof of compliance by the applicant with all provisions of the decision as to reinstatement. After revocation of a license upon any of the grounds set forth in this chapter, the license shall not be reinstated or reissued within a period of one year after the effective date of revocation.

CHAPTER 4. PRESCRIPTIONS

Article 1. Requirements of Prescriptions

11150. No person other than a physician, dentist, podiatrist, or veterinarian, or pharmacist acting within the scope of a project authorized under Article 18 (commencing with Section 429.70) of Chapter 2 of Part 1 of Division 1, or registered nurse acting within the scope of a project authorized under Article 18 (commencing with Section 429.70) of Chapter 2 of Part 1 of Division 1, or physician's assistant acting within the scope of a project authorized under Article 18 (commencing with Section 429.70) of Chapter 2 of Part 1 of Division 1 shall write a prescription.

11150.5. The provisions of this chapter shall be applicable to controlled substances subject to the Federal Controlled Substances Act (Title II, P.L. 91-513), as provided in subdivision (b) of Section 11007. References in this chapter to controlled substances classified in a particular schedule shall be [illegible] than a reference to the schedules set forth in Chapter 2 (commencing with Section 11053) of this division.

11151. A prescription written by an unlicensed person lawfully practicing medicine pursuant to Section 2147.5 of the Business and Professions Code, shall be filed only at a pharmacy maintained in the hospital which employs such unlicensed person.

11152. No person shall write, issue, fill, compound, or dispense a prescription that does not conform to this division.

11153. The responsibility for the proper prescribing and dispensing of controlled substances is upon the practitioner, but a corresponding liability rests with the pharmacist who fills the prescription. An order purporting to be a prescription issued to an addict or habitual user of controlled substances, which is not in the course of professional treatment nor part of an authorized methadone maintenance program, for the purpose of providing the user with controlled substances, sufficient to keep him comfortable by maintaining his customary use, is not a prescription within the meaning and intent of this division; and the person filling such an order, as well as the person issuing it, may be charged with violation of the law.

11154. Except in the regular practice of his profession, no person shall prescribe, administer, dispense, or furnish, a controlled substance to or for any person who is not under his treatment for a pathology or condition other than addiction to a controlled substance, except as provided in this division.

11155. Any physician, who by court order or order of any state or governmental agency, or who voluntarily surrenders his controlled substance privileges, shall not possess, administer, dispense, or prescribe a controlled substance unless and until such privileges have been restored, and he has obtained current registration from the appropriate federal agency as provided by law.

11156. No person shall prescribe for or administer, or dispense a controlled substance to an addict or habitual user, or to any person representing himself as such, except as permitted by this division.

11157. No person shall issue a prescription that is false or fictitious in any respect.

11158. Except as provided in Section 11159, no controlled substance classified in Schedule II shall be dispensed without a prescription meeting the requirements of this chapter. Except as provided in Section 11159 or when dispensed directly to an ultimate user by a practitioner, other than a pharmacist or pharmacy, no controlled substance classified in Schedule III, IV, or V may be dispensed without a prescription meeting the requirements of this chapter.

Except as otherwise prohibited or limited by law, a practitioner specified in Section 11150, may administer controlled substances in the [illegible]

11159. An order for controlled substances for use by a patient in a county or licensed hospital shall be exempt from all requirements of this article, but shall be in writing on the patient's record, signed by the prescriber, dated, and shall state the name and quantity of the controlled substance ordered and the quantity actually administered. The record of such orders shall be maintained as a hospital record for a minimum of seven years.

11161. Prescription blanks shall be issued by the Department of Justice in serially numbered groups of 100 forms each in triplicate, and shall be furnished free of cost to any person authorized to write a prescription, and such prescription blanks shall not be transferable. Any person possessing any such prescription blank otherwise than as herein provided is guilty of a misdemeanor.

11162. The prescription blanks shall be printed on distinctive paper, serial number of the group being shown on each form, and also each form being serially numbered.

11163. Not more than one such prescription group shall in any case be issued or furnished by the Department of Justice to the same prescriber at one time.

11164. Except as provided in Section 11167, no person shall prescribe a controlled substance, nor shall any person fill, compound, or dispense such a prescription unless it complies with the requirements of this section.

(a) Each prescription for a controlled substance classified in Schedule II which is a narcotic drug shall be wholly written in ink or indelible pencil in the handwriting of the prescriber upon the official prescription form issued by the Department of Justice. Such prescriptions shall be prepared in triplicate, signed and dated by the prescriber, and shall contain the name and address of the person for whom the controlled substance is prescribed, the name and quantity of the controlled substance prescribed, directions for use, and the address, category of professional licensure, and the federal controlled substance registration of the prescriber. The original and one copy of such a prescription shall be delivered to the pharmacist filling the prescription. The original shall be retained by the pharmacist and the copy, properly endorsed by him, shall be transmitted to the Department of Justice at the end of the month in which the prescription was filled.

(b) Each prescription for a controlled substance classified in Schedule II which is not a narcotic drug or for a controlled substance classified in Schedule III, IV, or V, except as authorized by subdivision (c), shall be subject to the following requirements:

(1) The prescription shall be signed and dated by the prescriber and shall contain the name of the person for whom the controlled substance is prescribed, the name and quantity of controlled substances prescribed, and directions for use. With respect to prescriptions for controlled substances classified in Schedule II or III which are not narcotic drugs, the signature, date, and information required by this paragraph shall be

wholly written in ink or indelible pencil in the handwriting of the prescriber.

(2) In addition, the prescription shall contain the name, address telephone number, category of professional licensure, and federal controlled substance registration number of the prescriber. The information required by this paragraph shall be either preprinted upon the prescription blank, typewritten, rubber stamped, or printed by hand.

(3) The prescription shall also contain the address of the person for whom the controlled substance is prescribed. If the prescriber does not specify such address on the prescription, the pharmacist filling the prescription or an employee acting under his direction shall write or type the address on the prescription.

(c) Any controlled substance classified in Schedule III, IV, or V may be dispensed upon an oral prescription, which shall be reduced to writing by the pharmacist filling the prescription or by such other person as is expressly authorized by provisions of the Business and Professions Code. The date of issue of the prescription and all the information required for a written prescription by subdivision (b) shall be included in such written record of the prescription. Pursuant to authorization of the prescriber, any employee of the prescriber on his behalf may orally transmit a prescription for a controlled substance classified in Schedule IV or V, if within a reasonable time thereafter the prescriber transmits to the pharmacist filling the prescription written evidence of the employee's authorization, and in such cases the written record of the prescription required by this subdivision shall also specify the name of the employee of the prescriber transmitting the prescription.

11165. Each written prescription for a controlled substance or for any material, compound, mixture, or preparation containing one or more controlled substances shall be set forth on a separate prescription blank.

11166. No person shall fill a prescription for a controlled substance classified in Schedule II which is tendered to him after the seventh day following the date of issue. No person shall knowingly fill a forged or altered prescription for a controlled substance except for the addition of the address of the person for whom the controlled substance is prescribed as provided by paragraph (3) of subdivision (b) of Section 11164.

11167. In the event of an epidemic or accident or calamity, any controlled substance classified in Schedule II may be dispensed upon an oral prescription if failure to issue such a prescription might result in loss of life or intense suffering. Prior to filling such a prescription, the pharmacist shall reduce it to writing. The date of issue of the prescription and all the information required for a written prescription by Section 11164 shall be included in such written record of the prescription.

Additionally, in such an emergency a prescriber may issue a written prescription for a controlled substance classified in Schedule II which is a narcotic drug upon a form other than the official prescription form issued by the Department of Justice. However, such a prescription shall in all other respects comply with the requirements of subdivision (a) of

Section 11164.

When an emergency oral or written prescription is issued pursuant to this section, the prescriber shall within 72 hours submit the prescription in the form required by Section 11164 to the pharmacy or pharmacist filling the prescription. If the prescriber does not provide such a prescription within 72 hours, the pharmacist filling the emergency prescription shall immediately so inform the Department of Justice.

11168. The prescription book containing the prescriber's copies of prescriptions issued shall be retained by the prescriber which shall be preserved for three years.

11169. When codeine, or dihydrocodeinone or tincture opii camphorata (paregoric) is not combined with other medicinal ingredients, it shall be prescribed on the official triplicate blanks.

11170. No person shall prescribe, administer, or furnish a controlled substance for himself.

11171. No person shall prescribe, administer, or furnish a controlled substance except under the conditions and in the manner provided by this division.

11172. No person shall antedate or postdate a prescription.

11173. (a) No person shall obtain or attempt to obtain controlled substances, or procure or attempt to procure the administration of or prescription for controlled substances, (1) by fraud, deceit, misrepresentation, or subterfuge; or (2) by the concealment of a material fact.

(b) No person shall make a false statement in any prescription, order, report, or record, required by this division.

(c) No person shall, for the purpose of obtaining controlled substances, falsely assume the title of, or represent himself to be, a manufacturer, wholesaler, pharmacist, physician, dentist, veterinarian, registered nurse, physician's assistant, or other authorized person.

(d) No person shall affix any false or forged label to a package or receptacle containing controlled substances.

11174. No person shall, in connection with the prescribing, furnishing, administering, or dispensing of a controlled substance, give a false name or false address.

11175. No person shall obtain or possess a prescription that does not comply with this division, nor shall any person obtain a controlled substance by means of a prescription which does not comply with this division or possess a controlled substance obtained by such a prescription.

11179. A person who fills a prescription shall keep it on file for at least three years from the date of filing it.

11180. No person shall obtain or possess a controlled substance obtained by a prescription that does not comply with this division.

Article 2. Prescriber's Record

11190. Every practitioner, other than a pharmacist, who issues prescription, or dispenses or administers a controlled substance classifie in Schedule II shall make a record that, as to the transaction, shows all the following:

(a) The name and address of the patient.

(b) The date.

(c) The character and quantity of controlled substances involved.

The prescriber's record shall show the pathology and purpose for whic the prescription is issued, or the controlled substance administere prescribed, or dispensed.

11191. The record shall be preserved for three years.

Every person who violates any provision of this section is guilty of misdemeanor.

11192. In a prosecution for a violation of Section 11190, proof that defendant received or has had in his possession at any time a greate amount of controlled substances than is accounted for by any recor required by law or that the amount of controlled substances possessed b a defendant is a lesser amount than is accounted for by any recor required by law is prima facie evidence of a violation of the section.

Article 3. Copies of Prescriptions

11195. Whenever the pharmacist's copy of a controlled substan prescription is removed by a peace officer, agent of the Attorney Gener or inspector of the Board of Pharmacy, or investigator of the Division Investigation of the Department of Consumer Affairs for the purpose investigation or as evidence, the officer or inspector or investigator sh give to the pharmacist a receipt in lieu thereof.

Article 4. Refilling Prescriptions

11200. No person shall refill a controlled substance prescription mo than six months after the date thereof or cause such a prescription to refilled more than five times, unless renewed by the prescriber. N prescription for a Schedule II substance may be refilled.

11201. A prescription for a controlled substance, except tho appearing in schedule II, may be refilled without the prescribe authorization if the prescriber is unavailable to authorize the refill and in the pharmacist's professional judgment, failure to refill the prescripti might present an immediate hazard to the patient's health and welfare might result in intense suffering. The pharmacist shall refill only reasonable amount sufficient to maintain the patient until the prescrib can be contacted. The pharmacist shall note on the reverse side of t prescription the date and quantity of the refill and that the prescriber w not available and the basis for his judgment to refill the prescripti

without the prescriber's authorization. The pharmacist shall inform the patient that the prescription was refilled without the prescriber's authorization, indicating that the prescriber was not available and that, in the pharmacist's professional judgment, failure to provide the drug might result in an immediate hazard to the patient's health and welfare or might result in intense suffering. The pharmacist shall inform the prescriber within a reasonable period of time. Prior to refilling a prescription pursuant to this section, the pharmacist shall make every reasonable effort contact the prescriber.

The prescriber shall not incur any liability as the result of a refiling of a prescription pursuant to this section.

Article 5. Pharmacists' Records

11205. The owner of a pharmacy or any person who purchases a controlled substance upon federal order forms as required pursuant to the provisions of the Federal "Comprehensive Drug Abuse Prevention and Control Act of 1970," (P.L. 91-513, 84 Stat. 1236), relating to the importation, exportation, manufacture, production, compounding, distribution, dispensing, and control of controlled substances, and who sells controlled substances obtained upon such federal order forms in response to prescriptions shall maintain and file such prescriptions in a separate file apart from noncontrolled substances prescriptions. Such files shall be preserved for a period of three years.

11206. The prescription file shall constitute a record that as to the transactions shall show all of the following:

(a) The name and address of the patient.

(b) The date.

(c) The character, quantity, and directions for use of the controlled substance involved.

(d) The name, address, telephone number, category of professional licensure, and the federal controlled substance registration number of the prescriber.

11207. No person other than a registered pharmacist under the laws of this state or an intern pharmacist, as defined in Section 4038.1 of the Business and Professions Code, who is under the personal supervision of a pharmacist, shall compound, prepare, fill or dispense a prescription for a controlled substance.

11208. In a prosecution under this division, proof that a defendant received or has had in his possession at any time a greater amount of controlled substances than is accounted for by any record required by law or that the amount of controlled substances possessed by the defendant is a lesser amount than is accounted for by any record required by law is prima facie evidence of guilt.

Chapter. 5. Use of Controlled Substances

Article 1. Lawful Medical Use Other Than Treatment of Addicts

11210. A physician, surgeon, dentist, veterinarian, or podiatrist, or pharmacist acting within the scope of a project authorized under Article 18 (commencing with Section 429.70) of Chapter 2 of Part 1 of Division 1, or registered nurse acting within the scope of a project authorized under Article 18 (commencing with Section 429.70) of Chapter 2 of Part 1 of Division 1, or physician's assistant acting within the scope of a project authorized under Article 18 (commencing with Section 429.70) of Chapter 2 of Part 1 of Division 1 may prescribe for, furnish to, or administer controlled substances to his patient when the patient is suffering from a disease, ailment, injury, or infirmities attendant upon old age, other than addiction to a controlled substance.

The physician, surgeon, dentist, veterinarian, or podiatrist, or pharmacist acting within the scope of a project authorized under Article 18 (commencing with Section 429.70) of Chapter 2 of Part 1 of Division 1, or registered nurse acting within the scope of a project authorized under Article 18 (commencing with Section 429.70) of Chapter 2 of Part 1 of Division 1, or physician's assistant acting within the scope of a project authorized under Article 18 (commencing with Section 429.70) of Chapter 2 of Part 1 of Division 1 shall prescribe, furnish, or administer controlled substances only when in good faith he believes the disease, ailment, injury, or infirmity, requires such treatment.

The physician, surgeon, dentist, veterinarian, or podiatrist, or pharmacist acting within the scope of a project authorized under Article 18 (commencing with Section 429.70) of Chapter 2 of Part 1 of Division 1, or registered nurse acting within the scope of a project authorized under Article 18 (commencing with Section 429.70) of Chapter 2 of Part 1 of Division 1, or physician's assistant acting within the scope of a project authorized under Article 18 (commencing with Section 429.70) of Chapter 2 of Part 1 of Division 1 shall prescribe, furnish, or administer controlled substances only in such quantity and for such length of time as are reasonably necessary.

11211. In order to provide a supply of controlled substances as may be necessary to handle emergency cases, any hospital which does not employ a resident pharmacist and which is under the supervision of a licensed physician, may purchase controlled substances on federal order forms for such institution, under the name of such hospital, such supply to be made available to a registered nurse for administration to patients in emergency cases, upon direction of a licensed physician.

11213. Persons who, under applicable federal laws or regulations, are lawfully entitled to use controlled substances for the purpose of research, instruction, or analysis, may lawfully obtain and use for such purposes such substances as are defined as controlled substances in this division, upon approval for use of such controlled substances in bona fide research, instruction, or analysis by the Research Advisory Panel established

pursuant to Sections 11480 and 11481.

Such research, instruction, or analysis shall be carried on only under the auspices of the head of a research project which has been approved by the Research Advisory Panel pursuant to Section 11480 or Section 11481. Complete records of receipts, stocks at hand, and use of these controlled substances shall be kept.

Article 2. Treatment of Addicts for Addiction

11215. Except as otherwise provided in this section, any narcotic controlled substance employed in treating an addict for addiction shall be administered by a physician, or by a registered nurse acting under his instruction. When acting under the direction of a physician, any psychiatric technician licensed pursuant to Chapter 10 (commencing with Section 4500) of Division 2 of the Business and Professions Code or any vocational nurse licensed pursuant to Chapter 6.5 (commencing with Section 2840) of Division 2 of the Business and Professions Code, or any pharmacist licensed pursuant to Chapter 9 (commencing with Section 4000) of Division 2 of the Business and Professions Code may administer methadone or other controlled substances orally in the treatment of an addict for addiction to a controlled substance.

11216. Except as otherwise provided in Section 11215, no physician or other person shall order, permit, or direct any person other than a registered nurse, or other physician, to administer a narcotic controlled substance to a person being treated for addiction to a controlled substance.

11217. No person shall treat an addict for addiction to a narcotic drug which is an opiate except in one of the following:

(a) An institution approved by the State Department of Health, and where the patient is at all times kept under restraint and control.

(b) A city or county jail.

(c) A state prison.

(d) A facility designated by a county and approved by the State Department of Health pursuant to Division 5 (commencing with Section 5000) of the Welfare and Institutions Code.

(e) A state hospital.

(f) A county hospital.

Methadone in the continuing treatment of addiction to a controlled substance shall be used only in those programs approved by the state department pursuant to Section 4351 of the Welfare and Institutions Code on either an inpatient or outpatient basis, or both.

This section does not apply during emergency treatment, or where the patient's addiction is complicated by the presence of incurable disease, serious accident, or injury, or the infirmities of old age.

Neither this section nor any other provision of this division shall be construed to prohibit the maintenance of a place in which persons seeking [illegible] and endeavor

that no person is treated for addiction in such place by means of administering, furnishing, or prescribing of controlled substances. The preceding sentence is declaratory of preexisting law. Every such place shall register with, and be approved by, the state department.

Neither this section or any other provision of this divison shall be construed to prohibit short-term methadone detoxification treatment in a controlled setting approved by the director and pursuant to rules and regulations of the director. Facilities and treatment approved by the director under this paragraph shall not be subject to approval or inspection by the Board of Medical Examiners of the State of California nor shall persons in such facilities be required to register with, or report the termination of residence with, the police department or sheriff's office.

11217.5. Notwithstanding the provisions of Section 11217, a licensed physician and surgeon may treat an addict for addiction in any office or medical facility which, in the professional judgment of such physician and surgeon, is medically proper for the rehabilitation and treatment of such addict. Such licensed physician and surgeon may administer to an addict under his direct care, those medications and therapeutic agents which, in the judgment of such physician and surgeon, are medically necessary, provided that nothing in this section shall authorize the administration of any narcotic drug.

11218. A physician treating an addict for addiction shall not prescribe for or furnish the addict more than any one of the following amounts of controlled substances during each of the first 15 days of such treatment:

(a) Eight grains of opium.
(b) Four grains of morphine.
(c) Six grains of Pantopon.
(d) One grain of Dilaudid.
(e) Four hundred milligrams of isonipecaine (Demerol).
(f) One hundred eighty millgrams of methadone.

11219. After 15 days of treatment the physician shall not prescribe or furnish to the addict more than any one of the following amounts of controlled substances during each day of such treatment:

(a) Four grains of opium.
(b) Two grains of morphine.
(c) Three grains of Pantopon.
(d) One-half grain of Dilaudid.
(e) Two hundred milligrams of isonipecaine (Demerol).
(f) One hundred eighty milligrams of methadone.

11220. At the end of 30 days from the first treatment, the prescribing or furnishing of controlled substances, except methadone, shall be discontinued.

11221. The physician prescribing, furnishing, or administering narcotic controlled substance in the treatment of an addict for addiction [illegible] days after the first treatment report by registered

over his signature, to the Attorney General stating the name and address of the patient, and the name and quantities of narcotic controlled substances prescribed.

The report shall state the progress of the patient under the treatment.

The physician shall in the same manner further report on the 15th day of the treatment and on the 30th day of the treatment, and thereafter shall make such further reports as are requested in writing by the Attorney General.

11222. In any case in which a person is taken into custody by arrest or other process of law and is lodged in a jail or other place of confinement, and there is reasonable cause to believe that such person is addicted to a controlled substance, it is the duty of the person in charge of the place of confinement to provide the person so confined with medical aid as necessary to ease any symptoms of withdrawal from the use of controlled substances.

In any case in which a person, who is participating in a methadone maintenance program, is incarcerated in a jail or other place of confinement, he shall, in the discretion of the director of such program, be entitled to continue in such program until conviction.

Article 3. Physicians' Reports

11230. A physician prescribing or furnishing a controlled substance classified in Schedule II to an habitual user shall within five days after first prescribing or furnishing the controlled substance personally report in writing by registered mail, over his signature, to the Attorney General.

The report shall contain all of the following:

(a) Name of the patient.
(b) Address of the patient.
(c) Character of the injury or ailment.
(d) Quantity and kind of controlled substance used.
(e) A statement as to whether or not the patient is an addict.

11231. The physician shall upon request in writing from the Attorney General furnish any additional reports upon the treatment of the user as the Attorney General may request in writing.

Article 4. Veterinarians

11240. No veterinarian shall prescribe, administer, or furnish a controlled substance for himself or any other human being.

11241. A prescription written by a veterinarian shall state the kind of animal for which ordered and the name and address of the owner or person having custody of the animal.

Article 5. Sale Without Prescription

11250. No prescription is required in case of the sale of controlled

substances at retail in pharmacies by pharmacists to any of the following:

(a) Physicians.
(b) Dentists.
(c) Podiatrists.
(d) Veterinarians.
(e) Pharmacists acting within the scope of a project authorized under Article 18 (commencing with Section 429.70) of Chapter 2 of Part 1 of Division 1, or registered nurses acting within the scope of a project authorized under Article 18 (commencing with Section 429.70) of Chapter 2 of Part 1 of Division 1, or physician's assistants acting within the scope of a project authorized under Article 18 (commencing with Section 429.70) of Chapter 2 of Part 1 of Division 1.

In any sale mentioned in this article, there shall be executed any written order that may otherwise be required by federal law relating to the production, importation, exportation, manufacture, compounding, distributing, dispensing, or control of controlled substances.

11251. No prescription is required in case of sales at wholesale by pharmacies, jobbers, wholesalers and manufacturers to any of the following:

(a) Pharmacies as defined in the Business and Professions Code.
(b) Physicians.
(c) Dentists.
(d) Podiatrists.
(e) Veterinarians.
(f) Other jobbers, wholesalers or manufacturers.
(g) Pharmacists acting within the scope of a project authorized under Article 18 (commencing with Section 429.70) of Chapter 2 of Part 1 of Division 1, or registered nurses acting within the scope of a project authorized under Article 18 (commencing with Section 429.70) of Chapter 2 of Part 1 of Division 1, or physician's assistants acting within the scope of a project authorized under Article 18 (commencing with Section 429.70) of Chapter 2 of Part 1 of Division 1.

11252. All wholesale jobbers, wholesalers, and manufacturers, mentioned in this division shall keep, in a manner readily accessible, the written orders or blank forms required to be preserved pursuant to federal law relating to the production, importation, exportation, manufacture, compounding, distributing, dispensing, or control of controlled substances.

11253. The written orders or blank forms shall be preserved for at least three years after the date of the last entry made.

11255. The taking of any order, or making of any contract or agreement, by any traveling representative or employee of any person for future delivery in this state of any controlled substance constitutes a sale within the meaning of this division.

11256. Within 24 hours after any purchaser in this state gives any order for a controlled substance classified in Schedule II to, or makes any

contract or agreement for purchases from or sales by, an out-of-state wholesaler or manufacturer of any controlled substances for delivery in this state, the purchaser shall forward to the Attorney General by registered mail a true and correct copy of the order, contract, or agreement.

Chapter. 6. Offenses and Penalties

Article 1. Offenses Involving Controlled Substances Formerly Classified as Narcotics

11350. Except as otherwise provided in this division, every person who possesses (1) any controlled substance specified in subdivision (b) or (c) of Section 11054, specified in paragraph (11), (12), or (17) of subdivision (d) of Section 11054, or specified in subdivision (b) or (c) of Section 11055, or (2) any controlled substance classified in Schedule III, IV, or V which is a narcotic drug, unless upon the written prescription of a physician, dentist, podiatrist, or veterinarian licensed to practice in this state, shall be punished by imprisonment in the state prison.

11351. Except as otherwise provided in this division, every person who possesses for sale (1) any controlled substance specified in subdivision (b) or (c) of Section 11054, specified in paragraph (11), (12), or (17) of subdivision (d) of Section 11054, or specified in subdivision (b) or (c) of Section 11055, or (2) any controlled substance classified in Schedule III, IV, or V which is a narcotic drug, shall be punished by imprisonment in the state prison for two, three, or four years.

11352. Except as otherwise provided in this division, every person who transports, imports into this state, sells, furnishes, administers, or gives away, or offers to transport, import into this state, sell, furnish, administer, or give away, or attempts to import into this state or transport (1) any controlled substance specified in subdivision (b) or (c) of Section 11054, specified in paragraph (11), (12), or (17) of subdivision (d) of Section 11054, or specified in subdivision (b) or (c) of Section 11055, or (2) any controlled substance classified in Schedule III, IV, or V which is a narcotic drug, unless upon the written prescription of a physician, dentist, podiatrist, or veterinarian licensed to practice in this state, shall be punished by imprisonment in the state prison for three, four or five years.

11352.5. The court shall impose a fine not exceeding fifty thousand dollars ($50,000), in the absence of a finding that the defendant would be incapable of paying such a fine, in addition to any term of imprisonment provided by law for any of following persons:

(1) Any person who is convicted of violating Section 11351 of the Health and Safety Code by possessing for sale one-half ounce or more of a substance containing heroin.

(2) Any person who is convicted of violating Section 11352 of the Health and Safety Code by selling or offering to sell one-half ounce or more of a substance containing heroin.

(3) Any person convicted of violating Section 11351 of the Health and Safety Code by possessing heroin for sale or convicted of violating Section 11352 of the Health and Safety Code by selling or offering to sell heroin, and who has one or more prior convictions for violating Section 11351 or Section 11352 of the Health and Safety Code.

11353. Every person 18 years of age or over who in any voluntary manner solicits, induces, encourages, or intimidates any minor with the intent that the minor shall knowingly violate any provision of this chapter or Section 11550 with respect to (1) a controlled substance which is specified in subdivision (b) or (c) of Section 11054, specified in paragraph (11), (12), or (17) of subdivision (d) of Section 11054, or specified in subdivision (b) or (c) of Section 11055 or, (2) any controlled substance classified in Schedule III, IV, or V which is a narcotic drug, who hires, employs, or uses a minor to knowingly and unlawfully transport, carry, sell, give away, prepare for sale, or peddle any such controlled substance, or who unlawfully sells, furnishes, administers, gives, or offers to sell, furnish, administer, or give, any such controlled substance to a minor shall be punished by imprisonment in the state prison for a period of three, four, or five years.

11354. (a) Every person under the age of 18 years who in any voluntary manner solicits, induces, encourages, or intimidates any minor with the intent that the minor shall knowingly violate any provision of this chapter or Section 11550, who hires, employs, or uses a minor to knowingly and unlawfully transport, carry, sell, give away, prepare for sale, or peddle (1) any controlled substance specified in subdivision (b) or (c) of Section 11054, specified in paragraph (11), (12), or (17) of subdivision (d) of Section 11054, or specified in subdivision (b) or (c) of Section 11055 or (2) any controlled substance classified in Schedule III, IV, or V which is a narcotic drug, or who unlawfully sells, furnishes, administers, gives, or offers to sell, furnish, administer, or give, any such controlled substance to a minor shall be punished by imprisonment in the state prison.

(b) This section is not intended to affect the jurisdiction of the juvenile court.

11355. Every person who agrees, consents, or in any manner offers to unlawfully sell, furnish, transport, administer, or give (1) any controlled substance specified in subdivision (b) or (c) of Section 11054, specified in paragraph (10), (11), (12), or (17) of subdivision (d) of Section 11054, or specified in subdivision (b) or (c) of Section 11055 or, (2) any controlled substance classified in Schedule III, IV, or V which is a narcotic drug to any person, or offers, arranges, or negotiates to have any such controlled substance unlawfully sold, delivered, transported, furnished, administered, or given to any person and then sells, delivers, furnishes, transports, administers, or gives, or offers, arranges, or negotiates to have sold, delivered, transported, furnished, administered, or given to any person any other liquid, substance, or material in lieu of any such controlled substance shall be punished by imprisonment in the county jail for not more than one year, or in the state prison.

11356. As used in this article "felony offense," and offense "punishable as a felony" refer to an offense for which the law prescribes imprisonment in the state prison as either an alternative or the sole penalty, regardless of the sentence the particular defendant received.

Article 2. Marijuana

11357. (a) Except as authorized by law, every person who possesses any concentrated cannabis shall be punished by imprisonment in the county jail for a period of not more than one year or by a fine of not more than five hundred dollars ($500), or by both such fine and imprisonment, or shall be punished by imprisonment in the state prison.

(b) Except as authorized by law, every person who possesses not more than one avoirdupois ounce of marijuana, other than concentrated cannabis, is guilty of a misdemeanor and shall be punished by a fine of not more than one hundred dollars ($100). Notwithstanding other provisions of law, if such person has been previously convicted three or more times of an offense described in this subdivision during the two-year period immediately preceding the date of commission of the violation to be charged, the previous convictions shall also be charged in the accusatory pleading and, if found to be true by the jury upon a jury trial or by the court upon a court trial or if admitted by the person, the provisions of Sections 1000.1 and 1000.2 of the Penal Code shall be applicable to him, and the court shall divert and refer him for education, treatment, or rehabilitation, without a court hearing or determination or the concurrence of the district attorney, to an appropriate community program which will accept him. If the person is so diverted and referred he shall not be subject to the fine specified in this subdivision. If no community program will accept him, the person shall be subject to the fine specified in this subdivision. In any case in which a person is arrested for a violation of this subdivision and does not demand to be taken before a magistrate, such person shall be released by the arresting officer upon presentation of satisfactory evidence of identity and giving his written promise to appear in court, as provided in Section 853.6 of the Penal Code, and shall not be subjected to booking.

(c) Except as authorized by law, every person who possess more than one avoirdupois ounce of marijuana, other than concentrated cannabis, shall be punished by imprisonment in the county jail for a period of not more than six months or by a fine of not more than five hundred dollars ($500), or by both such fine and imprisonment.

11358. Every person who plants, cultivates, harvests, dries, or processes any marijuana or any part thereof, except as otherwise provided by law, shall be punished by imprisonment in the state prison.

11359. Every person who possesses for sale any marijuana, except as otherwise provided by law, shall be punished by imprisonment in the state prison.

11360. (a) Except as otherwise provided by this section or as

authorized by law, every person who transports, imports into this state, sells, furnishes, administers, or gives away, or offers to transport, import into this state, sell, furnish, administer, or give away, or attempts to import into this state or transport any marijuana shall be punished by imprisonment in the state prison for a period of two, three or four years.

(b) Except as authorized by law, every person who gives away, offers to give away, transports, offers to transport, or attempts to transport not more than one avoirdupois ounce of marijuana, other than concentrated cannabis, is guilty of a misdemeanor and shall be punished by a fine of not more than one hundred dollars ($100). In any case in which a person is arrested for a violation of this subdivision and does not demand to be taken before a magistrate, such person shall be released by the arresting officer upon presentation of satisfactory evidence of identity and giving his written promise to appear in court, as provided in Section 853.6 of the Penal Code, and shall not be subjected to booking.

11361. Every person 18 years of age or over who hires, employs, or uses a minor in unlawfully transporting, carrying, selling, giving away, preparing for sale, or peddling any marijuana, who unlawfully sells, furnishes, administers, gives, or offers to sell, furnish, administer, or give any marijuana to a minor, or who induces a minor to use marijuana in violation of law shall be punished by imprisonment in the state prison for a period of three, four, or five years.

11361.5. (a) Records of any court of this state, any public or private agency that provides services upon referral under Section 1000.2 of the Penal Code, or of any state agency or local public agency pertaining to the arrest or conviction of any person for a violation of subdivision (b) or (c) of Section 11357 or subdivision (c) of Section 11360, shall not be kept beyond two years from the date of such a conviction, or from the date of the arrest if there was no conviction. It shall be the duty of each court and each such agency having custody of such records to provide for the timely destruction thereof in accordance with the provisions of subdivision (c). The requirements of this subdivision shall not apply to records of any conviction occurring prior to January 1, 1976, or records of any arrest not followed by a conviction occurring prior to such date.

(b) This subdivision shall be applicable only to records of convictions and arrests not followed by conviction occurring prior to January 1, 1976, for any of the following offenses:

(1) Any violation of Section 11357 or a statutory predecessor thereof.

(2) Unlawful possession of a device, contrivance, instrument or paraphernalia used for unlawfully smoking marijuana, in violation of Section 11364, as it existed prior to January 1, 1976, or a statutory predecessor thereof,

(3) Unlawful visitation or presence in a room or place in which marijuana is being unlawfully smoked or used, in violation of Section 11365, as it existed prior to January 1, 1976, or a statutory predecessor thereof.

(4) Unlawfully using or being under the influence of marijuana, in violation of Section 11550, as it existed prior to January 1, 1976, or a

statutory predecessor thereof.

Any person subject to such an arrest or conviction may apply to the Department of Justice for destruction of records pertaining thereto if two years or more have elapsed since the date of the conviction, or since the date of the arrest if not followed by a conviction. The application shall be submitted upon a form supplied by the Department of Justice and shall be accompanied by a fee, which shall be established by the department in such amount as will defray the cost of administering this subdivision and costs incurred by the state under subdivision (e), but which shall not exceed thirty-seven dollars and fifty cents ($37.50). The application form shall be made available at every local police or sheriff's department and from the Department of Justice and may require such information as the department determines is necessary for purposes of identification.

The department may request, but not require, the applicant to include a self-administered fingerprint upon the application. If the department is unable to sufficiently identify the applicant for purposes of this subdivision without such fingerprint or without additional fingerprints, it shall so notify the applicant and shall request the applicant to submit such fingerprints as may be required to effect identification, including a complete set if necessary, or, alternatively, to abandon the application and request a refund of all or a portion of the fee submitted with the application, as provided in this section. If the applicant fails or refuses to submit fingerprints in accordance with the department's request within such reasonable time as shall be established by the department or if the applicant requests a refund of the fee, the department shall promptly mail a refund to the applicant at the address specified in the application or at such other address as may be specified by the applicant. However, if the department has notified the applicant that election to abandon the application will result in forfeiture of a specified amount which is a portion of the fee, the department may retain such portion of the fee as the department may determine will defray the actual costs of processing the application, provided, the amount of such portion retained shall not exceed ten dollars ($10).

Upon receipt of a sufficient application, the Department of Justice shall destroy records of the department, if any, pertaining to such arrest or conviction in the manner prescribed by subdivision (c) and shall notify the Federal Bureau of Investigation, the law enforcement agency which arrested the applicant, and, if the applicant was convicted, the probation department which investigated the applicant and the Department of Motor Vehicles, of the application. Each state or local agency receiving such a notice from the Department of Justice shall destroy records of such agency, if any, pertaining to the arrest or conviction specified in the notice, in the manner prescribed by subdivision (c). The application form and the notices from the department to the agencies specified in this subdivision shall be destroyed by the department or agency, as the case may be, at the time the other records of the arrest or conviction are destroyed.

(c) Destruction of records of arrest or conviction pursuant to subdivision (a) or (b) of this section shall be accomplished by permanent

obliteration of all entries or notations upon such records pertaining to the arrest or conviction, and the record shall be prepared again so that it appears that the arrest or conviction never occurred. However, where (1) the only entries upon the record pertain to such arrest or conviction and (2) the record can be destroyed without necessarily effecting the destruction of other records, then the document constituting the record shall be physically destroyed.

(d) Notwithstanding subdivision (a) or (b), written transcriptions of oral testimony in court proceedings and published judicial appellate reports shall not be subject to the provisions of this section. Additionally, no records shall be destroyed pursuant to subdivision (a) if the defendant or a codefendant has filed a civil action against the peace officers or law enforcement jurisdiction which made the arrest or instituted the prosecution and if the agency which is the custodian of such records has received a certified copy of the complaint in such civil action, until the civil action has finally been resolved. Immediately following the final resolution of the civil action, records subject to subdivision (a) of this section shall be destroyed pursuant to subdivision (a) if more than two years has elapsed from the date of the conviction or arrest without conviction.

(e) Costs incurred by local agencies in complying with the provisions of subdivision (b) shall be reimbursed as provided in Section 2231 of the Revenue and Taxation Code.

11361.7. (a) Any record subject to destruction or permanent obliteration pursuant to Section 11361.5, or more than two years of age, of a record of a conviction for an offense specified in subdivision (a) or (b) of Section 11361.5 which became final more than two years previously, shall not be considered to be accurate, relevant, timely, or complete for any purposes by any agency or person. The provisions of this subdivision shall be applicable for purposes of the Privacy Act of 1974 (5 U.S.C. Section 552a) to the fullest extent permissible by law, whenever any information or record subject to destruction or permanent obliteration under Section 11361.5 was obtained by any state agency, local public agency, or any public or private agency that provides services upon referral under Section 1000.2 of the Penal Code, and is thereafter shared with or disseminated to any agency of the federal government.

(b) No public agency shall alter, amend, assess, condition, deny, limit, postpone, qualify, revoke, surcharge, or suspend any certificate, franchise, incident, interest, license, opportunity, permit, privilege, right, or title of any person because of an arrest or conviction for an offense specified in subdivision (a) or (b) of Section 11361.5, or because of the facts or events leading to such an arrest or conviction, on or after the date the records of such arrest or conviction are required to be destroyed by subdivision (a) of Section 11361.5, or two years from the date of such conviction or arrest without conviction with respect to arrests and convictions occurring prior to January 1, 1976. As used in this subdivision, "public agency" includes, but is not limited to, any state, county, city and county, city, public or constitutional corporation or entity, district, local or regional politic

subdivision, or any department, division, bureau, office, board, commission or other agency thereof.

(c) Any person arrested or convicted for an offense specified in subdivision (a) or (b) of Section 11361.5 may, two years from the date of such a conviction, or from the date of the arrest if there was no conviction, indicate in response to any question concerning his prior criminal record that he was not arrested or convicted for such offense.

(d) The provisions of this section shall be applicable without regard to whether destruction or obliteration of records has actually been implemented pursuant to Section 11361.5.

11362. As used in this article "felony offense," and offense "punishable as a felony" refer to an offense for which the law prescribes imprisonment in the state prison as either an alternative or the sole penalty, regardless of the sentence the particular defendant received.

Article 3. Peyote

11363. Every person who plants, cultivates, harvests, dries, or processes any plant of the genus Lophophora, also known as peyote, or any part thereof shall be punished by imprisonment in the county jail for a period of not more than one year or the state prison.

Article 4. Miscellaneous Offenses and Provisions

11364. It is unlawful to possess an opium pipe or any device, contrivance, instrument or paraphernalia used for unlawfully injecting or smoking (1) a controlled substance specified in subdivision (b) or (c) of Section 11054, specified in paragraph (11), (12), or (17) of subdivision (d) of Section 11054, or specified in subdivision (b) or (c) of Section 11055 or (2) a controlled substance which is a narcotic drug classified in Schedule III, IV or V.

11365. It is unlawful to visit or to be in any room or place where any controlled substances which are specified in subdivision (b) or (c) of Section 11054, specified in paragraph (11), (12), or (17) of subdivision (d) of Section 11054, or specified in subdivision (b) or (c) of Section 11055, or which are narcotic drugs classified in Schedule III, IV, or V, are being unlawfully smoked or used with knowledge that such activity is occurring.

11366. Every person who opens or maintains any place for the purpose of unlawfully selling, giving away, or using any controlled substance which is (1) specified in subdivision (b) or (c) of Section 11054, specified in paragraph (10), (11), (12), or (17) of subdivision (d) of Section 11054, or specified in subdivision (b) or (c) of Section 11055, or (2) which is a narcotic drug classified in Schedule III, IV, or V, shall be punished by imprisonment in the county jail for a period of not more than one year or the state prison.

11367. All duly authorized peace officers, while investigating violations of this division in performance of their official duties, and any person working under their immediate direction, supervision or instruction, ar immune from prosecution under this division.

11368. Every person who forges or alters a prescription or who issue or utters an altered prescription, or who issues or utters a prescriptio bearing a forged or fictitious signature for any narcotic drug, or wh obtains any narcotic drug by any forged, fictitious, or altered prescriptior or who has in possession any narcotic drug secured by such forgec fictitious, or altered prescription, shall for the first offense be punished b imprisonment in the county jail for not less than six months nor more tha one year, or in the state prison.

11369. When there is reason to believe that any person arrested fo violation of Section 11350, 11352, 11353, 11355, 11357, 11360, 11361, 1136 11366, 11368 or 11550, may not be a citizen of the United States, th arresting agency shall notify the appropriate agency of the United State having charge of deportation matters.

11370. (a) Any person convicted of violating Section 11350, 1135 11355, 11357, 11359, 11360, 11361, 11363, 11366, or 11368, or of committin any offense referred to in those sections, shall not, in any case, be grante probation by the trial court or have the execution of the sentence impose upon him suspended by the court, if he has been previously convicted c any offense described in subdivision (c).

(b) Any person who was 18 years of age or over at the time of th commission of the offense and is convicted for the first time of sellin furnishing, administering, or giving a controlled substance which is (1 specified in subdivision (b) or (c) of Section 11054, specified in paragrap (11), (12), or (17) of subdivision (d) of Section 11054, or specified i subdivision (b) or (c) of Section 11055, or, (2) which is a narcotic dru classified in Schedule III, IV, or V, to a minor or inducing a minor to us such a controlled substance in violation of law shall not, in any case, b granted probation by the trial court or have the execution of the sentenc imposed upon him suspended by the court.

(c) Any previous conviction of any of the following offenses, or of a offense under the laws of another state or of the United States which, committed in this state would have been punishable as such an offens shall render a person ineligible for probation or suspension of sentenc pursuant to subdivision (a) of this section:

(1) Any felony offense described in this division involving a controlle substance specified in subdivision (b) or (c) of Section 11054, specified i paragraph (10), (11), (12), or (17) of subdivision (d) of Section 11054, o specified in subdivision (b) or (c) of Section 11055.

(2) Any felony offense described in this division involving a narcoti drug classified in Schedule III, IV, or V.

11371. Any person who shall violate any of the provisions of Sectio 11152, 11153, 11154, 11155, or 11156 with respect to (1) a controlle substance specified in subdivision (b) or (c) of Section 11054, specified i paragraph (10), (11), (12), or (17) of subdivision (d) of Section 11054, o specified in subdivision (b) or (c) of Section 11055, or (2) a controlle

substance which is a narcotic drug classified in Schedule III, IV, or V, or who in any voluntary manner solicits, induces, encourages or intimidates any minor with the intent that such minor shall commit any such offense, shall be punished by imprisonment in the state prison or in a county jail not exceeding one year, or by a fine not exceeding twenty thousand dollars ($20,000), or by both such fine and imprisonment.

11371.1. Any person who shall violate any of the provisions of Section 11173 or 11174 with respect to (1) a controlled substance specified in subdivision (b) or (c) of Section 11054, specified in paragraph (10), (11), (12), or (17) of subdivision (d) of Section 11054, or specified in subdivision (b) or (c) of Section 11055, or (2) a controlled substance which is a narcotic drug classified in Schedule III, IV, or V, or who in any voluntary manner solicits, induces, encourages or intimidates any minor with the intent that such minor shall commit any such offense, shall be punished by imprisonment in the state prison or in a county jail not exceeding one year.

11372. In addition to the term of imprisonment provided by law for persons convicted of violating Section 11350, 11351, 11352, 11353, 11355, 11359, 11360, or 11361 of this code, the trial court may impose a fine not exceeding twenty thousand dollars ($20,000) for each such offense. In no event shall such fine be levied in lieu of or in substitution for the term of imprisonment provided by law for any of such offenses.

11373. Whenever any person is granted probation by the trial court after conviction for possession of any controlled substance classified in Schedule I or II, such trial court shall, as a condition of probation, order such person to secure education or treatment from a local community agency designated by such court, if such service is available and the person is likely to benefit from the service.

If such defendant is a minor, the trial court shall also order his parents or guardian to participate in such education or treatment to the extent the court determines will aid the education or treatment of the minor.

If a minor is found by a juvenile court to have been in possession of any controlled substance classified in Schedule I or II, in addition to any other order it may make, such juvenile court shall order the minor to receive education or treatment from a local community agency designated by such court, if such service is available and the person is likely to benefit from the service, and it shall also order his parents or guardian to participate in such education or treatment to the extent the court determines will aid the education or treatment of the minor.

11374. Every person who violates or fails to comply with any provision of this division, except one for which a penalty is otherwise in this division specifically provided, is guilty of a misdemeanor punishable by a fine in a sum not less than thirty dollars ($30) nor more than five hundred dollars ($500), or by imprisonment for not less than 15 nor more than 180 days, or by both.

Article 5. Schedules III, IV, and V

11376. Whenever any person is granted probation by the trial cou after conviction for possession of any controlled substance which is (classified in Schedule III, IV, or V and which is not a narcotic drug or (which is specified in subdivision (d) of Section 11054, except paragrap (10), (11), (12), and (17) of such subdivision, or specified in subdivisic (d) of Section 11055, such trial court shall, as a condition of probatio order such person to secure education or treatment from a loc community agency designated by such court, if such service is availat and the person is likely to benefit from the service.

If such defendant is a minor, the trial court shall also order his pare or guardian to participate in such education or treatment to the extent t court determines will aid the education or treatment of the minor.

If a minor is found by a juvenile court to have been in possession of a such controlled substance, in addition to any other order it may ma such juvenile court shall order the minor to receive education treatment from the local community agency designated by such court such service is available and the person is likely to benefit from the servi and it shall also order his parents or guardian to participate in s education or treatment to the extent the court determines will aid education or treatment of the minor.

11377. (a) Except as otherwise provided in Article 8 (commenc with Section 4211) of Chapter 9 of Division 2 of the Business Professions Code, every person who possesses any controlled substa which is (1) classified in Schedule III, IV, or V, other than any substa specified in paragraph (6) of subdivision (b) of Section 11056, and wl is not a narcotic drug or (2) which is specified in subdivision (d) of Sec 11054, except paragraphs (10), (11), (12), and (17) of such subdivisio specified in subdivision (d) of Section 11055, unless upon the prescrip of a physician, dentist, podiatrist, or veterinarian, or pharmacist ac within the scope of a project authorized under Article 18 (commen with Section 429.70) of Chapter 2 of Part 1 of Division 1, or regist nurse acting within the scope of a project authorized under Artic (commencing with Section 429.70) of Chapter 2 of Part 1 of Division physician's assistant acting within the scope of a project authorized u Article 18 (commencing with Section 429.70) of Chapter 2 of Part Division 1 licensed to practice in this state, shall be punishe imprisonment in the county jail for a period of not more than one yc the state prison.

(b) Except as otherwise provided in Article 8 (commencing Section 4211) of Chapter 9 of Division 2 of the Business and Profe Code, every person who possesses any controlled substance specifi paragraph (6) of subdivision (b) of Section 11056, unless upo prescription of a physician, dentist, podiatrist, or veterinaria pharmacist acting within the scope of a project authorized under A 18 (commencing with Section 429.70) of Chapter 2 of Part 1 of Di registered nurse acting within the scope of a project auth

under Article 18 (commencing with Section 429.70) of Chapter 2 of Part 1 of Division 1, or physician's assistant acting within the scope of a project authorized under Article 18 (commencing with Section 429.70) of Chapter 2 of Part 1 of Division 1 licensed to practice in this state, shall be punished by a fine of not exceeding five hundred dollars ($500), or by imprisonment in the county jail for not exceeding six months, or by both such fine and imprisonment.

11378. Except as otherwise provided in Article 8 (commencing with Section 4211) of Chapter 9 of Division 2 of the Business and Professions Code, every person who possesses for sale any controlled substance which is (1) classified in Schedule III, IV, or V and which is not a narcotic drug or (2) which is specified in subdivision (d) of Section 11054, except paragraphs (10), (11), (12), and (17) of such subdivision, or specified in subdivision (d) of Section 11055, shall be punished by imprisonment in the state prison.

11379. Except as otherwise provided in Article 8 (commencing with Section 4211) of Chapter 9 of Division 2 of the Business and Professions Code, every person who transports, imports into this state, sells, manufactures, compounds, furnishes, administers, or gives away, or offers to transport, import into this state, sell, manufacture, compound, furnish, administer, or give away, or attempts to import into this state or transport any controlled substance which is (1) classified in Schedule III, IV, or V and which is not a narcotic drug or (2) which is specified in subdivision (d) of Section 11054 except paragraphs (10), (11), (12), and (17) of such subdivision, or specified in subdivision (d) of Section 11055, unless upon the prescription of a physician, dentist, podiatrist, or veterinarian, or pharmacist acting within the scope of a project authorized under Article 18 (commencing with Section 429.70) of Chapter 2 of Part 1 of Division 1, or registered nurse acting within the scope of a project authorized under Article 15 (commencing with Section 429.70) of Chapter 2 of Part 1 of Division 1, or physician's assistant acting within the scope of a project authorized under Article 18 (commencing with Section 429.70) of Chapter 2 of Part 1 of Division 1 licensed to practice in this state, shall be punished by imprisonment in the state prison for a period of two, three, or four years.

11380. (a) Every person 18 years of age or over who violates any provision of this chapter involving controlled substances which are (1) classified in Schedule III, IV, or V and which are not narcotic drugs or (2) which are specified in subdivision (d) of Section 11054, except paragraphs (10), (11), (12), and (17) of such subdivision, or specified in subdivision (d) of Section 11055, by the use of a minor as agent, who solicits, induces, encourages, or intimidates any minor with the intent that the minor shall violate any provision of this article involving such controlled substances or who unlawfully furnishes, offers to furnish, or attempts to furnish such controlled substances to a minor shall be punished by imprisonment in the state prison for a period of three, four or five years.

(b) Nothing contained in this section shall apply to a registered pharmacist furnishing controlled substances pursuant to a prescription.

11381. As used in this article "felony offense" and offense "punishable as a felony" refer to an offense for which the law prescribes imprisonment in the state prison as either an alternative or the sole penalty, regardless of the sentence the particular defendant received.

11382. Every person who agrees, consents, or in any manner offers to unlawfully sell, furnish, transport, administer, or give any controlled substance which is (1) classified in Schedule III, IV, or V and which is not a narcotic drug, or (2) which is specified in subdivision (d) of Section 11054, except paragraphs (10), (11), (12), and (17) of such subdivision, or specified in subdivision (d) of Section 11055, to any person, or offers, arranges, or negotiates to have any such controlled substance unlawfully sold, delivered, transported, furnished, administered, or given to any person and then sells, delivers, furnishes, transports, administers, or gives or offers, or arranges, or negotiates to have sold, delivered, transported, furnished, administered, or given to any person any other liquid, substance, or material in lieu of any such controlled substance shall be punished by imprisonment in the county jail for not more than one year or in the state prison.

11382.5. All controlled substances in Schedules I, II, III, IV, and V, in solid or capsule form, except for such controlled substances in the possession or inventory of a wholesaler, retailer, or pharmacist on January 1, 1975, shall not be sold, furnished, or distributed in this state unless they have on the controlled substance if in solid form, or on the capsule if in capsule form, an identifying device, insignia, or mark of the manufacturer of such controlled substance. However, the exception for such controlled substances in the possession or inventory of a wholesaler, retailer, or pharmacist shall not be available to any wholesaler, retailer, or pharmacist under the control or jurisdiction of a manufacturer of controlled substances.

This section shall not apply to a pharmacist who, in accordance with applicable state law, compounds such controlled substance in the course of his practice as a pharmacist for direct dispensing by him upon a prescription of any person licensed to prescribe such controlled substances.

Article 6. Precursors of Methamphetamine and Phencyclidine

11383. (a) Any person who possesses both methylamine and phenyl-2-propanone (phenylacetone) at the same time with the intent to manufacture methamphetamine is guilty of a felony and shall be punished by imprisonment in the state prison for not less than one year nor more than five years.

(b) Any person who possesses both piperidine and cyclohexanone at the same time, or a combination product thereof, with intent to manufacture phencyclidine (PCP) is guilty of a felony and shall be punished by imprisonment in the state prison for not less than one ye

nor more than five years.

(c) For purposes of this section, possession of immediate precursors sufficient for the manufacture of methylamine, phenyl-2-propanone, piperidine, or cyclohexanone shall be deemed to be possession of such a derivative substance. Additionally, possession of any compound or mixture containing piperidine or cyclohexanone shall be deemed to be possession of such substance.

(d) The provisions of subdivisions (a), (b), and (c) shall not apply to drug manufacturers licensed by this state or persons authorized by regulation of the Board of Pharmacy to possess such combination of substances.

11384. The Board of Pharmacy shall, by regulation, authorize such persons to possess any combinations of substance specified in subdivision (a) or (b) of Section 11383 as it determines need and will use such substance for a lawful purpose.

Chapter 7. Bureau of Narcotic Enforcement

11450. The Attorney General may, in conformity with the State Civil Service Act, Part 2 (commencing with Section 18500), Division 5, Title 2 of the Government Code, employ such agents, chemists, clerical, and other employees as are necessary for the conduct of the affairs of the Department of Justice in carrying out its responsibilities specified in this division.

11453. The Department of Justice may employ a physician to interview and examine any patient for whom any controlled substance classified in Schedule I, II, or III has been prescribed or to whom any such controlled substance has been furnished or administered, or who is an habitual user of such a controlled substance, or who has a previous addiction record to a substance listed as a controlled substance classified in Schedules I, II, or III.

The patient shall submit to the interview and examination and shall not in any manner hinder or impede it.

The physician employed by the Department of Justice to conduct the interview and examination shall report the results of the examination and inverview to the department.

The physician so employed may testify in any action brought under this division or in any hearing before the State Board of Medical Examiners or the State Board of Osteopathic Examiners and his testimony is not privileged.

Every person who violates any provision of this section is guilty of a misdemeanor.

11454. The Attorney General and the agents appointed by him, when authorized so to do by the Attorney General, may expend such sums as the Attorney General deems necessary in the purchase of controlled [illegible] and in the employment of operators to obtain

The sums so expended shall be repaid to the officer making the expenditures upon claims approved by the Attorney General and subject to postaudit by the Department of Finance. The claims when approved shall be paid out of the funds appropriated or made available by law for the support or use of the Department of Justice.

Chapter 8. Seizure and Disposition

11470. The following are subject to forfeiture:

(a) All controlled substances which have been manufactured, distributed, dispensed, or acquired in violation of this division.

(b) All raw materials, products and equipment of any kind which are used, or intended for use, in manufacturing, compounding, processing, delivering, importing, or exporting any controlled substance in violation of this division.

(c) All property which is used, or intended for use, as a container for property described in subdivision (a) or (b).

(d) All books, records, and research products and materials, including formulas, microfilm, tapes, and data which are used, or intended for use, in violation of this division.

(e) The interest of any registered owner of a boat, airplane, or any vehicle other than an implement of husbandry, as defined in Section 36000 of the Vehicle Code, or a vehicle which may be lawfully driven upon the highway with a class 3 or class 4 license, as prescribed in Section 12804 of the Vehicle Code, used, in direct relation to the particular offense for which the owner or defendant is arrested and convicted, to unlawfully transport for sale any controlled substance.

11471. Property subject to forfeiture under this division may be seized by the Attorney General upon process issued by any court having jurisdiction over the property. Seizure without process may be made if any of the following situations exist:

(a) The seizure is incident to an arrest or a search under a search warrant.

(b) The property subject to seizure has been the subject of a prior judgment in favor of the state in a criminal injunction or forfeiture proceeding based upon this division.

(c) The Attorney General has probable cause to believe that the property is directly or indirectly dangerous to health or safety.

(d) The Attorney General has probable cause to believe that the property was used or is intended to be used in violation of this division.

11472. In the event of seizure pursuant to Section 11471, proceedings under Section 11473 shall be instituted promptly.

11473. Controlled substances and any device, contrivance, instrument or paraphernalia used for unlawfully using or administering a controlled substance, which are possessed in violation of this division, may be seized by any peace officer and in the aid of such seizure a search warrant may be [illegible] prescribed by law.

11474. All seizures under provisions of this chapter, except seizures of vehicles, boats, or airplanes, shall, upon conviction of the owner or defendant, be ordered destroyed by the judge of the court in which conviction was had and the judge shall turn all such evidence over to the Attorney General for destruction or disposition.

11474.5. All seizures of controlled substances, instruments, or paraphernalia used for unlawfully using or administering a controlled substance which are in possession of any city, county, or state official as the result of a case in which no trial was had or in a case which has been disposed of by way of dismissal or otherwise than by way of conviction, shall be turned over to the Attorney General for destruction or disposition under order of the court.

11475. Controlled substances listed in Schedule I that are possessed, transferred, sold, or offered for sale in violation of this division are contraband and shall be seized and summarily forfeited to the state. Controlled substances listed in Schedule I, which are seized or come into the possession of the state, the owners of which are unknown, are contraband and shall be summarily forfeited to the state.

11476. Species of plant from which controlled substances in Schedules I and II may be derived which have been planted or cultivated in violation of this division, or of which the owners or cultivators are unknown, or which are wild growths, may be seized and summarily forfeited to the state.

11477. The failure, upon demand by the Attorney General, or his authorized agent, of the person in occupancy or in control of land or premises upon which the species of plants are growing or being stored, to produce an appropriate registration, or proof that he is the holder thereof, constitutes authority for the seizure and forfeiture of the plants.

11478. The Attorney General may dispose of controlled substances, other than heroin or smoking opium, by gift to the medical superintendent of state prisons or state hospitals, for medical purposes. Marijuana shall be provided by the Attorney General to the heads of research projects which have been registered by the Attorney General, and which have been approved by the Research Advisory Panel pursuant to Section 11480.

The head of the approved research project shall personally receipt for such quantities of marijuana and shall make a record of their disposition. The receipt and record shall be retained by the Attorney General. The head of the approved research project shall also, at intervals and in the manner required by the Research Advisory Panel, report the progress or conclusions of the research project.

11479. Notwithstanding the provision of Sections 11474 and 11475, at any time after receipt by a publicly operated criminalistic laboratory of a suspected controlled substance for analysis, the person in charge of the laboratory may without a court order destroy that amount of the suspected controlled substance which exceeds 10 pounds in gross weight. Destruction shall not take place pursuant to this section until all of the following requirements are satisfied:

(a) A random sampling of the suspected controlled substance has been taken.

(b) The analysis of the random sampling has been completed.

(c) Photographs have been taken of the suspected controlled substance to be destroyed.

(d) The chief has approved a written request of the publicly operated criminalistic laboratory for the destruction of the suspected controlled substance. Such request shall specify the total weight of the suspected controlled substance, the total weight of such substance to be destroyed, and the total weight of such substance not to be destroyed.

(e) Not less than 30 days prior to the destruction of the suspected controlled substance, written notice shall be given to the defendant's attorney of record or, if the defendant has no attorney of record, to the defendant, stating the information contained in the request submitted to the chief pursuant to subdivision (d) and the date proposed for destruction of the suspected controlled substance, stating that destruction of such suspected controlled substance has been approved by the chief, and stating that any request to have samples taken from the whole mass of the suspected controlled substance must be done prior to the date proposed for such destruction.

11480. The Legislature finds that there is a need to encourage further research into the nature and effects of marijuana and hallucinogenic drugs and to coordinate research efforts on such subjects.

There is a Research Advisory Panel which consists of a representative of the State Department of Health, a representative of the California State Board of Pharmacy, a representative of the Attorney General, a representative of the University of California who shall be a pharmacologist or physician or a person holding a doctorate degree in the health sciences, a representative of a private university in this state who shall be a pharmacologist or physician or a person holding a doctorate degree in the health sciences, a representative of a statewide professional medical society in this state who shall be engaged in the private practice of medicine and shall be experienced in treating controlled substance dependency, and a representative appointed by and serving at the pleasure of the Governor, who shall hold a doctorate degree in the health sciences and shall have experience in drug abuse or controlled substance research. The Governor shall annually designate the private university and the professional medical society represented on the panel. Members of the panel shall be appointed by the heads of the entities to be represented, and they shall serve at the pleasure of the appointing power.

The panel shall annually select a chairman from among its members.

The panel may hold hearings on, and in other ways study, research projects concerning marijuana or hallucinogenic drugs in this state. Members of the panel shall serve without compensation, but shall be reimbursed for any actual and necessary expenses incurred in connection with the performance of their duties.

The panel may approve research projects, which have been registered by the Attorney General, into the nature and effects of marijuana or hallucinogenic drugs, and shall inform the Attorney General of the head of such approved research projects which are entitled to receive quantities of marijuana pursuant to Section 11478.

The panel may withdraw approval of a research project at any time, and when approval is withdrawn shall notify the head of the research project to return any quantitites of marijuana to the Attorney General.

The panel shall report annually to the Legislature and the Governor whose research projects approved by the panel, the nature of each research project, and, where available, the conclusions of the research project.

11481. The Research Advisory Panel may hold hearings on, and in other ways study, research projects concerning the treatment of abuse of controlled substances.

The panel may approve research projects, which have been registered by the Attorney General concerning the treatment of abuse of controlled substances and shall inform the chief of such approval. The panel may withdraw approval of a research project at any time and when approval is withdrawn shall so notify the chief.

The panel shall, annually and in the manner determined by the panel, report to the Legislature and the Governor those research projects approved by the panel, the nature of each research project, and where available, the conclusions of the research project.

11483. No provision of this division shall be construed to prohibit the establishment and effective operation of a methadone maintenance treatment program approved pursuant to Section 4351 of the Welfare and Institutions Code.

11485. When controlled substances have been seized pursuant to this division and the defendant or owner has escaped from custody and is a fugitive from justice, they shall upon demand of the Attorney General be turned over to it for safekeeping until such time as the owner or defendant is apprehended and prosecuted for violation of this division.

11486. When controlled substances have been seized pursuant to this division and the case has been disposed of by way of dismissal or otherwise than by way of conviction, they shall by order of the court, be turned over to the Attorney General unless the court finds that the controlled substances were lawfully possessed by the defendant.

11487. Each city, county, or state agency coming into possession of a controlled substance pursuant to the provisions of this chapter shall report semiannually to the Attorney General the amounts, kind, and disposition of controlled substances so seized.

The reports provided for by this section shall be in a form and contain such information as determined necessary by the Attorney General.

The Attorney General shall issue an annual report to the Governor and [illegible] correlating and summarizing the reports provided for by this section.

This section shall remain in effect only until January 1, 1980, and as of such date is repealed, unless a later enacted statute, which is chaptered before January 1, 1980, deletes or extends such date.

11490. Any peace officer of this state, upon making or attempting to make an arrest for a violation of Section 11351, 11352, 11355, 11359, 11360, 11378, or 11379, insofar as the offense involves sale, transportation for sale, or possession for sale, may seize any vehicle, boat, or airplane used to unlawfully transport for sale any controlled substance. If he does not hold the vehicle, boat, or airplane for evidence, he shall immediately deliver such vehicle, boat, or airplane to the State Department of Justice to be held as evidence until a forfeiture has been declared or a release ordered; otherwise he shall return the vehicle, boat, or airplane to the registered owner.

11491. (a) Within 15 days after such seizure, if the Department of Justice determines that the factual circumstances do not warrant that the vehicle, boat, or airplane come within subdivision (e) of Section 11470, or if for any other reason it decides not to seek forfeiture, it shall return the vehicle, boat, or airplane to the arresting officer who shall return it to the registered owner. If the Department of Justice does not return the vehicle, boat, or airplane to the arresting officer, it shall cause an investigation to be made as to any claimant to the vehicle, boat, or airplane whose right, title, interest, or lien is of record in the Department of Motor Vehicles or appropriate federal agency. Except as provided in subdivision (b), if the department finds that any person, other than the registered owner, is the legal owner thereof, and such ownership interest did not arise subsequent to the date and time of arrest or seizure of the vehicle, boat, or airplane, it shall forthwith send a notice of the seizure to such legal owner at his address appearing on the records of the Department of Motor Vehicles or appropriate federal agency. Notice of seizure and intended forfeiture proceedings shall be filed with the county clerk and shall be served on all owners whose interest will be affected thereby.

(b) A bona fide purchaser without notice of the arrest or seizure whose interest was acquired subsequent to the arrest or seizure shall be entitled to participate in the forfeiture proceedings to establish his claim.

(c) An assignee, purchaser, or holder in due course who had notice of the arrest or seizure at the time he acquired his interest and who sells, assigns, or conveys such interest is guilty of a fraudulent conveyance as provided for in Section 531 of the Penal Code, and civilly liable under Section 3439.07 of the Civil Code.

11491.1. Actual notice shall be given to each owner whose right, title or interest is of record in the Department of Motor Vehicles or appropriate federal agency, by mailing a copy of the notice by registered mail to the address as given upon the records of the Department of Motor Vehicles or appropriate federal agency; and to each owner whose name and address is known, to the last known address of the owner.

All other owners, whose addresses are unknown, but who are believed

to have an interest in the vehicle, boat, or airplane, by one publication in a newspaper of general circulation in the county where the seizure was made.

All notices shall set forth the time within which an answer is required to be filed pursuant to Section 11491.2.

11491.2. Within 10 days after receipt of actual notice or within 30 days of the publication of the notice, any owner of any right, title, or interest in, or lien upon, a seized vehicle, boat, or airplane may file a verified answer to the fact of the use of the vehicle, boat, or airplane alleged in the notice of seizure and of the intended forfeiture proceeding; and any person holding a valid lien, mortgage, security interest, or interest under a conditional sales contract may file a verified answer to the facts set forth in the notice and setting forth, if such be the fact, that he acquired his interest prior to the date of seizure without actual knowledge that the vehicle, boat, or airplane was to be used in the manner set forth in subdivision (e) of Section 11470.

11491.3. No extensions of time shall be granted for the purpose of filing the answer.

11491.4. If, at the end of the times set forth in Section 11491.2, there is no verified answer on file, the court, upon motion, shall declare the vehicle, boat, or airplane forfeited to the state upon conviction as provided in Section 11492. Notwithstanding any other provision of law, a certified copy of said declaration of forfeiture, duly filed with the Department of Motor Vehicles or appropriate federal agency, shall constitute authority for the state to convey clear title to the vehicle, boat, or airplane to any purchaser thereof in the manner provided in Sections 11493.1 and 11494.

11491.5. If a verified answer is filed, the forfeiture proceeding shall be set for hearing on a day not less than 30 days therefrom, and the proceeding shall have priority over other civil cases.

11491.6. Notice of the hearing shall be given in the same manner as provided in Section 11491.1.

11491.7. At the hearing, the state shall have the burden of establishing beyond a reasonable doubt that the owner of the vehicle, boat, or airplane, or the owner of an interest in such vehicle, boat, or airplane, consented to the use of such vehicle, boat, or airplane with the knowledge that it would be used for a violation of this chapter.

11492. No legal or registered title or interest in the vehicle, boat, or airplane shall be affected by the forfeiture decree under this article unless the state has proved that the owner of such interest consented to the use of such vehicle, boat, or airplane with knowledge that it was used for the purpose charged. No forfeiture shall be ordered unless and until a conviction is had for an offense set forth in Section 11490.

11493. The forfeiture hearing may be continued until after a verdict of guilt on the related charges has been decided. The forfeiture hearing shall be conducted in accordance with Sections 600 to 630, inclusive, of the Code of Civil Procedure if a trial by jury, and by Sections 631 to 636, inclusive, of the Code of Civil Procedure if by court. Unless the court or jury finds that the vehicle, boat, or airplane was used in violation of this chapter, the court shall order the vehicle, boat, or airplane released to the person entitled thereto.

If the court or jury finds that the vehicle, boat, or airplane was used in violation of this chapter, but does not find that a person holding a valid lien, mortgage, security interest, or interest under a conditional sales contract acquired his interest with actual knowledge that the vehicle, boat, or airplane was to be used for a purpose for which forfeiture is permitted, and if the amount due him is equal to, or in excess of, the appraised value of the vehicle, boat, or airplane, the court shall order the vehicle, boat, or airplane released to him. If the amount due him is less than the appraised value of the vehicle, boat, or airplane, he may pay to the Department of General Services the amount of the registered owner's equity, which shall be deemed to be the difference between the appraised value and the amount of the lien, mortgage, security interest, or interest under a conditional sales contract. Upon such payment, the state shall relinquish all claims to the vehicle, boat, or airplane. If the holder of the interest elects not to make such payment to the Department of General Services, the vehicle, boat, or airplane shall be deemed forfeited to the Department of General Services and the ownership certificate shall be forwarded. Appraised value is to be determined as of the date judgment is entered on a wholesale basis either by agreement between the legal owner and the Department of General Services, or if such persons cannot agree, then by the inheritance tax appraiser for the county in which the action is brought.

11493.1. If the amount due to a person holding a valid lien, mortgage, security interest, or interest under a conditional sales contract is less than the value of the vehicle, boat, or airplane, and the person elects not to make payment to the Department of General Services, the vehicle, boat, or airplane shall be sold at public auction by the Department of General Services.

11494. The Department of General Services shall publish a notice of the sale by one publication in a newspaper published and circulated in the city, community, or locality where the sale is to take place.

11495. In all cases where a vehicle, boat, or airplane seized by the Department of Justice is forfeited to the state and turned over to and sold by the Department of General Services, the proceeds of the sale shall be distributed as follows, in the order indicated:

(a) To the bona fide or innocent purchaser, conditional sales vendor, or mortgagee of the vehicle, boat, or airplane, if any, up to the amount of his interest in the vehicle, boat, or airplane, when the court declaring the forfeiture orders a distribution to such person.

(b) The balance, if any, to accumulate, and from time to time, as the proceeds become sufficient, to be distributed:

1. To the Department of General Services for all expenditures made or

incurred by it in connection with the sale, including expenditure for any necessary repairs, storage, or transportation, of any vehicle, boat, or airplane seized under this article.

2. To the Attorney General for all expenditures made or incurred by him in connection with the forfeiture proceedings of any vehicle, boat, or airplane seized under this article, including, but not limited to, expenditures for witness fees, reporters' fees, transcripts, printing, traveling, and investigation.

3. To the state for all expenditures for traveling, investigation, storage, and other expenses made or incurred by the Department of Justice after the seizure, and in connection with the forfeiture of any vehicle, boat, or airplane seized under this article.

4. The remainder, if any, to the State Treasury, for credit to the General Fund.

11498. The provisions of this division relative to forfeiture of vehicles, boats, or airplanes shall not apply to a common carrier, or to an employee acting within the scope of his employment in the enforcement of this division.

Chapter 9. Collection and Disposition of Fines

11500. The district attorney, or any person designated by him, of the county in which any violation of this division is committed shall conduct all actions and prosecutions for the violation.

However, the Attorney General, or special counsel employed by the Attorney General for that purpose, may take complete charge of the conduct of such actions or prosecutions. The Attorney General may fix the compensation to be paid for the service and may incur such other expense in connection with the conduct of the actions or prosecutions as he may deem necessary. No attorney employed as special counsel shall receive as compensation more than three thousand five hundred dollars ($3,500) in any one year.

11501. The State of California, or any political subdivision thereof, may maintain an action against any person or persons engaged in the unlawful sale of controlled substances for the recovery of any public funds paid over to such person or persons in the course of any investigation of violations of this division. All proceedings under this section shall be instituted in the superior court of the county where the funds were paid over, where the sale was made, or where the defendant resides. Notwithstanding Section 483.010 of the Code of Civil Procedure, in any action under this section, a writ of attachment may be issued, without the showing required by Section 485.010 of the Code of Civil Procedure, in the manner provided by Chapter 5 (commencing with Section 485.010) of Title 6.5 of Part 2 of the Code of Civil Procedure to attach any funds paid over or any other funds on the defendant's person at the time of his arrest.

11502. All moneys, forefeited bail, or fines received by any court under this division shall as soon as practicable after the receipt thereof be deposited with the county treasurer of the county in which such court is situated. Amounts so deposited shall be paid at least once a month as follows: 75 percent to the State Treasurer by warrant of the county auditor drawn upon the requisition of the clerk or judge of said court to be deposited in the State Treasury on order of the State Controller; and 25 percent to the city treasurer of the city, if the offense occurred in a city, otherwise to the treasurer of the county in which the prosecution is conducted.

Any money deposited in the State Treasury under the provisions of this section which is determined by the State Controller to have been erroneously deposited therein shall be refunded by him, subject to approval of the State Board of Control prior to the payment of such refund, out of any money in the State Treasury which is available by law for such purpose.

11503. Judges and magistrates who collect fines or forfeitures under this division shall keep a record thereof, and, upon the imposition of any such fine or forfeiture, shall at least monthly transmit a record of it to the county auditor. The county auditor shall transmit a record of the imposition, collection and payment of such fines or forfeitures to the State Controller at the time of transmittal of each warrant to the State Treasurer pursuant to this article.

11504. When an imprisonment has been imposed for a violation of this division, and before the termination of the sentence, the defendant is released by the vacation of the sentence of imprisonment and the imposition of a fine or forfeiture instead, the fine or forfeiture shall be recorded and accounted for in the same manner as though it had been imposed in the first instance.

11505. Whenever a fine has been imposed for violation of this division, and before the full payment of the fine a sentence of imprisonment is imposed instead, the imprisonment shall be recorded and accounted for to the county auditor.

11506. The State Controller shall check the reports and records received by him with the transmittals of fines and forfeitures and whenever it appears that fines or forfeitures have not been transmitted the county auditor shall and the State Controller may bring suit to enforce their collection or transmittal, or both.

11507. The official bond of any judge or magistrate is liable for his failure to transmit the fines or forfeitures imposed by him under this division.

11508. The records kept by a judge or magistrate under this division are open to public inspection, and may be checked by the State Controller, the Attorney General, the district attorney of the particular county, or the state bureau.

Chapter 10. Control of Users of Controlled Substances

Article 1. Addicts

11550. No person shall use, or be under the influence of any controlled substance which is (1) specified in subdivision (b) or (c) of Section 11054, specified in paragraph (11), (12), or (17) of subdivision (d) of Section 11054, or specified in subdivision (b) or (c) of Section 11055, or (2) which is a narcotic drug classified in Schedule III, IV, or V, excepting when administered by or under the direction of a person licensed by the state to dispense, prescribe, or administer controlled substances. It shall be the burden of the defense to show that it comes within the exception. Any person convicted of violating any provision of this section is guilty of a misdemeanor and shall be sentenced to serve a term of not less than 90 days nor more than one year in the county jail. The court may place a person convicted hereunder on probation for a period not to exceed five years and shall in all cases in which probation is granted require as a condition thereof that such person be confined in the county jail for at least 90 days. In no event does the court have the power to absolve a person who violates this section from the obligation of spending at last 90 days in confinement in the county jail.

11551. (a) Whenever any court in this state grants probation to a person who the court has reason to believe is or has been a user of controlled substances, the court may require as a condition to probation that the probationer submit to periodic tests by a city or county health officer, or by a physician and surgeon appointed by the city or county health officer with the approval of the Attorney General, to determine, by whatever means is available, whether the probationer is addicted to a controlled substance.

In any case provided for in this subdivision, the city or county health officer, or the physician and surgeon appointed by the city or county health officer with the approval of the Attorney General shall report the results of the tests to the probation officer.

(b) In any case in which a person is granted parole by a county parole board and the person is or has been a user of controlled substances, a condition of the parole may be that the parolee undergo periodic tests as provided in subdivision (a) and that the county or city health officer, or the physician and surgeon appointed by the city or county health officer with the approval of the Attorney General, shall report the results to the board.

(c) In any case in which any state agency grants a parole to a person who is or has been a user of controlled substances, it may be a condition of the parole that the parolee undergo periodic tests as provided in subdivision (a) and that the county or city health officer, or the physician and surgeon appointed by the city or county health officer with the approval of the Attorney General, shall report the results of the tests to such state agency.

(d) The cost of administering tests pursuant to subdivisions (a) and (b) shall be a charge against the county. The cost of administering tests pursuant to subdivision (c) shall be paid by the state.

(e) The state department, in conjunction with the Attorney General, shall issue regulations governing the administering of the tests provided for in this section and providing the form of the report required by this section.

11552. In any case in which a person has been arrested for a criminal offense and is suspected of being addicted to a controlled substance, a law enforcement officer having custody of such person may, with the written consent of such person, request the city or county health officer, or physician appointed by such health officer pursuant to Section 11551, to administer to the arrested person a test to determine, by whatever means is available whether the arrested person is addicted to a controlled substance, and such health officer or physician may administer such test to such arrested person.

11553. The fact that a person is or has been, or is suspected of being, a user of marijuana is not alone sufficient grounds upon which to invoke Section 11551 or 11552.

This section shall not be construed to limit the discretion of a judge to invoke Section 11551 or 11552 if the court has reason to believe a person is or has been a user of narcotics or drugs other than marijuana.

11554. The rehabilitation of persons addicted to controlled substances and the prevention of continued addiction to controlled substances is a matter of statewide concern. It is the policy of the state to encourage each county and city and county to make use, whenever applicable, of testing procedures to determine addiction to controlled substances or the absence thereof, and to foster research in means of detecting the existence of addiction to controlled substances and in medical methods and procedures for that purpose.

11555. The Attorney General is directed to promote and sponsor the use by agencies of local government of the provisions of this article. The Attorney General may assist such agencies to establish facilities for, and to train personnel to conduct testing procedures pursuant to Section 11551, and may conduct demonstrations thereof for limited periods. For these purposes the Attorney General may procure such medical supplies, equipment, and temporary services of physicians and qualified consultants as may reasonably be necessary. Subject to the availability of funds appropriated for the purpose, the Attorney General may contract with any county or city and county which undertakes to establish facilities and a testing program pursuant to Section 11551, and such contract may provide for payment by the state of such costs of initially establishing and demonstrating such program as the Attorney General may approve.

Article 2. Controlled Substances Treatment Control Units

11560. The Department of Corrections and the Department of the Youth Authority are authorized to establish controlled substances

treatment control units in state correctional facilities or training schools or as separate establishments for such study, research, and treatment as may be necessary for control of the addiction or imminent addiction to controlled substances of persons committed to the custody of the Director of Corrections or the Director of the Youth Authority.

11561. When the Adult Authority concludes that there are reasonable grounds for believing that a man on parole is addicted to, or is in imminent danger of addiction to, controlled substances it may issue an order to detain or place such person in a controlled substance treatment control unit for a period not to exceed 90 days. Such order shall be a sufficient warrant for any peace officer or employee of the Department of Corrections to return to physical custody any such person. Detention pursuant to such order shall not be deemed a suspension, cancellation or revocation of parole until such time as the Adult Authority so orders pursuant to Section 3060 of the Penal Code. A parolee taken into physical custody pursuant to Section 3060 of the Penal Code may be detained in a controlled substance treatment control unit established pursuant to this article.

11562. When the Youth Authority concludes that there are reasonable grounds for believing that a person committed to its custody, and on parole, is addicted to, or is in imminent danger of addiction to, controlled substances, it may issue an order to detain or place such person in a controlled substance treatment control unit for not to exceed 90 days. Such order shall be a sufficient warrant for any peace officer or employee of the Department of the Youth Authority to return to physical custody any such person. Detention pursuant to such order shall not be deemed a suspension, cancellation, or revocation of parole unless the Youth Authority so orders pursuant to Section 1767.3 of the Welfare and Institutions Code.

With the consent of the Director of Corrections, the Director of the Youth Authority may, pursuant to this section, confine the addicted or potentially addicted person, over 18 years of age, in a controlled substance treatment control unit established by the Department of Corrections.

11563. When the California Women's Board of Terms and Parole concludes that there are reasonable grounds for believing that a woman on parole is addicted to, or is in imminent danger of addiction to, controlled substances, it may issue an order to detain or place such person in a controlled substance treatment control unit for a period not to exceed 90 days. Such order shall be a sufficient warrant for any peace officer or employee of the Department of Corrections to return to physical custody any such person. Detention pursuant to such order shall not be deemed a suspension, cancellation or revocation of parole until such time as the board so orders pursuant to Section 3060 of the Penal Code. A parolee taken into physical custody pursuant to Section 3060, 6043, or 6044 of the Penal Code may be detained in a controlled substance treatment control unit established pursuant to this article.

11564. The authority granted to the Adult Authority and the Youth Authority in no way limits Sections 3060 and 3325 of the Penal Code.

Article 3. Abatement

11570. Every building or place used for the purpose of unlawfully selling, serving, storing, keeping, or giving away controlled substances as defined in this division, and every building or place wherein or upon which such acts take place, is a nuisance which shall be enjoined, abated, and prevented, whether it is a public or private nuisance.

11571. Whenever there is reason to believe that such a nuisance is kept, maintained or exists in any county, the district attorney of the county, in the name of the people, shall, or any citizen of the state resident in the county, in his own name, may, maintain an action to abate and prevent the nuisance and perpetually to enjoin the person conducting or maintaining it, and the owner, lessee, or agent of the building or place, in or upon which the nuisance exists, from directly or indirectly maintaining or permitting the nuisance.

11572. Unless filed by the district attorney, the complaint in the action shall be verified.

11573. If the existence of the nuisance is shown in the action to the satisfaction of the court or judge, either by verified complaint or affidavit, the court or judge shall allow a temporary writ of injunction to abate and prevent the continuance or recurrence of the nuisance.

11574. Except when it is granted on application of the people of the state, on granting the temporary writ the court or judge shall require a written undertaking on the part of the applicant, with sufficient sureties, to the effect that he will pay to the defendant enjoined such damages, not exceeding an amount to be specified, as the defendant sustains by reason of the injunction if the court finally decides that the applicant was not entitled to it.

11575. The action shall have precedence over all other actions, except criminal proceedings, election contests, hearings on injunctions, and actions to forfeit vehicles under this division.

11576. If the complaint is filed by a citizen it shall not be dismissed by him or for want of prosecution except upon a sworn statement made by him and his attorney, setting forth the reasons why the action should be dismissed, and by dismissal ordered by the court.

11577. In case of failure to prosecute the action with reasonable diligence, or at the request of the plaintiff, the court, in its discretion, may substitute any other citizen consenting thereto for the plaintiff.

11578. If the action is brought by a citizen and the court finds there was no reasonable ground or cause for the action, the costs shall be taxed against him.

11579. If the existence of the nuisance is established in the action, an

order of abatement shall be entered as part of the judgment in the case, and plaintiff's costs in the action are a lien upon the building or place. The lien is enforceable and collectible by execution issued by order of the court.

11580. A violation or disobedience of the injunction or order for abatement is punishable as a contempt of court by a fine of not less than two hundred dollars ($200) nor more than one thousand dollars ($1,000), or by imprisonment in the county jail for not less than one nor more than six months, or by both.

11581. If the existence of the nuisance is established in the action, an order of abatement shall be entered as a part of the judgment, which order shall direct the removal from the building or place of all fixtures, musical instruments, and other movable property used in conducting, maintaining, aiding, or abetting the nuisance and shall direct their sale in the manner provided for the sale of chattels under execution.

The order shall provide for the effectual closing of the building or place against its use for any purpose, and for keeping it closed for a period of one year, unless sooner released, as provided in this division.

11582. While the order of abatement remains in effect, the building or place is in the custody of the court.

11583. For removing and selling the movable property, the officer is entitled to charge and receive the same fees as he would for levying upon and selling like property on execution; and for closing the premises and keeping them closed, a reasonable sum shall be allowed by the court.

11584. The proceeds of the sale of the movable property shall be applied as follows:

First—To the fees and costs of the removal and sale.

Second—To the allowances and costs of closing and keeping closed the building or place.

Third—To the payment of the plaintiff's costs in the action.

Fourth—The balance, if any, to the owner of the property.

11585. If the proceeds of the sale of the movable property do not fully discharge all of the costs, fees, and allowances, the building and place shall then also be sold under execution issued upon the order of the court or judge and the proceeds of the sale shall be applied in like manner.

11586. If the owner of the building or place has not been guilty of any contempt of court in the proceedings, and appears and pays all costs, fees, and allowances that are a lien on the building or place and files a bond in the full value of the property, to be ascertained by the court, with sureties, to be approved by the court or judge, conditioned that he will immediately abate any such nuisance that may exist at the building or place and prevent it from being established or kept thereat within a period of one year thereafter, the court, or judge may, if satisfied of his good faith, order the building or place to be delivered to the owner, and the order of abatement canceled so far as it may relate to the property.

The release of property under the provisions of this division does not release it from any judgment, lien, penalty, or liability to which it may be subject.

11587. Whenever the owner of a building or place upon which the act or acts constituting the contempt have been committed, or the owner of any interest therein, has been guilty of a contempt of court, and fined in any proceedings under this division, the fine is a lien upon the building or place to the extent of his interest in it.

The lien is enforceable and collectible by execution issued by order of the court.

Article 4. Registration of Controlled Substance Offenders

11590. (a) Any person who, on or after the effective date of this section, is convicted in the State of California of any offense defined in Section 11350, 11351, 11352, 11353, 11354, 11355, 11357, 11358, 11359, 11360, 11361, 11363, 11366, 11368, or 11550, or any person who is, on or after such date, discharged or paroled from a penal institution where he was confined because of the commission of any such offense, or any person who is, on or after such date, convicted in any other state of any offense which, if committed or attempted in this state, would have been punishable as one or more of the above-mentioned offenses, shall within 30 days after the effective date of this section or within 30 days of his coming into any county or city, or city and county in which he resides or is temporarily domiciled for such length of time, register with the chief of police of the city in which he resides or the sheriff of the county if he resides in an unincorporated area.

(b) Any person who, on or after the effective date of this section is convicted in any federal court of any offense which, if committed or attempted in this state would have been punishable as one or more of the offenses enumerated in subdivision (a) shall within 30 days after the effective date of this section or within 30 days of his coming into any county or city, or city and county in which he resides or is temporarily domiciled for such length of time, register with the chief police of the city in which he resides or the sheriff of the county if he resides in an unincorporated area.

(c) This section does not apply to a conviction of a misdemeanor conviction under Section 11357 or 11360.

11591. Every sheriff or chief of police, upon the arrest for any of the controlled substance offenses enumerated in Section 11590, or Section 11364, insofar as that section relates to paragraph (9) of subdivision (d) of Section 11654, of any school employee, shall do either of the following:

(1) If such school employee is a teacher in any of the public schools of this state, he shall immediately notify by telephone the superintendent of schools of the school district employing such teacher and shall immediately give written notice of the arrest to the Commission for Teacher Preparation and Licensing and to the superintendent of schools in the county wherein such person is employed. Upon receipt of such

notice, the county superintendent of schools shall immediately notify the governing board of the school district employing such person.

(2) If such school employee is a nonteacher in any of the public schools of this state, he shall immediately notify by telephone the superintendent of schools of the school district employing such nonteacher and shall immediately give written notice of the arrest to the governing board of the school district employing such person.

(3) If such school employee is a teacher in any private school of this state, he shall immediately notify by telephone the private school authority employing such teacher and shall immediately give written notice of the arrest to the private school authority employing such teacher

11592. Any person who, on or after the effective date of this section is discharged or paroled from a jail, prison, school, road camp, or other institution where he was confined because of the commission or attempt to commit one of the offenses described in Section 11590 shall, prior to such discharge, parole, or release, be informed of his duty to register under that section by the official in charge of the place of confinement and the official shall require the person to read and sign such form as may be required by the Department of Justice, stating that the duty of the person to register under this section has been explained to him. The official in charge of the place of confinement shall obtain the address where the person expects to reside upon his discharge, parole, or release and shall report such address to the Department of Justice. The official in charge of the place of confinement shall give one copy of the form to the person, and shall send two copies to the Department of Justice, which, in turn, shall forward one copy to the appropriate law enforcement agency having local jurisdiction where the person expects to reside upon his discharge, parole, or release.

11593. Any person who, on or after the effective date of this section is convicted in the State of California of the commission or attempt to commit any of the above-mentioned offenses and who is released on probation or discharged upon payment of a fine shall, prior to such release or discharge, be informed of his duty to register under Section 11590 by the court in which he has been convicted and the court shall require the person to read and sign such form as may be required by the Department of Justice, stating that the duty of the person to register under this section has been explained to him. The court shall obtain the address where the person expects to reside upon his release or discharge and shall report within three days such address to the Department of Justice. The court shall give one copy of the form to the person, and shall send two copies to the Department of Justice, which, in turn, shall forward one copy to the appropriate law enforcement agency having local jurisdiction where the person expects to reside upon his discharge, parole, or release.

11594. The registration required by Section 11590 shall consist of (a) a statement in writing signed by such person, giving such information as may be required by the Department of Justice, and (b) the fingerprints and photograph of such person. Within three days thereafter the registering law enforcement agency shall forward such statement, fingerprints and photograph to the Department of Justice.

If any person required to register hereunder changes his residence address he shall inform, in writing within 10 days, the law enforcement agency with whom he last registered of his new address. The law enforcement agency shall, within three days after receipt of such information, forward it to the Department of Justice. The Department of Justice shall forward appropriate registration data to the law enforcement agency having local jurisdiction of the new place of residence.

All registration requirements set forth in this article shall terminate five years after the discharge from prison, release from jail or termination of probation or parole of the person convicted. Nothing in this section shall be construed to conflict with the provisions of Section 1203.4 of the Penal Code concerning termination of probation and release from penalties and disabilities of probation.

Any person required to register under the provisions of this section who shall knowingly violate any of the provisions thereof is guilty of a misdemeanor.

The statements, photographs and fingerprints herein required shall not be open to inspection by the public or by any person other than a regularly employed peace or other law enforcement officer.

11595. The provisions of former Article 6 (commencing with Section 11850) of Chapter 7 of Division 10 of this code, which is repealed by the act that adds this article, including Section 11850 as amended by Chapter 796 of the Statutes of 1972, shall remain in effect as to any person who comes within such provisions.

Notwithstanding Section 9605 of the Government Code, the changes which are made in former Section 11850 by Chapter 796 of the Statutes of 1972 shall be effective and operative for the purposes of this section.

CHAPTER 11. EDUCATIONAL PROGRAMS

11600. The Attorney General, the Board of Pharmacy, and other agencies shall carry out educational programs designed to prevent and deter misuse and abuse of controlled substances. In connection with these programs, he may do all of the following:

(a) Promote better recognition of the problems of misuse and abuse of controlled substances within the regulated industry and among interested groups and organizations.

(b) Assist the regulated industry and interested groups and organizations in contributing to the reduction of misuse and abuse of controlled substances.

(c) Consult with interested groups and organizations to aid them in solving administrative and organizational problems.

(d) Assist in the education and training of state and local law enforcement officials in their efforts to control misuse and abuse of controlled substances.

abuse of controlled substances. In connection with the research, and in furtherance of the enforcement of this division, he may do all of the following:

(a) Develop new or improved approaches, techniques, systems, equipment and devices to strengthen the enforcement of this division.

(b) Enter into contracts with public agencies, institutions of higher education, and private organizations or individuals for the purpose of conducting demonstrations or special projects which bear directly on misuse and abuse of controlled substances.

11602. The Attorney General may enter into contracts for educational and research activities without performance bonds.

11603. The Attorney General, with the approval of the Research Advisory Panel, may authorize persons engaged in research on the use and effects of controlled substances to withhold the names and other identifying characteristics of individuals who are the subjects of the research. Persons who obtain this authorization are not compelled in any civil, criminal, administrative, legislative, or other proceeding to identify the individuals who are the subjects of research for which the authorization was obtained.

11604. The Attorney General, with the approval of the Research Advisory Panel, may authorize the possession and distribution of controlled substances by persons engaged in research. Persons who obtain this authorization are exempt from state prosecution for possession and distribution of controlled substances to the extent of the authorization.

Chapter 12. State Office of Narcotics and Drug Abuse

11640. The Legislature hereby finds and declares that it is essential to the health and welfare of the people of this state that action be taken by state government to effectively and economically utilize federal and state funds for narcotic and drug abuse prevention, care, treatment and rehabilitation services. To achieve this, it is necessary that:

(a) Existing fragmented, uncoordinated, and duplicative narcotic and drug abuse programs be molded into a comprehensive and integrated statewide program for the prevention of narcotic and drug abuse and for the care, treatment, and rehabilitation of narcotic addicts and drug abusers.

(b) Responsibility and authority for planning programs and activities for prevention, care, treatment, and rehabilitation of narcotic addicts be concentrated in one agency. It is hereby declared to be the intent of the Legislature to assign responsibility and grant authority for planning narcotic and drug abuse prevention, care, treatment, and rehabilitation programs to a state agency whose functions shall be subject to periodic review by the Legislature and appropriate federal agencies.

11641. There is in the Health and Welfare Agency the State Office of Narcotics and Drug Abuse. This office shall be under the control of an executive officer known as the director. The director shall be appointed by, and hold office at the pleasure of, the Governor.

11642. The director may appoint:

(a) An assistant director.

(b) Such other employees as may be necessary for the proper discharge of the duties of his office.

11643. The duties of the State Office of Narcotics and Drug Abuse are:

(a) To coordinate state and local narcotics and drug abuse preventive, care, treatment, and rehabilitation programs.

(b) Consult with state and local health planning bodies and encourage and promote effective use of facilities, resources, and funds in the development of integrated, comprehensive local programs for the prevention, care, treatment, and rehabilitation of narcotics and drug abuse.

(c) Develop and implement a comprehensive and uniform plan for the prevention, care, treatment, and rehabilitation of narcotics and drug abuse throughout the state.

(d) Consult with federal, state, and local agencies involved in the provision and delivery of services of prevention, care, treatment, and rehabilitation of narcotics and drug abuse.

(e) Provide technical assistance, guidance, and information to local governments and state agencies with respect to the creation and implementation of programs and procedures for dealing effectively with narcotics and drug abuse prevention, care, treatment, and rehabilitation.

(f) Establish goals and priorities for all state agencies providing narcotic and drug abuse services. All state governmental units operating drug programs or administering or subventing state or federal funds for drug programs shall annually set their program priorities and allocate funds in coordination with the State Office of Narcotics and Drug Abuse.

(g) Identify, in conjunction and cooperation with the Department of Finance, all funds made available to the state by the federal government, the state, public agencies, and other sources which can be used in the prevention, care, treatment, and rehabilitation of narcotics and drug abuse.

(h) In the same manner and subject to the same conditions as other state agencies, develop and submit annually to the Department of Finance a program budget for the statewide narcotics and drug abuse program, including not only expenditures proposed to be made under this division, but also expenditures proposed to be made under any related program or by any other state agency, incidental to the prevention, control, and treatment of narcotics and drug abuse. The office may require state departments to contract with it for services to carry out provisions of this division.

(i) To coordinate all narcotics and drug abuse services and related programs conducted by state agencies with the federal government, and shall ensure that there is no duplication of such programs among state agencies and that all agreements, contracts, plans, and programs proposed to be submitted by any such agency, other than the Regents of the University of California, to the federal government in relation to narcotic

and drug abuse related problems shall first be submitted to the State Office of Narcotics and Drug Abuse for review and approval.

(j) To enter into such agreements and contracts with any person, agency, corporation, or other legal entity and such other actions as are necessary to carry out the purposes of this division. The office may require state departments to contract with it for services to carry out the provisions of this division.

(k) To accept and expend grants, gifts, and legacies of money, and with the consent of the Department of Finance, to accept, manage, and expend grants, gifts, and legacies of other properties in furtherance of the purposes of this division.

11645. Notwithstanding any other provision of law, the State Department of Health may provide advance payment of federal funds, to the extent permitted by the federal contract with the State Office of Narcotics and Drug Abuse and the interagency agreement between the state office and the state department, to private nonprofit or county drug abuse treatment and prevention programs which are under subcontract with the state department or which are under Division 5 (commencing with Section 5000) of the Welfare and Institutions Code.

CHAPTER 13. MISCELLANEOUS

11650. (a) Prosecution for any violation of law occurring prior to effective date of this division is not affected or abated by this division. If the offense being prosecuted is similar to one set out in Chapter 5 (commencing with Section 11350) of this division, then the penalties under Chapter 5 (commencing with Section 11350) apply if they are less than those under prior law.

(b) Civil seizures or forfeitures and injunctive proceedings commenced prior to effective date of this division are not affected by this division.

(c) All administrative proceedings pending under prior laws which are superseded by this division shall be continued and brought to a final determination in accord with the laws and rules in effect prior to effective date of this division. Any substance controlled under prior law which is not listed within Schedules I through V, is automatically controlled without further proceedings and shall be listed in the appropriate schedule.

(d) This division applies to violations of law, seizures and forfeiture, injunctive proceedings, administrative proceedings and investigations which occur on or after the effective date of this division.

11651. Any orders and regulations promulgated pursuant to any law affected by this division and in effect on the effective date of this division, not in conflict with this division, continue in effect until modified, superseded, or repealed.

EXCERPTS FROM CALIFORNIA WELFARE AND INSTITUTIONS CODE RELATING TO DRUG ADDICTS

Division 3. Narcotic Addicts

CHAPTER 1. COMMITMENT AND TREATMENT OF NARCOTIC ADDICTS

Article 1. Administration

3000. It is the intent of the Legislature that persons addicted to narcotics, or who by reason of repeated use of narcotics are in imminent danger of becoming addicted, shall be treated for such condition and its underlying causes, and that such treatment shall be carried out for nonpunitive purposes not only for the protection of the addict, or person in imminent danger of addiction, against himself, but also for the prevention of contamination of others and the protection of the public. Persons committed to the program provided for in this chapter who are uncooperative with efforts to treat them or are otherwise unresponsive to treatment nevertheless should be kept in the program for purposes of control. It is the further intent of the Legislature that persons committed to this program who show signs of progress after an initial or subsequent periods of treatment and observation be given reasonable opportunities to demonstrate ability to abstain from the use of narcotics under close supervision in outpatient status outside of the rehabilitation center provided for in Chapter 2 (commencing with Section 3300) of this division. Determinations of progress of persons committed to the program should be based upon criteria to be established by the Director of Corrections with the advice of clinically trained and experienced personnel.

The enactment of the preceding provisions of this section shall not be construed to be evidence that the intent of the Legislature was otherwise before such enactment.

3001. The narcotic detention, treatment and rehabilitation facilities referred to herein shall be one within the Department of Corrections whose principal purpose shall be the receiving, control, confinement, employment, education, treatment and rehabilitation of persons under the custody of the Department of Corrections or any agency thereof who are or have been addicted to narcotics or who by reason of repeated use of narcotics are in imminent danger of becoming addicted.

3002. Every person committed pursuant to this chapter or from Chapter 11 (commencing with Section 6399) of Title 7 of the Penal Code who escapes or attempts to escape from lawful custody is guilty of a crime punishable by imprisonment in the state prison. This section does not apply to unauthorized absence from a halfway house.

3003. The Director of Corrections may enter into agreements with

of narcotics in imminent danger of addiction, further proceedings shall be conducted in compliance with Sections 3104, 3105, 3106, and 3107.

If, after a hearing, the judge finds that the defendant is a narcotic addict, or is by reason of the repeated use of narcotics in imminent danger of becoming addicted to narcotics, he shall make an order committing such person to the custody of the Director of Corrections for confinement in the facility until such time as he is discharged pursuant to Article 5 of this chapter, except as this chapter permits earlier discharge. In any case to which Section 3052 applies, the judge may request the district attorney to investigate the facts relevant to the advisability of commitment pursuant to this section. In unusual cases, wherein the interest of justice would best be served, the judge may, with the concurrence of the district attorney and defendant, order commitment notwithstanding Section 3052. If, upon the hearing, the judge shall find that the defendant is not a narcotic addict and is not in imminent danger of becoming addicted to narcotics, he shall so certify and return the defendant to the department of the superior court which directed the filing of the petition for such further proceedings on the criminal charges as the judge of such department deems warranted.

If a person committed pursuant to this section is dissatisfied with the order of commitment he may within 10 days after the making of such order file a written demand for a jury trial in compliance with Section 3108.

3052. (a) Sections 3050 and 3051 shall not apply to persons convicted of, or who have been previously convicted of murder, assault with intent to commit murder, attempt to commit murder, kidnapping, robbery, burglary in the first degree, mayhem, a violation of Section 245 or a violation of any provision of Chapter 1 (commencing with Section 261) of Title 9 of Part 1 of the Penal Code (but excepting subdivision 1 of Section 261) any felonies involving bodily harm or attempt to inflict bodily harm or any offense set forth in Article 1 (commencing with Section 11500) or 2 (commencing with Section 11530) of Chapter 5 of Division 10 of the Health and Safety Code, or in Article 4 (commencing with Section 11710) of Chapter 7 of such Division 10 for which the minimum term prescribed by law is more than five years in state prison.

(b) Notwithstanding the provisions of subdivision (a) of this section or Section 3053, the fact a person comes within Section 1203.07 P.C. does not mean that he may not be committed and treated.

3053. If at any time following receipt at the facility of a person committed pursuant to this article, the Director of Corrections concludes that the person, because of excessive criminality or for other relevant reason, is not a fit subject for confinement or treatment in such narcotic detention, treatment and rehabilitation facility, he shall return the person to the court in which the case originated for such further proceedings on the criminal charges as that court may deem warranted.

3054. A person committed to the custody of the Director of Corrections pursuant to this article is not required to register pursuant to

Article 6 (commencing with Section 11850) of Chapter 7, Division 10 of the Health and Safety Code.

Article 3. Involuntary Commitment of Persons Not Charged With a Crime

3100. Anyone who believes that a person is addicted to the use of narcotics or by reason of the repeated use of narcotics is in imminent danger of becoming addicted to their use or any person who believes himself to be addicted or about to become addicted may report such belief to the district attorney, under oath, who may, when there is probable cause, petition the superior court for a commitment of such person to the Director of Corrections for confinement in the narcotic detention, treatment and rehabilitation facility. As used in this article the term "person" includes any person who is released on probation by any court of this state.

3100.6. Any peace officer or health officer who has reasonable cause to believe that a person is addicted to the use of narcotics or by reason of the repeated use of narcotics is in imminent danger of becoming addicted to their use may take the person, for his best interest and protection, to the county hospital or other suitable medical institution designated by the board of supervisors of the county.

Upon written application of the peace officer or health officer, the physician or superintendent in charge of the designated hospital or institution may admit the person believed to be addicted to the use of narcotics or in imminent danger of becoming addicted to their use. The application shall state the circumstances under which the person's condition was called to the officer's attention, shall state the date, time and place of taking the person into custody and shall state the facts upon which the officer has reasonable cause to believe that the person is addicted to the use of narcotics or by reason of the repeated use of narcotics is in imminent danger of becoming addicted to their use. The application shall be signed by the officer, and a copy of the application shall be presented to the person prior to his admittance to the hospital or institution.

Within 24 hours of admittance, a physician shall conduct an examination to determine whether the person is addicted to the use of narcotics or by reason of the repeated use of narcotics is in imminent danger of becoming addicted to their use and may provide the person with medical aid as necessary to ease any symptoms of withdrawal from the use of narcotics.

If, after examination, the physician does not believe that the person is addicted to the use of narcotics or by reason of the repeated use of narcotics is in imminent danger of becoming addicted to their use, he shall immediately report his belief to the physician or superintendent in charge of the hospital or institution, who shall discharge the person immediately.

If, after examination, the physician believes that further examination is necessary to determine whether the person is addicted to the use of narcotics or by reason of the repeated use of narcotics is in imminent danger of addiction to their use, he shall prepare an affidavit which states

Section 3050, 3051, 3106.6 or 3102, who shall testify as to the result of the examination, unless the presence of the physicians is waived and it is stipulated that their affidavit or report may be received in evidence.

3106.5. If the court determines that the person is not addicted to the use of narcotics, or in imminent danger of addiction, the petition shall be denied. If the court determines that the person is addicted to the use of narcotics or is by reason of the repeated use of narcotics in imminent danger of addiction, the court shall order the person committed to the custody of the Director of Corrections, until such time as he is discharged in accordance with Article 5 of this chapter, except as provided in Section 3109.

3107. Hearing may be waived by consent of the person, expressed in open court or in writing by the person after the arraignment required by Section 3104 and after consultation with counsel.

3108. If the person so committed or any friend in his behalf is dissatisfied with the order of commitment, he may within 10 days after the making of such order, file a written demand that the question of his addiction or imminent danger of addiction be tried by a jury in the superior court of the county in which he was committed. Thereupon, the court shall cause a jury to be summoned and to be in attendance at a date stated, not less than 4 days nor more than 30 days from the date of the demand for a jury trial. The court shall submit to the jury the question: Is the person addicted to the use of narcotics or is he by reason of the repeated use of narcotics in imminent danger of addiction? The order of commitment entered pursuant to Sections 3050, 3051, or 3106.5 shall not be read to the jury, nor alluded to in such trial. The trial shall be had as provided by law for the trial of civil cases and the petition shall be dismissed unless a verdict that the person is addicted or in imminent danger of addiction is found by at least three-fourths of the jury.

The person committed shall be awarded all his constitutional rights including, but not limited to, his right to counsel, his right to notice of the nature of the proceedings brought against him, his right to the process of the court to compel the attendance of witnesses in his behalf, and his right to be confronted with witnesses.

3109. If at any time following receipt at the facility of a person committed pursuant to this article, the Director of Corrections concludes that such person is not, because of excessive criminality or for other relevant reason, a fit subject for confinement or treatment in a facility of the Department of Corrections, he may order such person discharged.

3110. A person committed to the custody of the Director of Corrections pursuant to this article is not required to register pursuant to Article 6 (commencing with Section 11850) of Chapter 7, Division 10 of the Health and Safety Code.

3111. In the performance of acts and duties required by this article, [illegible] as is provided for public officers in Sections 820.2 and 821.6 of the Government Code.

Article 4. Release in Outpatient Status

3150. (a) There is in the state government a Narcotic Addict Evaluation Authority, hereafter referred to in this article as the "authority." The authority shall be composed of four members, each of whom shall be appointed by the Governor, for a term of four years and until the appointment and qualification of his successor. Members shall be eligible for reappointment. The chairman of the authority shall be designated by the Governor from time to time. The terms of the members first appointed to the authority shall expire as follows: one on January 15, 1965, one on January 15, 1966, one on January 15, 1967, and one on January 15, 1968. Their successors shall hold office for terms of four years, each term to commence on the expiration date of the term of the predecessor. The Governor shall fill every vacancy for the balance of the unexpired term. Insofar as practicable, persons appointed to the authority shall have a broad background in law, sociology, law enforcement, medicine, or education, and shall have a deep interest in the rehabilitation of narcotic addicts.

(b) Each member of the authority shall devote such time to the duties of his office as required for performance of his duties and shall be entitled to an annual salary of nine thousand five hundred dollars ($9,500) for attendance upon business of the authority. The chairman shall be entitled to an annual salary of ten thousand dollars ($10,000). In addition, each member shall be allowed actual expenses incurred in the discharge of his duties, including travel expenses.

(c) The authority shall maintain its headquarters at the California Rehabilitation Center and shall be provided with necessary office space, equipment and services from funds appropriated to the California Rehabilitation Center.

(d) The authority shall meet at the center or its branches at such times as may be necessary for a full and complete study of the cases of all patients who are certified by the Director of Corrections to the authority as having recovered from addiction or imminent danger of addiction to such an extent that release in an outpatient status is warranted. Other times and places of meetings may also be fixed by the authority. Where the authority performs its functions by meeting en banc in either public or executive sessions to decide matters of general policy, at least three members shall be present, and no such action shall be valid unless it is concurred in by a majority vote of those present. The authority may meet and transact business in panels. Each authority panel shall consist of at least two members of the authority. Two members of the authority shall constitute a quorum for the transaction of business of a panel. No action shall be valid unless concurred in by a majority of the members present.

(e) Members of other similar boards may be assigned to hear cases and make recommendations to the authority. Such recommendations shall be [illegible] policies established by a majority of the [illegible]

membership of the authority.

3151. After an initial period of observation and treatment of six months, and subject to the rules and policies established by the Director of Corrections, whenever a person committed under Article 2 or Article 3 of this chapter has recovered from his addiction or imminent danger of addiction to such an extent that, in the opinion of the Director of Corrections, release in an outpatient status is warranted, the director shall certify such fact to the authority. If the director has not so certified within the preceding 12 months, in the anniversary month of the commitment of any person committed under this chapter his case shall automatically be referred to the authority for consideration of the advisability of release in outpatient status. Upon any such certification by the director or such automatic certification, the authority may release such person in an outpatient status subject to all rules and regulations adopted by the authority and subject to all conditions imposed by the authority, whether of general applicability or restricted to the particular person released in outpatient status, and subject to being retaken and returned to inpatient status as prescribed in such rules, regulations, or conditions. The supervision of such persons while in an outpatient status shall be administered by the Department of Corrections. Such persons are not subject to the provisions of Penal Code Section 2600.

A single member of the authority may by written or oral order suspend the release in outpatient status of such a person and cause him to be retaken, until the next meeting of the authority. The written order of any member of the authority shall be a sufficient warrant for any peace officer to return such persons to physical custody.

It is hereby made the duty of all peace officers to execute any such order in like manner as ordinary criminal process.

3152. The rules for persons in outpatient status shall include but not be limited to close supervision of the person after release from the facility, periodic and surprise testing for narcotic use, counseling and return to inpatient status at the California Rehabilitation Center or its branches at the discretion of the authority, if from the reports of agents of the Department of Corrections or other information including reports of law enforcement officers as to the conduct of the person, the authority concludes that it is for the best interests of the person and society that this be done.

3153. The Director of Corrections is authorized to establish one or more halfway houses in large metropolitan areas as pilot projects in order to determine the effectiveness of such control on the addict's rehabilitation, particularly upon his release from the narcotic detention and treatment facility. Rules and regulations governing the operation of such halfway houses shall be established by the Director of Corrections and shall provide for control of the earnings of persons assigned to such halfway houses during their residence there, from which shall be deducted such charges for maintenance as the Director of Corrections may prescribe.

3154. A person released in an outpatient status from the California Rehabilitation Center may, with the approval of the Department of Corrections and the Narcotic Addict Evaluation Authority, voluntarily participate in a methadone maintenance project approved under Section 4351.

Participation in a methadone maintenance project shall not be construed to break the abstention from the use of narcotics for the purpose of Section 3200.

3155. In addition to any other payment to which he is entitled by law, each person who has been committed to the custody of the Director of Corrections pursuant to this chapter shall, upon his release, be paid the sum of two hundred dollars ($200), from such appropriations that may be made available for the purposes of this section.

The director may prescribe rules and regulations (a) to limit or eliminate any payments provided for in this section to persons who have not been confined at least six consecutive months prior to their release in instances where the director determines that such a payment is not necessary for the rehabilitation of the prisoner, and (b) to establish procedures for the payment of the sum of the two hundred dollars ($200) within the first 60 days of a prisoner's release.

The provisions of this section shall not be applicable if the person is released to the custody of another state or to the custody of the federal government.

Article 5. Discharge of Narcotic Addicts

3200. If at any time the Director of Corrections is of the opinion that a person committed pursuant to Article 3 of this chapter while in outpatient status has abstained from the use of narcotics for at least two consecutive years and has otherwise complied with the conditions of his release, or that an outpatient from the California Rehabilitation Center participating in a methadone program pursuant to Section 3154 has abstained from the use of narcotics for at least three consecutive years while on such program and has otherwise complied with the conditions of his release, he shall recommend to the Narcotic Addict Evaluation Authority that such person be discharged from the program. If the authority concurs in the opinion of the director, it shall discharge such person from the program.

If at any time the director is of the opinion that a person committed pursuant to Article 2 of this chapter while in outpatient status has abstained from the use of narcotics for at least two consecutive years and has otherwise complied with the conditions of his release, or that an outpatient from the California Rehabilitation Center participating in a methadone program pursuant to Section 3154 has abstained from the use of narcotics for at least three consecutive years while on such program and has otherwise complied with the conditions of his release, he shall so advise the Narcotic Addict Evaluation Authority. If the authority concurs in the opinion of the director it may file with the superior court of the county

in which the person was committed a certificate alleging such facts and recommending to the court the discharge of the person from the program. The authority shall serve a copy of such certificate upon the district attorney of the county. Upon the filing of such certificate, the court shall discharge the person from the program and may dismiss the criminal charges of which such person was convicted. Where such person was certified to the superior court from a municipal or justice court, the person shall be returned to such court, which may dismiss the original charges. In any case where the criminal charges are not dismissed and the person is sentenced thereon, time served while under commitment pursuant to Article 2 of this chapter shall be credited on such sentence. Such dismissal shall have the same force and effect as a dismissal under Section 1203.4 of the Penal Code, except the conviction is a prior conviction for purposes of Division 10 of the Health and Safety Code.

This section shall apply to persons convicted pursuant to the provisions of Section 1203.07 of the Penal Code, whether or not such person is on inpatient or outpatient status with the California Rehabilitation Center, if such person has been committed for a minimum period of 20 months.

3201. If a person committed pursuant to this chapter has not been discharged from the program prior to expiration of seven years, the Director of Corrections shall, on the expiration of such period, return him to the court from which he was committed, which court shall discharge him from the program and order him returned to the court in which criminal proceedings were adjourned, or the imposition of sentence suspended, prior to his commitment or certification to the superior court; or, if he was committed pursuant to Article 3, shall discharge him. If, however, it appears to the director that such person gives promise that, if his time on the program were extended, he could complete three consecutive years of abstinence from narcotics, the director shall return him to the court from which he was committed, with the recommendation that an extension not to exceed three years be ordered. The court may order such extension. If it declines to do so, it shall, if the person was committed pursuant to Article 3, discharge him, or, if he was committed pursuant to Article 2, return the person to the court in which criminal proceedings were adjourned, or the imposition of sentence suspended, prior to his commitment or certification to the superior court.

If an extension of the commitment is ordered pursuant to the preceding provisions of this section, the person must be returned to the court and discharged from the program on or before the expiration of 10 years from the date of the original commitment.

Any other provision of this chapter notwithstanding, in any case in which a person was committed pursuant to Article 3 as a result of such person's having requested the district attorney to file a petition for his commitment, such person must be discharged no later than two years and six months after his commitment.

No person committed pursuant to Chapter 11 (commencing with Section 6399) of Title 7 of Part 3 of the Penal Code, before the effective [illegible] to the program for

any longer period than the term of his commitment under the law as it read at the time he was committed.

Nothing in this chapter shall preclude a person who has been discharged from the program from being recommitted under the program, irrespective of the periods of time of any previous commitments.

CHAPTER 2. CALIFORNIA REHABILITATION CENTER

3300. There is hereby established an institution and branches under the jurisdiction of the Department of Corrections, to be known as the California Rehabilitation Center. Branches may be established in existing institutions of the Department of Corrections or of the Department of the Youth Authority, in halfway houses as described in Section 3153, in such other facilities as may be made available on the grounds of other state institutions, and in city and county correctional facilities where treatment facilities are available. Branches shall not be established on the grounds of such other institutions in any manner which will result in the placement of patients of such institutions into inferior facilities. Branches placed in a facility of the State Department of Health shall have prior approval of the Director of Health. The branches in the Department of the Youth Authority shall be established on order of the Secretary of the Human Relations Agency and shall be subject to the administrative direction of the Director of the Youth Authority. Branches placed in city or county facilities shall have prior approval of the legislative body of the city or county.

Persons confined pursuant to this section in branches established in city and county correctional facilities shall be housed separately from the prisoners therein, and shall be entitled to receive treatment substantially equal to that which would be afforded such persons if confined in the main institution of the California Rehabilitation Center.

3301. The principal purpose of the California Rehabilitation Center shall be the receiving control, confinement, employment, education, treatment and rehabilitation of persons under the custody of the Department of Corrections or any agency thereof who are addicted to the use of narcotics or are in imminent danger of becoming so addicted.

3302. The Director of Corrections shall acquire, or construct, and equip, in accordance with law, suitable buildings, structures and facilities for the California Rehabilitation Center.

3303. The Director of Corrections shall make rules and regulations for the government of the California Rehabilitation Center and the management of its affairs.

3304. A superintendent shall be appointed for the California Rehabilitation Center pursuant to Section 6050 of the Penal Code, and the Director of Corrections shall appoint, subject to civil service, such other officers and employees as may be necessary.

[illegible] control of the

Rehabilitation Center and the responsibility for the care, custody, training, discipline, employment and treatment of the persons confined therein are vested in the Director of Corrections. The provisions of Part 3 of the Penal Code apply to said institution as a prison under the jurisdiction of the Department of Corrections and to the persons confined therein insofar as such provisions may be applicable.

3306. The Director of Corrections may authorize the temporary removal from the California Rehabilitation Center or any of its branches under the jurisdiction of the Department of Corrections of any person confined therein. The director may require that such temporary removal be under custody Unless the person is removed for medical treatment, the removal shall not be for a period longer than three days. The director may require the person to reimburse the state, in whole or in part, for expenses incurred by the state in connection with such temporary removal other than for medical treatment.

Under specific regulations established by the director for the selection of confined persons, the director may authorize assignment to conservation camp programs.

EXCERPTS FROM CALIFORNIA VEHICLE CODE RELATING TO DRUG ADDICTS

12805. Grounds requiring refusal of license

The department shall not issue or renew a driver's license to any person:

(a) Who is not of legal age to receive such license.

(b) Who, because of excessive and continuous use of alcoholic liquors, is incapable of safely operating a motor vehicle, or who is addicted to the use of, or is an habitual user of, any drug to a degree that the person is rendered incapable of safely operating a motor vehicle.

(c) Who is insane or feebleminded or an idiot or an imbecile.

(d) Who has a disorder characterized by lapses of consciousness.

(e) Who is unable as shown by examination to understand traffic signs or signals or who does not have a reasonable knowledge of the provisions of this code governing the operations of vehicles upon the highways.

(f) When it appears by examination or other evidence that such person is unable to operate a motor vehicle upon a highway safely because of physical or mental defect or lack of skill.

(g) Who is unable to read and understand simple English used in highway traffic and directional signs. The provisions of this subdivision shall not apply to any person holding an operator's or chauffeur's license issued by this state and valid on September 11, 1957.

(h) Who holds a valid driver's license issued by a foreign jurisdiction unless he surrenders that license to the department.

(i) Who has ever held, or is the holder of a license to drive issued by another state, territory or possession of the United States, the District of Columbia, or the Commonwealth of Puerto Rico, and such license has been suspended by reason, in whole or in part, of a conviction of a traffic violation until the suspension period has terminated, except as provided in subdivision (b) of Section 12806.

(j) Who has ever held, or is the holder of a license to drive issued by another state, territory, or possession of the United States, the District of Columbia, or the Commonwealth of Puerto Rico, and such license has been revoked by reason, in whole or in part, of a conviction of a traffic violation until the revocation has been terminated or after the expiration of one year from the date the license was revoked, whichever occurs first, except as provided in subdivision (b) of Section 12806.

12806. Grounds not requiring refusal

(a) Any physical or mental defect of the applicant which in the opinion of the department does not affect the applicant's ability to exercise reasonable and ordinary control in operating a motor vehicle upon the highway shall not prevent the issuance of a license to the applicant.

(b) An applicant addicted to the use of narcotic drugs who is participating in a methadone maintenance program approved pursuant to Article 3 (commencing with Section 4350) of Chapter 3 of Part 1 of

subject to reasonable terms and conditions of probation if such drug usage does not affect the applicant's ability to exercise reasonable and ordinary control in operating a motor vehicle upon the highway.

(c) Any suspension or revocation by a state which is not a party to the Driver License Compact provided for in Chapter 6 (commencing with Section 15000) of Division 6 shall not prevent the issuance of a license to the applicant if in the opinion of the department it will be safe to issue such license.

12807. Additional grounds for refusal

The department shall not issue or renew a driver's license to any person:

(a) When a license previously issued to the person under this code has been suspended until the expiration of the period of the suspension, unless cause for suspension has been removed.

(b) When a license previously issued to the person under this code has been revoked until the expiration of one year after the date of the revocation, except where a different period of revocation is prescribed by this code, or unless the cause for revocation has been removed.

(c) When the department has received a notice pursuant to subdivision (a) of Section 40509, unless the department has received a certificate as provided in that subdivision.

(d) When the department has been notified by a court that the licensee has failed to pay a lawfully imposed fine within the time authorized by the court for any violation which is required to be reported pursuant to Section 1803.

12809. Grounds permitting refusal

The department may refuse to issue or renew a driver's license to any person:

(a) If the department is satisfied that the applicant is not entitled to the license under this code.

(b) If the applicant has failed to furnish the department the information required in the application or reasonable additional information requested by the department.

(c) If the department determines that the applicant has made or permitted unlawful use of any driver's license.

(d) If the department determines that such person has knowingly used a false or fictitious name in any application for a license or has impersonated another in making application or in taking any test, or has knowingly made a false statement or knowingly concealed a material fact, or otherwise committed any fraud in any such application.

(e) If the department determines that the applicant is a negligent or incompetent operator of a motor vehicle.

(f) If the applicant is convicted of any offense involving the transportation for purpose of sale, or the transportation for compensation, [illegible] Division 10 (commencing with Section

involved the use or operation of a motor vehicle.

If, however, the driving privilege of the applicant is on probation for a cause related to the use or possession of a narcotic controlled substance, the department may refuse to issue or renew a driver's license to such applicant if the applicant is subsequently convicted of any offense involving the use or possession of a narcotic controlled substance, whether or not the commission of such offense involved the use or operation of a motor vehicle.

The maximum period of time for which the department may refuse to issue or renew a driver's license to any person pursuant to this subdivision shall be three years from the date of conviction.

(g) If the applicant fails or refuses to surrender to the department upon its lawful demand, a nonresident minor's certificate which has been canceled.

12810. Traffic violation point count and negligent operation defined

In determining the violation point count, any conviction of failure to stop in the event of an accident resulting in damage to property or otherwise failing to comply with the requirements of Section 20002, or driving a motor vehicle while under the influence of intoxicating liquor or any drug, or under the combined influence of intoxicating liquor and any drug, or of reckless driving shall be given a value of two points and any other traffic conviction involving the safe operation of a motor vehicle upon the highway shall be given a value of one point; provided, that conviction for only one violation arising from one occasion of arrest or citation shall be counted in determining the violation point count for the purposes of this section.

Any person whose driving record shows a violation point count of four or more points in 12 months, six or more points in 24 months or eight or more points in 36 months shall be prima facie presumed to be a negligent operator of a motor vehicle.

Any accident in which the operator is deemed by the department to be responsible shall be given a value of one point.

In applying the provisions of this section to a driver, the department shall give due consideration to the amount of use or mileage traveled in the operation of a motor vehicle.

13201. Certain misdemeanors and drug use

A court may suspend the privilege of any person to operate a motor vehicle, for a period not exceeding six months, upon conviction of any of the following offenses:

(a) Failure of the driver of a vehicle involved in an accident to stop or otherwise comply with the provisions of Section 20002.

(b) Reckless driving proximately causing bodily injury to any person under Section 23104.

(c) Failure of the driver of a vehicle to stop at a railway grade crossing

(d) Driving while addicted to the use, or under the influence of, any drug under subdivisions (a) or (c) of Section 23105.

13201.5 Driving while under the influence

A court may suspend the privilege of any person to operate a motor vehicle, for a period not exceeding six months, upon conviction of driving while under the influence of intoxicating liquor or under the combined influence of intoxicating liquor and any drug.

13202. Illegal narcotics

(a) A court may suspend or order that the department revoke in which case the department shall revoke the privilege of any person to operate a motor vehicle upon conviction of any narcotic controlled substance offense as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code when the use of a motor vehicle was involved in, or incidental to, the commission of the offense.

(b) A court shall order that the department revoke and the department shall revoke the privilege of any person to operate a motor vehicle upon conviction of a violation of Section 11350, 11351, 11352, 11353, 11357, 11359, 11360, or 11361 of the Health and Safety Code when a motor vehicle was involved in, or incidental to, the commission of such offense.

(c) The period of time for suspension or the period after revocation during which the person may not apply for a license shall be determined by the court, but in no event shall such period exceed three years from the date of conviction.

13209. Record of prior conviction

Before sentencing a person upon a conviction of driving a motor vehicle while under the influence of intoxicating liquor or any drug, or under the combined influence of intoxicating liquor and any drug, other than under Section 23101 or 23106, the court shall obtain from the department a record of any prior convictions of that person for traffic violations. The department shall furnish such record upon the written request of the court.

Notwithstanding the provisions of Section 1449 of the Penal Code, in any such criminal action the time for pronouncement of judgment shall not commence to run until the time that the court receives the record of prior convictions from the department.

13210. Procedure upon first conviction

Notwithstanding any other provision of this code, whenever any person is convicted for the first time of driving a motor vehicle while under the influence of intoxicating liquor or any drug, or under the combined influence of intoxicating liquor and any drug, other than under Section 23101 or 23106, the court shall order the department to suspend the person's driving privilege unless the person shows good cause why such order should not be made. If the court does not order such suspension, the court may limit the person's driving privilege as a condition of probation without notifying the department of such condition.

13352. Influence of liquor or drugs

The department shall, except for a conviction or finding described in subdivision (a) where the court does not order the department to suspend, immediately suspend or revoke the privilege of any person to operate a motor vehicle upon receipt of a duly certified abstract of the record of any court showing that the person has been convicted of driving a motor vehicle while under the influence of intoxicating liquor or any drug, or while under the combined influence of intoxicating liquor and any drug, or in violation of subdivision (c) of Section 23105, or upon receipt of a report of a judge of the juvenile court, a juvenile traffic hearing officer, or a referee of a juvenile court showing that the person has been found to have committed the offense of operating a vehicle while under the influence of intoxicating liquor or any drug, or while under the combined influence of intoxicating liquor and any drug, or in violation of subdivision (c) of Section 23105. The suspension or revocation shall be as follows:

(a) Upon a first such conviction or finding, other than under Section 23101 or 23106 such privilege shall be suspended for a period of six months, if the court orders the department to suspend such privilege.

(b) Upon a first such conviction or finding under Section 23101 or 23106 such privilege shall be suspended for one year and shall not be reinstated until such person gives proof of ability to respond in damages as defined in Section 16430.

(c) Upon a second conviction or finding of driving a motor vehicle while under the influence of intoxicating liquor or any drug, or under the combined influence of intoxicating liquor and any drug, or in violation of subdivision (c) of Section 23105, or any combination of such convictions or findings within five years, such privilege shall be suspended for one year and shall not be reinstated unless and until such person gives proof of ability to respond in damages as defined in Section 16430.

(d) Upon a second such conviction or finding under Section 23101 or 23106 within three years, such privilege shall be permanently revoked.

(e) Upon a third or subsequent conviction or finding of driving a motor vehicle while under the influence of intoxicating liquor or any drug, or under the combined influence of intoxicating liquor and any drug, or in violation of subdivision (c) of Section 23105, or any combination of such convictions or findings within seven years such privilege shall be revoked and shall not be reinstated for a period of three years and until such person files proof of ability to respond in damages as defined in Section 16430.

For the purposes of subdivision (c), (d), and (e), the finding of the juvenile court judge, the juvenile traffic hearing officer, or the referee of a juvenile court, specified in the first paragraph of this section shall also be considered a conviction.

Each judge of a juvenile court, juvenile traffic hearing officer, or referee of a juvenile court shall immediately report such findings to the department.

13300. Investigations by the department

The department may conduct an investigation to determine whether the privilege of any person to operate a motor vehicle should be suspended or revoked or whether terms or conditions of probation should be imposed upon receiving information or upon a showing by its records:

(a) That the licensee has been involved as a driver in any accident causing death or personal injury or serious damage to property.

(b) That the licensee has been involved in three or more accidents within a period of 12 consecutive months.

(c) That the licensee is a reckless, negligent, or incompetent driver of a motor vehicle.

(d) That the licensee has permitted an unlawful or fraudulent use of his driver's license.

(e) That any ground exists for which a license might be refused. The receipt by the department of an abstract of the record of conviction of any offense involving the use or possession of narcotic controlled substances under Division 10 (commencing with Section 11000) of the Health and Safety Code shall be a sufficient basis for an investigation by the department to determine whether grounds exist for which a license might be refused.

23101. Influence of alcohol or alcohol and drugs causing death or injury

(a) It is unlawful for any person, while under the influence of intoxicating liquor, or under the combined influence of intoxicating liquor and any drug, to drive a vehicle upon a highway and when so driving do any act forbidden by law or neglect any duty imposed by law in the driving of such vehicle, which act or neglect proximately causes bodily injury to any person other than himself.

(b) It is unlawful for any person, while under the influence of intoxicating liquor, or under the combined influence of intoxicating liquor and any drug, to drive a vehicle other than on a highway and when so driving do any act, or neglect any duty imposed by law, which act or neglect proximately causes death or bodily injury to any person other than himself.

(c) Any person convicted under this section shall be punished by imprisonment in the state prison, or in the county jail for not less than 90 days nor more than one year and by fine of not less than two hundred fifty dollars ($250) nor more than five thousand dollars ($5,000).

23102. Influence of alcohol or alcohol and drugs

(a) It is unlawful for any person who is under the influence of intoxicating liquor, or under the combined influence of intoxicating liquor

and any drug, to drive a vehicle upon any highway.

(b) It is unlawful for any person who is under the influence of intoxicating liquor, or under the combined influence of intoxicating liquor and any drug, to drive a vehicle upon other than a highway.

The department shall not be required to provide patrol or enforce the provisions of this subdivision.

(c) Any person convicted under this section shall be punished upon first conviction by imprisonment in the county jail for not less than 48 hours nor more than six months or by fine of not less than two hundred fifty dollars ($250) nor more than five hundred dollars ($500) or by both such fine and imprisonment. If, however, any person so convicted consents to, and does participate and successfully completes, a driver improvement program or treatment program for persons who are habitual users of alcohol, or both such programs, as designed by the court the court shall punish such person by a fine of not less than one hundred fifty dollars ($150) nor more than five hundred dollars ($500) or by imprisonment in the county jail for not less than 48 hours nor more than six months or by both such fine and imprisonment.

(d) Any person convicted under this section shall be punished upon second or any subsequent conviction, within five years of a prior conviction, by imprisonment in the county jail for not less than 48 hours nor more than one year and by a fine of not less than two hundred fifty dollars ($250) nor more than one thousand dollars ($1,000). A conviction under this section shall be deemed a second conviction if the person has previously been convicted of a violation of Section 23101.

(e) If any person is convicted of a second or subsequent offense under this section within five years of a prior conviction and is granted probation it shall be a condition of probation that such person be confined in jail for at least 48 hours but not more than one year and pay a fine of at least two hundred fifty dollars ($250) but not more than one thousand dollars ($1,000).

(f) In no event does the court have the power to absolve a person who is convicted of a second or subsequent offense under this section within five years of a prior conviction from the obligation of spending at least 48 hours in confinement in the county jail and of paying a fine of at least two hundred fifty dollars ($250), except as provided in subdivision (g).

(g) Except in unusual cases where the interests of justice demand an exception, the court shall not strike a prior conviction of an offense under this section for purposes of sentencing in order to avoid imposing as part of the sentence or term of probation the minimum time in confinement in the county jail and the minimum fine, as provided in subdivision (f).

When such a prior conviction is stricken by the court for purposes of sentencing, the court shall specify the reason or reasons for such striking order.

On appeal by the people from such an order striking such a prior conviction it shall be conclusively presumed that such order was made only for the reasons specified in such order and such order shall be reversed if there is no substantial basis in the record for any of such reasons.

(h) The court may order that any person convicted under this section who is punished by imprisonment in jail, be imprisoned on days other than days of regular employment of the person, as determined by the court.

(i) If the person convicted under this section is under the age of 21 years and the vehicle used in any such violation is registered to such person, the vehicle may be impounded at the owner's expense for not less than one day nor more than 30 days.

(c) In any case, the court may order suitable treatment for the person, in addition to imposing any penalties required by this code.

23105. Influence of drug or addiction

(a) It is unlawful for any person who is under the influence of any drug to drive a vehicle upon any highway.

(b) It is unlawful for any person who is under the influence of any drug to drive a vehicle upon other than a highway.

The department shall not be required to provide patrol or enforce the provisions of this subdivision.

(c) It is unlawful for any person who is addicted to the use of any drug, except such a person who is participating in a methadone maintenance treatment program approved pursuant to Article 3 (commencing with Section 4350) of Chapter 1 of Part 1 of Division 4 of the Welfare and Institutions Code, to drive a vehicle upon any highway.

(d) Any person convicted under this section shall be punished upon a first conviction by imprisonment in the county jail for not less than 48 hours nor more than six months or by fine of not less than two hundred fifty dollars ($250) nor more than five hundred dollars ($500) or by both such fine and imprisonment. If, however, any person so convicted consents to participate, and does participate and successfully completes, a driver improvement program or a treatment program for persons who are habitual users of drugs, or both such programs, as designated by the court, a court shall punish such person by a fine of not less than one hundred fifty dollars ($150) nor more than five hundred dollars ($500) or by imprisonment in the county jail for not less than 48 hours nor more than six months or by both such fine and imprisonment.

(e) Any person convicted under this section shall be punished upon a second or any subsequent conviction, within five years of a prior conviction, by imprisonment in the county jail for not less than 48 hours nor more than one year and by a fine of not less than two hundred fifty dollars ($250) nor more than one thousand dollars ($1,000). A conviction under this section shall be deemed a second or subsequent conviction if the person has previously been convicted of a violation of driving a vehicle while under the influence of intoxicating liquor or any drug, or under the combined influence of intoxicating liquor and any drug.

(f) If any person is convicted of a second or subsequent offense under this section within five years of a prior conviction and is granted probation, it shall be a condition of probation that such person be confined in jail for at least 48 hours but not more than one year and pay a fine of at least two hundred fifty dollars ($250) but not more than one thousand dollars ($1,000).

(g) In no event does the court have the power to absolve a person who is convicted of a second or subsequent offense under this section within five years of a prior conviction from the obligation of spending at least 48 hours in confinement in the county jail and of paying a fine of at least two hundred fifty dollars ($250) except as provided in subdivision (h).

(h) Except in unusual cases where the interests of justice demand an exception, the court shall not strike a prior conviction of an offense under this section for purposes of sentencing in order to avoid imposing as part of the sentence or term of probation the minimum time in confinement in the county jail and the minimum fine, as provided in subdivision (g).

When such a prior conviction is stricken by the court for purposes of sentencing, the court shall specify the reason or reasons for such striking order.

On appeal by the people from such an order striking such a prior conviction it shall be conclusively presumed that such order was made only for the reasons specified in such order and such order shall be reversed if there is no substantial basis in the record for any of such reasons.

(i) The court may order that any person convicted under this section who is punished by imprisonment in jail, be imprisoned on days other than days of regular employment of the person, as determined by the court.

(j) If the person convicted under this section is under the age of 21 years and the vehicle used in any such violation is registered to such person, the vehicle may be impounded at the owner's expense for not less than one day nor more than 30 days.

23106. Influence of drugs causing injury

(a) It is unlawful for any person, while under the influence of any drug, to drive a vehicle upon a highway and when so driving do any act forbidden by law or neglect any duty imposed by law in the driving of such vehicle, which act or neglect proximately causes bodily injury to any person other than himself.

(b) It is unlawful for any person, while under the influence of any drug, to drive a vehicle other than on a highway and when so driving do any act, or neglect any duty imposed by law, which act or neglect proximately causes bodily injury to any person other than himself.

(c) Any person convicted under this section shall be punished by imprisonment in the state prison, or in the county jail for not less than 90 days nor more than one year and by fine of not less than two hundred fifty dollars ($250) nor more than five thousand dollars ($5,000).

23107. Defense to drug violations

The fact that any person charged with a violation of Section 23105 or 23106 is or has been entitled to use such drug under the laws of this state shall not constitute a defense against any violation of the sections.

EXCERPTS FROM BUSINESS AND PROFESSIONS CODE

Article 6. Hypodermics

4140. Permit to sell and dispense; renewal; transfer

The board may, upon written application, on a form furnished by the board, and in its discretion, issue a permit to any person, permitting and authorizing such person to sell and dispense hypodermic syringes and hypodermic needles for the purposes and uses specified by the board.

Separate certificates, licenses, permits or registrations, shall be required for each of the premises of any business establishment having more than one location. Such certificate, license, permit or registration shall be renewed annually, on or before January 1 of each year and shall not be transferable.

No person shall furnish, by sale or otherwise, any hypodermic syringe or hypodermic needle if he has not obtained a permit from the board, unless he is authorized to furnish a hypodermic syringe or hypodermic needle without a permit from the board, or unless he is otherwise exempted from such requirement.

4140.5. Nonresident hypodermic needle or syringe distributor's license; renewal; application; discipline; doing business in state

(a) A nonresident distributor of hypodermic needles or syringes doing business in this state that has not obtained a certificate, license, permit, registration, or exemption from the board and that sells or distributes hypodermic needles or syringes in this state through any person or medium other than a wholesaler which has obtained a certificate, license, permit, registration, or exemption pursuant to the provisions of this chapter or through a selling or distribution outlet which is licensed as a wholesaler pursuant to the provisions of this chapter, shall not conduct the business of selling or distributing hypodermic needles or syringes in this state without obtaining a nonresident hypodermic needle or syringe distributor's license from the board.

Separate certificates, licenses, permits or registrations shall be required for each of the premises of any business establishment having more than one location. Such certificate, license, permit or registration shall be renewed annually on or before January 1 of each year and shall not be transferable.

(b) Applications for a nonresident hypodermic needle or syringe distributor's license under this section shall be made on a form furnished by the board. The board may require such information as the board deems is reasonably necessary to carry out the purposes of the section.

(c) The board may deny, revoke, or suspend such nonresident distributor's license for any violation of this chapter.

(d) The Legislature, by enacting this section, does not intend a license pursuant to this section to serve as

4140.7. Confiscation of hypodermic needles or syringes not in possession of authorized person

All stocks of hypodermic needles or hypodermic syringes shall be confiscated if found upon any premises which are not in the possession of the person who was issued a permit under Section 4140, unless he is excepted therefrom.

4141. Record of furnishing

Any furnishing of a hypodermic syringe or hypodermic needle without a prescription shall at the time of furnishing be recorded in a book by the furnisher. The record of furnishing shall consist of the date and hour of such furnishing, the type or kind, size, and quantity of syringe or needle furnished, the purpose and use for which such needle or syringe was obtained, the signature of the furnisher, and the signature and address of the person to whom the needle or syringe was furnished. Such record book shall be available for inspection by any authorized officer of the law.

4142. Exceptions

The provisions of this article with reference to hypodermic syringes and needles do not apply to the sale at wholesale by pharmacies, drug jobbers, drug wholesalers and drug manufacturers or manufacturers and dealers in surgical instruments to pharmacies, physicians, dentists, podiatrists, veterinarians, or persons to whom a permit has been issued.

4143. Unlawful possession; exceptions; disposition of used needle or syringe

(a) It is unlawful for any person to have in his possession or under his control any hypodermic needle or hypodermic syringe.

(b) The provisions of this section do not apply to persons who have acquired possession and control of a hypodermic needle or hypodermic syringe in accordance with the provisions of this code authorizing and regulating the furnishing, possession and use of such needles and syringes.

Any used hypodermic needle or hypodermic syringe which is to be disposed of shall be destroyed in such a manner as to render such unit or units unfit for reuse in any manner. Such destruction may include, but is not limited to, grinding and disposal in sewerage systems where such disposal is authorized by the appropriate agency with jurisdiction over such sewerage system.

4145. Sale restrictions; exceptions

No hypodermic needle or hypodermic syringe shall be sold at retail except upon the prescription of a physician and surgeon, dentist, veterinarian, or podiatrist, or pharmacist acting within the scope of a prescription [illegible] conforming with Section 429.70) of Chapter [illegible] Safety Code [illegible]

acting within the scope of a project authorized under Article 18 (commencing with Section 429.70) of Chapter 2 of Part 1 of Division 1 of the Health and Safety Code, or physician's assistant acting within the scope of a project authorized under Article 18 (commencing with Section 429.70 of Chapter 2 of Part 1 of Division 1 of the Health and Safety Code.

4147. Authority to furnish without prescription; requirements

Notwithstanding any other provision of law, a pharmacist or physician may, without a prescription or a permit, furnish hypodermic needles and syringes for human use in the administration of insulin or adrenalin, a pharmacist or veterinarian may, without a prescription or a permit, furnish hypodermic needles and syringes for use on poultry or animals, and a person may, without a prescription or permit, obtain hypodermic needles and syringes from a pharmacist or physician for human use in the administration of insulin or adrenalin, or from a pharmacist, veterinarian, or permit holder, for use on poultry or animals, if all of the following requirements are met:

a. No needle or syringe shall be furnished to a person who is unknown to the furnisher and unable to properly establish his identity.

b. The furnisher, at the time the furnishing occurs makes a record of the furnishing in the manner required by Section 4141.

4148. Inapplicability of Sections 4141 and 4147 to industrial uses

The provisions of Sections 4141 and 4147 shall not apply to the furnishing or obtaining of hypodermic syringes or hypodermic needles for uses which the board determines are industrial. Notwithstanding any other provision of law, a person may obtain hypodermic syringes or needles, without prescription or permit, for such industrial uses.

Article 8. Dangerous Drugs

4211. Dangerous drug

"Dangerous drug" means any drug unsafe for self-medication, except preparations of drugs defined in subdivisions (e), (f), (h), and (i) hereof, designed for the purpose of feeding or treating animals (other than man) or poultry, and so labeled, and includes the following:

(a) Any hypnotic drug "Hypnotic drug" includes acetylurea derivatives, barbituric acid derivatives, chloral, paraldehyde, sulfomethane derivatives, or any compounds or mixtures or preparations that may be used for producing hypnotic effects.

(b) Aminopyrine, or compounds or mixtures thereof.

(c) Amphetamine, desoxyephedrine, or compounds or mixtures thereof except preparations for use in the nose and unfit for internal use.

(d) Cinchophen, neocinchophen, or compounds or mixtures thereof.

(e) Diethyl-stilbestrol, or compounds or mixtures thereof.

(f) Ergot, cotton root, or their contained or derived active compounds or mixtures thereof.

(g) Oils of croton, rue, savin or tansy or their contained or derived compounds or mixtures thereof.

(h) Sulfanilamide or substituted sulfanilamides, or compounds or mixtures thereof, except preparations for topical application only containing not more than five percent (5%) strength.

(i) Thyroid and its contained or derived active compounds or mixtures thereof.

(j) Phenylhydantoin derivatives.

(k) Any drug which bears the legend: "Caution: federal law prohibits dispensing without prescription;" or, any device which bears the statement: "Caution: federal law restricts this device to sale by or on the order of a _____," the blank to be filled in with the designation of the practitioner licensed to use or order use of the device. However, this section, nor any other provision of law, shall not prohibit the sale of such devices to skilled nursing facilities or intermediate care facilities licensed pursuant to Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code.

(l) Hypnotic drugs when combined and compounded with nonhypnotic drugs.

(m) Any narcotic antagonist drug which has been found by the federal government to have currently accepted medical use in treatment in the United States and to have no potential for abuse or abuse liability.

4213. Administer

"Administer," as used in this article, means the furnishing by a physician and surgeon, dentist, podiatrist, or veterinarian, or pharmacist acting within the scope of a project authorized under Article 18 (commencing with Section 429.70) of Chapter 2 of Part 1 of Division 1 of the Health and Safety Code, or registered nurse acting within the scope of a project authorized under Article 18 (commencing with Section 429.70) of Chapter 2 of Part 1 of Division 1 of the Health and Safety Code, or physician's assistant acting within the scope of a project authorized under Article 18 (commencing with Section 429.70) of Chapter 2 of Part 1 of Division 1 of the Health and Safety Code to his patient of such amount of drugs or medicines referred to in this article as are necessary for the immediate needs of the patient.

4227. Furnishing or dispensing drug without prescription; exceptions

(a) No person shall furnish any dangerous drug except upon the prescription of a physician, dentist, podiatrist or veterinarian, or pharmacist acting within the scope of a project authorized under Article 18 (commencing with Section 429.70) of Chapter 2 of Part 1 of Division 1 of the Health and Safety Code, or registered nurse acting within the scope of a project authorized under Article 18 (commencing with Section 429.70) of Chapter 2 of Part 1 of Division 1 of the Health and Safety Code, or physician's assistant acting within the scope of a project authorized un

Article 18 (commencing with Section 429.70) of Chapter 2 of Part 1 of Division 1 of the Health and Safety Code.

(b) The provisions of this section do not apply to the furnishing of any dangerous drug by a manufacturer or wholesaler or pharmacy to each other or to a physician, dentist, podiatrist or veterinarian, or pharmacist acting within the scope of a project authorized under Article 18 (commencing with Section 429.70) of Chapter 2 of Part 1 of Division 1 of the Health and Safety Code, or registered nurse acting within the scope of a project authorized under Article 18 (commencing with Section 429.70) of Chapter 2 of Part 1 of Division 1 of the Health and Safety Code, or physician's assistant acting within the scope of a project authorized under Article 18 (commencing with Section 429.70) of Chapter 2 of Part 1 of Division 1 of the Health and Safety Code, or to a laboratory under sales and purchase records that correctly give the date, the names and addresses of the supplier and the buyer, the drug and its quantity.

(c) A registered pharmacist, or a person exempted pursuant to Section 4050.7, may distribute dangerous drugs and devices directly to hemodialysis patients pursuant to regulations promulgated by the board. The board shall promulgate such regulations as are necessary to insure the safe distribution of such drugs and devices to hemodialysis patients without interruption of supply including, but not limited to, the following: vendor licensing, records and labeling, patient receipts, patient training, report records, specific product and quantity limitations, verification order forms, reports and supplies, adequate establishment facilities, and reports to the board. A person who violates a regulation promulgated pursuant to this subdivision shall be liable upon order of the board to surrender this personal license. These penalties shall be in addition to penalties which may be imposed pursuant to Sections 4389 and 4350.5. If the board finds any hemodialysis drugs or devices distributed pursuant to this subdivision to be ineffective or unsafe for the intended use, the board may institute immediate recall of any or all of such drugs or devices distributed to individual patients.

(d) Home hemodialysis patients who receive any drugs or devices pursuant to subdivision (c) shall have completed a full course of home training given by a renal dialysis center accredited by the State Department of Health. The physician and surgeon prescribing the hemodialysis products shall submit proof satisfactory to the manufacturer or wholesaler that the patient has completed such program.

4223. Container labels

(a) Except as provided in subdivision (b) of this section, no person shall dispense any dangerous drug upon prescription except in a container correctly labeled with the information required by Sections 4047.5 and 4048.

(b) Physicians, dentists, podiatrists, and veterinarians, and pharmacists acting within the scope of a project authorized under Article 18 (commencing with Section 429.70) of Chapter 2 of Part 1 of Division 1 of the Health and Safety Code, or registered nurses acting within the scope of a project authorized under Article 18 (commencing with Section 429.70) of Chapter 2 of Part 1 of Division 1 of the Health and Safety Code, or physician's assistants acting within the scope of a project authorized under Article 18 (commencing with Section 429.70) of Chapter 2 of Part 1 of Division 1 of the Health and Safety Code, may personally furnish any dangerous drug prescribed by them to the patient for whom prescribed, provided that such drug is properly labeled to show all information required in Sections 4047.5 and 4048 except the prescription number.

4229.5. Refilling prescription when prescriber is unavailable

A prescription for a dangerous drug may be refilled without the prescriber's authorization if the prescriber is unavailable to authorize the refill and if, in the pharmacist's professional judgment, failure to refill the prescription might present an immediate hazard to the patient's health and welfare or might result in intense suffering. The pharmacist shall refill only a reasonable amount sufficient to maintain the patient until the prescriber can be contacted. The pharmacist shall note on the reverse side of the prescription the date and quantity of the refill and that the prescriber was not available and the basis for his judgment to refill the prescription without the prescriber's authorization. The pharmacist shall inform the patient that the prescription was refilled without the prescriber's authorization, indicating that the prescriber was not available and that, in the pharmacist's professional judgment, failure to provide the drug might result in an immediate hazard to the patient's health and welfare or might result in intense suffering. The pharmacist shall inform the prescriber within a reasonable period of time. Prior to refilling a prescription pursuant to this section, the pharmacist shall make every reasonable effort to contact the prescriber.

The prescriber shall not incur any liability as the result of a refilling of a prescription pursuant to this section.

4230. Possession of drug without prescription

No person shall have in possession any preparation included in subdivision (a) or (c) of Section 4211 except that furnished to such person upon the prescription of a physician, dentist, * * * podiatrist, or veterinarian, or pharmacist acting within the scope of a project authorized under Article 18 (commencing with Section 429.70) of Chapter 2 of Part 1 of Division 1 of the Health and Safety Code, or registered nurse acting within the scope of a project authorized under Article 18 (commencing with Section 429.70) of Chapter 2 of Part 1 of Division 1 of the Health and Safety Code, or physician's assistant acting within the scope of a project authorized under Article 18 (commencing with Section 429.70) of Chapter 2 of Part 1 of Division 1 of the Health and Safety Code. The provisions of this section do not apply to the possession of any drug defined in subdivision (a) or (c) of Section 4211 by a manufacturer or wholesaler or a pharmacy or physician or * * * podiatrist or dentist or veterinarian or laboratory or [illegible] authorized [illegible]

18 (commencing with Section 429.70) of Chapter 2 of Part 1 of Division 1 of the Health and Safety Code, or registered nurse acting within the scope of a project authorized under Article 18 (commencing with Section 429.70) of Chapter 2 of Part 1 of Division 1 of the Health and Safety Code, or physician's assistant acting within the scope of a project authorized under Article 18 (commencing with Section 429.70) of Chapter 2 of Part 1 of Division 1 of the Health and Safety Code when in stock in containers correctly labeled with the name and address of the supplier or producer.

4231. Inspection of stock

All stock of any dangerous drug of a manufacturer, wholesaler, pharmacy, physician, dentist, podiatrist, or veterinarian, or pharmacist acting within the scope of a project authorized under Article 18 (commencing with Section 429.70) of Chapter 2 of Part 1 of Division 1 of the Health and Safety Code, or registered nurse acting within the scope of a project authorized under Article 18 (commencing with Section 429.70) of Chapter 2 of Part 1 of Division 1 of the Health and Safety Code, or physician's assistant acting within the scope of a project authorized under Article 18 (commencing with Section 429.70) of Chapter 2 of Part 1 of Division 1 of the Health and Safety Code, laboratory, shipments through a customs broker or carrier shall be at all times during business hours open to inspection by authorized officers of the law.

4232. Inspection of records; current inventory; offenses

All records of manufacture and of sale, purchase or disposition of dangerous drugs shall be at all times, during business hours, open to inspection by authorized officers of the law, and shall be preserved for at least three years from the date of making. A current inventory shall be kept by every manufacturer, wholesaler, pharmacy, physician, dentist, podiatrist or veterinarian, or pharmacist acting within the scope of a project authorized under Article 18 (commencing with Section 429.70) of Chapter 2 of Part 1 of Division 1 of the Health and Safety Code, or registered nurse acting within the scope of a project authorized under Article 18 (commencing with Section 429.70) of Chapter 2 of Part 1 of Division 1 of the Health and Safety Code, or physician's assistant acting within the scope of a project authorized under Article 18 (commencing with Section 429.70) of Chapter 2 of Part 1 of Division 1 of the Health and Safety Code, laboratory, clinic, hospital, institution, or establishment holding a currently valid and unrevoked certificate, license, permit, registration or exemption under Division 2 (commencing with Section 1200) of the Health and Safety Code or under Part 3 (commencing with Section 1620) of Division 2 of, Chapter 2 (commencing with Section 2390) of Division 3 of, or Part 2 (commencing with Section 5699) of Division 6 of, the Welfare and Institutions Code who maintains a stock of dangerous drugs.

Any person who fails, neglects, or refuses to maintain such records or who, when called upon by an authorized officer or a member of the board, fails, neglects or refuses to produce such records within a reasonable time,

or who willfully produces or furnishes records which are false, is guilty of a misdemeanor.

4235. Violation; offense

Every person who violates any provision of this article other than Section 4230 or Section 4227 insofar as sections relate to any preparation included in subdivision (a) or (c) of Section 4211, is guilty of a misdemeanor.

4390. Forgery of prescription; offense; punishment

Every person who signs the name of another, or of a fictitious person, or falsely makes, alters, forges, utters, publishes, passes, or attempts to pass as genuine, any prescription for any drugs is guilty of a forgery and upon conviction thereof shall be punished by imprisonment in the state prison, or by imprisonment in the county jail for not more than 1 year.

Every person who has in his possession any drugs secured by such forged prescription shall be punished by imprisonment in the state prison for not less than one year nor more than six years, or by imprisonment in the county jail for not more than one year.

4390.5. False representation as physician to obtain prescription drugs

Every person who, in order to obtain any drug or poison, falsely represents himself to be a physician or other person who can lawfully prescribe such drug, or falsely represents that he is acting on behalf of a person who can lawfully prescribe such drug or poison, in a telephone communication with a registered pharmacist, shall be punished by imprisonment in the county jail for not more than one year.

EXCERPTS FROM THE PENAL CODE

CHAPTER 4.5. PEACE OFFICERS

830.3. Particular officers

(a) The Deputy Director, assistant directors, chiefs, assistant chiefs, special agents, and narcotics agents of the Department of Justice, and such investigators who are so designated by the Attorney General, are peace officers.

The authority of any such peace officer extends to any place in the state as to a public offense committed or which there is probable cause to believe has been committed within the state.

(b) Any inspector or investigator regularly employed and paid as such in the office of a district attorney is a peace officer.

The authority of any such peace officer extends to any place in the state:

(1) As to any public offense committed, or which there is probable cause to believe has been committed, within the county which employs him; or

(2) Where he has the prior consent of the chief of police, or person authorized by him to give such consent, if the place is within a city or of the sheriff, or person authorized by him to give such consent, if the place is within a county; or

(3) As to any public offense committed or which there is probable cause to believe has been committed in his presence, and with respect to which there is immediate danger to person or property, or of the escape of the perpetrator of such offense.

CHAPTER 5c. CITATIONS FOR MISDEMEANORS

853.5. Infractions; release procedures

Except as otherwise provided by law, in any case in which a person is arrested for an offense declared to be an infraction, the person may be released according to the procedures set forth by this chapter for the release of persons arrested for an offense declared to be a misdemeanor.

853.6. Notice to appear; contents; bail; warrant

(a) In any case in which a person is arrested for an offense declared to be a misdemeanor and does not demand to be taken before a magistrate, such person may, instead of being taken before a magistrate, be released according to the procedures set forth by this chapter. If the arresting officer or his superior determines that the person should be released, such officer or superior shall prepare in duplicate a written notice to appear in court, containing the name and address of such person, the offense charged, and the time and place where and when such person shall appear in court. If the person is not released prior to being booked and the officer in charge of the booking determines that the person should

be released, such officer or superior shall prepare such written notice to appear in court.

(b) Unless waived by the person, the time specified in the notice to appear must be at least five (5) days after arrest.

(c) The place specified in the notice shall be the court of the magistrate before whom the person would be taken if the requirement of taking an arrested person before a magistrate were complied with, or shall be an officer authorized by such court to receive a deposit of bail.

(d) The officer shall deliver one copy of the notice to appear to the arrested person, and the arrested person, in order to secure release, must give his written promise so to appear in court by signing the duplicate notice which shall be retained by the officer. Thereupon the arresting officer shall forthwith release the person arrested from custody.

(e) The officer shall, as soon as practicable, file the duplicate notice with the magistrate specified therein. Thereupon the magistrate may fix the amount of bail which in his judgment, in accordance with the provisions of Section 1275 of the Penal Code, will be reasonable and sufficient for the appearance of the defendant and shall indorse upon the notice a statement signed by him in the form set forth in Section 815a of this code. The defendant may, prior to the date upon which he promised to appear in court, deposit with the magistrate the amount of bail thus set. Thereafter, at the time when the case is called for arraignment before the magistrate, if the defendant shall not appear, either in person or by counsel, the magistrate may declare the bail forfeited, and may in his discretion order that no further proceedings shall be had in such case, unless the defendant has been charged with violation of Section 374b or 374c of this code or of Section 13002 of the Health and Safety Code, or a violation punishable under Section 5008.7 of the Public Resources Code, and he has previously been convicted of a violation of such section or punishable under such section, except in cases where the magistrate finds that undue hardship will be imposed upon the defendant by requiring him to appear, the magistrate may declare the bail forfeited and order that no further proceedings shall be had in such case.

Upon the making of such order that no further proceedings be had, all sums deposited as bail shall forthwith be paid into the county treasury for distribution pursuant to Section 1463 of this code.

(f) No warrant shall issue on such charge for the arrest of a person who has given such written promise to appear in court, unless and until he has violated such promise or has failed to deposit bail, to appear for arraignment, trial or judgment, or to comply with the terms and provisions of the judgment, as required by law.

(g) The officer shall indicate on the notice to appear whether he desires the arrested person to be booked as defined in subdivision 21 of Section 7 of this code. In such event, the magistrate shall, before the proceedings are finally concluded, order the defendant to be booked by the arresting agency.

(h) A peace officer may use the written notice to appear procedure set forth in this section for any misdemeanor offense in which the officer has [illegible] Section 836 or in which he has taken custody

of a person pursuant to Section 847.

(i) If the arrested person is not released pursuant to the provisions of this chapter prior to being booked by the arresting agency, then at the time of booking the arresting officer, the officer in charge of such booking or his superior officer, or any other person designated by a city or county for this purpose shall make an immediate investigation into the background of the person to determine whether he should be released pursuant to the provisions of this chapter. Such investigation shall include, but need not be limited to, the person's name, address, length of residence at that address, length of residence within this state, marital and family status, employment, length of that employment, prior arrest record, and such other facts relating to the person's arrest which would bear on the question of his release pursuant to the provisions of this chapter.

(j) Whenever any person is arrested by a peace officer for a misdemeanor, other than an offense described in subdivision (b) of Section 11357 or subdivision (c) of Section 11360 of the Health and Safety Code, and is not released with a written notice to appear in court pursuant to this chapter, the arresting officer shall indicate, on a form to be established by his employing law enforcement agency, which of the following was a reason for such nonrelease:

(1) The person arrested was so intoxicated that he could have been a danger to himself or to others.

(2) The person arrested required medical examination or medical care or was otherwise unable to care for his own safety.

(3) The person was arrested for one or more of the offenses listed in Section 40302 of the Vehicle Code.

(4) There were one or more outstanding arrest warrants for the person.

(5) The person could not provide satisfactory evidence of personal identification.

(6) The prosecution of the offense or offenses for which the person was arrested or the prosecution of any other offense or offenses would be jeopardized by immediate release of the person arrested.

(7) There was a reasonable likelihood that the offense or offenses would continue or resume, or that the safety of persons or property would be imminently endangered by release of the person arrested.

(8) The person arrested demanded to be taken before a magistrate or refused to sign the notice to appear.

(9) Any other reason, which shall be specifically stated on the form by the arresting officer.

Such form shall be filed with the arresting agency as soon as practicable and shall be made available to any party having custody of the arrested person, subsequent to the arresting officer, and to any person authorized by law to release him from custody before trial.

Chapter 2.5. Special Proceedings in Narcotics and Drug Abuse Cases

1000. (a) This chapter shall apply whenever a case is before any court upon an accusatory pleading for violation of Section 11350, 11357, 11361,

11365, 11377, or 11550 of the Health and Safety Code, or Section 11358 of the Health and Safety Code if the marijuana planted, cultivated, harvested, dried, or processed is for personal use, or Section 381 or subdivision (f) of Section 647 of the Penal Code, if for being under the influence of a controlled substance, or Section 4230 of the Business and Professions Code, and it appears to the district attorney that, except as provided in subdivision (b) of Section 11357 of the Health and Safety Code, all of the following apply to the defendant:

(1) The defendant has no conviction for any offense involving controlled substances prior to the alleged commission of the charged divertible offense.

(2) The offense charged did not involve a crime of violence or threatened violence.

(3) There is no evidence of a violation relating to narcotics or restricted dangerous drugs other than a violation of the sections listed in this subdivision.

(4) The defendant's record does not indicate that probation or parole has ever been revoked without thereafter being completed.

(5) The defendant's record does not indicate that he has been diverted pursuant to this chapter within five years prior to the alleged commission of the charged divertible offense.

(6) The defendant has no prior felony conviction within five years prior to the alleged commission of the charged divertible offense.

(b) The district attorney shall review his file to determine whether or not paragraphs (1) to (6), inclusive, of subdivision (a) are applicable to the defendant. If the defendant is found ineligible, the district attorney shall file with the court a declaration in writing or state for the record the grounds upon which the determination is based, and shall make this information available to the defendant and his attorney.

1000.1. (a) If the district attorney determines that this chapter may be applicable to the defendant, he shall advise the defendant and his attorney in writing of such determination. This notification shall include:

(1) A full description of the procedures of diversionary investigation.

(2) A general explanation of the roles and authorities of the probation department, the district attorney, the community program, and the court in the diversion process.

(3) A clear statement that the court may decide in a hearing not to divert the defendant and that he may have to stand trial for the alleged offense.

(4) A clear statement that should the defendant fail in meeting the terms of his diversion, or should he be convicted of a misdemeanor which reflects the divertee's propensity for violence, or should the divertee be convicted of any felony, he may be required, after a court hearing, to stand trial for the original alleged offense.

(5) An explanation of criminal record retention and disposition resulting from participation in the diversion and the divertee's rights relative to answering questions about his arrest and diversion following successful completion of the diversion program.

(b) If the defendant consents and waives his right to a speedy trial the district attorney shall refer the case to the probation department. The probation department shall make an investigation and take into consideration the defendant's age, employment and service records, educational background, community and family ties, prior controlled substance use, treatment history, if any, demonstrable motivation and other mitigating factors in determining whether the defendant is a person who would be benefited by education, treatment, or rehabilitation. The probation department shall also determine which community programs the defendant would benefit from and which of those programs would accept the defendant. The probation department shall report its findings and recommendation to the court.

(c) No statement, or any information procured therefrom, made by the defendant to any probation officer or drug treatment worker, which is made during the course of any investigation conducted by the probation department or drug treatment program pursuant to subdivision (b), and prior to the reporting of the probation department's findings and recommendations to the court, shall be admissible in any action or proceeding brought subsequent to the investigation.

No statement, or any information procured therefrom, with respect to the specific offense with which the defendant is charged, which is made to any probation officer or drug program worker subsequent to the granting of diversion, shall be admissible in any action or proceeding.

In the event that diversion is either denied, or is subsequently revoked once it has been granted, neither the probation investigation nor statements or information divulged during that investigation shall be used in any sentencing procedures.

1000.2. The court shall hold a hearing and, after consideration of the probation department's report and any other information considered by the court to be relevant to its decision, shall determine if the defendant consents to further proceedings under this chapter and waives his right to a speedy trial and if the defendant should be diverted and referred for education, treatment, or rehabilitation. If the court does not deem the defendant a person who would be benefited by diversion, or if the defendant does not consent to participate, the proceedings shall continue as in any other case.

At such time that a defendant's case is diverted, any bail bond or undertaking, or deposit in lieu thereof, on file by or on behalf of the defendant shall be exonerated, and the court shall enter an order so directing.

The period during which the further criminal proceedings against the defendant may be diverted shall be for no less than six months nor longer than two years. Progress reports shall be filed by the probation department with the court not less than every six months.

1000.3. If it appears to the probation department that the divertee is performing unsatisfactorily in the assigned program, or that the divertee is not benefiting from education, treatment, or rehabilitation, or that the divertee has engaged in criminal misconduct which reflects the divertee's pro-

to the divertee, the court shall hold a hearing to determine whether the criminal proceedings should be reinstituted. If the court finds that the divertee is not performing satisfactorily in the assigned program, or that the divertee is not benefiting from diversion, or the court finds that the divertee has been convicted of a crime as indicated above, the criminal case shall be referred back to the court for resumption of the criminal proceedings. If the divertee has performed satisfactorily during the period of diversion, at the end of the period of diversion, the criminal charges shall be dismissed.

1000.4. This chapter shall remain in effect until January 1, 1979, and on such date is repealed.

1000.5. Any record filed with the Department of Justice shall indicate the disposition in those cases diverted pursuant to this chapter. Upon successful completion of a diversion program the arrest upon which the diversion was based shall be deemed to have never occurred. The divertee may indicate in response to any question concerning his prior criminal record that he was not arrested or diverted for such offense. A record pertaining to an arrest resulting in successful completion of a diversion program shall not, without the divertee's consent, be used in any way which could result in the denial of any employment, benefit, license, or certificate.

1203.03. (a) In any case in which a defendant is convicted of an offense punishable by imprisonment in the state prison, the court, if it concludes that a just disposition of the case requires such diagnosis and treatment services as can be provided at a diagnostic facility of the Department of Corrections, may order that defendant be placed temporarily in such facility for a period not to exceed 90 days, with the further provision in such order that the Director of the Department of Corrections report to the court his diagnosis and recommendations concerning the defendant within the 90-day period.

(b) The Director of the Department of Corrections shall, within the 90 days, cause defendant to be observed and examined and shall forward to the court his diagnosis and recommendation concerning the disposition of defendant's case. Such diagnosis and recommendation shall be embodied in a written report and copies of the report shall be served only upon the defendant or his counsel, the probation officer, and the prosecuting attorney by the court receiving such report. After delivery of the copies of the report, the information contained therein shall not be disclosed to anyone else without the consent of the defendant. After disposition of the case, copies of the report, except the one delivered to the defendant or his counsel, shall be filed in a sealed file and shall be available thereafter only to the defendant or his counsel, the prosecuting attorney, the court, the probation officer, or the Department of Corrections.

(c) Notwithstanding subdivision (b), the probation officer may retain a copy of the report for the purpose of supervision of the defendant if the defendant is placed on probation by the court. The report and information contained therein shall not be disclosed to

else without the written consent of the defendant. Upon the completion or termination of probation, the copy of the report shall be returned by the probation officer to the sealed file prescribed in subdivision (b).

(d) The Department of Corrections shall designate the place to which a person referred to it under the provisions of this section shall be transported. After the receipt of any such person, the department may return the person to the referring court if the director of the department, in his discretion, determines that the staff and facilities of the department are inadequate to provide such services.

(e) The sheriff of the county in which an order is made placing a defendant in a diagnostic facility pursuant to this section, or any other peace officer designated by the court, shall execute the order placing such defendant in the center or returning him therefrom to the court. The expense of such sheriff or other peace officer incurred in executing such order is a charge upon the county in which the court is situated.

(f) It is the intention of the Legislature that the diagnostic facilities made available to the counties by this section shall only be used for the purposes designated and not in lieu of sentences to local facilities.

(g) Time spent by a defendant in confinement in a diagnostic facility of the Department of Corrections pursuant to this section or as an outpatient or inpatient of the California Rehabilitation Center shall be credited on the term of imprisonment in state prison, if any, to which defendant is sentenced in the case.

(h) In any case in which a defendant has been placed in a diagnostic facility pursuant to this section and, in the course of his confinement, he is determined to be suffering from a remediable condition relevant to his criminal conduct, the department may, with the permission of defendant, administer treatment for such condition. If such treatment will require a longer period of confinement than the period for which defendant was placed in the diagnostic facility, the Director of Corrections may file with the court which placed defendant in the facility a petition for extension of the period of confinement, to which shall be attached a writing signed by defendant giving his consent to the extension. If the court finds the petition and consent in order, it may order the extension, and transmit a copy of the order to the Director of Corrections.

1203.07. (a) Notwithstanding the provisions of Section 1203, probation shall not be granted to, nor shall the execution or imposition of sentence be suspended for, any of the following persons:

(1) Any person who is convicted of violating Section 11351 of the Health and Safety Code by possessing for sale one-half ounce or more of a substance containing heroin.

(2) Any person who is convicted of violating Section 11352 of the Health and Safety Code by selling or offering to sell one-half ounce or more of a substance containing heroin.

(3) Any person convicted of violating Section 11351 of the Health and Safety Code by possessing heroin for sale or convicted of violating Section 11352 of the Health and Safety Code by selling or offering to sell heroin, and who has one or more prior convictions for violating Section 11351 or

Section 11352 of the Health and Safety Code.

(b) The existence of any fact which would make a person ineligible for probation under subdivision (a) shall be alleged in the information or indictment, and either admitted by the defendant in open court, or found to be true by the jury trying the issue of guilt or by the court where guilt is established by plea of guilty or nolo contendere or by trial by the court sitting without a jury.

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Penalties	SB 65 (1979)	Federal Controlled Substances Act	HB 549 (1978)	Existing AK. LAW	Uniform Act	Hawaii Law
Delivery of Amphetmines to Minors (Parr Sch. II)	0 – life / $25,000	0 – 10 yrs. / $30,000 } 1st. 0 – 15 yrs. / $45,000 } 2nd.	0 – 15 yrs / $20,000 5 yr. presumptive sentence for 1st.	0 – Life / $25,000	If defendant is 18 or older and minor is 18 or under and 3 yrs. his junior, authorized prison penalties are doubled	If minor is three yrs. Defendant's junior = 20 yrs / $10,000
Delivery of Hallucinogens to Minors (Parr Sch. II)	0 – life / $25,000	0 – 10 yrs. / $30,000 } 1st. 0 – 15 yrs. / $45,000 } 2nd.	0 – 7 yrs. / $10,000 2 yr. presumptive sentence for 1st.	0 – Life / $25,000	If defendant is 18 or older AND minor is 18 or under and 3yrs. his junior, Authorized imprisonment penalties are doubled.	If minor is Three yrs. Defendant's junior = 20 yrs / $10,000
Delivery of methaqualones to Minors (Parr Sch. II)	0 – life $25,000	0 – 10 yrs. / $30,000 } 1st. 0 – 15 yrs. / $45,000 } 2nd.			If defendant is 18 or older AND minor is 18 or under and 3yrs. his junior, Authorized imprisonment penalties are doubled.	If minor is Three yrs. Defendant's junior = 20 yrs. / $10,000

Penalties	SB 65 (1979)	Federal Controlled Substances Act	HB 549 (1978)	Existing AK. Law	Uniform Act	Hawaii Law
Delivery of Valium to Minors Parr Sch. IV)	0 – life / $25,000	0-6yrs. / $20,000 } 1st. 0 – 9yrs. / $30,000 } 2nd.			If defendant is 18yrs. or older AND minor is 18 or under AND 3yrs. his junior, authorized imprisonment penalties are doubled.	If minor is three yrs. Defendant's junior = 20 yrs. / $10,000
Delivery of Hash, Hash oil to Minors Parr Sch. IV) Hawaii-Sch. III)			0-7yrs. / $10,000 2yr. presumptive sentence 1st.		If defendant is 18 yrs. or older AND minor is 18 or under AND 3yrs. his junior authorized imprisonment penalties are doubled.	If minor is three yrs. Defendant's junior = 20 yrs. / $10,000

Penalties	SB 65 (1979)	Federal Controlled Substances Act	H.B. 549 (1978)	Existing AK. LAW	Uniform Act	Hawaii LAW
Possession of Amphetamines (Parr Sch. II)	0-1 yr. / $1000	0-1 yr. / $5000 1st. 0-2 yr. / $10,000 2nd. If no prior convictions conditional discharge is permitted.	0-1 yr. / $10,000 - 1st. 0-2 yr. / $10,000 - 2nd. $2,000 presumptive for 1st. 3 months presumptive for 2nd.	0-1 yr. / $1000	Misdemeanor	If 2 oz. or more: 20 yrs. / $10,000 If 50 caps or more or 1/2 oz. or more: 10 yrs. / $10,000 If less than Above: 5 yrs. / $5000
Possession of Hallucinogens (Parr Sch. II)	0-1 yr. / $1000	0-1 yr. / $5000 1st. 0-2 yr. / $10,000 2nd. If no prior convictions conditional discharge is permitted.	0-1 yr. / $2000 $1,000 presumptive sentence	0-1 yr. / $1000	Misdemeanor	SAME AS Amphetamines
Possession of Methaqualones (Parr Sch. II)	0-1 yr. / $1000	0-1 yr. / $500 1st. 0-2 yr. / $10,000 2nd If no prior convictions conditional discharge is permitted.			Misdemeanor	SAME AS Amphetamines
Possession of Valium (Parr Sch. IV)	0-1 yr. / $1000	0-1 yr. / $5000 1st. 0-2 yr. / $10,000 2nd If no prior convictions conditional discharge is permitted			Misdemeanor	If 400 caps or more: 20 yrs / $10,000 If 50 caps. or more: 10 yrs. / $10,000 If less than above: 1 yr. / $1000

Penalties	SB 65 (1979)	Federal Controlled Substances Act	H.B. 549 (1978)	Existing AK. LAW	Uniform Act	Hawaii Law
Possession of Hash, Hash oil (Parr Sch. IV) (Hawaii-Sch. III)		0-1 yr./$5000 1st. 0-2 yr./$10,000 2nd. If no prior convictions conditional discharge is permitted.	0-1 yr./$2000 $1,000 presumptive sentence		Misdemeanor	If 400 or more cigs. OR 1 oz or more: 20 yrs/$ If 50 or more cigs or 1/8 oz or more: 10 yrs/$10,000 If less than above: 1 yr./$1000

USAGE PATTERNS OF SCHEDULE II SEDATIVE - HYPNOTICS IN WISCONSIN AND THE U.S.

Report of Special Meeting

May, 1979

Wisconsin Controlled Substances Board

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I About the Controlled Substances Board

The Controlled Substances Board is a six-member statutory Board, created in 1969 to administer portions of the Uniform Controlled Substances Act. The Board is Wisconsin's scheduling authority and it issues controlled substances possession authorizations for researchers, teaching institutions, analytical laboratories and other special applications. The Board is advisory to the State Methadone Authority and conducts regular symposia to focus attention on specialized drug abuse topics. Symposia have been held on methadone, narcotic antagonists, the role of law in the social control of drugs, and on distribution patterns of prescription amphetamines.

Membership of the Board includes:

- Darold A. Treffert, M.D.; psychiatrist member, and Chairman; Director, Winnebago Mental Health Institute.

- Karl Marquardt, R.Ph., Vice Chairman; Executive Secretary of the Pharmacy Examining Board and representing Chairman D. Jack Myers.

- Donald E. Percy, Secretary, Department of Health and Social Services.

- John W. Calhoun, Assistant Attorney General; representing Attorney General Bronson LaFollette.

- Donald Willett, Director, Bureau of Laboratory Services, Department of Agriculture, Trade and Consumer Protection; representing Secretary Gary Rohde.

- June Dahl, Ph.D., pharmacologist member; Assistant Professor of Pharmacology, University of Wisconsin.

The Board is attached to the Department of Health and Social Services. Staff services are provided by the Bureau of Alcohol and Other Drug Abuse, Larry W. Monson, ACSW, Director.

II

Special Meeting

Usage Patterns of Schedule II
Sedative-Hypnotics in Wisconsin and the U.S.

Wednesday, March 21, 1979
Training Center, Gordon Hall
Winnebago Mental Health Institute
Winnebago, Wisconsin

PROGRAM

9:00 Registration

9:30 Welcome, Background, Introductory Remarks

- Darold A. Treffert, M.D.
  Chairman, Controlled Substances Board
  Director, Winnebago Mental Health Institute

- Larry W. Monson, ACSW
  Director, Bureau of Alcohol and Other Drug Abuse

- Robert T. Angarola
  Assistant Director, Domestic Policy Staff, The White House

10:30 Distribution Patterns of Sedative-Hypnotics in Wisconsin and the U.S.

- David E. Joranson, MSSW
  Drug Abuse Program Policy Specialist
  Bureau of Alcohol and Other Drug Abuse

12:00 Lunch

1:00 Reactor Panel and Discussion of Data, Implications for Wisconsin Policy and Programs

- Paul Bjerke
  Pharmacy Examining Board

- Ralph Paulick
  Wisconsin Pharmacy Association

- Darold Treffert, M.D.
  President-elect, State Medical Society

- Rudolph W. Link, M.D.
  Medical Examining Board

3:30 Adjourn

III Participants

1. Lee Ames; Upjohn Co.; Chicago, Illinois
2. Gary Andersen; U.S. Drug Enforcement Administration; Milwaukee, Wisconsin
3. Robert Angarola; Domestic Policy Staff, The White House; Washington, D.C.
4. Dan Bay; Unified Health Services Board of Outagamie County; Appleton, Wisconsin
5. Paul Bjerke; Pharmacy Examining Board; Madison, Wisconsin
6. Herb Boll; Brown County Mental Health Center; Green Bay, Wisconsin
7. Debi Bowen, MSSW; Bureau of Alcohol and Other Drug Abuse; Madison, Wisconsin
8. Dick Briggs; Brown County
9. Gail Briggs; Outagamie County
10. John W. Calhoun; Controlled Substances Board and Department of Justice; Madison, Wisconsin
11. Paul Cushman, Jr., M.D.; Department of Pharmacology, Medical College of Wisconsin and Wisconsin Alcoholism and Drug Abuse Research Institute; Milwaukee, Wisconsin
12. June Dahl, Ph.D.; Controlled Substances Board and Department of Pharmacology, University of Wisconsin; Madison Wisconsin
13. Frank Dolejsi; Crime Lab; Madison, Wisconsin
14. Scott Ewert; Alcohol and Drug Council of Kenosha County; Kenosha, Wisconsin
15. James A. Ferguson, DVM, Ph.D.; Office of Medical and Professional Affairs, National Institute on Drug Abuse; Washington, D.C.
16. Ron Frederick; Kenosha County Comprehensive Board; Kenosha, Wisconsin
17. Susan Fredlund; Department of Public Instruction; Madison, Wisconsin
18. Karen Gillespie; PraCon Incorporated; Vienna, Virginia
19. Mark Goff; Mental Health Planning Council; Milwaukee, Wisconsin
20. James Halikas, M.D.; Wisconsin Alcoholism and Drug Abuse Research Institute; Milwaukee, Wisconsin
21. J. J. Hannon; U.S. Drug Enforcement Administration; Chicago, Illinois
22. E. Johnson, M.D.; Brown County Mental Health Center; Green Bay, Wisconsin
23. David Joranson, MSSW; Bureau of Alcohol and Other Drug Abuse; Madison, Wisconsin
24. Paul Keys; Division of Community Services; Madison, Wisconsin
25. Allen Liegel; Department of Pharmacy, University of Wisconsin; Madison, Wisconsin
26. Rudolph Link, M.D.; Medical Examining Board; Madison, Wisconsin
27. Karl Marquardt, R. Ph.; Controlled Substances Board; Madison, Wisconsin
28. Philip McCullough, ACSW; Bureau of Alcohol and Other Drug Abuse; Madison, Wisconsin
29. Larry Monson, ACSW; Bureau of Alcohol and Other Drug Abuse; Madison, Wisconsin
30. Jack Myers; Pharmacy Examining Board; Madison, Wisconsin
31. Tony Novello; Sandoz; Cleveland, Ohio
32. James Pacella; U.S. Drug Enforcement Administration; Washington, D.C.
33. Ralph Paulick; Wisconsin Pharmaceutical Association; Madison, Wisconsin
34. Liz Plotkin, MSSW; Bureau of Alcohol and Other Drug Abuse; Madison, Wisconsin
35. Mary Reddin; Medical Examining Board; Madison, Wisconsin
36. Paul Schanen; Brown County Mental Health Center; Green Bay, Wisconsin
37. Darold Treffert, M.D.; Controlled Substances Board and Winnebago Mental Health Institute; Winnebago, Wisconsin
38. Alan White; Division of Health; Madison, Wisconsin
39. Donald Willett; Controlled Substances Board and Department of Agriculture, Trade and Consumer Protection; Madison, Wisconsin

IV Summary of Introductory Remarks

Darold A. Treffert, M.D.
Chairman, Controlled Substances Board
Director, Winnebago Mental Health Institute

Dr. Treffert described the Controlled Substances Board (CSB) and introduced the Board members. He briefly discussed the Board's last symposium which was on amphetamine usage in Wisconsin.

The scope of sedative-hypnotic usage was then reviewed. Sedative-hypnotics are largely taken for insomnia, by 15-20 million Americans. Dr. Treffert reviewed statistics on the reduction of these prescriptions in recent years. A large quantity of these controlled substances are diverted onto the street - "this is our concern today"; although fifty percent of these street drugs are stolen, the other half is from doctors' diversionary practices.

Barbiturates are a poor choice for inducing sleep. They produce a non-physiologic sleep, nightmares and agitation ("REM rebound" effect). Additionally, these drugs interfere with liver enzyme production. On the other hand, the benzodiazepines induce a more natural sleep and the likelihood of physical dependence is much less.

Dr. Treffert concluded by posing several questions to be explored today:

* Is there a problem with Schedule II sedative hypnotics in Wisconsin?
* If yes, is it widespread or limited to a few practitioners and pharmacists?
* Is diversion a large problem?
* Should the "remedy" be legislation, regulation or education?

Larry W. Monson, ACSW
Director, Bureau of Alcohol and Other Drug Abuse, Division of Community Services, Department of Health and Social Services (Single State Agency for Alcohol and Drug Abuse.)

Mr. Monson described the functions of the Bureau of Alcohol and Other Drug Abuse (BAODA), including the staff services it provides to CSB.

Mr. Monson commended the CSB and especially recognized Darold Treffert, Karl Marquardt and John W. Calhoun for their dedicated service on the Board since its beginnings.

The cooperative working relationship between federal and Wisconsin alcohol and other drug authorities was described and commended. Examples cited were the CSB monitoring of licit drug distribution as well as its monitoring of methadone maintenance programs in conjunction with BAODA and federal agencies. Gary Andersen, U.S. Drug Enforcement Administration, was introduced and recognized for his assistance with the sedative-hypnotic data.

Robert T. Angarola
Assistant Director, Domestic Policy Staff
The White House

Mr. Angarola discussed the drug problem from a federal perspective. He stated that the federal government is concerned with three areas of drug abuse policy: (1) international issues, (2) health issues (National Institute on Drug Abuse) and (3) enforcement (Drug Enforcement Administration).

In the White House, there is high interest on drug issues. One problem mentioned in President Carter's August 1977 message to Congress was physician overprescribing of barbiturates and other sedative-hypnotics.

Heroin, barbiturates and sedative-hypnotics are the major drug problems - these account for 90% of drug-related deaths. The White House has seen a curbing of the heroin problem and this success has led to optimism as far as sedative-hypnotic issues.

According to Mr. Angarola, the key to working through these problems is to work with the states (e.g., state-level regulatory boards). It is important to identify problem practitioners and investigate where necessary. Under the Controlled Substances Act, the major responsibility for regulation at the retail level lies with the states. Therefore, it is up to the federal government to work with the states, providing information, resources and training.

Ninety-eight percent of the time, drug prescribing problems are not an enforcement/criminal issue, but an education or regulatory issue. Some physicians and pharmacists are not keeping up with advancements in this area. An interagency group (including representatives of the Food and Drug Administration, National Institute on Drug Abuse, American Medical Association, Pharmaceutical Manufacturers Association and others) was formed to work together to promote the education of professionals and the strengthening of regulatory boards as well as professional groups (i.e., encouraging peer pressure measures). (David Joranson, BAODA, was present at one of these meetings.)

Wisconsin is a forerunner in getting people together in a non-threatening way and is to be commended for this; at the federal level, there seems to be distrust between regulatory and health professionals. Wisconsin amphetamine activity has acted as a basis for the actions taken by other states. Mr. Angarola stated that this is why he came to this Special Meeting. Wisconsin can and will serve as a model for utilizing Drug Enforcement Administration information. Wisconsin is unique as a state putting forth effort into this area

James A. Ferguson, D.V.M., Ph.D., Deputy Director
Office of Medical and Professional Affairs
National Institute on Drug Abuse

Mr. Ferguson expressed how impressed he is with Wisconsin's use of this data. He reviewed the National Institute on Drug Abuse (NIDA) report "Sedative-Hypnotic Drugs: Risks and Benefits".

Mr. Ferguson stated that prescriptions for all sedative-hypnotics is showing a decrease (except Flurazepam, or Dalmane) from 1977 to 1978. From 1971 to

1978, the number of prescriptions decreased 82% for barbiturate sedative-hypnotics and decreased 67% for nonbarbiturate sedative-hypnotics.

The increase in the number of sedative-hypnotic prescriptions has been halted and the trend is now downward; in Wisconsin, even Dalmane prescriptions are leveling off. This data is encouraging.

Far too many Americans use sedative-hynotics and for too long. There are "placebo effect" problems with barbiturates due to their known ineffectiveness over a period of time.

The NIDA report recommends a national education campaign for physicians and the public rather than taking these drugs off the market.

V Distribution Patterns of Sedative Hypnotics -

David E. Joranson, MSSW
Drug Abuse Program Policy Specialist
Bureau of Alcohol and Other Drug Abuse

"The Controlled Substances Board's first such data analysis project was in 1977, initially on purchases of but one amphetamine product - Biphetamine 20 - for only one strength - 20 milligrams - and for a period of one year.

Today's analysis is considerably more comprehensive and includes all products, and strengths in each general category of [illegible]al, pentobarbital, secobarbital and methaqualone, for a two year period. These drugs make up the class of Schedule II sedative-hypnotics that have high abuse potentials and accepted medical uses.

Most of today's materials and analysis have been developed using existing resources, specifically those of the Controlled Substances Board and the Bureau of Alcohol and Other Drug Abuse. Considerable time was spent in understanding, analyzing and preparing the data. I want to recognize the very valuable assistance contributed by Liz Plotkin and Debi Bowen.

The maps you will see were prepared by the University of Wisconsin Cartography Laboratory, on a small purchase order approved for this purpose by our Division Administrator, Dr. Len Ganser. In all, these maps cost approximately $600.

I want to emphasize the extremely valuable role of the Drug Enforcement Administration in providing this data, especially the special runs that Jim Pacella has provided us. Jim is head of the ARCOS unit in Washington, D.C.

Finally, I want to thank Gary Andersen, Compliance Investigator of the Milwaukee Resident Office of DEA for his ongoing assistance in analyzing and interpreting ARCOS information for the State of Wisconsin. The relation between Wisconsin and the Compliance and Regulatory functions of DEA is exemplary.

I want to caution everyone, including the press, that the following presentations must not be used as the exclusive basis for drawing conclusions as to the legitimacy of the use of drugs in any area of Wisconsin.

This presentation will be, for most of you, the first time you have ever seen such a detailed picture of these distribution patterns. You will see some unusual concentrations of certain drugs. We will look to our reactor panel this afternoon for insights into what these data mean, what positive trends and problems they see, and what actions may be needed, either of an educational, regulatory or enforcement nature - or, no action may be the best course in some instances. You will receive a copy of this presentation in the next few weeks.

There is a fair amount of material to present, so I would ask that we hold our discussion until this afternoon, but if you have clarification questions, please stop me.

In the distribution system for controlled substances, there are three possible distribution points which occur at the end of the system, at the community level, just before the drugs reach the ultimate user or consumer. The pharmacy distributes mainly to outpatient or nursing home patients, upon the order or prescription of a practitioner licensed to practice. The hospital distributes to inpatients or outpatients, also at the order of a practitioner. The practitioner may distribute to patients directly. This is called dispensing. All three, the pharmacy, hospital and practitioner order their drugs from the manufacturer or the distributor of their choice. For Schedule II drugs, a separate registration number must be obtained from DEA, and then all purchases are made on a triplicate order form, one copy of which finds its way back to Washington, D.C. and is programmed into ACROS. It is the analysis of these purchases that is the subject of this presentation.

I will follow a sequence in the presentation. First, I will describe the national pattern of distribution. Then, we'll move to the Wisconsin picture. For Wisconsin, I'll show you what accounts for the peaks of high per capita distribution by presenting profiles of the high purchases made by pharmacies, hospitals, or practitioners. Then I'll summarize the whole pattern, and go on to the next drug. I should point out that each area of high purchasing tends to draw attention as an area worthy of further study. There may or may not be any problem, however.

Let's start by looking at amobarbital. No United States distribution was prepared because, unfortunately, the aggregate data included dexamyl which is much more an amphetamine product even though it contains amobarbital.

(Mr. Joranson then presented charts, maps and graphs on distribution of amobarbital. They appear at the end of this section.)

Hospital total purchases were 31,500 dosage units, by 49 hospitals (of a total of 178 hospitals in Wisconsin). One hospital purchased 11,900, which was the highest hospital purchase. The average purchase was 642 dosage units.

Practitioner total purchases were 24,800 dosages, by 21 practitioners; 26% of these purchases come to zip area 549, the Fox River Valley, to two practitioners who dispense amobarbital. The average practitioner purchase was 1,180 dosages.

In Summary, the 1976-77 decrease of 37.8% for amobarbital in Wisconsin (including dexamyl) exceeds the national average decrease of 26.1% (also includes dexamyl). Decreases are largely among pharmacies, reflecting a decrease in physician prescribing. Hospital and practitioner purchases are decreasing too.

Questions are raised about: the high pharmacy purchases in northern Wisconsin; one large hospital utilization; and several large practitioner purchases. Compared to the upcoming description of other drugs, the overall baseline for distribution of amobarbital is low, but punctuated by several high peaks.

Now lets go to pentobarbital. Again, the national aggregate data is not presented because of the inclusion of veterinary use of pentobarbital.

(Mr. Joranson then presented charts, maps and graphs on distribution of pentobarbital. They appear at the end of this section.)

Hospitals total purchases of pentobarbital were 151,575 dosages by 118 hospitals, the largest purchase was 6,600 and the average was 1,284 dosages. Total purchases were nearly 5 times greater than hospital purchases of amobarbital. The average hospital purchase was twice as high as for amobarbital.

Practitioner total purchases were 138,600 dosages by 64 practitioners. The average purchase was 2,166, almost twice as high as the hospital average purchase. The highest purchase was 24,000 dosages.

In Summary, the 1976-77 decrease of 14.3% for pentobarbital in Wisconsin is less than the average national decrease of 23.7%. (These figures include pentobarbital for veterinary use.) Pharmacy decreases, which do not include veterinary use, dropped 31% during the same period, and is probably more accurate in describing Wisconsin's trend in prescribing pentobarbital. Overall purchases of pentobarbital are about 3 times as high as amobarbital.

Questions are raised about: a few moderately high pharmacy purchases; some high hospital utilization; and a very large practitioner purchase.

For secobarbital a national distribution is available, because the data is not "contaminated" by drugs of other classes or intended for non-human uses.

(Mr. Joranson presented the U.S. distribution of secobarbital; a U.S. surface map, and a rank order list, both of which appear at the end of this section.)

Within this distribution, Wisconsin ranks number 35. This means there are 34 states that have a higher per capita distribution of secobarbital than Wisconsin.

(Mr. Joranson then presented charts, maps and graphs of distribution of secobarbital in Wisconsin. They appear at the end of this section.)

The pharmacy purchases do not by themselves explain the high peaks, so we looked at practitioner purchases of secobarbital in the 549 area. (See Zip 549 graph of practitioner purchases of secobarbital.) Then, remembering earlier large amobarbital and pentobarbital purchases by practitioners in 549, we decided to aggregate all practitioner purchases. (See Zip 549 practitioner purchases of amobarbital, pentobarbital and secobarbital.)

Hospital total purchases were 167,550 dosages by 124 hospitals, average 1,351 dosages. Total purchases, number of hospitals and average purchases were all slightly ahead of pentobarbital.

Practitioner total purchases were 144,300 dosages by 64 practitioners. The average purchase was 2,255. The number of practitioners was equal to those purchasing pentobarbital, while total purchases and average purchases were slightly ahead of pentobarbital. There were several high purchases of 20,000 and 18,000 dosages, which you just saw aggregated in the zip area 549 graph.

In Summary, the 1976-77 trend in Wisconsin shows secobarbital decreasing by almost 40% compared to a national average decrease of 21%. Large decreases occured in pharmacy, hospital and practitioner purchases.

Questions are raised by: high pharmacy purchases in 532 Milwaukee area; several high pharmacy purchases, especially in the northwest; hospital utilization; and very high practitioner purchases in the 549 area, particularly when aggregated with amobarbital and pentobarbital.

For methaqualone, a national distribution is available too.

(Mr. Joranson presented the U.S. distribution of methaqualone, a U.S. surface map and a rank order list, both of which appear at the end of this section.)

Within this distribution, Wisconsin ranks number 33. This means there are 32 states that have a higher per capita distribution of methaqualone than Wisconsin.

(Mr. Joranson then presented charts, maps and graphs of distribution of methaqualone in Wisconsin. They appear at the end of this section.)

Fifty-one hospitals purchased 30,300 dosages for an average of 594 dosages. There was one large hospital purchase of 5,400 dosages.

Eighteen practitioners purchased 8,800 dosages for an average of 489. There were no notably high purchases, however dentists are among those purchasing methaqualone.

In Summary, the 1976-77 trend in Wisconsin shows methaqualone decreasing by 25% compared to a national average decrease of 21%. In spite of large increases in 537 pharmacy purchases, the state-wide trend appears to be declining rapidly enough to produce an overall state decrease. Questions are raised by the high prescribing of methaqualone in 537."

Mr. Joranson closed his remarks by again cautioning everyone not to draw conclusions solely on the basis of this data and urged the adoption of these techniques as a tool for problem analysis on a wider scale.

VI Maps and Charts

Figure 1 - Controlled Substances Monitoring System
Figure 2 - Wisconsin Zip Code Zone Centers

Amobarbital
Figure 3 - Amobarbital (gms.) - Wisconsin
Figure 4 - Wisconsin Distribution of Amobarbital - 1977
Figure 5 - Wisconsin Distribution of Amobarbital - 1977 - By Population Density
Figure 6 - Pharmacy Purchases of Amobarbital - 1977- Zip Zone 545

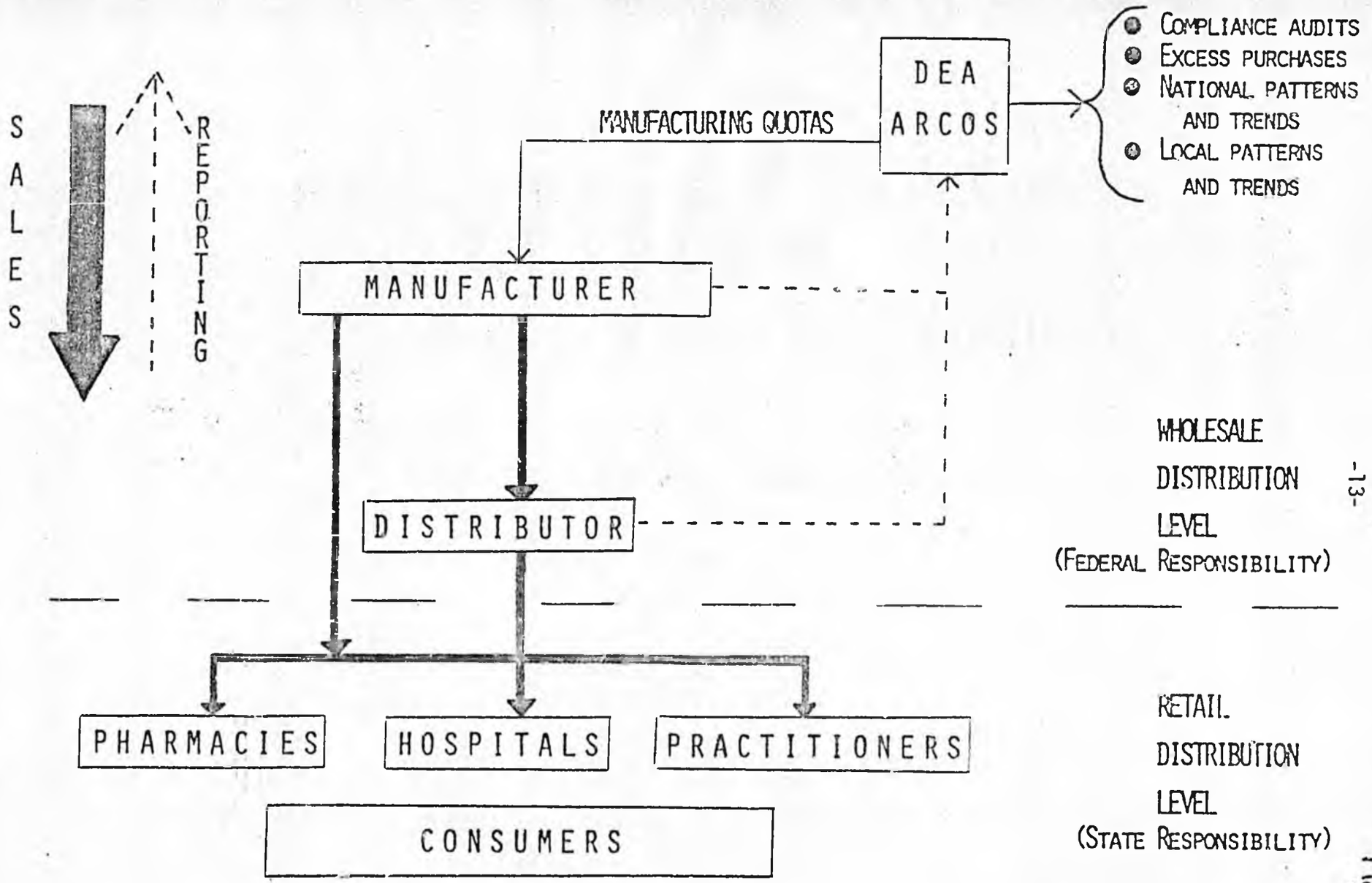
Pentobarbital
Figure 7 - Pentobarbital (gms.) - Wisconsin
Figure 8 - Wisconsin Distribution of Pentobarbital - 1977
Figure 9 - Wisconsin Distribution of Pentobarbital - 1977
Figure 10 - Pharmacy Purchases of Pentobarbital - 1977 - Zip Zone 538
Figure 11 - Pharmacy Purchases of Pentobarbital - 1977 - Zip Zone 540
Figure 12 - Pharmacy Purchases of Pentobarbital - 1977 - Zip Zone 549
Figure 13 - Pharmacy Purchases of Pentobarbital - 1977 - Zip Zone 532

Secobarbital
Figure 14 - U.S. Distribution of Secobarbital - 1977 - By Population Density
Figure 15 - U.S. Secobarbital Distribution to Retail Level - 1977
Figure 16 - Secobarbital (gms.) - Wisconsin
Figure 17 - Wisconsin Distribution of Secobarbital - 1977
Figure 18 - Wisconsin Distribution of Secobarbital - 1977 - By Population Density
Figure 19 - Pharmacy Purchases of Secobarbital - 1977 - Zip Zone 545
Figure 20 - Pharmacy Purchases of Secobarbital - 1977 - Zip Zone 532
Figure 21 - Pharmacy Purchases of Secobarbital - 1977 - Zip Zone 548
Figure 22 - Pharmacy Purchases of Secobarbital - 1977 - Zip Zone 549
Figure 23 - Practitioner Purchases of Secobarbital - 1977 - Zip Zone 549

Amobarbital, Pentobarbital and Secobarbital
Figure 24 - Practitioner Purchases of Amo-, Pento-, Seco-barbital - 1977 - Zip Zone 549

Methaqualone
Figure 25 - U.S. Distribution of Methaqualone - 1977 - By Population Density
Figure 26 - U.S. Methaqualone Distribution to Retail Level - 1977
Figure 27 - Methaqualone (gms.) - Wisconsin
Figure 28 - Wisconsin Distribution of Methaqualone - 1977
Figure 29 - Wisconsin Distribution of Methaqualone - 1977 - By Population Density
Figure 30 - Pharmacy Purchases of Methaqualone - 1977- Zip Zone 532
Figure 31 - Pharmacy Purchases of Methaqualone - 1977 - Zip Zone 549
Figure 32 - Pharmacy Purchases of Methaqualone - 1977 - Zip Zone 548
Figure 33 - Pharmacy Purchases of Methaqualone - 1977 - Zip Zone 537
Figure 34 - Pharmacy Purchases of Methaqualone, 300 mg. - in Zip Code Area 537 (Madison, Wisconsin) - 1975, 1976, 1977

CONTROLLED SUBSTANCES MONITORING SYSTEM*



*INCLUDES ALL DRUGS IN SCHEDULE I, II AND NARCOTICS IN III.

Figure 1

MARCH, 1978

Figure 2

WISCONSIN ZIP CODE ZONE CENTERS

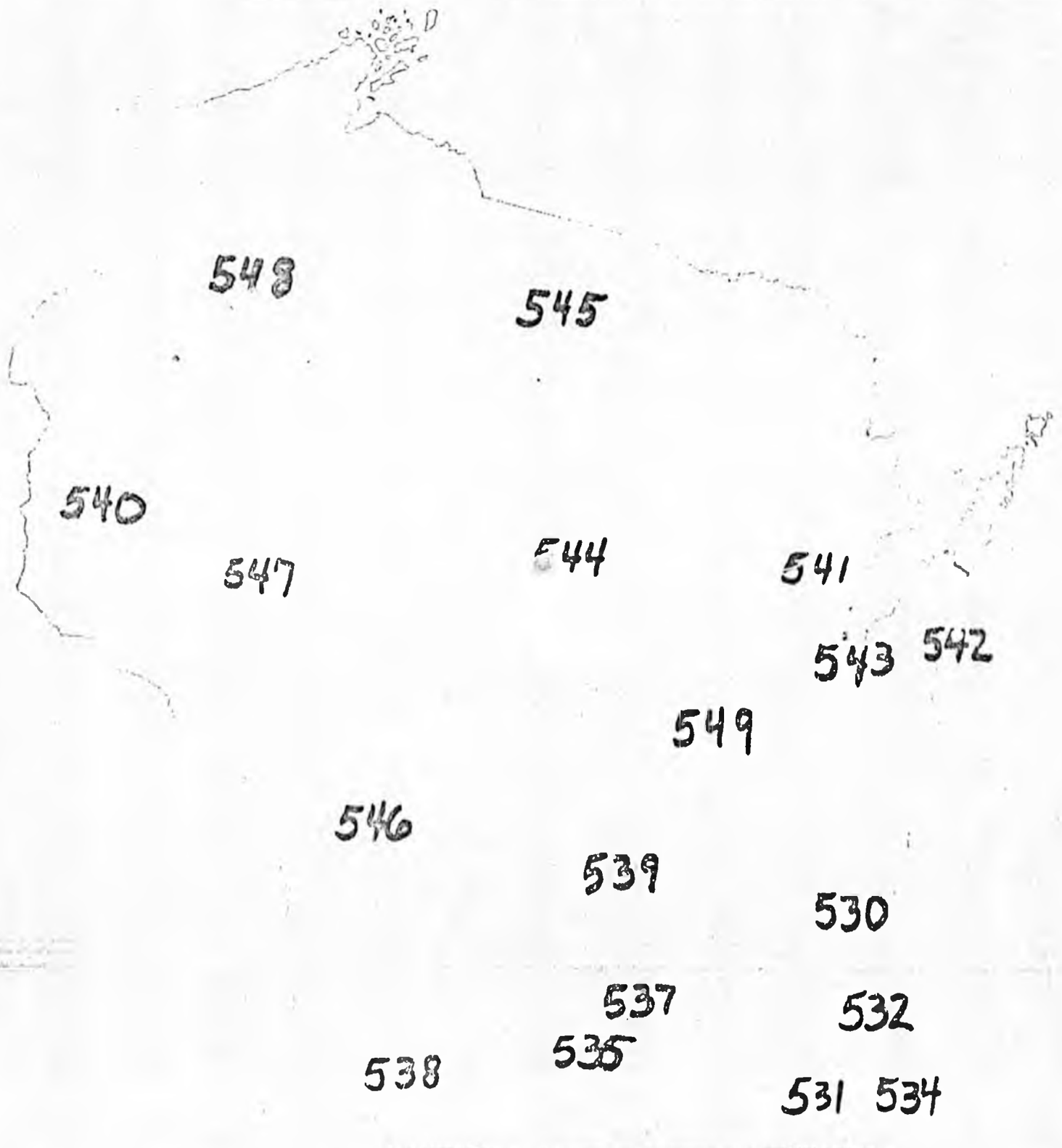


Figure 3

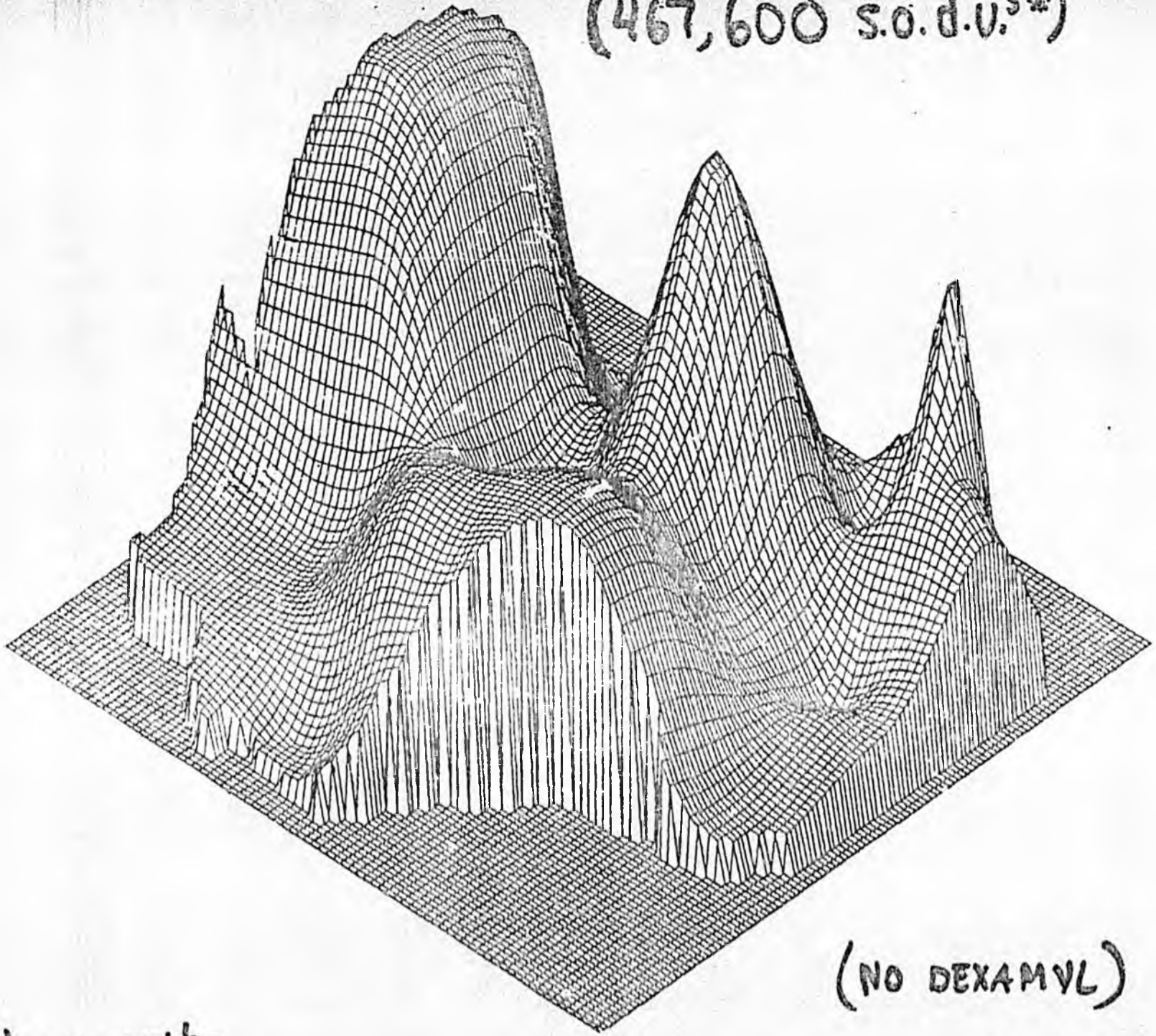
Amobarbital (gms.)-Wis.

	1976	1977	
Pharmacy	71,664	44,335	-38%
Hospital/Clinic	7,624	5,334	-30%
Practitioner	5,604	3,000	-47%
TOTAL	84,892	52,709*	
1976-1977 U.S. Trend	-26.1% (DEXAMYL)		
1976-1977 Wis. Trend	-37.8% (DEXAMYL)		

*includes Teaching Institution-40g

DISTRIBUTION OF AMOBARBITAL - 1971

(467,600 s.o.d.u.s*)



(NO DEXAMYL)

* solid oral dosage units

Figure 4

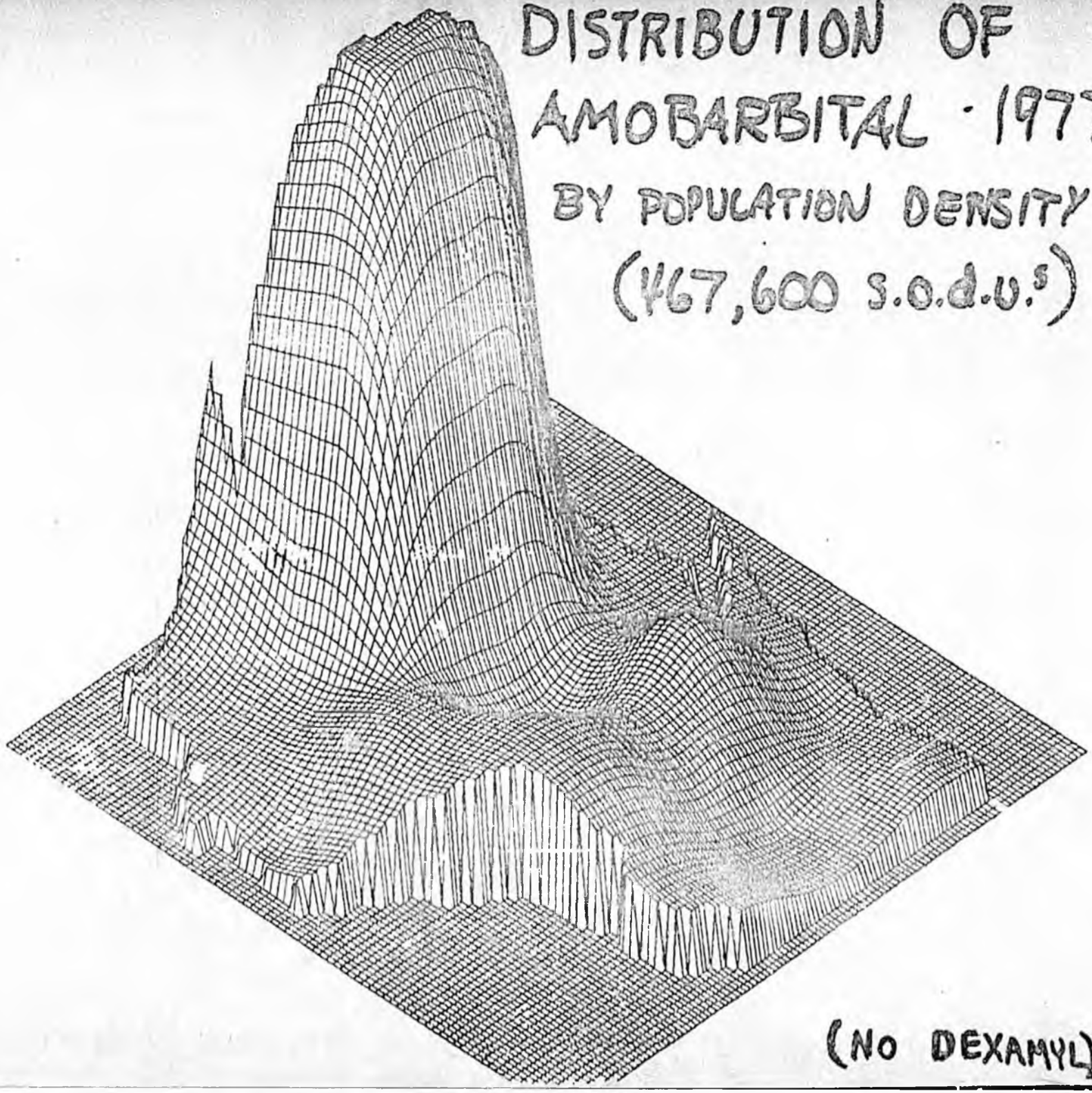
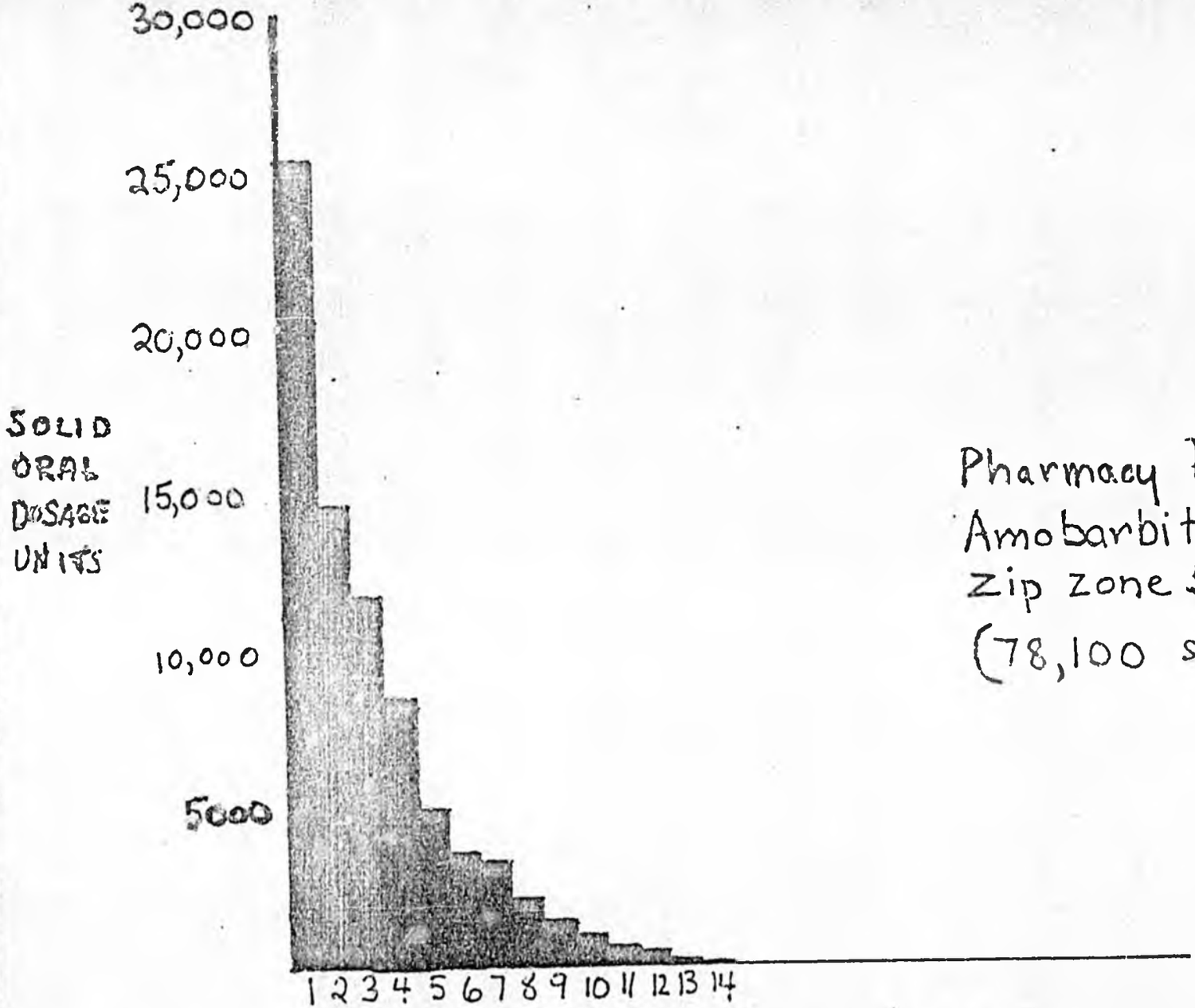

DISTRIBUTION OF
AMOBARBITAL · 1977
BY POPULATION DENSITY
(¥67,600 S.O.d.U.'s)
(NO DEXAMYL)

Figure 5



Pharmacy Purchases of Amobarbital, 1977, Zip zone 545 (78,100 s.d.u.s)

Figure 6

Figure 7

Pentobarbital (gms.)-Wis.

	1976	1977	
Pharmacy	92,295	63,246	-31%
Hospital/Clinic	23,123	19,546	-16%
Practitioner	58,575	64,930	+10.9%
TOTAL	173,990	147,722	
1976-1977 U.S. Trend	-23.7% (vet. use)		
1976-1977 Wis. Trend	-14.3% (vet. use)		

DISTRIBUTION OF PENTOBARBITAL
1977
(1,010,750 s.d.u.'s)

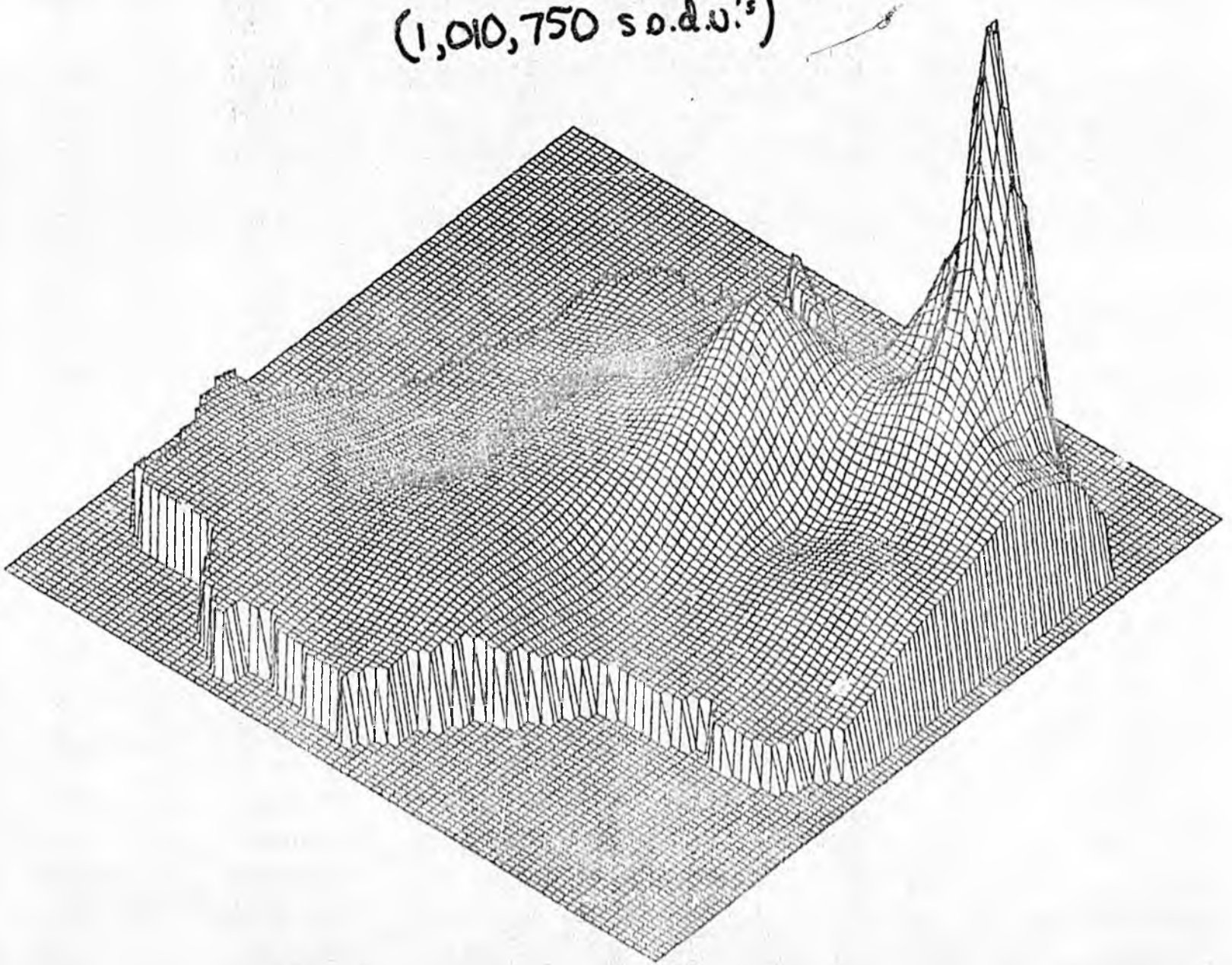


Figure 8

DISTRIBUTION OF PENTOBARBITAL
1977
BY POPULATION DENSITY
(1,010,750 s.o.d.u.'s)

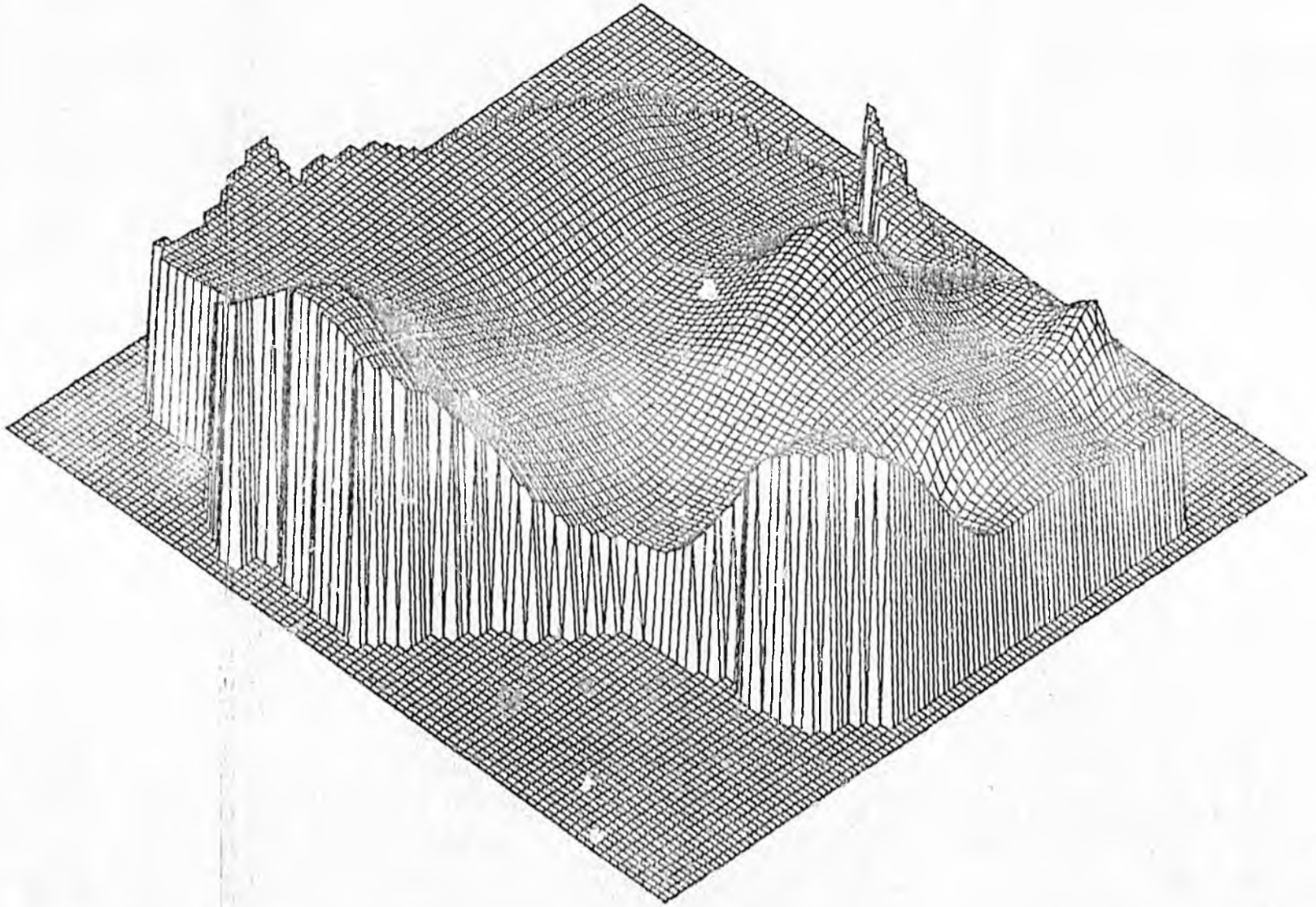
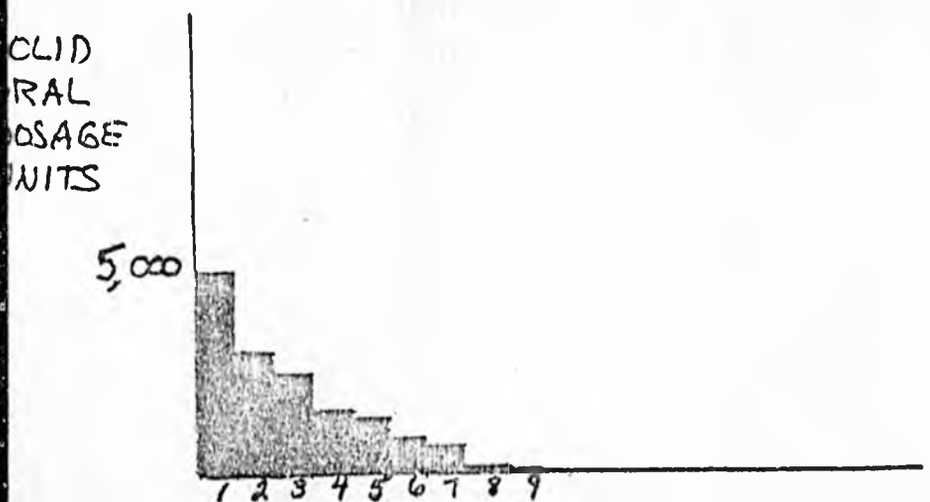


Figure 9

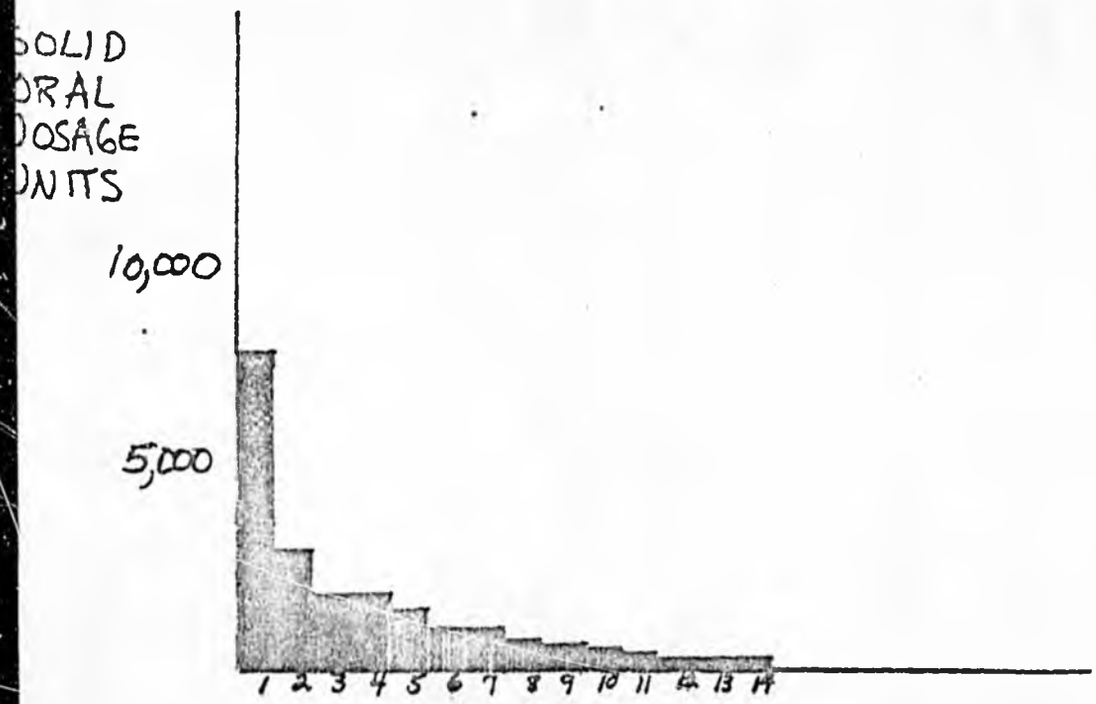
Pharmacy Purchases of
Pentobarbital, 1977
zip zone 538
(16,150 s.o.d.u.'s)



9 PHARMACIES

Figure 10

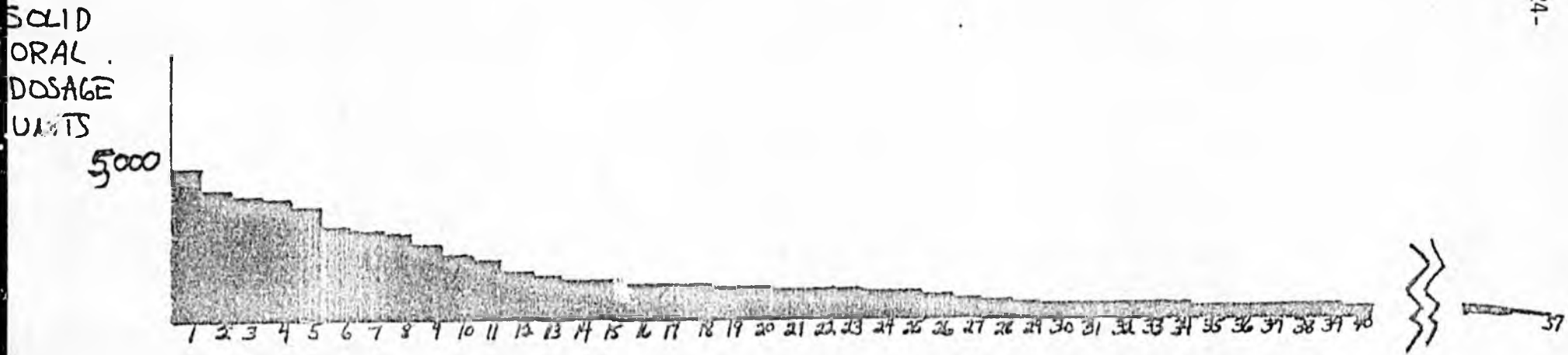
Pharmacy Purchases of
Pentobarbital, 1977
Zip zone 540
(22,900 s.o.d.u.'s)



14 PHARMACIES

Figure 11

Pharmacy Purchases of Pentobarbital, 1977 zip zone 549 (66,525 s.o.d.u.'s)

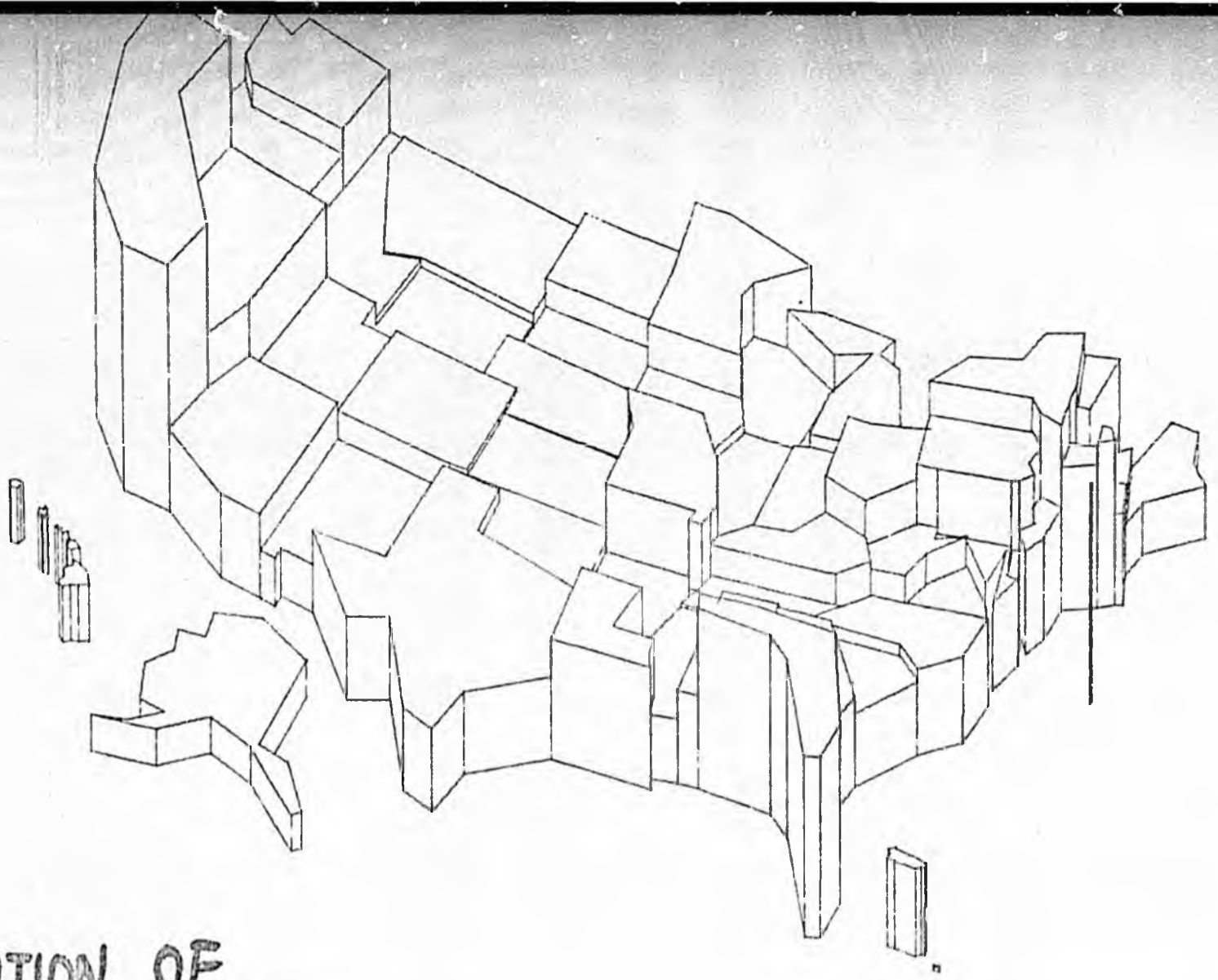


57 PHARMACIES

Figure 12

SOLID
ORAL
DOSAGE
UNITS
10,000
5,000
Pharmacy Purchases of
Pentobarbital - 1977
zip zone 532
163 Pharmacies

Figure 13



DISTRIBUTION OF
SECOBARBITAL - 1977
BY POPULATION DENSITY
(8,737,868 gms.)

Figure 14

Figure 15

U.S. SECOBARBITAL DISTRIBUTION TO RETAIL LEVEL-1977

State	mg./capita	Total Purchases(in gms)
1. California	81.7	1,757,209
2. Washington, D.C.	72.0	50,365
3. New York	61.4	1,110,605
4. Florida	60.0	503,437
5. Rhode Island	54.6	49,134
6. Vermont	54.1	17,057
7. Pennsylvania	50.1	596,350
8. Connecticut	47.5	147,304
9. Nevada	45.6	27,380
10. Ohio	45.3	484,875
11. Missouri	43.1	207,104
12. Minnesota	41.7	166,813
13. Louisiana	40.4	153,496
14. Washington	37.1	133,499
15. Michigan	36.5	332,195
16. New Jersey	33.8	246,921
17. Kentucky	33.0	112,107
18. Indiana	32.1	170,179
19. Alabama	31.0	114,768
20. West Virginia	30.6	55,091
21. Massachusetts	30.3	175,689
22. Georgia	30.0	149,911
23. Puerto Rico	29.1	8,740
24. Oregon	28.7	65,999
25. Maryland	28.6	117,150
26. North Carolina	28.5	145,506
27. Arizona	27.9	64,075
28. Texas	27.6	345,238
29. Iowa	27.5	79,898
30. Delaware	27.2	16,340

Figure 15 (continued)

Secobarbital(continued)1977

State	mg./capita	Total Purchases(in gms)
31. Colorado	25.5	66,232
32. Illinois	24.4	272,771
33. South Carolina	24.4	68,226
34. Nebraska	24.2	38,786
35. Wisconsin	23.9	109,917
36. Oklahoma	23.8	66,597
37. Kansas	23.7	54,417
38. New Hampshire	23.5	18,781
39. North Dakota	23.3	14,009
40. Tennessee	22.7	95,422
41. Utah	22.1	26,558
42. Mississippi	21.5	51,550
43. Virginia	20.7	103,442
44. Arkansas	20.5	43,097
45. Hawaii	18.6	16,771
46. Montana	18.1	14,490
47. Idaho	17.2	13,750
48. Maine	16.9	18,579
49. New Mexico	16.1	19,265
50. Wyoming	15.0	5,973
51. South Dakota	13.7	9,581
52. Alaska	12.2	4,878
53. Virgin Islands	1.1	341

SOURCE: Drug Enforcement Administration

Figure 16

Secobarbital (gms.)-Wis.

	1976	1977	
Pharmacy	126,014	83,638	-33%
Hospital/Clinic	21,369	14,077	-34%
Practitioner	34,689	11,841	-66%
TOTAL	182,072	109,556	
1976-1977 U.S. Trend	-21.2%		
1976-1977 Wis. Trend	-39.4%		

DISTRIBUTION OF SECOBARBITAL

1977

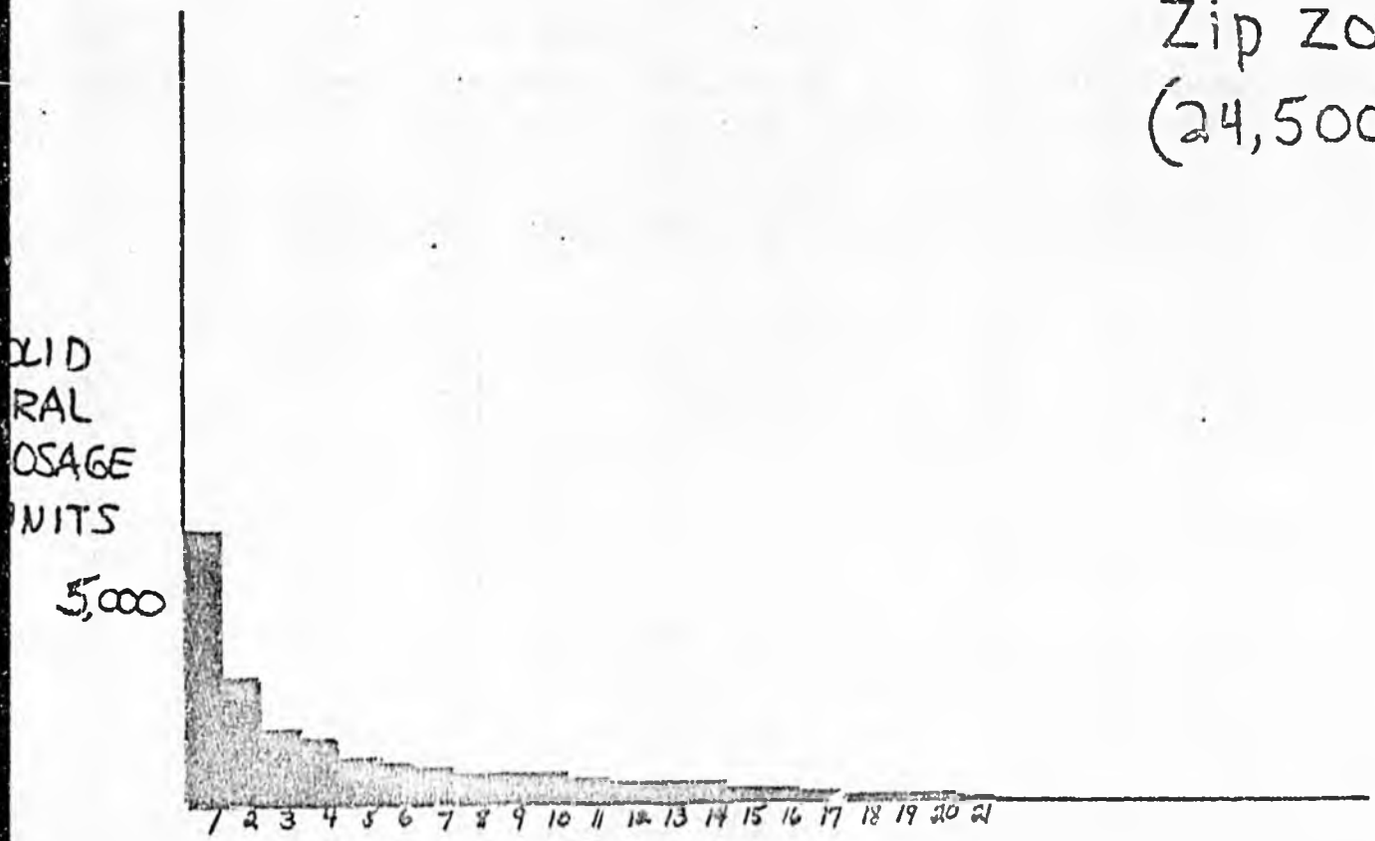
(1,426,350 S.O.D.U.'S)

Figure 17

DISTRIBUTION OF SECOBARBITAL 1977 - BY POPULATION DENSITY (1,426,350 s.o.d.u.'s)

Figure 18

Pharmacy Purchases of Secobarbital, 1977
Zip zone 545
(24,500 s.o.d.u.'s)



21 PHARMACIES

Figure 19

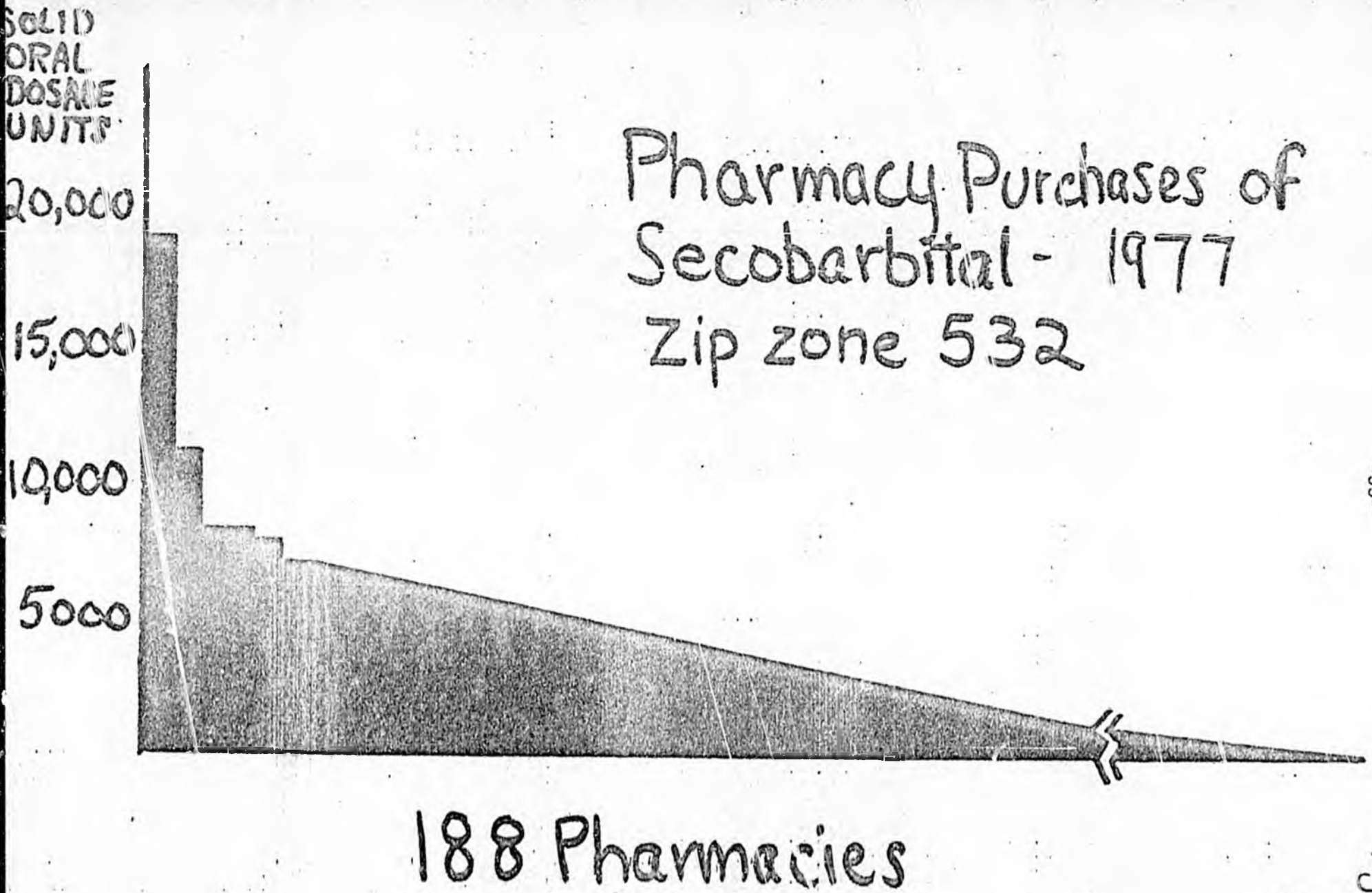
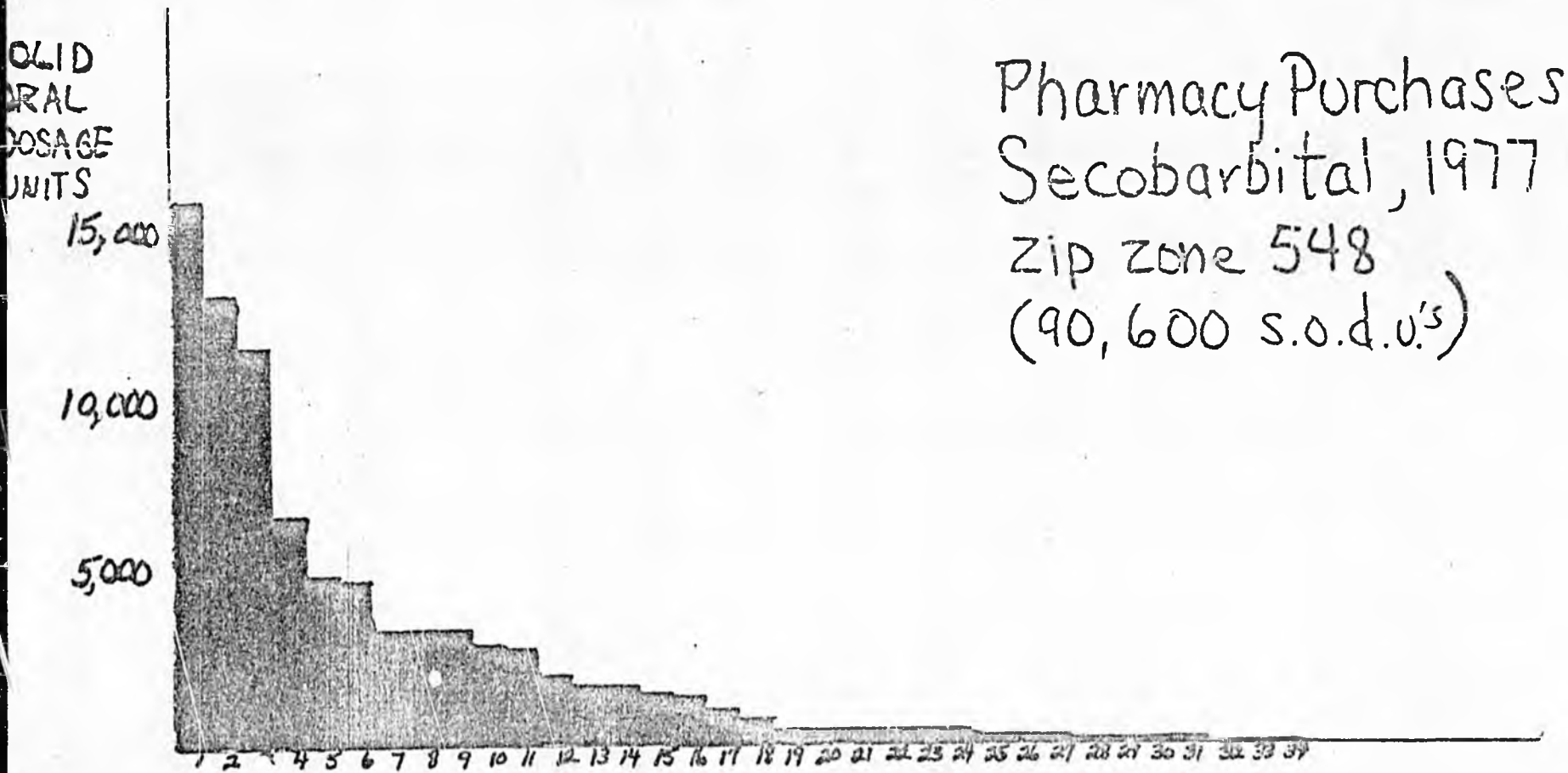

SOLID
ORAL
DOSAGE
UNITS
20,000
15,000
10,000
5000
Pharmacy Purchases of
Secobarbital - 1977
Zip zone 532
188 Pharmacies

Figure 20



Pharmacy Purchases of Secobarbital, 1977
Zip zone 548
(90,600 s.o.d.u.'s)

34 Pharmacies

Figure 21

Pharmacy Purchases of Secobarbital, 1977 Zip zone 549 (95,200 s.o.d.u.'s)

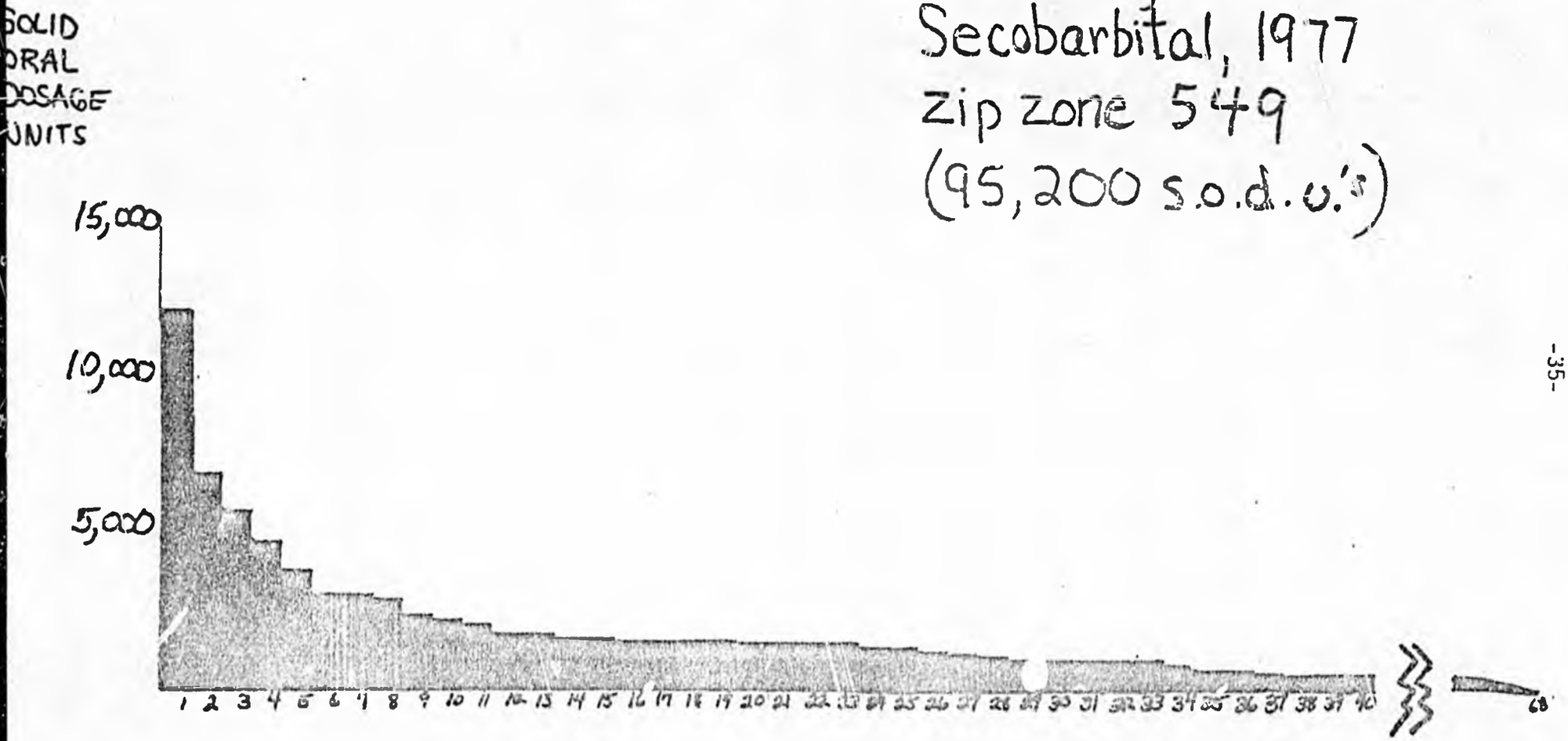
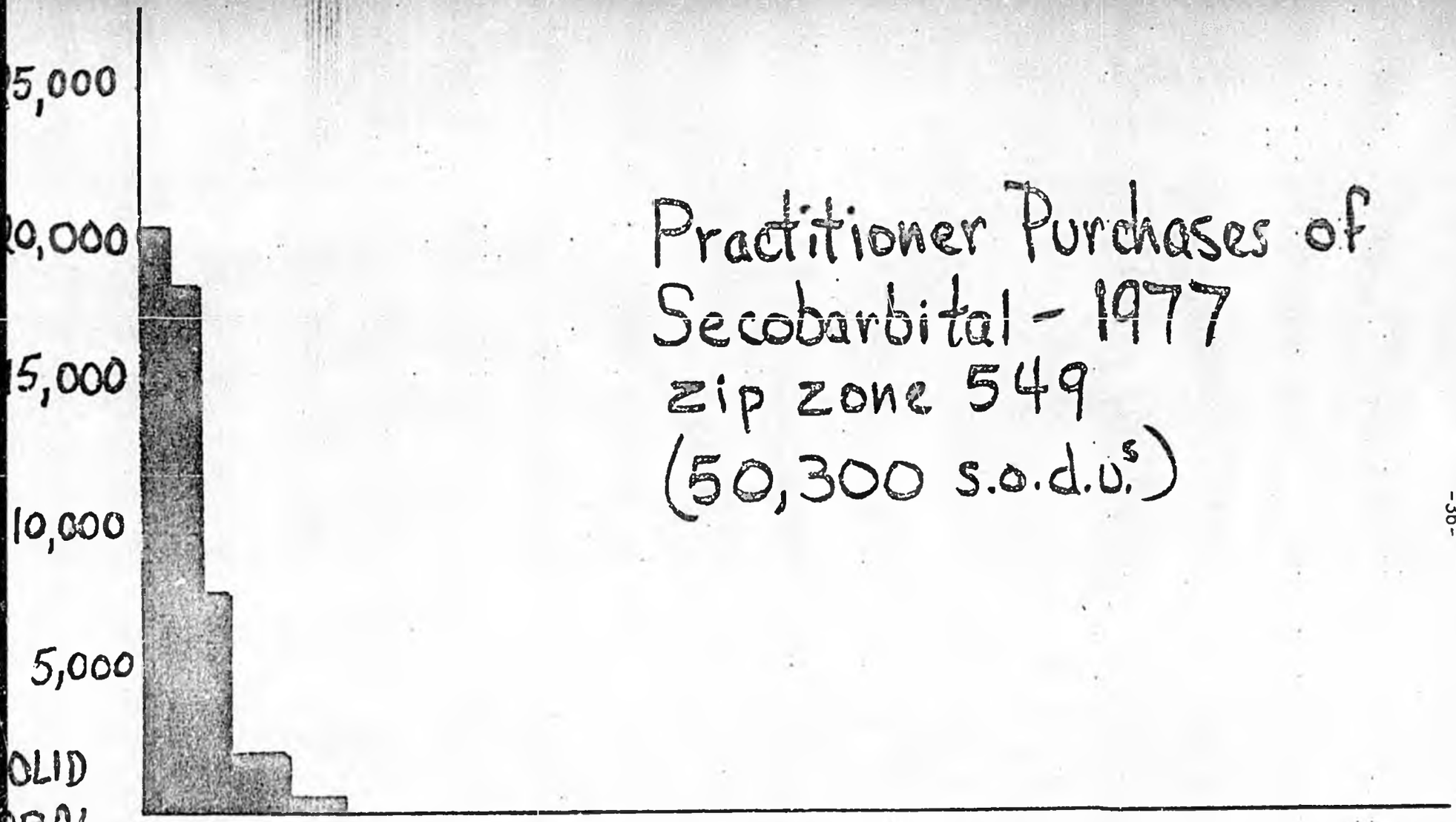


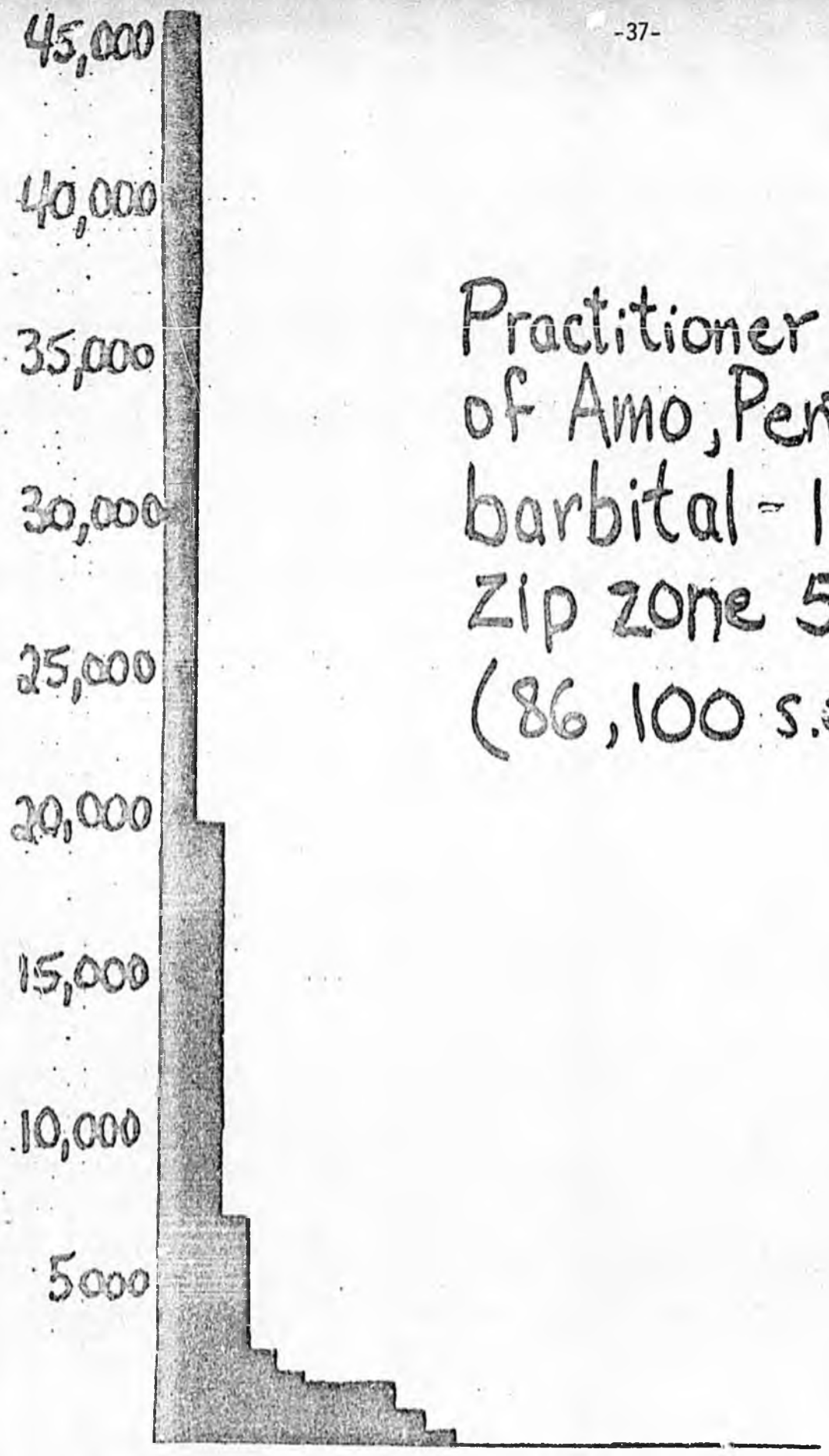
Figure 22



Practitioner Purchases of Secobarbital - 1977
zip zone 549
(50,300 s.o.d.u.s)

Figure 23

Figure 24


45,000
40,000
35,000
30,000
25,000
20,000
15,000
10,000
5000
Practitioner Purchases of Amo, Penta, Seco-barbital - 1977 Zip zone 549 (86,100 s.o.d.u.'s)
10 PRACTITIONERS

DISTRIBUTION OF METHAQUALONE - 1977 BY POPULATION DENSITY (13,464,575 qms)

Figure 25

Figure 26

U.S. METHAQUALONE DISTRIBUTION TO RETAIL LEVEL-1977

State	mg./capita	Total Purchases(in gms)
1. Nevada	267.9	160,760
2. Florida	177.6	1,491,918
3. California	154.6	3,323,664
4. Mississippi	90.5	217,235
5. Ohio	90.1	964,009
6. Hawaii	87.1	78,396
7. Texas	85.5	1,068,509
8. Kentucky	81.1	275,603
9. Oklahoma	79.4	222,214
10. Tennessee	78.1	328,071
11. Oregon	74.8	172,110
12. Alabama	70.9	262,263
13. Georgia	70.3	351,445
14. New Mexico	69.4	83,273
15. Indiana	69.2	366,699
16. Washington	68.1	245,331
17. Louisiana	65.9	250,412
18. Colorado	64.6	167,959
19. South Carolina	64.2	179,744
20. Missouri	62.9	301,832
21. Nebraska	57.2	91,583
22. Arizona	51.3	57,949
23. Kansas	51.2	137,655
24. Pennsylvania	49.8	592,358
25. Montana	48.8	39,055
26. North Carolina	40.9	225,075
27. Utah	40.4	48,501
28. Arkansas	39.4	82,731
29. Minnesota	38.8	155,242
30. Iowa	37.2	107,776
31. Wyoming	36.9	14,745

Figure 26 (continued)

Methaqualone (continued) 1977

State	mg./capita	Total Purchases (in gms)
32. Alaska	36.2	14,465
33. Wisconsin	31.9	146,845
34. Washington, D.C.	31.4	21,995
35. Rhode Island	31.3	28,192
36. Puerto Rico	31.2	9,345
37. West Virginia	28.9	51,962
38. Michigan	28.0	254,777
39. Massachusetts	25.3	146,847
40. New York	23.9	431,721
41. Idaho	21.6	17,240
42. New Jersey	20.2	147,449
43. South Dakota	19.0	13,282
44. Connecticut	18.3	56,625
45. Maryland	18.0	73,676
46. Virginia	17.7	88,454
47. Maine	16.0	17,507
48. New Hampshire	15.8	12,608
49. Illinois	12.3	138,095
50. Vermont	11.5	5,744
51. Delaware	10.7	6,430
52. North Dakota	7.4	4,468
53. Virgin Islands	1.3	393

SOURCE: Drug Enforcement Administration

Figure 27

Methaqualone (gms.) - Wis

	1976	1977	
Pharmacy	170,082	136,404	-20%
Hospital/Clinic	19,484	8,160	-58%
Practitioner	4,963	2,628	-47%
TOTAL	194,529	147,192	
1976-1977 U.S. Trend	-20.9%		
1976-1977 Wis. Trend	-24.5%		

DISTRIBUTION OF METHAQUALONE
1977
(503,400 s.d.u.'s)

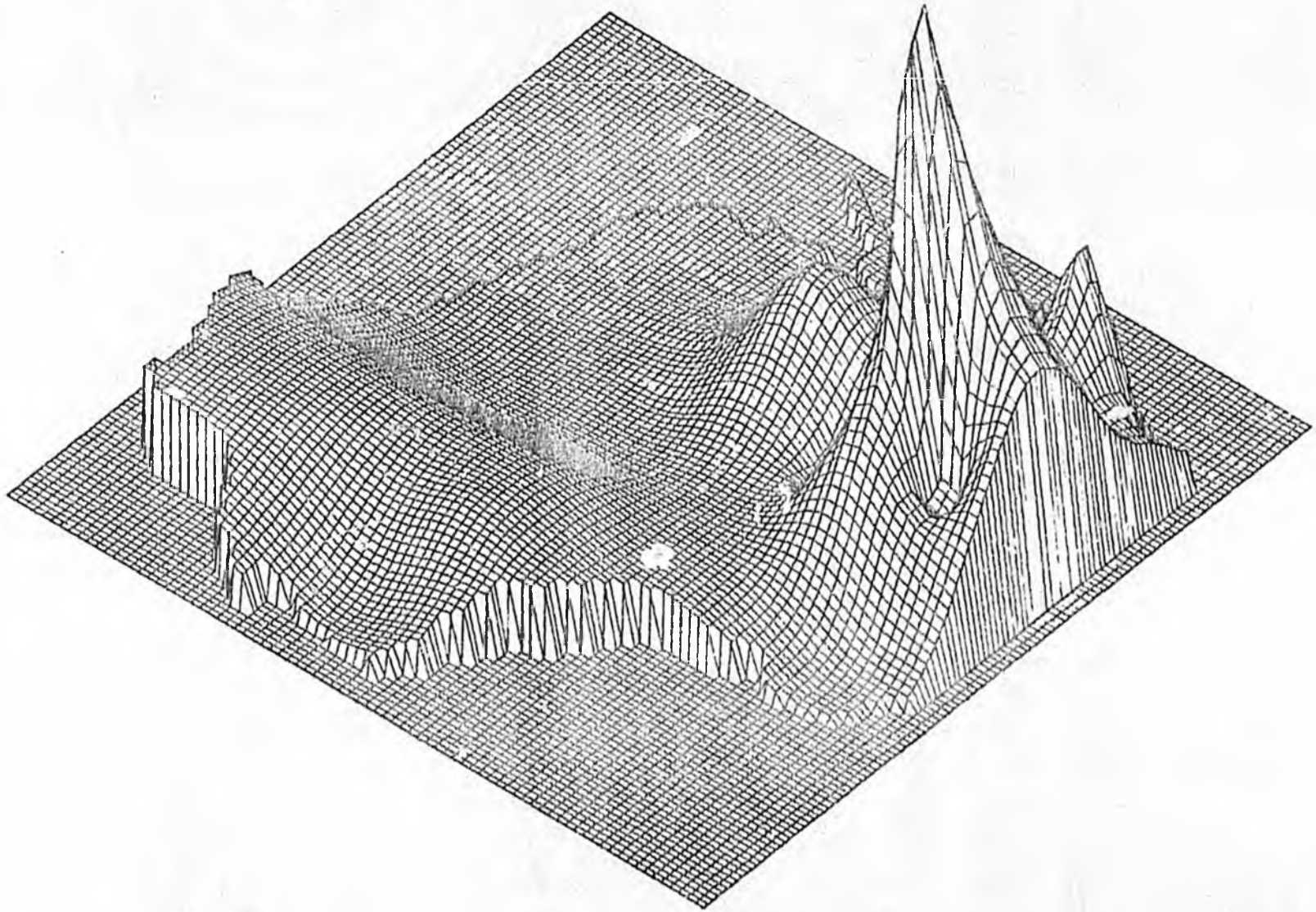


Figure 28

DISTRIBUTION OF METHAQUALONE
1977
BY POPULATION DENSITY
(503,400 s.o.d.u.'s)

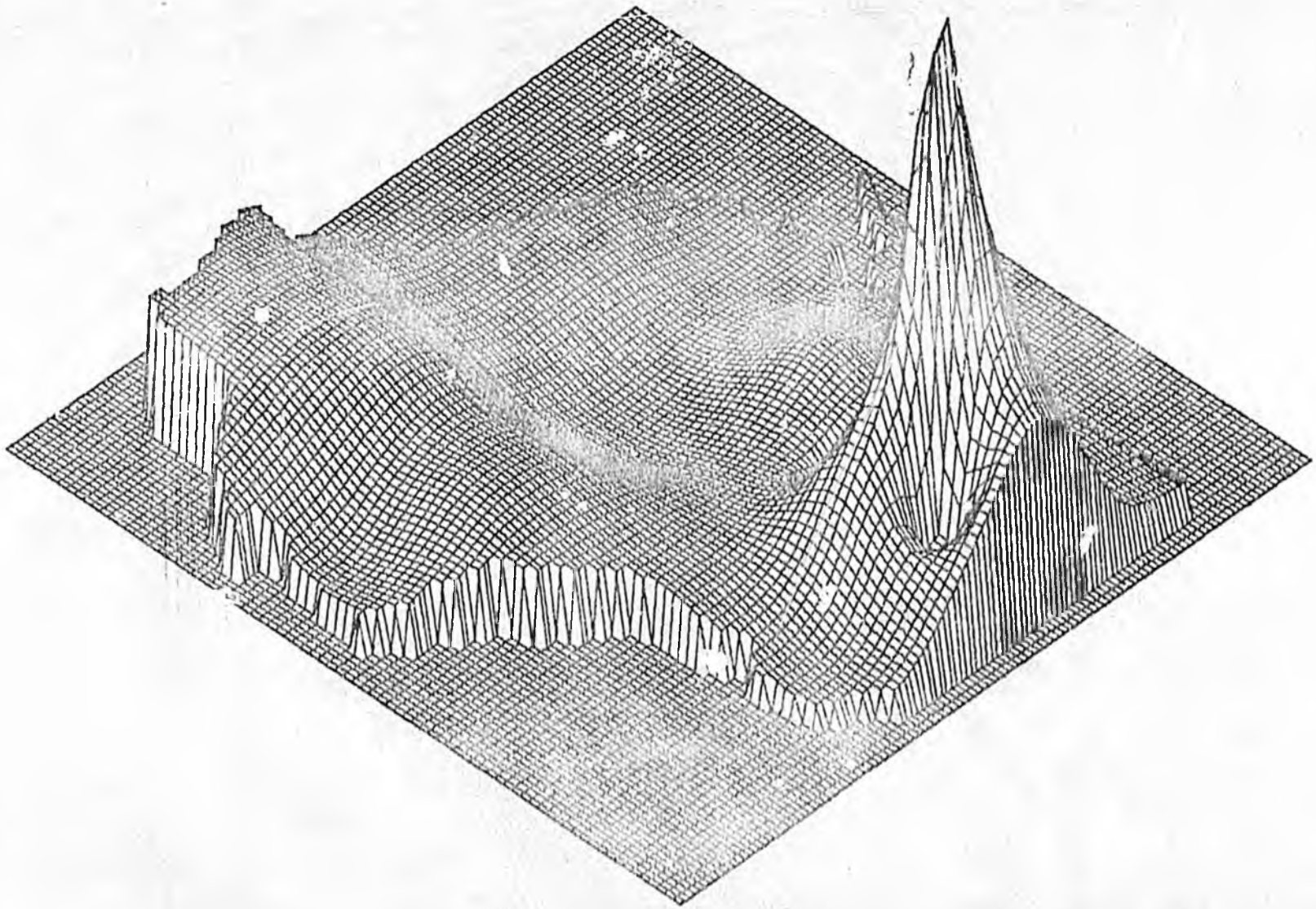
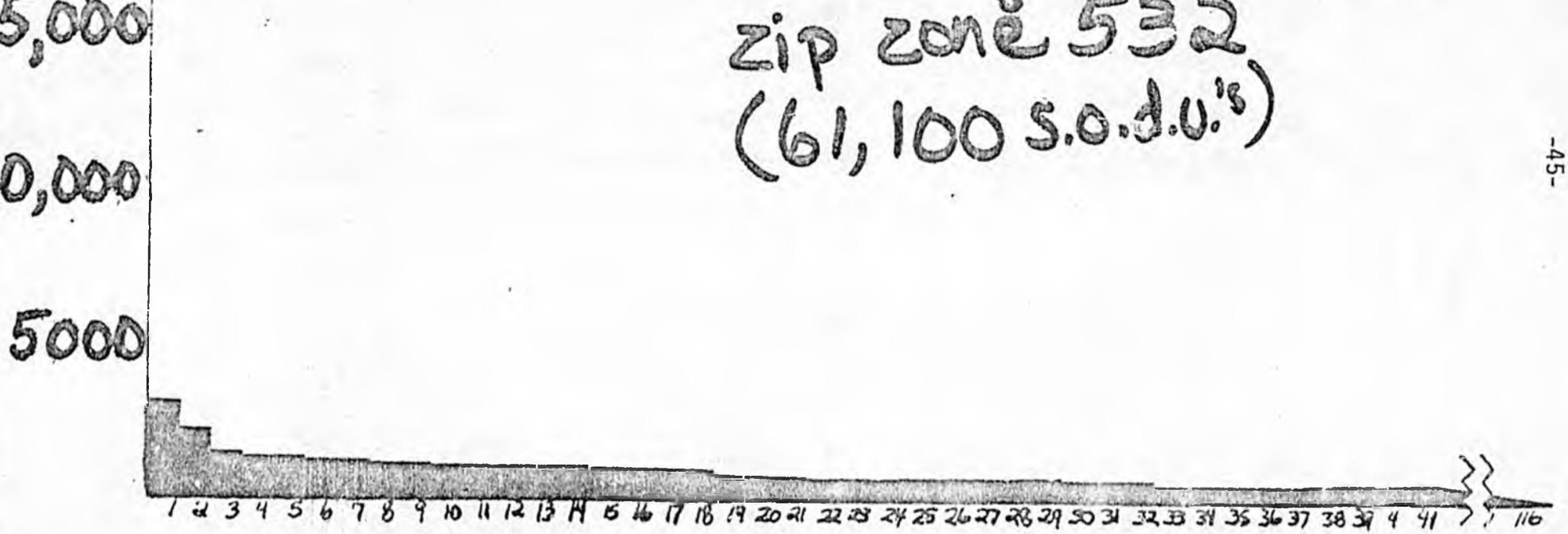


Figure 29

Pharmacy Purchases of Methaqualone, 1977
Zip zone 549
(42,300 s.o.d.u.'s)

Figure 30

Pharmacy Purchases of Methaqualone, 1977 zip zone 532 (61,100 s.o.d.u.'s)



116 Pharmacies

Figure 31

Pharmacy Purchases of Methaqualone, 1977
Zip zone 548
(27,500 s.o.d.u.s)

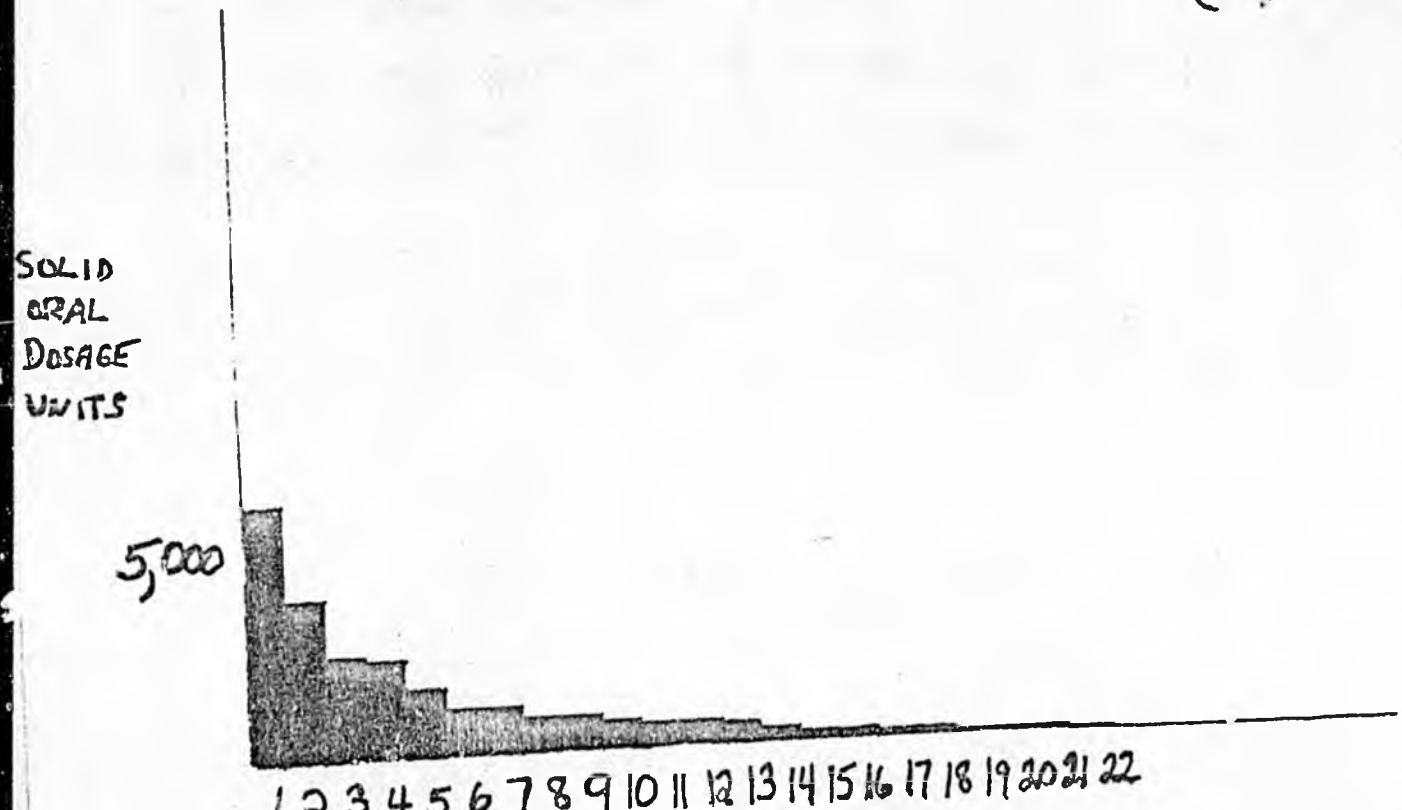


Figure 32

Figure 33

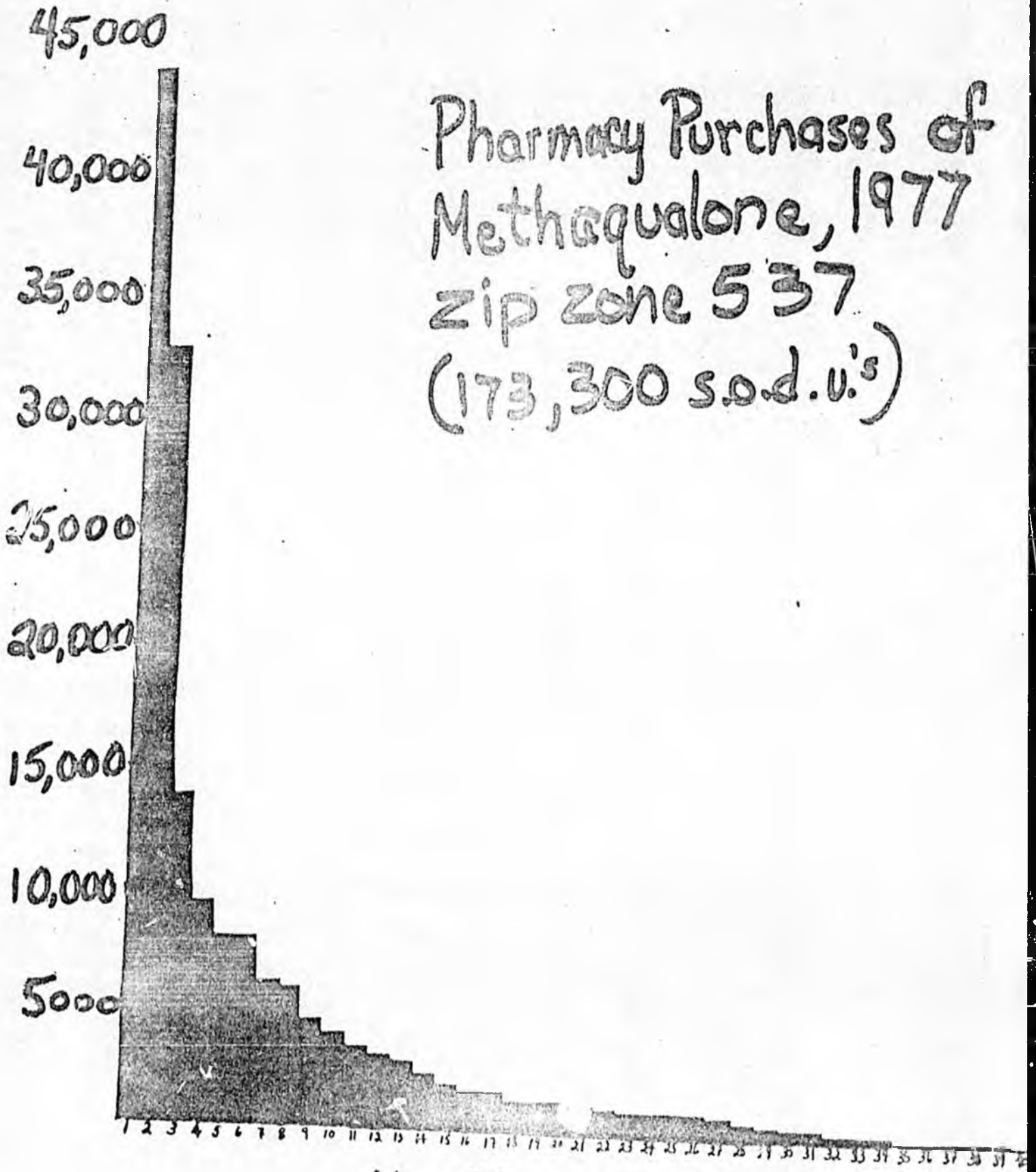
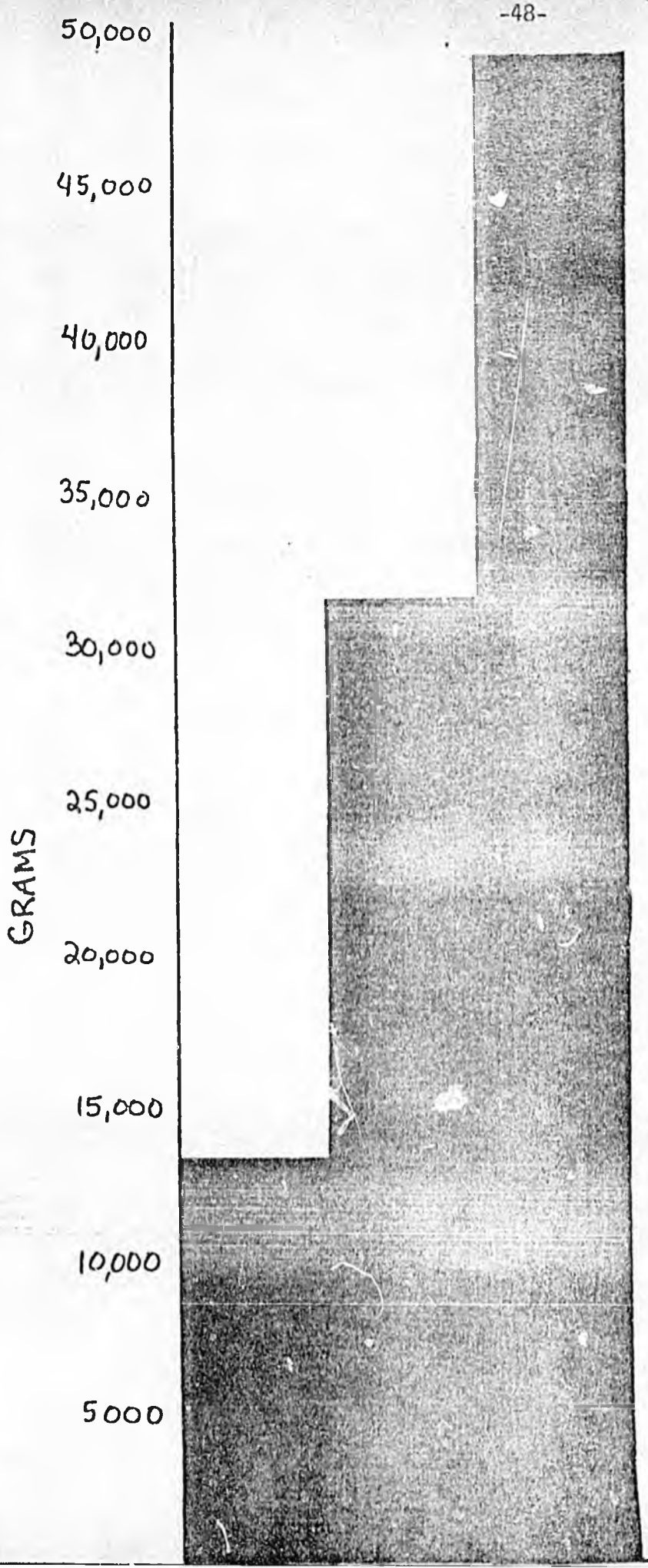

45,000
40,000
35,000
30,000
25,000
20,000
15,000
10,000
5000
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40
Pharmacy Purchases of Methaqualone, 1977
zip zone 537
(173,300 s.o.d.u.'s)
40 Pharmacies

Figure 34



Pharmacy Purchases of Methaqualone, 300 mg., in Zip Code Area 537 (Madison, Wi.), 1975, 1976, 1977.

Source: Drug Enforcement Administration

VII Summary of Reactor Panel Afternoon General Discussion

Reactor Panel:
- Darold Treffert, M.D., State Medical Society
- Rudolph Link, M.D., Medical Examining Board
- Paul Bjerke, Pharmacy Examining Board
- Ralph Paulick, Wisconsin Pharmaceutical Association
- Moderator: Karl Marquardt, R.Ph., Controlled Substances Board

Dr. Treffert's reactions to the morning presentation were in regard to the role the State Medical Society (SMS) should take (and is taking) as far as its physician members and the sedative-hypnotic issue. The three areas the SMS can take a part are:

(1) Education - post-graduate alcohol and other drug abuse education for physicians, including contemporary approaches to insomnia
(2) Encoragement of peer review/self-regulation as far as ethical considerations of prescribing sedative hypnotics
(3) Specification of the indications for sedative-hypnotics.

Dr. Link explained that 1/3 of the Medical Examining Board (MEB) cases presently under investigation are related to prescribing of controlled substances. The MEB requires continuing medical education for physicians. Dr. Link would like to see the MEB assist the SMS in determining the appropriate uses of barbiturates (e.g., for epilepsy).

Several of the peaks seen in the data presented are already being looked into by the MEB. However, due process requires very careful investigation before legal action is taken.

Dr. Link asked the audience if anyone could tell him the proper medical usage of methaqualone. There seemed to be consensus that one could not be determined.

The Pharmacy Examining Board (PEB) is also a state regulatory board. Mr. Bjerke thinks the PEB should examine the top five pharmacies that distribute secobarbital. The pharmacist, like the physician, has a responsibility here; the pharmacist should not fill prescriptions known to be improperly prescribed or abused. For example, a pharmacist should not refill methaqualone prescriptions after two months. The "physician-patient-pharmacist" relationship is very important.

Mr. Bjerke stated that the medical practitioner should follow the same dispensing rules as does the pharmacist and the PEB should have the authority to conduct audits on dispensing physicians. This would probably eliminate the few practitioners involved in this unprofessional activity, he said.

According to Mr. Bjerke, the dispensing physicians should be examined just as pharmacies are investigated.

Mr. Paulick, Wisconsin Pharmaceutical Association, expressed his support of the PEB in their concern about these drugs and the continued monitoring of pharmacies.

A two-hour open discussion followed.

Mr. Angarola and Dr. Treffert explored the use of peer pressure and education of physicians.

Ms. Reddin (MEB) responded to Mr. Bjerke's remarks, and agreed that the PEB should regulate physician dispensing. She then asked about the legitimate medical use of barbiturates. Dr. Link explained that barbiturates are not effective except for short periods of time. Dr. Treffert and Dr. Link explained that this is a complex question. Some prescribe these drugs for insomnia and anxiety, and anesthesia is a common usage.

Mr. Marquardt stated that this is a much more complex problem than the amphetamine issue where obesity was clearly not considered a proper indication for amphetamines.

The complexity of this problem was reiterated by Dr. Dahl. She said that there are honest differences of opinion over the barbiturates and the other sedative-hypnotics; some success with the barbiturates has been observed. However, physicians must take a closer look at complaints of, for example, insomnia - if upon closer examination the patient complains of early morning awakening, the problem may be depression which calls for other treatment. Dr. Dahl also said that the sleep laboratory data unfortunately is obtained from an artificial situation.

Dr. Ferguson explained that Dalmane is the only sedative-hypnotic effective over a longer period of time. He also pointed out that the discoveries of practitioners are often not published or disseminated, so some known information may not be available to us.

Dr. Halikas referred to pages 4-5 of the NIDA report which describes the use of the central nervous system depressants for insomnia and emphasized the importance of diagnosis preceeding treatment.

Dr. Dahl said that people must realize that anxiety and insomnia are normal reactions to some life situations. We are indoctrinated to turn to pills when something ails us and we need to realize that pharmacological solutions are not always necessary.

In conjunction with this, Dr. Ferguson pointed out that insomnia is a symptom, not a disease.

Dr. Cushman referred to page 93 of the NIDA report and noted the high purchase records. Dr. Ferguson explained that it is very difficult to relate Drug Abuse Warning Network (DAWN) data to prescription data. Dr. Cushman said it would be interesting to know if this same tendency is showing up at medical examiners. Dr. Ferguson then said that it is difficult to tell if the reduction of sedative-hypnotic cases at medical examiners is because of less use or less availability.

One drug abuse population that is presently underserved is women. Mr. Joranson brought up the benefits to women if less sedative-hypnotics are being prescribed. Dr. Treffert agreed that women will benefit more from a decline in use; however, he pointed out that more women are affected by this problem because there is an over-representation of women in the medical system. Dr. Ferguson agreed that the data regarding women and drug abuse must be evaluated carefully.

Mr. Liegel suggested that these drugs should not be stocked in oral dosage units in hospitals. For accreditation, hospitals must have pharmacy and therapeutics committees which monitor issues as this.

Dr. Link emphasized the importance of education for physicians and consumers, while Dr. Cushman and Dr. Dahl told of the importance of pharmokinetics. Dr. Halikas would like to see continuing medical education (CME) credits specifically required in alcohol and other drug abuse.

Mr. Hannon commended the CSB for its extensive efforts on this and other projects.

Dr. Treffert brought up the regulatory implications of the data presented. Dr, Link emphasized the need for this sound data, rather than heresay, before the MEB can revoke licenses.

Dr. Cushman pointed out that there are a variety of ways in which people decide what drugs to take and not to take, especially through media.

The problems of "package inserts" were discussed by Dr. Ferguson and Dr. Treffert.

Then, Dr. Treffert discussed the addicted physician. The practicing of prescribing for self and family is now illegal. Mr. Marquardt explained that there are federal and state regulations that prohibit anything other than prescribing in the "usual course of professional practice" and that it is up to the state regulatory boards to interpret the meaning of this. It was stated that a person may just go to a different pharmacy if a pharmacist hesitates to fill a prescription. Mr. Bjerke stated that the PEB should come out with a statement as to what action should be taken if unprofessional conduct is suspected by a pharmacist in regard to prescribing practices. Mr. Paulick explained that pharmacists are reluctant to not fill a prescription but when they have a rather good idea that something wrong is going on, they will call a physician.

Mr. Angarola said that at the federal level, a reduction has already been seen and cooperation exists, so the U.S. Food and Drug Administration will not be scheduling hearings on barbiturates in the near future. Previous to this, Dr. Treffert recommended not interfering since the use of barbiturates is decreasing anyway - there's been a 30% drop in the last year.

Mr. Angarola stated that the President's message expressed that these drugs have a high abuse potential. They are so dangerous that this is why so much time is being spent on them.

Dr. Dahl asked if abuse of methaqualone would continue if it is banned, because of drugs coming in form other countries. Mr. Andersen said that this would probably be the case.

Mr. Ferguson stated that a special NIDA panel on sedative-hypnotics was unwilling to recommend that any of these drugs be banned.

Dr. Treffert summarized the afternoon discussion. He said that there are still questions as to the extent of use, though it is known that this is decreasing. Dr. Treffert emphasized the importance of education and persuasion - or prosecution if necessary. Bans are not necessary at this point, he concluded, but he added that this could change. The Medical Society will continue to accelerate education, knowledge and awareness of barbiturates and sedative-hypnotics.

Dr. Treffert stated that the CSB will continue its annual symposiums, but that the topic of the next one is not yet known. His overall feeling from this meeting was that state agencies seem to be working well together.

Dr. Treffert expressed his appreciation to the federal representatives present.

POSITION PAPER/Department of Health & Social Services

POSITION PAPER
ON
HOUSE BILL NO. 479

"An act revising the drug laws of the state."

The Department of Health and Social Services endorses and supports the concept of the need to revise and update Chapter 17: Controlled Substances Act. The Department is pleased with the bill's similarity of the schedule of controlled substances in H.B. 479 with its federal counterpart.

The bill though appears to lack recognition of the public health aspects of drug addiction and use. Therefore, the Department would recommend that H.B. 479 could be strengthened by consideration of the following:

1. The bill does not address the matter of treatment. There is little doubt that many of the offenders who would be prosecuted under this legislation would be abusers of drugs in need of help. It would be appropriate to include provisions for such treatment of offenders while they are incarcerated and specially for counselling and treatment services after their confinement is completed. At present the Department of Health and Social Services, Division of Corrections, has little in the way of effective drug abuse treatment, due in part to fiscal contraints.

2. Include a mechanism whereby persons arrested under this act would be afforded an opportunity for pre-sentence screening and diagnosis to determine if habitual or chronic drug abuse or addiction was a contributing factor in the commission of the person's offense. If indicated, and depending upon the severity of the offense, and prior criminal record, the offender may be afforded treatment as a part of his or her sentence at some point while the person is in the custody of the State of Alaska.

3. Since data prepared in conjunction with the development of the Drug Abuse State Plan indicates Alaskans suffer more health problems and death from the abuse of prescription drugs rather than illicit drugs, perhaps H.B. 479 should set forth policies regarding monitoring the distribution of prescription drugs in Alaska paid by the State under Medicaid and General Relief-Medical programs to look for patterns of abuse or improper distribution. The states of Washington, California, Wisconsin, and Illinois have instituted such programs with significant success. Although the institution of such a system could possibly be done by administrative means, the Department sees placing it in law as an advantage for funding and enforcement purposes.

4. Since ethanol C_2H_5OH is the drug present in beverage alcohol - beer, wine, and liquor; and data indicates that alcohol abuse is

POSITION PAPER/Department of Health & Social Service

the major contributing factor to human suffering, and social costs in Alaska, consideration may be given to its inclusion in H.B. 479 as a Schedule VI Substance. Although regulation of beverage alcohol presently exists in Title 04, the educative value of its mention in the Controlled Substances Act as a potentially harmful drug appears worthwhile.

It would be desirable from the standpoint of public health be to include the recommendations listed above.

APPROVED BY: Helen D. Beirne 1-21-88

Helen D. Beirne, Commissioner
Department of Health and Social Services

DATE

Name	Address & Phone #	Organization	Bill No.
Helen D Beirne	D H S S 465-3030	D H S S	# HB 479
Commissioner Nicke	Dept of Public Safety		HB 479
Rep Charlie Parr (Sponsor)			
Peggy Berch (Judiciary staff)	House Judiciary		
Levi White (Atty	420 L St. Suite 502 Anchorage, Ak. 99501 279-2526	Ak. Judicial Council	HB 479

Penalties	SB 65 (1979)	Federal Controlled Substances Act	H.B. 549 (1978)	Existing AK. LAW	Uniform Act	Hawaii LAW
Possession of Amphetamines (Parr Sch. II)	0-1 yr. / $1000	0-1 yr. / $ 5000 1st. 0-2 yr. / $10,000 2nd. If no prior convictions conditional discharge is permitted.	0-1 yr. / $10,000 - 1st. 0-2 yr. / $10,000 - 2nd. $2,000 presumptive for 1st. 3 months presumptive for 2nd.	0-1 yr. / $1000	Misdemeanor	If 2 oz. or more: 20 yrs. / $10,000 If 50 caps or more or 1/2 oz or more: 10 yrs. / $10,000 If less than Above: 5 yrs. / $5000
Possession of Hallucinogens (Parr Sch. II)	0-1 yr. / $1000	0-1 yr. / $5000 1st. 0-2 yr. / $10,000 2nd. If no prior convictions conditional discharge is permitted.	0-1 yr. / $2000 $1,000 presumptive sentence	0-1 yr. / $1000	Misdemeanor	SAME AS Amphetamines
Possession of Methaqulones (Parr Sch. II)	0-1 yr. / $1000	0-1 yr. / $5000 1st. 0-2 yr. / $10,000 2nd. If no prior convictions conditional discharge is permitted.			Misdemeanor	same as Amphetamines
Possession of Valium (Parr Sch. IV)	0-1 yr. / $1000	0-1 yr. / $5000 1st. 0-2 yr. / $10,000 2nd. If no prior convictions conditional discharge is permitted.			Misdemeanor	If 400 caps or more: 20 yrs / $10,000 If 50 caps. or more: 10 yrs. / $10,000 If less than above: 1 yr. / $1000

Penalties	SB 65 (1979)	Federal Controlled Substances Act	H.B. 549 (1978)	Existing AK. LAW	Uniform Act	Hawaii Law
Possession of Hash, Hash oil (Parr Sch. IV) (Hawaii-Sch. III)		0-1 yr. / $5000 1st. 0-2 yr. / $10,000 2nd. If no prior convictions conditional discharge is permitted.	0-1 yr. / $2000 $1,000 presumptive sentence		Misdemeanor	If 400 or more cans OR 1 oz or more: 20 yrs / $ 1/4,000 If 50 or more cans or 1/8 oz or more: 10 yrs / $10,000 If less than above: 1 yr. / $1000

STATE OF ALASKA

JAY S. HAMMOND, GOVERNOR

DEPT. OF HEALTH AND SOCIAL SERVICES

DIVISION OF MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES

POUCH H 04 – JUNEAU 99811

January 23, 1980

Honorable Thelma Buchholdt
House of Representatives
Alaska State Legislature
Pouch V
Juneau, Alaska 99811

Document# 2-80

Dear Ms. Buchholdt:

I have compared the drugs listed in House Bill 479 and compared them to FDA Regulations 4/1/79, Chapter II, Drug Enforcement Administration, Department of Justice, § 1308.02, pages 85-90. You will find in the left hand margin of House Bill 479 where the drug is listed in the Federal Schedule if there is a difference. Best wishes in your hearings on House Bill 479.

Sincerely yours,

Verner Stillner, M.D., M.P.H.
Director

VS:prp

cc: Hoyt D. Beirne, Commissioner
Department of Health & Social Services

Enclosure

06-8100L.H

name, address, and official title of the person or agency to whom the controlled drugs are to be delivered, including the name and quantity of the substances desired and the purpose for which intended. The delivery of such controlled drugs shall be ordered by the Administrator, if, in his opinion, there exists a medical or scientific need therefor.

SPECIAL EXEMPT PERSONS

§ 1307.31 Native American Church.

The listing of peyote as a controlled substance in Schedule I does not apply to the nondrug use of peyote in bona fide religious ceremonies of the Native American Church, and members of the Native American Church so using peyote are exempt from registration. Any person who manufactures peyote for or distributes peyote to the Native American Church, however, is required to obtain registration annually and to comply with all other requirements of law.

PART 1308—SCHEDULES OF CONTROLLED SUBSTANCES

GENERAL INFORMATION

Sec.
1308.01 Scope of Part 1308.
1308.02 Definitions.
1308.03 Administration Controlled Substances Code Number.
1308.04 Submission of information by manufacturers.

SCHEDULES

1308.11 Schedule I.
1308.12 Schedule II.
1308.13 Schedule III.
1308.14 Schedule IV.
1308.15 Schedule V.

EXCLUDED NONNARCOTIC SUBSTANCES

1308.21 Application for exclusion of a nonnarcotic substance.
1308.22 Excluded substances.

EXEMPT CHEMICAL PREPARATIONS

1308.23 Exemption of certain chemical preparations; application.
1308.24 Exemption chemical preparations.

EXCEPTED STIMULANT OR DEPRESSANT COMPOUNDS

Sec.
1308.31 Application for exception of a stimulant or depressant compound.
1308.32 Excepted compounds.

HEARINGS

1308.41 Hearings generally.
1308.42 Purpose of hearing.
1308.43 Waiver or modification of Rules.
1308.44 Initiation of proceedings for rulemaking.
1308.45 Request for hearing or appearance; waiver.
1308.46 Burden of proof.
1308.47 Time and place of hearing.
1308.48 Final order.
1308.49 Control required under international treaty.
1308.50 Control of immediate precursors.
1308.51 Pending proceedings.

AUTHORITY: Secs. 201, 202, 501(b), 84 Stat. 1245, 1246, 1247, 1248, 1249, 1250, 1251, 1252, 1271, 21 U.S.C. 811, 812, 871(b).

SOURCE: 38 FR 8254, Mar. 30, 1973, unless otherwise noted. Redesignated at 38 FR 26609, Sept. 24, 1973.

NOMENCLATURE CHANGES: 38 FR 26609, Sept. 24, 1974.

GENERAL INFORMATION

§ 1308.01 Scope of Part 1308.

Schedules of controlled substances established by section 202 of the Act (21 U.S.C. 812), as they are changed, updated, and republished from time to time, are set forth in this part.

§ 1308.02 Definitions.

As used in this part, the following terms shall have the meanings specified:

(a) The term "Act" means the Controlled Substance Act (84 Stat. 1242; 21 U.S.C. 801) and/or the Controlled Substances Import and Export Act (84 Stat. 1285; 21 U.S.C. 951).

(b) The term "hearing" means any hearing held pursuant to this part for the issuance, amendment, or repeal of any rule issuable pursuant to section 201 of the Act.

(c) The term "isomer" means, except as used in § 1308.11(d), the optical isomer. As issued in § 1308.11(d), the term "isomer" means the optical, position or geometric isomer.

(d) The term "interested person" means any person adversely affected or aggrieved by any rule or proposed rule issuable pursuant to section 201 of the Act.

(e) The term "proceeding" means all actions taken for the issuance, amendment, or repeal of any rule issued pursuant to section 201 of the Act, commencing with the publication by the Administrator of the proposed rule, amended rule, or repeal in the FEDERAL REGISTER.

(f) Any term not defined in this section shall have the definition set forth in section 102 and 1001 of the Act (21 U.S.C. 802 and 951) and § 1301.02 of this chapter

§ 1308.03 Administration Controlled Substances Code Number.

(a) Each controlled substance, or basic class thereof, has been assigned a "Administration Controlled Substances Code Number" for purposes of identification of the substances or class on certain Certificates of Registration issued by the Administration pursuant to § 1301.44 of this chapter and on certain order forms issued by the Administration pursuant to § 1305.05(d) of this chapter. Certain applicants for registration must include the appropriate numbers on the application as required in § 1301.32(d) and applicants for procurement and/or individual manufacturing quotas must include the appropriate number on the application as required in §§ 1303.12(b) and 1303.22(a).

(b) Except as stated in paragraph (a) of this section, no applicant or registrant is required to use the Administration Controlled Substances Code Number for any purpose.

§ 1308.04 Submission of information by manufacturers.

(a) Each person who manufactures, packages, repackages, labels, relabels, or distributes under his own label any product (including any compound, mixture, or preparation, diagnostic, reagent, buffer, or biological) containing any quantity of any controlled substance (whether such product is itself controlled or is excepted, exempted, or excluded from some or all controls pursuant to § 1308.21-24 or § 1308.31-32) shall submit information required in paragraph (b) of this section for each such product being manufactured or sold on July 1, 1972. The information should be submitted by registered mail, return receipt requested, to the Assistant Director for Scientific Support, Attention: Label Project, Drug Enforcement Administration, Department of Justice, Washington, D.C. 28083, by August 31, 1972. In the case of new products manufactured after July 1, 1972, or new dosage forms or other unit forms manufactured after July 1, 1972, or changes in information submitted by August 31, 1972, the registrant shall submit the information regarding such item within 30 days after the date on which the manufacture commences or information change occurs. In the case of products, the manufacture of which is discontinued after July 1, 1972, the registrant shall submit notice of such discontinuance within 30 days after the date on which manufacture ceases. In the case of products the manufacture of which was discontinued before July 1, 1972, which are still being sold, the registrant shall submit a notice of such discontinuance with his initial submission.

(b) Two labels or other documents reflecting the following information shall be submitted with reference to each dosage form or other unit form of each item containing any quantity of any controlled substance:

(1) The trade name, brand name, or other commercial name of the product;

(2) The generic or chemical name and quantity of each active ingredient, including both controlled and noncontrolled substances (if any of this information is a proprietary trade secret, please indicate those portions);

(3) The National Drug Code Number assigned to the product, if any; and

(4) The weight (in metric measure) of each dosage unit or the weight (in metric measure) of the controlled substance per 100 grams of finished product for all items containing any quantity of any narcotic controlled substance in solid dosage forms.

SCHEDULES

§ 1308.11 Schedule I.

(a) Schedule I shall consist of the drugs and other substances, by whatever official name, common or usual name, chemical name, or brand name designated, listed in this section. Each drug or substance has been assigned the DEA Controlled Substances Code Number set forth opposite it.

(b) Opiates. Unless specifically excepted or unless listed in another schedule, any of the following opiates, including their isomers, esters, ethers, salts, and salts of isomers, esters, and ethers, whenever the existence of such isomers, esters, ethers, salts is possible within the specific chemical designation:

(1) Acetylmethadol	9601
(2) Allylprodine	9602
(3) Alphacetylmethadol	9603
(4) Alphameprodine	9604
(5) Alphamethadol	9605
(6) Benzethidine	9606
(7) Betacetylmethadol	9607
(8) Betameprodine	9608
(9) Betamethadol	9609
(10) Betaprodine	9611
(11) Clonitazene	9612
(12) Dextromoramide	9613
(13) Diampromide	9615
(14) Diethylthiambutene	9616
(15) Dioxaphetyl butyrate	9168
(16) Dimenoxadol	9617
(17) Dimepheptanol	9618
(18) Dimethylthiambutene	9619
(19) Dioxaphetyl butyrate	9621
(20) Dipipanone	9622
(21) Ethylmethylthiambutene	9623
(22) Etonitazene	9624
(23) Etoxeridine	9625
(24) Furethidine	9626
(25) Hydroxypethidine	9627
(26) Ketobemidone	9628
(27) Levomoramide	9629
(28) Levophenacylmorphan	9631
(29) Morpheridine	9632
(30) Noracymethadol	9633
(31) Norlevorphanol	9634
(32) Normethadone	9635
(33) Norpipanone	9636
(34) Phenadoxone	9637
(35) Phenampromide	9638
(36) Phenomorphan	9647
(37) Phenoperidine	9641
(38) Piritramide	9642
(39) Proheptazine	9643
(40) Properidine	9644
(41) Propiram	9649
(42) Racemoramide	9645
(43) Trimeperidine	9646

(c) *Opium derivatives.* Unless specifically excepted or unless listed in another schedule, any of the following opium derivatives, its salts, isomers, and salts of isomers whenever the existence of such salts, isomers, and salts of isomers is possible within the specific chemical designation:

(1) Acetorphine	9319
(2) Acetyldihydrocodeine	9051
(3) Benzylmorphine	9052
(4) Codeine methylbromide	9070
(5) Codeine-N-Oxide	9053
(6) Cyprenorphine	9054
(7) Desomorphine	9055
(8) Dihydromorphine	9145
(9) Drotebanol	9335
(10) Etorphine (except hydrochloride salt)	9056
(11) Heroin	9200
(12) Hydromorphinol	9301
(13) Methyldesorphine	9302
(14) Methyldihydromorphine	9304
(15) Morphine methylbromide	9305
(16) Morphine methylsulfonate	9306
(17) Morphine-N-Oxide	9307
(18) Myrophine	9308
(19) Nicocodeine	9309
(20) Nicomorphine	9312
(21) Normorphine	9313
(22) Pholcodine	9314
(23) Thebacon	9315

(d) *Hallucinogenic substances.* Unless specifically excepted or unless listed in another schedule, any material, compound, mixture, or preparation, which contains any quantity of the following hallucinogenic substances, or which contains any of its salts, isomers, and salts of isomers whenever the existence of such salts, isomers, and salts of isomers is possible within the specific chemical designation (for purposes of this paragraph only, the term "isomer" includes the optical, position and geometric isomers):

(1) 4-bromo-2,5-dimethoxy-amphetamine Some trade or other names: 4-bromo-2,5-dimethoxy-α-methylphenethylamine; 4-bromo-2,5-DMA	7391
(2) 2,5-dimethoxyamphetamine Some trade or other names: 2,5-dimethoxy-α-methylphenethylamine; 2,5-DMA	7396
(3) 4-methoxyamphetamine Some trade or other names: 4-methoxy-α-methylphenethylamine, paramethoxyamphetamine, PMA	7411
(4) 5-methoxy-3,4-methylenedioxy-amphetamine	7401
(5) 4-methyl-2,5-dimethoxy-amphetamine Some trade and other names: 4-methyl-2,5-dimethoxy-α-methylphenethylamine; "DOM"; and "STP"	7395

(8) 3,4 - methylenedioxy amphetamine 7400
(7) 3,4,5-trimethoxy amphetamine 7390
(8) Bufotenine 7433
Some trade and other names: 3 - (β - Dimethylaminoethyl)- 5 - hydroxyindole, 3-(2-dimethylaminoethyl) - 5 - indolol, *N, N* - dimethylserotonin, 5 - hydroxy - *N,N* - dimethyltryptamine, mappine.
(9) Diethyltryptamine 7434
Some trade and other names: *N,N*-Diethyltryptamine, DET.
(10) Dimethyltryptamine 7435
Some trade or other names: DMT.
(11) Ibogaine 7260
Some trade and other names: 7 - Ethyl - 6,6β,7,8,9,10,12,13 - octahydro - 2 - methoxy 6,9-methano-5H-pyrido [1', 2':1,2] azepino [5,4-b] indole; Tabernanthe iboga.
(12) Lysergic acid diethylamide 7315
(13) Marihuana 7360
(14) Mescaline 7381
(15) Peyote 7415
Meaning all parts of the plant presently classified botanically as *Lophophora williamsii Lemaire*, whether growing or not, the seeds thereof, any extract from any part of such plant, and every compound, manufacture, salts, derivative, mixture, or preparation of such plant, its seeds or extracts.

(Interprets 21 U.S.C. 812(c), Schedule I(c) (12))
(16) N-ethyl-3-piperidyl benzilate 7482
(17) N-methyl-3-piperidyl benzilate 7484
(18) Psilocybin 7437
(19) Psilocyn 7438
(20) Tetrahydrocannabinols 7370
Synthetic equivalents of the substances contained in the plant, or in the resinous extractives of *Cannabis*, sp. and/or synthetic substances, derivatives, and their isomers with similar chemical structure and pharmacological activity such as the following:
Δ1 cis or trans tetrahydrocannabinol, and their optical isomers
Δ6 cis or trans tetrahydrocannabinol, and their optical isomers
Δ3,4 cis or trans tetrahydrocannabinol, and its optical isomers
(Since nomenclature of these substances is not internationally standardized, compounds of these structures, regardless of numerical designation of atomic positions covered.)
(21) Ethylamine analog of phencyclidine 7455
Some trade or other names: N-ethyl-1-phenylcyclohexylamine), (1-phenylcyclohexyl)ethylamine, N-(1-phenylcyclohexyl)ethylamine, cyclohexamine, PCE.
(22) Pyrrolidine analog of phencyclidine 7458
Some trade or other names: 1-(1-phenylcyclohexyl) pyrrolidine, PCPy, PHP.
(23) Thiophene analog of phencyclidine 7470
Some trade or other names: 1-(1-(2-thienyl)-cyclohexyl) piperidine, 2-thienyl analog of phencyclidine, TPCP, TCP.

(c) *Depressants.* Unless specifically excepted or unless listed in another schedule, any material, compound, mixture, or preparation which contains any quantity of the following substances having a depressant effect on the central nervous system, including its salts, isomers, and salts of isomers whenever the existence of such salts, isomers, and salts of isomers is possible within the specific chemical designation:

(1) mecloqualone 2572

[39 FR 22141, June 20, 1974, as amended at 40 FR 19613, May 7, 1975; 40 FR 28611, July 8, 1975; 41 FR 4016, Jan. 28, 1976; 41 FR 43401, Oct. 1, 1976; 42 FR 15679, Mar. 23, 1977; 43 FR 43295, Sept. 25, 1978]

§ 1308.12 Schedule II.

(a) Schedule II shall consist of the drugs and other substances, by whatever official name, common or usual name, chemical name, or brand name designated, listed in this section. Each drug or substance has been assigned the Controlled Substances Code Number set forth opposite it.

(b) Substances, vegetable origin or chemical synthesis. Unless specifically excepted or unless listed in another schedule, any of the following substances whether produced directly or indirectly by extraction from substances of vegetable origin, or independently by means of chemical synthesis, or by a combination of extraction and chemical synthesis:

(1) Opium and opiate, and any salt, compound, derivative, or preparation of opium or opiate, excluding apomorphine, dextrorphan, nalbuphine, naloxone, and naltrexone, and their respective salts, but including the following:

1 Raw opium 9600
2 Opium extracts 9610
3 Opium fluid extracts 9620
4 Powdered opium 9639
5 Granulated opium 9640
6 Tincture of opium 9630
7 Codeine 9050
8 Ethylmorphine 9190
9 Etorphine hydrochloride 9059
10 Hydrocodone 9193
11 Hydromorphone 9150
12 Metopon 9260
13 Morphine 9300
14 Oxycodone 9143
15 Oxymorphone 9652
16 Thebaine 9333

(2) Any salt, compound, derivative, or preparation thereof which is chemically equivalent or identical with any of the substances referred to in paragraph (b) (1) of this section, except that these substances shall not include the isoquinoline alkaloids of opium.

(3) Opium poppy and poppy straw.

(4) Coca leaves (9040) and any salt, compound, derivative, or preparation of coca leaves, and any salt, compound, derivative, or preparation thereof which is chemically equivalent or identical with any of these substances, except that the substances shall not include decocainized coca leaves or extraction of coca leaves, which extractions do not contain cocaine (9041) or ecgonine (9180).

(5) Concentrate of poppy straw (the crude extract of poppy straw in either liquid, solid or powder form which contains the phenanthrine alkaloids of the opium poppy), 9670.

(c) Opiates. Unless specifically excepted or unless in another schedule any of the following opiates, including its isomers, esters, ethers, salts and salts of isomers, esters and ethers whenever the existence of such isomers, esters, ethers, and salts is possible within the specific chemical designation, dextrorphan excepted:

(1) Alphaprodine	9010
(2) Anileridine	9020
(3) Bezitramide	9800
(4) Dihydrocodeine	9120
(5) Diphenoxylate	9170
(6) Fentanyl	9801
(7) Isomethadone	9226
(8) Levomethorphan	9210
(9) Levorphanol	9220
(10) Metazocine	9240
(11) Methadone	9250
(12) Methadone-Intermediate, 4-cyano-2-dimethylamino-4,4-diphenyl butane	9254
(13) Moramide-Intermediate, 2-methyl-3-morpholino-1, 1-diphenylpropane-carboxylic acid	9802
(14) Pethidine (meperidine)	9230
(15) Pethidine-Intermediate-A, 4-cyano-1-methyl-4-phenylpiperidine	9232
(16) Pethidine-Intermediate-B, ethyl-4-phenylpiperidine-4-carboxylate	9233
(17) Pethidine - Intermediate - C, 1-methyl- 4 - phenylpiperidine- 4 -carboxylic acid	9234
(18) Phenazocine	9715
(19) Piminodine	9730
(20) Racemethorphan	9732
(21) Racemorphan	9733

(d) *Stimulants.* Unless specifically excepted or unless listed in another schedule, any material, compound, mixture, or preparation which contains any quantity of the following substances having a stimulant effect on the central nervous system:

(1) Amphetamine, its salts, optical isomers, and salts of its optical isomers	1100
(2) Methamphetamine, its salts, isomers, and salts of its isomers	1105
(3) Phenmetrazine and its salts	1631
(4) Methylphenidate	1724

(e) *Depressants.* Unless specifically excepted or unless listed in another schedule, any material, compound, mixture, or preparation which contains any quantity of the following substances having a depressant effect on the central nervous system, including its salts, isomers, and salts of isomers whenever the existence of such salts, isomers, and salts of isomers is possible within the specific chemical designation:

(1) Amobarbital	2125
(2) Methaqualone	2565
(3) Pentobarbital	2270
(4) Phencyclidine	7471
(5) Phencyclidine immediate precursors:	
(a) 1-phenylcyclohexylamine	7460
(b) 1-piperidinocyclohexanecarbonitrile(PCC)	8603
(6) Secobarbital	2315

[39 FR 22142, June 20, 1974, as amended at 40 FR 6780, Feb. 14, 1975; 40 FR 10456, Mar. 6, 1975; 41 FR 26568, June 28, 1976; 41 FR 43401, Oct. 1, 1976; 42 FR 15680, Mar. 23, 1977; 43 FR 21325, May 17, 1978]

§ 1308.13 Schedule III.

(a) Schedule III shall consist of the drugs and other substances, by whatever official name, common or usual name, chemical name, or brand name designated, listed in this section. Each drug or substance has been assigned the DEA Controlled Substances Code Number set forth opposite it.

(b) *Stimulants.* Unless specifically excepted or unless listed in another schedule, any material, compound, mixture, or preparation which contains any quantity of the following substances having a stimulant effect on the central nervous system, including its salts, isomers (whether optical, position, or geometric), and salts of such isomers whenever the existence of such salts, isomers, and salts of isomers is possible within the specific chemical designation:

40-051 O—79—7

(1) Those compounds, mixtures, or preparations in dosage unit form containing any stimulant substances listed in schedule II which compounds, mixtures, or preparations were listed on August 25, 1971, as excepted compounds under § 308.32, and any other drug of the quantitative composition shown in that list for those drugs or which is the same except that it contains a lesser quantity of controlled substances 1405
(2) Benzphetamine 1228
(3) Chlorphentermine 1645
(4) Clortermine 1647
(5) Mazindol 1605
(6) Phendimetrazine 1615

(c) *Depressants.* Unless specifically excepted or unless listed in another schedule, any material, compound, mixture, or preparation which contains any quantity of the following substances having a depressant effect on the central nervous system:

(1) Any compound, mixture or preparation containing:
(i) Amobarbital 2125
(ii) Secobarbital 2315
(iii) Pentobarbital 2270

or any salt thereof and one or more other active medicinal ingredients which are not listed in any schedule.

(2) Any suppository dosage form containing:
(i) Amobarbital 2125
(ii) Secobarbital 2315
(iii) Pentobarbital 2270

or any salt of any of these drugs and approved by the Food and Drug Administration for marketing only as a suppository.

(3) Any substance which contains any quantity of a derivative of barbituric acid or any salt thereof 2100
(4) Chlorhexadol 2510
(5) Glutethimide 2550
(6) Lysergic acid 7300
(7) Lysergic acid amide 7310
(8) Methyprylon 2575
(9) Sulfondiethylmethane 2600
(10) Sulfonethylmethane 2605
(11) Sulfonmethane 2610

(d) Nalorphine 9400.

(e) *Narcotics drugs.* Unless specifically excepted or unless listed in another schedule, any material, compound, mixture, or preparation containing limited quantities of any of the following narcotic drugs, or any salts thereof:

(1) Not more than 1.8 grams of codeine per 100 milliliters or not more than 90 milligrams per dosage unit, with an equal or greater quantity of an isoquinoline alkaloid of opium 9803
(2) Not more than 1.8 grams of codeine per 100 milliliters or not more than 90 milligrams per dosage unit, with one or more active, noncarcotic ingredients in recognized therapeutic amounts 9804
(3) Not more than 300 milligrams of dihydrocodeinone per 100 milliliters or not more than 15 milligrams per dosage unit, with a fourfold or greater quantity of an isoquinoline alkaloid of opium 9805
(4) Not more than 300 milligrams of dihydrocodeinone per 100 milliliters or not more than 15 milligrams per dosage unit, with one or more active nonnarcotic ingredients in recognized therapeutic amounts 9806
(5) Not more than 1.8 grams of dihydrocodeine per 100 milliliters or not more than 90 milligrams per dosage unit, with one or more active nonnarcotic ingredients in recognized therapeutic amounts 9807
(6) Not more than 300 milligrams of ethylmorphine per 100 milliliters or not more than 15 milligrams per dosage unit, with one or more active, nonnarcotic ingredients in recognized therapeutic amounts 9808
(7) Not more than 500 milligrams of opium per 100 milliliters or per 100 grams or not more than 25 milligrams per dosage unit, with one or more active, nonnarcotic ingredients in recognized therapeutic amounts 9809
(8) Not more than 50 milligrams of morphine per 100 milliliters or per 100 grams, with one or more active, nonnarcotic ingredients in recognized therapeutic amounts 9810

[39 FR 22142, June 20, 1974, as amended at 41 FR 43401, Oct. 1, 1976; 43 FR 3359, Jan. 25, 1978]

§ 1308.14 Schedule IV.

(a) Schedule IV shall consist of the drugs and other substances, by whatever official name, common or usual name, chemical name, or brand name designated, listed in this section. Each drug or substance has been assigned the DEA Controlled Substances Code Number set forth opposite it.

(b) *Narcotic drugs.* Unless specifically excepted or unless listed in another schedule, any material, compound, mixture, or preparation containing limited quantities of any of the following narcotic drugs, or any salts thereof:

(1) Not more than 1 milligram of difenoxin (DEA Drug Code No. 9618) and not less than 25 micrograms of atropine sulfate per dosage unit.

(c) *Depressants.* Unless specifically excepted or unless listed in another schedule, any material, compound, mixture, or preparation which contains any quantity of the following substances, including its salts, isomers, and salts of isomers whenever the existence of such salts, isomers, and salts of isomers is possible within the specific chemical designation:

(1) Barbital	2145
(2) Chloral betaine	2460
(3) Chloral hydrate	2465
(4) Chlordiazepoxide	2744
(5) Clonazepam	2737
(6) Clorazepate	2768
(7) Diazepam	2765
(8) Ethchlorvynol	2540
(9) Ethinamate	2545
(10) Flurazepam	2767
(11) Lorazepam	2885
(12) Mebutamate	2800
(13) Meprobamate	2820
(14) Methohexital	2264
(15) Methylphenobarbital (mephobarbital	2250
(16) Oxazepam	2835
(17) Paraldehyde	2585
(18) Petrichoral	2591
(19) Phenobarbital	2285
(20) Prazepam	2764

(d) *Fenfluramine.* Any material, compound, mixture, or preparation which contains any quantity of the following substances, including its salts, isomers (whether optical, position, or geometric), and salts of such isomers, whenever the existence of such salts, isomers, and salts of isomers is possible:

(1) Fenfluramine	1670

(e) *Stimulants.* Unless specifically excepted or unless listed in another schedule, any material, compound, mixture, or preparation which contains any quantity of the following substances having a stimulant effect on the central nervous system, including its salts, isomers (whether optical, position, or geometric), and salts of such isomers whenever the existence of such salts, isomers, and salts of isomers is possible within the specific chemical designation:

(1) Diethylpropion	1610
(2) Phentermine	1640
(3) Pemoline (including organometallic complexes and chelates thereof)	1530

(f) *Other substances.* Unless specifically excepted or unless listed in another schedule, any material, compound, mixture or preparation which contains any quantity of the following substances, including its salts:

(1) Dextropropoxyphene (alpha - (+) - 4 - dimethylamino-1, 2 - diphenyl - 3 - methyl - 2 - propionoxybutane)	8121
(2) Pentazocine	9709

[39 FR 22143, June 20, 1974; 40 FR 4150, Jan. 28, 1975, as amended at 40 FR 24001, June 4, 1975; 41 FR 43402, Oct. 1, 1976; 41 FR 55176, Dec. 17, 1976; 42 FR 8636, Feb. 11, 1977; 42 FR 54546, Oct. 7, 1977; 43 FR 38383, Aug. 28, 1978; 44 FR 2170, Jan. 10, 1979]

§ 1308.15 Schedule V.

(a) Schedule V shall consist of the drugs and other substances, by whatever official name, common or usual name, chemical name, or brand name designated, listed in this section.

(b) Narcotic drugs containing nonnarcotic active medicinal ingredients. Any compound, mixture, or preparation containing any of the following limited quantities of narcotic drugs or salts thereof, which shall include one or more nonnarcotic active medicinal ingredients in sufficient proportion to confer upon the compound, mixture, or preparation valuable medicinal qualities other than those possessed by the narcotic drug alone:

(1) Not more than 200 milligrams of codeine per 100 milliliters or per 100 grams.

(2) Not more than 100 milligrams of dihydrocodeine per 100 milliliters or per 100 grams.

(3) Not more than 100 milligrams of ethylmorphine per 100 milliliters or per 100 grams.

(4) Not more than 2.5 milligrams of diphenoxylate and not less than 25 micrograms of atropine sulfate per dosage unit.

(5) Not more than 100 milligrams of opium per 100 milliliters or per 100 grams.

(6) Not more than 0.5 milligram of difenoxin (DEA Drug Code No. 9618) and not less than 25 micrograms of atropine sulfate per dosage unit.

(c) Loperamide 8125.

[39 FR 22143, June 20, 1974, as amended at 42 FR 25499, May 18, 1977; 43 FR 38383, Aug. 28, 1978]

EXCLUDED NONNARCOTIC SUBSTANCES

§ 1308.21 Application for exclusion of a nonnarcotic substance.

(a) Any person seeking to have any nonnarcotic substance which may, under the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 301), be lawfully sold over the counter without a prescription, excluded from any schedule, pursuant to section 201(g) (1) of the Act (21 U.S.C. 811 (g) (1)), may apply to the Administrator, Drug Enforcement Administration, Department of Justice, Washington, D.C. 20537.

(b) An application for an exclusion under this section shall contain the following information:

(1) The name and address of the applicant;

(2) The name of the substance for which exclusion is sought; and

(3) The complete quantitative composition of the substance.

(c) Within a reasonable period of time after the receipt of an application for an exclusion under this section, the Administrator shall notify the applicant of his acceptance or nonacceptance of his application, and if not accepted, the reason therefore. The Administrator need not accept an application for filing if any of the requirements prescribed in paragraph (b) of this section is lacking or is not set forth as to be readily understood. If the applicant desires, he may amend the application to meet the requirements of paragraph (b) of this section. If the application is accepted for filing, the Administrator shall issue and publish in the FEDERAL REGISTER his order on the application, which shall include a reference to the legal authority under which the order is issued and the findings of fact and conclusions of law upon which the order is based. This order shall specify the date on which it shall take effect. The Administrator shall permit any interested person to file written comments on or objections to the order within 60 days of the date of publication of his order in the FEDERAL REGISTER. If any such comments or objections raise significant issues regarding any finding of fact or conclusion of law upon which the order is based, the Administrator shall immediately suspend the effectiveness of the order until he may reconsider the application in light of the comments and objections filed. Thereafter, the Administrator shall reinstate, revoke, or amend his original order as he determines appropriate.

(d) The Administrator may at any time revoke any exclusion granted pursuant to section 201(g) of the Act (21 U.S.C. 811(g)) by following the procedures set forth in paragraph (c) of this section for handling an application for an exclusion which has been accepted for filing.

§ 1308.22 Excluded substances.

The following nonnarcotic substances which may, under the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 301), be lawfully sold over the counter without a prescription, are excluded from all schedules pursuant to section 201(g) (1) of the Act (21 U.S.C. 811(g) (1)):

To: Representative Charlie Parr, Chairman
House Judiciary Committee
From: Margaret W. Berck, Administrative Assistant
House Judiciary Committee
Date: August 2, 1979

OVERVIEW OF HB 479

Introduction

Generally, the bill incorporates the basic principles established in the Federal Controlled Substances Act of 1970 and the Uniform Controlled Substances Act adopted for consideration by the various states by the Uniform Commissioners of State Laws. Similar drug legislation has been passed by some 44 states.

The basic goals and elements of this legislation are: (1) to list all the substances which require control and to divide them into several categories according to their dangers to society; (2) to establish a committee to factually determine the need for adjusting these schedules when, for example, new scientific information becomes available and/or new substances are discovered; (3) to provide the most serious penalties for illicit trafficking in drugs, particularly in connection with distribution to minors while classifying simple use possession of all substances as a misdemeanor; (4) closely regulate the legitimate drug industry to prevent diversion of controlled substances into illicit markets; and (5) promote research into drug issues in general and education of society on the dangers of drug abuse.

HB 479 differs from the federal and model state legislation in two primary respects. First, in determining the penalty to be given in either a possession or distribution offense, the quantity of the controlled substances involved is a decisive factor. The larger the amount possessed or distributed, the higher the penalty. In addition, the bill does not establish a separate offense for possession with intent to distribute. Because of difficulties of proof, the offense of intent to sell was eliminated in favor of establishing varying penalties based on the amount of the controlled substance possessed. Second, HB 479 sets out slang terms for included controlled substances to help lay persons understand the legislation. However, the use of slang terms has no effect on the prosecution of a particular drug offense. Another key feature of HB 479 is the fact that it ties its terminology and penalty system into the new criminal code.

Key Provisions

1. Controlled Substances Advisory Committee: HB 479 establishes a committee in the Department of Law with the [illegible] as Chairman. This provision follows

the federal law in which a similar committee is established in the U.S. Justice Department with the U.S. Attorney General serving as Chairman. Under HB 479, other members of the committee are the Commissioner of Public Safety, the Commissioner of Health and Social Services, a private pharmacist and a private criminal defense attorney, both of which are to be appointed by the governor.

Decisions of the committee are subject to close legislative scrutiny. Any regulation sought to be adopted by the committee would have to be submitted to the legislature which then would have 56 days to annul the proposed regulation through the passage of a bill. Without passage of a bill by both the House and Senate, the proposed regulation would become effective. However, once a proposed regulation was annuled by the legislature, the committee would be prohibited from raising the same issue again for three years. Finally, any change in the scheduling of controlled substances contained in the federal law would not automatically become law in the State of Alaska. In cases of changes in the federal schedules, the state advisory committee would have to hold hearings to determine whether a similar change would be appropriate for Alaska. And if the committee adopted the federal alteration, the proposed regulation would have to receive the same legislative oversight as outlined previously.

2. Criteria for Scheduling of Substances: HB 479 establishes six categories of controlled substances. These categories are enumerated as Schedule I through Schedule VI. Except for Schedule VI, which includes only marijuana, each schedule contains numerous substances. The most dangerous substances are contained in Schedule I, less dangerous substances are contained in Schedule II, and so on down to Schedule VI. The schedule assigned to a particular controlled substance is significant in determining the penalty for any drug offense. The higher the schedule, the greater the penalty.

Since future adjustments to the schedules are to be determined by the advisory committee with legislative oversight, HB 479 sets forth specific criteria for making such decisions. The bill specifies the "danger or probable danger" of any substances as the predominant criteria with a number of sub-criteria similar to but more inclusive than those in the uniform act. But unlike the uniform act, which follows a medical classification system HB 479 adopts a more simple public safety classification system much like the State of Hawaii.

Under this classification system, a separate schedule was created for marijuana. Such an approach was thought more logical than the five-schedule system utilized in the federal and uniform act, in which marijuana, heroin and LSD are contained in the same schedule because they lack any acceptable medical use. But because of this placement, both the federal and uniform acts must ultimately distinguish among the narcotic,

non-narcotic and hallucinogenic substances contained in the same schedule. However, in the public safety classification approach, the necessity of further classifying substances into such categories is avoided. Aside from these variations, the schedules provided in HB 479 are substantially the same as those established in the federal and uniform acts.

3. Offenses and Penalties: HB 479 establishes four basic drug offenses, including distribution of a controlled substance to a minor, manufacturing of a controlled substance, distribution of a controlled substance to an adult and possession of a controlled substance. Additionally, the bill creates certain other offenses such as possession of marijuana while operating a motor vehicle, maintaining a shop or airplane for use in drug trafficking and obtaining possession of a controlled substance by misrepresentation or fraud.

The most severe penalties contained in HB 479 would be levied against those over 18 years of age who distribute controlled substances to anyone under 18, reflecting society's special interest in protecting the young from those who encourage or induce them to experiment with drugs. In each category, the offense of distributing to a minor receives the most serious sanctions, except that the recipient must be at least three years younger than the distributor. The three-year difference was included to prevent imposition of stiffer penalties in a case where, for example, a 19-year-old college student gives marijuana cigarettes to his 17-year-old room-mate. In this situation, it was felt there was not the element of seduction so often found in cases where the distributor and recipient were far apart in age.

Both the federal law and the uniform act include the offense of manufacturing a controlled substance together with distribution and possession with intent to distribute a controlled substance for penalty purposes. Hence, the penalty is the same with regard to manufacturing or distributing a particular substance. However, HB 479 treats the manufacturing offense separately and subjects manufacturing to stiffer penalties because of the particular dangers associated with illicit drug laboratories and the substances involved. But in order to justify these heavier penalties, the offense of manufacturing set forth in HB 479 is limited to those who manufacture for other than their own personal use. The offense, however, does include cultivation of marijuana for other than personal use.

Under HB 479 the offenses of distribution to an adult and simple possession have varying penalties dependant upon the amount of the controlled substance involved in the offense. Current Alaska law, the Federal Controlled Substances Act, and the Uniform Act make no such differentiations. The approach taken in HB 479 attempts to provide some indicia of the defendant's role in the drug world. This approach permits more severe sanctions to be applied to the drug dealers involved in large scale trafficking operations. A similar

emphasis is also achieved by making simple possession of small amounts of each particular controlled substance a misdemeanor. Under both the Federal Controlled Substances Act and the Uniform Act, simple possession of any amount of a controlled substance is a misdemeanor. Unlike those acts, HB 479 establishes both felony and misdemeanor offenses for simple possession dependant upon the amount of the controlled substance involved in the offense.

4. Regulation of Legitimate Drug Industry: HB 479 requires the same reporting information by the drug industry as currently mandated by the federal law. Even though it was felt that the state has an interest in obtaining even more information, it was not believed necessary to demand additional reporting requirements. Under HB 479, reporting information must be submitted to the Commissioner of Health and Social Services. Existing Alaska law lodges regulatory responsibility with the Commissioner of Health and Social Services for depressant, hallucinogenic and stimulant drugs and gives the Board of Pharmacy responsibility for narcotic drugs. It was felt that this monitoring could more efficiently be done by one agency.

CITY of BETHEL

P. O. Box 388 • Bethel, Alaska 99559
543-2297 — Area Code 907

Robert Buttcane
Phillip's Alcoholism Treatment Center

January 23, 1980

Commissioner Helen Beirne
Dept. of Health and Social Services
Pouch H-01
Juneau, Alaska 99811

Dear Dr. Beirne,

I am writing to express my appreciation for the remarks you made to the legislature on HB-479. Your desire to include provisions for treatment and rehabilitation services to those incarcerated for drug related offenses in this bill has my full support.

An effective program of diagnosis, counseling and rehabilitation would provide a valuable supplement to the states effort to control the problems of drug abuse.

Sincerely,

Robert Buttcane
Program Director

cc: Representative Charlie Parr
Representative Thelma Buchholdt.

RB/mh

Alaska State Legislature

LEGISLATIVE AFFAIRS AGENCY

FAIRBANKS LEGISLATIVE
INFORMATION OFFICE
Room 250, Building F
101 College Road
Fairbanks, Alaska 99701
(907) 452-4448

January 25, 1980

Rep. Thelma Bucholdt
Chairperson: H.E.S.S.

Enclosed is the copy of Mr. Strauss's speach that you requested on the teleconference concerning the drug bill #HB479.

Sincerely,

Maxine

Maxine Walton
Moderator FBX/LIO

January 25, 1980

Joe H. Strauss
1 mile Persinger Dr.
Fairbanks, Alaska

House Bill 479

I would like to begin by saying that House bill 479 is, in my opinion, a superior bill to the present legislation concerning drugs in this state. However being better does not make it perfect and I feel that there are ambiguities and inconsistencies and in my opinion outright mistakes in this bill. I will try to address these in the order they appear in the bill.

It is my understanding of the bill that the classification of drugs into sections 1-6 basically follows guidelines and standards set up by the Federal Government. However I feel that there is something inconsistent about classifying the compound T.H.C. as as schedule II substance and hashish as a schedule IV substance when marijuana is classified as a schedule VI substance. This apperas to be the only case in which the derivitives of a ~~drug~~ substance are classified as more dangerous than the ~~compound~~ substance they are derived from.

Also it would appear that marijuana is classed by itself as the least dangerous of classified substances. However I have with me an article which appeared in the Fairbanks Daily News Miner only tuesday of this week which indicates that in the minds of many of our countrys best medical people, marijuana may be much more dangerous that some people now contend. Wouldn't it be much better to classify it as a more dangerous drug until we know for sure? And at least as dangerous as T.H.C., the active compound found in marijuana?

Thirdly, while the stated goal of this bill is to provide more stringent penalties for distribution of drugs. It classifies distribution of small amounts of marijuana in the most common amount found in the distribution of this drug as only a class B misdemeaner essentially giving the common pusher a free hand.

Fourth, it is the stated purpose and accomplished fact of this bill to make possesion of small amount of any drug a misdemeanor. I don't think I need to remind our legislators of the effect the common possesion of drugs by large segments of a society has on the socicty as a whole. They need only look to countries where the possesion of drugs has been tolerated in the past to see this effect. Do we really wish this sort of thing on ourselves as a whole? At least when a substance is controlled its effects can be contained in a small segment of society.

This bill also makes it completely legal, as I read it, for a person to possess any amount of marijuana up to one pound. I don't know if Mr. Parr was aware of how much a pound of marijuana is when he wrote this bill, but it is my understanding that this is far more than what the average user of marijuana would consume in a month. Ladies and Gentlemen, few of us keep more food in our homes than we can consume in a month, yet this bill makes it legal to keep more of a drug classed as dangerous in our homes that would be consumed in a month. Does this seem resonable or responsible?

On the hunorous side, it might be noted that while this bill would make it legal to posses up to a pound of marijuana - if a person who did so owned a home where he kept said marijuana (section 17. 17. 380) makes owning that home a felony. Another inconsistency.

Sixth. This bill makes the possesion or use of any amount of marijuana while operating a vehicle illegal and this is good. However, I believe more strict penalties should be designated for this and it should at least carry the same mandatory sentencing as OMVI does.

Seventh. While this bill does make the public display or use of marijuana and the possesion of it by a minor illegal, in neither case does it classify the violation or provide a penalty for it. To me this is like telling your child not to do something but not punishing him when he does. Or perhaps a better illustration would be to compare it to Salt 2.

In conclusion let me reiterate that while we feel that this bill is better than the drug laws we have at present we still feel that if we are to prevent the moral degeneration of our society, we must have more stringent penalties for the possesion and distribution of all drugs.

Doctors debate marijuana dangers

By JANET STAIHAR
Associated Press Writer

WASHINGTON—People who smoke marijuana are endangering their brain, lungs and reproductive and immune systems, says a Columbia University medical professor. But a Harvard professor argues frequent marijuana use does not seriously damage the mind or body.

The two were appearing today before a Senate subcommittee, examining the health effects of marijuana.

The hearing of the Judiciary Committee's subcommittee on criminal justice was called by Sen. Charles McC. Mathias Jr., R-Md., who is re-evaluating his past support for a Senate move to lessen the criminal penalties for marijuana possession. A Mathias spokesman, asking not to be named, said the senator feels that in the past few years, there has been new medical evidence on marijuana's health hazards.

Dr. Gabriel G. Nahas, professor of anesthesiology at the Columbia University College of Physicians and Surgeons, said in prepared testimony that marijuana harms the brain, the reproductive system, the lungs and the body's immune system.

"In man, marijuana smoking decreases sperm production . . . and is associated with an increased incidence of abnormal forms of sperm," said Nahas.

"In women," he said, "marijuana smoking is associated with a higher incidence of shorter menstrual cycles . . . and a cycle without an ovum."

Nahas said children and teen-agers are the most vulnerable to marijuana's harmful effects because their brain and hormone system are still developing.

The Columbia doctor said at least five groups of people should be warned against using marijuana: people with lung or heart disorders, adolescents, women of child-bearing age, epileptics, and people with a tendency toward schizophrenia and mental illness.

But Dr. Lester Grinspoon, associate professor of psychiatry at Harvard Medical School, said, "The chronic use of marijuana does not do serious damage to the body or mind."

In prepared testimony, he said marijuana is "markedly safe" compared with alcohol and drugs. He also discounted reseachers who say it permanently alters the mind or personality.

The Senate will likely vote this year on an overall proposal to revise the federal criminal code, part of which contains a section softening the penalties for the possession of small amounts of marijuana.

Under current law, possession of small amounts of marijuana is punishable by up to a year in prison plus a $5,000 fine for the first offense. Subsequent offenses may bring up to two years in prison and a maximum $10,000 fine.

MRS. BUCHHOLDT/MR. CHATTERTON

I WAS THE THIRD FAIRBANKS PERSON TO TESTIFY AT THE HEARING TODAY, AND I MUST APOLOGIZE FOR MY INCOHERENT TESTIMONY. I'M NEW AT SPEAKING, BUT I WILL SOON BE BETTER.

THERE ARE SEVERAL PROVISIONS IN THIS BILL THAT I WOULD LIKE TO ADDRESS. FIRST, I DO NOT LIKE THE IDEA OF GRADUATING SENTENCES TO MATCH GROWING STOCKPILES OF DRUGS. IS IT REALLY RESPONSIBLE TO SAY THAT 'X' AMOUNT IS REAL BAD, BUT THAT 'Y' AMOUNT IS JUST BAD. YOU ARE DEALING WITH THE LIMITS A ILLEGAL OPERATION WILL OPERATE IN. THAT OPERATION WILL NOT CEASE, BUT WILL CHOOSE THE AVENUE OF LEAST RESISTANCE. I WOULD LIKE TO SEE THE SOURCE OF THE PRODUCT DRIED UP, WITHOUT TO MUCH HARM TO THE CONSUMER.

I RECOMMEND THAT THERE SHOULD LEGALLY BE TWO AMOUNTS ASSIGNED TO A GIVEN DRUG. ONE AMOUNT BEING DEFINED AS THE AMOUNT OF NORMAL CONSUMPTION AND THE OTHER BEING DEFINED AS ANY AMOUNT OVER THE PREVIOUS AMOUNT. A BY-PRODUCT OF THIS SYSTEM IS THE FACT THAT A PERSON WOULD NO LONGER HAVE TO PROVE INTENT TO SALE. A PERSON ARRESTED WITH ANY AMOUNT OVER THE AMOUNT OF CONSUMPTION WOULD BE GUILTY OF A CLASS C FELONY. WITH THE STIPULATION THAT THAT PERSON SERVE A MANDATORY FIVE YEARS. A PERSON ARRESTED WITH THE DEFINED AMOUNT OF CONSUMPTION WOULD RECEIVE A LIGHT SENTENCE, SAY A CLASS B MISDEMEANOR. A SECOND OFFENDER WOULD HAVE TO DEALT WITH HARSHER IN BOTH CASES. I REALIZE THAT THIS MAY SOUND SOMEWHAT HYPOCRITICAL IN VIEW OF THE ABOVE PARAGRAPH. BUT I DO NOT HONESTLY PERCEIVE OF A ORGANIZATION PUSHING A PRODUCT ONE OR TWO PILLS AT A TIME. HOPEFULLY, AS A BY-PRODUCT OF INCREASED RESTRICTIVENESS AND THE SLOWER TIME OF MOVEMENT FOR THE PRODUCT, THE COST WOULD ALSO RISE. THIS COULD FORCEFULLY ASSIST SOME OF OUR GOOD PEOPLE OUT OF THE DRUG CULTURE.

SECONDLY, I WOULD LIKE TO ADDRESS SEC. 17.17.200. THIS MINOR PROVISION IS DEFINITELY A PAPER TIGER. THIS BILL, UNDER SECTION 17.17.900 DEFINES A

OUR CURRENT DRUG PROBLEM COULD BE A BY-PRODUCT OF THE BIGGEST PROBLEM THAT OUR INCREASED TECHNOLOGY HAS GIVEN US....TIME.

IN CLOSING, LET US LOOK TO THE FUTURE. DOES NOT THE USE OF DRUGS TO ESCAPE REALITY REVEAL A DETERIORATION OF OUR SOCIETY. IS IT INDICATIVE OF A WEAKENING OF OUR NATIONS CHARACTER AND FORTITUDE, NOT ALONE TURNING AWAY FROM OUR CREATOR DRUG ABUSE IS NOT ENLIGHTENMENT, IT IS ESCAPISM. TO PUT IT IN PERPESTIVE, MY QUESTION IS, WHAT HAPPENS AFTER I EXERCISE MY RIGHT TO INGEST A DRUG? DO I STILL KNOW THE DISTINCTION BETWEEN GOOD AND EVIL NOW THAT MY JUDGEMENT IS IMPAIRED? AM I EVEN CAPABLE OF DETERMINING IF MY JUDGEMENT IS IMPAIRED? YET, IF I'M NOT CAPABLE OF REASON AND JUDGEMENT, THEN I'M NO LONGER SUPERIOR TO A COMMON ANIMAL. IN OUR HEARTS WE KNOW THE ANSWER.

THE LORD GAVE US A DECENT PLACE TO LIVE, LET US KEEP IT THAT WAY.

SINCERELY,

RIC L. ADAMS

415 LAKEVIEW TRAILER COURT
FAIRBANKS, ALASKA 99701
HOME PHONE #456-8078

THANKFULLY IT IS NOT NEEDED, THE OFFENSES ARE DEFINED BY THE AMOUNTS IN PREVIOUS PROVISIONS.

I DO HAVE TWO OTHER RECOMMENDATIONS: ONE; A RIDER, SIMILAR TO PRESENT FISH AND GAME REGULATIONS, BE INSERTED TO ALLOW FOR FORFEITURE OF PERSONAL PROPERTY THAT WAS USED WHILE ENGAGED IN ILLEGAL DRUG ACTIVITIES. TWO; A SECOND RIDER, SIMILAR TO SEC. 17.12.120, REHABILITATION, BUT REVISED TO ADDRESS ONLY ADDICTS SERVING THEIR DRUGS. THIS PROVISION SHOULD ALLOW FOR A MEDICALLY PROVEN ADDICT TO BE PUT IN THE CARE OF A DRUG REHABILITATION CENTER. UPON GRADUATION, SAID PERSON SHOULD BE REWARDED WITH THE ERASING OF THE RECORD OF THE ARREST THAT ORIGINALLY PUT HIM IN THE CENTER. THIS PERSON WOULD THEN HAVE THE HELP NEEDED TO BREAK HIS HABIT IF HE WANTED TO. IF NOT, SAID PERSON IS A THREAT AND SHOULD BE DEALT WITH ACCORDINGLY.

IN RETROSPECT LET ME SAY THAT WHEN I SPEAK OF DRUGS I INCLUDE MARIJUANA. I RECOGNIZE THAT GRASS IS THE LESSER OF THE EVILS. AT ONE TIME IN MY LIFE I SMOKED QUITE A BIT OF GRASS, AND PLAYED WITH OTHER DRUGS AS WELL. TO ANSER MR. CHATTERTON'S QUESTION, A OUNCE IS WHAT WE WOULD ALWAYS BUY FOR PERSONAL USE. WHEN WE WOULD GET LOW ON OUR SUPPLY WE WOULD BUY ANOTHER OUNCE, ECT.

THE BIGGEST EVIL IN MARIJUANA IS ITS WIDESPREAD ACCEPTANCE AND THE PROBLEMS OF ENFORCEMENT THAT ACCOMPANY THAT ACCEPTANCE. I BELIEVE THAT GRASS IN ITSELF IS NO GREAT DANGER, BUT IT PUTS YOU IN A ENVIRONMENT WITH DIFFERENT PEOPLE WHO COULD BE A DANGER TO YOU. MRS. JAN TAYLOR'S TESTIMONY ABOUT THE CHILD WHO HAD STARTED TO SMOKE GRASS AND THE RESULTING DROP IN HIS ACADEMIC ACHIEVEMENT, IS INDICATIVE OF WHAT I'M TRYING TO SAY. I DO NOT BELIEVE THAT THE GRASS ITSELF WAS THE CAUSE OF HIS LOWER SCORES, BUT THE ATTITUDE THAT COMES WITH THE DRUG. FOR LACK OF A BETTER DEFINITION, I WILL CALL IT A SEMI-REBELLIOUS, CARE-FREE ATTITUDE. THE SWORD OF PEER PRESSURE CUTS A BIG SWATH AMONG PEOPLE. PEOPLE DO NOT NEED GRASS AND IT SHOULD BE ABOLISHED.

MINOR AS A PERSON UNDER 18 YEARS OF AGE. WE CAN ALMOST REST EASY, KNOWING THAT A INTELLIGENT DISTRIBUTOR CAN FIND SOMEONE IN HIS SUB-CULTURE OF A AGE YOUNG ENOUGH TO NOT ONLY SUPERSEDE THIS PARER BARRIER, BUT TO DO IT LEGALLY. HERE AGAIN IS IT RESPONSIBLE TO SAY, (FOR EXAMPLE) THAT IT IS WRONG FOR A 30 YEAR OLD MAN TO SELL DRUGS TO A HIGH SCHOOL STUDENT. BUT THEN TURN A-ROUND AND ALLOW THIS SAME 30 YEAR OLD MAN DELEGATE HIS OBJECTIVE TO SOMEONE YOUNGER.

I HAVE A RECOMMENDATION, WE SHALL DRAW A LINE. FIRST, LET US REDEFINE THE AGE OF A MINOR. THIS NEW BRACKET WOULD BE "UNDER 19 YEARS OF AGE". HOPE-FULLY THIS WOULD PLACE ALL HIGH SCHOOL STUDENTS IN THE CATEGORY OF MINOR FOR THE CONSIDERATION OF THIS CHAPTER. NOW, ANY ADULT, SELLING TO ANY MINOR A CONTROLLED SUBSTANCE, WILL BE GUILTY OF A CLASS B FELONY. WITH A RIDER STIPULATING A MANDATORY 7 YEARS.

WE MUST REMEMBER THAT THE YOUTH MARKET IS A GROWING (sic) MARKET. HABITS AND PREFERENCES DEVELOPED NOW CAN LAST A LIFETIME. IT MUST BE STOPPED.

THIRD, I WOULD LIKE TO ADDRESS SEC. 17.17.400 OFFENSES DEFINED BY AMOUNTS. IN RESPECT TO THIS BILL, THIS PROVISION DEFINITELY NEEDS CLARIFICATION. YOU CANNOT PLEAD A LOWER CLASS OF OFFENSE THAN THAT OFFENSE WHICH IS ESTAB-LISHED BY THE EVIDENCE. BECAUSE IT IS THE EVIDENCE THAT ESTABLISHES THE OFFENSE, PERIOD. AND IN DIRECT REBUTTAL TO THE WORDING OF THAT SECTION, IF A LOWER CLASS OF OFFENSE IS ESTABLISHED BY THE EVIDENCE, THE AMOUNT IN QUESTION (READ EVIDENCE) CANNOT BE LARGER THAN THE AMOUNT WHICH WOULD MAKE THE OFFENSE A HIGHER CLASS OF OFFENSE, BECAUSE IT ESTABLISHED THE LOWER CLASS OF OFFENSE. (IN THE FIRST PLACE). I HAD THE HARDEST TIME TRYING TO LOGICALLY DECIPHER THIS PROVISION UNTIL I REALIZED THAT IT IS IMPOSSIBLE. THIS PROVISION MUST BE ABOLISHED, IF FOR NO OTHER REASON THAN THE CONFUSION IT WILL INITIATE.

HOUSE RESEARCH AGENCY
Pouch Y - State Capitol
Juneau, Alaska 99811
465-3991

MEMORANDUM

February 26, 1980

TO: Representative Thelma Buchholdt
Chairperson, HESS

Committee Members Munson, Hurlbert, Miles, Barnes, Beirne and Chatterton

FROM: Jan Erickson, Issues Analyst

RE: California Drug Laws
Research Request No. 47

Enclosed please find as requested a summary of the California drug laws (California Uniform Controlled Substances Act, Sections 11000 - 11835, with amendments). Schedules for the drugs as well as key definitions are included with the attached relevant statutes.

A summary of the 1972 act is also included for comparison with the amended version of 1977-78. The amendments significantly alter the earlier act insofar as penalties are often not specified, nor is there much distinction for repeat offenses. Additional minor amendments from 1979 are being sent from the California Attorney General's office. (A single reference copy of the Act and amendments has been placed with the staff for your use.)

If you should have any questions concerning these materials, please do not hesitate to contact me.

JE/bf
Encls.

CALIFORNIA UNIFORM CONTROLLED SUBSTANCES ACT

PENALTIES FOR CERTAIN OFFENSES*

Brief Summary

1. Unlawful Possession.

   A. Heroin -- (HS 11350) — Punishment by imprisonment, no specified terms. No distinction as to repeat offenders. Fine: up to $50,000.

   B. Cocaine -- (HS 11350) — Punishment by imprisonment, no specified terms. No distinction as to repeat offenses and penalties.

   C. Marijuana -- (HS 11357) — Possession of any amount of concentrated cannabis, not less than one year in county jail or $500 fine or both. Possession of less than 1 oz. of marijuana $500 fine and release, repeat offenders rehabilitated.

   D. Amphetamines -- (HS 11377) — Not more than 1 year county jail or state prison.

   E. Barbiturates -- (HS 11377) — Not more than 1 year county jail or in state prison.

2. Unlawful Possession for Sale.

   A. Heroin -- (HS 11351) — Punishment by imprisonment for 2, 3 or 4 years. No distinction for repeat offenses and specific penalties. Fine of up to $50,000.

   B. Cocaine -- (HS 11351) — Punishment by imprisonment for 2, 3, or 4 years. No distinction for repeat offenses.

   C. Marijuana -- (HS 11359) — Punished by imprisonment, no specified terms.

   D. Amphetamine -- (HS 11378) — Punishment by imprisonment, no specific terms.

   E. Barbiturate -- (HS 11378) — Punished by imprisonment, no specified terms.

3. Unlawful Transportation, Sale, Administration, etc.

   A. Heroin -- (HS 11352) — Punished by imprisonment for 3, 4, or 5 years. Fine of up to $50,000 imposed in addition.

   B. Cocaine -- (HS 11352) — Punishment by imprisonment for 3, 4, or 5 years.

   C. Marijuana -- (HS 11360) — Punishment by imprisonment for any amount 2, 3 or 4 years. Less than 1 oz. fine of $100 and released.

* In addition to terms of imprisonment, trial court may impose a fine up to $20,000 for each offense under Sections 11350, 11351, 11353, 11355, 11359, 11360, 11361.

3. Unlawful Transportation, Sale, Administration, etc. (Con't.)

D. Amphetamines -- (HS 11352) Same as barbiturates.

E. Barbiturates -- (HS 11379) Punishment by imprisonment 2, 3, or 4 years.

4. Adult Influence a Minor.

A. Heroin -- (HS 11353) Punishment by imprisonment, no specified terms.

B. Cocaine -- (HS 11353) Same as heroin.

C. Marijuana -- (HS 11361) Punishment by imprisonment for 3, 4, or 5 years.

D. Amphetamines -- (HS 11380) Punishment by imprisonment 3, 4, or 5 years.

E. Barbiturates -- (HS 11380) Punishment by imprisonment 3, 4, or 5 years.

5. Miscellaneous.

Minor Influence a Minor -- (HS 11354) Punishment by imprisonment - no specified terms. (Jurisdiction maintained in juvenile court.)

Paraphernalia -- (HS 11364) Unlawful to possess instrument, paraphernalia, etc. for injection or smoking substances. No penalty prescribed.

Education -- (HS 11376) Trial court shall as condition of probation for anyone convicted of possession of controlled substance, Sched. I & II, order education or treatment. In case of juveniles, parents or guardians to participate.

Unlawful Presence -- (HS 11365) Unlawful to visit or be present in any room where any controlled substance or narcotic drugs are being unlawfully smoked or used. No penalty specified.

(1972 Act below, significantly modified in 1977)

CALIFORNIA UNIFORM CONTROLLED SUBSTANCES ACT

PENALTIES FOR CERTAIN OFFENSES*

Brief Summary

1. Unlawful Possession.

A. Heroin -- (HS 11350)	First: 2-10, elig. parole/release after 2 yrs. Second: 5-20, elig. parole/release after 5 yrs. Third or more: 15-life, elig. parole after 15 yrs.
B. Cocaine -- (HS 11350)	First: 5-15, elig. parole/release after 2½ yrs. Second: not less than 10, elig. parole/release 6 yrs Third or more: not less than 15 yrs., elig. parole/release after 15 yrs.
C. Marijuana -- (HS 11357)	First: Possession of any amount, not less than 1 yr. in county jail or more than 10 in state prison. Second: 2-20 , elig. parole/release after 2 yrs. Third or more: 5-life, elig. parole/release 5 yrs.
D. Amphetamines-- (HS 11377)	First: Not more than 1 yr., county jail, to 10 yrs. state prison. Second: 2-20, elig. parole/release after 5 yrs.
E. Barbiturates -- (HS 11377)	First: Not more than 1 yr. county jail, to 10 yrs. in state prison. Second: 2-20, elig. parole /release after 2 yrs.

2. Unlawful Possession for Sale.

A. Heroin -- (HS 11351)	First: 5-15, elig. parole /release after 2½ yrs. Second: not less than 10, elig. parole /rel. 6 yrs. Third or more: not less than 15 yrs., elig. parole /release after 15 yrs.
B. Cocaine -- (HS 11351)	Same as heroine.
C. Marijuana -- (HS 11359)	First: 2-10, elig. parole/release after 2 yrs.. Second:5-15, elig. parole/release after 3 yrs. Third or more: 10-life, elig. parole/release 6 yrs
D. Amphetamine -- (HS 11378)	Same as barbiturates.
E. Barbiturate -- (HS 11378)	First: 2-10, elig. parole / release after 2 yrs. Second: 5-15, elig. parole /release after 3 yrs. Third or more: 10-life, parole /release after 6 yrs

3. Unlawful transportation, sale, administration, etc.

A. Heroin -- (HS 11352)	First: 5-life, elig. parole/release after 3 yrs. Second: 10-life, elig. parole/release after 10 yrs Third or more: 15-life, elig. parole/release 15 yr
B. Cocaine (HS 11352)	Same as heroin.

*In addition to terms of imprisonment, trial court may impose a fine up to $20,000 for each offense under Sections 11350, 11351, 11353, 11355, 11359, 11360, 11361.

3. Unlawful transportation, sale, administration, etc. (Con't.)

C. Marijuana -- (HS 11360)	First: 5-life, elig. parole/release after 3 yrs. Second: 5-life, elig. parole/release after 5 yrs. Third or more: 10-life, elig. parole/release after 10 yrs.
D. Amphetamines -- (HS 11352)	Same as barbiturates.
E. Barbiturates -- (HS 11379)	First: 5-life, elig. parole/release after 3 yrs. Second: 5-life, elig. parole/release after 5 yrs. Third or more: 10-life, elig. parole/release after 10 yrs.

4. Adult Influence a Minor.

A. Heroine -- (HS 11353)	First: 10-life, elig. parole/release after 5 yrs. Second: 10-life, elig. parole/release after 10 yrs. Third or more: 15-life, elig. parole/release after 15 yrs.
B. Cocaine -- (HS 11353)	Same as heroin.
C. Marijuana -- (HS 11361)	First: 10-life, elig. parole/release after 5 yrs. Second: 10-life, elig. parole/release after 10 yrs. Third or more: 15-life, elig. parole/release after 15 yrs.
D. Amphetamines -- (HS 11380)	First: 10-life, elig. parole/release after 5 yrs. Second: 10-life, elig. parole/release after 10 yrs. Third or more: 15-life, elig. parole/release after 15 yrs.
E. Barbiturates -- (HS 11380)	First: 10-life, elig. parole/release after 5 yrs. Second: 10-life, elig. parole/release after 10 yrs. Third or more: 15-life, elig. parole/release after 15 yrs.

5. Miscellaneous.

Minor Influence A Minor--

Specified controlled Substances and Narcotic Drugs (HS11354)	First: Not less than 5 yrs. Second: Not less than 10 yrs. (Jurisdiction maintained in juvenile court.)
Paraphernalia -- (HS 11364)	Unlawful to possess instrument, paraphernalia, etc. for injection or smoking substances. No penalty prescribed.
Education -- (HS 11376)	Trial court shall as condition of probation for anyone convicted of possession of controlled substance, Sched. I & II, order education or treatment. In case of juveniles, parents or guardians to participate.
Unlawful Presence -- (HS 11365)	Unlawful to visit or be present in any room where any controlled substance or narcotic drugs are being unlawfully smoked or used. No penalty specified.

HOUSE BILL 479 REVISION STATE DRUG LAWS

The advisory committee is composed of five members. I suggest two additional members for better representation: #6 Physician Appointed by Govenor

#7 Citizen Appointed by Govenor

The majority of the Committee have special expertise in dealing with drugs. A public member would insure an opportunity for Citizen participation.

We cannot understand what the author had in mind when he wrote this bill. It's okay for adults to have a pound of marijuana and children cannot. If this bill passes, it tells children it's alright for parents to sneak out and find his pusher, obtain at least a pound of marijuana, then sneak home again and then the parent is legal. Again it's obvious misinterpretation by young people. One ounce of marijuana will provide 40 to 50 marijuana cigarettes.

This bill makes possession of one fourth ounce of cocaine a misdemeanor. I can not believe anyone would give a serious thought to passing a law like this. We have had two suicides of 17 and 18 year olds, cocaine connected. Cocaine should continue to be a felony.

We feel the penalties in this bill changed on each classification from the criminal code detracts and will continue to be confusing. We also feel when a person is convicted of a drug related arrest of furnishing, they should not be able to bail out of jail.

The Citizens of Kodiak feel the intent of a drug bill should discourage narcotics trafficking. Therefore, we recommend you do not pass House Bill No. 479.

I sincerely believe if you give a pass on House Bill No. 479 you will set a course that will profoundly affect the quality of life for hundreds of your fellow Alaskans.

James L. Rhines
Chief of Police
Box 509
Kodiak 99615

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James L. Rhines
Chief of Police
Box 509
Kodiak 99615

House Health, Education & Social Services Committee — Meeting/Hearing on ~~HB~~ 479 — Date: 2/2/80

	Name	Address and Phone	Organization/Self	For/Against or Observing
1/	DAN Hickey		att general Dept.	
2/				
3/	mr. McConcle		Pharmacist w/Bd of Pharmacy	would like to testify
4/	~~DAN Hickey~~			
5/	Frank Gold	3098 Airport Way Fbks, AK 99701	Kila, Inc. Fbks Drug Treatment Center	"cadaxon"
6/				
7/				
8/				
9/				
10/				
11/				
12/				
13/				

TO: Thelma Buchholdt, Chairman, and members of the House HESS Committee

FROM: Margaret W. Berck, Counsel to House Judiciary Committee

TITLE: HOUSE BILL NO. 479

1. CONTROLLED SUBSTANCES ADVISORY COMMITTEE
2. SCHEDULES
3. OFFENSES AND PENALTIES
   - A. DISTRIBUTING CONTROLLED SUBSTANCES TO MINORS
   - B. DISTRIBUTING CONTROLLED SUBSTANCES TO ADULTS
   - C. MANUFACTURING CONTROLLED SUBSTANCES
   - D. POSSESSION OF CONTROLLED SUBSTANCES
   - E. MARIJUANA OFFENSES
     - a. POSSESSION OF MARIJUANA WHILE OPERATING A MOTOR VEHICLE, VESSEL, OR AIRCRAFT
     - b. PUBLIC DISPLAY OR USE OF MARIJUANA
     - c. POSSESSION OF MARIJUANA BY A MINOR
4. REGULATION OF LEGITIMATE DRUG INDUSTRY
5. FORFEITURES
6. EDUCATION AND RESEARCH

Commissioner Nicke testimony on HB479 Dept of Public Safety

I appreciate the opportunity to give testimony before this Committee concerning the importance of revising the State's Drug Laws.

Our Department's statutory responsibilities deal primarily with the enforcement activity of Legislation passed by you. My testimony today is directed at that aspect of HB 479.

I am very encouraged at this Bills attempt to modernize Alaska's Drug Laws. The consolidation of existing laws and tying those into the sentencing structure of the new Criminal Code are major steps in discouraging illicit drug trafficking and the use of drugs. There has obviously been a great deal of work and expertise in developing this bill.

There are certain provisions on HB 479 that I would like to address from strictly a law enforcement view.

In HB 479 the responsibility for scheduling/rescheduling controlled substances is vested in a controlled substances committee.

The criteria whether a drug should be controlled basically follows the Federal Controlled Substances Act, which I feel could be greatly improved upon if additional criteria were added. Such as, the relationship between the use of the substance and other criminal activity including:

Whether a persons ingaged in illicit trafficking are also engaged in other criminal activities.

Whether the nature of the relative profitability of the substance encourages illicit trafficking in the substance.

Whether the commission of other crimes is one of the effects of the use of the substance.

Whether addiction to the substance relates to the commission of other crimes related to the continued use of the substance.

We feel strongly that this additional criteria should be used in controlling and scheduling drugs. Where drugs are placed on the schedule which ties them to the sentencing scheme, directly affects the use and trafficking of drugs.

There is a direct relationship between use, abuse, and other criminal activities. For instance, as the popularity of cocaine as a recreational drug increased so did our homicide rate. From 1976 through 1979 we are aware of 29 homicide cases in Alaska, directly related to drug trafficking with cocaine being the primary drug involved.

The penalty provisions of the Bill appear reasonable. However, I am concerned with the manner in which possession of specific amounts are tied to the penalty provisions.

In the Bill it refers to exact amounts, be it in the form of capsules, tablets, syrettes, or bulk. But as I read the Bill it does not address the size of the container, or the purity of the substance. This raises

some very interesting problems in prosecuting defendants, which will be addressed by the Department of Law. It raises some serious problems for the enforcement person, such as, field testing for small amounts, expending our limited resources on apprehending drug traffickers where there are only trace amounts involved. Such as, the State vs. Davis Stone. Case

HB 479 makes the possession of 0 to ~~29~~ 25 capsules, etc. or 1/8th or less of an ounce of heroin a misdemeanor. If the contents of the 25 capsules is more than 1/8th of an ounce, is it still a misdemeanor? 1/8th of an ounce of pure herion would produce approximately 1/2 pound of heroin for street use, worth between 36/40 K. Another example is cocaine, 1/4 oz. of pure coke in possession would produce 1 oz. for street use or 28 slips or approximately 56 hits. In the past, we have found that persons trafficking drugs are as versed in the law as we are, and will adjust their business accordingly. So, may I suggest that we will seldom find a vendor with more than enough in their possession, at first blush anyway, to warrant a felony charge. I believe the same holds true for any substance contained in Schedule I or II as presently written in HB 479.

In summary, I would like to again express my thoughts, or concern if you will, over certain provisions in HB 479.

1. The criteria for deciding whether a drug should be controlled and the criteria for deciding in which Schedule a drug should be classified should include factors concerning the relationship between use of the drug and other criminal activities.
2. The association between penalties and specific amounts of controlled substances listed in Schedule I and II creates serious if not

insurmountable problems for law enforcement.

I would like to mention that Governor Hammond will introduce to this Legislature a Drug Bill which addresses the concerns expressed by me today.

AKEELA HOUSE

January 25, 1990

Thelma Buchholdt, Chairman
House H.E.S.S. Committee
Alaska State Legislature
Pouch V
Juneau, Alaska 99811

Dear Chairman Buchholdt and other Committee members;

In regard to HB 479, you have already heard from AKEELA HOUSE via teleconference public testimony. This letter reiterates the basic points which we wished to make at that time:

1.) Sec. 17.17.010 outlines the creation and composition of a Controlled Substances Advisory Committee. It is our belief that this Committee should include an expert in the field of addiction rehabilitation, someone with a professional background and a successful track record in getting criminal abusers back into society as law-abiding citizens. The occupational history of this person might include counseling, psychology, or administrative work in such a program. Such a person could assist the Committee in determining the association between specific drugs, use and abuse patterns, and criminal or anti-social behavior, as well as the general mechanics of the considerations spelled out in Sec. 17.17.020 (c).

2.) Sec. 17.17.020 (e) states that the Controlled Substances Advisory Committee has no jurisdiction over alcohol. It is our hope that this provision will be given careful reconsideration by you. There is no question that alcohol is Alaska's most serious drug problem and that tighter controls on alcohol as a substance should be investigated. The physical, psychological, and social damage resulting from alcohol is many times greater than all other controlled substances combined. The situation, if left unaddressed, is especially dangerous for our native populations; the latest statistics strongly indicate that our native people will join the ranks of the Mandans and other extinct groups of indigenous Americans if measures are not taken, soon, to reverse the trend of alcoholism, alcohol-related deaths, and infant alcohol syndrome.

3.) Sec. 17.17.780 refers to education. We ask the Committee to consider strengthening this section to include <u>rehabilitation</u> as an alternative to or in addition to use-related incarceration and fines. We respectfully remind the Committee of the success rate of our kind

(Continued)

P. O. Box 8-9049 / Anchorage, Alaska 99508
Residential (907) 272-4476 / Outpatient (907) 276-1276

of program (@ 60%) versus the success rate of the corrections system (@ 20-30%), as well as the cost difference between our program and the prisons. We believe that the taxpayer realizes a more efficient use of public monies and a more crime-free society over all when every option and avenue of genuine rehabilitation is utilized.

Also, puruant to a request by members of your committee, AKEELA HOUSE staff has obtained copies of SB 65 and HB 101, and reviewed these bills. Our observations are:

1.) That HB 479 evidences greater care in preparation, pharmacology, and ascertaining the sociological implications of substance abuse. The language of this bill, also, is easier for the layman to understand.

2.) SB 65 and HB 101--the two are for all practical purposes identical--make no reference to rehabilitation or education and do not provide for an advisory board to respond to new developments such as: the discovery and entry into the market of new substances, new research data about existing substances, or ongoing social realities of substance use/abuse. These bills appear to have been written to address the concerns only of some law enforcement personnel without considering the impact and implications to the social order as a whole; and because of the complexity of language, these bills present a greater risk of being disproportionately applied to less advantaged members of the Alaskan population than does HB 479.

3.) The difference in penalties dictated between the various bills will probably have no impact on the problem of substance abuse as it currently exists. No evidence exists to suggest that the degree of punishment has any measurable impact on illicit use of controlled substances.

We appreciate being given the chance to present our views to the Committee. If you would like us to make any further comments, we will be glad to do so.

Yours for a drug-free lifestyle,

Sincerely,

J. C. Joe DiMatteo

Joseph C. DiMatteo
Executive Director

JD:md

HOUSE RESEARCH AGENCY
Pouch Y - State Capitol
Juneau, Alaska 99811
465-3991

MEMORANDUM January 28, 1980

TO: Representative Charles Parr

FROM: Jack Fargnoli, Issues Analyst
House Research Agency

RE: Research Request No. 23
(Drug Possession and Sales: Hawaii)

Prosecutor Lee Nakamura of the Prosecutor's Office, Department of the Attorney General in Honolulu, confirmed in a January 25 telephone conversation that the purity or concentration of controlled substances is not addressed specifically in Hawaii statutes and that, further, it is not considered as a factor in enforcement or in judicial proceedings. The purity or concentration of a drug is not used as the basis for determining the "amount" of a drug held in possession, as described in the Hawaii statutes; nor is it used as a basis in decisions to prosecute or in setting criminal sentences. However, occasionally a decision not to proceed with prosecution is reached in cases where extremely small, i.e., "trace," amounts of a controlled substance have been found in a mixture.

Mr. Nakamura informed us that all decisions to prosecute in Hawaii drug cases are made on a case by case basis, and that to date the question of drug purity has not produced any problems (or even been raised as an issue) in the federal courts. Should the courts object in the future, he said, adjustments would be made in the statutes; he did not view this as likely to occur, however.

Please let us know if you have any additional questions.

/dp

LAY MEMBERS
KENNETH L. BRADY
JOHN E. LONGWORTH
ROBERT H. MOSS

LAW MEMBERS
MARCUS R. CLAPP
MICHAEL M. HOLMES
JOSEPH L. YOUNG

CHAIRMAN EX OFFICIO
JAY A. RABINOWITZ
CHIEF JUSTICE
SUPREME COURT

Alaska Judicial Council

420 L Street, Suite 502
ANCHORAGE, ALASKA
99501
(907) 279-2526

EXECUTIVE DIRECTOR
MICHAEL L. RUBINSTEIN

January 23, 1980

M E M O R A N D U M

TO: MARGARET BERCK, STAFF COUNSEL
HOUSE JUDICIARY COMMITTEE

FROM: MICHAEL L. RUBINSTEIN, EXECUTIVE DIRECTOR
ALASKA JUDICIAL COUNCIL

RE: STATISTICS ON DRUGS

I hope the enclosed memo is useful. If you need more information, please call. If you give me a week's notice, Nick Maroules, who prepared the statistics, can testify.

M. L. R.

Enclosure

LAY MEMBERS
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EXECUTIVE DIRECTOR
MICHAEL L. RUBINSTEIN

January 23, 1980

M E M O R A N D U M

TO: MICHAEL L. RUBINSTEIN

FROM: NICK MAROULES

RE: HOUSE JUDICIARY COMMITTEE DATA REQUEST

This memo is in response to the House Judiciary Committee's request of October, 1979 for empirical information regarding drug offenses. The data upon which this analysis is predicated consists of 1901 felony convictions rendered in all ten Superior Court locations from July, 1976 to July, 1979. The first part of the analysis concerns the relationship of drug and alcohol use to crime. The request deals in part with the use of cocaine in relation to other criminal behavior. Unfortunately, our data sources (including court case files and presentence reports) did not include systematic information concerning the specific type of past drug use. We do have general information, however, concerning drug and/or alcohol addiction and heavy drug use. The analysis here presented should facilitate some understanding of the relationship of drug/alcohol use and crime. The request also concerned the relationship between the use of one drug, particularly marijuana, and other drugs. Again, our data is not amenable to this issue.

The second part of this analysis concerns the range of drug quantities typically involved in sale and possession offenses and corresponding penalties.

I. RELATIONSHIP OF DRUG AND ALCOHOL USE TO CRIME

Our new felony sentencing data contains information from presentence reports about drug and alcohol use. The information includes (1) indications of past (or ongoing) drug and/or alcohol addiction, (2) drug and/or alcohol use at the time of the offense, and (3) the defendant's record of previous (or current) treatment for drug and/or alcohol problems.

Table I, below, indicates that a significant positive relationship exists between drug or alcohol addiction and severity of the defendant's prior record. Specifically, those defendants identified by the presentence reporter as having had alcohol or drug problems also had substantially more serious criminal histories than those without such problems.

TABLE I

Severity of Prior Record By Drug/Alcohol Addiction (N=1669) *

	Drug Addiction History	Alcohol Addiction History	Neither
No Prior Record	12.8%	14.0%	49.6%
Misdem. Only	37.6%	52.0%	30.7%
One Prior Felony	25.2%	21.1%	13.7%
Two/More Felonies	24.3%	12.9%	6.1%
	100.0% (218)	100.0% (450)	100.0% (1001)

Significant at .001

*(There were 232 cases for which information of past drug/alcohol use was unavailable.)

The above contingency distributions indicate that defendants with no histories of drug or alcohol problems were four times more likely to have been first offenders than those with a history of drug/alcohol abuse. Nearly half of those with no histories of substance abuse were first offenders, compared to 12.8% and 14.0%, respectively, for those with drug and alcohol problems. At the other end of the scale, those with a drug or alcohol problem were substantially more likely to have prior felony convictions than those with no such history. These observed differences are statistically significant at the .001 level which means that there is only one chance in a thousand that the differences were due to chance.

Table I represents the overall relationship between prior record and drug/alcohol use for all defendants without regard to the type (or class) of their offense. Table A, in the appendix to this memorandum sets forth the relationship between these two variables for each of five broad classes of offense--violent felonies, property felonies (burglary, larceny, etc.), frauds/forgeries/embezzlements, drug crimes, and "morals" offenses. An examination of these tables reveals that the relationship observed in Table I persists among all offense classes.

As noted above, our data also includes information on drug or alcohol use at the time of the offense. Table II, below, indicates the proportion of cases in which the defendant was reported to have used drugs, drugs in combination with alcohol, or alcohol alone at the time of his offense, for each of four classes of offenses (drug offenses are eliminated from this aspect of the analysis).

TABLE II

Frequency of Use of Drugs and Alcohol
At Time of Offense for Four Offense Classes*

	Total Cases	Used Drugs	Used Drugs & Alcohol	Used Alcohol
Violent Offenses	(N=586)	3.2% (19)	4.9% (29)	56.3% (330)
Property Offenses	N=729)	4.0% (29)	4.4% (32)	39.2% (286)
Forgery/Fraud Offenses	(N=264)	2.7% (7)	0.8% (2)	9.1% (24)
"Morals" Offenses	(N=91)	1.1% (1)	9.9% (9)	46.2% (42)

* (Percents indicate proportion of all cases within class.)

Table II shows that alcohol use is much more often associated with criminal behavior than is drug use. The magnitude of alcohol use is staggering in comparison with drugs. It should be mentioned, however, that the relative difficulty in detecting drug intoxication as compared with alcohol use probably accounts for at least a portion of the difference.

II. DRUG QUANTITIES AND SENTENCES FOR SALE AND POSSESSION

Table III, below, reflects a distribution of drug types and amounts for possession and sale offenses. The proportion of cases within each amount-group receiving probation (or no active jail sentence) and the corresponding mean sentence (computed only for those with an active sentence) is also included.

TABLE III

Quantities and Sentences for
Possession and Sale Offense Convictions

	N of Cases	Proportion Probation	Mean* Sentence (In Months)	
I. POSSESSION OF NARCOTIC				
TYPE AND AMOUNT OF DRUG:				
Cocaine - Less than 1 gm.	15	53.3%	3.24	(7)
- 1 to 14 gms.	12	75.0%	15.00	(3)
- Over 14 gms.	7	57.1%	24.08	(3)
Heroin - Less than 1 gm.	6	33.3%	24.75	(4)
- 1 to 7 gms.	6	33.3%	54.00	(4)
- Over 7 gms.	5	20.0%	124.50	(4)
	N=51			
II. SALE OF NARCOTIC				
TYPE AND AMOUNT OF DRUG:				
Cocaine - Less than 1 gm.	11	36.4%	8.34	(7)
- 1 to 14 gms.	40	40.0%	26.58	(24)
- Over 14 gms.	10	20.0%	39.85	(8)
Heroin - Less than 1 gm.	2	0.0%	30.00	(2)
- 1 to 14 gms.	9	33.3%	46.00	(6)
- Over 14 gms.	4	25.0%	24.00	(3)
	N=76			
III. POSSESSION SALE HDS **				
TYPE AND AMOUNT OF DRUG:				
Cocaine - Over 14 gms.	(1)	0.0%	36.00	(1)
Marijuana - Over 2 #s	(10)	50.0%	16.80	(5)
	N=11			

TABLE III (CON'T)

IV. SALE OF HDS

	N of Cases	Proportion Probation	Mean* Sentence (In Months)
TYPE AND AMOUNT OF DRUG:			
Marijuana - Less than 2 oz.	4	0.0%	15.25 (4)
- 2 oz. to 2 #	8	87.5%	48.00 (1)
- Over 2 #	6	33.3%	34.00 (4)
Amph-Barb.- Less than 100	2	0.0%	7.00 (2)
- 100 to 999	1	100.0%	-----
- Over 1000	1	0.0%	1.00 (1)
Hallu-			
cinogens - Less than 20	7	57.1%	6.11 (3)
- 20 - 99	--	--	--
- Over 100	1	0.0%	12.00 (1)
	N=30		

* Mean sentences calculated excluding straight probation, or no time to serve.
** Three cases involving amphetamines or hallucinogens not included.

According to Table III, of N=51 convictions for Possession of a Narcotic (A.S. 17.10.200), 15 involved less than 1 gram of cocaine. Of these 15 cases, 53.3% received straight probation (or no active jail sentence). The mean sentence for the 7 defendants actually sentenced to jail time was 3.24 months.

Among narcotic offenses, cases involving heroin generally received longer (mean) sentences and were less likely to receive probation than those involving cocaine. Offenses involving cocaine received more severe penalties when the conviction was for sale rather than possession.

The opposite was true for heroin: possession offenses were sentenced more severely than sale offenses. This was especially surprising because often the amounts of heroin possessed were equal to or smaller than the amounts sold, but the sentences imposed were still longer.

N. M.

APPENDIX

TABLE A

SEVERITY OF PRIOR RECORD BY PAST DRUG/ALCOHOL USE FOR EACH OFFENSE CLASS

I. Violent Felonies (N=586)

	Past Drug Problem	Past Alcohol Problem	Neither
No Priors	9.3%	16.0%	47.1%
Misdmrs. Only	40.0%	53.1%	28.6%
One Felony	16.0%	17.8%	16.8%
Two/More Felonies	34.7%	13.1%	7.6%
	100.0%	100.0%	100.0%
	(75)	(213)	(238)

(60 Missing Cases)*
Significant at .001

II. Burglary, Larceny Offenses (N=729)

	Past Drug Problem	Past Alcohol Problem	Neither
No Priors	7.1%	10.9%	54.8%
Misdmrs. Only	27.1%	52.4%	28.5%
One Felony	40.0%	23.8%	11.4%
Two/More Felonies	25.7%	12.9%	5.3%
	100.0%	100.0%	100.0%
	(70)	(147)	(376)

(136 Missing Cases,*
Significant at .001

TABLE A, (Cont.)

III. Fraud, Forgery, Embezzlement Offenses (N=264)

	Past Drug Problem	Past Alcohol Problem	Neither
No Priors	26.1%	10.3%	49.2%
Misdmrs. Only	39.1%	35.9%	26.0%
One Felony	26.1%	35.9%	17.7%
Two/More Felonies	8.7%	17.9%	7.2%
	100.0%	100.0%	100.0%
	(23)	(39)	(181)

(21 Missing Cases)*
Significant at .001

IV. Drug Offenses (N=231)

	Past Drug Problem	Past Alcohol Problem	Neither
No Priors	23.8%	7.1%	41.3%
Misdmrs. Only	50.0%	64.3%	41.9%
One Felony	11.9%	21.4%	12.0%
Two/More Felonies	14.3%	7.1%	4.8%
	100.0%	100.0%	100.0%
	(42)	(14)	(167)

(8 Missing Cases)*
Significant at .05

TABLE A, (Cont.)

V. "Morals" Offenses (N=91)

	Past Drug Problem	Past Alcohol Problem	Neither
No Priors	0%	21.6%	51.3%
Misdmrs. Only	37.5%	56.8%	38.5%
One Felony	50.0%	13.5%	5.1%
Two/More Felonies	12.5%	8.1%	5.1%
	100.0%	100.0%	100.0%
	(8)	(37)	(39)

Significant at .01

* Cases noted as missing from the breakdown analysis concern theft for which past drug/alcohol histories or prior record information was unascertainable.

Alaska State Legislature

House of Representatives

Committee on Judiciary

Official Business

Pouch V
State Capitol
Juneau, Alaska 99811

M E M O R A N D U M February 28, 1980

TO: Charlie Parr, Chairman, House Judiciary Committee

FROM: Margaret W. Berck, Staff

SUBJECT: Sectional Analysis of HB 479

I. STANDARDS AND PROCEDURES.

*Section 1

Sec. 17.17.010. This section establishes a Controlled Substances Advisory Committee in the Department of Law. The members of the Committee are the Attorney General, Commissioners of Health and Social Services and Public Safety, a pharmacist and a criminal defense attorney. The latter two members are appointed by the Governor. All members serve without pay, but are entitled to travel expenses and per diem.

Sec. 17.17.020. This section defines the authority of the Controlled Substances Advisory Committee. The Committee is empowered to add, delete or re-schedule substances. All such actions must be adopted under the Administrative Procedures Act and in accord with the "public safety" criteria contained in this section. Should there be a change in the Federal schedules, the Committee is required to consider a similar change to Alaska law. The Committee is free to determine that such a Federal change is not warranted in Alaska, but must report such a decision, together with findings of fact, to the Lieutenant Governor.

Decisions by the Committee have no legal effect until the Legislature is given an opportunity to review them. Committee decisions must be submitted to the Legislature within the first 10 days of a session. The Legislature must act by the 56th day of the session if it wants to annul a proposal. All legislative annulments must take place in the form of a bill. Should the Legislature reject a proposal by

the Committee, the Committee cannot re-assert such a proposal to the Legislature for three years.

The Committee has no authority over tobacco or alcohol.

Sec. 17.17.030. This section provides that the inclusion of slang terms for drugs to assist the layperson in identifying controlled substances, has no bearing or effect in a criminal prosecution.

Sec. 17.17.040 - Sec. 17.17.090. These sections establish six schedules of controlled substances. The most dangerous substances are contained in Schedule I, while the least dangerous, marijuana, is contained in Schedule VI.

II. OFFENSES AND PENALTIES.

Sec. 17.17.200. This section creates a criminal offense and provides penalties for distributing a controlled substance to a minor. Although the penalties vary depending upon the schedule classification of the particular controlled substance distributed, all violations of this section would constitute a felony.

This section is designed to impose stiffer penalties on those persons over 18 years of age who distribute controlled substances to persons under 18 years of age. However, the recipient must be at least three years younger than the distributor before this section comes into effect. If the three-year age differential does not exist, the distributor would be subject to prosecution under the general distribution offenses.

This scheme was taken from the Uniform Controlled Substances Act and their rationale is as follows: "The three-year age differential is included to prevent imposition of the stiffer penalties in a case such as where a 19-year-old college student distributes two or three marijuana cigarettes to his 17-year-old roommate. In this situation, there is not the element of seduction so often found in cases where the distributor and recipient are far apart in age."

Sec. 17.17.210. This section creates a criminal offense and provides penalties for manufacturing a controlled substance. Although the penalties vary depending upon the schedule classification of the particular controlled substance manufactured, all violations of this section would constitute a felony. The definition of "manufacture" (Sec. 17.17.900(14))

includes propagation of certain of the substances, such as marijuana. In order to comply with the Alaska Constitution as interpreted in Ravin, and in order to justify the stiffer penalties for this offense, the definition of "manufacture" excludes manufacturing for personal use. A person manufacturing controlled substances for his personal use would be subject to prosecution under possession offenses.

Sec. 17.17.220 - Sec. 17.17.270. These sections create a criminal offense and provide penalties for distributing a controlled substance. Separate sections are provided for each schedule classification. Penalties vary depending upon the schedule classification and the amount involved. Despite penalty variations, distribution of any amount of a Schedule I, II, III, or IV substance would constitute a felony offense. Distributions of small amounts of a Schedule V or a Schedule VI substance would constitute a Class A misdemeanor. Furthermore, a "non-remuneration defense" is provided for the distribution of an ounce or less of a Schedule VI substance (marijuana). If the distributor is successful in providing that such a distribution was made for no remuneration to a person 18 years of age or older, the penalty is reduced from a Class A misdemeanor to a Class B misdemeanor. This provision is compatible with Federal law which provides that a person who distributes a small amount of marijuana for no remuneration is guilty of a misdemeanor rather than a felony. (21 USCA 841) Furthermore under Federal law (21 USCA 844), if such a person has never been previously convicted of a drug offense, the court may place the person on probation and subsequently dismiss the criminal charge against the person if he does not violate his parole. Under this Federal provision, the person would not acquire a criminal record.

Sec. 17.17.280 - Sec. 17.17.330. These sections create a criminal offense and provide penalties for possessing a controlled substance. Separate sections are provided for each schedule classification. Penalties vary depending upon the schedule classification and the amount involved. Possession of small amounts of any substance would constitute a Class A misdemeanor. This provision is compatible with Federal law which establishes misdemeanor penalties for simple possession of any controlled substance. Unlike the Federal law, however, HB 479 would establish felony offenses for the possession of large amounts of any controlled substance. This scheme was adopted in HB 479, in order to facilitate the capture of drug dealers who are not caught in the act of distribution. Traditionally, these individuals have been prosecuted under a "possession with intent to sell" offense. But due to the difficulties in prosecuting "intent to sell"

offenses, HB 479 eliminates that type of offense and looks strictly to the amount possessed in determining appropriate penalties.

In order to comply with the Alaska Constitution as interpreted in Raven, possession of less than a pound of marijuana by an adult would not constitute a criminal offense.

Sec. 17.17.340. This section makes it a Class B misdemeanor to possess any amount of marijuana in your immediate control while operating a motor vehicle, vessel, or aircraft. Under existing law, the maximum punishment for this type of offense is a $1,000 fine. Under HB 479 an offender is subject to a 90 day jail sentence, or a $1,000 fine, or both.

Sec. 17.17.350. This section makes it a violation (a fine of up to $300) to display or use any amount of marijuana in a public place.

Sec. 17.17.360. This section makes it unlawful for a minor to possess any amount of marijuana. A minor who violates this section is guilty of a violation.

Sec. 17.17.370. This section is directed at the legitimate drug industry. It makes it a Class B misdemeanor for a person to refuse or fail to make or keep all records required by this Act.

Sec. 17.17.380. This section also is directed at the legitimate drug industry. It makes it a Class C felony to do any of the following: (1) to keep or maintain any structure for storing or selling controlled substances in violation of this Act; (2) to use a registration number that is ficticious, revoked or suspended; (3) to obtain a controlled substance by fraud, forgery or deception; (4) to make, distribute, or possess a die to print a trademark upon a drug or container so as to render a drug a counterfeit substance; and (5) to furnish false or fraudulent information on any record required to be made and kept by this Act.

Sec. 17.17.390. This section provides for the creation of a three-year felony offense for certain possession and distribution offenses. In order to graduate the penalties in relation to type of offense, substance classification and quantities, an additional felony offense to those established in the new criminal code was required.

Sec. 17.17.400. This section provides that in those offenses which require the consideration of an amount for determining

appropriate penalties, it is no defense to a prosecution that the amount was in fact larger than that required for the offense charged.

Sec. 17.17.410. This section provides that a penalty imposed under this law is in addition to other civil or administrative penalties imposed by law.

Sec. 17.17.420. This section prohibits the prosecution of an individual under this law, if the individual's act constituted an offense under Federal law or the law of another state and the individual was convicted or acquitted under those laws.

III. REGULATION OF MANUFACTURE, DISTRIBUTION AND DISPENSING OF CONTROLLED SUBSTANCES

Sec. 17.17.550. This section empowers the Commissioner of Health and Social Services to adopt regulations under the Administrative Procedure Act and to establish reasonable fees relating to the regulation of the legitimate drug industry.

Sec. 17.17.560. This section requires any person who manufactures, distributes, or dispenses controlled substances in this State to register annually with the Commissioner of Health and Social Services. Certain individuals, such as employees of registered dispensers or common carriers, need not register. Furthermore, the commissioner may inspect the establishment of a registrant or applicant.

Sec. 17.17.570. This section establishes the standards whereby the Commissioner of Health and Social Services may grant or deny registration. A person is entitled to registration if he complies with Federal registration requirements.

Sec. 17.17.580. This section establishes the standards whereby the Commissioner of Health and Social Services may revoke or suspend a registration to manufacture, distribute, or dispense a controlled substance.

Sec. 17.17.590. This section provides for the due process rights of an individual whose registration is the subject of a denial, suspension, or revocation. Prior to taking action, the Commissioner of Health and Social Services must serve the individual with a factual statement on which the proposed action is based. The individual is entitled to an adjudication under the Administrative Procedure Act. The commissioner may suspend the registration during the administrative proceedings only if he finds there is an imminent danger to the public.

Sec. 17.17.600. This section requires a registrant to keep and maintain records in conformance with the requirements of Federal law and with the additional requirements the commissioner may adopt.

Sec. 17.17.610. This section provides that the distribution of controlled substances must conform to Federal requirements regarding order forms and prescriptions.

IV. ENFORCEMENT AND ADMINISTRATION.

Sec. 17.17.750. This section requires the Commissioner of Public Safety, the Attorney General, and all law enforcement officers of the State to cooperate with drug enforcement agencies of the United States and other states.

Sec. 17.17.760. This section provides for the forfeiture of various items of property utilized in violation of this Act. Aircraft, motor vehicles and vessels are not subject to forfeiture if their use was committed by a person other than the owner or secured party unless such owner or secured party was privy to the violation.

Such property may be forfeited to the state upon a criminal conviction of the defendant or upon a judgment of a court in a civil proceeding against the property.

The property may be seized by the Commissioner of Public Safety upon an order issued by a court finding that probable cause exists that the property is subject to forfeiture. Seizure without a court order may be made if: (1) it is incident to a valid arrest or valid search warrant; (2) it has been the subject of a prior judgment in favor of the State in either a criminal or civil proceeding; or (3) there is probable cause that the property was or is being used in a drug violation and the property is easily movable. Property seized under this last provision, may not be held over 48 hours or until an order may be applied for and issued by a court, whichever is earlier.

Property forfeited under this section shall be disposed of according to court order.

Sec. 17.17.770. This section provides that the burden of proof is on the State to prove by clear and convincing evidence that the property in question is subject to forfeiture. Liability is not imposed upon a State or local officer engaged in the lawful performance of his duties.

Sec. 17.17.780. This section requires the Commissioner of Health and Social Services to provide educational programs designed to prevent and deter abuse of controlled substances. Additionally, the commissioner shall encourage research on controlled substances.

V. GENERAL PROVISIONS.

Sec. 17.17.900. This section provides the definitions of various terms used in this Act.

Sec. 17.17.990. This section provides that the Act may be cited as the Controlled Substances Act.

*Section 2 and *Section 3.

These sections amend existing statutes that refer to current drug titles that would be repealed by this Act.

*Section 4.

This section amends AS 12.55.155(c) to provide additional aggravating sentencing factors to be utilized in drug offenses. These additional factors are: (1) smuggling a controlled substance into the State; (2) the commission of an offense involving large quantities of controlled substances; and (3) the commission of an offense involving the distribution of a controlled substance adulterated with a toxic substance.

*Section 5.

This section amends AS 12.55.155(d) to provide additional mitigating sentencing factors to be employed in drug offenses. Those additional factors are: (1) the commission of an offense involving small quantities of controlled substances; (2) the commission of an offense involving the distribution of a controlled substance for no remuneration to a personal acquaintance 19 years of age or older; and (3) the commission of an offense involving the possession of a controlled substance for personal use in the defendant's home.

*Section 6.

This section amends existing law regarding the duties of the Department of Health and Social Services.

Section 7.

This section provides for the continuation of various proceedings commenced prior to the effective date of this Act.

*Section 8.

This section provides for the continuation of orders and regulations not in conflict with this Act until modified, superseded, or repealed.

*Section 9.

This section provides for the repeal of existing drug statutes.

MWB:vc

Button manilla folder – Reg Dep Chapt 8 Calif Law

#1 Sec. analysis – Peggy Berch

#2 ~~letter~~ memo to Rep Parr from H. Research re: purity of controlled ~~substance~~ substance.

#3. DATA (Drug Tables) requested by this committee from AK Judicial Council (Drug tables.)

#4. Comparison of HB479 w/ FDA regs. by Dr. Verner Stellner.

5. letter from Kenai Police Dep

6. letter from exec. direct. of Rural Cap

7. letter from ~~program~~ exec direct. Akeela House

8. letter from ~~Salvation~~ program direct Phillips alcoholism treatment center.

9. Copy of teleconference testimony re. Sol as requested by committee. Strauss 7 pgs

10. copy of testimony from re. Kic Adams 7 pgs.

11. folder

STATE OF ALASKA
THE LEGISLATURE

POUCH Y - STATE CAPITOL
JUNEAU, ALASKA 99811
907-465-3800

LEGISLATIVE AFFAIRS AGENCY

M E M O R A N D U M March 19, 1980

SUBJECT: CS for HB 479

TO: Representative Thelma Buchholdt, Chairman
House Health, Education and Social Services
Committee
Attn: Shannon Garrett, A.A.

FROM: Thomas A. Sofo
Legislative Counsel

The attached committee substitute for House Bill 479 contains the additions which you requested from the governor's bill (HB 628). There are several problems which remain in this most recent version of the bill. First, it should be noted that the "advisory" committee which we have created seems to possess some powers in excess of those typically held by a committee whose function is merely advisory. The committee substitute allows the advisory committee to adopt regulations at least so far as they pertain to the addition of controlled substances to the various schedules in this Act. This quasi-lawmaking authority probably serves to take the committee out of the advisory category.

Secondly, the membership of the committee includes a legislator. Although that legislator is a non-voting member, there are several potential problems raised by his presence on the committee. There is the practical problem of having the governor appoint a legislator to such a committee. There is possibly a more serious problem of constitutional dimensions in having a legislator serve on a committee which exercises executive functions. Even though he may not be drawing a salary or allowed to vote on committee business, the presence of a legislator on such a committee is open to attack on the grounds that his mere presence alone will in some way affect the decisions which the committee reaches. If this were not so, we would not have placed such an individual on the committee. There is also a possible additional argument regarding the constitutional provision against dual office holding by legislators. The latter concern may be satisfied by reference to the fact that the legislator will not be drawing any salary for his service on the committee.

I would suggest that the committee consider changing the title of this advisory committee by deleting the adjective "advisory". The bill would also be stronger if we could eliminate the legislative member on the committee. I would be happy to discuss the above points with you at your convenience.

TAS:ljb

Enclosure

STATE OF ALASKA
THE LEGISLATURE

POUCH Y - STATE CAPITOL
JUNEAU, ALASKA 99811
907-465-3800

LEGISLATIVE AFFAIRS AGENCY

MEMORANDUM March 19, 1980

SUBJECT: CS for HB 479

TO: Representative Thelma Buchholdt, Chairman
House Health, Education and Social Services
Committee
Attn: Shannon Garrett, A.A.

FROM: Thomas A. Sofo
Legislative Counsel

Amended

The attached committee substitute for House Bill 479 contains the additions which you requested from the governor's bill (HB 628). There are several problems which remain in this most recent version of the bill. First, it should be noted that the "advisory" committee which we have created seems to possess some powers in excess of those typically held by a committee whose function is merely advisory. The committee substitute allows the advisory committee to adopt regulations at least so far as they pertain to the addition of controlled substances to the various schedules in this Act. This quasi-lawmaking authority probably serves to take the committee out of the advisory category.

Secondly, the membership of the committee includes a legislator. Although that legislator is a non-voting member, there are several potential problems raised by his presence on the committee. There is the practical problem of having the governor appoint a legislator to such a committee. There is possibly a more serious problem of constitutional dimensions in having a legislator serve on a committee which exercises executive functions. Even though he may not be drawing a salary or allowed to vote on committee business, the presence of a legislator on such a committee is open to attack on the grounds that his mere presence alone will in some way affect the decisions which the committee reaches. If this were not so, we would not have placed such an individual on the committee. There is also a possible additional argument regarding the constitutional provision against dual office holding by legislators. The latter concern may be satisfied by reference to the fact that the legislator will not be drawing any salary for his service on the committee.

I would suggest that the committee consider changing the title of this advisory committee by deleting the adjective "advisory". The bill would also be stronger if we could eliminate the legislative member on the committee. I would be happy to discuss the above points with you at your convenience.

TAS:ljb

Enclosure

wo 6432
Sofo

Original sponsor: Parr

IN THE HOUSE BY THE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

CS FOR HOUSE BILL NO. 479

IN THE LEGISLATURE OF THE STATE OF ALASKA

ELEVENTH LEGISLATURE - SECOND SESSION

A BILL

For an Act entitled: "An Act revising the drug laws of the state."

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

* Section 1. AS 17 is amended by adding a new chapter to read:

CHAPTER 17. CONTROLLED SUBSTANCES ACT.

ARTICLE 1. STANDARDS AND PROCEDURES.

Sec. 17.17.010. CONTROLLED SUBSTANCES ADVISORY COMMITTEE. (a) There is created within the Department of Law the Controlled Substances Advisory Committee, composed of

(1) the attorney general or his designee;

(2) the commissioner of health and social services or his designee;

(3) the commissioner of public safety or his designee;

(4) a pharmacist appointed by the governor;

(5) an attorney appointed by the governor;

(6) a physician appointed by the governor;

(7) a psychiatrist appointed by the governor;

(8) a member of the legislature appointed by the governor;

(9) a member of the general public appointed by the governor.

(b) The attorney general, the commissioner of health and social services, and the commissioner of public safety, and the legislator serve ex officio and are nonvoting members of the committee. The members appointed by the governor serve terms of four years and until their successors are appointed and qualify, except that the attorney initially appointed under (a)(5) of this section serves a term of three years and

until his successor is appointed and qualifies.

(c) The members receive no compensation for their service on the committee but are entitled to travel expenses and per diem under AS 39.-20.180.

(d) The committee shall meet at the call of the attorney general. Three voting members constitute a quorum. The committee may adopt bylaws for its proceedings.

Sec. 17.17.020. AUTHORITY TO SCHEDULE CONTROLLED SUBSTANCES. (a) The committee may recommend to the legis the addition and deletion of by regulation adopted under the Administrative Procedure Act (AS 44.62) add substances to the schedules in AS 17.17.-040 - 17.17.090. The committee may not delete substances from those schedules or reclassify substances from one schedule to another. In making a recommendation determination regarding the addition or deletion of a substance, the committee shall assess the danger or probable danger of the substance by considering the following:

(1) the actual or probable abuse of the substance, including

(A) its history and current pattern of abuse;

(B) the scope, duration, and significance of abuse; and

(C) the degree of actual or probable detriment which may result from abuse of the substance;

(D) the probable physical and social impact of widespread abuse of the substance;

(2) the biomedical hazard of the substance, including

(A) its pharmacology: the effects and modifiers of effects of the substance;

(B) its toxicology: the acute and chronic toxicity, interaction with other substances whether controlled or not, and liability to psychological or physiological dependence;

(C) its risk to public health and the particular suscepti

bility of segments of the population;

(3) whether the substance is an immediate precursor of a substance already controlled under this chapter;

(4) the current state of scientific knowledge regarding the substance;

(5) the relationship between the use of the substance and other criminal activity including

(A) whether persons engaged in illicit trafficking of the substance are also engaged in other criminal activity;

(B) whether the nature and relative profitability of the substance encourage illicit trafficking in the substance;

(C) whether the commission of other crimes is one of the effects of the use of the substance;

(D) whether addiction to the substance relates to the commission of crimes to support the continued use of the substance.

(b) If, after considering the factors set out in (a) of this section, the committee finds that a substance should be added to or deleted from a schedule, the committee shall adopt a regulation in accordance with its findings. request the H.C. and CCU to prepare legislation

(c) The committee shall advise the governor and the legislature as to the need to add delete or reschedule substances in the schedules in AS 17.17.040 -17.17.090. In making recommendations regarding a substance, the committee shall assess the danger or probable danger of the substance by considering the factors set out in (a) of this section.

(d) If the committee designates a substance as an immediate precursor of a controlled substance, substances which are precursors of the controlled precursor are not subject to control solely because they are precursors of the controlled precursor.

(e) By the 30th day of each legislative session, the committee shall prepare and present to the governor and the legislature a report

discussing the actions of the committee during the preceding year. If the committee has ~~adopted~~ recommended a regulation adding a controlled substance, the report shall include the committee's findings of fact and other supporting information it considers appropriate.

(f) The committee has no authority over tobacco or over intoxicating liquor as defined in AS 04.20.010.

Sec. 17.17.030. NOMENCLATURE. The controlled substances listed in the schedules in AS 17.17.040 - 17.17.090 or in the regulations adopted under this chapter are included by whatever official, common, usual, chemical, or trade name designated. In some instances, slang terms are listed after a controlled substance. In a prosecution or other proceeding under this chapter, it is not a defense and it is immaterial that a slang term is listed after more than one controlled substance, that a slang term listed after a controlled substance is inaccurately applied to that controlled substance, that no slang term is listed after a controlled substance, or that slang terms other than those listed apply in fact to a controlled substance.

Sec. 17.17.040. SCHEDULE I. (a) A substance shall be placed in Schedule I if it is found under AS 17.17.020 to have the highest degree of danger or probable danger.

(b) Unless specifically excepted or unless listed in another schedule, Schedule I controlled substances include any material compound which contains any quantity of a substance listed in this subsection, including its salts, its isomers, (whether optical, position, or geometric), and the salts of its isomers whenever the existence of those salts, isomers, or salts of isomers is possible within the specific chemical designation, regardless of whether the listed substance is produced directly or indirectly by extraction from substances of vegetable origin or independently by means of chemical synthesis or by a

combination of extraction and chemical synthesis:

(1) opium and opiate, and any salt, compound, derivative, or preparation of opium or opiate, excluding apomorphine, dextrorphan, nalbuphine, naloxone, and naltrexone, and their respective salts, but including the following:

(A) raw opium (slang terms: op, pen yan, hop, tar, black stuff);

(B) opium extracts;

(C) opium fluid extracts;

(D) powdered opium;

(E) granulated opium;

(F) tincture of opium;

(G) codeine (slang term: school boy);

(H) ethylmorphine;

(I) etorphine hydrochloride;

(J) hydrocodone;

(K) hydromorphone;

(L) metopon;

(M) morphine (slang terms: cube, first line, hocus, Miss Emma, morph, morpho, morphy, mud, white stuff, hard stuff, M, unkie);

(N) oxycodone;

(O) oxymorphone;

(P) thebaine;

(2) any salt, compound, derivative, or preparation of these which is chemically equivalent or identical with any of the substances referred to in (1) of this subsection, except that these substances do not include the isoquinoline alkaloids of opium;

(3) opium poppy and poppy straw;

(4) concentrate of poppy straw (the crude extract of poppy straw in liquid, solid, or powder form which contains the phenanthrine alkaloids of the opium poppy);

(5) acetylmethadol;

(6) allylprodine;

(7) alphacetylmethadol;

(8) alphameprodine;

(9) alphamethadol;

(10) anileridine;

(11) alphaprodine;

(12) benzethidine;

(13) betacetylmethadol;

(14) betameprodine;

(15) betamethadol;

(16) betaprodine;

(17) clonitazene;

(18) dextromoramide;

(19) diampromide;

(20) diethylthiambutene;

(21) difenoxin;

(22) dimenoxadol;

(23) dimepheptanol;

(24) dimethylthiambutene;

(25) dioxaphetyl butyrate;

(26) dipipanone;

(27) ethylmethylthiambutene;

(28) etonitazene;

(29) etoxeridine;

(30) furethidine;

(31) hydroxpethidine;

(32) ketobemidone;

(33) levomoramide;

(34) levophenacylmorphan;

(35) morpheridine;

(36) noracymethadol;

(37) norlevorphanol;

(38) normethadone;

(39) norpipanone;

(40) phenadoxone;

(41) phenampromide;

(42) phenomorphan;

(43) phenoperidine;

(44) piritramide;

(45) proheptazine;

(46) properidine;

(47) propiram;

(48) racemoramide;

(49) trimeperidine;

(50) acetorphine;

(51) acetyldihydrocodeine;

(52) benzylmorphine;

(53) codeine methylbromide;

(54) codeine-N-oxide;

(55) cyprenorphine;

(56) desomorphine;

(57) dihydromorphine;

(58) drotebanol;

(59) etorphine;

(60) heroin (slang terms: big H, boy, brown, brown sugar, caballo, Chinese red, chiva, crap, doojee, H, Harry, horse, junk, Mexican mud, powder, scag, smack, stuff, thing, joy powder, white stuff, sugar, hairy, skag, schmeck);

(61) hydromorphinol;

(62) methyldesorphine;

(63) methyldihydromorphine;

(64) morphine methylbromide;

(65) morphine methylsulfonate;

(66) morphine-N-oxide;

(67) myrophine;

(68) nicocodeine;

(69) nicomorphine;

(70) normorphine;

(71) pholcodine;

(72) thebacon;

(73) alpheprodine;

(74) anileridine;

(75) bezitramide;

(76) dihydrocodeine;

(77) diphenoxylate;

(78) fentanyl;

(79) isomethadone;

(80) levomethorphan;

(81) levorphanol;

(82) metazocine;

(83) methadone;

(84) methadone-intermediate, 4-cyano-2-dimethylamino-4, 4-diphenyl butane;

(85) moramide-intermediate, 2-methyl-3-morpholino-1, 1-diphenylpropane-carboxylic acid;

(86) pethidine (meperidine);

(87) pethidine-intermediate-A, 4-cyano-1-methyl-4-phenylpiperidine;

(88) pethidine-intermediate-B, ethyl-4-phenylpiperidine-4-carboxylate;

(89) pethidine-intermediate-C, 1-methyl-4-phenylpiperidine-4-carboxylic acid;

(90) phenazocine;

(91) piminodine;

(92) racemethorphan;

(93) racemorphan.

Sec. 17.17.050. SCHEDULE II. (a) A substance shall be placed in Schedule II if it is found under AS 17.17.020 to have a degree of danger or probable danger lower than Schedule I controlled substances but higher than Schedule III controlled subtances.

(b) Unless specifically excepted or unless listed in another schedule, Schedule II controlled substances include any material compound which contains any quantity of a substance listed in this subsection, including its salts, its isomers (whether optical, position, or geometric), and the salts of its isomers whenever the existence of those salts, isomers, or salts of isomers is possible within the specific chemical designation, regardless of whether the listed substance is produced directly or indirectly by extraction from substances of vegetable origin or independently by means of chemical synthesis or by a combination of extraction and chemical synthesis:

(1) cocaine and any compound, derivative, or preparation of coca leaves produced directly or indirectly by extraction from coca

leaves, or independently by means of chemical synthesis, or by a combination of extraction and chemical synthesis, including the isomers, salts, and salts of isomers of cocaine and other derivatives of coca leaves whenever the existence of such isomers and salts is possible, but does not include decocainized coca leaves or extractions of coca leaves which do not contain cocaine or ecogonine (slang terms: Bernice, bernies, big C, blow, C, coke, dream, flake, girl, gold dust, heaven dust, nose candy, paradise, rock, white, happy dust, speedballs, snow birds, Cecil, stardust, Corine, Carrie, dust, Burese);

(2) 4-bromo-2,5-dimethoxy-amphetamine, also known as bromo-2, 5-dimethoxy-a-methylphenethylamine and 4-bromo-2,5-DMA;

(3) 2,5-dimethoxyamphetamine, also known as 2,5-dimethoxy-a-methylphenethylamine and 2,5-DMA;

(4) 4-methoxyamphetamine, also known as 4-methoxy-a-methylphenethylamine and paramethoxyamphetamine, PMA;

(5) 5-methoxy-3,4-methylenedioxy-amphetamine;

(6) 4-methyl-2,5-dimethoxy-amphetamine, also known as 4-methyl-2,5-dimethoxy-a-methylphenethylamine (slang terms: DOM, MDA, STP, serenity, tranquility, and peace, cone drug);

(7) 3,4-methylenedioxy amphetamine;

(8) 3,4,5-trimethoxy amphetamine;

(9) bufotenine, also known as 3-(b-dimethylaminoethyl)-5-hydroxyindole and 3-(2-dimethylaminoethyl)-5-indolol and N,N-dimethylserotonin and 5-hydroxy-N,N-dimethyltryptamine and mappine;

(10) diethyltryptamine, also known as N,N-diethyltryptamine and DET;

(11) dimethyltryptamine, also known as DMT (slang terms: businessman's special, lunch-hour trip);

(12) ibogaine, also known as 7-ethyl-6,6,B,7,8,9,10,12,13-

octahydro-2-methoxy-6,9-methano-5H-pyrido [1', 2':1,2] azepino [5,4-b] indole and Tabernanthe iboga;

(13) lysergic acid diethylamide (slang terms: Alice D, acid, beast, big D, blue cheer, blue heaven, blue mist, brown dots, California sunshine, chocolate chips, coffee, contact lens, cupcakes, haze, mellow yellows, microdots, orange mushrooms, orange wedges, Owsley, paper acid, royal blue, strawberry fields, sugar, sunshine, the hawk, wedges, white lightning, window pane, yellows, cubes, 25, Lucy in the sky with diamonds);

(14) mescaline (slang terms: mesc, mescal, moon);

(15) peyote, meaning all parts of the plant presently classified botanically as Lophophora williamsii Lemaire, whether growing or not, the seeds of the plant, any extract from any part of the plant, and every compound, manufacture, salts, derivative, mixture, or preparation of the plant, its seeds, or extracts (slang terms: buttons, cactus, mescal buttons, mesc, mescal, plants);

(16) N-ethyl-3-piperidyl benzilate;

(17) N-methyl-3-piperidyl benzilate (slang term: LBJ);

(18) psilocybin (slang terms: magic mushroom, mushroom);

(19) psilocyn (slang terms: magic mushroom, mushroom);

(20) chemically synthesized tetrahydrocannabinols, also known as THC;

(21) thiophene analog of phencyclidine, also known as: 1-[1-(2-thienyl) cyclohexyl] piperidine and 2-thienyl analog of phencyclidine and TPCP;

(22) phencyclidine, also known as PCP (slang terms: angel dust, DOA (Dead On Arrival), hog, killer weed (when combined with marijuana or other plant material), peace pill);

(23) mecloqualone;

(24) amphetamine, its salts, optical isomers, and salts of its optical isomers (slang terms: beans, bennies, black beauties, blackbirds, black Mollies, bumblebees, cartweels, chalk, chicken powder, copilots, crank, crossroads, crystal, dexies, double cross, eye openers, hearts, jelly beans, lightning, meth, minibennies, nuggets, oranges, pep pills, speed, roses, thrusters, truck drivers, turnabouts, uppers, ups, wake-ups, peaches, whites, browns, greenies, bombido, jugs, bottles, lid proppers, football, coast-to-coast, L.A. turnabouts);

(25) methamphetamine, its salts, isomers, and salts of its isomers (slang terms: bombido, crystal, meth, speed, splash);

(26) phenmetrazine and its salts;

(27) methylphenidate;

(28) methaqualone (slang terms: ludes, quas, quads, soapers, sopes);

(29) amobarbital (slang terms: barbs, block busters, Christmas trees, downers, green dragons, peanuts, sleeping pills, stumblers, goofballs, goofs, tuinal, tuies, rainbow, double trouble, red and blues);

(30) secobarbital (slang terms: barbs, block busters, Christmas trees, downers, green dragons, peanuts, sleeping pills, stumblers, goofballs, goofs, tuinal, tuies, rainbow, double trouble, red and blues, reds, red birds, red devils, seccy, pink, seggy, pink ladies, marshmallow reds, Mexican reds);

(31) pentobarbital (slang terms: barbs, block busters, Christmas trees, downers, green dragons, peanuts, sleeping pills, stumblers, goofballs, goofs, yellow jackets, yellows, nimbys, nimbies, nobbies).

Sec. 17.17.0[illegible]. SCHEDULE III. (a) A substance shall be placed in Schedule III if it is found under AS 17.17.020 to have a degree of

danger or probable danger lower than Schedule II controlled substances but higher than Schedule IV controlled substances.

(b) Unless specifically excepted or unless listed in another schedule, Schedule III controlled substances include any material compound which contains any quantity of a substance listed in this subsection, including its salts, its isomers (whether optical, position, or geometric), and the salts of its isomers whenever the existence of those salts, isomers, or salts of isomers is possible within the specific chemical designation, regardless of whether the listed substance is produced directly or indirectly by extraction from substances of vegetable origin or independently by means of chemical synthesis or by a combination of extraction and chemical synthesis:

(1) benzphetamine;

(2) chlorphentermine;

(3) clortermine;

(4) mazindol;

(5) phendimetrazine;

(6) any compound, mixture, or preparation containing amobarbital, secobarbital, or pentobarbital or any salt of any of these substances combined with one or more other active medicinal ingredients which are not listed in any classification in this section;

(7) any suppository dosage form containing amobarbital, secobarbital, or pentobarbital or any salt of any of these substances which are approved by the federal Food and Drug Administration for marketing only as a suppository;

(8) any substance, having a depressant effect on the central nervous system, which contains any quantity or derivative of barbituric acid or any salt of these;

(9) chlorhexadol;

(10) glutethimide (slang terms: C.D., cibas);

(11) lysergic acid;

(12) lysergic acid amide;

(13) methyprylon;

(14) sulfondiethylmethane;

(15) sulfonethylmethane;

(16) sulfonmethane;

(17) nalorphine;

(18) any material, compound, mixture, or preparation containing limited quantities of any of the following substances or any of their salts:

(A) not more than 1.8 grams of codeine per 100 milliliters or not more than 90 milligrams per dosage unit, with an equal or greater quantity of an isoquinoline alkaloid of opium;

(B) not more than 1.8 grams of codeine per 100 milliliters or not more than 90 milligrams per dosage unit, with one or more active, nonnarcotic ingredients in recognized therapeutic amounts;

(C) not more than 300 milligrams of dihydrocodeinone per 100 milliliters or not more than 15 milligrams per dosage unit, with a fourfold or greater quantity of an isoquinoline alkaloid of opium;

(D) not more than 300 milligrams of dihydrocodeinone per 100 milliliters or not more than 15 milligrams per dosage unit, with one or more active nonnarcotic ingredients in recognized therapeutic amounts;

(E) not more than 1.8 grams of dihydrocodeine per 100 milliliters or not more than 90 milligrams per dosage unit, with one or more active nonnarcotic ingredients in recognized thera-

peutic amounts;

(F) not more than 300 milligrams of ethylmorphine per 100 milliliters or not more than 15 milligrams per dosage unit, with one or more active, nonnarcotic ingredients in recognized therapeutic amounts;

(G) not more than 500 milligrams of opium per 100 milliliters or per 100 grams or not more than 25 milligrams per dosage unit, with one or more active, nonnarcotic ingredients in recognized therapeutic amounts;

(H) not more than 50 milligrams of morphine per 100 milliliters or per 100 grams, with one or more active, nonnarcotic ingredients in recognized therapeutic amounts.

Sec. 17.17.070. SCHEDULE IV. (a) A substance shall be placed in Schedule IV if it is found under AS 17.17.020 to have a degree of danger or probable danger lower than Schedule III controlled substances but higher than Schedule V controlled substances.

(b) Unless specifically excepted or unless listed in another schedule, Schedule IV controlled substances include any material compound which contains any quantity of a substance listed in this subsection, including its salts, its isomers (whether optical, position, or geometric), and the salts of its isomers whenever the existence of those salts, isomers, or salts of isomers is possible within the specific chemical designation, regardless of whether the listed substance is produced directly or indirectly by extraction from substances of vegetable origin or independently by means of chemical synthesis or by a combination of extraction and chemical synthesis:

(1) barbital;

(2) chloral betaine;

(3) chloral hydrate (slang terms: knockout drops, Mickey

Finn, Mickey, Peter);

(4) chlordiazepoxide;

(5) clonazepam;

(6) clorazepate;

(7) diazepam;

(8) ethchlorvynol;

(9) ethinamate;

(10) flurazepam;

(11) lorazepam;

(12) mebutamate;

(13) meprobamate;

(14) methohexital;

(15) methylphenobarbital (mephobarbital);

(16) oxazepam;

(17) paraldehyde;

(18) petrichloral;

(19) phenobarbital;

(20) prazepam;

(21) pentazocine;

(22) fenfluramine;

(23) diethlpropion;

(24) phentermine;

(25) pemoline, including organometallic complexes and chelates thereof;

(26) dextropropoxyphene (alpha-(+)-4-dimethylamino-1,2-diphenyl-3-methyl-2-propionoxybutane);

(27) hashish and hashish oil (slang terms: black Russian, hash, kif, quarter moon, soles).

Sec. 17.17.080 SCHEDULE V. (a) A substance shall be placed in

Schedule V if it is found under AS 17.17.020 to have a degree of danger or probable danger lower than Schedule IV controlled substances but higher than Schedule VI controlled substances.

(b) Unless specifically excepted or unless listed in another schedule, Schedule V controlled substances include loperamide and any material compound which contains any quantity of a substance listed in this subsection, including its salts, its isomers (whether optical, position, or geometric), and the salts of its isomers whenever the existence of those salts, isomers, or salts of isomers is possible within the specific chemical designation, regardless of whether the listed substance is produced directly or indirectly by extraction from substances of vegetable origin or independently by means of chemical synthesis or by a combination of extraction and chemical synthesis. Schedule V controlled substances include the following controlled substances, otherwise listed in AS 17.17.040(b), when they are combined in the following portions with one or more nonnarcotic active medicinal ingredients in sufficient portion to confer upon the compound mixture preparation valuable medicinal qualities other than those possessed by the Schedule I controlled substance:

(1) not more than 200 milligrams of codeine per 100 milliliters or per 100 grams;

(2) not more than 100 milligrams of dihydrocodeine per 100 milliliters or per 100 grams;

(3) not more than 100 milligrams of ethylmorphine per 100 milliliters or per 100 grams;

(4) not more than 2.5 milligrams of diphenoxylate and not less than 25 micrograms of atropine sulfate per dosage unit;

(5) not more than 100 milligrams of opium per 100 milliliters or per 100 grams.

Sec. 17.17.090. SCHEDULE VI. (a) A substance shall be placed in Schedule VI if it is found under AS 17.17.020 to have the lowest degree of danger or probable danger.

(b) Schedule VI controlled substances include marijuana (slang terms: Acapulco gold, broccoli, bush, dry high, gage, ganga, grass, griffo, hay, hemp, herb, J, Jay, Jane, Mary Jane, mota, mutah, Panama red, pod, pot, reefer, sativa, smoke, stick, tea, weed, stuff, rope, joints, Texas tea, goof butt, jive, sweet lunch, stinkweed, locoweed, mezz, Mary Waner, Indian hay, fu, bobo bush).

ARTICLE 2. OFFENSES AND PENALTIES.

Sec. 17.17.200. DISTRIBUTING A CONTROLLED SUBSTANCE TO A MINOR. (a) Except as authorized in this chapter, it is unlawful for a person knowingly to distribute a controlled substance to a minor who is three or more years younger than the person.

(b) A person who violates this section with respect to

(1) a Schedule I controlled substance is guilty of an unclassified felony;

(2) a Schedule II controlled substance is guilty of a class A felony;

(3) a Schedule III controlled substance is guilty of a class A felony;

(4) a Schedule IV controlled substance is guilty of a class B felony;

(5) a Schedule V controlled substance is guilty of a class B felony;

(6) a Schedule VI controlled substance is guilty of a class B felony.

Sec. 17.17.210. MANUFACTURING a controlled substance. (a) Except as authorized in this chapter, it is unlawful for a person knowingly to manufacture a con-

trolled substance.

(b) A person who violates this section with respect to

(1) a Schedule I controlled substance is guilty of a class A felony;

(2) a Schedule II controlled substance is guilty of a class A felony;

(3) a Schedule III controlled substance is guilty of a class B felony;

(4) a Schedule IV controlled substance is guilty of a class B felony;

(5) a Schedule V controlled substance is guilty of a class C felony;

(6) a Schedule VI controlled substance is guilty of a class C felony.

Sec. 17.17.220. DISTRIBUTING A CONTROLLED SUBSTANCE. (a) Except as authorized in this chapter, it is unlawful for a person knowingly to distribute a controlled substance.

(b) A person is guilty of

(1) a class A felony if he knowingly distributes a Schedule I controlled substance;

(2) a class A felony if he knowingly distributes a Schedule II controlled substance;

(3) a class B felony if he knowingly distributes a Schedule III controlled substance;

(4) a class C felony if he knowingly distributes a Schedule IV controlled substance;

(5) a class C felony if he knowingly distributes a Schedule V controlled substance.

Sec. 17.17.230. DISTRIBUTING A SCHEDULE VI CONTROLLED SUBSTANCE.

(a) Except as authorized in this chapter, it is unlawful for a person knowingly to distribute a Schedule VI controlled substance.

(b) A person is guilty of a class C felony if he violates this section by knowingly distributing one or more preparations, compounds, mixtures, or substances of an aggregate weight of two ounces or more containing a Schedule VI controlled substance.

(c) A person is guilty of a class A misdemeanor if he violates this section by knowingly distributing one or more preparations, compounds, mixtures, or substances of an aggregate weight of less than two ounces containing a Schedule VI controlled substance. However, in a prosecution under this subsection, it is a defense which reduces the crime to a class B misdemeanor that the preparations, compounds, mixtures, or substances containing a Schedule VI controlled substance were of an aggregate weight of one ounce or less and that the distribution was made for no remuneration to a person 18 years of age or older. As used in this subsection, "defense" has the meaning ascribed to it in AS 11.81.900(b).

Sec. 17.1[illegible].240. POSSESSION OF CONTROLLED SUBSTANCES. (a) Except as authorized in this chapter, it is unlawful for a person knowingly to possess a Schedule I controlled substance. A person is guilty of

(1) a class A felony if he knowingly possesses

(A) 100 or more capsules, tablets, ampules, or syrettes containing a Schedule I controlled substance; or

(B) one or more preparations, compounds, mixtures, or substances of an aggregate weight of

(i) one ounce or more containing heroin or morphine or any of their respective alkaloids or salts; or

(ii) two ounces or more containing a Schedule I controlled substance other than heroin or morphine or any of their

respective alkaloids or salts;

(2) a class B felony if he knowingly possesses

(A) 50 or more but fewer than 100 capsules, tablets, ampules, or syrettes containing a Schedule I controlled substance; or

(B) one or more preparations, compounds, mixtures, or substances of an aggregate weight of

(i) one-fourth ounce or more but less than one ounce containing heroin or morphine or any of their respective alkaloids or salts; or

(ii) one-half ounce or more but less than two ounces containing a Schedule I controlled substance other than heroin or morphine or any of their respective alkaloids or salts;

(3) a class C felony if he knowingly possesses

(A) 25 or more but fewer than 50 capsules, tablets, ampules, or syrettes containing a Schedule I controlled substance; or

(B) one or more preparations, compounds, mixtures, or substances of an aggregate weight of

(i) one-eighth ounce or more but less than one-fourth ounce containing herion or morphine or any of their respective alkaloids or salts; or

(ii) one-fourth ounce or more but less than one-half ounce containing a Schedule I controlled substance other than heroin or morphine or any of their respective alkaloids or salts;

(4) a class A misdemeanor if he knowingly possesses a Schedule I controlled substance in a smaller amount than the ranges specified in (3) of this subsection.

(b) Except as authorized in this chapter, it is unlawful for a

person knowingly to possess a Schedule II controlled substance. A person is guilty of

(1) a class A felony if he knowingly possesses

(A) 200 or more capsules, tablets, ampules, or syrettes containing a Schedule II controlled substance; or

(B) one or more preparations, compounds, mixtures, or substances of an aggregate weight of two ounces or more containing a Schedule II controlled substance;

(2) a class B felony if he knowingly possesses

(A) 100 or more but fewer than 200 capsules, tablets, ampules, or syrettes containing a Schedule II controlled substance; or

(B) one or more preparations, compounds, mixtures, or substances of an aggregate weight of one-half ounce or more but less than two ounces containing a Schedule II controlled substance;

(3) a class C felony if he knowingly possesses

(A) 50 or more but fewer than 100 capsules, tablets, ampules, or syrettes containing a Schedule II controlled substance; or

(B) one or more preparations, compounds, mixtures, or substances of an aggregate weight of one-fourth ounce or more but less than one-half ounce containing a Schedule II controlled substance;

(4) a class A misdemeanor if he knowingly possesses a Schedule II controlled substance in a smaller amount than the ranges specified in (3) of this subsection.

(c) Except as authorized in this chapter, it is unlawful for a person knowingly to possess a Schedule III controlled substance. A person is guilty of

(1) a class B felony if he knowingly possesses

(A) 400 or more capsules, tablets, ampules, or syrettes containing a Schedule III controlled substance; or

(B) one or more preparations, compounds, mixtures, or substances of an aggregate weight of two ounces or more containing a Schedule III controlled substance;

(2) a class C felony if he knowingly possesses

(A) 100 or more but fewer than 400 capsules, tablets, ampules, or syrettes containing a Schedule III controlled substance; or

(B) one or more preparations, compounds, mixtures, or substances of an aggregate weight of one-half ounce or more but less than two ounces containing a Schedule III controlled substance;

(3) a class A misdemeanor if he knowingly possesses a Schedule III controlled substance in a smaller amount than the ranges specified in (2) of this subsection.

(d) Except as authorized in this chapter, it is unlawful for a person knowingly to possess a Schedule IV controlled substance. A person is guilty of

(1) a class C felony if he knowingly possesses

(A) 400 or more capsules, tablets, ampules, or syrettes containing a Schedule IV controlled substance; or

(B) one or more preparations, compounds, mixtures, or substances of an aggregate weight of two ounces or more containing a Schedule IV controlled substance;

(2) a class C felony if he knowingly possesses

(A) 100 or more but fewer than 400 capsules, tablets, ampules, or syrettes containing a Schedule IV controlled substance;

or

(B) one or more preparations, compounds, mixtures, or substances of an aggregate weight of one-half ounce or more but less than two ounces containing a Schedule IV controlled substance;

(3) a class A misdemeanor if he knowingly possesses a Schedule IV controlled substance in a smaller amount than the ranges specified in (c) of this section.

(e) Except as authorized in this chapter, it is unlawful for a person knowingly to possess a Schedule V controlled substance. A person is guilty of

(1) a class C felony if he knowingly possesses

(A) 400 or more capsules or tablets containing a Schedule V controlled substance; or

(B) one or more preparations, compounds, mixtures, or substances of an aggregate weight of one ounce or more containing a Schedule V controlled substance;

(2) a class A misdemeanor if he knowingly possesses a Schedule V controlled substance in a smaller amount than the ranges specified in (1) of this subsection.

Sec. 17.17.250. POSSESSION OF A SCHEDULE VI CONTROLLED SUBSTANCE. (a) Except as authorized in this chapter, it is unlawful for a person knowingly to possess a Schedule VI controlled substance.

(b) A person who knowingly (1) uses a Schedule VI controlled substance in a public place, (2) possesses more than an ounce of a Schedule VI controlled substance in a public place, (3) possesses any amount of a Schedule VI controlled substance while operating a motor vehicle or airplane, or (4) while under the age of 18 possesses or uses any amount of a Schedule VI controlled substance, is, upon conviction, guilty of a misdemeanor punishable by a fine of not more than $1,000.

(c) A person 18 years of age or older who violates this chapter by possession of any amount of marijuana in other than a public place, when his possession is for his own use, or by possession of one ounce or less of marijuana in a public place, is punishable by a civil fine of not more than $100. Punishment under this subsection shall be initiated only by civil complaint or citation. The court may establish procedures for payment of fines by mail.

(d) In this section, "public place" means a place which is either in public ownership or a place available to public access including public streets, sidewalks, carriers and business establishments.

Sec. 17.17.260. FAILURE TO MAKE, KEEP, OR FURNISH REQUIRED INFORMATION. (a) Except as authorized in this chapter, it is unlawful for a person knowingly to refuse or fail to make, keep, or furnish a record, notification, order form, statement, invoice, or information required under this chapter.

(b) A person who violates this section is guilty of a class B misdemeanor.

Sec. 17.17.270. MISCELLANEOUS OFFENSES. (a) Except as authorized in this chapter, it is unlawful for a person

(1) knowingly to keep or maintain a store, shop, warehouse, dwelling, building, vehicle, vessel, aircraft, or other structure or place which is used for keeping or selling controlled substances in violation of this chapter;

(2) to use in the course of the manufacture or distribution of a controlled substance a registration number which is ficticious, revoked, suspended, or issued to another person;

(3) to obtain possession of a controlled substance by misrepresentation, fraud, forgery, or other deception;

(4) to make, distribute, or possess a punch, die. plate,

stone, or other thing designed to print, imprint, or reproduce the trademark, trade name, or other identifying mark, imprint, or device of another or any likeness of any of the foregoing upon a drug or container or labeling so as to render a drug a counterfeit substance;

(5) to furnish false or fraudulent material information in, or omit material information from, an application, report, record, or other document required to be kept or filed under this chapter.

(b) A person who violates this section is guilty of a class C felony.

Sec. 17.17.280. OFFENSES DEFINED BY AMOUNTS. Whenever a provision of this chapter defining an offense requires a determination of an amount, it is not a defense to the lowest class of offense established by the evidence that the amount in question was larger than the amount which would make the offense a higher class of offense, and a person may be charged and convicted accordingly.

Sec. 17.17.290. PENALTIES UNDER OTHER LAWS. A penalty imposed for a violation of this chapter is in addition to, and not in place of, a civil or administrative penalty or sanction otherwise authorized by law.

ARTICLE 3. REGULATION OF MANUFACTURE, DISTRIBUTION, AND DISPENSING OF CONTROLLED SUBSTANCES.

Sec. 17.17.550. REGULATIONS. The commissioner shall adopt regulations under the Administrative Procedure Act (AS 44.62) which are necessary for the administration of AS 17.17.550 - 17.17.610 and may charge reasonable fees relating to the registration and control of the manufacture, distribution, and dispensing of controlled substances in this state.

Sec. 17.17.560. REGISTRATION REQUIREMENTS. (a) A person who manufactures, distributes, or dispenses a controlled substance in this state or who proposes to engage in the manufacture, distribution, or

dispensing of a controlled substance in this state, shall annually register with the commissioner in accordance with regulations adopted under AS 17.17.550.

(b) A person registered by the commissioner under AS 17.17.550 - 17.17.610 to manufacture, distribute, or dispense controlled substances, including any such activity in the conduct of research, may possess, manufacture, distribute, or dispense those substances to the extent authorized by his registration and in conformity with the other provisions of AS 17.17.550 - 17.17.610.

(c) The following persons need not register and may lawfully possess controlled substances under this chapter:

(1) an agent or employee of a registered manufacturer, distributor, or dispenser of a controlled substance if the possession is incidental to the agent's or employee's acting in the usual course of business or employment;

(2) a common or contract carrier or warehouseman, or his employee, whose possession of a controlled substance is in the usual course of business or employment;

(3) a person in possession of a controlled substance under an order of a registered practitioner.

(d) The commissioner may, by regulation, waive the requirement for registration of certain manufacturers, distributors, or dispensers if he finds it consistent with the public health and safety.

(e) A separate registration is required for each principal place of business or professional practice where the applicant manufactures, distributes, or dispenses controlled substances.

(f) The commissioner may inspect the establishment of a registrant or applicant for registration in accordance with his regulations.

Sec. 17.17.570. REGISTRATION. (a) The commissioner shall

register an applicant to manufacture, distribute, or dispense controlled substances included in the schedules in AS 17.17.040 - 17.17.090 unless he finds that the registration would be inconsistent with the public interest. In determining the public interest, the commissioner shall consider

(1) maintenance of effective controls against diversion of controlled substances into other than legitimate medical, scientific, or industrial channels;

(2) compliance with applicable state and local law;

(3) any conviction of the applicant under federal or state laws relating to controlled substances;

(4) past experience in the manufacture or distribution of controlled substances, and the existence in the applicant's establishment of effective controls against diversion;

(5) furnishing by the applicant of false information in an application filed under this chapter;

(6) suspension or revocation of the applicant's federal registration to manufacture, distribute, or dispense controlled substances as authorized by federal law; and

(7) any other factors relevant to the public health and safety.

(b) A practitioner registered under federal law to manufacture, distribute, or dispense controlled substances is exempt from registration under this section.

Sec. 17.17.580. REVOCATION AND SUSPENSION OF REGISTRATION. (a) A registration under AS 17.17.570 to manufacture, distribute, or dispense a controlled substance may be suspended or revoked by the commissioner upon a finding that the registrant

(1) has furnished false or fraudulent material information in

an application filed under this chapter;

(2) has been convicted of a felony under state or federal law relating to a controlled substance; or

(3) has had his federal registration to manufacture, distribute, or dispense controlled substances suspended or revoked.

(b) The commissioner may limit the revocation or suspension of a registration to the particular controlled substance with respect to which grounds for revocation or suspension exist.

(c) If the commissioner suspends or revokes a registration, all controlled substances owned or possessed by the registrant at the time of suspension or the effective date of the revocation order may be placed under seal. A disposition may not be made of substances under seal until the time for taking an appeal has elapsed or until all appeals have been concluded unless a court, upon application, orders the sale of perishable substances and the deposit of the proceeds of the sale with the court. Upon a revocation order becoming final, all controlled substances are forfeited to the state.

(d) The commissioner shall promptly notify the Drug Enforcement Administration of all orders suspending or revoking registration and all forfeitures of controlled substances.

Sec. 17.17.590. ORDER TO SHOW CAUSE. (a) Before denying, suspending or revoking a registration, or refusing a renewal of registration, the commissioner shall serve upon the applicant or registrant an order to show cause why registration should not be denied, revoked, or suspended, or why the renewal should not be refused. The order to show cause shall contain a statement of the basis for it and shall call upon the applicant or registrant to appear before the commissioner at a time and place not less than 30 days after the date of the service of the order, but in the case of a refusal of renewal of registration the show

cause order shall be served not later than 30 days before the expiration of the registration. These proceedings shall be conducted under the administrative adjudication provisions of the Administrative Procedure Act (AS 44.62.330 - 44.62.630) without regard to criminal prosecution or other proceeding. Proceedings to refuse renewal of registration do not abate the existing registration, which remains in effect pending the outcome of the administrative hearing.

(b) The commissioner may, without an order to show cause, suspend a registration simultaneously with the institution of proceedings under AS 17.17.580 if he finds that there is an imminent danger to the public health or safety which warrants this action. The suspension shall continue in effect until the conclusion of the proceedings, including judicial review of the proceedings, unless sooner withdrawn by the commissioner or dissolved by a court of competent jurisdiction.

Sec. 17.17.600. RECORDS OF REGISTRANTS. A person registered to manufacture, distribute, or dispense controlled substances under this chapter shall keep records and maintain inventories in conformance with the record-keeping and inventory requirements of federal law and with additional regulations the commissioner may adopt.

Sec. 17.17.610. ORDER FORMS; PRESCRIPTIONS. (a) A controlled substance may be distributed by one registrant to another registrant only if the distribution is in accordance with federal requirements for order forms.

(b) A controlled substance may not be dispensed by a practitioner except in accordance with federal requirements regarding prescriptions for controlled substances; however, a controlled substance may be dispensed directly by a practitioner, other than a pharmacist, to an ultimate user without a prescription.

ARTICLE 4. ENFORCEMENT AND ADMINISTRATION.

Sec. 17.17.750. ENFORCEMENT COOPERATION. It is the duty of the commissioner of public safety, officers of the division of state troopers, officers appointed to enforce criminal law in this state or another state, local government law enforcement officers, the attorney general, and all prosecuting attorneys to enforce all provisions of this chapter and to cooperate with agencies charged with enforcement of the laws relating to controlled substances of the United States, of this state, and of all other states.

Sec. 17.17.760. FORFEITURES. (a) The following are subject to forfeiture:

(1) a controlled substance which has been manufactured, distributed, acquired, or possessed in violation of this chapter;

(2) raw materials, products, and equipment which are used in manufacturing or distributing a controlled substance in violation of this chapter;

(3) property which is used as a container for property described in (1) or (2) of this subsection;

(4) conveyances, including aircraft, vehicles, or vessels which are used to transport or in any manner to facilitate transportation of property described in (1) or (2) of this subsection for the purpose of sale or receipt, except

(A) a conveyance is not subject to forfeiture under this section if its use in violation of this chapter was committed by a person other than the owner of the conveyance and the owner was not privy to the violation;

(B) a forfeiture of a conveyance encumbered by a bona fide security interest at the time of seizure is subject to the interest of the secured party if its use in violation of this chapter was committed by a person other than the secured party and

the secured party was not privy to the violation;

(5) all books, records, and research products and materials, including formulas, microfilm, tapes, and data which are used in violation of this chapter.

(b) Property listed in (a) of this section may be forfeited to the state upon conviction of the defendant of a violation of this chapter or upon judgment of a court of competent jurisdiction in a civil proceeding in rem that an item is subject to forfeiture.

(c) Property subject to forfeiture under this section may be seized by the commissioner of public safety upon an order issued by the court having jurisdiction over the property upon a showing of probable cause that the property is subject to forfeiture. Seizure without a court order may be made if

(1) the seizure is incident to a valid arrest or a search under a valid search warrant;

(2) the property subject to seizure has been the subject of a prior judgment in favor of the state in a criminal proceeding or a civil proceeding in rem based upon this chapter;

(3) there is probable cause that the property was or is being used in violation of this chapter and the property is easily movable.

(d) Property seized under (c)(3) of this section may not be held over 48 hours or until an order may be applied for and issued by a court, whichever is earlier.

(e) Property seized or detained under this section is in the custody of the Department of Public Safety subject only to the orders and decrees of the court having jurisdiction over the forfeiture proceedings. If property is seized under this section, the Department of Public Safety may

(1) place the property under seal;

(2) remove the property to a place designated by the court; or

(3) take custody of the property and remove it to an appropriate location for disposition in accordance with law.

(f) Property forfeited under this section shall be disposed of according to court order. The court may order the Department of Public Safety to

(1) destroy property harmful to the public;

(2) sell the property and use the proceeds for payment of all proper expenses of the proceedings for forfeiture and sale, including expenses of seizure and custody and court costs;

(3) take custody of the property and use it in the enforcement of this chapter or transfer it to another agency of the state for a use designated by the court in furtherance of the administration of justice;

(4) take custody of the property and remove it for disposition in accordance with law; or

(5) forward it to the Drug Enforcement Administration for disposition.

(g) For purposes of this section, an attempt under AS 11.31.100 or a solicitation under AS 11.31.110 to commit a crime defined by this chapter is considered a violation of this chapter.

Sec. 17.17.770. BURDEN OF PROOF; LIABILITIES. (a) It is not necessary for the state to negate an exemption or exception in this chapter in a complaint, information, indictment, or other pleading under this chapter. However, once a person asserts an exemption or exception under this chapter, the burden is upon the state to disprove the existence of the exemption or exception by clear and convincing evidence.

(b) In a civil proceeding in rem under AS 17.17.760, the burden is

upon the state to prove by clear and convincing evidence that the item in question is subject to forfeiture.

(c) Liability is not imposed by this chapter upon an authorized state or local officer engaged in the lawful performance of his duties.

Sec. 17.17.780. EDUCATION AND RESEARCH. (a) The commissioner shall carry out educational programs designed to prevent and deter abuse of controlled substances. In connection with these programs, the commissioner may

(1) promote better recognition of the problems of abuse of controlled substances within the regulated industry and among interested groups and organizations;

(2) assist the regulated industry and interested groups and organizations in contributing to the reduction of abuse of controlled substances;

(3) consult with interested groups and organizations to aid them in solving administrative and organizational problems;

(4) evaluate procedures, projects, and techniques conducted or proposed as part of educational programs on abuse of controlled substances;

(5) disseminate the results of research on abuse of controlled substances to promote a better public understanding of the problems which exist and their solutions; and

(6) assist in the education and training of state and local law enforcement officials in their efforts to prevent abuse of controlled substances.

(b) The commissioner shall encourage research on controlled substances and may

(1) establish methods to assess the effects of controlled substances and identify and characterize those with potential for abuse;

(2) undertake research to

(A) develop new or improved approaches, techniques, systems, equipment, and devices to strengthen the enforcement of this chapter;

(B) determine patterns of abuse of controlled substances and their social effects;

(C) improve methods for preventing, predicting, and understanding the abuse of controlled substances;

(3) enter into contracts with public agencies, institutions of higher education, and organizations or individuals for conducting research on abuse of controlled substances and for performing related educational activities.

ARTICLE 5. GENERAL PROVISIONS.

Sec. 17.17.900. DEFINITIONS. As used in this chapter, unless the context requires otherwise,

(1) "administer" means the direct application of a controlled substance, whether by injection, inhalation, ingestion, or any other means, to the body of a patient or research subject by

(A) a practitioner or, in his presence, by his authorized agent, or

(B) the patient or research subject at the direction and in the presence of a practitioner;

(2) "agent" means an authorized person who acts on behalf of or at the direction of a manufacturer, distributor, or dispenser; "agent" does not include a common or contract carrier, public warehouseman, or employee of the carrier or warehouseman;

(3) "commissioner" means the commissioner of health and social services;

(4) "committee" means the Controlled Substances Advisory

Committee;

(5) "controlled substance" means a drug, substance, or immediate precursor included within any of the schedules in AS 17.17.-040 - 17.17.090;

(6) "counterfeit substance" means a controlled substance which, or the container or labeling of which, without authorization, bears the trademark, trade name, or other identifying mark, imprint, number, or device, or any likeness to it, of a manufacturer, distributor, or dispenser other than the person who in fact manufactured, distributed, or dispensed the substance;

(7) "deliver" or "delivery" means the actual, constructive, or attempted transfer from one person to another of a controlled substance, whether or not there is an agency relationship;

(8) "dentist" means a person authorized by law to practice dentistry in this state;

(9) "dispense" means to deliver a controlled substance to an ultimate user or research subject by a practitioner, including the prescribing, administering, packaging, labeling, or compounding necessary to prepare the substance for that delivery;

(10) "distribute" means to deliver, other than by administering or dispensing, a controlled substance;

(11) "drug"

(A) means

(i) substances recognized as drugs in the official United States Pharmacopoeia, official Homeopathic Pharmacopoeia of the United States, or official National Formulary, or any supplement to any of them;

(ii) substances intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease in

humans or animals;

(iii) substances, other than food, intended to affect the structure or any function of the body of humans or animals; and

(iv) substances intended for use as a component of any article specified in (i), (ii), or (iii) of this subparagraph;

(B) does not include devices or their components, parts, or accessories;

(12) "hashish" means the resin produced by the plant (genus) Cannabis;

(13) "hashish oil" means the viscous liquid concentrate of tetrahydrocannabinols extracted from hashish;

(14) "immediate precursor" means a substance which the Controlled Substances Advisory Committee has found to be and is by regulation designated as the principal compound commonly used or produced primarily for use, and which is an immediate chemical intermediary used or likely to be used, in the manufacture of a controlled substance, the control of which is necessary to prevent, curtail, or limit manufacture;

(15) "manufacture" means the production, preparation, propagation, compounding, conversion, or processing of a controlled substance, either directly or indirectly by extraction from substances of natural origin or independently by means of chemical synthesis, or by a combination of extraction and chemical synthesis, and includes any packaging or repackaging of the substance or labeling or relabeling of its container, except that this term does not include the preparation or compounding of a controlled substance by an individual for his own use or the preparation, compounding, packaging, or labeling of a controlled substance

(A) by a practitioner as an incident to his administering or dispensing a controlled substance in the course of his professional practice, or

(B) by a practitioner, or by his authorized agent under his supervision, for the purpose of, or as an incident to, research, teaching, or chemical analysis and not for sale;

(16) "marijuana" means the leaves, stems, flowers, and seeds of the plant (genus) Cannabis, whether growing or not, but does not include the resin or oil extracted from any part of the plant, or any compound, manufacture, salt, derivative, mixture, or preparation from the resin or oil, including hashish and natural or synthetic tetrahydrocannabinol; it does not include the mature stalks of the plant, fiber produced from the stalks, oil or cake made from the seeds of the plant, any other compound, manufacture, salt, derivative, mixture, or preparation of the mature stalks, fiber, oil or cake, or the sterilized seed of the plant which is incapable of germination;

(17) "minor" means a person who is under 18 years of age;

(18) "opiate" means a substance having an addiction-forming or addiction-sustaining liability similar to morphine or being capable of conversion into a drug having addiction-forming or addiction-sustaining liabilty; it does not include, unless specifically designated as controlled under AS 17.17.020, the dextrorotatory isomer of 3-methoxy-n-methylmorphinan and its salts (dextromethorphan); it does include its racemic and levorotatory forms;

(19) "opium poppy" means the plant of the species Papaver somniferum L., except its seeds;

(20) "poppy straw" means all parts, except the seeds, of the opium poppy, after mowing;

(21) "practitioner" means

(A) a physician, dentist, veterinarian, scientific investigator, or other person licensed, registered, or otherwise permitted to distribute, dispense, conduct research with respect to, or administer a controlled substance in the course of professional practice or research in this state;

(B) a pharmacy, hospital, or other institution licensed, registered, or otherwise permitted to distribute, dispense, conduct research with respect to, or administer a controlled substance in the course of professional practice or research in this state;

(22) "production" includes the manufacture, planting, cultivation, growing, or harvesting of a controlled substance;

(23) "ultimate user" means a person who lawfully possesses a controlled substance for his own use, for the use of a member of his household, or for administering to an animal owned by him or a member of his household.

Sec. 17.17.990. SHORT TITLE. This chapter may be cited as the Controlled Substances Act.

* Sec. 2. AS 08.64.380(3)(B) is amended to read:

(B) habitual overuse of alcoholic beverages or <u>controlled substances as defined in AS 17.17</u> [DEPRESSANT, HALLUCINOGENIC OR STIMULANT DRUGS, AS DEFINED IN AS 17.12.150(3), OR ADDICTION TO THE USE OF NARCOTIC DRUGS AS DEFINED IN AS 17.10.230(13)];

* Sec. 3. AS 08.80.470 is amended to read:

Sec. 08.80.470. CONSTRUCTION. Nothing in this chapter amends, modifies, repeals or otherwise changes any provision of the <u>Controlled Substances Act (AS 17.17)</u> [UNIFORM NARCOTIC DRUG ACT (AS 17.10)] or the Alaska Food, Drug and Cosmetic Act (AS 17.20).

* Sec. 4. AS 12.30.040(b) is amended to read:

(b) Notwithstanding the provisions of (a) of this section, if the

offense a person has been convicted of is murder in the first degree (as defined in AS 11.41.100), kidnapping (as defined in AS 11.41.300), sexual assault in the first degree (as defined in AS 11.41.410(a)(1) and (2)), robbery in the first degree (as defined in AS 11.41.500), or distributing a Schedule I controlled substance to a minor (as defined in AS 17.17.200(b)(1)), or an offense that involves the manufacture, distribution, or possession with intent to manufacture or distribute a Schedule I or II controlled substance in violation of AS 17.17.-210.(b)(1) and (2)or 17.17.220(b)(1) and (2) under circumstances manifesting an intent to distribute the substance as part of a commercial enterprise [FIRST DEGREE MURDER, ARMED ROBBERY, KIDNAPPING, OR RAPE (AS DEFINED IN AS 11.15.130)], he may not be released on bail either before sentencing or pending appeal.

* Sec. 5. AS 12.45 is amended by adding a new section to read:

Sec. 12.45.155. LABORATORY REPORT OF CONTROLLED SUBSTANCE. (a) In a prosecution under AS 17.17.200 - 17.17.250, a complete copy of an official laboratory report from the Department of Public Safety or a laboratory operated by another law enforcement agency is prima facie evidence of the content, identity, and weight of the substance. The report must be signed by the person performing the analysis and must state that the substance which is the basis of the alleged offense has been weighed and analyzed. It must also state with specificity findings as to the content, weight, and identity of the substance.

(b) A notarized statement executed by the signer of the report provided for in (a) of this section must be attached to the report. The statement must set out the identity of the signer and include a statement that he is an employee of the laboratory issuing the report and that performing the analysis is a part of his regular duties. The statement must also include an outline of his education, training, and

experience for performing an analysis. The signer shall attest that scientifically accepted tests were performed with due caution, and that the evidence was handled in accordance with established and accepted procedures while in the custody of the laboratory.

(c) The prosecuting attorney shall serve a copy of the report on the attorney of record for the accused, or on the defendant if he has no attorney, no later than 10 days before a proceeding in which the report is to be used against the accused. However, at a preliminary hearing or grand jury proceeding the report may be used without having been previously served upon the accused.

(d) The accused or his attorney may demand the testimony of the person signing the report, by serving a written demand showing cause, upon the prosecuting attorney within seven days from receipt of the report.

(e) A report issued for use under this section must contain notice of the right of the accused to demand the testimony of the person signing the report.

* Sec. 6. AS 12.55.035(b)(1) is amended to read:

(1) $75,000 for murder in the first or second degree, [OR] kidnapping, or distributing a Schedule I controlled substance to a minor as defined in AS 17.17 200(b)(1);

* Sec. 7. AS 12.55.125(b) is amended to read:

(b) A defendant convicted of murder in the second degree, [OR] kidnapping, or distributing a Schedule I controlled substance to a minor as defined in AS 17.17.200(b)(1) shall be sentenced to a definite term of imprisonment of at least five years but not more than 99 years.

* Sec. 8. AS 12.55.155(c) is amended by adding new paragraphs to read:

(15) the defendant is convicted of an offense specified in AS 17.17 and the offense involved the delivery of a controlled substance

under circumstances manifesting an intent to distribute the substance as part of a commercial enterprise;

(16) the defendant is convicted of an offense specified in AS 17.17 and the offense involved the smuggling of a controlled substance into the state;

(17) the defendant is convicted of an offense specified in AS 17.17 and the offense involved the distribution of a controlled substance that had been adulterated with a toxic substance.

* Sec. 9. AS 12.55.155(d) is amended by adding new paragraphs to read:

(13) the defendant is convicted of an offense specified in AS 17.17 and the offense involved small quantities of a controlled substance;

(14) the defendant is convicted of an offense specified in AS 17.17 and the offense involved the distribution of a controlled substance, other than a Schedule I controlled substance, to a personal acquaintance who is 18 years of age or older for no profit;

(15) the defendant is convicted of an offense specified in AS 17.17 and the offense involved the possession of a small amount of a controlled substance for personal use in the defendant's home.

* Sec. 10. AS 44.29.020 is amended to read:

Sec. 44.29.020. DUTIES OF DEPARTMENT. The Department of Health and Social Services shall administer the state programs of public health and social services, including: (1) maternal and child health services; (2) preventive medical services; (3) public health nursing services; (4) sanitation and engineering services; (5) nutrition services; (6) health education; (7) laboratories; (8) mental health treatment and diagnosis; (9) management of state institutions; (10) medical facilities; (11) old age assistance; (12) aid to dependent children; (13) aid to the blind; (14) child welfare services; (15) general relief; (16) licensing and

supervision of child care facilities; [AND] (17) probation and parole supervision; and (18) control of drug abuse in accordance with AS 17.17.

* Sec. 11. (a) Prosecution for a violation of law occurring before the effective date of this Act is not affected or abated by this Act. If the offense being prosecuted is similar to one defined in AS 17.17, then the penalties under AS 17.17 apply if they are less than those under the prior law.

(b) Civil seizures or forfeitures and injunctive proceedings begun before the effective date of this Act are not affected by this Act.

(c) Administrative proceedings pending under laws which are superseded by this Act shall be continued and brought to a final determination in accordance with the laws in effect before the effective date of this Act.

(d) The commissioner of health and social services shall permit a person who owns or operates an establishment engaged in the manufacture, distribution, or dispensing of a controlled substance on or before the effective date of this Act and who is registered or licensed by the state to register under AS 17.17.

(e) This Act applies to violations of law, seizures and forfeitures, injunctive proceedings, administrative proceedings, and investigations which occur on or after the effective date of this Act.

* Sec. 12. Orders issued and regulations adopted under a law affected by this Act and in effect on the effective date of this Act and not in conflict with this Act continue in effect until modified, superseded, or repealed.

* Sec. 13. AS 17.10; AS 17.12; and AS 17.15 are repealed.

AS MR HICKEY SAID, HE HAS BEEN WORKING WITH THE SECRETARY AND PRESIDENT OF THE BOARD OF PHARMACY OVER THE WEEKEND, AND SINCE I ASSUME THAT THE RESULTS ARE INCORPORATED IN THE MATERIAL HE HAS JUST HANDED OUT, MY TESTIMONY WILL BE BRIEF.

WE FEEL THAT THE CRIMINAL PORTIONS OF THE BILL SHOULD BE MOVED TO CHAPTER 11, AND THE MEDICAL PORTIONS SHOULD REMAIN IN CHAPTER 17.

WE RECOMMEND THAT SECT ARTICLE 3 BE CHANGED TO READ: THE STATE BOARD OF PHARMACY SHALL ADMINISTER THIS CHAPTER AND CONTROLLED SUBSTANCES SCHEDULES FOR LEGITIMATE MEDICAL PROFESSIONS WHO QUALIFY UNDER FEDERAL REGISTRATION REQUIREMENT SHALL BE THE FEDERAL UNIFORM CONSTROLLED SUBSTANCE ACT OF 1970 WITH AMENDMENTS. IF ANY SUBSTANCE IS DESIGNATED RESCHEDULED OR DELETED AS A CONTROLLED SUBSTANCE UNDER FEDERAL LAW AND NOTICE THEREOF IS GIVEN TO THE BOARD, THE SUBSTANCE SHALL BE SIMILARLY CONTROLLED UNDER THIS CHAPTER AFTER EXPIRATION OF 30 DAYS FROM PUBLICATION IN THE FEDERAL REGISTER OF A FINAL ORDER DESIGNATING A SUBSTANCE AS A CONTROLLED SUBSTANCE OR RESCHEDULING OR DELETING A SUBSTANCE.
THIS DOES NOT EXTEND TO DISTILLED SPIRITS OR TOBACCO.

EXCEPTION: PROVIDED THAT A PROFESSIONAL PRACTITIONER LICENSED IN ALASKA UNDER THE PROFESSIONAL LICENSING ACTS SHALL NOT BE REQUIRED TO BE REGISTERED UNDER THIS CHAPTER ALSO UNLESS SPECIFIC EXEMPTION IS DENIED UNDER ADMINISTRATIVE PROCEDURES ACT FOR VIOLATION OF ANY PROVISIONS OF THIS CHAPTER.

Introduced: 4/26/79
Referred: Health, Education & Social Services and Judiciary

IN THE HOUSE BY PARR

HOUSE BILL NO. 479

IN THE LEGISLATURE OF THE STATE OF ALASKA

ELEVENTH LEGISLATURE - FIRST SESSION

A BILL

For an Act entitled: "An Act revising the drug laws of the state. for prosecution purp

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

* Section 1. AS ~~17~~ 11 is amended by adding a new chapter to read:

CHAPTER ~~17~~ 11. Alaska CONTROLLED SUBSTANCES ACT.

ARTICLE 1. STANDARDS AND PROCEDURES.

Sec. ~~17.17~~ 11.010. CONTROLLED SUBSTANCES ADVISORY COMMITTEE. (a) There is created within the Department of Law the Controlled Substances Advisory Committee, composed of

(1) the attorney general or his designee;

(2) the commissioner of health and social services or his designee;

(3) the commissioner of public safety or his designee;

(4) a pharmacist appointed by the governor;

(5) an attorney experienced in criminal defense appointed by the governor.

(b) The attorney general, the commissioner of health and social services, and the commissioner of public safety serve ex officio. The members appointed by the governor serve terms of four years and until their successors are appointed and qualify, except that the attorney initially appointed under (a)(5) of this section serves a term of three years and until his successor is appointed and qualifies.

(c) The members receive no compensation for their service on the committee but are entitled to travel expenses and per diem under AS 39.-20.180.

(d) The committee shall meet at the call of the attorney general. Three members constitute a quorum. The committee may adopt bylaws for its proceedings.

Sec. ~~17~~ 11.17.020. AUTHORITY TO SCHEDULE CONTROLLED SUBSTANCES. (a) The Controlled Substances Advisory Committee may adopt regulations under the Administrative Procedure Act (AS 44.62) which add, delete, or reschedule substances in the Alaska schedules in AS ~~17.17.040 - 17.17.090~~ 11. The committee shall prescribe the effective date of a regulation adopted under this section. This date may not be sooner than the 56th day of the next regular session of the legislature following adoption of the regulation. Within 10 days after the convening of a regular session of the legislature, the committee shall submit to the legislature the regulations adopted under this section which have not taken effect and shall submit findings of fact and other information which it considers appropriate. Notwithstanding AS 44.62.320, a regulation adopted under this section may not be annulled by resolution. A regulation adopted under this section which is annulled by statute may not be readopted within three years after its annulment.

(b) If a substance is added, deleted, or rescheduled as a controlled substance under federal law and notice of the designation is given to the Department of Law, the committee shall give notice under AS 44.62.190 of proposed adoption of a regulation making a corresponding change in Alaska law and shall hold a hearing under AS 44.62.210. If the committee decides not to adopt the regulation, it shall file a notice of that decision and findings of fact with the lieutenant governor.

(c) In making a determination regarding the addition, deletion, or rescheduling of a substance under this section, the committee shall assess the danger or probable danger of the substance after considering

(1) the actual or probable abuse of the substance, including

(A) its history and current pattern of abuse;

(B) the scope, duration, and significance of abuse; and

(C) the degree of actual or probable detriment which may result from the abuse of the substance;

(2) the biomedical hazard of the substance, including

(A) its pharmacology: the effects and modifiers of effects of the substance;

(B) its toxicology: the acute and chronic toxicity, interaction with other substances, whether controlled or not, and liability to form or sustain psychological or physiological dependence;

(C) the risk to public health and particular susceptibility of segments of the population; and

(D) the existence of therapeutic alternatives for substances which are or may be used for medical purposes;

(3) the probable physical and social impact of widespread abuse of the substance;

(4) whether the substance is an immediate precursor of a substance already controlled under this chapter;

(5) the current state of scientific knowledge regarding the substance.

(d) If the committee designates a substance as an immediate precursor, substances which are precursors of the controlled precursor are not subject to control solely because they are precursors of the controlled precursor.

(e) The committee has no authority over tobacco or over intoxicating liquor as defined in AS 04.20.010.

Sec. ~~17.17.030.~~ // NOMENCLATURE. The controlled substances listed

in the schedules in AS ~~17.17.040~~ 11 ~~17.17.090~~ or the regulations adopted under this chapter are included by whatever official, common, usual, chemical, or trade name designated. In some instances, slang terms are listed after a controlled substance. In a prosecution or other proceeding under this chapter, it is not a defense and it is immaterial that a slang term is listed after more than one controlled substance, that a slang term listed after a controlled substance is inaccurately applied to that controlled substance, that no slang term is listed after a controlled substance, or that slang terms other than those listed apply in fact to a controlled substance.

Sec. ~~17.17.040~~ 11. SCHEDULE A (a) A substance shall be placed in Schedule I if it is found under AS ~~17.17.020~~ to have the highest degree of danger or probable danger.

(b) Unless specifically excepted or unless listed in another schedule, Schedule I controlled substances include any material compound which contains any quantity of a substance listed in this subsection, including its salts, its isomers, (whether optical, position, or geometric), and the salts of its isomers whenever the existence of those salts, isomers, or salts of isomers is possible within the specific chemical designation, regardless of whether the listed substance is produced directly or indirectly by extraction from substances of vegetable origin or independently by means of chemical synthesis or by a combination of extraction and chemical synthesis:

(1) opium and opiate, and any salt, compound, derivative, or preparation of opium or opiate, excluding apomorphine, dextrorphan, nalbuphine, naloxone, and naltrexone, and their respective salts, but including the following:

(A) raw opium (slang terms: op, pen yan, hop, tar, black stuff);

(B) opium extracts;

(C) opium fluid extracts;

(D) powdered opium;

(E) granulated opium;

(F) tincture of opium;

(G) codeine (slang term: school boy);

(H) ethylmorphine;

(I) etorphine hydrochloride;

(J) hydrocodone;

(K) hydromorphone;

(L) metopon;

(M) morphine (slang terms: cube, first line, hocus, Miss Emma, morph, morpho, morphy, mud, white stuff, hard stuff, M, unkie);

(N) oxycodone;

(O) oxymorphone;

(P) thebaine;

(2) any salt, compound, derivative, or preparation of these which is chemically equivalent or identical with any of the substances referred to in (1) of this subsection, except that these substances do not include the isoquinoline alkaloids of opium;

(3) opium poppy and poppy straw;

(4) concentrate of poppy straw (the crude extract of poppy straw in liquid, solid, or powder form which contains the phenanthrine alkaloids of the opium poppy);

(5) acetylmethadol;

(6) allylprodine;

(7) alphacetylmethadol;

(8) alphameprodine;

(9) alphamethadol;

(10) benzethidine;

(11) betacetylmethadol;

(12) betameprodine;

(13) betamethadol;

(14) betaprodine;

(15) clonitazene;

(16) dextromoramide;

(17) diampromide;

(18) diethylthiambutene;

(19) difenoxin;

(20) dimenoxadol;

(21) dimepheptanol;

(22) dimethylhiambutene;

(23) dioxaphetyl butyrate;

(24) dipipanone;

(25) ethylmethylthiambutene;

(26) etonitazene;

(27) etoxeridine;

(28) furethidine;

(29) hydroxpethidine;

(30) ketobemidone;

(31) levomoramide;

(32) levophenacylmorphan;

(33) morpheridine;

(34) noracymethadol;

(35) norlevorphanol;

(36) normethadone;

(37) norpipanone;

(38) phenadoxone;

(39) phenampromide;

(40) phenomorphan;

(41) phenoperidine;

(42) piritramide;

(43) proheptazine;

(44) properidine;

(45) propiram;

(46) racemoramide;

(47) trimeperidine;

(48) acetorphine;

(49) acetyldihydrocodeine;

(50) benzylmorphine;

(51) codeine methylbromide;

(52) codeine-N-oxide;

(53) cyprenorphine;

(54) desomorphine;

(55) dihydromorphine;

(56) drotebanol;

(57) etorphine;

(58) heroin (slang terms: big H, boy, brown, brown sugar, caballo, Chinese red, chiva, crap, doojee, H, Harry, horse, junk, Mexican mud, powder, scag, smack, stuff, thing, joy powder, white stuff, sugar, hairy, skag, schmeck);

(59) hydromorphinol;

(60) methyldesorphine;

(61) methyldihydromorphine;

(62) morphine methylbromide;

(63) morphine methylsulfonate;

(64) morphine-N-oxide;

(65) myrophine;

(66) nicocodeine;

(67) nicomorphine;

(68) normorphine;

(69) pholcodine;

(70) thebacon;

(71) alphaprodine;

(72) anileridine;

(73) bezitramide;

(74) dihydrocodeine;

(75) diphenoxylate;

(76) fentanyl;

(77) isomethadone;

(78) levomethorphan;

(79) levorphanol;

(80) metazocine;

(81) methadone;

(82) methadone-intermediate, 4-cyano-2-dimethylamino-4, 4-diphenyl butane;

(83) moramide-intermediate, 2-methyl-3-morpholino-1, 1-diphenylpropane-carboxylic acid;

(84) pethidine (meperidine);

(85) pethidine-intermediate-A, 4-cyano-1-methyl-4-phenylpiperidine;

(86) pethidine-intermediate-B, ethyl-4-phenylpiperidine-4-carboxylate;

(87) pethidine-intermediate-C, 1-methyl-4-phenylpiperidine-4-carboxylic acid;

(88) phenazocine;

(89) piminodine;

(90) racemethorphan;

(91) racemorphan.

Sec. ~~17.17.050.~~ 17.17.040 ~~SCHEDULE II~~ SCHEDULE B. (a) A substance shall be placed in schedule II if it is found under AS 17.17.020 to have a degree of danger or probable danger lower than Schedule I controlled substances but higher than Schedule ~~III~~ C controlled subtances.

(b) Unless specifically excepted or unless listed in another schedule, Schedule ~~II~~ B controlled substances include any material compound which contains any quantity of a substance listed in this subsection, including its salts, its isomers (whether optical, position, or geometric), and the salts of its isomers whenever the existence of those salts, isomers, or salts of isomers is possible within the specific chemical designation, regardless of whether the listed substance is produced directly or indirectly by extraction from substances of vegetable origin or independently by means of chemical synthesis or by a combination of extraction and chemical synthesis:

(1) coca leaves and any salt, compound, derivative, or preparation of coca leaves, and any salt, compound, derivative, or preparation of these which is chemically equivalent or identical with any of these substances, except that the substances do not include decocainized coca leaves or extractions of coca leaves, which extractions do not contain cocaine or ecgonine (slang terms: Bernice, bernies, big C, blow, C, coke, dream, flake, girl, gold dust, heaven dust, nose candy, paradise, rock, white, happy dust, speedballs, snow birds, Cecil, stardust, Corine, Carrie, dust, Burese);

(2) 4-bromo-2,5-dimethoxy-amphetamine, also known as bromo-2, 5-dimethoxy-a-methylphenethylamine and 4-bromo-2,5-DMA;

(3) 2,5-dimethoxyamphetamine, also known as 2,5-dimethoxy-a-methylphenethylamine and 2,5-DMA;

(4) 4-methoxyamphetamine, also known as 4-methoxy-a-methylphenethylamine and paramethoxyamphetamine, PMA;

(5) 5-methoxy-3,4-methylenedioxy-amphetamine;

(6) 4-methyl-2,5-dimethoxy-amphetamine, also known as 4-methyl-2,5-dimethoxy-a-methylphenethylamine (slang terms: DOM, MDA, STP, serenity, tranquility, and peace, cone drug);

(7) 3,4-methylenedioxy amphetamine;

(8) 3,4,5-trimethoxy amphetamine;

(9) bufotenine, also known as 3-(b-dimethylaminoethyl)-5-hydroxyindole and 3-(2-dimethylaminoethyl)-5-indolol and N,N-dimethylserotonin and 5-hydroxy-N,N-dimethyltryptamine and mappine;

(10) diethyltryptamine, also known as N,N-diethyltryptamine and DET;

(11) dimethyltryptamine, also known as DMT (slang terms: businessman's special, lunch-hour trip);

(12) ibogaine, also known as 7-ethyl-6,6,B,7,8,9,10,12,13-octahydro-2-methoxy-6,9-methano-5H-pyrido [1', 2':1,2] azepino [5,4-b] indole and Tabernanthe iboga;

(13) lysergic acid diethylamide (slang terms: Alice D, acid, beast, big D, blue cheer, blue heaven, blue mist, brown dots, California sunshine, chocolate chips, coffee, contact lens, cupcakes, haze, mellow yellows, microdots, orange mushrooms, orange wedges, Owsley, paper acid, royal blue, strawberry fields, sugar, sunshine, the hawk, wedges, white lightning, window pane, yellows, cubes, 25, Lucy in the sky with diamonds);

(14) mescaline (slang terms: mesc, mescal, moon);

(15) peyote, meaning all parts of the plant presently classi-

fied botanically as Lophophora williamsii Lemaire, whether growing or not, the seeds of the plant, any extract from any part of the plant, and every compound, manufacture, salts, derivative, mixture, or preparation of the plant, its seeds, or extracts (slang terms: buttons, cactus, mescal buttons, mesc, mescal, plants);

(16) N-ethyl-3-piperidyl benzilate;

(17) N-methyl-3-piperidyl benzilate (slang term: LBJ);

(18) psilocybin (slang terms: magic mushroom, mushroom);

(19) psilocyn (slang terms: magic mushroom, mushroom);

(20) chemically synthesized tetrahydrocannabinols, also known as THC;

(21) thiophene analog of phencyclidine, also known as: 1-[1-(2-thienyl) cyclohexyl] piperidine and 2-thienyl analog of phencyclidine and TPCP;

(22) phencyclidine, also known as PCP (slang terms: angel dust, DOA (Dead On Arrival), hog, killer weed (when combined with marijuana or other plant material), peace pill);

(23) mecloqualone;

(24) amphetamine, its salts, optical isomers, and salts of its optical isomers (slang terms: beans, bennies, black beauties, blackbirds, black Mollies, bumblebees, cartweels, chalk, chicken powder, copilots, crank, crossroads, crystal, dexies, double cross, eye openers, hearts, jelly beans, lightning, meth, minibennies, nuggets, oranges, pep pills, speed, roses, thrusters, truck drivers, turnabouts, uppers, ups, wake-ups, peaches, whites, browns, greenies, bombido, jugs, bottles, lid proppers, football, coast-to-coast, L.A. turnabouts);

(25) methamphetamine, its salts, isomers, and salts of its isomers (slang terms: bombido, crystal, meth, speed, splash);

(26) phenmetrazine and its salts;

(27) methylphenidate;

(28) methaqualone (slang terms: ludes, quas, quads, soapers, sopes);

(29) amobarbital (slang terms: barbs, block busters, Christmas trees, downers, green dragons, peanuts, sleeping pills, stumblers, goofballs, goofs, tuinal, tuies, rainbow, double trouble, red and blues);

(30) secobarbital (slang terms: barbs, block busters, Christmas trees, downers, green dragons, peanuts, sleeping pills, stumblers, goofballs, goofs, tuinal, tuies, rainbow, double trouble, red and blues, reds, red birds, red devils, seccy, pink, seggy, pink ladies, marshmallow reds, Mexican reds);

(31) pentobarbital (slang terms: barbs, block busters, Christmas trees, downers, green dragons, peanuts, sleeping pills, stumblers, goofballs, goofs, yellow jackets, yellows, nimbys, nimbies, nobbies).

Sec. ~~17.17.060~~ 11. SCHEDULE ~~III~~ C. (a) A substance shall be placed in Schedule ~~III~~ S if it is found under AS ~~17.17.020~~ 11 to have a degree of danger or probable danger lower than Schedule II controlled substances but higher than Schedule ~~IV~~ 3 controlled substances.

(b) Unless specifically excepted or unless listed in another schedule, Schedule ~~III~~ D controlled substances include any material compound which contains any quantity of a substance listed in this subsection, including its salts, its isomers (whether optical, position, or geometric), and the salts of its isomers whenever the existence of those salts, isomers, or salts of isomers is possible within the specific chemical designation, regardless of whether the listed substance is produced directly or indirectly by extraction from substances of vegetable origin or independently by means of chemical synthesis or by a

combination of extraction and chemical synthesis:

(1) benzphetamine;

(2) chlorphentermine;

(3) clortermine;

(4) mazindol;

(5) phendimetrazine;

(6) any compound, mixture, or preparation containing amobarbital, secobarbital, or pentobarbital or any salt of any of these substances combined with one or more other active medicinal ingredients which are not listed in any classification in this section;

(7) any suppository dosage form containing amobarbital, secobarbital, or pentobarbital or any salt of any of these substances which are approved by the federal Food and Drug Administration for marketing only as a suppository;

(8) any substance, having a depressant effect on the central nervous system, which contains any quantity or derivative of barbituric acid or any salt of these;

(9) chlorhexadol;

(10) glutethimide (slang terms: C.D., cibas);

(11) lysergic acid;

(12) lysergic acid amide;

(13) methyprylon;

(14) sulfondiethylmethane;

(15) sulfonethylmethane;

(16) sulfonmethane;

(17) nalorphine;

(18) any material, compound, mixture, or preparation containing limited quantities of any of the following substances or any of their salts:

(A) not more than 1.8 grams of codeine per 100 milliliters or not more than 90 milligrams per dosage unit, with an equal or greater quantity of an isoquinoline alkaloid of opium;

(B) not more than 1.8 grams of codeine per 100 milli liters or not more than 90 milligrams per dosage unit, with one or more active, nonnarcotic ingredients in recognized therapeutic amounts;

(C) not more than 300 milligrams of dihydrocodeinone per 100 milliliters or not more than 15 milligrams per dosage unit, with a fourfold or greater quantity of an isoquinoline alkaloid of opium;

(D) not more than 300 milligrams of dihydrocodeinone per 100 milliliters or not more than 15 milligrams per dosage unit, with one or more active nonnarcotic ingredients in recognized therapeutic amounts;

(E) not more than 1.8 grams of dihydrocodeine per 100 milliliters or not more than 90 milligrams per dosage unit, with one or more active nonnarcotic ingredients in recognized therapeutic amounts;

(F) not more than 300 milligrams of ethylmorphine per 100 milliliters or not more than 15 milligrams per dosage unit, with one or more active, nonnarcotic ingredients in recognized therapeutic amounts;

(G) not more than 500 milligrams of opium per 100 milliliters or per 100 grams or not more than 25 milligrams per dosage unit, with one or more active, nonnarcotic ingredients in recognized therapeutic amounts;

(H) not more than 50 milligrams of morphine per 100 milliliters or per 100 grams, with one or more active, nonnarcotic

ingredients in recognized therapeutic amounts.

Sec. ~~17.17.070~~ 11 D. SCHEDULE ~~IV.~~ (a) A substance shall be placed in Schedule ~~IV~~ D if it is found under AS ~~17.17.020~~ 11 to have a degree of danger or probable danger lower than Schedule ~~III~~ D controlled substances but higher than Schedule ~~V~~ E controlled substances.

(b) Unless specifically excepted or unless listed in another schedule, Schedule IV controlled substances include any material compound which contains any quantity of a substance listed in this subsection, including its salts, its isomers (whether optical, position, or geometric), and the salts of its isomers whenever the existence of those salts, isomers, or salts of isomers is possible within the specific chemical designation, regardless of whether the listed substance is produced directly or indirectly by extraction from substances of vegetable origin or independently by means of chemical synthesis or by a combination of extraction and chemical synthesis:

(1) barbital;

(2) chloral betaine;

(3) chloral hydrate (slang terms: knockout drops, Mickey Finn, Mickey, Peter);

(4) chlordiazepoxide;

(5) clonazepam;

(6) clorazepate;

(7) diazepam;

(8) ethchlorvynol;

(9) ethinamate;

(10) flurazepam;

(11) lorazepam;

(12) mebutamate;

(13) meprobamate;

(14) methohexital;

(15) methylphenobarbital (mephobarbital);

(16) oxazepam;

(17) paraldehyde;

(18) petrichloral;

(19) phenobarbital;

(20) prazepam;

(21) pentazocine;

(22) fenfluramine;

(23) diethlpropion;

(24) phentermine;

(25) pemoline, including organometallic complexes and chelates thereof;

(26) dextropropoxyphene (alpha-(+)-4-dimethylamino-1,2-diphenyl-3-methyl-2-propionoxybutane);

(27) hashish and hashish oil (slang terms: black Russian, hash, kif, quarter moon, soles).

Sec. ~~17.17.080.~~ SCHEDULE V. (a) A substance shall be placed in Schedule V if it is found under AS 17.17.020 to have a degree of danger or probable danger lower than Schedule IV controlled substances but higher than Schedule VI controlled substances.

(b) Unless specifically excepted or unless listed in another schedule, Schedule V controlled substances include loperamide and any material compound which contains any quantity of a substance listed in this subsection, including its salts, its isomers (whether optical, position, or geometric), and the salts of its isomers whenever the existence of those salts, isomers, or salts of isomers is possible within the specific chemical designation, regardless of whether the listed substance is produced directly or indirectly by extraction from

substances of vegetable origin or independently by means of chemical synthesis or by a combination of extraction and chemical synthesis. Schedule V controlled substances include the following controlled substances, otherwise listed in AS 17.17.040(b), when they are combined in the following portions with one or more nonnarcotic active medicinal ingredients in sufficient portion to confer upon the compound mixture preparation valuable medicinal qualities other than those possessed by the Schedule I controlled substance:

(1) not more than 200 milligrams of codeine per 100 milliliters or per 100 grams;

(2) not more than 100 milligrams of dihydrocodeine per 100 milliliters or per 100 grams;

(3) not more than 100 milligrams of ethylmorphine per 100 milliliters or per 100 grams;

(4) not more than 2.5 milligrams of diphenoxylate and not less than 25 micrograms of atropine sulfate per dosage unit;

(5) not more than 100 milligrams of opium per 100 milliliters or per 100 grams.

Sec. ~~17.17.~~090. SCHEDULE ~~VI.~~ (a) A substance shall be placed in Schedule ~~VI~~ if it is found under AS ~~17.17.~~020 to have the lowest degree of danger or probable danger.

(b) Schedule VI controlled substances include marijuana (slang terms: Acapulco gold, broccoli, bush, dry high, gage, ganga, grass, griffo, hay, hemp, herb, J, Jay, Jane, Mary Jane, mota, mutah, Panama red, pod, pot, reefer, sativa, smoke, stick, tea, weed, stuff, rope, joints, Texas tea, goof butt, jive, sweet lunch, stinkweed, locoweed, mezz, Mary Waner, Indian hay, fu, bobo bush).

ARTICLE 2. OFFENSES AND PENALTIES.

Sec. ~~17.17.~~200. DISTRIBUTING A CONTROLLED SUBSTANCE TO A MINOR.

(a) Except as authorized in this chapter, it is unlawful for a person knowingly to distribute a controlled substance to a minor who is at least three years his junior.

(b) A person who violates this section with respect to

(1) a Schedule I controlled substance is guilty of a class .. felony;

(2) a Schedule II controlled substance is guilty of a class A felony;

(3) a Schedule III controlled substance is guilty of a class A felony;

(4) a Schedule IV controlled substance is guilty of a class B felony;

(5) a Schedule V controlled substance is guilty of a class C felony;

(6) a Schedule VI controlled substance is guilty of a class C felony.

Sec. 17.17.210. MANUFACTURING. (a) Except as authorized in this chapter, it is unlawful for a person knowingly to manufacture a controlled substance.

(b) A person who violates this section with respect to

(1) a Schedule A controlled substance is guilty of a class A felony;

(2) a Schedule B controlled substance is guilty of a class A felony;

(3) a Schedule II controlled substance is guilty of a class B felony;

(4) a Schedule IV controlled substance is guilty of a class B felony;

(5) a Schedule V controlled substance is guilty of a class C

felony;

(6) a Schedule F controlled substance is guilty of a class C felony.

Sec. ~~17.17.~~11.220. DISTRIBUTING A SCHEDULE ~~I~~ A CONTROLLED SUBSTANCE. (a) Except as authorized in this chapter, it is unlawful for a person knowingly to distribute a Schedule I controlled substance.

(b) A person is guilty of a class A felony if he violates this section by knowingly distributing

(1) 50 or more capsules, tablets, ampules, or syrettes containing a Schedule I controlled substance; or

(2) one or more preparations, compounds, mixtures, or substances of an aggregate weight of

(A) one-eighth ounce or more containing heroin or morphine or any of their respective alkaloids or salts; or

(B) one-half ounce or more containing a Schedule I controlled substance other than heroin or morphine or any of their respective alkaloids or salts.

(c) A person is guilty of a class B felony if he violates this section by knowingly distributing a Schedule I controlled substance in a smaller amount than the ranges specified in (b) of this section.

Sec. ~~17.17.~~11.230. DISTRIBUTING A SCHEDULE B CONTROLLED SUBSTANCE. (a) Except as authorized in this chapter, it is unlawful for a person knowingly to distribute a Schedule B controlled substance.

(b) A person is guilty of a class A felony if he violates this section by knowingly distributing

(1) 50 or more capsules, tablets, ampules, or syrettes containing a Schedule B controlled substance; or

(2) one or more preparations, compounds, mixtures, or substances of an aggregate weight or one-half ounce or more containing a

Schedule ~~II~~ controlled substance.

(c) A person is guilty of a class B felony if he violates this section by knowingly distributing a Schedule II controlled substance in a smaller amount than the ranges specified in (b) of this section.

Sec. ~~17.17~~.240. DISTRIBUTING A SCHEDULE ~~III~~ CONTROLLED SUBSTANCE. (a) Except as authorized in this chapter, it is unlawful for a person knowingly to distribute a Schedule III controlled substance.

(b) A person is guilty of a class B felony if he violates this section by knowingly distributing

(1) 50 or more capsules, tablets, ampules, or syrettes containing a Schedule III controlled substance; or

(2) one or more preparations, compounds, mixtures, or substances of an aggregate weight of one-half ounce or more containing a Schedule III controlled substance.

(c) A person is guilty of a class C felony if he violates this section by knowingly distributing a Schedule III controlled substance in a smaller amount than the ranges specified in (b) of this section.

Sec. ~~17.17~~.250. DISTRIBUTING A SCHEDULE IV CONTROLLED SUBSTANCE. (a) Except as authorized in this chapter, it is unlawful for a person knowingly to distribute a Schedule IV controlled substance.

(b) A person is guilty of a class C felony if he violates this section by knowingly distributing

(1) 50 or more capsules, tablets, ampules, or syrettes containing a Schedule IV controlled substance; or

(2) one or more preparations, compounds, mixtures, or substances of an aggregate weight of one-half ounce or more containing a Schedule IV controlled substance.

(c) A person who violates this section by knowingly distributing a Schedule IV controlled substance in a smaller amount than the ranges

specified in (b) of this section is guilty of a class C felony and is punishable as provided in AS 12.55 except that a term of imprisonment, if imposed, may not exceed three years and a fine, if imposed, may not exceed $10,000.

Sec. ~~17.17~~ 11.260. DISTRICTING A SCHEDULE ~~V~~ E CONTROLLED SUBSTANCE. (a) Except as authorized in this chapter, it is unlawful for a person knowingly to distribute a Schedule V controlled substance.

(b) A person who violates this section by knowingly distributing (1) 50 or more capsules or tablets containing a Schedule ~~V~~ E controlled substance or (2) one or more preparations, compounds, mixtures, or substances of an aggregate weight of one-half ounce or more containing a Schedule ~~V~~ E controlled substance is guilty of a class C felony and is punishable as provided in AS 12.55 except that a term of imprisonment, if imposed, may not exceed three years and a fine, if imposed, may not exceed $10,000.

(c) A person who violates this section by knowingly distributing a Schedule ~~V~~ E controlled substance in a smaller amount than the ranges specified in (b) of this section is guilty of a class A misdemeanor.

Sec. ~~17.17~~ 11.270. DISTRIBUTING A SCHEDULE ~~VI~~ F CONTROLLED SUBSTANCE. (a) Except as authorized in this chapter, it is unlawful for a person knowingly to distribute a Schedule ~~VI~~ F controlled substance.

(b) A person is guilty of a class C felony if he violates this section by knowingly distributing one or more preparations, compounds, mixtures, or substances of an aggregate weight of 2.2 pounds or more containing a Schedule ~~VI~~ F controlled substance.

(c) A person who violates this section by knowingly distributing one or more preparations, compounds, mixtures, or substances of an aggregate weight of one-half pound or more but less than 2.2 pounds containing a Schedule ~~VI~~ F controlled substance is guilty of a class C

felony and is punishable as provided in AS 12.55 except that a term of imprisonment, if imposed, may not exceed three years and a fine, if imposed, may not exceed $10,000.

(d) A person is guilty of a class A misdemeanor if he violates this section by knowingly distributing one or more preparations, compounds, mixtures, or substances of an aggregate weight of less than one-half pound containing a Schedule ~~VI~~ F controlled substance. However, in a prosecution under this subsection, it is a defense which reduces the crime to a class B misdemeanor that the preparations, compounds, mixtures, or substances containing a Schedule ~~VI~~ F controlled substance were of an aggregate weight of one ounce or less and that the distribution was made for no remuneration to a person 18 years of age or older. As used in this subsection, "defense" has the meaning ascribed to it in AS 11.81.900(b).

Sec. ~~17.17~~ 11.280. POSSESSION OF A SCHEDULE ~~I~~ A CONTROLLED SUBSTANCE. (a) Except as authorized in this chapter, it is unlawful for a person knowingly to possess a Schedule ~~I~~ A controlled substance.

(b) A person is guilty of a class A felony if he violates this section by knowingly possessing

(1) 100 or more capsules, tablets, ampules, or syrettes containing a Schedule I controlled substance; or

(2) one or more preparations, compounds, mixtures, or substances of an aggregate weight of

(A) one ounce or more containing heroin or morphine or any of their respective alkaloids or salts; or

(B) two ounces or more containing a Schedule I controlled substance other than heroin or morphine or any of their respective alkaloids or salts.

(c) A person is guilty of a class B felony if he violates this

section by knowingly possessing

(1) 50 or more but fewer than 100 capsules, tablets, ampules, or syrettes containing a Schedule ~~I~~ 4 controlled substance; or

(2) one or more preparations, compounds, mixtures, or substances of an aggregate weight of

(A) one-fourth ounce or more but less than one ounce containing heroin or morphine or any of their respective alkaloids or salts; or

(B) one-half ounce or more but less than two ounces containing a Schedule I controlled substance other than heroin or morphine or any of their respective alkaloids or salts.

(d) A person is guilty of a class C felony if he violates this section by knowingly possessing

(1) 25 or more but fewer than 50 capsules, tablets, ampules, or syrettes containing a Schedule I controlled substance; or

(2) one or more preparations, compounds, mixtures, or substances of an aggregate weight of

(A) one-eighth ounce or more but less than one-fourth ounce containing herion or morphine or any of their respective alkaloids or salts; or

(B) one-fourth ounce or more but less than one-half ounce containing a Schedule I controlled substance other than heroin or morphine or any of their respective alkaloids or salts.

(e) A person is guilty of a class A misdemeanor if he violates this section by knowingly possessing a Schedule I controlled substance in a smaller amount than the ranges specified in 3 (d) of this section.

Sec. ~~17~~ 11.17.290. POSSESSION OF A SCHEDULE ~~II~~ CONTROLLED SUBSTANCE. (a) Except as authorized in this chapter, it is unlawful for a person knowingly to possess a Schedule ~~II~~ 3 controlled substance.

(b) A person is guilty of a class A felony if he violates this section by knowingly possessing

(1) 200 or more capsules, tablets, ampules, or syrettes containing a Schedule I controlled substance; or

(2) one or more preparations, compounds, mixtures, or substances of an aggregate weight of two ounces or more containing a Schedule I controlled substance.

(c) A person is guilty of a class B felony if he violates this section by knowingly possessing

(1) 100 or more but fewer than 200 capsules, tablets, ampules, or syrettes containing a Schedule I controlled substance; or

(2) one or more preparations, compounds, mixtures, or substances of an aggregate weight of one-half ounce or more but less than two ounces containing a Schedule I controlled substance.

(d) A person is guilty of a class C felony if he violates this section by knowingly possessing

(1) 50 or more but fewer than 100 capsules, tablets, ampules, or syrettes containing a Schedule I controlled substance; or

(2) one or more preparations, compounds, mixtures, or substances of an aggregate weight of one-fourth ounce or more but less than one-half ounce containing a Schedule I controlled substance.

(e) A person is guilty of a class A misdemeanor if he violates this section by knowingly possessing a Schedule II controlled substance in a smaller amount than the ranges specified in (d) of this section.

Sec. ~~17.17.~~300. POSSESSION OF A SCHEDULE ~~III~~ C CONTROLLED SUBSTANCE. (a) Except as authorized in this chapter, it is unlawful for a person knowingly to possess a Schedule C controlled substance.

(b) A person is guilty of a class B felony if he violates this section by knowingly possessing

(1) 400 or more capsules, tablets, ampules, or syrettes containing a Schedule ~~III~~ C controlled substance; or

(2) one or more preparations, compounds, mixtures, or substances of an aggregate weight of two ounces or more containing a Schedule III controlled substance.

(c) A person is guilty of a class C felony if he violates this section by knowingly possessing

(1) 100 or more but fewer than 400 capsules, tablets, ampules, or syrettes containing a Schedule ~~III~~ C controlled substance; or

(2) one or more preparations, compounds, mixtures, or substances of an aggregate weight of one-half ounce or more but less than two ounces containing a Schedule ~~III~~ C controlled substance.

(d) A person is guilty of a class A misdemeanor if he violates this section by knowingly possessing a Schedule ~~III~~ C controlled substance in a smaller amount than the ranges specified in (c) of this section.

Sec. ~~17.17~~ 11.310. POSSESSION OF A SCHEDULE ~~IV~~ D CONTROLLED SUBSTANCE. (a) Except as authorized in this chapter, it is unlawful for a person knowingly to possess a Schedule ~~IV~~ D controlled substance.

(b) A person is guilty of a class C felony if he violates this section by knowingly possessing

(1) 400 or more capsules, tablets, ampules, or syrettes containing a Schedule ~~IV~~ D controlled substance; or

(2) one or more preparations, compounds, mixtures, or substances of an aggregate weight of two ounces or more containing a Schedule ~~IV~~ D controlled substance.

(c) A person who violates this section by knowingly possessing (1) 100 or more but fewer than 400 capsules, tablets, ampules, or syrettes containing a Schedule IV controlled substance or (2) one or more preparations, compounds, mixtures, or substances of an aggregate weight of

one-half ounce or more but less than two ounces containing a Schedule IV controlled substance is guilty of a class C felony and is punishable as provided in AS 12.55 except that a term of imprisonment, if imposed, may not exceed three years and a fine, if imposed, may not exceed $10,000.

(d) A person is guilty of a class A misdemeanor if he violates this section by knowingly possessing a Schedule IV controlled substance in a smaller amount than the ranges specified in (c) of this section.

Sec. 17.17.320. POSSESSION OF A SCHEDULE V CONTROLLED SUBSTANCE. (a) Except as authorized in this chapter, it is unlawful for a person knowingly to possess a Schedule V controlled substance.

(b) A person who violates this section by knowingly possessing (1) 400 or more capsules or tablets containing a Schedule V controlled substance or (2) one or more preparations, compounds, mixtures, or substances of an aggregate weight of one ounce or more containing a Schedule V controlled substance is guilty of a class C felony and is punishable as provided in AS 12.55 except that a term of imprisonment, if imposed, may not exceed three years and a fine, if imposed, may not exceed $10,000.

(c) A person is guilty of a class A misdemeanor if he violates this section by knowingly possessing a Schedule V controlled substance in a smaller amount than the ranges specified in (b) of this section.

Sec. 17.17.330. POSSESSION OF LARGE AMOUNTS OF A SCHEDULE VI CONTROLLED SUBSTANCE. (a) Except as authorized in this chapter, it is unlawful for a person knowingly to possess one or more preparations, compounds, mixtures, or substances of an aggregate weight of one pound or more containing a Schedule VI controlled substance.

(b) A person who violates this section by knowingly possessing one or more preparations, compounds, mixtures, or substances of an aggregate weight of 2.2 pounds or more containing a Schedule VI controlled sub-

stance is guilty of a class C felony and is punishable as provided in AS 12.55 except that a term of imprisonment, if imposed, may not exceed three years and a fine, if imposed, may not exceed $10,000.

(c) A person is guilty of a class A misdemeanor if he violates this section by knowingly possessing one or more preparations, compounds, mixtures, or substances of an aggregate weight of one pound or more but less than 2.2 pounds containing a Schedule ~~VI~~ F controlled substance.

Sec. ~~17.~~ 11 17.340. POSSESSION OF A SCHEDULE ~~VI~~ F CONTROLLED SUBSTANCE WHILE OPERATING A MOTOR VEHICLE, VESSEL, OR AIRCRAFT. (a) It is unlawful for a person to operate a motor vehicle, vessel, or aircraft with any amount of a Schedule ~~VI~~ F controlled substance in his immediate control.

(b) A person who violates this section is guilty of a class B misdemeanor.

Sec. ~~17.~~ 11 17.350. PUBLIC DISPLAY OR USE OF A SCHEDULE ~~VI~~ F CONTROLLED SUBSTANCE. (a) It is unlawful for a person to display or use any amount of a Schedule ~~VI~~ F controlled substance in a public place. As used in this subsection, "public place" has the meaning ascribed to it in AS 11.81.900(b).

(b) A person who violates this section is guilty of a violation.

Sec. ~~17.~~ 11 17.360. ~~POSSESSION~~ F OF A SCHEDULE ~~VI~~ CONTROLLED SUBSTANCE BY A MINOR. (a) It is unlawful for a minor knowingly to possess any amount of a Schedule ~~VI~~ F controlled substance.

(b) A person who violates this section is guilty of a violation.

Sec. ~~17.~~ 11 17.370. FAILURE TO MAKE, KEEP, OR FURNISH REQUIRED INFORMATION. (a) Except as authorized in this chapter, it is unlawful for a person knowingly to refuse or fail to make, keep, or furnish a record, notification, order form, statement, invoice, or information required

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under this chapter.

(b) A person who violates this section is guilty of a class B misdemeanor.

Sec. 17.17.380. MISCELLANEOUS OFFENSES. (a) Except as authorized in this chapter, it is unlawful for a person

(1) knowingly to keep or maintain a store, shop, warehouse, dwelling, building, vehicle, vessel, aircraft, or other structure or place which is used for keeping or selling controlled substances in violation of this chapter;

(2) to use in the course of the manuf. ture or distribution f a controlled substance a registration number which is ficticious, revoked, suspended, or issued to another person;

(3) to obtain possession of a controlled substance by misrepresentation, fraud, forgery, or other deception;

(4) to make, distribute, or possess a punch, die, plate, stone, or other thing designed to print, imprint, or reproduce the trademark, trade name, or other identifying mark, imprint, or device of another or any likeness of any of the foregoing upon a drug or container or labeling so as to render a drug a counterfeit substance;

(5) to furnish false or fraudulent material information in, or omit material information from, an application, report, record, or other document required to be kept or filed under this chapter.

(b) A person who violates this section is guilty of a class C felony.

Sec. 17.17.390. LIMITATION ON PRESUMPTIVE SENTENCING. If, in a prosecution under AS 17.17.250(c), 17.17.260(b), 17.17.270(c), 17.17.-310(c), 17.17.320(b), or 17.17.330(b), a defendant is subject to presumptive sentencing under AS 12.55.125(e), the presumptive term to which he is subject may not be adjusted so as to result in a term of imprisonment

of more than three years.

Sec. ~~17~~ 11.17.400. OFFENSES DEFINED BY AMOUNTS. Whenever a provision of this chapter defining an offense requires a determination of an amount, it is not a defense to the lowest class of offense established by the evidence that the amount in question was larger than the amount which would make the offense a higher class of offense, and a person may be charged and convicted accordingly.

Sec. ~~17~~ 11.17.410. PENALTIES UNDER OTHER LAWS. A penalty imposed for a violation of this chapter is in addition to, and not in place of, a civil or administrative penalty or sanction otherwise authorized by law.

Sec. ~~17~~ 11.17.420. BAR TO PROSECUTION. If a violation of this chapter is a violation of a federal law or the law of another state, a conviction or acquittal under federal law or the law of another state for the same conduct is a bar to prosecution in this state.

ARTICLE 3. REGULATION OF MANUFACTURE, DISTRIBUTION, AND DISPENSING OF CONTROLLED SUBSTANCES.

Sec. 17.17.550. REGULATIONS. The ~~commissioner~~ Board of Pharmacy shall adopt regulations under the Administrative Procedure Act (AS 44.62) which are necessary for the administration of AS 17.17.550 - 17.17.610 and may charge reasonable fees relating to the registration and control of the manufacture, distribution, and dispensing of controlled substances in this state.

Sec. 17.17.560. REGISTRATION REQUIREMENTS. (a) A person who manufactures, distributes, or dispenses any controlled substance in this state or who proposes to engage in the manufacture, distribution, or dispensing of a controlled substance in this state, shall annually register with the ~~commissioner~~ Bd Pharm in accordance with regulations adopted under AS 17.17.550.

(b) A person registered by the ~~commissioner~~ Bd Pharm under AS 17.17.550 -

17.17.610 to manufacture, distribute, or dispense controlled substances, including any such activity in the conduct of research, may possess, manufacture, distribute, or dispense those substances to the extent authorized by his registration and in conformity with the other provisions of AS 17.17.550 - 17.17.610.

(c) The following persons need not register and may lawfully possess controlled substances under this chapter:

(1) an agent or employee of a registered manufacturer, distributor, or dispenser of a controlled substance if the possession is incidental to the agent's or employee's acting in the usual course of business or employment; Sampling of C.S.

(2) a common or contract carrier or warehouseman, or his employee, whose possession of a controlled substance is in the usual course of business or employment;

(3) a person in possession of a controlled substance under an order of a registered practitioner.

(d) The ~~commissioner~~ Board may, by regulation, waive the requirement for registration of certain manufacturers, distributors, or dispensers if he finds it consistent with the public health and safety,

(e) A separate registration is required for each principal place of business or professional practice where the applicant manufactures, distributes, or dispenses controlled substances.

(f) The ~~commissioner~~ Board may inspect the establishment of a registrant or applicant for registration in accordance with his regulations.

Sec. 17.17.570. REGISTRATION. (a) The ~~commissioner~~ Board shall register an applicant to manufacture, distribute, or dispense controlled substances included in the schedules in AS ~~17.17.070 - 17.17.090~~ Reg. Schedules unless he finds that the registration would be inconsistent with the public interest. In determining the public interest, the ~~commissioner~~ Bd shall consider

(1) maintenance of effective controls against diversion of controlled substances into other than legitimate medical, scientific, or industrial channels;

(2) compliance with applicable state and local law;

(3) any conviction of the applicant under federal or state laws relating to controlled substances;

(4) past experience in the manufacture or distribution of controlled substances, and the existence in the applicant's establishment of effective controls against diversion;

(5) furnishing by the applicant of false information in an application filed under this chapter;

(6) suspension or revocation of the applicant's federal registration to manufacture, distribute, or dispense controlled substances as authorized by federal law; and

(7) any other factors relevant to the public health and safety.

(b) A practitioner registered under federal law to manufacture, distribute, or dispense controlled substances in the conduct of research may be issued a registration to manufacture, distribute, or dispense those substances in the conduct of research in this state upon furnishing the ~~commissioner~~ Board with evidence of the federal registration. if auth to conduct research/dispense in AK.

(c) Compliance by a manufacturer or distributor with the provisions of the federal law respecting registration, excluding fees, entitles him to be registered under this chapter.

Sec. 17.17.580. REVOCATION AND SUSPENSION OF REGISTRATION. (a) A registration under AS 17.17.570 to manufacture, distribute, or dispense a controlled substance may be suspended or revoked by the ~~commissioner~~ Bd of Pharm upon a finding that the registrant or EXEMPTION from REGISTRATION

(1) has furnished false or fraudulent material information in

an application filed under this chapter;

(2) has been convicted of a felony under state or federal law relating to a controlled substance; or

(3) has had his federal registration to manufacture, distribute, or dispense controlled substances suspended or revoked.

(b) The ~~commissioner~~ Bd Pharm may limit the revocation or suspension of a registration to the particular controlled substance with respect to which grounds for revocation or suspension exist.

(c) If the ~~commissioner~~ Bd suspends or revokes a registration, all controlled substances owned or possessed by the registrant at the time of suspension or the effective date of the revocation order may be placed under seal. A disposition may not be made of substances under seal until the time for taking an appeal has elapsed or until all appeals have been concluded unless a court, upon application, orders the sale of perishable substances and the deposit of the proceeds of the sale with the court. Upon a revocation order becoming final, all controlled substances are forfeited to the state.

(d) The ~~commissioner~~ Bd shall promptly notify the Drug Enforcement Administration of all orders suspending or revoking registration and all forfeitures of controlled substances.

Procedure for Denial, Suspension or Revocation of Reg.

Sec. 17.17.590. ORDER TO SHOW CAUSE. (a) Before denying, suspending or revoking a registration, or refusing a renewal of registration, the ~~commissioner~~ Bd shall serve upon the applicant or registrant an order to show cause why registration should not be denied, revoked, or suspended, or why the renewal should not be refused. The order to show cause shall contain a statement of the basis for it and shall call upon the applicant or registrant to appear before the ~~commissioner~~ Bd at a time and place not less than 30 days after the date of the service of the order, but in the case of a refusal of renewal of registration the show

cause order shall be served not later than 30 days before the expiration of the registration. These proceedings shall be conducted under the administrative adjudication provisions of the Administrative Procedure Act (AS 44.62.330 - 44.62.630) without regard to criminal prosecution or other proceeding. [Proceedings to refuse renewal of registration do not abate the existing registration, which remains in effect pending the outcome of the administrative hearing.]

(b) The ~~commissioner~~ Bd may, without an order to show cause, suspend a registration simultaneously with the institution of proceedings under AS 17.17.580 if ~~he~~ it finds that there is an imminent danger to the public health or safety which warrants this action. The suspension shall continue in effect until the conclusion of the proceedings, including judicial review of the proceedings, unless sooner withdrawn by the ~~commissioner~~ Bd or dissolved by a court of competent jurisdiction.

Sec. 17.17.600. RECORDS OF REGISTRANTS. A person registered or exempted from Reg to manufacture, distribute, or dispense or administer controlled substances under this chapter shall keep records and maintain inventories in conformance with the record-keeping and inventory requirements of federal law and with additional regulations the ~~commissioner~~ Bd may adopt.

Sec. 17.17.610. ORDER FORMS; PRESCRIPTIONS. (a) A controlled substance may be distributed by one registrant to another registrant only if the distribution is in accordance with federal requirements for order forms.

(b) A controlled substance may not be dispensed by a practitioner except in accordance with federal requirements regarding prescriptions for controlled substances; however, a controlled substance may be dispensed directly by a practitioner, other than a pharmacist, to an ultimate user without a prescription, in conformance with applicable labeling Reg. AS 8.80.90

ARTICLE 4. ENFORCEMENT AND ADMINISTRATION.

Different Wording

Sec. 17.17.750. ENFORCEMENT COOPERATION. It is the duty of the commissioner of public safety, officers of the division of state troopers, officers appointed to enforce criminal law in this state or another state, local government law enforcement officers, the attorney general, and all prosecuting attorneys to enforce all provisions of this chapter and to cooperate with agencies charged with enforcement of the laws relating to controlled substances of the United States, of this state, and of all other states.

Sec. 17.17.760. Seizure FORFEITURES. (a) The following are subject to forfeiture:

(1) a controlled substance which has been manufactured, distributed, acquired, or possessed in violation of this chapter;

(2) raw materials, products, and equipment which are used in manufacturing, (Compounding) or distributing a controlled substance in violation of this chapter;

(3) property which is used as a container for property described in (1) or (2) of this subsection;

(4) conveyances, including aircraft, vehicles, or vessels which are used to transport or in any manner to facilitate transportation of property described in (1) or (2) of this subsection for the purpose of sale or receipt, except

(A) a conveyance is not subject to forfeiture under this section if its use in violation of this chapter was committed by a person other than the owner of the conveyance and the owner was not privy to the violation;

(B) a forfeiture of a conveyance encumbered by a bona fide security interest at the time of seizure is subject to the interest of the secured party if its use in violation of this chapter was committed by a person other than the secured party and

the secured party was not privy to the violation;

(5) all books, records, and research products and materials, including formulas, microfilm, tapes, and data which are used in violation of this chapter.

(b) Property listed in (a) of this section may be forfeited to the state upon conviction of the defendant of a violation of this chapter or upon judgment of a court of competent jurisdiction in a civil proceeding in rem that an item is subject to forfeiture.

(c) Property subject to forfeiture under this section may be seized by the commissioner of public safety upon an order issued by the court having jurisdiction over the property upon a showing of probable cause that the property is subject to forfeiture. Seizure without a court order may be made if

(1) the seizure is incident to a valid arrest or a search under a valid search warrant;

(2) the property subject to seizure has been the subject of a prior judgment in favor of the state in a criminal proceeding or a civil proceeding in rem based upon this chapter;

(3) there is probable cause that the property was or is being used in violation of this chapter and the property is easily movable.

(d) Property seized under (c)(3) of this section may not be held over 48 hours or until an order may be applied for and issued by a court, whichever is earlier.

(e) Property seized or detained under this section is in the custody of the Department of Public Safety subject only to the orders and decrees of the court having jurisdiction over the forfeiture proceedings. If property is seized under this section, the Department of Public Safety may

(1) place the property under seal;

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upon the state to prove by clear and convincing evidence that the item in question is subject to forfeiture.

(c) Liability is not imposed by this chapter upon an authorized state or local officer engaged in the lawful performance of his duties.

Sec. 17.17.780. EDUCATION AND RESEARCH. (a) The ~~commissioner~~ Bd shall carry out educational programs designed to prevent and deter abuse of controlled substances. In connection with these programs, the commissioner may

(1) promote better recognition of the problems of abuse of controlled substances within the regulated industry and among interested groups and organizations;

(2) assist the regulated industry and interested groups and organizations in contributing to the reduction of abuse of controlled substances;

(3) consult with interested groups and organizations to aid them in solving administrative and organizational problems;

(4) evaluate procedures, projects, and techniques conducted or proposed as part of educational programs on abuse of controlled substances;

(5) disseminate the results of research on abuse of controlled substances to promote a better public understanding of the problems which exist and their solutions; and

(6) assist in the education and training of state and local law enforcement officials in their efforts to prevent abuse of controlled substances.

(b) The commissioner shall encourage research on controlled substances and may

(1) establish methods to assess the effects of controlled substances and identify and characterize those with potential for abuse;

(2) undertake research to

(A) develop new or improved approaches, techniques, systems, equipment, and devices to strengthen the enforcement of this chapter;

(B) determine patterns of abuse of controlled substances and their social effects;

(C) improve methods for preventing, predicting, and understanding the abuse of controlled substances;

(3) enter into contracts with public agencies, institutions of higher education, and organizations or individuals for conducting research on abuse of controlled substances and for performing related educational activities.

ARTICLE 5. GENERAL PROVISIONS.

Sec. 17.17.900. DEFINITIONS. As used in this chapter, unless the context requires otherwise,

(1) "administer" means the direct application of a controlled substance, whether by injection, inhalation, ingestion, or any other means, to the body of a patient or research subject by

(A) a practitioner or, in his presence, by his authorized agent, or PA

(B) the patient or research subject at the direction and in the presence of a practitioner;

(2) "agent" means an authorized person who acts on behalf of or at the direction of a manufacturer, distributor, or dispenser; "agent" does not include a common or contract carrier, public warehouseman, or employee of the carrier or warehouseman;

(3) "commissioner" means the commissioner of health and social services; B to Pharm

(4) "controlled substance" means a drug, substance, or

immediate precursor included within any of the Fedl schedules in AS ~~17.17.040 - 17.17.( )~~;

(5) "counterfeit substance" means a controlled substance which, or the container or labeling of which, without authorization, bears the trademark, trade name, or other identifying mark, imprint, number, or device, or any likeness to it, of a manufacturer, distributor, or dispenser other than the person who in fact manufactured, distributed, or dispensed the substance;

(6) "deliver" or "delivery" means the actual, constructive, or attempted transfer from one person to another of a controlled substance, whether or not there is an agency relationship;

(7) "dentist" means a person authorized by law to practice dentistry [in this state;]

(8) "dispense" means to deliver a controlled substance to an ultimate user or research subject by a practitioner, including the prescribing, administering, packaging, labeling, or compounding necessary to prepare the substance for that delivery;

(9) "distribute" means to deliver, other than by administering or dispensing, a controlled substance;

(10) "drug"

(A) means

(i) substances recognized as drugs in the official United States Pharmacopoeia, official Homeopathic Pharmacopoeia of the United States, or official National Formulary, or any supplement to any of them;

(ii) substances intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease in humans or animals;

(iii) substances, other than food, intended to affect

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the structure or any function of the body of humans or animals; and

(iv) substances intended for use as a component of any article specified in (i), (ii), or (iii) of this subparagraph;

(B) does not include devices or their components, parts, or accessories;

(11) "hashish" means the resin produced by the plant (genus) Cannabis;

(12) "hashish oil" means the viscous liquid concentrate of tetrahydrocannabinols extracted from hashish;

(13) "immediate precursor" means a substance which the Controlled Substances Advisory Committee has found to be and is by regulation designated as the principal compound commonly used or produced primarily for use, and which is an immediate chemical intermediary used or likely to be used, in the manufacture of a controlled substance, the control of which is necessary to prevent, curtail, or limit manufacture;

17 (14) "manufacture" means the production, preparation, propagation, compounding, conversion, or processing of a controlled substance, either directly or indirectly by extraction from substances of natural origin or independently by means of chemical synthesis, or by a combination of extraction and chemical synthesis, and includes any packaging or repackaging of the substance or labeling or relabeling of its container, except that this term does not include the preparation or compounding of a controlled substance by an individual for his own use or the preparation, compounding, packaging, or labeling of a controlled substance

(A) by a practitioner as an incident to his administering or dispensing a controlled substance in the course of his

professional practice, or

(B) by a practitioner, or by his authorized agent under his supervision, for the purpose of, or as an incident to, research, teaching, or chemical analysis and not for sale;

-17 (15) "marijuana" means the leaves, stems, flowers, and seeds of the plant (genus) Cannabis, whether growing or not, but does not include the resin or oil extracted from any part of the plant, or any compound, manufacture, salt, derivative, mixture, or preparation from the resin or oil, including hashish and natural or synthetic tetrahydrocannabinol; it does not include the mature stalks of the plant, fiber produced from the stalks, oil or cake made from the seeds of the plant, any other compound, manufacture, salt, derivative, mixture, or preparation of the mature stalks, fiber, oil or cake, or the sterilized seed of the plant which is incapable of germination;

(16) "minor" means a person who is under 18 years of age;

(17) "opiate" means a substance having an addiction-forming or addiction-sustaining liability similar to morphine or being capable of conversion into a drug having addiction-forming or addiction-sustaining liabilty; it does not include, unless specifically designated as controlled under AS 17.17.020, the dextrorotatory isomer of 3-methoxy-n-methylmorphinan and its salts (dextromethorphan); it does include its racemic and levorotatory forms;

(18) "opium poppy" means the plant of the species Papaver somniferum L., except its seeds;

(19) "poppy straw" means all parts, except the seeds, of the opium poppy, after mowing;

(20) "practitioner" means

(A) a physician, dentist, veterinarian, scientific investigator, or other person licensed, registered, or otherwise

permitted to distribute, dispense, conduct research with respect to, or administer a controlled substance in the course of professional practice or research in this state;

(B) a pharmacy, hospital, or other institution licensed, registered, or otherwise permitted to distribute, dispense, conduct research with respect to, or administer a controlled substance in the course of professional practice or research in this state;

(21) "production" includes the manufacture, planting, cultivation, growing, or harvesting of a controlled substance;

(22) "ultimate user" means a person who lawfully possesses a controlled substance for his own use, for the use of a member of his household, or for administering to an animal owned by him or a member of his household.

Sec. 17.17.990. SHORT TITLE. This chapter may be cited as the Controlled Substances Act.

* Sec. 2. AS 08.64.380(3)(B) is amended to read:

(B) habitual overuse of alcoholic beverages or <u>controlled substances as defined in AS 17.17</u> [DEPRESSANT, HALLUCINOGENIC OR STIMULANT DRUGS, AS DEFINED IN AS 17.12.150(3), OR ADDICTION TO THE USE OF NARCOTIC DRUGS AS DEFINED IN AS 17.10.230(13)];

* Sec. 3. AS 08.80.470 is amended to read:

Sec. 08.80.470. CONSTRUCTION. Nothing in this chapter amends, modifies, repeals or otherwise changes any provision of the <u>Controlled Substances Act (AS 17.17)</u> [UNIFORM NARCOTIC DRUG ACT (AS 17.10)] or the Alaska Food, Drug and Cosmetic Act (AS 17.20).

* Sec. 4. AS 12.55.155(c) is amended by adding new paragraphs to read:

(15) the offense is defined in AS 17.17, and the commmission of the offense involved smuggling controlled substance into this state;

(16) the offense is defined in AS ~~17~~ 11.17, and the commission of the offense involved large quantities of a controlled substance;

(17) the offense is defined in AS 17.17, and the commission of the offense involved the distribution of a controlled substance adulterated with a toxic substance.

* Sec. 5. AS 12.55.155(d) is amended by adding new paragraphs to read:

(13) the offense is defined in AS ~~17~~ 11.17, and the commission of the offense involved small quantities of a controlled substance;

(14) the offense is defined in AS ~~17~~ 11.17, and the commission of the offense involved the distribution of a controlled substance for no remuneration to a personal acquaintance 19 years of age or older;

(15) the offense is defined in AS ~~17~~ 11.17, and the commission of the offense involved the possession of a controlled substance for personal use in the defendant's home.

* Sec. 6. AS 44.29.020 is amended to read:

Sec. 44.29.020. DUTIES OF DEPARTMENT. The Department of Health and Social Services shall administer the state programs of public health and social services, including: (1) maternal and child health services; (2) preventive medical services; (3) public health nursing services; (4) sanitation and engineering services; (5) nutrition services; (6) health education; (7) laboratories; (8) mental health treatment and diagnosis; (9) management of state institutions; (10) medical facilities; (11) old age assistance; (12) aid to dependent children; (13) aid to the blind; (14) child welfare services; (15) general relief; (16) licensing and supervision of child care facilities; [AND] (17) probation and parole supervision; and (18) control of drug abuse in accordance with AS ~~17~~ 11.17. Not 17

* Sec. 7. (a) Prosecution for a violation of law occurring before the effective date of this Act is not affected or abated by this Act. If the

offense being prosecuted is similar to one defined in AS 17.17, then the penalties under AS 17.17 apply if they are less than those under prior law.

(b) Civil seizures or forfeitures and injunctive proceedings commenced before the effective date of this Act are not affected by this Act.

(c) All administrative proceedings pending under prior laws which are superseded by this Act shall be continued and brought to a final determination in accord with the laws and rules in effect before the effective date of this Act.

Bd of Pharm

(d) The commissioner of health and social services shall initially permit persons to register under AS 17.17 who own or operate an establishment engaged in the manufacture, distribution, or dispensing of a controlled substance before the effective date of this Act and who are registered or licensed by this state.

(e) This Act applies to violations of law, seizures and forfeitures, injunctive proceedings, administrative proceedings, and investigations which occur on or after the effective date of this Act.

* Sec. 8. Orders issued and regulations adopted under a law affected by this Act and in effect on the effective date of this Act and not in conflict with this Act continue in effect until modified, superseded, or repealed.

* Sec. 9. AS 17.10; AS 17.12; and AS 17.15 are repealed.

May be some others.

HB

487

THE LEGISLATURE OF THE STATE OF ALASKA
ELEVENTH LEGISLATURE

FISCAL NOTE

I. REQUEST
Bill/Resolution No. HB 487
Title An Act relating to arbitration in teacher negotiations
Requested by House HESS Date 1/24/80

II. FISCAL DETAIL
Agency Affected Department of Education
Program Category Affected Education
BRU, Program, or Subprogram(s) Affected
(Note: If more than one budget component is affected, separate line item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 80	FY 81	FY 82	FY 83	FY 84	FY 85
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL						
400 COMMODITIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC.						
TOTAL		0	0	0	0	0

FUNDING (Thousands of Dollars)

GENERAL FUND		0	0	0	0	0
FEDERAL FUNDS						
OTHER (Specify Fund Source)						

POSITIONS

FULL TIME						
PART TIME						
TEMPORARY						

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

Fiscal impact cannot be quantified.

IV. DATE 1/28/80 PREPARED BY William D. Thomson, Deputy Commissioner
AGENCY Department of Education
PHONE 465-2800

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)

33-001 (Rev. 12/79)

ASSOCIATION OF ALASKA SCHOOL BOARDS
SUITE 3, 204 NORTH FRANKLIN STREET • JUNEAU, ALASKA 99801 • PHONE 586-1083

FOUR BARGAINING PRINCIPLES

1. Collective bargaining is not a process whereby the general form, quantity or quality of publicservices are to be, or should be, determined. It is not a process for the management of public services.

2. Collective bargaining is not a device to determine public policy except as it may be used to determine the wages and economic benefits that are to be provided for public employees.

3. Collective bargaining is not, nor should it be, a substitute for the proper functioning of a representative government.

4. Collective bargaining should not be permitted to constrain the proper functioning of representative government.

THE RIGHTS OF PUBLIC EMPLOYEES TO STRIKE Vs. THE RIGHTS OF THE PUBLIC.

Because of the basic nature of public services wherein there is no real alternative choice to the established public service, special consideration must be afforded to the protection of both the interests of the general public and the interests of the public employees.

The interests of the general public dictate that any accommodation for collective bargaining and strikes in the public services... ..especially in the public schools... must carefully weigh, and balance, the desire of the employees to organize, bargain and strike against the rights of the public to expect the continued and uninterrupted provision of the public services that public policy has determined should exist. For example, permitting legalized strikes by public employees so upsets the process that the general public cannot withstand the imbalance of power that so results.

IOWA—

Personnel of the board shall be employed pursuant to the provisions of chapter 19A.

5. Members of the board and other employees of the board shall be allowed their actual and necessary expenses incurred in the performance of their duties. All expenses and salaries shall be paid from appropriations for such purposes and the board shall be subject to the budget requirements of chapter 8.

Referred to in sec. 20.3(5)

20.6 General powers and duties of the board. The board shall:

1. Administer the provisions of this chapter.

2. Collect, for public employers other than the state and its boards, commissions, departments, and agencies, data and conduct studies relating to wages, hours, benefits and other terms and conditions of public employment and make the same available to any interested person or organization.

3. Maintain, after consulting with employee organizations and public employers, a list of qualified persons representative of the public to be available to serve as mediators and arbitrators and establish their compensation rates.

4. Hold hearings and administer oaths, examine witnesses and documents, take testimony and receive evidence, issue subpoenas to compel the attendance of witnesses and the production of records, and delegate such power to a member of the board, or persons appointed or employed by the board, including hearing officers for the performance of its functions. The board may petition the district court at the seat of government or of the county wherein any hearing is held to enforce a board order compelling the attendance of witnesses and production of records.

5. Adopt rules in accordance with the provisions of chapter 17A as it may deem necessary to carry out the purposes of this chapter.

20.7 Public employer rights. Public employers shall have, in addition to all powers, duties, and rights established by constitutional provision, statute, ordinance, charter, or special act, the exclusive power, duty and the right to:

1. Direct the work of its public employees.

2. Hire, promote, demote, transfer, assign and retain public employees in positions within the public agency.

3. Suspend or discharge public employees for proper cause.

4. Maintain the efficiency of governmental operations.

5. Relieve public employees from duties because of lack of work or for other legitimate reasons.

6. Determine and implement methods, means, assignments and personnel by which the public employer's operations are to be conducted.

7. Take such actions as may be necessary to carry out the mission of the public employer.

8. Initiate, prepare, certify and administer its budget.

9. Exercise all powers and duties granted to the public employer by law.

20.8 Public employee rights. Public employees shall have the right to:

1. Organize, or form, join, or assist any employee organization.

2. Negotiate collectively through representatives of their own choosing.

3. Engage in other concerted activites for the purpose of collective bargaining or other mutual aid or protection insofar as any such activity is not prohibited by this chapter or any other law of the state.

4. Refuse to join or participate in the activities of employee organizations, including the payment of any dues, fees or assessments or service fees of any type.

Referred to in sec. 20.10

20.9 Scope of negotiations. The public employer and the employee organization shall meet at reasonable times, including meetings reasonably in advance of the public employer's budget-making process, to negotiate in good faith with respect to wages, hours, vacations, insurance, holidays, leaves of absence, shift differentials, overtime compensation, supplemental pay, seniority, transfer procedures, job classifications, health and safety matters, evaluation procedures, procedures for staff reductions, in-service training and other matters mutually agreed upon. Negotiations shall also include terms authorizing dues checkoff for members of the employee organization and grievance procedures for resolving any questions arising under the agreement, which shall be embodied in a written agreement and signed by the parties. If an agreement provides for dues checkoff, a member's dues may be checked off only upon the member's written request and the member may terminate the dues checkoff at any time by giving thirty days' written notice. Such obligation to negotiate in good faith does not compel either party to agree to a proposal or make a concession.

Nothing in this section shall diminish the authority and power of the merit employment department, board of regents' merit system, educational radio and television facility board's merit system, or any civil service commission established by constitutional provision, statute, charter or special act to recruit employees, prepare, conduct and grade examinations, rate candidates in order of their relative scores for certification for appointment or promotion or for other matters of classification, reclassification, or appeal rights in the classified service of the public employer served.

All retirement systems shall be excluded from the scope of negotiations.

Referred to in secs. 20.10, 20.17

20.10 Prohibited practices.

1. It shall be a prohibited practice for any public employer, public employee or employee organization to willfully refuse to negotiate in good faith with respect to the scope of negotiations as defined in section 20.9.

GREATER SITKA BOROUGH SCHOOL DISTRICT
ACCREDITED BY THE NORTHWEST ASSOCIATION OF SECONDARY SCHOOLS & COLLEGES

P. O. BOX 179 SITKA, ALASKA 99835

JOHN E COFFEE
SUPERINTENDENT

January 30, 1980

Representative Thelma Buchholdt
AK State House of Representatives
Pouch V, State Capitol Building
Juneau, AK 99811

Dear Representative Buchholdt:

I am writing because of my concern about two pieces of legislation that are before your H. E. S. S. Committee at this time. They are H.B. 487 and H.B. 453. The passage of these bills would result in the following:

(1) give teachers the right to strike
(2) allow school district classified employees the right to organize and strike
(3) expand what is bargainable
(4) provide binding arbitration in teacher bargaining

I believe that these bills together constitute a tremendous threat to local decision making and the local school board's right to operate a district responsibly and make some final decisions.

Binding arbitration would effectively place decision making authority in the hands of an entity outside the school district. This would be in direct contradiction to the local control theory of government. School boards are elected by law to manage the affairs of the district. They are, further, required by law to bargain in good faith on various items. This is currently done throughout the State. The result has been, generally, the highest paid teachers in the nation, working, in my view, in some of the best working conditions in the nation. I would refer you to the 1978-79 Alaska Association of School Boards publication entitled Survey of School District Budgeted Revenues, Expenditures, and Employee Benefits. It is my view that teacher unions are doing very well without having further advantages of binding arbitration, expanded bargainable items, and the right to strike.

In Sitka, we have recently received an advisory arbitrator's report that the Board has approved and that the teacher's union will vote on

soon. Hopefully, this will be the culmination of negotiations that began in November of 1978. If the report is accepted we will have a beginning teacher salary here of over $20,000. and a top salary of over $36,000.

The school boards I have worked for in Juneau and Sitka have been made up of reasonable people whose main motives have been to serve the community they represent. Final decision making authority on items that are bargainable must not be taken away from such local officials and given to an outside arbitrator.

I am hopeful that the representative of the Alaska School Board's Association, Mr. Robert Greene, and the respresentative of the Alaska Association of School Administrators, Dr. Cliff Hartman, will be listened to carefully by the H. E. S. S. Committee when they discuss the ramifications of these prooosed bills. It is vital that such legislation not become law.

Sincerely,

John E. Coffee, Superintendent
Sitka Borough School District

cc: Senator Pete Meland
Representative Richard Eliason
Mr. Robert Greene, A. A. S. B.
Dr. Cliff Hartman, A. A. S. A.
Sitka School Board

JEC:vhv

TELEGRAM

ALASCOM, INC.
PHONE: 586-0442
JUNEAU, AK 99802

1980 JAN 30 PM 9 21

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02123 NL TDA CORDOVA ALASKA 117 01-30 0410P AST

PMS REP THELMA BUCHHOLDT

1450

JUN

THE CORDOVA BOARD OF EDUCATION FEELS

THAT HOUSE BILLS 487 AND 453 CONTAIN ISSUES THAT SERIOUSLY REDUCE THE LOCAL SCHOOL BOARDS RIGHT TO MAKE DECISIONS,

THAT BINDING ARBITRATION IS NOT THE SOLUTION THAT WILL CURE THE ILLS OF THE NEGOTIATION PROCESS,

THAT THE INTENT OF AS14.20.550 THROUGH AS14.20.600 OF THE ALASKA SCHOOL LAW IS NOT TO ABROGATE THE LEGAL RESPONSIBILITIES, POWERS, OR DUTIES OF THE LOCAL SCHOOL BOARDS.

THAT THE INTENT OF THE LAW IS THAT SCHOOL BOARDS HAVE THE RIGHT TO MAKE FINAL DECISIONS ON POLICY AND EMPLOY EXCLUSIVE MANAGEMENT.

THE ISSUE OF ARBITRATION IS ADEQUATELY ADDRESSED IN AS14.20.530 AND FURTHER DEFINED UNDER CHAPTER 80 TITLE 4 EDUCATIONAL REGULATIONS.

JACK LAMB, PRESIDENT CORDOVA BOARD OF EDUCATION

CITY AND BOROUGH OF JUNEAU SCHOOL DISTRICT
P.O. BOX 808 • DOUGLAS, ALASKA 99824

February 5, 1980

The Honorable Thelma Buchholdt
Alaska State House of Representatives
Pouch V
Juneau, Alaska 99811

Dear Representative Buchholdt:

The Juneau School Board wishes to go on record as being opposed to House Bill 453 and House Bill 487 for the following reasons and respectfully request that you do not support them.

House Bill 453 provides the right to strike to all employees of the School District, and in addition, provides mandatory bargaining to all employees with broad interpretations to what must be bargained. At the present time the Juneau School District negotiates with their classified employees so the legislation is not necessary, and above all, should not include the right for any employees to strike. Please remember that school boards in Alaska cannot raise money on their own, but must come to the Borough Assembly or Legislature for additional revenue. A striking action against the Board allows them no additional revenue with which to resolve the strike. Therefore, educational programs are cut back.

House Bill 487 on binding arbitration removes the decision making authority from the elected representatives of the people. Instead of leading to a solution of the problem by serious negotiations by both parties to avoid arbitration, often one or the other parties will hold out for arbitration. Historically arbitrators split the difference and everyone holds out with extreme offers as tactical maneuvers.

It is our opinion that the State Board of Education request to the Governor to form a Blue Ribbon Committee to seek the best alternative to the serious problems of negotiation should be honored. Passage of legislation before the study would be premature.

With the legislatures having second thoughts over the collective bargaining of State employees and contemplating some modifications, it seems appropriate to allow a study of the problems to take place before enacting legislation that may not serve any useful purpose.

The Juneau School District would appreciate your support on these two matters.

Sincerely,

Carole Burger

Carole Burger, President
Juneau School Board

DLMK/CB:m

cc: Mr. Robert Greene, Executive Secretary, Association of Alaska School Boards

TELEGRAM

ALASCOM, INC.
PHONE: 586-6442
JUNEAU, AK 99802

#

02047 NL TDA SKAGWAY ALASKA 50 02-07 102P AST

PMS REP THELMA BUCHHOLDT

JUNEAU AK 1838

THE SKAGWAY SCHOOL BOARD CAN NOT SUPPORT BILLS NBR HB453 AND HB487.
WE URGE YOU TO DEFEAT THIS TYPE OF LEGISLATION. THIS WILL ONLY
ALLOW FOR TEACHER UNION AND COURTS TO REGULATE LOCAL EDUCATIONAL
NEEDS. PLEASE DEFEAT HB453 AND HB487.

CARL ROSE, PRESIDENT

SKAGWAY SCHOOL BOARD

'80 FEB 7 PM 3 45

Alaska State Legislature

House of Representatives

Committee on

Health, Education & Social Services

Official Business

Pouch V
State Capitol
Juneau, Alaska 99811

Office phones:
907/465-3777 or
907/465-3797

February 10, 1980

Carl Rose
President
Skagway School Board
Skagway, Alaska

Dear Carl:

I have received your recent telegram. It will be entered into the record of the next House HESS Committee public hearing on HB 487 and HB 453. I would like to respond personally to your telegram with a few comments.

I do not believe that either bill would allow a teachers' union or the court system to totally regulate education in localities. The bills provide a framework for just settlement of negotiations between school boards and their employees. Each side would have an equal chance in negotiations and the outcome of negotiation would be decided by an independent, objective party. Thus, the bills would negate boards' power to refuse to negotiate with their employees, but they would not allow employees to automatically receive their demands. Rather, they would establish a structure for negotiation of those demands; each side would have an equal chance to get what it wants. Since the bills do not provide that all employee demands would be negotiable, the boards would retain total decision making power over certain issues. Moreover, the bills address collective bargaining and arbitration only, and do not attempt to reduce or even to address any of the local boards decision making rights in other areas.

The primary intent of the bills is to provide for final and

incontrovertible settlement of teacher-board disputes as quickly as possible. I believe the past history of teacher-board disputes demonstrates that to achieve final settlement in a timely manner, it is necessary that an outside observer be responsible for an ultimate decision instead of having one side or the other within the locality vested with this power.

I understand your position, but I believe that current law in this area is in need of revision.

Sincerely,

Thelma

Thelma Buchholdt
State Representative
District 9 (Spenard);
Chair, House HESS Committee

187

(d) The arbitrator may not make an award which incorporates union security provisions, including but not limited to a union shop or agency shop provision or agreement that fails to safeguard —

453 (c)

Name	Address & Phone #	Organization	Bill No.
✓Charlie Huteago	208 Seward Building	NEA-Alaska	HB 487
✓Betty Briggs	1411 W 33rd Ave, Anchorage 274-0536	Anchorage Education Association	HB 487
✓Lori Sears	1411 W 33rd Ave. Anchorage 2[illegible]-0536	Anchorage Education Assoc	HB 487
✓CLIFF HARTMAN	1433 W 13th Anch. 279-8176	AK. Council of Sch. Adm	HB 487
Carl Peterson	Box 305 Bethel AK 543-2677	Lower Kuskokwim Sch Dist	HB 487
Bob Manners	207 Seward Bldg - Juneau	NEA-Alaska	HB 487
Bob Van Houte	207 Seward Bldg 586-3090	NEA-ALASKA	HB 487
Bob Greene	204 North Franklin - Juneau	AASB	H.B. 487
Vince Casey	1024 LA Touche	SBE (State Board of Ed).	HB 487

HB

488

THE LEGISLATURE OF THE STATE OF ALASKA
ELEVENTH LEGISLATURE

FISCAL NOTE

I. REQUEST

Bill/Resolution No. HB-488 (Revised 5/20/80)

Title An Act relating to class size.

Requested by House HESS Date 5/20/80

II. FISCAL DETAIL

Agency Affected Department of Education

Program Category Affected Elementary and Secondary

BRU, Program, or Subprogram(s) Affected Foundation Support Programs

(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

		FY 80	FY 81	FY 82	FY 83	FY 84	FY 85
100	PERSONAL SERVICES						
200	TRAVEL						
300	CONTRACTUAL						
400	COMMODITIES						
500	EQUIPMENT						
600	LAND & STRUCTURES						
700	GRANTS, CLAIMS, ETC.		136,670.0	23,874.0*	28,648.8	34,378.6	41,254.3
	TOTAL						

FUNDING (Thousands of Dollars)

GENERAL FUND		136,670.0	23,874.0*	28,648.8	34,378.6	41,254.3
FEDERAL FUNDS						
OTHER (Specify Fund Source)						

POSITIONS

FULL TIME	N/A					
PART TIME						
TEMPORARY						

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

See Attached.

*Inflation rate of 20% is used to reflect increase in operation and maintenance costs of added facilities.

IV. DATE 5/20/80 PREPARED BY

AGENCY Department of Education

PHONE 465-2800

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)

33-001 (Rev. 12/79)

Minimum Fiscal Impact

Assumptions: 1. All additional teachers will enter on lowest salary placement with lowest benefit schedule ($20,000 + 15%)

2. Weighting factor average for special education students is absolute minimum (1.5)

3. Weighting adjustment accommodates all PTR reductions required by the bill, i.e., this fiscal note does not include the cumulative cost of dispersing mainstreamed special education students required by sec. 14.30.248 of the bill.

4. All present K-3 classes have a PTR of 1-20 or fewer. While we know this assumption is erroneous (Juneau's K-3 classes run between 1-19 and 1-30) we do not have data for all districts.

5. All districts will construct required classrooms during FY-81, and suitable excess space does not presently exist.

6. The Legislature will fully fun all costs of the bill during FY-81, rather than pick up debt retirement in third fiscal year.

7. Teachers will not negotiate lower special education PTRs, permitted by sec. 14.30.249(b) of the bill.

8. Adjustment of urban district PTR to state average will accommodate class size limitations imposed by the bill.

Teacher Costs

FY-79 Final ADM 87,300
FY-79 Classroom Teachers 5,057
FY-79 Special Ed. students 13,000
Adjusted Special Education Count (13,000 x 1.5) = 19,500
Total Adjusted ADM 93,800
Additional Teachers at state average (93,800 ÷ 17.3 - 5,057) = 365
Urban district PTR adjustment required to reduce PTRs to state average 500
Total Teacher cost (865 teachers x 23,000 minimum salary) = 19,895,000

Facility Costs
865 classrooms (minimum) x 900 square feet x $150 per square foot (minimum cost in state) = 116,775,000

Minimum Fiscal Impact (based upon assumptions) FY-81 $136,670,000

ASSOCIATION OF ALASKA SCHOOL BOARDS
SUITE 3, 204 NORTH FRANKLIN STREET • JUNEAU, ALASKA 99801 • PHONE 586-1083

May 20, 1980

The Honorable Thelma Buchholdt & Members
of House HESS Committee
Pouch V, State Capitol Building
Juneau, Alaska 99811

Dear Representative Buchholdt:

I am writing to express strong opposition to HB 488 regarding class size for several reasons which I will attempt to describe to you here.

One reason for AASB's opposition is the potential extreme high costs. I say potential because it is extremely difficult to assess the cost of the weighting factor and the impact on negotiating the number of exceptional children in a class. A number of school districts have attempted, however, to cost out the known quantities of the bill and I would like to share these with you.

Anchorage assesses its needs under the bill at requiring one hundred and seventy-four additional classroom teachers. They feel that they would have to construct approximately one hundred and fourteen additional teaching stations. Suffice it to say, it would certainly solve the school closure problem in Anchorage. This bill would use up all existing space available plus requiring approximately six additional schools at an estimated cost of $30 million.

Salaries for the additional teachers would require $5,863,800 if the figure of $33,700 per teacher is used to cover salary plus fringe benefits. No estimate is included here for increases in support services or materials required to enable these additional teachers to function. Nothing is included to cover the potential for negotiations to limit exceptional children in each class.

A conservative cost estimate for additional required support services would be an additional $3 million.

In summary, this bill has a potential impact well in excess of $38 million on Anchorage in the first year with an additional $10 million annually thereafter.

Kodiak reports requiring a minimum of $1.5 million in operating funds adding 43 additional classrooms and teachers. Construction costs were not reported.

Ketchikan did not do an in-depth study, but indicated a cost figure of approximately $1.5 million.

Delta Junction would need to add eight teachers to its existing 61 at a direct cost of $240,000 and would require five additional teaching stations at an estimated construction cost of a half million dollars.

The Matanuska-Susitna Borough School District estimates their needs at thirty-six added elementary teachers costing $1,195,992 for salary and fringe benefits with an additional thirty-six teachers in the secondary program for a total of 72 teachers costing $2,391,984. No support service costs were figured, but can be estimated at $1.5 million. Mat-Su's construction needs would require fifty-two additional classrooms.

School districts reviewing the bill expressed particular concern that the provisions contained therein would eliminate the concept of large group instruction. Traditionally band, chorus, P.E., and vocational classes such as typing are set up on a scale that exceeds the maximum 25 in secondary schools as proposed. This bill would essentially eliminate the effectiveness of the above-mentioned programs and require duplication of the schools most expensive facilities.

The section of the bill permitting the negotiation of the number of exceptional children in a single classroom has the greatest potential of all sections to create a problem, probably because of unknown factors. One potential might be to cause districts to be in violation of Federal Statute 94-142 requiring handicapped children be placed in the "least restrictive environment", i.e., the regular classroom. This section has the potential of making all other sections of the bill unnecessary.

In summary, it would appear that exclusive of construction costs required to provide additional teaching stations, this bill should require an average of 10 to 20 percent increases in school budgets at a conservative estimate of $30 million statewide.

The Association of Alaska School Boards would urge you to oppose passage of this legislation contained in HB 488.

Sincerely,

BOB GREENE

Robert C. Greene
Executive Secretary

RCG:bld

To: House HESS Cmte
For: HEARING ON 22 MAY AT 1:30 PM
RE: HB488

GREATER SITKA BOROUGH SCHOOL DISTRICT

May 21, 1980

I wish to testify in opposition to House Bill #488. Should such a bill be passed it will have the effect of eroding local school board authority. Certainly such issues as size of classes are the kinds of decisions school boards are expected to make by their constituents who elect them. The portion of the bill that calls for weighted counts of special education students who are in regular classes for a portion of the day only has the effect of making a bad bill worse. School Districts in Alaska are by law obligated to adhere to the stringent special education laws embodied in P. L. 94-142 to insure that proper programs are being offered. This we are doing in most districts in a conscientious, effective manner in my view.

The various studies that have attempted to look at optimal class size have usually come to the conclusion that class size has very little to do with educational productivity. However, most school boards and school administrators still work hard to keep class sizes small. Average class sizes in most Alaska districts are very small. Such decisions should be made locally by the elected school board and must be based upon available funding and the wishes of local residents.

Special education accounting, necessarily, involves tremendous amounts of paperwork. H.B. #488 will simply compound that. It will also result in endless grievances from teachers regarding the various

GREATER SITKA BOROUGH SCHOOL DISTRICT

"weighted children" in their classes. I can anticipate being unable to add one more child to a class because we have reached the arbitrary, maximum number. I contend that this would be absolutely ridiculous! The teacher, with the help of the law, should not be dictating to the employer how many children will be assigned to his or her classroom.

This proposed bill will undoubtedly have the strong backing of teachers since it would reduce class size. It would also increase costs in many districts drastically and, in my view, result in no improvements for children. The worst feature is that school boards would be prohibited from making decisions that I contend only they should make.

John E. Coffee
Superintendent
Sitka School District

JEC:vhv

THE LEGISLATURE OF THE STATE OF ALASKA
ELEVENTH LEGISLATURE

FISCAL NOTE

I. REQUEST

Bill/Resolution No. HB-488

Title An Act relating to Class Size

Requested by House HESS Date 5-6-80

II. FISCAL DETAIL

Agency Affected Education

Program Category Affected Elementary and Secondary

BRU, Program, or Subprogram(s) Affected Foundation Support, Special Education Adjustment

(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 80	FY 81	FY 82	FY 83	FY 84	FY 85
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL						
400 COMMODITIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC.						
TOTAL						

FUNDING (Thousands of Dollars)

GENERAL FUND						
FEDERAL FUNDS						
OTHER (Specify Fund Source)						

POSITIONS

FULL TIME						
PART TIME						
TEMPORARY						

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

While we cannot estimate in an accurate fashion the impact of this bill, we can state that it likely would require additional classroom space construction and it would undoubtedly have a substantial impact on the number of teachers districts must employ to conform to the limitations of the bill. This is not a zero fiscal note, it is rather, merely impossible to estimate the true cost of the bill.

IV. DATE 5/6/80 PREPARED BY Steve Hole

AGENCY Department of Education

PHONE 465-2800

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)

33-001 (Rev. 12/79)

GOVERNOR'S COUNCIL FOR THE HANDICAPPED AND GIFTED
Meeting of January 24-25, 1980
Centennial Building
Sitka, Alaska

MINUTES

MEMBERS PRESENT:

Marsha Buck
Joe Betit
Alistair Chalmers
Ro Chatterton
Mike Cummings
Wes Doran
Bob Gregovich
Ludy Jacobs
Glenn Johnson
Joan Jordan
John Nuttal
Dave Spence
Carol Welsh
Blanche Walters (arrived Friday)
Caroline Wolf

STAFF PRESENT:

Dorothy Truran
Laurie Goggin

GUESTS:

Tom Buckner, representing the Office for Exceptional Children
Pat Young, representing Mike Morgan, Office of Vocational Rehabilitation
Dave Canterbury
Lizette Burns-Stiehr
Jane Brodie
Jeff Hubbard
Terry Coon, Director of Special Education, Sitka
John Coffee, Supt. of Schools, Sitka
Diane LeResche, DOE/OEC Gifted Programs
Sam Granato, Osborne/Granato Associates
Debra Gilbreath, Sitka School District
Roy Anderson, Alaska Resources for the Moderately/Severely Impaired
Janice Rhoades, G/T teacher, Sitka

The roll was called. Thirteen members were present and a quorum was established. Chairperson Marsha Buck welcomed members and introduced guests. The agenda was adopted. It was noted that Allan Korhonen and Vern Stillner of the Department of Health and Social Services would not be able to address the Council since bad weather caused their flight from Juneau to be cancelled. Carol Welsh informed members that Wanda Gnerich is in the hospital and unable to attend the meeting. Carol encouraged members to call or visit Wanda.

APPROVAL OF MINUTES

The minutes of the October, 1979 Council meeting were approved as amended. (Motion: Nuttal/Jordan)

[Attachment "A" - January Council meeting minutes]

COMMUNICATIONS

Pertinent information was available for members and guests at the display table.

Debra Gilbreath, Terry Coon, and Superintendent John Coffee were unable to address the Council in the morning. Arrangements were made to hear from them later during the meeting.

5. that the Council adopt the "State Plan Development Policies-January 1980" as amended. (Chalmers/Welsh) [Carried]

Laurie Goggin asked that Council members review the "State Plan Development Policies" information which was distributed during yesterdays meeting. She stated that basically the resolution sets down some statements about the expectations & relationship between the Council and various state agencies providing services to the developmentally disabled for the purpose of developing the state plan this year. Laurie briefly went over the resolution with the Council. Dot Truran advised that basically it just puts in writing the procedures that the Council has been following in developing the state plan over the last three years.

6. that the Council adopt the "Classification of Services into Federal Priority Areas - FY81-83 State Plan" as amended. (Chalmers/Jacobs) [Carried]

Alistair Chalmers pointed out the following amendments:

- Transportation and recreation were previously listed under "Support Services" for both children and adults. It was proposed that transportation and recreation be deleted under "Support Services" and inserted under the classification of "Alternative Community Living Arrangements" for both children and adults.
- Infant learning was unintentionally included under adults and this has been deleted.

Laurie Goggin advised that there is no intent to prioritize services in terms of the Council's activities. The only intent is to develop a "dictionary" to be used in developing the state plan that places the different services that we have called support, etc. into the new federal categories.

Membership and Nominating

7. that the nominations for Executive Committee member-at-large to fill the vacancy left by John Stamm be closed and that a unanimous ballot be cast for Dave Spence to fill that position. (Welsh/Betit) [Carried]

Legislative Committee

8. that the Council write a position against HB 488 and submit that position paper to the House HESS and Senate Committees and the Commissioner of Education. (Spence/Wolf) [Amended below]

Amendment #1

that the words "position paper" be deleted from Motion #8 and "written statement" inserted. (Welsh/Johnson) [See final motion below]

Final Motion

that the Council issue a statement in opposition to HB 488. (Spence/Wolf) [Carried]

Dave Spence advised that HB 488 is a one page bill now before the legislature which relates to class size and legislates maximum class size for regular education as well as special education. With regard to special education, it gives a weighting of handicaps - a formula by which only a limited number of exceptional children can be in any one classroom. It limits the number to four exceptional children as individuals or, if there is a weighting consideration, a multiply handicapped student would perhaps limited the number of exceptional children to less than four.

By legislating a maximum number of handicapped children to be served in any one classroom, teachers could then cite class size as a collective bargaining issue. The Legislative Committee feels that class size is not an appropriate factor to legislate because class size limitation has not been proven to be directly related to the quality of education.

John Nuttal feels its not wise for the Council to go on record opposing a maximum class size for special education children. He feels that if the Council states its opposition to limit special education class sizes, the Council will be negating its goal of increasing the quality of education to special education children. However, he stated that he does not agree with weighting children and does not feel that because a deaf child is placed in one class that two other children should be placed elsewhere. If that child is qualified to be in the classroom than he should be there, if not he shouldn't be there.

Marsha Buck advised that some school districts have policies which attempt to limit class size. According to state regulation, no special education teacher may work with more than 15 full time equivalency students. In regular education there are no set regulations at present.

Carol Welsh stated that she does not think the Council should oppose a realistic limitation on class sizes for exceptional children. The reason this bill is not one the Council should support is because it is a politically oriented bill with a hidden agenda which attempts to legislate class size so that teacher's unions can use such legislation as a bargaining lever. Carol stated that this bill definitely labels children. There are times when you have to label children according to their disabilities for reporting purposes, but to do it in the manner prescribed in this bill is unacceptable. For example, hyperactive children are given a weighted factor of 2.5 which is more than a deaf child who is weighted at 2.0.

Pat Young stated that he would like to have some limitation on class sizes so the teachers know what they have to deal with on a day-to-day basis.

Ludy Jacobs feels there should be some type of class size limitation based on the severity of handicap.

Carol Welsh pointed out that the problem with this bill is that it is poorly designed and poorly written and has other agendas built into it. These factors should be the reason for Council opposition.

Glenn Johnson pointed out that the bill also is discriminatory in that it sets a maximum limit of exceptional children in an integrated class at

four. Lizette Burns-Stiehr pointed out that the way the bill weighs children, an orthopedically handicapped and an emotionally disturbed child could not be in the same class. In some cases this weighting may work, but in rural areas the weighting should be individually determined and not legislated.

Dave Spence clarified that his motion simply stated that the Council opposes this bill and in speaking to the motion he gave some rationale that would presumably be built into such a statement on the bill as to why the Council was opposed to the bill.

John Nuttal does not feel the Council should say it has not been proven that maximum class size does not show better education. He feels that is a poor thing for the Council to go against.

Marsha Buck stated that if the motion passes, she would direct that the entire conversation just held be considered and included in the written statement.

9. that the Council's Position Paper favoring SB 339 and HB 572 be forwarded to the House and Senate Judiciary Committees and to the Commissioner of the Department of Health & Social Services. (Spence/Chatterton) [Carried]

Bob Gregovich questioned whether the fiscal impact was the same as last year - with most of the expenditures involving the Court System. Dot replied that the fiscal statement deals mostly with the cost of the public guardian function and that the Council has not dealt with the present court system costs for all the guardianship cases that presently come before the court system. That is an on-going cost of the Court System and we are not addressing that. We are addressing the fiscal impact of this bill which will not impact on the number of guardianship cases directly but will result in having a new office perform some duties that were not formerly performed by state government.

Dave Spence pointed out that the effect of this bill in establishing priorities for guardians and setting up an office of public guardian would give a mechanism to drum up support and public awareness for the need for those first five priorities of guardians. At the present time the problem is there, but there is no organized way to address it. This would at least establish one state position and get us further along the road of getting more people to come forward and volunteer to be guardians. The legislation structures the whole guardianship process so that you could get a partial guardianship and have guardianship tailored to the person's needs.

Discussion followed regarding the fiscal note on the bill. Dot suggested she and Dave Spence review the fiscal note and obtain information from Debbie Behr prior to submitting the attachments to the position paper.

Bob Gregovich reported that Debbie Behr has just assigned him the responsibility for doing the fiscal note and that much of the fiscal note will come from the information already available. He stated it is next to impossible to guess what the Court System is going to have as their fiscal note without doing their fiscal note for them. He feels the current fiscal note is

THE FOLLOWING DOCUMENT(S) MAY NOT FILM LEGIBLY BECAUSE OF POOR QUALITY OF THE ORIGINAL.

To: House Hess Cmte.

May 21, 1980

FOR: HEARING ON 22 MAY AT 1:30 PM

RE: HB488

My name is CarolWelsh from Sitka and I would like to offer testimony to the committee in opposition to HB 488. I address my objections from two perspectives: first, as a school board member; and second, as the parent of three developmentally disabled children, two of whom are adopted.

HB 488 is clearly an attempt to legislate class size and/or make it statutorily permissible to include class size as part of the bargaining process. I oppose both of these attempts to solve what is felt to be a problem for our educators.

Legislating class size not only removes fiscal and administrative responsibility from the LEA's, but also has the potential of financially hamstringing districts where space or budget restraints may develop, and in the event of unexpected enrollment increases.

As a parent, I would be quite wary of allowing class size to be part of the negotiating process especially when it may involve special education students. It has been my observation that MONEY is generally the ultimate item of concern at the bargaining table and I must voice my disapproval of my state government implying that it would be OK for retarded or otherwise handicapped children to be used as pawns and tradeoffs, especially when those involved in the bargaining process do not always have the sensitivity towards and understanding of special education needs and requirements.

The weighted average daily membership concept as suggested in HB 488 is not the answer to achieving appropriate integration procedures in our school districts. The weight schedule as outlined in this bill does not permit equitable class balance and I take great exception to children being statutorily classified by disability which implies that all children of a given disability learn, behave, and develop in the same way, at the same rate, and with the same expected outcomes. Placement in any classroom situation, whether it be integration into a regular classroom or a self-contained special education setting, must depend on the "unique needs of the individual child" as mandated by both P.L. 94-142 and Sec. 504 of the Vocational Rehabilitation Law Amendments of 1973. To categorize children by specific disability with a corresponding weight factor ignores the requirement of an individualized placement determination and would seem to be in violation of existing state and federal mandates. To me, this represents a gross example of stereotyping that could render an "appropriate" placement nearly impossible to achieve.

I feel it is important for all of us to be aware of the many problems that surround the education of exceptional children, especially in the areas of funding inequities, cost of related services, and the achieving of "least restrictive environment." It is understandable that regular classroom teachers feel threatened and overburdened at the prospect of having handicapped children returned to the "mainstream" of education. However, properly handled integration does not mean the indiscriminate dumping of of exceptional children into the regular classroom; if this is occuring, proper placement procedures are not being used very well. In addition, regular classroom teachers should rightfully expect and receive support services from special education in order to facilitate a good integration process for both them and the special education students being placed in their classrooms.

In conclusion, I feel HR 488 to be a self-serving piece of legislation that has the potential of causing more problems in special education than we are currently experiencing and does nothing to improve educational opportunities for children. The fiscal impact of this proposal would probably drive the cost of special education up considerably. It would seem far more prudent to have these and related problem areas in special education studied in depth with the purpose in mind of developing a future comprehensive piece of legislation that would be of benefit to all. Such an effort would be of even greater benefit if it were addressed jointly by the various entities currently dealing with special education issues.

Thank you.

Jacket at start
of this committee
(fiche # 787)

1979-1980

HOUSE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

LIST OF FILES (PAGE 1)

DEPARTMENT OF EDUCATION

INTERIM

STATE HEALTH INSURANCE (FILE NO. 1)

STATE HEALTH INSURANCE (FILE NO. 2)

STATE HEALTH INSURANCE (FILE NO. 3)

STATE HEALTH INSURANCE (FILE NO. 4)

STATE HEALTH INSURANCE (FILE NO. 5)

FISCAL NOTES - HB 977 / SB 277

CHILDREN'S CODES (SB 106 / HB 204, 1977-78)

HB 2

HB 4

HB 11

HB 15

HB 76

HB 79

HB 82

HB 86

HB 125

HB 126

HB 129

HB 145

HB 219

HB 226 & HB 228

HB 231

HB 287

HB 333

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HOUSF HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

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HB 374

HB 391

HB 401

HB 419

HB 453

HB 455

HB 479

HB 487

HB 488

HB 540

HP 545

HB 561

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HB 609

HB 610

HB 611

HB 615

HB 617

HB 618

HB 620

HB 628

HB 629

HB 637

HB 651

HB 664

HB 672

HB 690

1979-1980

HOUSE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

LIST OF FILES (PAGE 3)

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HB 704

HB 720

HB 751

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HB 802

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HB 821

HB 826

HB 830

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HB 861

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HCR 43

1979-1980

HOUSE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

LIST OF FILES (PAGE 4)

HJR 19

HJR 29

SB 15

SB 32

SB 88

SB 162

SB 163

SB 227

SB 522

SB 539

SB 549

SCR 40

HB
540

THE LEGISLATURE OF THE STATE OF ALASKA
ELEVENTH LEGISLATURE

FISCAL NOTE

I. REQUEST
Bill/Resolution No. HB-540
Title An Act establishing the Alaska school competitive activities fund
Requested by House HESS Date 1/22/80

II. FISCAL DETAIL
Agency Affected Education
Program Category Affected Elementary and Secondary
BRU, Program, or Subprogram(s) Affected Financial Support Programs
(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

		FY 80	FY 81	FY 82	FY 83	FY 84	FY 85
100	PERSONAL SERVICES						
200	TRAVEL						
300	CONTRACTUAL						
400	COMMODITIES						
500	EQUIPMENT						
600	LAND & STRUCTURES						
700	GRANTS, CLAIMS, ETC.		412.6	495.1	594.1	712.9	855.5
	TOTAL						

FUNDING (Thousands of Dollars)

GENERAL FUND		412.6	495.1*	594.1*	712.9*	855.5*
FEDERAL FUNDS						
OTHER (Specify Fund Source)						

POSITIONS

FULL TIME						
PART TIME						
TEMPORARY						

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

*inflated at 20% per year based upon increased participation, normal inflation and escalated travel inflation based upon fuel costs.

FY-81 estimate based upon 2,005 participants x 3 day tournament x $25.00 per day room and board (including coaches) = $150.4

FY-80 tournament cost (approximate) inflated by 20% to accommodate anticipated increase in participation and FY-80 inflation occasioned by fuel/travel increases = $262.2

Total = $412.6

IV. DATE 1/23/80 PREPARED BY William D. Thomson
AGENCY Education
PHONE 465-2800

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)

33-001 (Rev. 12/79)

LAW OFFICES

JOSEPHSON, TRICKEY & LORENSEN, INC.

210 NORTH FRANKLIN STREET
JUNEAU, ALASKA 99801
907 586[illegible]94, 586-6997

JOE P. JOSEPHSON
HOWARD S. TRICKEY
RONALD W. LORENSEN*
NANCY R. GORDON
TIM MacMILLAN

*Juneau

ANCHORAGE:
425 "G" STREET
SUITE 930
ANCHORAGE, ALASKA 99501
907 276-7133

January 24, 1980

The Honorable Thelma Buchholdt
State Representative
Chairman, House HESS Committee
State Capitol
Pouch V
Juneau, Alaska 99811

Re: HB 540, Establishing the Alaska School Competitive Activities Fund

Dear Representative Buchholdt:

As you probably know, our firm represents a number of school districts around the state. When I was informed a few days ago by the committee that you would be taking up HB 540 on this date, I made attempts to contact our clients to determine their views with respect to the proposed bill.

In those cases where I was able to contact the superintendent of the district, it became clear that my call represented the first knowledge they had received concerning the proposal set out in HB 540. With regard to those superintendents that I was able to contact, none of them felt that they could take a position on behalf of their school boards until after the boards had had an opportunity to consider the proposal. A question did come up, however, as to the intended scope of the legislation. For instance, it is not clear from the bill whether the intent of the school competitive activities fund is to provide assistance to a school district for all its costs of travel associated with interscholastic activities, or only those travel costs associated with participation in statewide tournaments.

Consequently, I am unable to relay to your committee at this time the points of view of any of our client school districts on HB 540. With regard to the personal view points of the superintendents whom I was able to contact, I can only relay to you that those opinions were not uniform in nature. These opinions ranged from enthusiastic support for any legislation which would provide assistance to the district in meeting the high costs of travel associated with interscholastic activities, to the feeling that travel for interscholastic activities is just another element which should be taken into consideration in establishing the parameters of the public school foundation formula.

From a legal point of view, we have some concern that the legislation does not provide any standards by which the Alaska School Activities Association would make its determination as to the amount of payment to be made to the various school disticts. We would recommend that the legislation either set out the kinds of factors to be taken into consideration by the activities association in making allocations to the school districts, or, at a minimum, that the legislation direct the school activities association or the state Board of Education, which has oversight responsibilities for the activities association, to adopt regulations regarding the standards for allocation of monies from the school competitive activities fund.

Sincerely yours,

JOSEPHSON, TRICKEY & LORENSEN, INC.

By: Ronald W. Lorensen

RWL:jf

By Buchholdt

A BILL

For an Act entitled: An Act creating a fund for High School Student travel to and from Alaska State Level competitive activities.

Be it enacted by the legislature of the State of Alaska:

Article 1. 14.07 is amended by adding a new section to read:

Sec. 14.07.0555. Alaska State School Competitive Activities Fund.

The legislature shall fund the cost of travel of high school students who participate in Alaska State Level competitive activities in the following manner.

(a) Only high school students grades nine (9) through twelve (12) are eligible for funding under this section.

(b) The number of students eligible for funding from each Alaska School Activities Association region in Alaska shall not exceed ten (10) percent of the registered high school student population in each region.

(c) The number of registered high school students in each region shall be determined on September 30 of each school year.

(d) The following competitive activities shall be funded under this Section: Honors Band, Choir, Orchestra, Cross-Country Running, Volleyball, Gymnastics, Swimming, Diving, Basketball, Cross-Country Skiing, Hockey, Wrestling, Forensics, Track and Field.

(e) The Alaska School Activities Association shall administer this program.

Information

Under current Alaska School Activities Association rules approximately 1800 Alaska High School students would be eligible for funding under this bill during the 1980-81 school year.

The cost of the program for FY '81 is estimated to be $340,000. Travel costs includes transportation, food and lodging.

There are approximately 26,000 high school students attending class in Alaska during the current (1979-80) school year. An estimated 18,300 student units will participate in interscholastic activities during the year. (Note a single student may equal a number of student units if he/she participates in more than one activity).

Funding for this program is seperate from the Public School Foundation Program.

The bill covers only high school student travel costs. Coaches, teachers, etc. travel expenses to state events are not covered. If they are to be included, travel costs will increase by approximately 10 percent.

The bill places an upper limit on the number of students who are eligible for state funding (10 percent). The bill does not prevent school districts from sending more students to state competition if ASAA rules allow and the school districts provide the extra money.

The Alaska School Activities Association is a non-profit state legislative-approved organization of member schools operating under the auspices of the State Department of Education and local school districts. The ASAA is the governing body within Alaska that regulates interschool competition and activities in music, speech and drama, and athletics. The activities eligible for funding under this bill are all the state level activities currently listed by the ASAA.

Royce
3711
3799

Introduced: 1/16/80
Referred: Health, Education & Social Services and Finance

IN THE HOUSE

BY BUCHHOLDT, ANDERSON, HALFORD, MARTIN, MUNSON AND PHILLIPS

HOUSE BILL NO. 540

IN THE LEGISLATURE OF THE STATE OF ALASKA

ELEVENTH LEGISLATURE - SECOND SESSION

A BILL

For an Act entitled: "An Act establishing the Alaska school competitive activities fund."

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

* Section 1. AS 14.07 is amended by adding a new section to read:

Sec. 14.07.056. ALASKA SCHOOL COMPETITIVE ACTIVITIES FUND. (a) There is established in the Department of Education the Alaska school competitive activities fund. The Alaska School Activities Association (AS 14.07.053) shall administer the fund. The legislature may make annual appropriations to the fund.

(b) Money in the fund shall be used to pay for the cost of travel of high school students to State Wide tournament who are

(1) registered in schools which are members of the Alaska School Activities Association established in AS 14.07.053; and

(2) participating in State competitive activities.

(c) The number of high school students whose travel costs may be paid from the fund may not exceed 10 percent of the total number of registered high school students in the schools that are members of the association. The total number of high school students registered in the schools that are members of the association shall be determined by the association annually on September 30.

(d) In this section:

(1) "competitive activities" means band, choir, orchestra, cross-country running, volleyball, gymnastics, swimming, diving, basketball, cross-country skiing, hockey, wrestling, forensics, or track and

field;

(2) "high school student" means a student registered in grade nine, ten, eleven, or twelve.

Introduced: 1/16/80
Referred: Health,Education &
Social Services and Finance

IN THE HOUSE

BY BUCHHOLDT,ANDERSON,HALFORD,
MARTIN,MUNSON AND PHILLIP

HOUSE BILL NO. 540

IN THE LEGISLATURE OF THE STATE OF ALASKA

ELEVENTH LEGISLATURE - SECOND SESSION

A BILL

For an Act entitled: "An Act establishing the Alaska school competitive activities fund."

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

* Section 1. AS 14.07 is amended by adding a new section to read:

Sec. 14.07.056. ALASKA SCHOOL COMPETITIVE ACTIVITIES FUND. (a) There is established in the Department of Education the Alaska school competitive activities fund. The Alaska School Activities Association (AS 14.07.053) shall administer the fund. The legislature may make annual appropriations to the fund.

(b) Money in the fund shall be used to pay for the cost of travel of high school students [to statewide tournaments] who are

(1) registered in schools which are members of the Alaska School Activities Association established in AS 14.07.053; and

(2) participating in competitive activities.

(c) The number of high school students whose travel costs may be paid from the fund may not exceed 10 percent of the total number of registered high school students in the schools that are members of the association. The total number of high school students registered in the schools that are members of the association shall be determined by the association annually on September 30.

(d) In this section:

(1) "competitive activities" means band, choir, orchestra, cross-country running, volleyball, gymnastics, swimming, diving, basketball, cross-country skiing, hockey, wrestling, forensics, or track and [include but are not limited to] [riflery]

field;

(2) "high school student" means a student registered in grade nine, ten, eleven, or twelve.

A BILL

For an Act entitled: An Act creating a fund for High School Student travel to and from Alaska State Level competitive activities.

Be it enacted by the legislature of the State of Alaska:

Article 1. 14.07 is amended by adding a new section to read:

Sec. 14.07.0555. Alaska State School Competitive Activities Fund.

The legislature shall fund the cost of travel of high school students who participate in Alaska State Level competitive activities in the following manner.

(a) Only high school students grades nine (9) through twelve (12) are eligible for funding under this section.

(b) The number of students eligible for funding from each Alaska School Activities Association region in Alaska shall not exceed ten (10) percent of the registered high school student population in each region.

(c) The number of registered high school students in each region shall be determined on September 30 of each school year.

(d) The following competitive activities shall be funded under this Section: Honors Band, Choir, Orchestra, Cross-Country Running, Volleyball, Gymnastics, Swimming, Diving, Basketball, Cross-Country Skiing, Hockey, Wrestling, Forensics, Track and Field.

(e) The Alaska School Activities Association shall administer this program.

JOHN S. VANIA
Regional Game Supervisor

State of Alaska
Dept. of Fish & Game
Home Phone: (907) ~~[illegible]~~ 243-2872

333 Raspberry Rd.
Anchorage, Alaska 99502
Phone: (907) 344-0541

THIS [✓] BILL [ ] RESOLUTION [ ] CITATION

has been prepared by the staff of the Legislative Affairs Agency in response to the request and at the direction of the sponsoring member or committee. The staff has attempted to place the document in proper legal and clerical form, subject to any special limitations or instructions of the requestor.

If we may be of further assistance in this matter, please contact the Director of Legal Services or the Director of Research Services, as appropriate.

Delivered to requestor 1-30-80

LA-L 40

omit

Sec. 1 (d) (3) B

d 3 BC

a tournament

~~operated~~
under the purview
of a local School Activities
~~Association~~
of a competitive activity
as defined in (d)(1)

omit Sec. 1 (d) 3 (B)

in which at least one of the participating schools is more than 100 miles from the site of the tournament and

(C) which includes as participants schools from at least two of the grade districts established by the State Supreme Court on June 26, 1974

Constitutionality

School Activities Association

But not [illegible] to Riflery

3) Who have achieved excellence in sch—

Spelling Bee(?)

Name	Address & Phone #	Organization	Bill To.
John Jensen	PO Box 249 Douglas, 364-2277	City / Boro Assembly	#540
Karen Ryals	~~Pouch F~~ Education	Department of Ed	#540
John Vanica	4006 Arkansas Dr	Region IV Activities Ass.	#540
Ron Lorensen	Anchorage, AK 99503	Alaska Wrestling Coaches Ass.	

STATE OF ALASKA
THE LEGISLATURE

LEGISLATIVE AFFAIRS AGENCY

POUCH Y · STATE CAPITOL
JUNEAU, ALASKA 99811
907-465-3800

M E M O R A N D U M February 1, 1980

SUBJECT: Competitive activities fund aid to private schools. (House Bill 540)

TO: Representative Thelma Buchholdt
Chairman, House HESS Committee

FROM: Billy G. Berrier
Director
Division of Legal Services

You have asked whether payments for costs of travel for students of private schools for participation in competitive activities is unconstitutional.

In my opinion, this effect would not be held unconstitutional by our Supreme Court. In the only case in Alaska on point, our Supreme Court reached the opposite conclusion. However, a later decision has cast substantial doubt on the continued vitality of that case and apparently adopted a different test which would appear to support the constitutionality of inclusion of private schools in competitive activities fund distribution.

In 1961 our Court considered a class action concerning the constitutionality of transportation of private school students on public school buses. Section 1 of Article VII of the Alaska State Constitution provides:

> "SECTION 1. The legislature shall by general law establish and maintain a system of public schools open to all children of the State, and may provide for other public educational institutions. Schools and institutions so established shall be free from sectarian control. No money shall be paid from public funds for the direct benefit of any religious or other private educational institution."

In this case, Matthews v. Quinton, 362 P.2d 932 (Alaska 1961), the Court decided, over a strong dissent from Justice Dimond, that transportation of private school children represented a direct benefit to the school and was prohibited by the quoted section of the Constitution. (The case also considered the Organic Act which is not relevant here.)

While the facts in Matthews varied somewhat since that case concerned transportation to school while the bill relates to transportation to athletic events, the discussion was largely related to pupil transportation broadly. It would be difficult to distinguish the case on the factual differences although an argument could be made that transportation for out-of-town travel to competitive activities is not so directly related to the educational process as is transportation to the schools from the students' homes.

However, in 1979, the validity of the tuition grant program came before our Court. The same constitutional provision was in question. This case, Sheldon Jackson College v. State, 599 P.2d 127 (Alaska 1979), is not directly on point because of the substantial fact differences. The Court drew four generalizations from the authorities on the question saying:

> "First, constitutional provisions governing aid to private schools have generally been perceived as requiring neutrality rather than hostility from the state; thus the breadth of the class to which statutory benefits are directed is a critical area of judicial scrutiny. For example, though the police and fire protection afforded a private school may provide the school with quite direct benefits, as when a campus fire is extinguished, such benefits are provided without regard to status and affiliation, and have universally been presumed to be constitutional. Conversely, a benefit flowing only to private institutions, or to those served by them, does not reflect the same neutrality and non-selectivity.
>
> "A second central criterion in determining the constitutionality of a state aid program, is the nature of the use to which the public funds are to be put. As is apparent from the convention debate, the core of the concern expressed in the direct benefit prohibition involves government aid to education conducted outside the public schools. Though any state assistance that

> relieves the burden on a private school to provide for the health and welfare of its students will free the school to concentrate its funds on its private educational mission, numerous delegates voiced their understanding that the direct benefit clause would not bar such incidental support. An analogous distinction has frequently been drawn in establishment clause cases, where the pertinent inquiry is whether a statute impacts 'essentially secular educational functions' that are separable from the school's religious instruction.
>
> "Third, in determining whether a school is directly benefitted by public funds, a court must consider, though not in isolation, the magnitude of the benefit conferred. A trivial, though direct, benefit may not rise to the level of a constitutional violation, whereas a substantial, though arguably indirect, benefit may.
>
> "Finally, while a direct transfer of funds from the state to a private school will of course render a program constitutionally suspect, merely channeling the funds through an intermediary will not save an otherwise improper expenditure of public monies. The courts have expressly noted that the superficial form of a benefit will not suffice to define its substantive character."

In a footnote the Court questioned the continuing vitality of Matthews saying

> "In Matthews v. Quinton, 362 P.2d 932 (Alaska 1961); cert. denied, 368 U.S. 517, 82 S.Ct. 530, 7 L.Ed.2d 522 (1962), a statute enabling private school children living far from their schools to ride public school buses at public expense, was held violative of the direct benefit prohibition. We do not rely on Matthews in reaching today's decision, and thus have no occasion to overrule or re-affirm it. A substantial question, however, can be raised as to its continuing vitality in light of the analysis which we employ in the present opinion."

Based upon the principles set out, the Court found the tuition grant program a direct benefit to the school and therefore constitutionally prohibited.

Although Matthews was not overruled, the indication that the tests used in Sheldon Jackson will be the tests used in future cases even where a Matthews type situation is involved is quite strong.

Under this analysis, it appears this program is neutral; the class to which the benefit is provided is broad, covering all schools who are members of the Alaska School Activities Association which includes public and private schools.

There are differing views concerning the degree to which competitive activities are "educational." A strong argument could be made that travel for these activities is incidental rather than direct benefits.

The benefit is not trivial; but in relation to the whole program of the schools, payment of these travel costs would not appear so substantial as to transform an indirect benefit to a direct benefit.

Channeling the benefits through the Alaska school competitive activities fund would not save an otherwise improper program. Factually, this may, however, aid in showing the breadth of the class benefitted and the degree to which the activity is "educational" in the sense used here.

Although the law is not clearly settled here and any conclusion must be reached with caution, it is my opinion that under the tests set out in Sheldon Jackson, the Court would not find the program established by HB 540 unconstitutional.

BGB:jdn

HB
545

POSITION PAPER/Department of Health & Social Services

POSITION PAPER

HOUSE BILL NO. 545

"An Act amending the child protection laws; and providing for an effective date."

House Bill No. 545 is comprised of nine sections, one of which amends 47.10.010, and seven of which amend 47.17, the child protection statute. Specific comments regarding each section follow:

Section 1. This amendment to 47.10.010(a)(2) provides for a new condition under which a child may be declared a child in need of aid (CINA). It reads as follows: (F) the child having suffered substantial mental or physical neglect as a result of conditions created by the child's parent, guardian or custodian.

While the Department supports adding mental harm to the conditions for CINA, a change is recommended in the wording, deleting physical neglect and reading instead: (f) the child having suffered substantial mental harm as a result of conditions created by the child's parent, guardian, or custodian. Physical neglect is already covered under AS 47.10.010(a)(2)(C) which states that there is "imminent and substantial risk that the child will suffer harm as a result of the actions done by or conditions created by his parent..."

The 1977 changes in the Children's Code were intended to clearly tie grounds for adjudication to the actual harm which would result to the child rather than to parental faults or habits. The Department favors keeping such a focus on the harms to the child.

Section 2. This amendment to 47.17.010 adds mental abuse to the harms which must be reported to the Department. It also deletes requiring the attention of a practioner of the healing arts from the phrase pertaining to the harms, moving that phrase to the requirement to report.

This amendment appears to be consistent with other proposed changes, and is supported by the Department.

Section 3. This amendment strengthens the present provisions indicating persons who are required to report by including school administrative staff members. The Department supports this section as worded because there have been known instances of failure to report by some school districts. This change would make school administrators mandatory reporters also.

Section 4. This amendment expands persons mandated to report to include individuals involved in day care and foster care. The Department supports this section as worded because persons who are involved in day care and foster care may be in a position to identify abuse or neglect which may not come to the attention of others.

RECEIVED
JAN 28 1980
Management and Budget Section

POSITION PAPER/Department of Health & Social Services

Section 5. This amendment expands the definition of child abuse or neglect which must be reported to include mental injury or neglect. There are instances in which mental injury or neglect may be the only indications that a child is in need of protection. Generally, persons are so conservative in their reporting that children who are in danger of harm fail to be reported. This would make it more apparent that protection is called for in situations where the more obvious problem may be an emotional problem but where often physical harm also exists.

Section 6. This section amends the definition of child to mean a person under 18 years of age. This amendment will resolve present inconsistencies in age which exist between AS 47.17.070(1) and (2). Since age 18 was the age used in the latest statutory revision of 47.17, it would appear that this age was intended to apply. This is the age used in AS 47.10 also. The Department supports this change.

Section 7. This section amends 47.17.070 to define "mental injury or neglect" to mean "injury or neglect to the intellectual or psychological capacity of a child evidenced by a substantial impairment to the child's ability to function within the child's normal range of performance and behavior."

The Department has serious concerns about this definition because it does not take into account cultural factors which affect a child's performance on psychological tests which measure intelligence or "normal behavior." With this definition it would become quite easy to justify identifying many children who are not of the dominant culture as being abused or neglected.

We would prefer to see this statute be consistent with 47.10.010(a)(2)(B) which specifies that mental harm is "evidenced by failure to thrive severe anxiety, withdrawal, or untoward agressive behavior or hostility toward others."

Section 8. This section amends 47.17 be adding two sections. Section 47.17.064 permits a mandated reporter to take photographs of areas of trauma visible on a child and, if medically indicated, permits the taking of X-rays without parental permission. This amendment could be very useful in proving cases of physical abuse, and would generally have most utility where medical personnel are the first to suspect physical abuse. Under this proposed statute, a person required to report would be allowed to take photographs of bruised or fractured areas as well as to perform X-rays when either current or past fractures are suspected. Many severe cases of child battering show evidence, upon X-ray examination, of repeated fractures over several years which may have healed and which would not show up without radiological examination. The Department finds this to be a very significant strengthening of protection for vulnerable children.

Section 47.17.068 specifies that a person who is required to report abuse or neglect and who willfully or knowingly fails or refuses to report the harm is guilty of a class B misdemeanor. This is an important provision because under the current statute there is no sanction against ignoring or refusing to comply with the statute. The Department is aware of instances of severe physical abuse which have gone unreported because doctors or hospitals hesitated to get involved and knew there was no penalty for their not doing so.

POSITION PAPER/Department of Health & Social Services

The Department strongly supports both 47.17.064 and 47.17.068 as proposed.

Section 9. This section allows for an effective date of July 1, 1980, which appears to be a reasonable time for enactment.

Summary. In summary, the Department position is as follows:

Section 1. Supports, with amendment

Section 2. Supports

Section 3. Supports

Section 4. Supports

Section 5. Supports

Section 6. Supports

Section 7. Oppose as worded, amendment suggested

Section 8. Supports

Section 9. Supports

RECOMMENDED BY: Art Holmberg DATE: 1-25-80
Art Holmberg, Director
Division of Social Services

APPROVED BY: Helen D. Beirne DATE: 2-4-80
Helen D. Beirne, Commissioner
Department of Health and Social Services

THE LEGISLATURE OF THE STATE OF ALASKA
ELEVENTH LEGISLATURE

FISCAL NOTE

I. REQUEST
Bill/Resolution No. House Bill No. 545
Title amending the child protection laws and providing for an effective date.
Requested by _____ Date January 25, 1980

II. FISCAL DETAIL
Agency Affected Department of Health and Social Services
Program Category Affected Social Services
BRU, Program, or Subprogram(s) Affected Social Services
(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 79	FY 80	FY 81	FY 82	FY 83	FY 84
100 PERSONAL SERVICES	0	0	0	0	0	0
200 TRAVEL	0	0	0	0	0	0
300 CONTRACTUAL	0	0	0	0	0	0
400 COMMODITIES	0	0	0	0	0	0
500 EQUIPMENT	0	0	0	0	0	0
600 LAND & STRUCTURES	0	0	0	0	0	0
700 GRANTS, CLAIMS, ETC.	0	0	0	0	0	0
	0	0	0	0	0	0
TOTAL	0	0	0	0	0	0

FUNDING (Thousands of Dollars)

GENERAL FUND	0	0	0	0	0	0
FEDERAL FUNDS	0	0	0	0	0	0
OTHER (Specify Fund Source)	0	0	0	0	0	0
	0	0	0	0	0	0
	0	0	0	0	0	0

POSITIONS

FULL TIME	0	0	0	0	0	0
PART TIME	0	0	0	0	0	0
TEMPORARY	0	0	0	0	0	0

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

This Bill has no fiscal impact on the Department of Health and Social Services. While these changes will probably add to the caseload, these additions will be absorbed by existing staff.

IV. DATE January 25, 1980 PREPARED BY [signature] Art Holmberg, Director
AGENCY Dept. of Health & Social Services/Div. Soc. Svcs.
PHONE 465-3170

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)

Reviewed by Michael Ordaz
Director of Mgt & Budget
DHSS 1/28/80

33-001 (Rev. 12/78)

SELECTED STATISTICS ON CHILD ABUSE AND NEGLECT

Region X
February 5, 1979

	Total	Alaska	Idaho	Oregon	Washington
1976	26,891	774	4089	*909	21,119
1977	30,839	**435	1095	*1023	28,286
1977***		1.2	1.3	.4	8.1

* Abuse only
** Six months only
*** Number of reports per 1,000 people

Attachments

#1
Alaska
Table 5.1 1977 Semi-annual report on involved children on validated reports, age and sex.

#2
Idaho
Type of abuse by age, sex and race. Disposition of cases for children still receiving services.

#3
Oregon
Abuse cases by months and years.

#4
Washington
Table 31 (one month)

TABLE 5.1
INVULVED CHILDREN ON VALIDATED REPORTS
AGE AND SEX

STATE OF ALASKA
1977 SEMI-ANNUAL REPORT

AGE	ABUSE ONLY				NEGLECT ONLY				ABUSE & NEGLECT				ALL CASES			
	M	F	SUBTOT	COL %	M	F	SUBTOT	COL %	M	F	SUBTOT	COL %	M	F	SUBTOT	COL %
<1	5	6	11	14.5	5	8	13	7.0	1	1	2	3.6	11	15	26	8.2
1	3	2	5	6.6	3	6	9	4.8	1	2	3	5.5	7	10	17	5.3
2	4	3	7	9.2	5	4	9	4.8	2	1	3	5.5	11	8	19	6.0
3	3	2	5	6.6	3	2	5	2.7	4	1	5	9.1	10	5	15	4.7
4	2	2	4	5.3	9	4	13	7.0	1	1	2	3.6	12	7	19	6.0
5	0	0	0	0.0	5	9	14	7.5	1	0	1	1.8	6	9	15	4.7
6	4	2	6	7.9	5	5	10	5.3	0	5	5	9.1	9	12	21	6.6
7	3	2	5	6.6	2	4	6	3.2	3	2	5	9.1	8	8	16	5.0
8	2	2	4	5.3	9	4	13	7.0	2	3	5	9.1	13	9	22	6.9
9	1	1	2	2.6	10	7	17	9.1	2	2	4	7.3	13	10	23	7.2
10	2	1	3	3.9	11	5	16	8.6	2	0	2	3.6	15	6	21	6.6
11	0	0	0	0.0	3	9	12	6.4	4	0	4	7.3	7	9	16	5.0
12	3	1	4	5.3	8	5	13	7.0	1	3	4	7.3	12	9	21	6.6
13	1	0	1	1.3	6	4	10	5.3	2	1	3	5.5	9	5	14	4.4
14	1	3	4	5.3	3	7	10	5.3	1	1	2	3.6	5	11	16	5.0
15	1	6	7	9.2	2	6	8	4.3	2	1	3	5.5	5	13	18	5.7
16	0	3	3	3.9	2	3	5	2.7	0	2	2	3.6	2	8	10	3.1
17	1	4	5	6.6	1	3	4	2.1	0	0	0	0.0	2	7	9	2.8
TOT	36	40	76	100.0	92	95	187	100.0	29	26	55	100.0	157	161	318	100.0

MISSING OBSERVATIONS = 1

STATE OF IDAHO
DEPARTMENT OF HEALTH AND WELFARE

FOR TIME PERIOD FROM 06/25/76 TO 07/25/77 CHILD ABUSE/NEGLECT STATISTICS

DISPOSITION OF CASES FOR CHILDREN STILL RECEIVING SERVICES

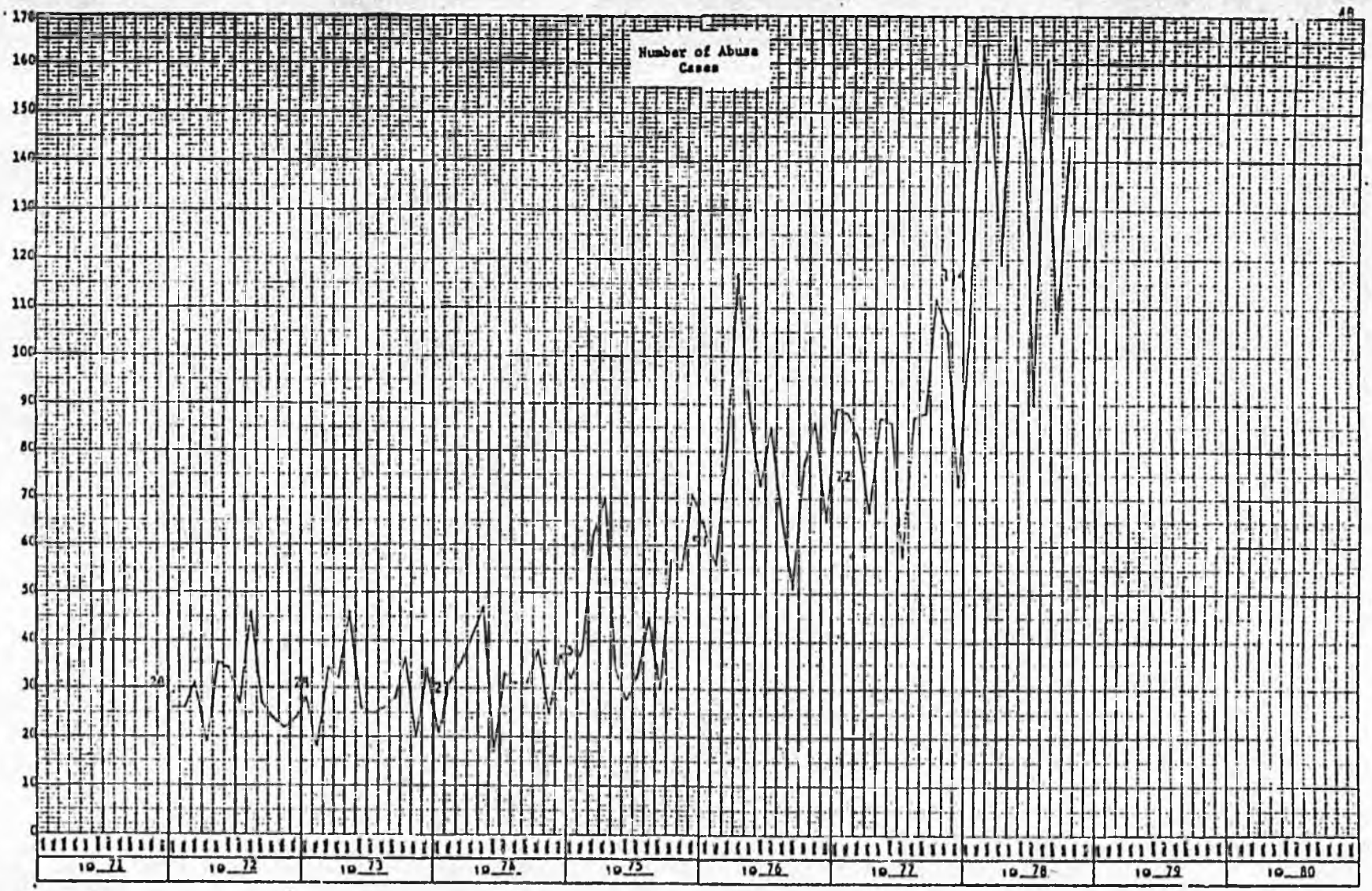
	TOTAL CHILDREN REPORTED	RETURNED TO OWN HOME	PLACED IN FOSTER CARE	PLACED IN SHELTER CARE	PLACED IN RELATIVE HOME	RELEASED TO NEW FOR ADOPTION	COURT ACTION PENDING	OTHER DISP.
REGION I	174	6	11	5	1		71	82
REGION II P	159	3	18	1	3		61	76
REGION III	250	18	18	5	9		132	72
REGION IV	298	11	30	2	5		60	190
REGION V	101	5	8		1		57	30
REGION VI	148		10				57	81
REGION VII	62	1	12	1			35	13
REGION VIII								
STATE TOTAL	1,192	44	107	14	19		473	544

WSSH05P REPORT 1 — STATE OF IDAHO
DEPARTMENT OF HEALTH AND WELFARE
ATE OF RUN 12/29/77
CHILD ABUSE/NEGLECT STATISTICS
OR TIME PERIOD FROM 06/25/76 TO 07/25/77
TYPE AND SEVERITY BY AGE, SEX AND RACE
FOR STATE

YPE AND SEVERITY	AGE						SEX		RACE						TYPE TOTAL
	UNDER 1	1-4	5-9	10-14	15-17	18-20	FEMALE	MALE	UNKN	BLACK	INDIAN	ORIENTAL	SPANISH	WHITE	UNKN	
BANDONMENT		21	21	27	16		45	45	8	2	7		15	70	4	98
ATINGS	1	37	43	36	11	2	66	69	22	2	3			112	34	157
ONE FRACTURE		2	3	5	2		4	9			1			12		13
AIN DAMAGE/ SKULL FRACTURE		2	1	3	1		1	6						7		7
URNS, SCALDS		6	2	4		1	5	4	5		1			8	5	14
NGENITAL DRUG ADDICTION			3	4			2	3	5				2	2	6	10
RTS,BRUISES,WELTS		25	23	15	14	3	42	47	11	2	4		4	72	18	104
EAD ON ARRIVAL		1	2	1			4	1					4	1		5
ISLOCATION/SPRAINS TWISTING/SHAKING		1	5	2	5	3	10	11			1		2	15	3	21
UCATIONAL NEGLECT	1	13	23	43	17	3	68	48	5	1	2		13	96	9	121
UTRITIONAL NEGLECT	4	76	101	89	61	0	212	169	31	3	11	1	27	334	34	412
XPOSURE TO ELEMENT	1	6	14	14	4	2	30	18	2		4		5	36	5	50
AILURE TO THRIVE	1	21	10	5	3		21	23	4		3		2	34	7	40
NTERNAL INJURIES		1		1				2						2		2
ACK OF SUPERVISION	2	44	56	72	29		123	91	29		21	1	15	170	27	243
OCKING IN/OUT		1	6	4			3	8	1		3		1	7	1	12
ALNUTRITION	2	3	7	9	4	2	16	10	4		4			23	3	30
EDICAL NEGLECT	2	16	22	16	7	4	48	26	6		2		3	69	6	80
THER	12	59	52	66	29	6	128	102	30	1	15	1	12	193	38	269
HYSICAL NEGLECT	3	31	43	22	8	1	50	55	10		4		14	87	18	123
OISONING			2				1	1						2		2
EXUAL ASSAULT	1	1	8	34	28	2	57	18	19	2	1		7	61	23	94
UBDURAL HEMORRHAGE OR HEMATOMA		1		1			1	1						2		2
TOTAL	30	367	447	473	239	37	937	767	200	13	87	3	132	1,428	241	1,904
ULTIPLE TYPES	6	78	107	106	52	9	233	189	38	2	18	1	37	295	41	424

OUNT OF ADULTS (311)

OREGON



CASES OF ABUSE BY MONTH

	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	FY AVG.
FY 1971-72							26	26	31	19	35	34	28
72-73	27	46	27	24	22	24	28	18	34	32	46	26	28
73-74	25	26	28	36	20	34	21	31	35	41	47	17	27
74-75	33	31	32	39	25	37	32	38	62	70	34	28	35
75-76	33	45	30	57	55	71	64	56	81	117	88	73	58
76-77	85	66	51	77	86	65	89	86	83	67	87	86	72
77-78	58	87	88	112	105	73	102	164	150	119	166	142	114
78-79	90	161	105	143									125

Service month parameters are displayed.

TABLE 3I: PROTECTIVE SERVICES FOR CHILDREN: NUMBER OF CASES (CHILDREN) OPENED AND NUMBER SERVED, BY ADMINISTRATIVE UNIT, JUNE 1978 1/

LOCAL OFFICE OR ADMINISTRATIVE UNIT	CASES OPENED DURING MONTH	TOTAL SERVED DURING MONTH
TOTAL	2,136	10,661
Asotin-Garfield	16	53
Benton-Franklin	70	272
Chelan-Douglas	38	135
Clallam	21	65
Clark	61	719
Cowlitz-Wahkiakum	78	427
Grant-Adams	61	93
Grays Harbor	94	357
Island	16	87
Jefferson	3	9
King, total 2/	399	1,929
Kitsap	54	286
Kittitas	7	19
Klickitat-Skamania	36	88
Lewis	40	179
Mason	13	35
Okanogan	17	239
Pacific	12	42
Pend Oreille	3	63
Pierce, total 2/	232	1,483
Skagit	46	190
Everett	140	644
Mountlake Terrace	65	414
Spokane-Lincoln	326	1,061
Stevens-Ferry	9	221
Thurston	58	349
Walla Walla-Columbia	39	225
Whatcom-San Juan	56	289
Whitman	4	84
Yakima	75	408
Toppenish	41	174
Sunnyside	4	22

1/ Protective services are specialized social services initiated on the basis of a complaint that a child or adult is being physically or emotionally neglected, abused, exploited or cruelly treated.

2/ Breakout by local office not available for Pierce and King Counties.

TABLE 3J: PROTECTIVE SERVICES FOR CHILDREN: OPENINGS BY SOURCE OF COMPLAINT, JUNE 1978

SOURCE OF COMPLAINT	NUMBER OF OPENINGS
TOTAL	2,136
Court/court staff	49
Law enforcement-prosecuting attorney, sheriff, police	256
School officials	188
Physicians (private practice)	63
Health agencies	134
Within local office	80
Within other local offices	70
Other social agencies	124
Relatives	294
Neighbors	459
Anonymous	202
Other 1/	217

1/ A total of 36 openings resulted from self-referrals.

TABLE 3K: PROTECTIVE SERVICES FOR CHILDREN: CLOSINGS BY REASON, JUNE 1978

REASONS FOR CLOSING	NUMBER OF CLOSINGS
TOTAL	2,478
No abuse/neglect exists	726
Family functioning with no further need for CPS or other service	630
Family functioning with no further need for CPS, referred to Ongoing Services or continued with Ongoing worker	235
Family functioning with no further need for CPS, referred to another agency or professional for other services	181
Family referred to Juvenile Court for removal of children	26
Child(ren) placed out of home, referred to children's worker	97
Family moved out of LO's jurisdiction	185
Family moved and can't be located	94
Family refused to cooperate, referral to Juvenile Court not possible	169
Other	135

REPORTING CHILD ABUSE

Who Reports or Causes a Report to be made?

In each of the states in Region X, any citizen may report a suspected instance of child abuse or neglect. Each of the states, however, have designated certain people as being required to make reports.

ALASKA: Required (no stated penalty)

> In the performance of their professional duties, practitioners of the healing arts (chiropractors, dentists, health aides, nurses, optometrists, osteopaths, physical therapists, physicians, psychiatrists, psychologists, religious healing practitioners, and surgeons); social workers; school teachers; peace officers and officers of the Division of Corrections; and administrative officers of institutions.

IDAHO: Required (no stated penalty)

> Any physician, resident on a hospital staff, intern, nurse, coroner, school teacher, day care personnel, social worker, or other person having reasonable cause to believe that a child under the age of eighteen (18) has been abused or who observes the child being subjected to conditions or circumstances which would reasonably result in abuse, shall report.

OREGON: Required (penalty--misdemeanor, fine of $ 250)

> Physicians (including interns and residents); dentists; school employees; licensed practical or registered nurses; employees of the Department of Human Resources, county health departments, community mental health programs, county juvenile departments, or licensed child care agencies; peace officers; psychologists; clergymen; social workers; optometrists; chiropractors; certified providers of day care, foster care or employees thereof; attorneys.

WASHINGTON: Required (penalty--misdemeanor)

> Medical practitioners (licensed podiatrists, optometrists, chiropractors, registered or licensed nurses, dentists, osteopaths, surgeons, physicians, and religious healing practitioners); professional school personnel; social workers; licensed psychologists; pharmacists; employees of the Department of Social and Health Services.

What to Report?

ALASKA:

Abuse--Non-accidental infliction of injury or physical harm on a child's body.

Neglect--Failure to provide necessary food, care, clothing, shelter or medical attention for a child.

IDAHO:

Abuse--Any case in which a child has been the victim of conduct resulting in skin bruising, bleeding, malnutrition, sexual molestation, burns, fracture of any bone, subdural hematoma, soft tissue swelling, failure to thrive or death, and such condition or death not justifiably explained, or at variance with the history given for it, or if circumstances indicate it may not be the product of an accidental occurrence.

Neglect--Without proper parental care and control or subsistence, education, medical or other care necessary for well-being because of the conduct or omission of his/her parents, guardian or other custodian or their neglect or refusal to provide them; whose parents, guardian or other custodian are unable to discharge their duties to and for the child because of incarceration, hospitalization, or other physical or mental incapacity; who has been placed for care or adoption in violation of law.

Abandonment--Failure of parent to maintain a normal parental relationship with his child including but not limited to reasonable support or regular personal contact.

OREGON:

Any physical injury to a child which appears to have been caused by other than accidental means, including any injury which appears to be at variance with the explanation given of the injury; neglect which leads to physical harm; sexual molestation.

WASHINGTON:

Instances of non-accidental injury, neglect, death, sexual abuse, and cruelty to children by their parents, custodians or guardians, and instances where child is deprived of his/her right to conditions of minimal nurture, health and safety.

Definition of "Child"

ALASKA: Any person 16 years or under.

IDAHO: Any person under the age of 18.

OREGON: Any unmarried person under the age of 18.

WASHINGTON: Any person under the age of 18 and any developmentally disabled person, regardless of age.

How to Report?

ALASKA:

To whom? An immediate report should be made to nearest office of the Department of Health and Social Services. If unable to contact the nearest office and immediate action is necessary for the well-being of the child, a peace officer may be contacted and the situation reported to the Department at the earliest opportunity.

When? Immediately.

Information Required: Not specified.

IDAHO:

To whom? The proper law enforcement agency or, in the case of attending hospital or institutional staff, to the person in charge of the institution who shall make the necessary reports.

When? Within 24 hours.

Information required: Not specified.

OREGON:

To whom? The local office of the Children's Protective Services Division or the local law enforcement agency (city or municipal police department, county sheriff's office, Oregon State Police, or county juvenile department).

When? Immediately by phone or in person. Written reports are not required.

Information required: Names and addresses of the child and the adults responsible for her/his care, the child's age, nature and extent of the abuse (including any evidence of previous abuse), the explanation given for the abuse and any other information which might be helpful in establishing the cause of the abuse and the identity of the perpetrator of the abuse.

WASHINGTON:

To whom? Law enforcement agency or Department of Social and Health Services.

When? Immediately by phone (in writing, if requested).

Information required: Name, address and age of child; name and address of adult having custody; nature and extent of injury, neglect and/or sexual abuse; any evidence of previous injuries and their nature and extent; and any other information helpful to establish the cause of the injury and identity of perpetrator(s).

HB
561

Delta/Greely School District REAA #15

Ft. Greely School
P.O. Box 229
Ft. Greely, Alaska 99790

907-872-3240

January 22, 1980

Frank R. Ferguson
Box 131
Kotzebue, Ak. 99752

Dear Sir:

We, the members of the Community School Committee, Ft. Greely, Alaska, are vitally concerned about the needs of the Ft. Greely School students. These needs were first identified in 1969 by Mr. William L. Stormer, Director of School Assistance in Federally Affected Areas, H.E.W. An extensive study was conducted by Mr. James Woofter, Acting Chief of School Construction, H.E.W., in 1975. This study delineated the necessary improvements needed to upgrade the Ft. Greely School. During 1976-78 time frame, the cause of school improvement at Ft. Greely has received continual "lip service" but little else in the way of positive action. (See Enclosure 1) Everyone from the Federal to the state level has recognized the problem but no one has done anything about it. The losers in this political battle are the children--civilian and military students who are receiving a substandard education because of defects in the present facility.

It is our belief that the modernization of the education facility at Adak Naval Station was a positive step in the right direction and it is our hope that it will serve as a model in the legislature's efforts to upgrade the Fort Greely facilities. As you know, the legislature, in its 1978 session, authorized the expenditure of two million dollars for the construction of elementary classrooms at Adak. That was the first time that state monies have been spent on a H.E.W. facility.

The Alaska Committee of the Northwest Association of Schools and Colleges has added further impetus to our situation (See Enclosure 2). Our conditional accreditation status specifically highlighted our three major problem areas.

I. The lack of an adequate gymnasium has forced the Ft. Greely School to satellite its Physical Education program onto the military at Ft. Greely. A stop-gap arrangement has

Northwest Association of Schools and Colleges

Commission on Schools
State Committee

December 17, 1979

Mr. John Mikesell
Ft. Greely Junior High School
Delta Junction, Alaska 99737

Dear John:

The Northwest Association of Schools and Colleges has awarded Ft. Greely Junior High School approved w/c status for the 1979-80 school year. The Alaska Committee recognizes and commends your efforts in expanding the math curricula offerings. Expansions of this nature certainly provide enrichment to students.

The annual report indicates deviations in Standards III, IV and VI. We would encourage your continuing efforts in securing the necessary resources to eliminate the existing substandard conditions in the gymnasium, kitchen and library facilities.

If we can be of further assistance please contact us.

Sincerely,

Jeff G. Jeffers
Secretary-Treasurer
Alaska Committee
Northwest Association of Schools and Colleges

JCJ/mjh

TABS

TAB A	Request for Assistance for Fort Greely School from Commander, Fort Greely, Alaska
TAB B	Request for Assistance for Fort Greely School to General Frederick J. Kroesen from BG Boatner with copy furnished Ted Stevens
TAB C	Letter to Mr. William L. Stormer, Director SAFA U.S. Office of Education from Marshall L. Lind Commissioner of Education
TAB D	Improvements at Fort Greely School from Mary Ann Simpson, Staff Assisant to Senator Stevens to BG James G. Boatner
	Letter to BG James G. Boatner from General Frederick J. Kroesen with copy of letter in TAB C
TAB E	Letter to BG James G. Boatner from BG Robert A. Holloman, III
	Letter from General Bernard W. Rogers to Commander FORSCOM
	Letter from Ernest L. Boyer, U. S. Commissioner of Education to Lieutenant General Dewitt C. Smith, Jr., Deputy Chief of Staff for Personnel
TAB F	Letter from Mike Gravel to Marshall Lind
TAB G	Letter from William L. Stormer, Director, School Assistance in Federally Affected Areas to Mr. Marshall L. Lind
TAB H	Letter from MG James G. Boatner to Jay Hammond
TAB I	Letter from Jay Hammond to MG James G. Boatner

AFZT-STG 5 January 1978

SUBJECT: Request for Assistance for Fort Greely School

Commander
172nd Infantry Brigade (Alaska)
Fort Richardson, Alaska 99505

1. A request for assistance has been received from Mr. Frank Brocato, Principal for the on base Fort Greely School, to obtain command support for needed school improvements.

2. The Fort Greely School is a Health, Education and Welfare School staffed by the State of Alaska. Funding for the schools physical plant is through H.E.W. and Congress. Fort Greely School serves all military dependents in grades Kindergarten through eight and local Delta Junction students in grades seven and eight.

3. The present physical plant does not meet needed requirements for physical education, auditorium space, or cafeteria facilities. Fort Greely facilities are utilized by the school on a mutual arrangement for athletic training and competition and auditorium space as an interim measure; however, post facilities for troop use are also limited and this arrangement imparts on post morale and efficiency. The hot lunch program served in most schools is not provided at Greely and a Class A soup and sandwich lunch is fed in lieu of. Construction of a school gymnasium and cafeteria is a vital requirement if the school is to meet the educational needs of our dependent children at Fort Greely.

4. Recommend this matter be addressed to the State Board of Education and Alaska Congressional Delegation for resolution.

DAVID R. PINNEY
COL, IN
Commanding

CF:
Mr. Frank Brocato
Mr. Glen Chowning

DEPARTMENT OF THE ARMY
HEADQUARTERS, 172D INFANTRY BRIGADE (ALASKA)
FORT RICHARDSON, ALASKA 99505

AFZT-PA-H

24 APR 1978

General Frederick J. Kroesen
Commander
US Army Forces Command
Fort McPherson, Georgia 30330

Dear General Kroesen:

We need your help in getting the long-recognized needed improvements for the Fort Greely school off dead-center.

The Fort Greely School is a Health, Education and Welfare School staffed by the State of Alaska. Funding for the school's physical plant is through HEW and Congress. The school serves all military dependents in grades kindergarten through eight and local Delta Junction students in grades seven and eight.

I am told that Mr. William L. Stormer, Director for School Assistance in Federally Affected Areas, Department of Health, Education and Welfare (HEW) has been aware of the construction needs for the Fort Greely School since 1969. An extensive study was made in July 1975 by a team headed by Mr. James Wooster, then Acting Chief of School Construction of HEW. This study group recommended numerous construction needs to the Department. Despite numerous letters about the study 1976 to and by Senators Mike Gravel and Ted Stevens, Congressman Don Young, plus Mr. Stormer and others, little progress has been made in improving the Fort Greely School.

The present physical plant does not meet needed requirements for physical education, auditorium space, or cafeteria facilities. Fort Greely facilities are used by the school on a mutual arrangement for

athletic training and competition and auditorium space as an interim measure; however, post facilities for troop use are also limited, and this arrangement impacts on post morale and efficiency. The hot lunch program served in most schools is not provided at Greely and a Class A soup and sandwich lunch is fed in lieu of. Construction of a school gymnasium and cafeteria is a vital requirement if the school is to meet the educational needs of our dependent children at Fort Greely.

The long harsh winter environment, the relative isolation of Fort Greely, and the perception that nothing is being done to correct the problems have an adverse effect on the post population and the school staff.

Any help you can give us would be appreciated.

Sincerely,

JAMES G. BOATNER
Brigadier General, USA
Commanding

DEPARTMENT OF THE ARMY
HEADQUARTERS, 172D INFANTRY BRIGADE (ALASKA)
FORT RICHARDSON, ALASKA 99505

AFZT-CS

25 APR 1978

Honorable Ted Stevens
United States Senate
Washington, D. C. 20510

Dear Senator Stevens:

Attached is a letter I sent General Kroesen asking for his help in getting the improvements for our Fort Greely school off dead-center.

I know of your interest in this matter and would appreciate any help you could give us.

Sincerely,

JAMES G. BOATNER
Brigadier General, USA
Commanding

1 Incl
As stated

JAY S. HAMMOND
GOVERNOR

DEPARTMENT OF EDUCATION

OFFICE OF THE COMMISSIONER
POUCH F - ALASKA OFFICE BUILDING
JUNEAU 99811

June 9, 1978

William L. Stormer, Director
SAFA-U.S. Office of Education
400 Maryland Avenue, S. W., Room 2107
Washington, D. C. 20202

Dear Mr. Stormer:

The Alaska Department of Education considers the provision of adequate school facilities to be basic and essential to the successful delivery of educational programs, and to this end I wish to focus attention on the need for additional facilities at two of the on-base school locations in Alaska.

The absence of adequate physical education, auditorium, and cafeteria space at the Fort Greely School has been discussed by various federal and state officials for some ten years. The sharing of physical education and auditorium space with the troops causes obvious scheduling problems and leaves both students and the troops with less than sufficient space for these activities. The absence of a cafeteria has caused the school to offer only a soup and sandwich lunch program, while most schools of this size have a full hot lunch program. The Delta/Greely School District would offer a full hot lunch program if facilities were available.

Another on-base school which is lacking adequate facilities is at Adak. The elementary school is currently overcrowded, with many classes being held in portable units which have surpassed their useful life expectancy, especially considering the very harsh climate at Adak. The basement of the main school floods, and the building has many other deficiencies. The present site is very restricted in size, indicating need for a new site for the facility. I understand that the number of dependents at Adak will be increasing in the near future, which will further crowd the school.

The need for the above facilities is well documented, and I urge you to make these facilities a high priority for funding as soon as possible, so that these federally-dependent children will have adequate school buildings, thus enabling teachers and administrators to expend more of their time and resources toward education.

Sincerely,

Marshall L. Lind nc

Marshall L. Lind
Commissioner of Education

cc: Senator Ted Stevens
Senator Mike Gravel

DEPARTMENT OF THE ARMY
HEADQUARTERS, 172D INFANTRY BRIGADE (ALASKA)
FORT RICHARDSON, ALASKA 99505
Office of the Director of Personnel and Community Activities

28 JUN 1978

AFZT-PA-H

SUBJECT: Improvements at Fort Greely School

Post Commander/Commander, Special Troops, Fort Greely, APO Seattle 98733
Deputy Commander, Reserve Components, Fort Richardson, Alaska 99505

The inclosed letter is forwarded for your information and action, if appropriate.

1 Incl
as

L. R. TASSIE
COL, GS
DPCA

Received
Jun 30 1978

[illegible] PROXMIRE, WIS.
DANIEL K. INOUYE, HAWAII
ERNEST F. HOLLINGS, S.C.
BIRCH BAYH, IND.
THOMAS F. EAGLETON, MO.
LAWTON CHILES, FLA.
J. BENNETT JOHNSTON, LA.
WALTER D. HUDDLESTON, KY.
QUENTIN N. BURDICK, N. DAK.
PATRICK J. LEAHY, VT.
JIM SASSER, TENN.
DENNIS DE CONCINI, ARIZ.
DALE BUMPERS, ARK.

EDWARD W. [illegible]
MARK O. HATFIELD, OREG.
TED STEVENS, ALASKA
CHARLES MC C. MATHIAS, JR., MD.
RICHARD S. SCHWEIKER, PA.
HENRY BELLMON, OKLA.
LOWELL P. WEICKER, JR., CONN.

JAMES R. CALLOWAY
CHIEF COUNSEL AND STAFF DIRECTOR

United States Senate
COMMITTEE ON APPROPRIATIONS
WASHINGTON, D.C. 20510

May 30, 1978

James G. Boatner
Brigadier General, USA
Commanding
172D Infantry Brigade
Fort Richardson, Alaska 99505

Dear General Boatner:

Senator Stevens is in Alaska and asked that I respond to your letter regarding needed improvements at the Fort Greely school. We contacted the Impact Aid office at HEW and were advised that Fort Greely is currently on HEW's highest priority list for needed repairs and improvement. However, the Attorney General's office in Juneau is reviewing a proposal that may put Fort Greely in a lower category. We have contacted the Attorney General's office to provide us with their comments on this matter.

With best wishes,

Cordially,

Mary Ann Simpson

Mary Ann Simpson
Staff Assistant to
Senator Ted Stevens

HEADQUARTERS, UNITED STATES ARMY FORCES COMMAND
FORT MCPHERSON, GEORGIA 30330

AFPR-PSE

24 May 1978

Dear General Boatner:

I have forwarded your letter of 24 April 1978 regarding construction of a cafeteria and gymnasium for the Fort Greely dependent school, to the Chief of Staff, Army (copy inclosed).

I do not expect any immediate action on your request as the Department of Health, Education and Welfare (HEW) has a construction and repair backlog for dependent schools, including Fort Greely, in excess of $200 million. They expect only $16 million in Fiscal 1979 with which to attack the problem. I support Department of the Army's recommendation to the Secretary of HEW that the $16 million be spread among schools at five Army installations with an average daily attendance far exceeding building design capacities. Four of these are FORSCOM installations -- Forts Bragg, Campbell, Stewart and Riley. The $16 million, if spread among these installations, will only partially relieve the extreme inadequacy of facilities.

These schools have handled double sessions and severe overcrowding only because the installation commanders were able to furnish underutilized or excess Army buildings to house the extra students. I realize the extreme cold and isolation of Fort Greely may preclude your adoption of a similar interim solution for a cafeteria and gymnasium.

Even though I cannot give you a lot of hope for immediate resolution, I appreciate your letter which helps us to continue building a case for upgrading the inadequacy of dependent schools on military installations.

Sincerely,

FREDERICK J. KROESEN
General, U. S. Army
Commanding

1 Incl (Not included)
as

Brigadier General James G. Boatner
Commander
172d Infantry Brigade (Alaska)
Fort Richardson, Alaska 99505

JAY S HAMMOND
GOVERNOR

DEPARTMENT OF EDUCATION

OFFICE OF THE COMMISSIONER POUCH F ALASKA OFFICE BUILDING
JUNEAU 99811

June 9, 1978

William L. Stormer, Director
SAFA-U.S. Office of Education
400 Maryland Avenue, S. W., Room 2107
Washington, D. C. 20202

Dear Mr. Stormer:

The Alaska Department of Education considers the provision of adequate school facilities to be basic and essential to the successful delivery of educational programs, and to this end I wish to focus attention on the need for additional facilities at two of the on-base school locations in Alaska.

The absence of adequate physical education, auditorium, and cafeteria space at the Fort Greely School has been discussed by various federal and state officials for some ten years. The sharing of physical education and auditorium space with the troops causes obvious scheduling problems and leaves both students and the troops with less than sufficient space for these activities. The absence of a cafeteria has caused the school to offer only a soup and sandwich lunch program, while most schools of this size have a full hot lunch program. The Delta/Greely School District would offer a full hot lunch program if facilities were available.

Another on-base school which is lacking adequate facilities is at Adak. The elementary school is currently overcrowded, with many classes being held in portable units which have surpassed their useful life expectancy, especially considering the very harsh climate at Adak. The basement of the main school floods, and the building has many other deficiencies. The present site is very restricted in size, indicating need for a new site for the facility. I understand that the number of dependents at Adak will be increasing in the near future, which will further crowd the school.

The need for the above facilities is well documented, and I urge you to make these facilities a high priority for funding as soon as possible, so that these federally-dependent children will have adequate school buildings, thus enabling teachers and administrators to expend more of their time and resources toward education.

Sincerely,

Marshall L. Lind

Marshall L. Lind
Commissioner of Education

cc: Senator Ted Stevens
Senator Mike Gravel

DEPARTMENT OF THE ARMY
HEADQUARTERS, UNITED STATES ARMY FORCES COMMAND
FORT MCPHERSON, GEORGIA 30330

AFPR-PSE

30 JUN 1978

Dear General Boatner:

General Kroesen has asked me to keep you informed on the dependent school facilities situation.

In his letter of 24 May 1978, General Kroesen informed you that he had forwarded to General Rogers your letter of 24 April 1978 requesting assistance in upgrading the Fort Greely dependent school facility. General Rogers' reply, including correspondence from the Commissioner of Education to LTG Smith, is at inclosure 1.

In his letter, the Commissioner indicates a willingness to consider giving higher priority to upgrading our unsafe and inaccessible school facilities in Fiscal 1979 and 1980. This recognition of the problem can help the Fort Greely situation in the long run by reducing deplorable conditions at other military installations.

Currently the FY 79 Health, Education, and Welfare budget that will partially fund high priority construction is before the House Appropriation Committee and the Senate Appropriation Committee. I will keep you informed of progress that seems likely to impact upon your situation.

Sincerely,

Robert A. Holloman III

ROBERT A. HOLLOMAN, III
Brigadier General, GS
Acting Deputy Chief of Staff,
Personnel

1 Incl
as

Note: I'll discuss this in more detail during my visit on 6-7 July.
Bob H

Brigadier General James G. Boatner
Commander
172d Infantry Brigade (Alaska)
Fort Richardson, Alaska 99505

UNITED STATES ARMY

THE CHIEF OF STAFF

19 June 1978

SUBJECT: Fort Greely Dependent School Facilities

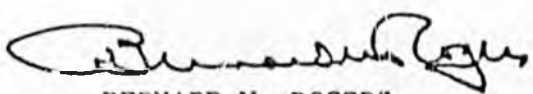
Commander
U.S. Army Forces Command
Fort McPherson, Georgia 30330

1. Reference your 24 May 78 letter concerning the need for additional facilities for the dependent school at Fort Greely, Alaska.

2. A copy of a recent letter from the Commissioner of Education on this subject is inclosed. For the past several months Army Staff members have had many discussions on the condition of these schools with staff members of the Senate and House Committees on Education and Labor, with staff members of the Office of Management and Budget, with civilian aides to the Secretary of the Army, and with members of Congress representing areas where the schools are located. In addition, this situation was mentioned in my posture statement submitted to the Congress with the President's budget for FY 79.

3. The situation at Fort Greely and other Army installations with regard to dependent schools maintained under Section 10, PL 81-815 is understood by the staff of Department of Health, Education and Welfare. We are advised that the recently completed survey of these facilities will reinforce requests to Congress for funds to correct unsatisfactory conditions at Section 10 schools.

4. When Congressional action on the FY 79 HEW appropriation is announced, we will ask the Secretary of Defense to chair an interdepartmental meeting on these schools. We hope to develop a memorandum of understanding with the Department of Health, Education and Welfare and the Office of Management and Budget on these schools and develop a strategy to solve the problems. Your Headquarters will be kept advised of progress and developments.



1 Incl
as

BERNARD W. ROGERS
General, U.S. Army
Chief of Staff

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
OFFICE OF EDUCATION
WASHINGTON, D.C. 20202

JUL 11 1978

Lieutenant General Dewitt C. Smith, Jr.
Deputy Chief of Staff for Personnel
Office of the Deputy Chief of
Staff for Personnel
Department of the Army
Washington, D.C. 20310

Dear General Smith:

Secretary Califano has asked me to thank you for your letter concerning our mutual problem of dependent schools on Army installations.

The Secretary has recently forwarded to the Congress our completed indepth study of Section 10 facilities. I am enclosing a copy for your information. As we conducted the study, it became very evident to me that a number of the Section 10 facilities represented particularly deplorable life/safety conditions. These are the very same situations for which you indicated concern in your letter. I have recommended to the Secretary that we consider revising our current funding priority system to make possible the immediate funding of the projects. As you know, our current priority system places a higher priority on the funding of projects which have been accepted for transfer by a local education agency. Although we remain committed to a policy of local education agencies accepting responsibility for the education of military dependents whenever possible, insuring a safe and accessible educational environment must take priority. The change in the priority system (outlined on page 21 of the indepth study) would allow us to direct the limited funds that we have available in the manner which you requested.

With respect to the future appropriation picture for Section 10, we will review the cost estimates contained in the study in developing our Fiscal Year 1980 budget and in considering possible adjustments to out Fiscal Year 1979 budget. We will be sure to keep you and your staff officers apprised of our progress.

Sincerely,

CF: TAGO - Gen Smith is forwarding his ltr to

If you have any further questions please don't hesitate to let me know.

Cordially,

Ernest L. Boyer
U.S. Commissioner
of Education

~~Enclosure~~ w/d

MIKE GRAVEL
ALASKA

United States Senate

WASHINGTON, D.C. 20510

July 17, 1978

RECEIVED
JUL 28 1978

The Honorable Marshall Lind
Commissioner of Education
State of Alaska
Pouch F
Juneau, Alaska 99811

Dear Marshall:

Thank you for sending me the copy of your letter to Mr. Stormer, regarding the need for additional educational facilities at two of the on-base school locations in Alaska. Specifically Fort Greely and Adak.

After contacting Mr. Stormer's office, it is my understanding that under the present priority system there are seventeen projects with projected total costs of approximately $100 million which are above Adak and Greely in priority. I am, however, assured that a Mr. Chase has been in touch with your office and in fact has been in the state of Alaska and conducted on-site visits to both locations. Because of his awareness of the problems being faced in both locations, I am certain that wherever and whenever possible these schools will get additional funding to assist in financing their upgrading.

Once again, thank you for expressing your concerns to me in this regard. Should there be any other way in which I or any member of my staff might be of further assistance, please do not hesitate to let me know.

Best regards.

Sincerely,

Mike Gravel

THE FOLLOWING DOCUMENT(S) MAY NOT FILM LEGIBLY BECAUSE OF POOR QUALITY OF THE ORIGINAL.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
OFFICE OF EDUCATION
WASHINGTON, D. C. 20202

AUG 31 1972

Mr. Marshall L. Lind
Commissioner of Education
Department of Education
State of Alaska
Pouch F - Alaska Office Building
Juneau 99811

Dear Commissioner Lind:

This is in response to your letter concerning upgrading of school facilities at Fort Greeley and at Adak.

An in-depth study of school construction needs on Federal property, those under Section 10 of P.L. 81-815, including the facilities on Fort Greely and Adak Naval Station, was conducted by the United States Commissioner of Education. The findings of the study document a total estimated need of nearly $200 million for renovation, new facilities, or new construction to bring all of these facilities up to present law requirements and standards.

The school facilities needs suggested on Fort Greely were to provide 1) a kitchen facility; 2) a media center; 3) a physical activity area, and 4) correct all barrier-free design deficiencies and life safety code deficiencies. Those suggested for Adak Naval Station were to 1) construct a new elementary school; 2) repair and remodel the existing Adak school to serve as a Junior-Senior High School and 3) correct all barrier-free design deficiencies and all life safety code deficiencies. Cost estimates for the work at Fort Greeley are $1.9 million and at Adak, $13.3 million.

A number of construction needs established in the study are based on the serious nature of the life safety conditions in many of the section 10 schools, including Fort Greeley and Adak. The safety of children being educated in buildings under the cognizance of the U.S. Commissioner of Education is a prime concern. Secretary Richardson has stated publicly that meeting life safety and fire hazard access standards on Federal property is clearly a Federal responsibility and requires immediate attention.

On the basis of the Secretary's statement, therefore, we will use our appropriated Section 10 funds to bring as many of the Section 10 buildings up to those standards as soon as possible. The balance of the unobligated FY 78 funds will take care of about one-half of the facilities and the rest will be accomplished with FY 79 appropriations. The majority of the buildings in this category will require relatively minor repairs and upgrading.

Certain Section 10 facilities, however, cannot be made life safe. An example is old wooden buildings with "unacceptable burn rates." Therefore, construction of replacement facilities is required. Since the current regulatory priority system precludes the Commissioner from targeting money toward this effort, steps are being taken to revise the regulations When this is done and additional appropriations authorized, the needed construction can take place.

In keeping with Secretary Califano's directive, the facilities at Fort Greeley and Adak are scheduled to be adapted for the life safety and handicapped requirements in FY 79. The additions to the Fort Geeley building and the new construction and repair and remodeling at Adak are scheduled to occur after the emergency needs are met and additional funding is made available by the Congress.

We will keep you informed as we progress with this work.

Sincerely yours,

for William L. Stormer

William L. Stormer
Director, School Assistance
in Federally Affected Areas

THE PRECEDING DOCUMENT(S) MAY NOT FILM LEGIBLY BECAUSE OF POOR QUALITY OF THE ORIGINAL.

3 OCT 1978

AFZT-PA-H

Honorable Jay S. Hammond
Pouch A
Juneau, Alaska 99811

Dear Governor Hammond:

As my departure from Alaska nears, I feel obligated to ask for your help in getting state support for long-recognized and much-needed improvements for the Fort Greely School.

As you are probably aware, the Fort Greely School is a Health, Education and Welfare School staffed by the State of Alaska. Funding for the school's physical plant is through HEW and Congress. The school serves all military dependents in grades kindergarten through eight as well as local Delta Junction students in grades seven and eight.

A significant disparity exists between the Fort Greely and Delta Junction Schools. The Delta Junction School is adequate in all vital areas while the present Fort Greely School physical plant does not meet needed requirements for physical education, auditorium space, or cafeteria facilities. Through mutual agreement, Fort Greely facilities are used by the school for athletic training and competition and auditorium space as an interim measure. Post facilities for troop use, however, are limited and this arrangement impacts on post morale and efficiency. The hot lunch program served in most schools is not provided at Greely, and a Class A soup and sandwich lunch is fed in lieu of this. Construction of a gymnasium and cafeteria is a vital requirement if the school is to meet the educational needs of the children that use the school.

AFZT-PA-H
Honorable Jay S. Hammond

I am told that Mr. William L. Stormer, Director of School Assistance in Federally Affected Areas, Department of Health, Education and Welfare (HEW), has been aware of the construction needs for Fort Greely School since 1969. An extensive study was made in July 1975 by a team headed by Mr. James Woofter, then Acting Chief of School Construction of HEW. This study group recommended numerous construction needs to the Department. Despite numerous letters about the study in 1976 to and by Senators Mike Gravel and Ted Stevens, Congressman Don Young, plus Mr. Stormer and others, little progress has been made in improving the Fort Greely School. Earlier this year, I brought this matter to the attention of my commander at US Army Forces Command, Fort McPherson, Georgia, who in turn forwarded my letter to Headquarters, Department of the Army. I was informed that although our needs were recognized, the priority for limited HEW construction money was higher at other installations. I am prohibited by Army regulations, based on Federal statutes, from expending Army construction funds to improve the Fort Greely School. Colonel Bernard Jones, the representative on the State Board of Education, informs me that the Alaska State Commissioner on Education, Dr. Marshall L. Lind, visited the Fort Greely School this summer and has agreed to pursue a program to encourage state officials to upgrade the Fort Greely School even though it is an HEW facility. I am informed that the state has provided funds previously to upgrade other HEW school facilities in Alaska.

At the present time, I am convinced this is the only course of action that offers any possibility for near term upgrading. It is our hope that the state will eventually accept responsibility for the school from HEW.

I solicit whatever assistance you may deem appropriate to gain state financial assistance in upgrading the Fort Greely School.

My family and I have thoroughly enjoyed our assignment in Alaska and hope some day to return.

Sincerely,

JAMES G. BOATNER
Major General, USA
Commanding

HEADQUARTERS, 172D INFANTRY BRIGADE (ALASKA)
FORT RICHARDSON, ALASKA 99505

AFZT-PA-H

7 DEC 1978

SUBJECT: Improvements for the Fort Greely School

Senior Army Advisor
MacKay Building
338 Denali Street
Anchorage, Alaska 99501

Post Commander
Fort Greely, Alaska
APO 98733

1. Reference letter, AFZT-PA-H, 3 October 1978, subject CG's request to Governor Hammond for Fort Greely School.

2. Inclosed is a copy of the Governor's response for your information and appropriate action.

FOR THE COMMANDER:

L. R. TASSIE
Colonel, GS
DPCA

1 Incl
as

STATE OF ALASKA
OFFICE OF THE GOVERNOR
JUNEAU

November 17, 1978

Major General James G. Boatner
Headquarters, 172d Infantry
Brigade (Alaska)
Fort Richardson, Alaska 99505

Dear General Boatner:

Your letter of October 3, 1978 concerning the construction needs at the Fort Greely School was appreciated.

The Alaska Department of Education and this office have been aware of the needs at Fort Greely for some time, and have recently been working toward acquiring the facilities from the Department of Health, Education and Welfare. As you have noted, federal funds have long been awaited, and the near term availability of such funding appears bleak in light of the nationwide demand for the limited congressional appropriations for this purpose.

Therefore, in an effort to upgrade the facilities to a status which is minimally acceptable under state codes, thereby clearing the path for state ownership, the Department of Education has requested $150,000 for code upgrade at Fort Greely as their Number Four statewide priority for FY-80. In addition, $2,500,000 has been requested for a multipurpose room/kitchen and an additional $300,000 for major maintenance.

I am expecting a funding level recommendation for FY-80 from the Budget Review Committee within a month. At that time we will be better prepared to say how many of the Department of Education's project requests this office will be able to recommend for legislative appropriation in FY-80. Unfortunately, the FY-80 funding level will be necessarily low, as our major construction programs are funded in odd-numbered fiscal years.

Dr. Marshall Lind, Commissioner of Education, has lent his support to the Fort Greely needs. The State Board of Education toured the facilities on September 8, 1978, at which time Colonel Bernard Jones stated his concerns for upgrading the facilities. Additional discussion of these needs took place at the October 19-20, 1978 State Board meeting in Anchorage.

Please be assured that I will give these needs my attention in preparing the FY-80 and future capital budgets.

I would like to take this opportunity to congratulate you on a most successful command assignment in Alaska, and to thank you for your contribution to the future of Alaska. Again, thank you for your support, and best wishes in your next assignment.

Sincerely,

Jay S. Hammond
Governor of Alaska

January 9, 1980

Frank Ferguson
Box 131
Kotzebue, Alaska 99752

Re: Proposed Swimming Pool Complex - Kotzebue

Dear Frank:

As requested, we have prepared an exhibit demonstrating the cost effectiveness of utilizing this proposed pool as a sprinkler system water supply for all High School properties.

Assumptions made are those outlined in the exhibit: values, rates, continuing inflation.

Projecting rates ten years is extremely difficult, due to cyclic pricing changes within the insurance industry. Presently property rates are at bottom and the trend to increasing rates is expected.

Of the comparative rates shown in the exhibit, the "current rate" is subject to the pricing pressure to increase. Sprinklered rates tend strongly to remain stable.

Summarizing the estimated premium savings over ten years, if the High School properties were to be sprinklered:

Comparison	Savings
Standard Rate - Sprinklered Rate	$2,150,000
Current Rate - Sprinklered Rate	$1,075,000

These may be considered the minimum and maximum premium savings, with actual savings greater than the minimum due to expectations of increased pricing.

2525 C STREET, SUITE 507, ANCHORAGE, ALASKA 99503 • TELEPHONE (907) 279-0555 • TELEX 26-609

INSURANCE

We have noted major considerations other than premium savings. Those are property conservation; greatly reducing the probability of a major fire loss and life safety, a most important consideration.

Do let us know if we can be of additional assistance.

Sincerely yours,

Robert M. Cunningham
Senior Vice President

RMC:lmb

enc.

2525 C STREET, SUITE 507 • ANCHORAGE, ALASKA 99503 • TELEPHONE (907) 279-0555 • TELEX 26-609

Proposed Swimming Pool Complex - Kotzebue

and

Cost Effectiveness Of Its Utilization as Sprinkler System Reservoir

Assumptions:

1. -Pool complex value $2,000,000.
   -Capacity 100,000 gallons +
   -To include necessary pumps for sprinkler system, and sprinkler system within pool building.
2. -Present value of High School Complex $15,000,000.
   -All to be sprinklered
3. Values will increase at 10 percent per year
4. Comparitive rates will remain stable.

Comparitive Rates:

Standard ISO Fire	$1.11
Current	.65
Estimated Sprinklered Rate	.20

Premium Savings If Sprinklered based on Comparitive Rates:

	High School Complex		Pool Complex	
Year	Standard Rate	Current Rate	Standard Rate	Current Rate
1	$135,000.	$67,500.	$18,000.	$9,000.
2	148,500.	74,250.	19,800.	9,900.
3	163,350.	81,675.	21.800.	10,900.
4	179,685.	89,840.	24,000.	12,000.
5	197,650.	98,830.	26,300.	13,200.
6	217,400.	108,700.	29,000.	14,500.
7	239,200.	119,580.	31,900.	16,000.
8	263,100.	131,540.	35,100.	17,500.
9	289,400.	144,690.	38,600.	19,300.
10	318,300.	159,160.	42,400.	21,200.
Total	$2,151,585.	$1,075,765.	$286,900.	$143,500.

Other Major Considerations:

- Life Safety
- Property Conservation

THE LE[illegible]ATURE OF THE STATE OF ALASKA
EVENTH LEGISLATURE

FISCAL NOTE

I. REQUEST

Bill/Resolution No. House Bill 561

Title An Act providing for issuance of General Obligation bonds

Requested by House HESS Date 1/26/80

II. FISCAL DETAIL

Agency Affected Education

Program Category Affected Education

BRU, Program, or Subprogram(s) Affected

(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 80	FY 81	FY 82	FY 83	FY 84	FY 85
100 PERSONAL SERVICES		22.3	24.8	27.5	30.5	33.9
200 TRAVEL		-0-	-0-	-0-	-0-	-0-
300 CONTRACTUAL		-0-	-0-	-0-	-0-	-0-
400 COMMODITIES		.5	.6	.7	.8	.9
500 EQUIPMENT		2.0	-0-	-0-	-0-	-0-
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC.						
TOTAL		24.8	25.4	28.2	31.3	34.8

FUNDING (Thousands of Dollars)

GENERAL FUND		24.8	25.4	28.2	31.3	34.8
FEDERAL FUNDS						
OTHER (Specify Fund Source)						

POSITIONS

FULL TIME						
PART TIME						
TEMPORARY						

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

SEE ATTACHMENT 1

IV. DATE February 4, 1980 PREPARED BY William D. Thomson, Deputy Commissioner

AGENCY Education

PHONE 465-2800

Original: Legislative Finance

cc: Budget and Management
Prime Sponsor (First Legislator Named)

33-001 (Rev. 12/79)

ATTACHMENT 1

Project (1) - no cost, administration can be done by existing staff.

Projects 2-28

1. Fiscal Impact FY 81

   Accounting Technician I, Step A

Object Code 100	Personal Services Salary and Benefits	22.3
400	Commodities	.5
500	Equipment	2.0
		24.8

2. Assumes 11% inflation in succeeding fiscal years (equipment considered as one-time item in FY 81).

Rationale

The magnitude of the number of projects requires one position for financial accounting of capital projects for rural schools. Such project funds would be transferred by reimbursable services agreement to the Department of Transportation/Public Facilities per the provisions of AS 35.15.080.

Project 29 - No cost for administration. Administered by Department of Education, Division of State Libraries/Museum per the provisions of AS 14.56.065.

House Health, Education & Social Services Committee Meeting/Hearing on HB 561 Date: 2/4/80

	Name	Address and Phone	Organization/Self	For/Against or Observing
1/	Bill Thomson	2800	Doe	
2/	Sen Ferguson			
3/	Bob Richardson	907-224-5246 Box 615 Seward Ak	Alaska Skill Center	
4/	Bob Booker	" " "	" " "	
5/	Dick Eugen			
6/				
7/				
8/				
9/				
10/				
11/				
12/				
13/				

MATCHING GRANTS
COMMUNITY LIBRARY CONSTRUCTION ($3,000,000.)

Fund Status

Bond Sales Costs	$22,750
GRANTS	
Kenai	$366,406
Bristol Bay	5,319
Coffman Cove	1,700
Delta Junction	5,965
Kodiak	142,500
Kenny Lake	4,800
Seward	78,525
Skagway	225,000
Dillingham	57,014
Wasilla	320,000
Seldovia	150,000
Eagle	35,300
Soldotna	122,256
Nome	225,000
Valdez	500,000
Galena	40,000
Craig	175,606
Anderson	40,000
Homer	270,000
Nondalton	30,000
Haines	149,394
Fort Yukon	6,700
Port Lions	4,635
TOTAL	$2,978,870.
Remaining balance	21,130.

REGIONAL RESOURCE LIBRARIES

Anchorage	$2,900,000.	Local vote, Fall 1979
Fairbanks	$2,000,000.	Completed

STATE OF ALASKA

JAY S. HAMMOND, GOVERNOR

DEPARTMENT OF REVENUE

OFFICE OF THE COMMISSIONER / POUCH S – JUNEAU 99811

February 6, 1980

The Honorable Thelma Buchholdt
Chairman
House Health, Education &
Social Services Committee
Room 112 - Capitol Building
Juneau, Alaska 99811

Dear Ms. Buchholdt:

Re: House Bill No. 561

House Bill No. 561, an Act providing for the issuance of general obligation bonds in the amount of $22,060,900 for the purpose of paying the cost of capital improvements for educational and library facilities, was introduced in the House on January 18, 1980 and was referred to the House Health, Education and Social Services Committee and the House Finance Committee.

For the consideration of the House Health, Education and Social Services Committee, I am enclosing a copy of a letter from Mr. Eric E. Wohlforth, Wohlforth and Flint, Anchorage, State Bond Counsel for the State Bond Committee which concerns in part House Bill No. 561.

Mr. Wohlforth also indicates that the amount of bonds authorized be rounded to the nearest $5,000. General obligation bonds of the State and nearly all other state and local governments are issued in the denomination of $5,000, the standard unit.

Using House Bill No. 561 as an example, this would result in issuing less than the total amount of bonds authorized or in issuing one odd bond in the denomination of $900 along with 4,412 bonds in the usual denomination of $5,000.

04-D2LH

Issuing a bond in an odd denomination requires extra time and expense and confusion in the printing of the one odd bond with all of its special coupons and all of the paying activities.

Sincerely,

R. D. Stevenson
Special Assistant

cc: Russ Meekins
Chairman
House Finance Committee

Thomas K. Williams
Commissioner of Revenue
Secretary, State Bond Committee

Eric E. Wohlforth
Wohlforth and Flint
Anchorage, Alaska

LAW OFFICES
WOHLFORTH & FLINT
A PROFESSIONAL CORPORATION
900 WEST 5TH AVENUE, SUITE 505
ANCHORAGE, ALASKA 99501

ERIC E. WOHLFORTH
ROBERT B. FLINT
TIMOTHY G. MIDDLETON
PETER ARGETSINGER
SARAH FORBES

TELEPHONE
AREA CODE 907
276-6401

January 31, 1980

Mr. R. D. Stevenson
Special Assistant
Department of Revenue
Pouch S
Juneau, Alaska 99811

Re: Bond Bills - State Bond Committee - Our File No. 3610.

Dear Bob:

In H. B. 560 providing for the issuance of general obligations bonds in the amount of $18,100,000 for State facilities, I question the purpose of the bond issue which is stated as "paying the cost of energy conservation, code upgrade, and architectural barrier removal". These terms, no doubt, have meaning to architects or engineers but I think are not understandable to most of the general public. Accordingly, I would suggest the language be amended to words in more commonly accepted usage such as, for "code upgrade", if this is its meaning, "life and safety improvements to state facilities". I have no suggestion for "architectural barrier removal" as I do not know what is intended by this phrase.

In S. B. 343, "An Act providing for the issuance of general obligation bonds in the amount of $20,550,000 for the purpose of paying the costs of capital improvements for University of Alaska facilities", I question the item under Project entitled "(2) Perform major maintenance and repairs - Statewide - 950,000". Depending on the nature of the items in fact contemplated, this purpose may not be comprehended within the term "capital improvements" which is stated in the bond proposition.

In H. B. 561, "An Act providing for the issuance of general obligation bonds in the amount of $22,060,900 for the purpose of paying the cost of capital improvements for education and library facilities", I question the item under Project entitled "(7) Construct arctic entry and paint school - Nelson Island - 265,000". Painting would only, it seems to me, be an appropriate capital improvement in connection with the original construction of a building which may be the case here.

OVL

In this bond bill, as well as in S. B. 342 and H. B. 563, the amount of the bonds authorized should be rounded to the nearest $5,000.

Very truly yours,

WOHLFORTH & FLINT

By Eric E. Wohlforth
Eric E. Wohlforth

EEW.jr

cc: C. Richard Walker, Esq.

PROJECT TITLE	LOCATION(S)	AREA SERVED	ELECTION DISTRICT(S)
Shishmaref High School Reroofing	Shishmaref	Local	22

OBJ. NO(S)	OPERATING BUDGET BRU(S)	NAME(S)	BUDGET COMPONENT NUMBERS	START DATE	COMPLETION DATE
3.3 & 4.1		N/A	N/A	May, 1982	Dec., 1982

PROJECT NARRATIVE

I. Project Need Statement:
Present roof is beyond repair.

II. Project Description:
This project provides for a new roof to replace the existing roof.

III. Documentation of Estimated Capital Cost:
The figure of $200.0 was provided by the school district. This figure should be verified by a qualified engineer.

IV. Analysis of Estimate of Operational Expense:
The school is operated by the school district under A.S. 14.17, Public School Foundation Program, and therefore, the project will not impact operation expenses.

V. Identification of Alternatives Considered:
1. Do nothing; rejected because of potential damage to facility by weather.
2. Postpone; rejected because of the effect of inflation on construction costs.

PROJECT TYPE

- ☐ Building Construction (C)
- ☒ Other Improvement (I)
- ☐ Equipment (E)
- ☐ Land (L)
- ☐ Professional Services (P)
- ☐ Other (O)

APPROPRIATION REQUEST

1002	FED. RCPTS.	
1003	G/F MATCH	
1004	GEN. FUND	
1005	I/A RCPTS.	
	G.O. BONDS	200.0
	TOTAL	200.0

PROJECT CHARACTERISTICS

- ☐ Totally New Facility
- ☒ Addition to Existing Facility
- ☐ Renovation of Existing Facility
- ☐ Major Maintenance or Repair
- ☐ Supplement Previously Authorized Funds to Enable Completion
- ☐ One of Several Phases
- ☐ Major External Funding Source
- ☐ Other

PROJECT PURPOSES

- ☐ Protect Human Health & Safety
- ☒ Protect Capital Assets
- ☐ Protect Natural Resources or Natural Environment
- ☐ Improve Efficiency & Economy of State Government
- ☐ Improve Services or Accommodate Increased Demand for Services
- ☐ Accommodate New Program Requirements
- ☐ Respond to Legal or Policy Mandate
- ☐ Improve Efficiency & Economy of Alaskan Infrastructure
- ☐ Other

SITE FEATURES

NO	YES	
☐	☒	Site Currently Owned?
☐	☒	All Utilities Available?
☐	☒	Access Already Available?

OPERATIONAL COST & NO. PERSONNEL INCREASE (DECREASE)		FIRST OPERATING YEAR FY 83	ULTIMATE ANNUAL YEAR FY 83	PREVIOUS YR–PRIORITY
FUNDING SOURCE	FED. RCPTS.	N/A	N/A	AGENCY PRIORITY 81-18
	GEN. FUND	"	"	
		"	"	GOVERNOR'S PRIORITY
TOTAL ANNUAL OPERATIONAL COST		"	"	
POSITION (FTE)		"	"	

CATEGORY Education AGENCY Education PROGRAM Rural Education

01-1035a (7/79)

35a PROPOSED CAPITAL PROJECT

REVISED DATE 11/26/79

PROJECT TITLE	LOCATION(S)	AREA SERVED	ELECTION DISTRICT(S)
Renovation - Kongiganak Elementary School	Koniganak	Local	17

OBJ. NO(S)	OPERATING BUDGET BRU(S)	NAME(S)	BUDGET COMPONENT NUMBERS	START DATE	COMPLETION DATE
3.3 & 4.1		N/A	N/A	June, 1981	Jan., 1982

PROJECT NARRATIVE

I. Project Need Statement:
The existing school building is an old log structure which is substandard, and the proposed renovation is necessary to house adequately the elementary school program at this location.

II. Project Description:
Renovation of Kongignak Elementary School.

III. Documentation of Estimated Capital Cost:
Original cost estimate of $750.0 was given by the school district. The figure on 35a and 35b were given by DOT/PF Condition Survey.

IV. Analysis of Estimate of Operational Expense:
The school is operated by the school district under A.S. 14.17, Public School Foundation Program, and therefore, the project will not impact operation expenses.

V. Identification of Alternatives Considered:
Do nothing or postpone; rejected because renovation is necessary in order to house adequately the elementary program and to protect the structure.

PROJECT TYPE

- [X] Building Construction (C)
- [ ] Other Improvement (I)
- [ ] Equipment (E)
- [ ] Land (L)
- [ ] Professional Services (P)
- [ ] Other (O)

APPROPRIATION REQUEST

1002	FED. RCPTS.	
1003	G/F MATCH	
1004	GEN. FUND	
1005	I/A RCPTS.	
	G.O. BONDS	200.0
	TOTAL	200.0

PROJECT CHARACTERISTICS

- [ ] Totally New Facility
- [ ] Addition to Existing Facility
- [X] Renovation of Existing Facility
- [ ] Major Maintenance or Repair
- [ ] Supplement Previously Authorized Funds to Enable Completion
- [ ] One of Several Phases
- [ ] Major External Funding Source
- [ ] Other

PROJECT PURPOSES

- [X] Protect Human Health & Safety
- [X] Protect Capital Assets
- [ ] Protect Natural Resources or Natural Environment
- [X] Improve Efficiency & Economy of State Government
- [ ] Improve Services or Accommodate Increased Demand for Services
- [ ] Accommodate New Program Requirements
- [X] Respond to Legal or Policy Mandate
- [ ] Improve Efficiency & Economy of Alaskan Infrastructure
- [ ] Other

SITE FEATURES

NO	YES	
[ ]	[X]	Site Currently Owned?
[ ]	[X]	All Utilities Available?
[ ]	[X]	Access Already Available?

OPERATIONAL COST & NO. PERSONNEL INCREASE (DECREASE)		FIRST OPERATING YEAR FY 83	ULTIMATE ANNUAL YEAR FY 83
FUNDING SOURCE	FED. RCPTS.	N/A	N/A
	GEN. FUND	"	"
		"	"
		"	"
TOTAL ANNUAL OPERATIONAL COST		"	"
POSITION (FTE)		"	"

PREVIOUS YR–PRIORITY

AGENCY PRIORITY 81-20

GOVERNOR'S PRIORITY

CATEGORY Education AGENCY Education PROGRAM Rural Education

01-1035a (7/79)

35a PROPOSED CAPITAL PROJECT

REVISED DATE 11/26/79

PROJECT TITLE	LOCATION(S)	AREA SERVED	ELECTION DISTRICT(S)
Major Maintenance & Repair Kongiganak H.S.	Kongiganak	Local	17

OBJ. NO(S)	OPERATING BUDGET BRU(S)	NAME(S)	BUDGET COMPONENT NUMBERS	START DATE	COMPLETION DATE
3.3 & 4.1		N/A	N/A	June, 1981	Jan., 1982

PROJECT NARRATIVE

I. Project Need Statement:
Problems related to the design and construction of the existing facility have been a reocurring issue on an annual basis since the building has been occupied. The requested funds are necessary to make needed repairs to the building and its support system.

II. Project Description:
Major maintenance and repairs to the Kongiganak High School.

III. Documentation of Estimated Capital Cost:
Original cost estimate of $1160.0 was provided by the school district. The figure on 35a and 35b were provided by DOT/PF Condition Survey.

IV. Analysis of Estimate of Operational Expense:
The school is operated by the school district under A.S. 14.17, Public School Foundation Program, and therefore, the project will not impact operation expenses.

V. Identification of Alternatives Considered:
Do nothing or postpone; rejected because the major maintenance and repairs are necessary to protect structure.

PROJECT TYPE

- [X] Building Construction (C)
- [ ] Other Improvement (I)
- [ ] Equipment (E)
- [ ] Land (L)
- [ ] Professional Services (P)
- [ ] Other (O)

APPROPRIATION REQUEST

1002	FED. RCPTS.	
1003	G/F MATCH	
1004	GEN. FUND	
1005	I/A RCPTS.	
	G.O. BONDS	600.0
	TOTAL	600.0

PROJECT CHARACTERISTICS

- [ ] Totally New Facility
- [ ] Addition to Existing Facility
- [X] Renovation of Existing Facility
- [X] Major Maintenance or Repair
- [ ] Supplement Previously Authorized Funds to Enable Completion
- [ ] One of Several Phases
- [ ] Major External Funding Source
- [ ] Other

PROJECT PURPOSES

- [X] Protect Human Health & Safety
- [X] Protect Capital Assets
- [ ] Protect Natural Resources or Natural Environment
- [X] Improve Efficiency & Economy of State Government
- [ ] Improve Services or Accommodate Increased Demand for Services
- [ ] Accommodate New Program Requirements
- [ ] Respond to Legal or Policy Mandate
- [ ] Improve Efficiency & Economy of Alaskan Infrastructure
- [ ] Other

SITE FEATURES

NO	YES	
[ ]	[X]	Site Currently Owned?
[ ]	[X]	All Utilities Available?
[ ]	[X]	Access Already Available?

OPERATIONAL COST & NO. PERSONNEL INCREASE (DECREASE)		FIRST OPERATING YEAR FY 83	ULTIMATE ANNUAL YEAR FY 83
FUNDING SOURCE	FED. RCPTS.	N/A	N/A
	GEN. FUND	"	"
		"	"
		"	"
TOTAL ANNUAL OPERATIONAL COST		"	"
POSITION (FTE)		"	"

PREVIOUS YR–PRIORITY

AGENCY PRIORITY 81-21

GOVERNOR'S PRIORITY

CATEGORY Education AGENCY Education PROGRAM Rural Education

01-1035a (7/79)

35a PROPOSED CAPITAL PROJECT

REVISED DATE 11/26/79

PROJECT TITLE	LOCATION(S)	AREA SERVED	ELECTION DISTRICT(S)
Shishmaref Voc. Ed. Addition	Shishmaref	Local	22

OBJ. NO(S)	OPERATING BUDGET BRU(S)	NAME(S)	BUDGET COMPONENT NUMBERS	START DATE	COMPLETION DATE
3.3 & 4.1		N/A	N/A	May, 1982	Dec., 1982

PROJECT NARRATIVE

I. Project Need Statement:
The program offers vocational education to secondary students and to some elementary students. There is no existing facility to house this program.

II. Project Description:
This project will provide a vocational education classroom and shop, wood frame facility with adequate heating, lighting systems.

III. Documentation of Estimated Capital Cost:
The figure of $525.0 was provided by the school district. The figures on 35a and 35b were provided by DOT/PF's LCC analysis.

IV. Analysis of Estimate of Operational Expense:
The school is operated by the school district under A.S. 14.17, Public School Foundation Program, and therefore, the project will not impact operation expenses.

V. Identification of Alternatives Considered:
1. Do nothing; rejected because the program cannot be conducted without this facility.
2. Postpone; rejected because of the effect of inflation on construction costs.

PROJECT TYPE

- [X] Building Construction (C)
- [ ] Other Improvement (I)
- [ ] Equipment (E)
- [ ] Land (L)
- [ ] Professional Services (P)
- [ ] Other (O)

APPROPRIATION REQUEST

1002	FED. RCPTS.	
1003	G/F MATCH	
1004	GEN. FUND	
1005	I/A RCPTS.	
	G.O. BONDS	406.0
	TOTAL	406.0

PROJECT CHARACTERISTICS

- [ ] Totally New Facility
- [X] Addition to Existing Facility
- [ ] Renovation of Existing Facility
- [ ] Major Maintenance or Repair
- [ ] Supplement Previously Authorized Funds to Enable Completion
- [ ] One of Several Phases
- [ ] Major External Funding Source
- [ ] Other

PROJECT PURPOSES

- [ ] Protect Human Health & Safety
- [ ] Protect Capital Assets
- [ ] Protect Natural Resources or Natural Environment
- [ ] Improve Efficiency & Economy of State Government
- [ ] Improve Services or Accommodate Increased Demand for Services
- [X] Accommodate New Program Requirements
- [ ] Respond to Legal or Policy Mandate
- [ ] Improve Efficiency & Economy of Alaskan Infrastructure
- [ ] Other

SITE FEATURES

NO	YES	
[ ]	[X]	Site Currently Owned?
[ ]	[X]	All Utilities Available?
[ ]	[X]	Access Already Available?

OPERATIONAL COST & NO. PERSONNEL INCREASE (DECREASE)		FIRST OPERATING YEAR FY 83	ULTIMATE ANNUAL YEAR FY 83	PREVIOUS YR–PRIORITY
FUNDING SOURCE	FED. RCPTS.	N/A	N/A	AGENCY PRIORITY
	GEN. FUND	"	"	81-30
		"	"	
		"	"	GOVERNOR'S PRIORITY
TOTAL ANNUAL OPERATIONAL COST		"	"	
POSITION (FTE)		"	"	

CATEGORY Education AGENCY Education PROGRAM Rural Education

01-1035a (7/79)

35a PROPOSED CAPITAL PROJECT

REVISED DATE 11/26/79

PROJECT TITLE	LOCATION(S)	AREA SERVED	ELECTION DISTRICT(S)
Vocational Education Shop, Togiak	Togiak	Local	16

OBJ. NO(S)	OPERATING BUDGET BRU(S)	NAME(S)	BUDGET COMPONENT NUMBERS	START DATE	COMPLETION DATE
3.3 & 4.1		N/A	N/A	May, 1981	Sept., 1981

PROJECT NARRATIVE

I. Project Need Statement:
The high school program was designed to offer Voc. Ed., however, previous construction project could not provide funding for a shop.

II. Project Description:
The proposed project will provide a one story, wood frame building with a total of 1600 sq. ft. with equipment.

III. Documentation of Estimated Capital Cost:
Original cost estimate of $600.0 was provided by the school district. The figures provided on 35a and 35b rflect DOT/PF's LCC analysis.

IV. Analysis of Estimate of Operational Expenses:
The school is operated by the school district under A.S. 14.17, Public School Foundation Program, and therefore, the project will not impact operation expenses.

V. Identification of Alternatives Considered:
1. Do nothing; rejected because of vocational ed program requires shop space to meet standards.
2. Postpone; rejected because of the effect of inflation on construction costs.

PROJECT TYPE

- [X] Building Construction (C)
- [ ] Other Improvement (I)
- [ ] Equipment (E)
- [ ] Land (L)
- [ ] Professional Services (P)
- [ ] Other (O)

APPROPRIATION REQUEST

1002	FED. RCPTS.	
1003	G/F MATCH	
1004	GEN. FUND	
1005	I/A RCPTS.	
	G.O. BONDS	347.0
	TOTAL	347.0

PROJECT CHARACTERISTICS

- [X] Totally New Facility
- [ ] Addition to Existing Facility
- [ ] Renovation of Existing Facility
- [ ] Major Maintenance or Repair
- [ ] Supplement Previously Authorized Funds to Enable Completion
- [ ] One of Several Phases
- [ ] Major External Funding Source
- [ ] Other

PROJECT PURPOSES

- [ ] Protect Human Health & Safety
- [ ] Protect Capital Assets
- [ ] Protect Natural Resources or Natural Environment
- [ ] Improve Efficiency & Economy of State Government
- [ ] Improve Services or Accommodate Increased Demand for Services
- [X] Accommodate New Program Requirements
- [ ] Respond to Legal or Policy Mandate
- [ ] Improve Efficiency & Economy of Alaskan Infrastructure
- [ ] Other

SITE FEATURES

NO	YES	
[ ]	[X]	Site Currently Owned?
[ ]	[X]	All Utilities Available?
[ ]	[X]	Access Already Available?

OPERATIONAL COST & NO. PERSONNEL INCREASE (DECREASE)		FIRST OPERATING YEAR FY 83	ULTIMATE ANNUAL YEAR FY 83	PREVIOUS YR–PRIORITY
FUNDING SOURCE	FED. RCPTS.	N/A	N/A	AGENCY PRIORITY
	GEN. FUND	"	"	81-31
		"	"	GOVERNOR'S PRIORITY
TOTAL ANNUAL OPERATIONAL COST		"	"	
POSITION (FTE)		"	"	

CATEGORY Education AGENCY Education PROGRAM Rural Education

01-1035a (7/79)

35a PROPOSED CAPITAL PROJECT

REVISED DATE 11/26/79

PROJECT TITLE	LOCATION(S)	AREA SERVED	ELECTION DISTRICT(S)
Nulato Classroom Addition	Nulato	Local	18

OBJ. NO(S)	OPERATING BUDGET BRU(S)	NAME(S)	BUDGET COMPONENT NUMBERS	START DATE	COMPLETION DATE
3.3 & 4.1		N/A	N/A	May, 1981	Octo., 1981

PROJECT NARRATIVE

I. Project Need Statement:
The school uses a relocatable classroom that is 10 years old and substandard. They have replaced all but this building with new construction completed this year.

II. Project Description:
This project will provide a classroom addition to the new building as called for in the additive alternate called for when new building was bid but funds were insufficient. This is an elementary building.

III. Documentation of Estimated Capital Cost:
Original cost estimate of $200.0 was provided by the school district. The figure provided on 35a and 35b reflect DOT/PF's LCC analysis.

IV. Analysis of Estimate of Operational Expense:
The school is operated by the school district under A.S. 14.17, Public School Foundation Program, and therefore, the project will not impact operation expenses.

V. Identification of Alternatives Considered:
1. Do nothing; rejected because existing classroom is overcrowded and substandard in condition.
2. Postpone; rejected because of the effect of inflation on building costs.

PROJECT TYPE

- [X] Building Construction (C)
- [ ] Other Improvement (I)
- [ ] Equipment (E)
- [ ] Land (L)
- [ ] Professional Services (P)
- [ ] Other (O)

APPROPRIATION REQUEST

1002	FED. RCPTS.	
1003	G/F MATCH	
1004	GEN. FUND	
1005	[illegible] RCPTS.	
	G.O. BONDS	315.0
	TOTAL	315.0

PROJECT CHARACTERISTICS

- [ ] Totally New Facility
- [X] Addition to Existing Facility
- [ ] Renovation of Existing Facility
- [ ] Major Maintenance or Repair
- [ ] Supplement Previously Authorized Funds to Enable Completion
- [ ] One of Several Phases
- [ ] Major External Funding Source
- [ ] Other

PROJECT PURPOSES

- [ ] Protect Human Health & Safety
- [ ] Protect Capital Assets
- [ ] Protect Natural Resources or Natural Environment
- [ ] Improve Efficiency & Economy of State Government
- [X] Improve Services or Accommodate Increased Demand for Services
- [ ] Accommodate New Program Requirements
- [ ] Respond to Legal or Policy Mandate
- [ ] Improve Efficiency & Economy of Alaskan Infrastructure
- [ ] Other

SITE FEATURES

NO	YES	
[ ]	[X]	Site Currently Owned?
[ ]	[X]	All Utilities Available?
[ ]	[X]	Access Already Available?

OPERATIONAL COST & NO. PERSONNEL INCREASE (DECREASE)		FIRST OPERATING YEAR FY 83	ULTIMATE ANNUAL YEAR FY 83	PREVIOUS YR–PRIORITY
FUNDING SOURCE	FED. RCPTS.	N/A	N/A	AGENCY PRIORITY 81-32
	GEN. FUND	"	"	
		"	"	
		"	"	GOVERNOR'S PRIORITY
TOTAL ANNUAL OPERATIONAL COST		"	"	
POSITION (FTE)		"	"	

CATEGORY Education AGENCY Education PROGRAM Rural Education

01-1035a (7/79)

35a PROPOSED CAPITAL PROJECT

REVISED DATE 11/26/79

PROJECT TITLE	LOCATION(S)	AREA SERVED	ELECTION DISTRICT(S)
Elementary School - Shishmaref	Shishmaref	Local	22

O&M NO(S)	OPERATING BUDGET BRU(S)	NAME(S)	BUDGET COMPONENT NUMBERS	START DATE	COMPLETION DATE
3.3 & 4.1		N/A	N/A	May, 1981	Dec., 1981

PROJECT NARRATIVE

I. Project Need Statement:
The original school was constructed many years ago by the BIA. The school consists of old buildings not connected together. They are substandard in size and in poor condition.

II. Project Description:
This project will provide a remodeled elementary building to house the K-8 program approximately 9750 sq. ft. single story wood frame construction.

III. Documentation of Estimated Capital Cost:
Original cost estimate of $3207.0 was provided by the school district. DOT/PF's LCC analysis gave the figure of $2491.0. The figures provided on 35a and 35b were given from a survey done by DOT/PF

IV. Analysis of Estimate of Operational Expense:
The school is operated by the school district under A.S. 14.17, Public School Foundation Program, and therefore, the project will not impact operation expenses.

V. Identification of Alternatives Considered:
1. Continue as is; rejected because of building condition and overcrowding.
2. Remodel existing; rejected because of costs.
3. Postpone; rejected becuase of effect of inflation on construction costs.

PROJECT TYPE

- [X] Building Construction (C)
- [ ] Other Improvement (I)
- [ ] Equipment (E)
- [ ] Land (L)
- [ ] Professional Services (P)
- [ ] Other ( )

APPROPRIATION REQUEST

1002	FED. RCPTS.	
1003	G/F MATCH	
1004	GEN. FUND	
1005	I/A RCPTS.	
	G.O. BONDS	450.0
	TOTAL	450.0

PROJECT CHARACTERISTICS

- [ ] Totally New Facility
- [ ] Addition to Existing Facility
- [X] Renovation of Existing Facility
- [ ] Major Maintenance or Repair
- [ ] Supplement Previously Authorized Funds to Enable Completion
- [ ] One of Several Phases
- [ ] Major External Funding Source
- [ ] Other

PROJECT PURPOSES

- [ ] Protect Human Health & Safety
- [ ] Protect Capital Assets
- [ ] Protect Natural Resources or Natural Environment
- [ ] Improve Efficiency & Economy of State Government
- [X] Improve Services or Accommodate Increased Demand for Services
- [ ] Accommodate New Program Requirements
- [ ] Respond to Legal or Policy Mandate
- [ ] Improve Efficiency & Economy of Alaskan Infrastructure
- [ ] Other

SITE FEATURES

NO	YES	
[ ]	[X]	Site Currently Owned?
[X]	[ ]	All Utilities Available?
[ ]	[X]	Access Already Available?

OPERATIONAL COST & NO. PERSONNEL INCREASE (DECREASE)		FIRST OPERATING YEAR FY 83	ULTIMATE ANNUAL YEAR FY 83	PREVIOUS YR-PRIORITY
FUNDING SOURCE	FED. RCPTS.	N/A	N/A	AGENCY PRIORITY
	GEN. FUND	"	"	81-35
		"	"	GOVERNOR'S PRIORITY
		"	"	
TOTAL ANNUAL OPERATIONAL COST		"	"	
POSITION (FTE)		"	"	

CATEGORY Education AGENCY Education PROGRAM Rural Education

01-1035a (7/79)

35a PROPOSED CAPITAL PROJECT

REVISED DATE 11/26/79

PROJECT TITLE	LOCATION(S)	AREA SERVED	ELECTION DISTRICT(S)
School Addition - Cold Bay	Cold Bay	Local	15

OBJ. NO(S)	OPERATING BUDGET BRU(S)	NAME(S)	BUDGET COMPONENT NUMBERS	START DATE	COMPLETION DATE
3.3 & 4.1		N/A	N/A	May, 1981	May, 1982

PROJECT NARRATIVE

I. Project Need Statement:
The present school facility does not adequately serve instructional program needs of the 65 student in K-12th grade at this location. Lacking sufficient space, program offersings are diminished.

II. Project Description:
The design and construction of a 14,825 square feet addition to the Cold Bay School to include classroom, library-media, vocational education, and multipurpose space.

III. Documentation of Estimated Capital Cost:
Original cost estimates of $2,965.0 was provided by the school district. The figure provided on 35a and 35b reflect DOT/PF's LCC analysis.

IV. Analysis of Estimate of Operational Expense:
The school is operated by the school district under A.S. 14.17, Public School Foundation Program, and therefore, the project will not impact operation expenses.

V. Identification of Alternatives Considered:
Do nothing or postpone; rejected because the existing facility is so inadequate that a satisfactory elementary/secondary program cannot be offered at the present time.

PROJECT TYPE

- [X] Building Construction (C)
- [ ] Other Improvement (I)
- [ ] Equipment (E)
- [ ] Land (L)
- [ ] Professional Services (P)
- [ ] Other (O)

APPROPRIATION REQUEST

1002	FED. RCPTS.	
1003	G/F MATCH	
1004	GEN. FUND	
1005	I/A RCPTS.	
	G.O. BONDS	3106.0
	TOTAL	3106.0

PROJECT CHARACTERISTICS

- [ ] Totally New Facility
- [X] Addition to Existing Facility
- [ ] Renovation of Existing Facility
- [ ] Major Maintenance or Repair
- [ ] Supplement Previously Authorized Funds to Enable Completion
- [ ] One of Several Phases
- [ ] Major External Funding Source
- [ ] Other

PROJECT PURPOSES

- [X] Protect Human Health & Safety
- [X] Protect Capital Assets
- [ ] Protect Natural Resources or Natural Environment
- [ ] Improve Efficiency & Economy of State Government
- [X] Improve Services or Accommodate Increased Demand for Services
- [X] Accommodate New Program Requirements
- [ ] Respond to Legal or Policy Mandate
- [ ] Improve Efficiency & Economy of Alaskan Infrastructure
- [ ] Other

SITE FEATURES

NO	YES	
[ ]	[X]	Site Currently Owned?
[ ]	[ ]	All Utilities Available?
[ ]	[X]	Access Already Available?

OPERATIONAL COST & NO. PERSONNEL INCREASE (DECREASE)		FIRST OPERATING YEAR FY 83	ULTIMATE ANNUAL YEAR FY 83	PREVIOUS YR-PRIORITY
FUNDING SOURCE	FED. RCPTS.	N/A	N/A	AGENCY PRIORITY
	GEN. FUND	"	"	81-36
		"	"	GOVERNOR'S PRIORITY
		"	"	
TOTAL ANNUAL OPERATIONAL COST		"	"	
POSITION (FTE)		"	"	

CATEGORY Education AGENCY Education PROGRAM Rural Education

01-1035a (7/79)

35a PROPOSED CAPITAL PROJECT

REVISED DATE 11/26/79

PROJECT TITLE	LOCATION(S)	AREA SERVED	ELECTION DISTRICT(S)
Emmonak Classroom Addition	Emmonak	Local	18

OBJ. NO(S)	OPERATING BUDGET BRU(S)	NAME(S)	BUDGET COMPONENT NUMBERS	START DATE	COMPLETION DATE
3.3 & 4.1		N/A	N/A	May, 1981	Sept., 1981

PROJECT NARRATIVE

I. Project Need Statement:
The present facility was not designed to handle the present enrollment.

II. Project Description:
This project will provide classroom space for approximately 60 students, grades 7-9.

III. Documentation of Estimated Capital Cost:
Original cost estimate of $750.0 was provided by the school district. The figures provided on 35a and 35b reflect DOT/PF's LCC analysis.

IV. Analysis of Estimate of Operational Expense:
The school is operated by the school district under A.S. 14.17, Public School Foundation Program, and therefore, the project will not impact operation expenses.

V. Identification of Alternatives Considered:
1. Do nothing; rejected becasue of overcrowding.
2. Postpone; rejected because of the effect of inflation on construction cost.

PROJECT TYPE

- [X] Building Construction (C)
- [ ] Other Improvement (I)
- [ ] Equipment (E)
- [ ] Land (L)
- [ ] Professional Services (P)
- [ ] Other (O)

APPROPRIATION REQUEST

1002	FED. RCPTS.	
1003	G/F MATCH	
1004	GEN. FUND	
1005	I/A RCPTS.	
	G.O. BONDS	750.0
	TOTAL	750.0

PROJECT CHARACTERISTICS

- [ ] Totally New Facility
- [X] Addition to Existing Facility
- [ ] Renovation of Existing Facility
- [ ] Major Maintenance or Repair
- [ ] Supplement Previously Authorized Funds to Enable Completion
- [ ] One of Several Phases
- [ ] Major External Funding Source
- [ ] Other

PROJECT PURPOSES

- [ ] Protect Human Health & Safety
- [ ] Protect Capital Assets
- [ ] Protect Natural Resources or Natural Environment
- [ ] Improve Efficiency & Economy of State Government
- [ ] Improve Services or Accommodate Increased Demand for Services
- [X] Accommodate New Program Requirements
- [ ] Respond to Legal or Policy Mandate
- [ ] Improve Efficiency & Economy of Alaskan Infrastructure
- [ ] Other

SITE FEATURES

NO	YES	
[ ]	[X]	Site Currently Owned?
[ ]	[X]	All Utilities Available?
[ ]	[X]	Access Already Available?

OPERATIONAL COST & NO. PERSONNEL INCREASE (DECREASE)		FIRST OPERATING YEAR FY 83	ULTIMATE ANNUAL YEAR FY 83	PREVIOUS YR–PRIORITY
FUNDING SOURCE	FED. RCPTS.	N/A	N/A	AGENCY PRIORITY
	GEN. FUND	"	"	81-37
		"	"	
		"	"	GOVERNOR'S PRIORITY
TOTAL ANNUAL OPERATIONAL COST		"	"	
POSITION (FTE)		"	"	

CATEGORY Education AGENCY Education PROGRAM Rural Education

01-1035a (7/79)

35a PROPOSED CAPITAL PROJECT

REVISED DATE 11/26/79

PROJECT TITLE	LOCATION(S)	AREA SERVED	ELECTION DISTRICT(S)
Industrial Education Shop - Ekwok	Ekwok	Local	16

OBJ. NO(S)	OPERATING BUDGET BRU(S)	NAME(S)	BUDGET COMPONENT NUMBERS	START DATE	COMPLETION DATE
3.3 & 4.1		N/A	N/A	May, 1981	Sept., 1981

PROJECT NARRATIVE

I. Project Need Statement:
There is no shop facility at this site. The secondary program started here requires shop in its program.

II. Project Description:
This project will provide a single story shop room of 800 square feet with equipment.

III. Documentation of Estimated Capital Cost:
Original cost estimate of $300.0 was provided by the school district. The figures provided on 35a and 35b reflect DOT/PF's LCC analysis.

IV. Analysis of Estimate of Operational Expense:
The school is operated by the school district under A.S. 14.17, Public School Foundation Program, and therefore, the project will not impact operation expenses.

V. Identification of Alternatives Considered:
1. Do nothing; rejected because the shop is necessary to the educational program.
2. Postpone; rejected because of the effect of inflation on building costs.

PROJECT TYPE

- [X] Building Construction (C)
- [ ] Other Improvement (I)
- [ ] Equipment (E)
- [ ] Land (L)
- [ ] Professional Services (P)
- [ ] Other (O)

APPROPRIATION REQUEST

1002	FED. RCPTS.	
1003	G/F MATCH	
1004	GEN. FUND	
1005	I/A RCPTS.	
	G.O. BONDS	192.0
	TOTAL	192.0

PROJECT CHARACTERISTICS

- [ ] Totally New Facility
- [X] Addition to Existing Facility
- [ ] Renovation of Existing Facility
- [ ] Major Maintenance or Repair
- [ ] Supplement Previously Authorized Funds to Enable Completion
- [ ] One of Several Phases
- [ ] Major External Funding Source
- [ ] Other

PROJECT PURPOSES

- [ ] Protect Human Health & Safety
- [ ] Protect Capital Assets
- [ ] Protect Natural Resources or Natural Environment
- [ ] Improve Efficiency & Economy of State Government
- [ ] Improve Services or Accommodate Increased Demand for Services
- [X] Accommodate New Program Requirements
- [ ] Respond to Legal or Policy Mandate
- [ ] Improve Efficiency & Economy of Alaskan Infrastructure
- [ ] Other

SITE FEATURES

NO	YES	
[ ]	[X]	Site Currently Owned?
[ ]	[X]	All Utilities Available?
[ ]	[X]	Access Already Available?

OPERATIONAL COST & NO. PERSONNEL INCREASE (DECREASE)		FIRST OPERATING YEAR FY 83	ULTIMATE ANNUAL YEAR FY 83	PREVIOUS YR–PRIORITY
FUNDING SOURCE	FED. RCPTS.	N/A	N/A	AGENCY PRIORITY 81-38
	GEN. FUND	"	"	
		"	"	
		"	"	GOVERNOR'S PRIORITY
TOTAL ANNUAL OPERATIONAL COST		"	"	
POSITION (FTE)		"	"	

CATEGORY Education AGENCY Education PROGRAM Rural Education

01-1035a (7/79)

35a PROPOSED CAPITAL PROJECT

REVISED DATE 11/26/79

PROJECT TITLE	LOCATION(S)	AREA SERVED	ELECTION DISTRICT(S)
Classroom Remodel - Ekwok	Ekwok	Local	16

OBJ. NO(S)	OPERATING BUDGET BRU(S)	NAME(S)	BUDGET COMPONENT NUMBERS	START DATE	COMPLETION DATE
3.3 & 4.1		N/A	N/A	May, 1981	Sept., 1981

PROJECT NARRATIVE

I. Project Need Statement:
The existing facility does not have a resource center or office space.

II. Project Description:
The project will result in remodeling of existing classroom into a media center, office space, & teacher work space.

III. Documentation of Estimated Capital Cost:
Original cost estimate of $320.0 was provided by the school district. The figures provided on 35a and 35b reflect DOT/PF's LCC analysis.

IV. Analysis of Estimate of Operational Expense:
The school is operated by the school district under A.S. 14.17, Public School Foundation Program, and therefore, the project will not impact operation expenses.

V. Identification of Alternatives Considered:
1. Do nothing; rejected as program space is required for media center.
2. Postpone; rejected because of the effect of inflation on building costs.

PROJECT TYPE

- [X] Building Construction (C)
- [ ] Other Improvement (I)
- [ ] Equipment (E)
- [ ] Land (L)
- [ ] Professional Services (P)
- [ ] Other (O)

APPROPRIATION REQUEST

1002	FED. RCPTS.	
1003	G/F MATCH	
100	GEN. FUND	
1005	I/A RCPTS.	
	G.O. BONDS	320.0
	TOTAL	320.0

PROJECT CHARACTERISTICS

- [ ] New Facility
- [ ] ...n to Existing Facility
- [ ] Renovation of Existing Facility
- [X] Major Maintenance or Repair
- [ ] Supplement Previously Authorized Funds to Enable Completion
- [ ] One of Several Phases
- [ ] Major External Funding Source
- [ ] Other

PROJECT PURPOSES

- [ ] Protect Human Health & Safety
- [ ] Protect Capital Assets
- [ ] Protect Natural Resources or Natural Environment
- [ ] Improve Efficiency & Economy of State Government
- [ ] Improve Services or Accommodate Increased Demand for Services
- [X] Accommodate New Program Requirements
- [ ] Respond to Legal or Policy Mandate
- [ ] Improve Efficiency & Economy of Alaskan Infrastructure
- [ ] Other

SITE FEATURES

NO	YES	
[ ]	[X]	Site Currently Owned?
[ ]	[X]	All Utilities Available?
[ ]	[X]	Access Already Available?

OPERATIONAL COST & NO. PERSONNEL INCREASE (DECREASE)		FIRST OPERATING YEAR FY 83	ULTIMATE ANNUAL YEAR FY 83	PREVIOUS YR-PRIORITY
FUNDING SOURCE	FED. RCPTS.	N/A	N/A	AGENCY PRIORITY
	GEN. FUND	"	"	81-40
		"	"	GOVERNOR'S PRIORITY
		"	"	
TOTAL ANNUAL OPERATIONAL COST		"	"	
POSITION (FTE)		"	"	

CATEGORY Education AGENCY Education PROGRAM Rural Education

01-1035a (7/79)

35a PROPOSED CAPITAL PROJECT

REVISED DATE 11/26/79

PROJECT TITLE	LOCATION(S)	AREA SERVED	ELECTION DISTRICT(S)
Pitkas Point Elementary School Replacement	Pitkas Point	Local	18

OBJ. NO(S)	OPERATING BUDGET BRU(S)	NAME(S)	BUDGET COMPONENT NUMBERS	START DATE	COMPLETION DATE
3.3 & 4.1		N/A	N/A	May, 1981	Dec., 1981

PROJECT NARRATIVE

I. Project Need Statement:
The existing facility was poorly constructed and is substandard in size.

II. Project Description:
The proposed project will provide an elementary school facility for 35 students, grades 1-8.

III. Documentation of Estimated Capital Cost:
Original cost estimate of $600.0 was provided by the school district. The figures provided on 35a and 35b reflect DOT/PF's LCC analysis.

IV. Analysis of Estimate of Operational Expense:
The school is operated by the school district under A.S. 14.17, Public School Foundation Program, and therefore, the project will not impact operation expenses.

V. Identification of Alternatives Considered:
1. Continue with present facility; rejected because existing facility is substandard and overcrowded.
2. Postpone; rejected because of the effect of inflation of construction costs.

PROJECT TYPE

- [X] Building Construction (C)
- [ ] Other Improvement (I)
- [ ] Equipment (E)
- [ ] Land (L)
- [ ] Professional Services (P)
- [ ] Other (O)

APPROPRIATION REQUEST

1002	FED. RCPTS.	
1003	G/F MATCH	
1004	GEN. FUND	
1005	I/A RCPTS.	
	G.O. BONDS	600.0
	TOTAL	600.0

PROJECT CHARACTERISTICS

- [X] Totally New Facility
- [ ] Addition to Existing Facility
- [ ] Renovation of Existing Facility
- [ ] Major Maintenance or Repair
- [ ] Supplement Previously Authorized Funds to Enable Completion
- [ ] One of Several Phases
- [ ] Major External Funding Source
- [ ] Other

PROJECT PURPOSES

- [ ] Protect Human Health & Safety
- [ ] Protect Capital Assets
- [ ] Protect Natural Resources or Natural Environment
- [X] Improve Efficiency & Economy of State Government
- [ ] Improve Services or Accommodate Increased Demand for Services
- [ ] Accommodate New Program Requirements
- [X] Respond to Legal or Policy Mandate
- [ ] Improve Efficiency & Economy of Alaskan Infrastructure
- [ ] Other

NO	YES	SITE FEATURES
[ ]	[X]	Site Currently Owned?
[ ]	[X]	All Utilities Available?
[ ]	[X]	Access Already Available?

OPERATIONAL COST & NO. PERSONNEL INCREASE (DECREASE)		FIRST OPERATING YEAR FY 83	ULTIMATE ANNUAL YEAR FY 83	PREVIOUS YR–PRIORITY
FUNDING SOURCE	FED. RCPTS.	N/A	N/A	AGENCY PRIORITY 81-42
	GEN. FUND	"	"	
		"	"	GOVERNOR'S PRIORITY
		"	"	
TOTAL ANNUAL OPERATIONAL COST		"	"	
POSITION (FTE)		"	"	

CATEGORY Education AGENCY Education PROGRAM Rural Education

01-1035a (7/79)

35a PROPOSED CAPITAL PROJECT

REVISED DATE 11/26/79

PROJECT TITLE	LOCATION(S)	AREA SERVED	ELECTION DISTRICT(S)
School Addition - Atka	Atka	Local	15

OBJ. NO(S)	OPERATING BUDGET BRU(S)	NAME(S)	BUDGET COMPONENT NUMBERS	START DATE	COMPLETION DATE
3.3 & 4.1		N/A	N/A	May, 1981	May, 1982

PROJECT NARRATIVE

I. Project Need Statement:
The present school facility does not adequately serve instructional program needs of the 25 students in grades K-12 at this location. Lacking needed space, program offerings are diminished.

II. Project Description:
The design and construction of a 6,834 square feet addition to Atka School to include secondary classroom, library-media, and multipurpose space.

III. Documentation of Estimated Capital Cost:
Original cost estimate of $1,366.8 was provided by the school district. The figures on 35a and 35b reflect DOT/PF's LCC analysis.

IV. Analysis of Estimate of Operational Expenses:
The school is operated by the school district under A.S. 14.17, Public School Foundation Program, and therefore, the project will not impact operation expenses.

V. Identification of Alternatives Considered:
Do nothing or postpone; rejected because of the existing facility cannot meet present program demands.

PROJECT TYPE

- [X] Building Construction (C)
- [ ] Other Improvement (I)
- [ ] Equipment (E)
- [ ] Land (L)
- [ ] Professional Services (P)
- [ ] Other (O)

APPROPRIATION REQUEST

1002	FED. RCPTS.	
1003	G/F MATCH	
1004	GEN. FUND	
1005	I/A RCPTS.	
	G.O. BONDS	1548.0
	TOTAL	1548.0

PROJECT CHARACTERISTICS

- [ ] Totally New Facility
- [X] Addition to Existing Facility
- [ ] Renovation of Existing Facility
- [ ] Major Maintenance or Repair
- [ ] Supplement Previously Authorized Funds to Enable Completion
- [ ] One of Several Phases
- [ ] Major External Funding Source
- [ ] Other

PROJECT PURPOSES

- [X] Protect Human Health & Safety
- [X] Protect Capital Assets
- [ ] Protect Natural Resources or Natural Environment
- [ ] Improve Efficiency & Economy of State Government
- [X] Improve Services or Accommodate Increased Demand for Services
- [X] Accommodate New Program Requirements
- [ ] Respond to Legal or Policy Mandate
- [ ] Improve Efficiency & Economy of Alaskan Infrastructure
- [ ] Other

SITE FEATURES

NO	YES	
[ ]	[X]	Site Currently Owned?
[X]	[ ]	All Utilities Available?
[ ]	[X]	Access Already Available?

OPERATIONAL COST & NO. PERSONNEL INCREASE (DECREASE)		FIRST OPERATING YEAR FY 83	ULTIMATE ANNUAL YEAR FY 83	PREVIOUS YR–PRIORITY
FUNDING SOURCE	FED. RCPTS.	N/A	N/A	AGENCY PRIORITY
	GEN. FUND	"	"	81-43
		"	"	GOVERNOR'S PRIORITY
TOTAL ANNUAL OPERATIONAL COST		"	"	
POSITION (FTE)		"	"	

CATEGORY Education AGENCY Education PROGRAM Rural Education

01-1035a (7/79)

35a PROPOSED CAPITAL PROJECT

REVISED DATE 11/26/79

PROJECT TITLE	LOCATION(S)	AREA SERVED	ELECTION DISTRICT(S)
Nikolai Elementary Replacement	Nikolai	Local	18

OBJ. NO(S)	OPERATING BUDGET BRU(S)	NAME(S)	BUDGET COMPONENT NUMBERS	START DATE	COMPLETION DATE
3.3 & 4.1		N/A	N/A	May, 1982	Dec., 1982

PROJECT NARRATIVE

I. Project Need Statement:
The present elementary structure is very old and lacks proper space for elementary program. The facility is difficult to heat & maintain.

II. Project Description:
This project will provide 2430 sq. ft. of elementary school space of two classrooms, restrooms, and related space.

III. Documentation of Estimated Capital Cost:
The figure of $607.5 was provided by the school district and should be verfied by a qualified engineer.

IV. Analysis of Estimate of Operational Expense:
The school is operated by the school district under A.S. 14.17, Public School Foundation Program, and therefore, the project will not impact operation expenses.

V. Identification of Alternatives Considered:
1. Continue as is; rejected because of the inadequacy of the program offering limitations.
2. Postpone; rejected because of the effect of inflation on construction costs.

PROJECT TYPE

- [X] Building Construction (C)
- [ ] Other Improvement (I)
- [ ] Equipment (E)
- [ ] Land (L)
- [ ] Professional Services (P)
- [ ] Other (O)

APPROPRIATION REQUEST

1002	FED. RCPTS.	
1003	G/F MATCH	
1004	GEN. FUND	
1005	I/A RCPTS.	
	G.O. BONDS	607.5
	TOTAL	607.5

PROJECT CHARACTERISTICS

- [X] Totally New Facility
- [ ] Addition to Existing Facility
- [ ] Renovation of Existing Facility
- [ ] Major Maintenance or Repair
- [ ] Supplement Previously Authorized Funds to Enable Completion
- [ ] One of Several Phases
- [ ] Major External Funding Source
- [ ] Other

PROJECT PURPOSES

- [ ] Protect Human Health & Safety
- [ ] Protect Capital Assets
- [ ] Protect Natural Resources or Natural Environment
- [ ] Improve Efficiency & Economy of State Government
- [X] Improve Services or Accommodate Increased Demand for Services
- [ ] Accommodate New Program Requirements
- [ ] Respond to Legal or Policy Mandate
- [ ] Improve Efficiency & Economy of Alaskan Infrastructure
- [ ] Other

NO	YES	SITE FEATURES
[ ]	[X]	Site Currently Owned?
[ ]	[X]	All Utilities Available?
[ ]	[X]	Access Already Available?

OPERATIONAL COST & NO. PERSONNEL INCREASE (DECREASE)		FIRST OPERATING YEAR FY 83	ULTIMATE ANNUAL YEAR FY 83	PREVIOUS YR–PRIORITY
FUNDING SOURCE	FED. RCPTS.	N/A	N/A	AGENCY PRIORITY 81-44
	GEN. FUND	"	"	
		"	"	GOVERNOR'S PRIORITY
		"	"	
TOTAL ANNUAL OPERATIONAL COST		"	"	
POSITION (FTE)		"	"	

CATEGORY Education AGENCY Education PROGRAM Rural Education

01-1035a (7/79)

35a PROPOSED CAPITAL PROJECT

REVISED DATE 11/26/79

PROJECT TITLE	LOCATION(S)	AREA SERVED	ELECTION DISTRICT(S)
Elementary/Secondary School - Rampart	Rampart	Local	19

OBJ. NO(S)	OPERATING BUDGET BRU(S)	NAME(S)	BUDGET COMPONENT NUMBERS	START DATE	COMPLETION DATE
3.3 & 4.1		N/A	N/A	June, 1981	Sept., 1982

PROJECT NARRATIVE

I. Project Need Statement:
Present school facility is substandard and represents a health and safety hazard for the 21 students in grades K-12 at this location. Moreover, because of inadequate space, program offerings are diminished.

II. Project Description:
The design and construction of a new 5100 square feet elementary/secondary school at Rampart to include classroom, library-media, vocational education and multipurpose space.

III. Documentation of Estimated Capital Cost:
Original estimate of $2,600.0 was provided by the school district. The figures provided on 35a and 35b reflect DOT/PF's LCC analysis.

IV. Analysis of Estimate of Operational Expense:
The school is operated by the school district under A.S. 14.17, Public School Foundation Program, and therefore, the project will not impact operation expenses.

V. Identification of Alternatives Considered:
Continue to use existing facility; rejected because of health and safety factors and inadequacy of space with respect to demands of instructional program.

PROJECT TYPE

- [X] Building Construction (C)
- [ ] Other Improvement (I)
- [ ] Equipment (E)
- [ ] Land (L)
- [ ] Professional Services (P)
- [ ] Other (O)

APPROPRIATION REQUEST

1002	FED. RCPTS.	
1003	G/F MATCH	
1004	GEN. FUND	
1005	I/A RCPTS.	
	G.O. BONDS	1430.0
	TOTAL	1430.0

PROJECT CHARACTERISTICS

- [X] Totally New Facility
- [ ] Addition to Existing Facility
- [ ] Renovation of Existing Facility
- [ ] Major Maintenance or Repair
- [ ] Supplement Previously Authorized Funds to Enable Completion
- [ ] One of Several Phases
- [ ] Major External Funding Source
- [ ] Other

PROJECT PURPOSES

- [X] Protect Human Health & Safety
- [ ] Protect Capital Assets
- [ ] Protect Natural Resources or Natural Environment
- [X] Improve Efficiency & Economy of State Government
- [X] Improve Services or Accommodate Increased Demand for Services
- [ ] Accommodate New Program Requirements
- [ ] Respond to Legal or Policy Mandate
- [ ] Improve Efficiency & Economy of Alaskan Infrastructure
- [ ] Other

SITE FEATURES

NO	YES	
[ ]	[X]	Site Currently Owned?
[X]	[ ]	All Utilities Available?
[ ]	[X]	Access Already Available?

OPERATIONAL COST & NO. PERSONNEL INCREASE (DECREASE)		FIRST OPERATING YEAR FY 83	ULTIMATE ANNUAL YEAR FY 83	PREVIOUS YR–PRIORITY
FUNDING SOURCE	FED. RCPTS.	N/A	N/A	AGENCY PRIORITY
	GEN. FUND	"	"	81-45
		"	"	GOVERNOR'S PRIORITY
		"	"	
TOTAL ANNUAL OPERATIONAL COST		"	"	
POSITION (FTE)		"	"	

CATEGORY Education AGENCY Education PROGRAM Rural Education

01-1035a (7/79)

35a PROPOSED CAPITAL PROJECT

REVISED DATE 11/26/79

PROJECT TITLE	LOCATION(S)	AREA SERVED	ELECTION DISTRICT(S)
Library Media Center - Levelock	Levelock	Local	16

OBJ. NO(S)	OPERATING BUDGET BRU(S)	NAME(S)	BUDGET COMPONENT NUMBERS	START DATE	COMPLETION DATE
3.3 & 4.1		N/A	N/A	May, 1981	Sept., 1981

PROJECT NARRATIVE

I. Project Need Statement:
The school program is designed to include the use of resources to be contained in the Library/Media Center.

II. Project Description:
This project will provide a single story, wood frame structure of 1100 square feet with equipment.

III. Documentation of Estimated Capital Cost:
Original cost estimate of $350.0 was provided by the school district. The figures provided on 35a and 35b reflect DOT/PF's LCC analysis.

IV. Analysis of Estimate of Operational Expense:
The school is operated by the school district under A.S. 14.17, Public School Foundation Program, and therefore, the project will not impact operation expenses.

V. Identification of Alternatives Considered:
1. Do nothing; rejected because of need for center in conducting educational program.
2. Postpone; rejected because of the effect of inflation on building costs.

PROJECT TYPE

- [X] Building Construction (C)
- [ ] Other Improvement (I)
- [ ] Equipment (E)
- [ ] Land (L)
- [ ] Professional Services (P)
- [ ] Other (O)

APPROPRIATION REQUEST

1002	FED. RCPTS.	
1003	G/F MATCH	
1004	GEN. FUND	
1005	I/A RCPTS.	
	G.O. BONDS	234.0
	TOTAL	234.0

PROJECT CHARACTERISTICS

- [ ] Totally New Facility
- [X] Addition to Existing Facility
- [ ] Renovation of Existing Facility
- [ ] Major Maintenance or Repair
- [ ] Supplement Previously Authorized Funds to Enable Completion
- [ ] One of Several Phases
- [ ] Major External Funding Source
- [ ] Other

PROJECT PURPOSES

- [ ] Protect Human Health & Safety
- [ ] Protect Capital Assets
- [ ] Protect Natural Resources or Natural Environment
- [ ] Improve Efficiency & Economy of State Government
- [ ] Improve Services or Accommodate Increased Demand for Services
- [X] Accommodate New Program Requirements
- [ ] Respond to Legal or Policy Mandate
- [ ] Improve Efficiency & Economy of Alaskan Infrastructure
- [ ] Other

SITE FEATURES

NO	YES	
[ ]	[X]	Site Currently Owned?
[ ]	[X]	All Utilities Available?
[ ]	[X]	Access Already Available?

OPERATIONAL COST & NO. PERSONNEL INCREASE (DECREASE)		FIRST OPERATING YEAR FY 83	ULTIMATE ANNUAL YEAR FY 83	PREVIOUS YR-PRIORITY
FUNDING SOURCE	FED. RCPTS.	N/A	N/A	AGENCY PRIORITY 81-46
	GEN. FUND	"	"	
		"	"	
		"	"	GOVERNOR'S PRIORITY
TOTAL ANNUAL OPERATIONAL COST		"	"	
POSITION (FTE)		"	"	

CATEGORY Education AGENCY Education PROGRAM Rural Education

01-1035a (7/79)

35a PROPOSED CAPITAL PROJECT

REVISED DATE 11/26/79

PROJECT TITLE	LOCATION(S)	AREA SERVED	ELECTION DISTRICT(S)
Vocational Education Shop - Levelock	Levelock	Local	16

OBJ. NO(S)	OPERATING BUDGET BRU(S)	NAME(S)	BUDGET COMPONENT NUMBERS	START DATE	COMPLETION DATE
3.3 & 4.1		N/A	N/A	May, 1981	Sept., 1981

PROJECT NARRATIVE

I. Project Need Statement:
Existing facility does not have space for shop classes as required in new secondary program.

II. Project Description:
Project will provide one story structure of 600 square feet with equipment.

III. Documentation of Estimated Capital Cost:
Original cost estimate of $200.0 was provided by the school district. The figures provided on 35a and 35b reflect on DOT/PF's LCC analysis.

IV. Analysis of Estimate of Operational Expense:
The school is operated by the school district under A.S. 14.17, Public School Foundation Program, and therefore, the project will not impact operation expenses.

V. Identification of Alternatives Considered:
1. Do nothing; rejected as the shop is reuqired in the program.
2. Postpone; rejected because of the effect of inflation on building costs.

PROJECT TYPE

- [X] Building Construction (C)
- [ ] Other Improvement (I)
- [ ] Equipment (E)
- [ ] Land (L)
- [ ] Professional Services (P)
- [ ] Other (O)

APPROPRIATION REQUEST

1002	FED. RCPTS.	
1003	G/F MATCH	
1004	GEN. FUND	144.0
1005	I/A RCPTS.	
	G.O. BONDS	
	TOTAL	144.0

PROJECT CHARACTERISTICS

- [X] Totally New Facility
- [ ] Addition to Existing Facility
- [ ] Renovation of Existing Facility
- [ ] Major Maintenance or Repair
- [ ] Supplement Previously Authorized Funds to Enable Completion
- [ ] One of Several Phases
- [ ] Major External Funding Source
- [ ] Other

PROJECT PURPOSES

- [ ] Protect Human Health & Safety
- [ ] Protect Capital Assets
- [ ] Protect Natural Resources or Natural Environment
- [ ] Improve Efficiency & Economy of State Government
- [ ] Improve Services or Accommodate Increased Demand for Services
- [X] Accommodate New Program Requirements
- [ ] Respond to Legal or Policy Mandate
- [ ] Improve Efficiency & Economy of Alaskan Infrastructure
- [ ] Other

SITE FEATURES

NO	YES	
[ ]	[X]	Site Currently Owned?
[ ]	[X]	All Utilities Available?
[ ]	[X]	Access Already Available?

OPERATIONAL COST & NO. PERSONNEL INCREASE (DECREASE)		FIRST OPERATING YEAR FY 83	ULTIMATE ANNUAL YEAR FY 83	PREVIOUS YR–PRIORITY
FUNDING SOURCE	FED. RCPTS.	N/A	N/A	AGENCY PRIORITY 81-47
	GEN. FUND	"	"	
		"	"	
		"	"	GOVERNOR'S PRIORITY
TOTAL ANNUAL OPERATIONAL COST		"	"	
POSITION (FTE)		"	"	

CATEGORY Education AGENCY Education PROGRAM Rural Education

01-1035a (7/79)

35a PROPOSED CAPITAL PROJECT

REVISED DATE 11/26/79

PROJECT TITLE	LOCATION(S)	AREA SERVED	ELECTION DISTRICT(S)
School Addition - Nelson Lagoon	Nelson Lagoon	Local	15

OBJ. NO(S)	OPERATING BUDGET BRU(S)	NAME(S)	BUDGET COMPONENT NUMBERS	START DATE	COMPLETION DATE
3.3 & 4.1		N/A	N/A	May, 1981	May, 1982

PROJECT NARRATIVE

I. Project Need Statement:
The present school facility does not adequately serve instructional program needs of the 30 students in grades K-12 at this location. Moreover, lacking needed space, program offerings are diminished.

II. Project Description:
The design and construction of 3,944 square feet addition to the Nelson Lagoon School to include library-media, vocational education, and multipurpose space.

III. Documentation of Estimated Capital Cost:
Original cost estimate of $788.8 was provided by the school district. The figures provided on 35a and 35b reflect DOT/PF's LCC analysis.

IV. Analysis of Estimate of Operational Expenses:
The school is operated by the school district under A.S. 14.17, Public School Foundation Program, and therefore, the project will not impact operation experses.

V. Identification of Alternatives Considered:
Do nothing or postpone; rejected because the existing facility cannot meet present program demands.

PROJECT TYPE

- [X] Building Construction (C)
- [ ] Other Improvement (I)
- [ ] Equipment (E)
- [ ] Land (L)
- [ ] Professional Services (P)
- [ ] Other (O)

APPROPRIATION REQUEST

1002	FED. RCPTS.	
1003	G/F MATCH	
1004	GEN. FUND	
1005	I/A RCPTS.	
	G.O. BONDS	826.0
	TOTAL	826.0

PROJECT CHARACTERISTICS

- [ ] Totally New Facility
- [X] Addition to Existing Facility
- [ ] Renovation of Existing Facility
- [ ] Major Maintenance or Repair
- [ ] Supplement Previously Authorized Funds to Enable Completion
- [ ] One of Several Phases
- [ ] Major External Funding Source
- [ ] Other

PROJECT PURPOSES

- [X] Protect Human Health & Safety
- [X] Protect Capital Assets
- [ ] Protect Natural Resources or Natural Environment
- [ ] Improve Efficiency & Economy of State Government
- [X] Improve Services or Accommodate Increased Demand for Services
- [X] Accommodate New Program Requirements
- [ ] Respond to Legal or Policy Mandate
- [ ] Improve Efficiency & Economy of Alaskan Infrastructure
- [ ] Other

SITE FEATURES

NO	YES	
[ ]	[X]	Site Currently Owned?
[X]	[ ]	All Utilities Available?
[ ]	[X]	Access Already Available?

OPERATIONAL COST & NO. PERSONNEL INCREASE (DECREASE)		FIRST OPERATING YEAR FY 83	ULTIMATE ANNUAL YEAR FY 83	PREVIOUS YR–PRIORITY
FUNDING SOURCE	FED. RCPTS.	N/A	N/A	AGENCY PRIORITY 81-48
	GEN. FUND	"	"	
		"	"	
		"	"	GOVERNOR'S PRIORITY
TOTAL ANNUAL OPERATIONAL COST		"	"	
POSITION (FTE)		"	"	

CATEGORY Education AGENCY Education PROGRAM Rural Education

01-1036a (7/79)

35a PROPOSED CAPITAL PROJECT

REVISED DATE 11/26/79

PROJECT TITLE	LOCATION(S)	AREA SERVED	ELECTION DISTRICT(S)
Vocational Education Shop - Koliganak	Koliganak	Local	16

OBJ. NO(S)	OPERATING BUDGET BRU(S)	NAME(S)	BUDGET COMPONENT NUMBERS	START DATE	COMPLETION DATE
3.3 & 4.1		N/A	N/A	May, 1981	Sept., 1981

PROJECT NARRATIVE

I. Project Need Statement:
The school program is designed to include Vocational Ed. The program is designed to meet terms of Consent Decree.

II. Project Description:
The project will provide a single story wood frame structure of 1200 square feet with equipment.

III. Documentation of Estimated Capital Cost:
Original cost estimate of $400.0 was provided by the school district. The figures provided on 35a and 35b reflect DOT/PF's LCC analysis.

IV. Analysis of Estimate of Operational Expense:
The school is operated by the school district under A.S. 14.17, Public School Foundation Program, and therefore, the project will not impact operation expenses.

V. Identification of Alternatives Considered:
1. Do nothing; rejected because the program is required.
2. Postpone; rejected because of the effect of inflation on building costs.

PROJECT TYPE

- [X] Building Construction (C)
- [ ] Other Improvement (I)
- [ ] Equipment (E)
- [ ] Land (L)
- [ ] Professional Services (P)
- [ ] Other (O)

APPROPRIATION REQUEST

1002	FED. RCPTS.	
1003	G/F MATCH	
1004	GEN. FUND	
1005	I/A RCPTS.	
	G.O. BONDS	400.0
	TOTAL	400.0

PROJECT CHARACTERISTICS

- [X] Totally New Facility
- [ ] Addition to Existing Facility
- [ ] Renovation of Existing Facility
- [ ] Major Maintenance or Repair
- [ ] Supplement Previously Authorized Funds to Enable Completion
- [ ] One of Several Phases
- [ ] Major External Funding Source
- [ ] Other

PROJECT PURPOSES

- [ ] Protect Human Health & Safety
- [ ] Protect Capital Assets
- [ ] Protect Natural Resources or Natural Environment
- [ ] Improve Efficiency & Economy of State Government
- [ ] Improve Services or Accommodate Increased Demand for Services
- [X] Accommodate New Program Requirements
- [ ] Respond to Legal or Policy Mandate
- [ ] Improve Efficiency & Economy of Alaskan Infrastructure
- [ ] Other

SITE FEATURES

NO	YES	
[ ]	[X]	Site Currently Owned?
[ ]	[X]	All Utilities Available?
[ ]	[X]	Access Already Available?

OPERATIONAL COST & NO. PERSONNEL INCREASE (DECREASE)		FIRST OPERATING YEAR FY 83	ULTIMATE ANNUAL YEAR FY 83	PREVIOUS YR–PRIORITY
FUNDING SOURCE	FED. RCPTS.	N/A	N/A	AGENCY PRIORITY
	GEN. FUND	"	"	81-49
		"	"	
		"	"	GOVERNOR'S PRIORITY
TOTAL ANNUAL OPERATIONAL COST		"	"	
POSITION (FTE)		"	"	

CATEGORY Education AGENCY Education PROGRAM Rural Education

01 1035a (7/79)

35a PROPOSED CAPITAL PROJECT

REVISED DATE 11/26/79

PROJECT TITLE	LOCATION(S)	AREA SERVED	ELECTION DISTRICT(S)
Elementary Remodel - Koyuk	Koyuk	Local	22

OBJ. NO(S)	OPERATING BUDGET BRU(S)	NAME(S)	BUDGET COMPONENT NUMBERS	START DATE	COMPLETION DATE
3.3 & 4.1		N/A	N/A	May, 1982	Dec., 1982

PROJECT NARRATIVE

I. Project Need Statement:
This facility was designed as an elementary school. A secondary program has been developed for implementation. The facilities require remodeling to provide space for the high school program.

II. Project Description:
This project will provide remodeling of existing space to accomodate, shop, science lab, business and math instructional areas.

III. Documentation of Estimated Capital Cost:
Original cost estimate of $1500.0 was provided by the school district. DOT/PF's LCC analysis provided the figure of $12211.0. The figures on 35a and 35b were provided by DOT/PF's Condition Survey.

IV. Analysis of Estimate of Operational Expense:
The school is operated by the school district under A.S. 14.17, Public School Foundation Program, and therefore, the project will not impact operation expenses.

V. Identification of Alternatives Considered:
1. Do nothing; rejected because existing space is not adequate for secondary program.
2. Postpone; rejected because of the effect of inflation on construction costs.
3. Replace with new structure; rejected because remodeling existing structure will provide service needed.

PROJECT TYPE

- [X] Building Construction (C)
- [ ] Other Improvement (I)
- [ ] Equipment (E)
- [ ] Land (L)
- [ ] Professional Services (P)
- [ ] Other (O)

APPROPRIATION REQUEST

1002	FED. RCPTS.	
1003	G/F MATCH	
1004	GEN. FUND	
1005	I/A RCPTS.	
	G.O. BONDS	700.0
	TOTAL	700.0

PROJECT CHARACTERISTICS

- [ ] Totally New Facility
- [ ] Addition to Existing Facility
- [X] Renovation of Existing Facility
- [ ] Major Maintenance or Repair
- [ ] Supplement Previously Authorized Funds to Enable Completion
- [ ] One of Several Phases
- [ ] Major External Funding Source
- [ ] Other

PROJECT PURPOSES

- [ ] Protect Human Health & Safety
- [ ] Protect Capital Assets
- [ ] Protect Natural Resources or Natural Environment
- [X] Improve Efficiency & Economy of State Government
- [ ] Improve Services or Accommodate Increased Demand for Services
- [ ] Accommodate New Program Requirements
- [ ] Respond to Legal or Policy Mandate
- [ ] Improve Efficiency & Economy of Alaskan Infrastructure
- [ ] Other

SITE FEATURES

NO	YES	
[ ]	[X]	Site Currently Owned?
[ ]	[X]	All Utilities Available?
[ ]	[X]	Access Already Available?

OPERATIONAL COST & NO. PERSONNEL INCREASE (DECREASE)		FIRST OPERATING YEAR FY 83	ULTIMATE ANNUAL YEAR FY 83
FUNDING SOURCE	FED. RCPTS.	N/A	N/A
	GEN. FUND	"	"
		"	"
		"	"
TOTAL ANNUAL OPERATIONAL COST		"	"
POSITION (FTE)		"	"

PREVIOUS YR–PRIORITY

AGENCY PRIORITY 81-55

GOVERNOR'S PRIORITY

CATEGORY Education AGENCY Education PROGRAM Rural Education

01-1035a (7/79)

35a PROPOSED CAPITAL PROJECT

REVISED DATE 11/26/79

PROJECT TITLE	LOCATION(S)	AREA SERVED	ELECTION DISTRICT(S)
Wales Elementary School Remodeling	Wales	Local	22

OBJ. NO(S)	OPERATING BUDGET BRU(S)	NAME(S)	BUDGET COMPONENT NUMBERS	START DATE	COMPLETION DATE
3.3 & 4.1		N/A	N/A	May, 1982	Dec., 1982

PROJECT NARRATIVE

I. Project Need Statement:
The existing facility was constructed in 1962 and is in poor condition and does not meet present code

II. Project Description:
This project will provide for the remodeling of existing structure to provide for new building systems, realignment of floor space and provide new equipment.

III. Documentation of Estimated Capital Cost:
Original estimate of $1200.0 was provided by the school district. The figures on 35a and 35b were provided by Budget & Management.

IV. Analysis of Estimate of Operational Expense:
The school is operated by the school district under A.S. 14.17, Public School Foundation Program, and therefore, the project will not impact operation expenses.

V. Identification of Alternatives Considered:
1. Do nothing; rejected because the present facility represents life safety and code violations.
2. Postpone; rejected because of the effect of inflation on construction costs.

PROJECT TYPE

- [X] Building Construction (C)
- [ ] Other Improvement (I)
- [ ] Equipment (E)
- [ ] Land (L)
- [ ] Professional Services (P)
- [ ] Other (O)

APPROPRIATION REQUEST

1002	FED. RCPTS.	
1003	G/F MATCH	
1004	GEN. FUND	
1005	I/A RCPTS.	
	G.O. BONDS	579.0
	TOTAL	579.0

PROJECT CHARACTERISTICS

- [ ] Totally New Facility
- [ ] Addition to Existing Facility
- [X] Renovation of Existing Facility
- [ ] Major Maintenance or Repair
- [ ] Supplement Previously Authorized Funds to Enable Completion
- [ ] One of Several Phases
- [ ] Major External Funding Source
- [ ] Other

PROJECT PURPOSES

- [ ] Protect Human Health & Safety
- [ ] Protect Capital Assets
- [ ] Protect Natural Resources or Natural Environment
- [X] Improve Efficiency & Economy of State Government
- [ ] Improve Services or Accommodate Increased Demand for Services
- [ ] Accommodate New Program Requirements
- [ ] Respond to Legal or Policy Mandate
- [ ] Improve Efficiency & Economy of Alaskan Infrastructure
- [ ] Other

SITE FEATURES

NO	YES	
[ ]	[X]	Site Currently Owned?
[ ]	[X]	All Utilities Available?
[ ]	[X]	Access Already Available?

OPERATIONAL COST & NO. PERSONNEL INCREASE (DECREASE)		FIRST OPERATING YEAR FY 83	ULTIMATE ANNUAL YEAR FY 83	PREVIOUS YR–PRIORITY
FUNDING SOURCE	FED. RCPTS.	N/A	N/A	AGENCY PRIORITY
	GEN. FUND	"	"	81-56
		"	"	GOVERNOR'S PRIORITY
		"	"	
TOTAL ANNUAL OPERATIONAL COST		"	"	
POSITION (FTE)		"	"	

CATEGORY Education AGENCY Education PROGRAM Rural Education

01-1035a (7/79)

35a PROPOSED CAPITAL PROJECT

REVISED DATE 11/26/79

PROJECT TITLE	LOCATION(S)	AREA SERVED	ELECTION DISTRICT(S)
Library Construction Grants	Local Communities	State	All

OBJ. NO(S)	OPERATING BUDGET BRU(S)	NAME(S)	BUDGET COMPONENT NUMBERS	START DATE	COMPLETION DATE
1,3		State Library	05-13-70-20	7/80	6-81

PROJECT NARRATIVE

I. Project Need Statement

Many communities throughout Alaska have inadequate or no community library facility. State grants matched by local communities under AS 14.56.065 and .240 enable communities to establish or to remodel facilities for public library use. Funds made available for grants through SLA 1974 chapter 116 have a current balance of $21,130. Needs exceed the balance available. As more communities are becoming aware of health, safety, and access requirements for public buildings and as more library-related programs are implemented, more communities are expressing a need for a community library facility which may be separate or part of another community facility such as a school, community college, or municipal building. Library - related programs include community college extension courses, literacy and G.E.D. programs, pre-school and public school education, satellite courses, Native Corporation training workshops, etc. All of these and regular information and recreation or cultural resources needs are part of community library services. Attached sheets contain a summary of community needs.

II. Project Description

The project consists of a variety of local projects to remodel or construct and equip community library facilities. Communities in applying for grants indicate project cost estimates, plans for service and operating funds as well as grant and local match funds needed and/or available. Projects may be in communities of less than 300 people if a need

PROJECT TYPE

- [X] Building Construction (C)
- [X] Other Improvement (I)
- [X] Equipment (E)
- [ ] Land (L)
- [ ] Professional Services (P)
- [ ] Other (O)

APPROPRIATION REQUEST

1002	FED. RCPTS.	
1003	G/F MATCH	
1004	GEN. FUND	500.0
1005	I/A RCPTS.	
	G.O. BONDS	
	TOTAL	500.0

PROJECT CHARACTERISTICS

- [X] Totally New Facility
- [X] Addition to Existing Facility
- [X] Renovation of Existing Facility
- [ ] Major Maintenance or Repair
- [ ] Supplement Previously Authorized Funds to Enable Completion
- [ ] One of Several Phases
- [ ] Major External Funding Source
- [ ] Other

PROJECT PURPOSES

- [X] Protect Human Health & Safety
- [X] Protect Capital Assets
- [ ] Protect Natural Resources or Natural Environment
- [ ] Improve Efficiency & Economy of State Gove: nent
- [X] Improve Services or Accommodate Increased Demand for Services
- [ ] Accommodate New Program Requirements
- [ ] Respond to Legal or Policy Mandate
- [X] Improve Efficiency & Economy of Alaskan Infrastructure
- [ ] Other

SITE FEATURES

NO	YES	
[ ]	[ ]	Site Currently Owned?
[ ]	[ ]	All Utilities Available?
[ ]	[ ]	Access Already Available?

OPERATIONAL COST & NO. PERSONNEL INCREASE (DECREASE)		FIRST OPERATING YEAR ____	ULTIMATE ANNUAL YEAR ____	PREVIOUS YR–PRIORITY
FUNDING SOURCE	FED. RCPTS.			80-4
	GEN. FUND			AGENCY PRIORITY
				81-1
				GOVERNOR'S PRIORITY
TOTAL ANNUAL OPERATIONAL COST				
POSITION (FTE)				

CATEGORY Education AGENCY Education PROGRAM State Library

01-1035a (7/79)

35a PROPOSED CAPITAL PROJECT

REVISED DATE ____

PROJECT TITLE	LOCATION(S)	AREA SERVED	ELECTION DISTRICT(S)
Secondary School (New) - Nightmute	Nightmute	Local	17

OBJ. NO(S)	OPERATING BUDGET BRU(S)	NAME(S)	BUDGET COMPONENT NUMBERS	START DATE	COMPLETION DATE
3.3 & 4.1		N/A	N/A	June, 1981	August, 1982

PROJECT NARRATIVE

I. Project Need Statement:
No secondary school facility presently exists at this location, and the village has requested a secondary school program. The proposed building therefore, is needed in order to house this program.

II. Project Description:
Project is for the construction of a new secondary school facility for approximately 25 unhoused students, and will include classrooms, library-media center, multipurpose room, and related space.

III. Documentation of Estimated Capital Cost:
Original cost information, $3,350.0 was provided by the school district based on its cost-per-square-foot results for like facilities in the bidding on Chapter 131/76 and Chapter 134/78 schools in the region. The figures provided on 35a and 35b reflect the "Hootch" attorneys agreement.

IV. Analysis of Estimate of Operational Expense:
The school is operated by the school district under A.S. 14.17, Public School Foundation Program, and therefore, the project will not impact operation expenses.

V. Identification of Alternatives Considered:
1. Rent or lease space; rejected because space is unavailable.
2. Use old BIA facility; rejected because of over-crowding and/or double-shifting.

PROJECT TYPE

- [X] Building Construction (C)
- [ ] Other Improvement (I)
- [ ] Equipment (E)
- [ ] Land (L)
- [ ] Professional Services (P)
- [ ] Other (O)

APPROPRIATION REQUEST

1002	FED. RCPTS.	
1003	G/F MATCH	
1004	GEN. FUND	2465.0
1005	I/A RCPTS.	
	G.O. BONDS	
	TOTAL	2465.0

PROJECT CHARACTERISTICS

- [X] Totally New Facility
- [ ] Addition to Existing Facility
- [ ] Renovation of Existing Facility
- [ ] Major Maintenance or Repair
- [ ] Supplement Previously Authorized Funds to Enable Completion
- [ ] One of Several Phases
- [ ] Major External Funding Source
- [ ] Other

PROJECT PURPOSES

- [X] Protect Human Health & Safety
- [ ] Protect Capital Assets
- [ ] Protect Natural Resources or Natural Environment
- [X] Improve Efficiency & Economy of State Government
- [X] Improve Services or Accommodate Increased Demand for Services
- [X] Accommodate New Program Requirements
- [X] Respond to Legal or Policy Mandate
- [ ] Improve Efficiency & Economy of Alaskan Infrastructure
- [ ] Other

SITE FEATURES

NO	YES	
[ ]	[X]	Site Currently Owned?
[X]	[ ]	All Utilities Available?
[ ]	[X]	Access Already Available?

OPERATIONAL COST & NO. PERSONNEL INCREASE (DECREASE)		FIRST OPERATING YEAR FY 83	ULTIMATE ANNUAL YEAR FY 83	PREVIOUS YR-PRIORITY
FUNDING SOURCE	FED. RCPTS.	N/A	N/A	AGENCY PRIORITY 81-1
	GEN. FUND	"	"	
		"	"	
		"	"	GOVERNOR'S PRIORITY
TOTAL ANNUAL OPERATIONAL COST		"	"	
POSITION (FTE)		"	"	

CATEGORY Education AGENCY Education PROGRAM Rural Education

PROJECT TITLE	LOCATION(S)	AREA SERVED	ELECTION DISTRICT(S)
Little Diomede Secondary School	Little Diomede	Local	22

OBJ. NO(S)	OPERATING BUDGET BRU(S)	NAME(S)	BUDGET COMPONENT NUMBERS	START DATE	COMPLETION DATE
3.3 & 4.1		N/A	N/A	May, 1981	Dec., 1981

PROJECT NARRATIVE

I. Project Need Statement:
The state has assumed the responsibility to construct a new secondary facility. Existing funding is inadequate to complete the project.

II. Project Description:
This project will provide a secondary school building of wood frame to provide a compadable education for local students who previously had to leave the island.

III. Documentation of Estimated Capital Cost:
The figure of 1932.0 was provided by DOT/PF and the architects as what is needed to insure completion of the project.

IV. Analysis of Estimate of Operational Expense:
The school is operated by the school district under A.S. 14.17, Public School Foundation Program, and therefore, the project will not impact operational expenses.

V. Identification of Alternatives Considered:
1. Do nothing; rejected because the project has been approved.
2. Postpone; rejected because of the effect of inflation on construction costs.

PROJECT TYPE

- [X] Building Construction (C)
- [ ] Other Improvement (I)
- [ ] Equipment (E)
- [ ] Land (L)
- [ ] Professional Services (P)
- [ ] Other (O)

APPROPRIATION REQUEST

1002	FED. RCPTS.	
1003	G/F MATCH	
1004	GEN. FUND	1932.0
1005	I/A RCPTS.	
	G.O. BONDS	
	TOTAL	1932.0

PROJECT CHARACTERISTICS

- [X] Totally New Facility
- [ ] Addition to Existing Facility
- [ ] Renovation of Existing Facility
- [ ] Major Maintenance or Repair
- [ ] Supplement Previously Authorized Funds to Enable Completion
- [ ] One of Several Phases
- [ ] Major External Funding Source
- [ ] Other

PROJECT PURPOSES

- [ ] Protect Human Health & Safety
- [ ] Protect Capital Assets
- [ ] Protect Natural Resources or Natural Environment
- [ ] Improve Efficiency & Economy of State Government
- [ ] Improve Services or Accommodate Increased Demand for Services
- [X] Accommodate New Program Requirements
- [ ] Respond to Legal or Policy Mandate
- [ ] Improve Efficiency & Economy of Alaskan Infrastructure
- [ ] Other

SITE FEATURES

NO	YES	
[X]	[ ]	Site Currently Owned?
[X]	[ ]	All Utilities Available?
[X]	[ ]	Access Already Available?

OPERATIONAL COST & NO. PERSONNEL INCREASE (DECREASE)		FIRST OPERATING YEAR FY 83	ULTIMATE ANNUAL YEAR FY 83	PREVIOUS YR-PRIORITY
FUNDING SOURCE	FED. RCPTS.	N/A	N/A	AGENCY PRIORITY 81-2
	GEN. FUND	"	"	
		"	"	
		"	"	GOVERNOR'S PRIORITY
TOTAL ANNUAL OPERATIONAL COST		"	"	
POSITION (FTE)		"	"	

CATEGORY Education AGENCY Education PROGRAM Rural Education

01-1035a (7/79)

35a PROPOSED CAPITAL PROJECT

REVISED DATE 11/26/79

PROJECT TITLE	LOCATION(S)	AREA SERVED	ELECTION DISTRICT(S)
Secondary School (New) - Kasigluk	Kasigluk	Local	17

OBJ. NO(S)	OPERATING BUDGET BRU(S)	NAME(S)	BUDGET COMPONENT NUMBERS	START DATE	COMPLETION DATE
3.3 & 4.1		N/A	N/A	June, 1981	August, 1982

PROJECT NARRATIVE

I. Project Need Statement:
No secondary school facility presently exists at this location, and the viallage has requested a secondary school program. The proposed building, therefore, is needed in order to house this program.

II. Project Description:
Project is for the construction of a new secondary school facility for approximately 40 unhoused secondary school students, and will include classrooms library-media center, multipurpose room, and related spaces.

III. Documentation of Estimated Capital Cost:
Original cost information, $3735.0 was provided by the school district based on its cost-per-square-foot results for like facilities in the bidding of Chapter 131/76 and Chapter 124/78 schools in the region. The figures provided on 35a and 35b reflect the "Hootch" attorneys agreement.

IV. Analysis of Estimate of Operational Expense:
The school is operated by the school district under A.S. 14.17, Public School Foundation Program, and therefore, the project will not impact operation expenses.

V. Identification of Alternatives Considered:
1. Rent or lease space; rejected because space is unavailable.
2. Use old BIA facility; rejected because of overcrowding and/or double-shifting.

PROJECT TYPE

- [X] Building Construction (C)
- [ ] Other Improvement (I)
- [ ] Equipment (E)
- [ ] Land (L)
- [ ] Professional Services (P)
- [ ] Other (O)

APPROPRIATION REQUEST

1002	FED. RCPTS.	
1003	G/F MATCH	
1004	GEN. FUND	3162.4
1005	I/A RCPTS.	
	G.O. BONDS	
	TOTAL	3162.4

PROJECT CHARACTERISTICS

- [X] Totally New Facility
- [ ] Addition to Existing Facility
- [ ] Renovation of Existing Facility
- [ ] Major Maintenance or Repair
- [ ] Supplement Previously Authorized Funds to Enable Completion
- [ ] One of Several Phases
- [ ] Major External Funding Source
- [ ] Other

PROJECT PURPOSES

- [X] Protect Human Health & Safety
- [ ] Protect Capital Assets
- [ ] Protect Natural Resources or Natural Environment
- [X] Improve Efficiency & Economy of State Government
- [X] Improve Services or Accommodate Increased Demand for Services
- [X] Accommodate New Program Requirements
- [X] Respond to Legal or Policy Mandate
- [ ] Improve Efficiency & Economy of Alaskan Infrastructure
- [ ] Other

SITE FEATURES

NO	YES	
[ ]	[X]	Site Currently Owned?
[X]	[ ]	All Utilities Available?
[ ]	[X]	Access Already Available?

OPERATIONAL COST & NO. PERSONNEL INCREASE (DECREASE)		FIRST OPERATING YEAR FY 83	ULTIMATE ANNUAL YEAR FY 83	PREVIOUS YR–PRIORITY
FUNDING SOURCE	FED RCPTS.	N/A	N/A	AGENCY PRIORITY
	GEN. FUND	"	"	81-3
		"	"	
		"	"	GOVERNOR'S PRIORITY
TOTAL ANNUAL OPERATIONAL COST		"	"	
POSITION (FTE)		"	"	

CATEGORY Education AGENCY Education PROGRAM Rural Education

01-1035a (7/79)

35a PROPOSED CAPITAL PROJECT

REVISED DATE 11/26/79

PROJECT TITLE	LOCATION(S)	AREA SERVED	ELECTION DISTRICT(S)
Shaktoolik Secondary School - Overrun	Shaktookik	Local	22

OBJ. NO(S)	OPERATING BUDGET BRU(S)	NAME(S)	BUDGET COMPONENT NUMBERS	START DATE	COMPLETION DATE
3.3 & 4.1		N/A	N/A	Sept., 1979	Dec. 1979

PROJECT NARRATIVE

I. Project Need Statement:
This project was started with a combination of State and Federal funds. Revised cost estimates indicate a need for additional funding.

II. Project Description:
A single story wood framed elementary/secondary school to replace existing facility would provide for additional secondary program. Hootch Site.

III. Documentation of Estimated Cost:
The figure of $450.0 was provided by the district, architects, and engineers.

IV. Analysis of Estimate of Operational Expense:
The school is operated by the school district under A.S. 14.17, Public School Foundation Program, and therefore, the project will not impact operation expenses.

V. Identification of Alternatives Considered:
1. Do nothing; rejected because the project is part of a legal agreement.

PROJECT TYPE

- [X] Building Construction (C)
- [ ] Other Improvement (I)
- [ ] Equipment (E)
- [ ] Land (L)
- [ ] Professional Services (P)
- [ ] Other (O)

APPROPRIATION REQUEST

1002	FED. RCPTS.	
1003	G/F MATCH	
1004	GEN. FUND	450.0
1005	I/A RCPTS.	
	G.O. BONDS	
	TOTAL	

PROJECT CHARACTERISTICS

- [ ] Totally New Facility
- [ ] Addition to Existing Facility
- [ ] Renovation of Existing Facility
- [ ] Major Maintenance or Repair
- [X] Supplement Previously Authorized Funds to Enable Completion
- [ ] One of Several Phases
- [ ] Major External Funding Source
- [ ] Other

PROJECT PURPOSES

- [ ] Protect Human Health & Safety
- [ ] Protect Capital Assets
- [ ] Protect Natural Resources or Natural Environment
- [ ] Improve Efficiency & Economy of State Government
- [ ] Improve Services or Accommodate Increased Demand for Services
- [X] Accommodate New Program Requirements
- [ ] Respond to Legal or Policy Mandate
- [ ] Improve Efficiency & Economy of Alaskan Infrastructure
- [ ] Other

SITE FEATURES

NO	YES	
[ ]	[X]	Site Currently Owned?
[ ]	[X]	All Utilities Available?
[ ]	[X]	Access Already Available?

OPERATIONAL COST & NO. PERSONNEL INCREASE (DECREASE)		FIRST OPERATING YEAR FY 80	ULTIMATE ANNUAL YEAR FY 80	PREVIOUS YR–PRIORITY
FUNDING SOURCE	FED. RCPTS.	N/A	N/A	AGENCY PRIORITY 81-4
	GEN. FUND	"	"	
		"	"	GOVERNOR'S PRIORITY
		"	"	
TOTAL ANNUAL OPERATIONAL COST		"	"	
POSITION (FTE)		"	"	

CATEGORY Education AGENCY Education PROGRAM Rural Education

01-1035a (7/79)

35a PROPOSED CAPITAL PROJECT

REVISED DATE 11/26/79

House Bill 619
Zharoff

Chiniak School
Construction

Kodiak Island
Regional Education Board

January 21, 1980

The Honorable Fred F. Zharoff
Alaska State House of Representatives
Pouch "V" State Capitol Building
Juneau, Alaska 99811

Dear Representative Zharoff:

I would like to take this opportunity to ask for your support of the "Proposal for Funding of a Combined Elementary/Secondary School Facility in Karluk, Alaska for Consideration at the 1980 State Legislative Session" in the name of the Kodiak Island Regional Education Board (REB). The REB unanimously approved a motion in support of this proposal at its January 17th and 18th 1980 meeting.

The REB is composed of the Advisory School Board/Indian Parent Committee Chairmen from six Native villages of Kodiak Island and the Indian Parent Committee from the City of Kodiak. This Board is elected by the parents of Native children in the schools of Kodiak Island Borough and represents the total Native community of Kodiak Island.

Your support of this proposal will greatly assist in providing a quality education for the children of Karluk.

Sincerely,

Nick Peterson, Sr.
Chairman
Kodiak Island
Regional Education Board

/cb

Funding Information
General Fund $3,300,000
Other Funds -0-
$3,300,000

Introduced: 1/24/80
Referred: Health,Education & Social Services and Finance

IN THE HOUSE BY ZHAROFF

HOUSE BILL NO. 619

IN THE LEGISLATURE OF THE STATE OF ALASKA

ELEVENTH LEGISLATURE - SECOND SESSION

A BILL

For an Act entitled: "An Act making a special appropriation to the Department of Transportation and Public Facilities for construction of a school at Chiniak; and providing for an effective date."

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

* Section 1. The sum of $3,300,000 is appropriated from the general fund to the Department of Transportation and Public Facilities for payment as a grant to the Kodiak Island Borough for construction of a school at Chiniak.

* Sec. 2. This Act takes effect immediately in accordance with AS 01.10.-070(c).

KODIAK ISLAND BOROUGH

Telephones 486-5736 - 486-5737 — Box 1246
KODIAK, ALASKA 99615

September 26, 1979

The Honorable Mr. Fred Zharoff
Alaska State House of Representatives
POUCH V
Juneau, Alaska 99811

RE: Your request for information

Dear Mr. Zharoff,

The following Capital Improvement project recommedations reflect the opinions of the Kodiak Island Borough Administrative staff. Do to the short response time allowed we were unable to obtain project nonimations or priority rebuttal reflecting the opinions of the Borough Mayor and Assembly. However, Mayor Wallin has reviewed this letter and several projects reflect her opinions.

1. Akhiok Elementary School. The existing school at Akhiok was a temporary building designed to last for a few years. Thus far this temporary expedient has been used for ten (10) years. This building should be replaced by the State.

2. Cape Chiniak Elementary School. The existing facility at Chiniak is operating at capacity increased enrollment requires an increase in school facilities. The proposed Job Corp Center will create additional school facilities needs for faculty member's dependent children.

3. Kodiak Boat Harbor Facilities. It is imperative that new boat harbor facilities be constructed at Kodiak. We can not afford to wait for the U.S. Congress and Corps of Engineers to act, as they have been promising this facility for over a decade. To date all we have seen from Washington are revised reports and lots of political rhetoric. Unfortunately we can not moor boats in a harbor constructed on Congressional rhetoric.

   It is our feeling that low interest loans and direct construction grant aid will provide the most expeditious method of financing these urgently need harbor facilities. We will be happy to provide you with specific cost and need justification data prior to the January 1980 Legislative Session.

4. Rural Alaskan Economic Development. If we are to ultimately establishable economic stability in rural Alaska. The State should make low interest economic development loans available through the permanent fund or a revolving self perpetuating economic development fund.

5. Planning Grant Assistance. The State should provide 100% funding for the Planning grants when the issues have regional, State wide, or National significance such as the O.C.S. Planning Programs. We need plans prepared by and for the local Community rather than those prepared for us by Federal and State agencies. It has been our experience that the Federal and State planning considerations are not always the same as those of the local community. Since we have planning power and responsibility, provide us the funds to carry out those responsibilities. Funding levels for O.C.S. and Coastal Zone Programs should be at the 100% level with State agency coordination in work scoping project review.

6. MONASHKA DAM LOW INTEREST CONSTRUCTION LOANS AND DIRECT CONSTRUCTION GRANTS TO DAM CONSTRUCTION. STATE LEGAL ASSISTANCE IN RESOLVING LAND CLAIMS CONFLICTS IN WATER SHED AREA.

7. PAVE ROADS IN KODIAK URBAN AREA.

8. CONSTRUCT ROADS IN MONASHKA BAY, MILLER POINT AND RUSSIAN CREEK SUBDIVISION

9. PARKING LOT IMPROVEMENTS AT KODIAK COMMUNITY COLLEGE

April 8, 1979
Kodiak, Alaska

Representative Fred Zharoff
Pouch V
Juneau, Alaska

Dear Representative Zharoff

The citizens of Chiniak are in need of your assistance. We are facing a crisis situation at our school.

The Federal Government has leased the old Chiniak Tracking Station from Koniag and will open its doors as a job corp center on October 15th of this year. Staffing of the facility will require sixty persons, many of them professionals. The offspring of both the job corp personal and job corp students will be attending our Chiniak school. The center intends to hire as many local people as possible but even with that effort the impact will be great. David McGuigans, the director, is projecting an increase of twenty-five to thirty students for our school, and it may well be more.

Our present facilities are meager. They consist of an eight year old temporary unit, modest living quarters for our sole teacher and his wife, and a small storage/t.v. room which joins the two facilities. The above is located at mile 41 of the Chiniak Road on a ten are plot of borough owned land. The structure stands on a minimum ammount of gravel fill. The filled area also accommodates a driveway and a playground.

The present studentbody consists of fourteen children, kindergarden thru eighth grade, and that is all the facility can handle. What will we do with the twenty-five or thirty more children that arrive in the Fall?

For months the Chiniak commity has been working in earnest to solve this dilemma. We've been to the Kodiak School Board and school administration. We've talked to the Borough Assembly, Mayor Wallen, and job corp representatives. Theres been some press coverage and a Chiniak School open house was held to which all of the above persons were invited. The response of everyone we've talked to has been the same; There are no moneys anywhere to accommodate this influx of students. Our only headway came last week when Chiniak was included in an all-inclusive bond. If it is passed Chiniak will receive $150,000. The problem with the bond issue is that it may, or may not pass and of course it will not be in time to releive our predicament. If a permanent school is to be built it must be started immediately. It its to be an atco unit the order must be placed now. Additional land fill is required to accommodate either.

The job corp is a fine program and we are opt mistic about its addition to our community. But we wonder; Why was'nt an impact study done by the Ferderal Government? Why did'nt Govenor Hammond order one at the time he signed his support of the Chiniak sight?

We are a stable, wor ing, tax paying community who want good quality education and accommodations for our new neighbors children as well as our own. But we need your help. We need your support and advice. We have exhausted all local avenues in search of a building fund. There is none. It has become apparent that we both need, and are deserving of either State or Federal moanys to orb the impact on our school. How can such an application be made? Where do we find a commitment, a possitive action toward readying our school for Fall?

Your support and any insight or advice you have to offer will be greatly appreciated. Thank you for your attention.

Sincerely

Crystal A. Ranney

Crystal A. Ranney
Secretary-treasurer
Chiniak Advisory School Board
P.O. Box 228
Kodiak, Alaska
99615

Note: The enclosed information is intended only to show the abundant community interest that exists in regards to our school

We the undersigned residents of Chiniak are concerned about the proposed alternatives for elementary education in our community. To better familiarize the Kodiak Island Borough Assembly and the Kodiak Island Borough School District with the conditions and the alternatives, we extend this invitation to an open house at the Chiniak School on Sunday, March 4, 1979 from 2pm to 4pm.

11

Jan Pennington

Ron Jonahan

Linda Jaquet

Kristie L. Harris

We the undersigned residents of Chiniak are concerned about the proposed alternatives for elementary education in our community. To better familiarize the Kodiak Island Borough Assembly and the Kodiak Island Borough School District with the conditions and the alternatives, we extend this invitation to an open house at the Chiniak School on Sunday, March 4, 1979 from 2pm to 4pm.

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//

P.O. Box 2191
Kodiak, Alaska 99615
December 10, 1979

Fred F. Zharoff
Representative
P.O. Box 405
Kodiak, Alaska 99165

Dear Sir:

On behalf of the Chiniak Advisory School Board, I want to thank you for attending the special public meeting of October 24, 1979 at the Chiniak School.

Gary Shepard, Asst. Principal for Villiage Schools, has been assigned to put together a proposal to the State Board of Education and in turn will be submitted to the legislature for funding. The package will include a summary of our school and the Chiniak Community along with plans for new facilities.

Again we appreciate the time and effort you have shown. We will keep you aware of progress on our ever continuing problem.

Sincerely,

J. Clifford Stone
Secretary
Chiniak Advisory
School Board

Jan 22-80

Mr. Zharoff,

I am a concerned parent with a daughter presently going to the Chignik school. It is really a shame to see how run down + overcrowded this school has become. It is a small school + very much needed for our area as we are so far from Kodiak True we are on a road system but I believe there is also a limit of travel time a child is to be on a school bus. We need this school to eliminate a long hazardous + sometimes impossible drive to Kodiak. It is not unusual for my high school son to be on the road 2 hours + 45 min. a 50 mile trip. As you know the Jet Cargo will be in operation by the end of the year + this will drop at least 20 more school age children in our area. The Chignik elementary school cannot handle the growing amount of students, let alone a whole new group. I know there are native villages much smaller than our area which obtain funds for new schools & I'd sure like to know why we cannot get funds for a new Chignik elementary + high

school. The high school children who live out here now would gladly give up all the big school facilities to be able to attend school closer to home. My son has discussed quitting school just to eliminate that bus ride, & I would say the borough is contributing to lack of education in our case. The borough owns 10 acres the Chinook school presently sets on & that's where we'd like a new school built. If the state has 4½ billion dollars in excess, it would seem a very small thing to ask a new school for Chinook. We pay our taxes just like town & I don't feel we are asking too much to allow our elementary & high school children a decent education at a decent distance from home. Please help us get our school up to date & ready for the future.

Mr & Mrs. William Crowley
Box 2105
Kodiak, AK.
99615

BOX 172
KODIAK, ALASKA 99615
PHONE (907) 486-5725

April 4, 1979

Mr. Ed Grieser
Alaska State Department
of Education
Pouch F
Juneau, Alaska 99801

Dear Mr. Grieser:

I am writing to you concerning Steve Crawley, a student from Chiniak. Steve is a Junior at the high school here who must bus 90+ miles a day round trip to and from school. He would like to enter the Boarding Home Program and board in Kodiak while attending school. He inquired last year and this year and was refused because your office has maintained that an educational program was accessible to him.

It is my contention that the program is not as completely accessible as it should be. Steve must bus for two (2) hours to get to school and leave promptly at 3:30 p m. to bus two (2) hours to go home again. Inclement weather and road conditions tend to increase the busing time, leaves little time to study or for participation in other school activities, such as sports, that are an integral part of the high school's educational program. Therefore, Steve does not have access to the study time or extra-curricular activities that are available to other students at the high school. I feel that his request to be included in the State's Boarding Program is both justifiable and reasonable.

Sincerely,

KODIAK AREA NATIVE ASSOCIATION
Frank R. Peterson, President

Yvonne Zharoff,
JOM Counselor

cc: Dr. John Antonnen, Superintendent of Schools KIBSD
Mr. Wischer, Principal, KIBSD, Kodiak High School
Senator Bob Mulcahy, Juneau
Representative Fred Zharoff, Pouch V, Juneau
Civil Rights Commission
Dr. Marshall Lind, Commissioner, Alaska Department Education
Jane Petrich, Director, KANA Education Department

PE. SONAL

14

STATE OF ALASKA

JAY S. HAMMOND, GOVERNOR

DEPARTMENT OF EDUCATION

DIVISION OF ADMINISTRATIVE SERVICES / POUCH F – STATE OFFICE BUILDING
JUNEAU 99811

April 9, 1979

Dr. John Anttonen, Superintendent
Kodiak Island Borough Schools
P.O. Box 886
Kodiak, Alaska 99615

Dear John:

I received a letter from Yvonne Zharoff of the Kodiak Area Native Association regarding Steve Crawley. We have not received any correspondence from your district regarding Mr. Crawley's participation in the Boarding Home Program.

Since regulations provide an option for parents of students who travel longer than 120 minutes per day, we would have no particular problem with allowing Steve to be in the Boarding Home Program for the next two months providing his parents request it. However, since your district is the recipient of the grant, do you wish this to happen and do you plan to request an amendment to your current program? If so, how much of an increase would you need? Is Steve the only secondary student who travels to Kodiak from Chiniak? It appears he is now riding on existing bus routes at no extra cost.

Please let me know the details of this situation as soon as possible.

Sincerely,

Kenneth C. Grieser

Kenneth C. Grieser
Deputy Director
Management, Law & Finance

cc: Representative Fred Zharoff
Betty Vic Young
Yvonne Zharoff, JOM Counselor

Alaska State Legislature

REPRESENTATIVE
FRED F. ZHAROFF
P.O. Box 405
Kodiak, Alaska 99615
(907) 486-3254

WHILE IN JUNEAU
Pouch V
Juneau, Alaska
99811
(907) 465-4886
465-4951

House of Representatives

April 18, 1979

DISTRICT 14:

Belleflats
Chiniak
Kodiak
Ouzinkie

Crystal A. Ranney
Secretary-Treasurer
Chiniak Advisory School Board
P.O. Box 228
Kodiak, Alaska 99615

Dear Crystal:

Thank you for your letter of April 8, 1979, expressing your concerns about the Chiniak school in relationship to potential growth resulting from the Job Corp. program at the Chiniak tracking station.

I have been in contact with Dr. John Anttonen, Superintendent of Schools, and although monies are going to be very tight this year as far as construction is concerned, I am trying to see what I can do to alleviate any financial problems that the district might have in regards to upgrading and adding on to existing school structures at the Chiniak school. I will be in contact with Dr. Anttonen and request that he advise you of our progress. There are some monies available but they are very limited at this time.

Again, thank you for expressing your concern.

Sincerely,

Fred F. Zharoff

Fred F. Zharoff
District 14 Representative

FFZ:lms

P.S. My first two years of teaching were done out at the Chiniak school and at this time it is one of the most beautiful places to be on the Island. I am very envious of everyone out there for that reason.

Habibi Tufts
chiniak School
Alaska

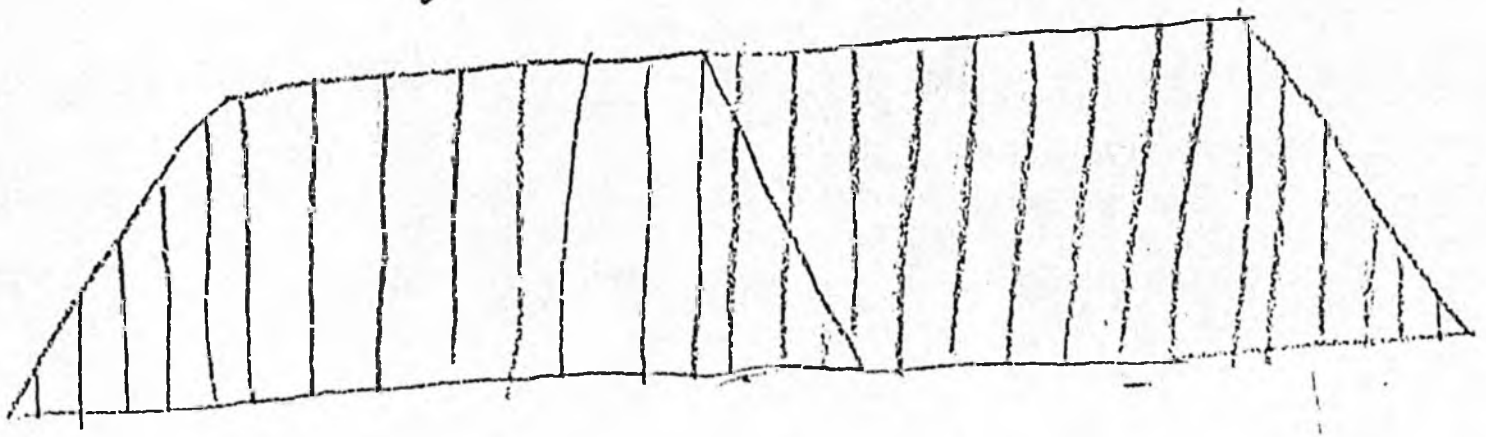
Dear Representative Zharoff

My name is Habibi Tafts and Iam in fourth grade at Chiniak School. Iam writing you This letter because Ifeel That we need a new and Larger School because our building is old, and falling apart. Our library is way to small. We have no clean water and when we have to go to The bath room we have to run out in The cold snow to The outhouse. And when we eat lunch we make a big mess for the Teacher. We dont have room for Games. SO That means we need a new Gym. And when it comes to going to school if is so cold that we have to wear our jackets and work. So What I am Talking about is That we need a new school.

Thank you

from Habibi Tufts

Chiniak Out houses



Berrrrrrrr

Its cold in here

William Earl Pryor
Chiniak School
Alaska

Dear Representative Zharoff,

My name is William and I am a fourth grade student at Chiniak School. I am writing this letter because I feel that we need a new and larger school. We have no clearwater and no lunchroom. And our library is too small and we are all squished in one room. The high school kids ride a bus 50 miles one way on icy road's.

Thank You

Sincerely

William Earl Pryor

THE FOLLOWING DOCUMENT(S) MAY NOT FILM LEGIBLY BECAUSE OF POOR QUALITY OF THE ORIGINAL.

Jacke Lucas
Chinik School
Alaska

Dear Representative Zhoro??
My name is Jacke Lucas I'm
in fourth grade. We need
a new School. because
We have no clean water.
We sometimes we have a
one room School. [illegible] School
bus gose 50 miles one way
on icy roads.

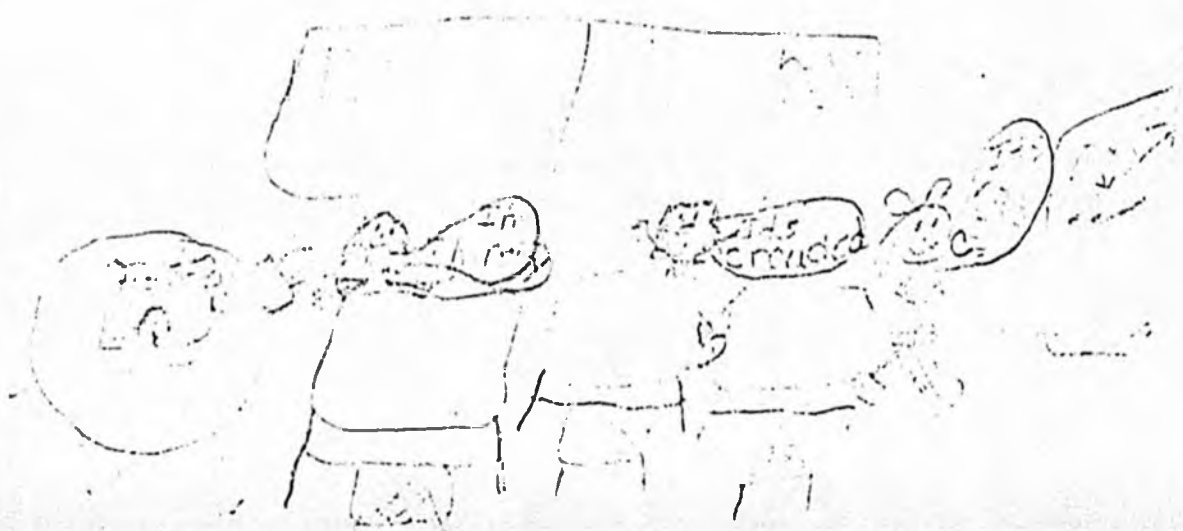
Sincerely,
Jacke Lucas

Jennifer
Chiniak
School
Alaska

Dear Representative Zharoff

My name is Jennifer Lucas I'm in sixth grade. Our school of Chiniak is much too small. We don't have any heat or clean water. And we have to use an out door bath room and it's cold. The library is too small and all the grades are in the same room. The high school kids have to ride a bus 100 miles every day and three years from now we all have to go to a new school.

Sincerely
Jennifer



Tammi Sargent
Chiniak School
Chiniak, Alaska
99615

Dear Representative Fred Zharoff

My name is Tammi and I a
am a second grade student
Chiniak school. I am writing you
this letter because I feel That we
need a new And larger school
Please do all you can
To help us Here is a picture of
our school Thank-you Tammi

Christy Pennington
Chiniak School
Kodiak Alaska

Dear Representative Fred Zharoff,

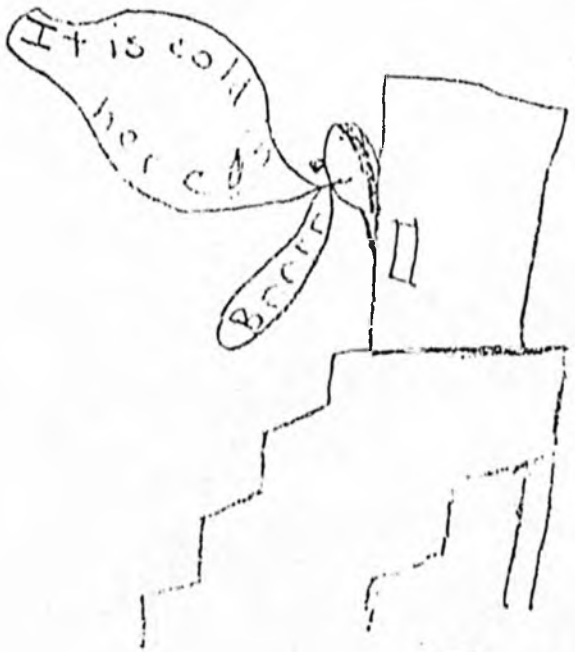
My name is Christy Pennington and I am in fourth grade at Chiniak School. I am writing this letter because I feel we need a new and larger school. Here are all the reasons. First of all we are too crowded and have too many grades in one room. Second of all we have no gym for when it rains, and it rains alot here. We have books strung all over the school because our library is to small. Our library is 1/4 of our school, and our school is only 750 square feet. Also the highschoolers have to ride 100 miles a day on

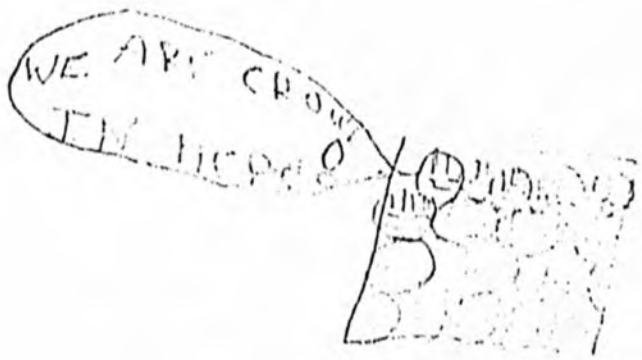
glare ice. Thank you for your time

and cooperation.

Sincerely,

Christy Pennington


It is cold
here
Brrr


WE ARE CROW
IN HERE

Shoghi Tufts
Chiniak School
Chiniak, Alaska
99615

Dear Representative Zharoff,

My Name is Shoghi I'm in fourth
rade. I feel that we need a new school
I ... to crowded. There are to
many grades. The water is very
irty. Too dirty to drink. We ha...
o heat at all. The school is old and
ruky. The library is too small for
ll the books. The high school kids
ave too much to fit. Please help
s get a new school.

Thank you. Sincerely, Shoghi

Danny Harris
chinlak school
Alaska

Dear Representativ Zharoff

my name is danny I am in The 6th grade. And I am writing This letter to you. I really think That we need a new and larger school, were crowded, too crowded. our library is tos small for our books. "no clean water" no play room for rainy days. I am asking you for a new school,

Thank you for your time

sincerely

Danny

Alana McCormick
Chiniak School
Alaska

Dear Representative Zharoff

My name is Alana I'm in fourth grade. We nead a new school because the water is not clean and there is no heat. there are eight grades in one room and the high school bus goes fifty miles one way on icy roads. We have two out houses, and they are very cold.

Sincerely,

Alana

Linda Pennirgton
Chiniak School
alaska

Dear Representative Zharoff.

My name is Linda and I am in third grade There is no clean water And we dont have a lunchroom. So we have to eat at our own desk and all of us are squished in one room. And the high schoolers have to ride 50 miles to town.

please try to get us a new school
Thankyou for your time.

Linda pennington

Todd Schmeil
Chinuk Schoo
Alaska

Dear Representative Zharoff

My name is Todd Schmeil. I am in the 8th grade. I have been going to chinuk School for nine years. We have a very small one room School with 20 students from Kindergarten to 8th grade. We have to haul our drinking water because the tap water is not drinkable. I like Sports but there isn't room and right now our heater is out and it is 10° F outside. I will be going to high School next year and if we don't have a high School in chinuk I will have to ride the bus 100 miles per day.

Sincerly

Todd Schmeil

Melissa Lorne
Chiniak School
Chiniak, AK

Dear Representative Zharoff,

I am a Kodiak high student and I would like a new school.

Thank-You
Melissa

Unalakleet
Alaska
7th Grade

Dear Representative Grange,

I'm in 7th Grade and my name is Shay Lowky and I'm here for 3 years and I'm familiar with the school it is very crowded and, no room to play or have Physical Education which we need a lot for Very talk and wrestling or any other sports. Not only that but when you are in the 7th Grad and you have all grades from K to 8th. You dont like listening to the Kindergarten playing with blocks or yelling and screaming. And when you go to get a drink of water, you have wave self a glass and the Lunch stuff and [illegible]

[illegible]

The high Schools is ready for them. Because my Brother and about 6 other kids have to walk to the school. I'm sorry

And in the winter the roads are really deep and we use the bus jumping and sliding all over the road. All I can say is we all hope to get a new school. Thank you for your time.

Sincerely,
Staff
Nadine

Tyler Schneil
Chiniak School
Alaska

Dear Representative Zharoff

My name is Tyler and I am in fourth grade. We need a new school at Chiniak. Our school has no lunch room. and has no heat. All the kids are in one room. We have no clean water. We are too crowded and we have to use the outhouses.

Sincerely
Tyler Schneil

Billy Ingram
Chinik School
Chinak, Alaska

Dear Representative Zhroff,

I am in the first grade at Chinik School and my name is Billy Please do all you can to help us get a new school

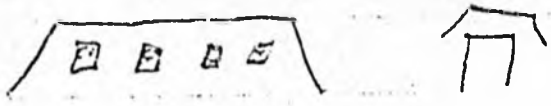
Thank-by

Billy

Misti Ingram
Chiniak School
Chiniak, Alaska
99615

Dear Representative Fred Zharoff

My name is Misti and I am a second grade student at Chiniak school. I am writing you this letter because I feel that we need a new and larger school. Pleased all you can to help us here is a picture of our school.



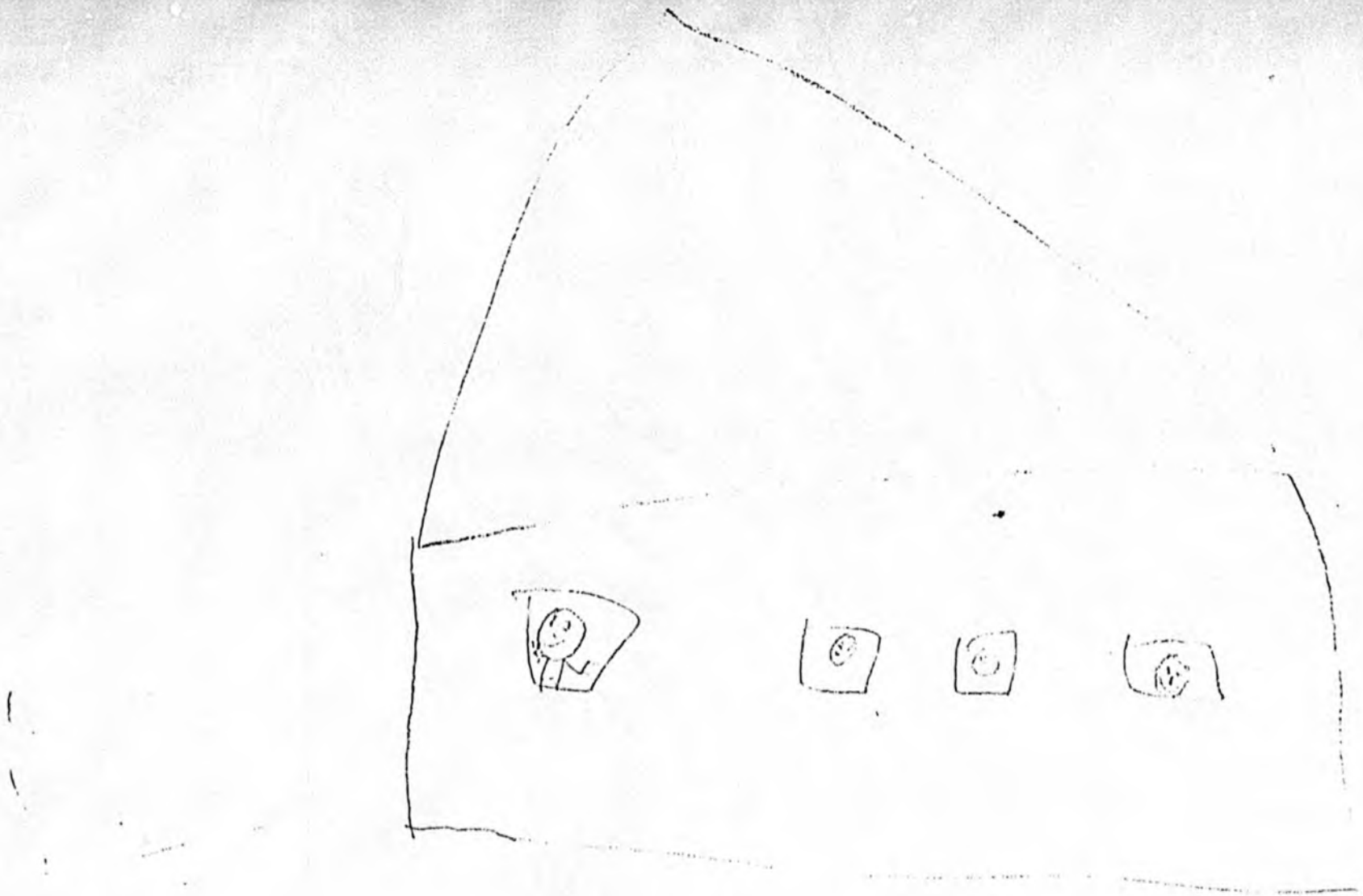
Thank-y
Misti

Jessica St-[illegible]
Chuk School
Chuk Alaska

Dear R[illegible] Yaroff;

We need a new school in
Chuk Please help

Thank-Y[illegible]
J[illegible]

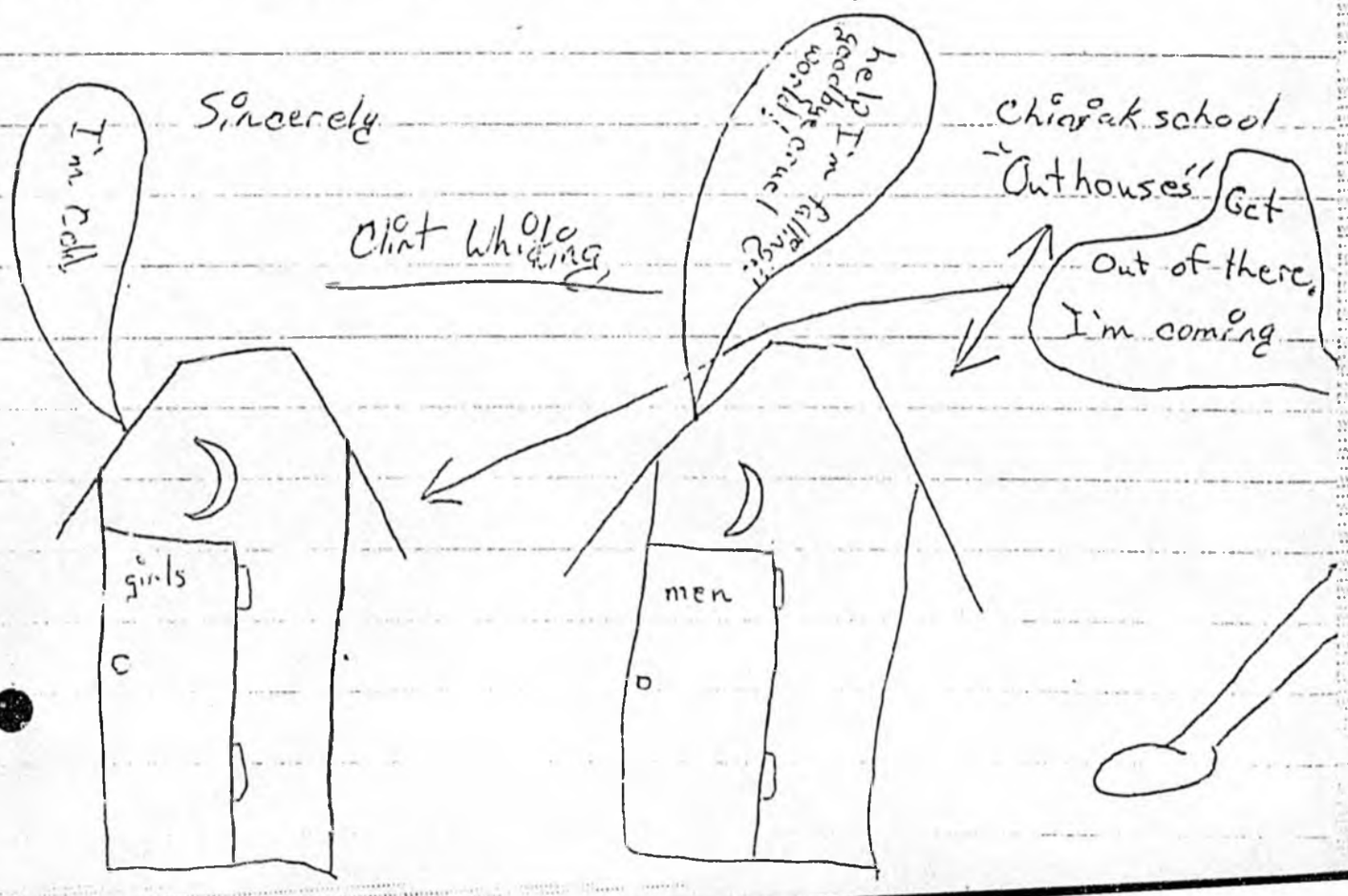


Clint Whiting
Chinick School
6th Grades

dear Representative Zharhoff

My name is Clint Whiting and I am in 6th grades, I have not been in Alaska long, but hope to be in Alaska for a long time.

Our school at Chinick is much to small for 20 kids, we are expecting 20 more next year if 3 cabeons open. I really like football but we don't have enough grass or enough recreation room. We have library, lunchroom, classes through kindergarten - 5th grade. I feel sorry for the high school kids, who have to ride 100 miles to school on icy roads a day.



Troy Schmeil
7th grade
chinlak school
alaska

Dear Representative Zharoff

My name is Troy Schmeil and I am in 7th grade in chinlak School. We have only 75 square feet for 20 kids and were expecting at least 15 more next year. We haven't had clean water for at least two years. We don't have any heat. We have outhouses for bathroom. We also don't have enough library space. When they put the school here 8 years ago. Please try to get us a new school

Sincerely

Troy Schmeil

THE PRECEDING DOCUMENT(S) MAY NOT FILM LEGIBLY BECAUSE OF POOR QUALITY OF THE ORIGINAL.

Alaska State Legislature

REPRESENTATIVE
FRED F. ZHAROFF
P.O. Box 405
Kodiak, Alaska 99615
(907) 486-3254

WHILE IN JUNEAU
Pouch V
Juneau, Alaska
99811
(907) 465-4926
465-4951

House of Representatives

January 25, 1980

DISTRICT 14:

BELLEFLATS
CHINIAK
KODIAK
OUZINKIE

Chiniak School
P.O. Box 886
Kodiak, Alaska 99615

Dear Students:

Thank you for your letters and pictures supporting a new school for Chiniak. I would like to write a letter to each of you, but at the present time I am very busy trying to get legislation together to meet all of the needs of our area. I hope to be able to write each of you a letter as soon as I get all of the busy work out of the way.

I have introduced legislation which, if passed, will provide $3,300,000.00 for construction of a new school at Chiniak. This legislation is House Bill 619. I have included a copy for you in the enclosed folder. House Bill 619 has been referred to the House Health, Education and Social Services Committee with a second referrel to the House Finance Committee. I will use all of your letters and others that I have on file, as testimony when the bills come up for hearing in these committees.

Once again, thank you for your letters and pictures. If you have any other areas of concern, please do not hesitate to write again.

Sincerely yours,

Fred F. Zharoff

Fred F. Zharoff
District 14 Representative

FFZ:lms

Enclosure

Alaska State Legislature

REPRESENTATIVE
FRED F. ZHAROFF
P.O. Box 405
Kodiak, Alaska 99615
(907) 486-3254

WRITE IN JUNEAU
Pouch V
Juneau, Alaska
99811
(907) 465-4926
465-4951

House of Representatives

January 25, 1980

DISTRICT 14:

BELLEFLATS
CHINIAK
KODIAK
OUZINKIE

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P.O. Box 386
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Sincerely yours,

Fred F. Zharoff

Fred F. Zharoff
District 14 Representative

FFZ:lms

Enclosure

northern alaska health resources association, inc.

April 11, 1980

The Honorable Thelma Buchholdt, Chairman
House HESS Committee
Pouch V
Juneau, AK 99811

Dear Representative Buchholdt:

On behalf of Northern Alaska Health Resources Association (NAHRA), I am writing to encourage your support for HB 545, which would amend the child protection laws.

NAHRA's plans recommend prevention and intervention in cases of domestic violence and sexual assault, the development of mental health crisis intervention services, and the development of community mental health programs for children and adolescents.

Since HB 545 would extend the child protection laws to cover mental as well as physical abuse and neglect and would require reporting of such cases whether or not they require medical attention, we feel that passage of HB 545 would work toward improving the health and safety of Alaska's children. By so doing, HB 545 would help to implement NAHRA's plans, which were developed by the citizens of the northern region.

We urge you to join us in supporting HB 545. Please let us know your stance.

Sincerely,

J.B. Carnahan
President

JBC/SEM/rlw

529 5th avenue, suite 8 fairbanks, alaska 99701 telephone (907) 456-2553

northern alaska health resources association, inc.

April 11, 1980

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Sincerely,

J.B. Carnahan
President

JBC/SEM/rlw

529 5th avenue, suite 8 fairbanks, alaska 99701 telephone (907) 456-2553

HB
603

ANCHORAGE COMMUNITY COLLEGE
2533 PROVIDENCE AVENUE • ANCHORAGE, ALASKA 99504 • (907) 263-1200

December 19, 1979

The Honorable Thelma Buchholdt
House of Representatives, State of Alaska
Pouch Y
Juneau, Alaska 99811

Dear Thelma:

Enclosed is the proposal of the Anchorage Community College Women's Center Task Force. We have had excellent participation on the part of those community and campus leaders whom you met, and wherever we have spoken with people in Anchorage about the work of the Task Force, they have expressed enthusiastic support for the proposal.

Please let me know if you want someone to testify before the Finance Committee on this proposal. Members of the Task Force have volunteered to write and/or wire if you think such communications might be in order. We would need your advice on the timing involved, if you think the idea is a good one.

This proposal has been carefully studied by Dr. Ed Biggerstaff, ACC Campus President, and it carries with it his full approval and support. All of us who are involved with administration at ACC are deeply grateful to you for your interest in the needs for a Women's Center, and for your willingness to call these needs to the attention of our House Finance Committee. Please let me know if I may be of help in any way, at any time.

Sincerely,

Mary Hale

Mary Hale, Assistant to the President
Director, Public Services Department

A PROPOSAL

of the

WOMEN's CENTER TASK FORCE

ANCHORAGE COMMUNITY COLLEGE

December, 1979

Members of the Task Force: Mary Hale, Chairman pro tem, Anita Robinson, Thelma Buchholdt, Sharon Moore, Toni Jones, Ilene Sackett, Lisa Rudd, Jewell Jones, Helen Fisher, Helen Roberts, Midge Clouse, Sharon White, Carol Nolfi, Marge Fowler, Barbara Zickuhr, Joan Haig, Luz McDade, Elaine Ramos Abraham, Eleanor Bolesta, Rena Mulcahy, Deeta Lonergan, Mim Carlson, and Sanna Green.

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INTRODUCTION

For the past two years, a Women's Committee has served in an advisory capacity to the Campus President of Anchorage Community College, pointing up pertinent problems and providing assessments of crucial needs for additional programming and services for women on our campus. Upon the request of a number of women from the community at large, as well as the urging of staff, faculty, students and the Campus President at ACC, a Task Force was formed in the fall of 1979 to set forth plans for a Women's Center which would provide both programs and services needed by women of the Anchorage community, with a target date for beginning operation of July 1, 1980. The following proposal is the result of their planning efforts.

Funding for an adequate women's program has held top priority among administrators at ACC for the third year in a row. But due to less than maintenance budgeting and the moratorium that was placed on all new programming, no real progress has been made in meeting the special needs of women at ACC. The FY 81 budget, which goes into effect on July 1 of 1980, was submitted without a funding request for women's programs some eleven months prior to this date. We therefore respectfully request consideration of the attached budget as an addition to the regularly submitted budget from the University of Alaska.

Administration of the Women's Center is the responsibility of the Public Services Department of Anchorage Community College, directed by Mary Hale, Assistant to the Campus President. Physical facilities for this program have been reserved in the Campus Center, with the north lounge area designated for use of Center personnel and clientele. This particular area is most convenient to both campuses and is easily locatable by community people who enter through the south door to the Campus Center. The Food Service and other service areas within the Campus Center are conveniently close at hand.

The Master Plan for ACC, written last year with the help of ninety community leaders from every area of our Anchorage, calls for expanded services and classes for women. The Community Needs Assessment report, also published in 1978, highlights requests for increased number of classes for women during the early morning and evening hours. All planning and research at ACC has pointed up the need for a Women's Center, especially during the past three years, as our enrollment figures have underlined this need in their ever-growing margin of women students over the number of men now studying at ACC. For example, in 1978 women numbered 4,501, with 3,427 the count for men. This fall, based on statistics released as of November 26, 1979, the total number of students at ACC stands at 8.279 of which 4,959 are women and 3,320 are men. As the numbers of women students increase, needs for a special service center are growing and will continue to expand.

In last year's student newspaper, one student described the ACC campus as "the loneliest place in the world for a woman." We would like to change that scene in a number of ways: to help students feel welcome, non-threatened, with help available from professionals who can assist them with adequate testing, career counseling, academic advisement, tutorial support as needed, with information about other opportunities for women in Anchorage, and with child care referral help. We want to provide

A special appropriation of 138,000 for the Women's Center at the Anchorage Community College to

Introduction continued

opportunities for women to realize their full potential, to do the "catching up" which years of working only in the home have made necessary, to be able to gain in their job situations upward mobility which is now not usually possible, to be able to pursue that educational interest which will be enriching and fulfilling. We sincerely believe that a Women's Center, as described here, given adequate funding and astute administration with capable, sympathetic personnel, will accomplish these goals. We solicit your support for our purposes, which are:

A. To provide comprehensive educational programs for and about women, both on campus and in outreach locations within the Anchorage Community, and

B. To establish, maintain and coordinate services for women, such as financial aids, tutoring, testing, counseling, career advisement, referrals and placement.

OUR TARGET POPULATION

It is important to emphasize that the ACC Women's Center is planned not to duplicate services already available to women at the Alaska Women's Resource Center and at the YMCA, as well as in several churches and through at least one or more of our service clubs. Instead, the Center is considered as a source of services and specialized training not now available for all women in the Anchorage area. Coordination of programming with other local agencies is a requisite for the planning at ACC, and it is hoped that a number of workshops and conferences can be undertaken jointly with groups that are dedicated to serving women.

In the survey of homemakers just completed for the Alaska Commission on the Status of Women, one striking statistic is worthy of an underline: seventy-one per cent of the homemakers not now attending classes are interested in doing so! With so many thousands of Anchorage citizens already planning for their continuing education, the challenge is tremendous and the timing is now for establishing both programs and services which will serve well the needs of these women. The almost unanimous response of the homemakers surveyed to a question about how they would do things differently with their lives involved establishing a career earlier in life or having gone further with their education before marriage. By far the majority of these homemakers are interested in re-entry into education for the purpose of becoming trained for gainful employment.

There are also thousands of women who are already among the working population who are seeking additional education not just in order to advance along the job trail, but primarily for enrichment purposes. The ACC Educational Needs Survey of Federal Employees, made in August of 1979, reveals that 91.7% of employees responding indicated they wished to continue their education. 49.5% of these were women, giving as their reasons for seeking more education and training "to upgrade skills and move to more responsible jobs"(57%) and "to learn new skills and hopefully change occupations"(23.4%). Continuing, lifelong learning is one of the exciting ever-more-popular interests being developed by women of all ages, everywhere.

Our Target Population continued

While we know we cannot be all things to all women, we certainly hope to serve a variety of needs through the services and programs of the Center. We are aware of a great need for a professionally-done needs assessment among the women of Anchorage, after which the broad purposes of the Women's Center can certainly be modified to reflect more specific target populations, but until such time as we are aware of such needs for specialization, the Center would be administered to meet its two main, broad objectives as stated. Our target population is in fact the women of the Anchorage community.

PROGRAMS

Among others to be offered on the basis of proven need, here are suggestions of workshops, courses both for credit and non-credit, support programs and conferences which have been requested of the Women's Center:

Workshops

Time Management
Resume Writing and Job Interviews
Financial Opportunities in Anchorage
Career Opportunities in Non-Traditional Fields
Basic Life Skills

Courses

Suddenly Single
Oral History: Alaskan Women
Women and the Law of Alaska
Movement Therapy
Assertiveness Training
Women's Sexuality
Minority Women in Alaska
Child Care and Parenting
Health Care during Pregnancy
Women and Technology
Women in Science
Women in Politics: the Use of Power
Women in Literature
The Women of History
Anthropology's Story of Woman

Support Programs

Consciousness Raising
Career Counseling
Parenting
Study Skills
Coping with Child Care Needs in Anchorage
Handling LOSS(loss of someone special)

Conferences

On Re-entry: Job-related and Educational
Women in Science and Technology
Women Alone
How Women Can Advance in Employment
Parenting
Re-directed Homemakers

One major conference is planned annually, with outstanding Alaskan women as speakers and participants.

PERSONNEL

One full-time coordinator

One full-time administrative assistant

One half-time accounts clerk

Two assigned counselors (40%) from the ACC Counseling Center

One assigned counselor from the Educational Opportunities Center

Three part-time peer counselors to be trained by the ACC Counseling Center personnel, and specifically assigned to work with minority groups in the community, primarily in off-campus locations.

QUALIFICATIONS

Required: Baccalaureate degree

Paid or volunteer work experience in women's programs and/or organizations.

Supervisory work experience to include organizing, planning, budgeting, and implementing broad-aspect programs.

Preferred: Work/teaching experience in a post-secondary educational institution.

Formal training and/or work experience in individual advising and group process.

Master's Degree

GENERAL RESPONSIBILITIES

The Women's Center Coordinator is responsible for organizing, planning and implementing programs and services helpful to women on campus as well as in the community. In addition, the Coordinator performs such other tasks as may be required to accomplish institutional goals and objectives through the following specific responsibilities:

1. Reaching women in the community through presentations, workshops and publications, plus coordinating at least one annual conference;

2. Organizing and facilitating educational programs in conjunction with appropriate ACC departments with special attention to the needs of ethnic women;

3. Advising the Student Services personnel, faculty and staff regarding the special needs of women in such matters as orientation. admission, and financial aid;

4. Assisting the Learning Resources Center in establishing a specialized library for women;

5. Providing information about child care availability;

6. Assuming responsibility for development and management of the Women's Center, including the hiring and supervising of personnel;

7. Serving as an information officer for programs and services available to women in Anchorage;

8. Facilitating re-entry for returning women students;

9. Serving as an ex-officio member of advisory committees to women's programs;

Job Description continued

10. Developing faculty and staff in-service training on sex stereotyping;

11. Obtaining grant monies to enhance the opportunities for women at ACC;

12. Attending conferences on women's programs and services as approved;

13. Performing other duties related to the Women's Center and programs as assigned by the Director of Public Services or by the Campus President of ACC.

Proposed Salary	$25,812.00	base
	$ 5,704.45	benefits (22.1%)
	$ 1,806.84	COLA (7%)
TOTAL	$33,323.29	

QUALIFICATIONS

Required: A. A. degree or equivalent

Three to five years' general office experience, with one or more in a people-oriented environment.

Typing 50 wpm, ability to organize and maintain filing system, e telephone manner, ability to manage office with little supervis

Above-average public relations skills, including excellent wri en and verbal communications skills.

Preferred: Baccalaureate degree

Familiarity with community college system.

Familiarity with women's programs and organizations in Anchorage.

GENERAL RESPONSIBILITIES

1. Serving as receptionist, this person will be the initial contact for all people coming to and calling the Center, directing inquiries to the proper channels and disseminating information as needed.

2. Managing routine office work, assisting in writing reports, ordering supplies, handling correspondence.

3. Organizing and maintaining filing system, including library materials; working with the Learning Resources Center to establish a resource library for women.

4. Responsible for various duties as assigned by the Coordinator, in addition to managing day-to-day office functions.

JOB DESCRIPTION ACCOUNTS CLERK III (HALF-TIME POSITION)

QUALIFICATIONS

Required: High school graduation or the equivalent. Three-years' clerical accounts experience. Appropriate education beyond the high school level may be substituted for two years of the required experience. Knowledge of modern office practices, accounting procedures and business machines. Ability to work with little or no supervision, perform all accounting functions for the office efficiently and accurately; work with others in reconciling and correcting accounts.

Preferred: Two years' college; bookkeeping and accounting experience beyond the minimum requirements.

GENERAL RESPONSIBILITIES

1. Keeps all soft ledgers for the office.
2. Performs all Cost Center Clerk duties.
3. Orders all materials, processes purchase requisitions, check requests and other financial paperwork.
4. Maintains and checks financial records with status reports, and reports any irregularities.
5. Processes time sheets, receives and distributes checks.
6. Compiles fiscal reports for funding sources, keeps records of same.
7. Processes employee appointment proposals.
8. Performs other related duties as assigned.

SALARY

Grade 10 -	(half time)	$7,550.40
	staff benefits	$1,668.64
	COLA	$ 528.53
		$9,747.57

BUDGET

Personnel

Coordinator		Salary	$25,812.00
		Fringe	$ 5,704.45
		COLA	$ 1,806.84
	TOTAL		$33,323.29
Administrative Assistant I		Salary	$16,764.80
		Fringe	$ 3,705.02
		COLA	$ 1,173.54
	TOTAL		$21,643.36
Accounts Clerk III		Salary	$ 7,550.40
		Fringe	$ 1,668.64
		COLA	$ 528.53
	TOTAL		$9,747.57
Counselors from ACC (40% of two)		Salary	$26,000.00
Part-time peer counselors 18 hours weekly for 50 weeks		Salary	$21,600.00
		Fringe	$ 1,706.00
	TOTAL		$23,306.40

BUDGET

Contractual

Professional fees and services (speakers for conferences, etc.)		$2,600.00
Honoraria		$1,000.00
Rentals (Films, etc.)		$ 500.00
Duplicating		$1,000.00
Printing		$2,370.00
Postage (including freight)		$ 559.88
Advertising and Publicity		$4,800.00
	TOTAL	$12,829.88

BUDGET

Commodities

Stationery and office supplies	$1,096.45
Educational and instructional supplies	$271.59
Periodical subscriptions, books and tapes	$750.00
Other (including coffee for forums)	$337.50
Tables 4 @ $99	$396.00
TOTAL	$2,851.54

BUDGET

Equipment

Item	Quantity	Unit Price	Total
Pedestal desks, 30x60	2	$325.92	$651.84
Typewriter attachments for desks	2	$178.81	$357.62
Desk chairs	2	$144.42	$288.84
File cabinets, 2-drawer with locks	2	$138.17	$276.34
Typewriters, IBM Selectric with correcting ribbon	2	$830.00	$1660.00
Calculator, Victor 100	1	$140.00	$140.00
Table, 30x60, with folding legs	1	$170.00	$170.00
Side chairs, pedestal base	6	$155.76	$934.56
Couches	2	$250.00	$500.00
		TOTAL	$4,979.20

BUDGET

Personnel		$114,020.62
Travel		$ 3,000.00
Contractual Services		$ 12,829.00
Commodities		$ 2,851.54
Equipment		$ 4,979.20
	TOTAL	$137,681.24

alaska
women's
resource
center

P.O.BOX 188
ANCHORAGE, ALASKA 99510
PHONE (907)276-3528

December 17, 1979

TO WHOM IT MAY CONCERN:

The Alaska Women's Resource Center supports the concept of a Campus Women's Center at the Anchorage Community College. Staff members from the Alaska Women's Resource Center have participated in the planning of such a Center and would use it in the Information and Referral Program whenever possible.

At our Center, in trying to help women in the Displaced Homemaker's Program, it is found that most of these women do not have adequate educational background to apply for the jobs that are available. The Center would support efforts to counsel women to obtain this needed education, and to encourage the supportative services to remain in school.

Sincerely,

Helen Fisher, Director

JAY S. HAMMOND
GOVERNOR

PHONE
(907) 276-3003

STATE OF ALASKA
OFFICE OF THE GOVERNOR

ALASKA COMMISSION ON THE STATUS OF WOMEN
338 DENALI STREET, SUITE 850
ANCHORAGE, ALASKA 99501

December 18, 1979

To Whom It May Concern:

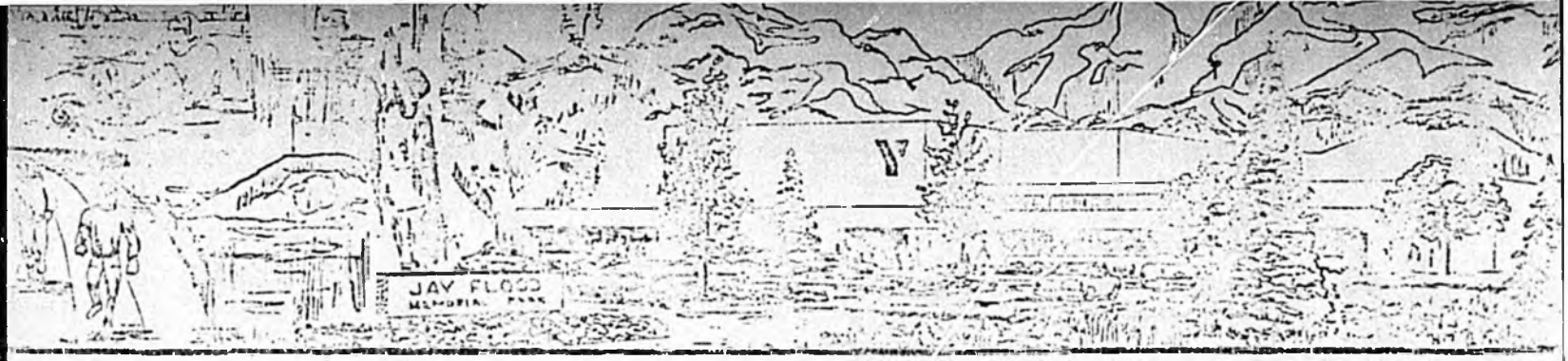
Women at Anchorage Community College have for several years been working as volunteers in an effort to establish a campus women's center. At several organizing meetings which I have attended in the past such needs as educational counseling, rap and reading rooms, skill-building classes, childcare, and roommate exchanges have been listed as prime needs of campus women.

Because each year campus women again express some combination of these needs as primary, I am pleased to see that the College has responded with a proposed program. I strongly recommend that it be given serious consideration, since it will provide a needed community service.

Sincerely yours,

Lynne Woods

Lynne Woods
Executive Director



December 17,1979

To Whom It May Concern:

As an Alaskan resident and working professional woman, I would like to extend my suppor' for the "Women's Center " proposal. I have worked with many groups of women in my profession and agree with the proposed programs and services the "Women's Center" can offer

I am willing to discuss my thoughts and comments written above at any time.

Sincerely,

Claudia Bieber
Anchorage Community YMCA

Anchorage Community YMCA / 5333 Lake Otis Pkwy / Anchorage, Alaska 99507 (907) 344-0506
at Jay Flood Memorial Park

HB
609

THE LEGISLATURE OF THE STATE OF ALASKA
ELEVENTH LEGISLATURE

FISCAL NOTE

I. REQUEST

Bill/Resolution No. H. B. 609

Title Amending the Formula for Property Tax Equivalency Payments for Senior Citizens

Requested by Rules Committee (Interim Committee on Services to the Elderly) Date 1-25-80

II. FISCAL DETAIL

Agency Affected Department of Community & Regional Affairs

Program Category Affected Social Services

Budget Request Unit(s) Affected Senior Citizen Property Tax Exemption

EXPENDITURES (Thousands of Dollars)

	FY 79	FY 80	FY 81	FY 82	FY 83	FY 84
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL						
400 COMMODITIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC.			158,000	177,000	198,000	212,000
TOTAL		0	158,000	177,000	198,000	212,000

FUNDING (Thousands of Dollars)

GENERAL FUND		0	158,000	177,000	198,000	212,000
FEDERAL FUNDS						
OTHER (Specify)						

POSITIONS

FULL TIME						
PART TIME						
TEMPORARY						

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

Assume 12% increase in program through FY 83 and 7% increase thereafter.

The bill effectively doubles payment to program beneficiaries and removes the $375 limit on each payment. Assume that grant requirement will double. No fiscal impact to administration.

In line 14, mil should be spelled mill.

IV. DATE 1-25-80 PREPARED BY LaDonna Brown LaDonna Brown

AGENCY Local Government Assistance

PHONE 465-4739

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)

33-001 (Rev. 10/78)

STATE OF ALASKA

Inter-Department Route Slip

TO:
MAIL STATION NUMBER 3100

DEPARTMENT Alaska State Legislature

ATTENTION Representative Thelma Buckholdt

☐ Approval	☐ Note & Return
☐ Signature	☐ Initial & Return
☐ Comment	☐ Return As Requested
☐ Contact Me	☐ Return For Approval
☐ Prepare Reply	☐ Necessary Action
☐ For Your File	☐ Your Information

Remarks:

FROM:
MAIL STATION NUMBER 2100

DEPARTMENT Community & Regional Affairs

BY Lee M Anderson/sdo DATE 3-28-80

02-002 (REV.10/73)

STATE OF ALASKA

JAY S. HAMMOND, Governor

DEPT. OF COMMUNITY & REGIONAL AFFAIRS

OFFICE OF THE COMMISSIONER / POUCH B—JUNEAU 99801

March 28, 1980

The Honorable Thelma Buchholdt, Chairman
Health, Education, & Social Services Committee
Alaska State House of Representatives
Pouch V
Juneau, Alaska 99811

Dear Representative Buchholdt:

RE: COMPANION BILLS SB 324 and HB 609 AMENDING THE FORMULA FOR THE SENIOR CITIZEN RENTER'S PROPERTY TAX EQUIVALENCY PAYMENT

The Department supports the conceptual formula which increases payment to Senior Citizen renters, as the increased payment will be more equitable with exemptions currently received by Senior Citizen homeowners.

However, as you consider this legislation, there are areas of concern we would like to bring to your attention. It is felt that, with your guidance, these concerns will not be compounded by the passage of this legislation.

The Department's concerns which we ask to be addressed are as follows:

A. ASHA & HUD Owned Housing: These housing projects are exempt from property taxes and consequently when rents are fixed, there is not a component included for property taxes. There are projects, however, which do make a payment in-lieu of property tax, but this payment is not an ongoing item. A large percentage of applicants in the program, as currently administered, reside in this type of housing.

B. Other Exempt Housing: State or municipal owned and operated facilities are also exempt from property tax. The rental fees for this type of housing, such as the Pioneer Homes, do not include a component for taxes.

Is it the intent of the legislature that Senior Citizens which reside in these types of facilities be eligible for reimbursement?

In addition to the types of facilities which should be included, there is also concern regarding the definition of "rent".

The term "rent" includes many items which may or may not be within the scope of intent of the legislature. A few of the items which some landlords include in rent are; utilities, trash collection, and an isolated case of dog-walking.

While a few items encountered in this program border on the absurd, there are some which appear to be unfair. A case in point is a rental fee for a Senior Citizen which includes utilities versus the Senior who pays utilities as a seperate item.

Guidance from the legislature would alleviate the concerns and help promote a more equitable and useful program.

Thank you in advance for your prompt attention to this matter.

Sincerely,

Lee

Lee McAnerney
Commissioner

HB
610

BACKGROUND ON HB 610 - 611/SB 326 -327: $1 million to Office on Aging

HB 610 is the appropriation bill, HB 611 is the authorization bill. The amount of the appropriation is $1 million. The provisions of the authorization bill are as follow:.

* The money goes to the Department of Administration for distribution by the Older Alaskans Commission.

* At least 60% of the money is to be distributed as community program grants. The balance is to be distributed for pilot projects.

- The purposes of the preceeding provisions are: (1) to supplement Older Americans Act federal dollars with state General Fund dollars; (2) to ensure that the majority of the new money goes to programs which have a demonstrated record of service to older Alaskans; (3) to provide a reasoned mechanism for providing funding for either new types of programs or programs in new communities.

* Any sponsor receiving any of these funds is required to make a contribution to the total cost of the project. The formula to be used is identical to one which passed into law last year for cultural facilities. It is an attempt to share the burden among all sponsors so that those with the least ability to provide local support are required to provide the least amount.

* The administrative requirements addressed in the bill are intended to insure program accountability.

* The types of programs which are eligible for funding are essentially those which are presently allowed under the Older Americans Act.

House Health, Education & Social Services Committee — Meeting/Hearing on HB 610 + HB 611 — Date: 2/27/80

	Name	Address and Phone	Organization/Self	For/Against or Observing
2)	1/ Helen Berine			
	2/ ~~Jim Waldo~~			
1)	3/ → or Pat Rodney			
3)	4/ ~~Danny Platnick~~			
	5/ Judy Crandall (administration) just here to listen			
	6/			
	7/			
	8/			
	9/			
	10/			
	11/			
	12/			

POSITION PAPER/Department of Health & Social Services

POSITION PAPER
ON
HOUSE BILL NO. 610
(Identical to Senate Bill #327)

"An Act making a special appropriation to the Department of Administration, Older Alaskans Commission, for programs of benefit to older Alaskans."

House Bill 610 provides for $1 million dollars of state general funds in FY 81 to be appropriated to the Older Alaskans Commission (established by House Bill 618) in the Department of Administration. The additional monies would be utilized to provide grants for service programs of benefit to older Alaskans. The scope and design of these programs is elaborated in House Bill 611.

The Department of Health and Social Services recognizes that there are many services and programs needed by seniors that are currently not routinely provided at an adequate level by any public or private source. House Bill 610 would help to bridge that gap by providing funds for pilot projects to aid seniors and for expanded community grants.

The pilot project funds could be utilized to develop innovative programs that in the long run have a potential of cost-savings to the State and could be designed in such a way to fit the needs of Alaskan seniors. Such projects might be in the areas of home nursing, group homes or residential care as alternatives to costly institutionalization. Some funds might be earmarked for pilot projects to aid the quality of life for seniors. These might include low-cost denture program, training programs for those persons providing services to seniors (such as counselors) and other purposes.

The bill and its companion H.B. 611 would provide for increased community project grants. These funds could be used to cover rising costs of doing business by local senior centers to broaden the scope of existing senior center programs or to expand service into areas that are presently not served by any local program. We support the bill's requirement that sponsors receiving grants provide matching cash or in-kind funds based on ability to pay, as a condition to receiving the state grant funds.

The Department of Health and Social Services endorse the concept of providing for the ever increasing service needs of our seniors that cannot be supported by existing Aging funds. We would also like to refer the Committee to the Department's position paper on H.B. 618 - the creation of Older Alaskans Commission - and reconfirm our position that we do not believe it appropriate for the Commission to handle day-to-day grant management functions such as those anticipated by H.B. 610 and H.B. 611.

Approved by: Helen D. Beirne 2-26-80

Helen D. Beirne, Commissioner (DATE)
Department of Health and Social Services

FISCAL NOTE

I. REQUEST

Bill/Resolution No. House Bill No. 610

Title Spec. Appro. to Dept of Admin., Older Alaskans Comm. for prog. of benefit to older

Requested by _____ Date _____ Alaskans.

II. FISCAL DETAIL

Agency Affected Department of Health and Social Sevices

Program Category Affected Social and Economic Assistance to the Aged.

BRU, Program, or Subprogram(s) Affected Office on Aging

(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 80	FY 81	FY 82	FY 83	FY 84	FY 85
100 PERSONAL SERVICES	-0-	-0-	-0-	-0-	-0-	-0-
200 TRAVEL	-0-	-0-	-0-	-0-	-0-	-0-
300 CONTRACTUAL	-0-	-0-	-0-	-0-	-0-	-0-
400 COMMODITIES	-0-	-0-	-0-	-0-	-0-	-0-
500 EQUIPMENT	-0-	-0-	-0-	-0-	-0-	-0-
600 LAND & STRUCTURES	-0-	-0-	-0-	-0-	-0-	-0-
700 GRANTS, CLAIMS, ETC.	-0-	-0-	-0-	-0-	-0-	-0-
TOTAL	-0-	-0-	-0-	-0-	-0-	-0-

FUNDING (Thousands of Dollars)

GENERAL FUND	-0-	-0-	-0-	-0-	-0-	-0-
FEDERAL FUNDS	-0-	-0-	-0-	-0-	-0-	-0-
OTHER (Specify Fund Source)	-0-	-0-	-0-	-0-	-0-	-0-

POSITIONS

FULL TIME	-0-	-0-	-0-	-0-	-0-	-0-
PART TIME	-0-	-0-	-0-	-0-	-0-	-0-
TEMPORARY	-0-	-0-	-0-	-0-	-0-	-0-

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)

Prepared by: M.D. Plotnick Date: 2/27/80
XXXXXXXXOffice: on Aging PH: 465-4903
Department of Health & Social Services

33-001 (Rev. 12/79)
Modify by DHSS (11-28-79)

Approval DHSS Mgt. & Bdgt: Mike Oullare Date: 2/27/80

Page ____ of _____

HB
611

SENATE AMENDMENT

By Rodey

To: Authorizing state aid SENATE BILL No. #326

To: Authorizing state aid HOUSE BILL No. #611

PAGE: 5 LINE: 8

ADD: (L) educational activities; and
(N) employment services;

S 70

northern alaska health resources association, inc.

April 11, 1980

The Honorable Thelma Buchholdt, Chairman
House HESS Committee
Pouch V
Juneau, AK 99811

Dear Representative Buchholdt:

On behalf of the Northern Alaska Health Resources Association (NAHRA), I am writing to encourage your support of HB 611, which would authorize State aid for service programs for older Alaskans.

During the past several months, NAHRA has devoted a great deal of effort to planning for long term care services. In particular, we are encouraging the development of nutrition, recreation, information and referral, and home health services. However, none of those programs can be implemented successfully without State assistance.

Community program grants as proposed by HB 611 would allow continued operation of existing senior service programs at a time when federal cutbacks threaten their existence. Seed monies for pilot programs would facilitate start-up of services which might otherwise never develop, especially outside of Anchorage and Fairbanks. Because of these attributes, HB 611 is highly consistent with NAHRA's plans.

We urge your support of HB 611. Please inform us of your position.

Sincerely,

J.B. Carnahan
President

JBC/SEM/rlw

529 5th avenue, suite 8 fairbanks, alaska 99701 telephone (907) 456-2553

POSITION PAPER/Department of Health & Social Services

POSITION PAPER
ON
HOUSE BILL NO. 611

"An Act authorizing state aid for service programs for the benefit of older Alaskans."

House Bill 611 creates a state aid program for providing services to benefit older Alaskans. The program would be administered by the Older Alaskans Commission, (created by House Bill 618). House Bill 611 would provide for grants for pilot projects and community service programs. Each sponsor receiving a grant would be required to provide cash or in-kind match, as a condition of receiving state grant funds. The amount of the sponsor contribution would be based on the community's ability to pay, which is determined by property values and the population planned to be served by the grants. The cost of the grants provided for in H.B. 610 is $1 million dollars in state general funds in FY 81.

The Department of Health and Social Services recognizes that there are many programs and services needed by seniors that are currently not routinely provided by any public or private source. House Bill 610 would help bridge the gap by provided funds for pilot project to experiment on innovative and potential cost-saving ways to provide services to seniors and by providing funds for expanded commu ity service grants.

Potential Discussion Areas

1. With no requirement that the Commission consider geographical diversity of grant awards, it may be possible for the entire appropriation to go to a single area of the state, rather than be distributed equally throughout Alaska.

2. The Department of Health and Social Services prepares extensive needs assessments and state plans, especially in the areas of health and facility construction. It may be useful to include a requirement that the Commission utilize existing state plans and needs assessments in its evaluation of the merits of proposed projects.

3. The multitude of programs eligible for grants may provide a scattergun approach to service needs of seniors, rather than a clearly defined comprehensive look to solve a specific problem. For example, the needs for residential care in the state are great and could easily absorb the entire $1 million dollars appropriation. It may be useful for the bill to include a list of priorities to assist the Commission in its deliberations. Such as, in the first year, a priority might be funding projects that have potential of long run cost effectiveness and provide for increased self-sufficiency of seniors.

POSITION PAPER/Department of Health & Social Services

4. We can foresee that such an extensive grant program that covers a multitude of services will attract alot of interest from many parties. This would require the Commission to process and evaluate many grant applications. These extensive grant reviews and evaluation processes could serve to bog down the Commission. Since it plans to meet only six (6) times a year, necessary coordination of programs and providing advice to state departments may be potentially neglected, as a result.

The Department of Health and Social Services supports the concepts embodied in House Bill 611. We would also like to refer the Committee to the Department's position paper on H.B. 618 - the creation of the Older Alaskans Commission - and reconfirm our position that we do not believe it appropriate for the Commission to handle day-to-day management functions such as those anticipated by House Bill 610 and House Bill 611.

Approved by: Helen D Beirne 2-26-80

Helen D. Beirne, Commissioner
Department of Health and Social Services

(DATE)

FISCAL NOTE

I. REQUEST

Bill/Resolution No. House Bill No. 611

Title Authorizing state aid for service prog. for benefit of older Alaskans.

Requested by _____ Date _____

II. FISCAL DETAIL

Agency Affected Department of Health and Social Sevices

Program Category Affected Social and Economic Assistance to the Aged.

BRU, Program, or Subprogram(s) Affected Office on Aging

(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 80	FY 81	FY 82	FY 83	FY 84	FY 85
100 PERSONAL SERVICES	-0-	-0-	-0-	-0-	-0-	-0-
200 TRAVEL	-0-	-0-	-0-	-0-	-0-	-0-
300 CONTRACTUAL	-0-	-0-	-0-	-0-	-0-	-0-
400 COMMODITIES	-0-	-0-	-0-	-0-	-0-	-0-
500 EQUIPMENT	-0-	-0-	-0-	-0-	-0-	-0-
600 LAND & STRUCTURES	-0-	-0-	-0-	-0-	-0-	-0-
700 GRANTS, CLAIMS, ETC.	-0-	-0-	-0-	-0-	-0-	-0-
TOTAL	-0-	-0-	-0-	-0-	-0-	-0-

FUNDING (Thousands of Dollars)

GENERAL FUND	-0-	-0-	-0-	-0-	-0-	-0-
FEDERAL FUNDS	-0-	-0-	-0-	-0-	-0-	-0-
OTHER (Specify Fund Source)	-0-	-0-	-0-	-0-	-0-	-0-

POSITIONS

FULL TIME	-0-	-0-	-0-	-0-	-0-	-0-
PART TIME	-0-	-0-	-0-	-0-	-0-	-0-
TEMPORARY	-0-	-0-	-0-	-0-	-0-	-0-

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)

Prepared by: M.D. Plotnick Date: 2/27/80
Division/Office: on Aging PH: 465-4903
Department of Health & Social Services

Approval DHSS Mgt. & Bdgt: [signature] Date: 2/27/80

33-001 (Rev. 12/79)
Modify by DHSS (11-28-79)

HB
615

Senior Citizen Motor Vehicle Registration Tax
FY 79 Program

Municipality	No. of Affidavits	$ MVRT	Total No. of Affidavits	Total $ MVRT	% of Total No. of Affidavits	% of Total $ MVRT
Exempt Seniors						
Anchorage, Municipality of	1,256	$25,344				
Ketchikan Gateway Borough	231	4,716				
Petersburg, City of	6	140	1,493	$30,200	49.1%	52.9%
No Tax on Vehicles						
Fairbanks North Star Borough	362	$ 5,683				
Juneau, City & Borough of	196	3,885				
Cordova, City of	37	830				
Craig, City of	1	5				
Eagle, City of	2	80				
Pelican, City of	0	0				
Valdez, City of	7	135				
Wrangell, City of	26	300				
Yakutat, City of	1	10	632	$10,928	20.8%	19.1%
Seniors not Exempt						
Bristol Bay Borough	0	$ 0				
Haines Borough	54	970				
Kenai Peninsula Borough	298	5,131				
Kodiak Island Borough	30	785				
Matanuska-Susitna Borough	312	5,338				
North Slope Borough	0	0				
Sitka, City & Borough of	66	1,335				
Dillingham, City of	8	295				
King Cove, City of	0	0				
Nenana, City of	0	0				
Nome, City of	20	255				
Skagway, City of	14	165				
Unalaska, City of	0	0	802	$14,274	26.4%	25.0%
Non-Reimbursable						
(Outside Taxing Jurisdictions)	115	$ 1,681	115	$ 1,681	3.7%	3.0%
TOTAL			3,042	$57,083		

DEPARTMENT OF COMMUNITY AND REGIONAL AFFAIRS

TO: Marie Pignalberi
Deputy Commissioner

DATE: April 9, 1980

FILE NO:

THRU: Terry L. Earley
State Assessor

TELEPHONE NO:

FROM: LaDonna Brown
Project Assistant

SUBJECT: HB 615 Senior Citizen Motor Vehicle Property Tax Exemption

The following comments have been prepared in response to the request for information concerning the senior citizen motor vehicle exemption. These comments also address HB 615 which is intended to correct problems within that program.

There are three major problems with the program as it is currently written. The following explain these problems and the solutions advanced by HB 615.

1. The property tax exemption should not be located in Title 28. It is important that all property tax exemptions be located together in Title 29.

Section 3 of HB 615 annuls the unsatisfactory section in Title 28 and places the statute with other mandatory exemptions in Title 29.

2. The current law does not provide for exemption of local property tax levies on vehicles. The exemption is solely for those municipalities that have chosen the option to have their vehicle tax collected by the state. To date, this includes Anchorage, Ketchikan, Matanuska-Susitna, and Petersburg.

Paragraph (j) of HB 615 exempts seniors from property tax on vehicles statewide.

3. There are three kinds of municipalities currently being paid for senior citizen vehicles within their jurisdiction. They are:

A. Those four previously mentioned that are actually exempting senior citizens through the state collection option.

These municipalities are reimbursed for revenue loss under the present law and will also be paid under HB 615.

B. Municipalities that must, under current law, collect property tax from seniors locally. Under the current law the state is paying the municipality for the vehicle and then the senior citizen also must pay the tax.

HB 615 will allow this exemption and reimburse the municipality for revenue loss.

C. Several municipalities do not levy a tax on motor vehicles. Current law pays these municipalities in the absence of revenue loss.

HB 615 allows municipal reimbursement only for revenue loss, so municipalities that do not tax vehicles would not be paid.

HB 615 is currently in the House HESS Committee. The companion bill, SB 319, is in Senate Finance.

THE LEGISLATURE OF THE STATE OF ALASKA
ELEVENTH LEGISLATURE

FISCAL NOTE

I. REQUEST

Bill/Resolution No. H. B. 615

Title An Act Relating to Exemption from Municipal Property Taxation

Requested by Rules Committee (Interim Committee on Services to the Elderly. Date 1-25-80

II. FISCAL DETAIL

Agency Affected Department of Community & Regional Affairs

Program Category Affected Social Services (grant) Development (Administration)

Budget Request Unit(s) Affected Senior Citizen Property Tax Exemption

EXPENDITURES (Thousands of Dollars)

		FY 79	FY 80	FY 81	FY 82	FY 83	FY 84
100	PERSONAL SERVICES						
200	TRAVEL						
300	CONTRACTUAL						
400	COMMODITIES						
500	EQUIPMENT						
600	LAND & STRUCTURES						
700	GRANTS, CLAIMS, ETC.						
	TOTAL	0	0	0	0	0	0

FUNDING (Thousands of Dollars)

GENERAL FUND						
FEDERAL FUNDS						
OTHER (Specify)						

POSITIONS

FULL TIME						
PART TIME						
TEMPORARY						

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

Reduces grant requirement for FY 81 from $150,000 to $120,000. There is no impact to administration.

Present law does not exempt seniors from ad valorem tax on their vehicles, just from state collected registration tax. This bill corrects the present law to exempt seniors from property tax on vehicles, statewide.

Present law pays municipalities that do not tax vehicles. This bill corrects law to only reimburse municipalities for revenue lost. This accounts for the reduced need for revenue to fund the program.

IV. DATE January 25, 1980 PREPARED BY LaDonna Brown LaDonna Brown

AGENCY Local Government Assistance

PHONE 465-4739

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)

33-001 (Rev. 10/78)

inter: House

Attached is proposed legislation for the motor vehicle exemption which the department feels is unacceptable in its present form for the following reasons:

1. The exemption should be located in Title 29 along with other prescribed property tax exemptions. Therefore, Section 3 of the proposed bill annulls the unsatisfactory section in Title 28.

2. The current law does not provide for exemption of local property tax levies on vehicles, only those levied through the state collection option are presently exempted.

Paragraph (j) of the proposed legislation provides exemption regardless of the collection procedure.

3. Three kinds of municipalities are currently being reimbursed:

    1. Those actually exempting seniors through the state collection option;
    2. Those that must, under the current law, collect ad valorem property tax from seniors locally; and
    3. Those that do not tax vehicles at all.

Paragraph (k) of the proposed bill allows reimbursement to municipalities only for revenue lost due to actual exemptions granted.

ELEVENTH LEGISLATURE

FISCAL NOTE

I. REQUEST

Bill/Resolution No. SB 34 / HB 615

Title Motor Vehicle Property Tax Exemption

Requested by Patrick Rodey Date 12/7/79

II. FISCAL DETAIL

Agency Affected Community & Regional Affairs

Program Category Affected Social & Economic Assistance to the Aged

Budget Request Unit(s) Affected Senior Citizen Tax Relief.

EXPENDITURES (Thousands of Dollars)

		FY 79	FY 80	FY 81	FY 82	FY 83	FY 84
100	PERSONAL SERVICES						
200	TRAVEL						
300	CONTRACTUAL						
400	COMMODITIES						
500	EQUIPMENT						
600	LAND & STRUCTURES			Ø			
700	GRANTS, CLAIMS, ETC.			Ø			
	TOTAL						

FUNDING (Thousands of Dollars)

GENERAL FUND			Ø			
FEDERAL FUNDS						
OTHER (Specify)						

POSITIONS

FULL TIME			Ø			
PART TIME			Ø			
TEMPORARY			Ø			

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

The proposal can be expected to reduce the present grant requirement about 20%. There is little or no impact to administration.

IV. DATE 12/7/79 PREPARED BY LaDonna Brown LaDonna Brown

AGENCY State Assessor

PHONE 465-4739

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)

33-001 (Rev. 10/78)

POSITION PAPER/Department of Health and Social Services

POSITION PAPER
Senate Bill No. 319

"An Act relating to an exemption from municipal property taxation; and providing for an effective date."

The Department of Health and Social Services supports the intent of SB 319. The bill in its current form, however, seems to need clarification on two areas:

1) What happens in the case of a married couple? If both are 65 years of age or older, will they be entitled to exemptions on two vehicles?

2) What constitutes residency for purposes of this bill?

This bill will not impact on the Department of Health and Social Services but will impact on the Department of Community and Regional Affairs.

The Department of Health and Social Services recommends that Senate Bill 319 not be passed without revisions to address the above-stated concerns.

Recommended by: Neil M. Faust for
M. D. Plotnick, Coordinator

Date: 1/25/80

Approved by:
Commissioner
Department of Health and
Social Services

Date: 1/25/80

ELEVENTH LEGISLATURE

FISCAL NOTE

REQUEST
Bill/Resolution No. SENATE BILL NO. 319
Title "An Act relating to an exemption from municipal property taxation;..."
Requested by Rules Committee Date 1/15/80

II. FISCAL DETAIL
Agency Affected No impact on Department of Health and Social Services
Program Category Affected
Budget Request Unit(s) Affected

EXPENDITURES (Thousands of Dollars)

		FY 79	FY 80	FY 81	FY 82	FY 83	FY 84
100	PERSONAL SERVICES						
200	TRAVEL						
300	CONTRACTUAL						
400	COMMODITIES						
500	EQUIPMENT						
600	LAND & STRUCTURES						
700	GRANTS, CLAIMS, ETC.						
	TOTAL	0	0	0	0	0	0

For Department of Health and Social Services

FUNDING (Thousands of Dollars)

GENERAL FUND						
FEDERAL FUNDS						
OTHER (Specify)						

POSITIONS

FULL TIME						
PART TIME						
TEMPORARY						

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

No impact on Department of Health and Social Services.

IV. DATE 1/25/80 PREPARED BY Clayton Rowat for M. D. Plotnick Controller
AGENCY Department of Health and Social Services
PHONE 465-4903

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)

Reviewed by Michael Dukes
Director of Mgt + Budget
DHSS 1/25/80

33-001 (Rev. 10/78)

DEPARTMENT OF COMMUNITY & REGIONAL AFFAIRS

Lynn Wegener, Director
Administrative Services Division

June 20, 1979

Thru: Palmer McCarter, Director

LaDonna Brown
Project Assistant
Office of State Assessor

FY 81 Grant Programs
Senior Citizen Property
Tax Exemption

The following estimates of grant requirements for FY 81 were requested by Rebecca Birch, Budget and Management for her use on June 21.

I would appreciate your approval and/or suggestions.

Senior Citizen
Homeowner

Appropriations
FY 79 2,196,700
FY 80 2,535,000

Summary of Program Impact

FY	Number of Applicants	% of Increase	Average Exempt Tax	% of Increase	Total Tax Exempt	% of Increase
73	911		216		$197,050	
74	1,887	107	335	55	631,891	221
75	2,426	29	384	15	930,915	47
77	2,603	7	449	17	1,171,227	26
78	2,909	12	520	16	1,512,983	29
[1]79 approx.	3,109	7	572	10	1,778,242	18
[2]80 estimates	3,512	13	616	8	2,164,194	22
[3]81 projected	3,969	13	702	14	2,786,238	29
Rounded, projected general fund grant required for FY 81 100% funding:					$2,787,000	

1 Program is at least 99% complete
2 95% from municipal estimates less than 5% projected.
3 Rate of increase projected

Senior Citizen
Renter

Appropriations
FY 79 $314,200
FY 80 $200,000

Summary of Program Impact

FY	Number of Applicants	% of Increase	Average Payment Per Applicant	% of Increase	Total Payments	% of Increase
77 Actual	324		55		$17,867.97	
77 Projected Full Year	324		192		62,283.78	
78	538		181		97,142.28	
79	533		178		94,823.55	
*80 Projected	602	13	203	14	122,206	29
*81 Projected	680	13	231	14	157,080	29
Rounded, projected general fund grant required for FY 81 100% funding:					$158,000	

*Projected rate of increase from Homeowner Program

		Appropriations
Senior Citizen	FY 79	201,600
Sewer & Water	FY 80	256,500

Summary of Program Impact

FY	Number of Applicants	Average Deferred Assessment Per Applicant	Deferred Assessment
77	124	867	107,546.50
78	17	909	15,447.72
79 approx.[1]	20	1,658	33,157.81
80 estimates[2]	65 +	2,187	142,165 +
81 estimates[3]	23 +	1,609	37,000 +

It is the opinion of this office that the general fund grant required for FY 81 100% funding is: $150,000

1 Program appears to be complete for the year
2 From municipal estimates, City of Seward also has project of undetermined scope.
3 Most municipalities did not respond to request for estimate this far in the future.

		Appropriations
Senior Citizen	FY 79	$150,000
Motor Vehicle Registration Tax	FY 80	$150,000

	Number of Affidavits	$ MVRT
Payable Affidavits Received January 1 Through June 8, 1979:	2,619	$49,527
23 Weeks ÷ 52 = 44.23%		
$49,527 ÷ 44.23% = Grant required for FY 80		$111,976
Inflation and new program growth increase		50%
Projected general fund grant required for FY 81 100% funding:		$167,964
Rounded		$168,000

LDB:jh

THE LEGISLATURE OF THE STATE OF ALASKA
ELEVENTH LEGISLATURE

FISCAL NOTE

I. REQUEST

Bill/Resolution No. H. B. 615

Title An Act Relating to Exemption from Municipal Property Taxation

Requested by Rules Committee (Interim Committee on Services to the Elderly. Date 1-25-80

II. FISCAL DETAIL

Agency Affected Department of Community & Regional Affairs

Program Category Affected Social Services (grant) Development (Administration)

Budget Request Unit(s) Affected Senior Citizen Property Tax Exemption

EXPENDITURES (Thousands of Dollars)

	FY 79	FY 80	FY 81	FY 82	FY 83	FY 84
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL						
400 COMMODITIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC.						
TOTAL	0	0	0	0	0	0

FUNDING (Thousands of Dollars)

GENERAL FUND						
FEDERAL FUNDS						
OTHER (Specify)						

POSITIONS

FULL TIME						
PART TIME						
TEMPORARY						

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

Reduces grant requirement for FY 81 from $150,000 to $120,000. There is no impact to administration.

Present law does not exempt seniors from ad valorem tax on their vehicles, just from state collected registration tax. This bill corrects the present law to exempt seniors from property tax on vehicles, statewide.

Present law pays municipalities that do not tax vehicles. This bill corrects law to only reimburse municipalities for revenue lost. This accounts for the reduced need for revenue to fund the program.

IV. DATE January 25, 1980 PREPARED BY LaDonna Brown LaDonna Brown

AGENCY Local Government Assistance

PHONE 465-4739

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)

33-001 (Rev. 10/78)

HB

617

POSITION PAPER/Department of Health & Social Services

POSITION PAPER
ON
SENATE BILL NO. 325
(Identical to House Bill #617)

"An Act providing for the issuance of general obligation bonds in the amount of $15,000,000 for the purpose of paying the cost of construction and development of senior citizen housing; and providing for an effective date."

The Department of Health and Social Services, Office on Aging supports the concept included in Senate Bill 325.

Our Office of Aging has found that there is a the need for senior housing. Seniors living on fixed income, from Old Age Assistance or a retirement program, cannot always afford to pay the current high cost of housing in many areas of Alaska. For example, a senior receiving the maximum monthly benefit under Old Age Assistance is eligible for $413 a month. That $413 must cover the costs of housing, fuel, food, transportation, clothing, and other necessities. Seniors report difficulties in making ends meet under such situation. Low cost housing program could serve to supplement their income.

Also, it may be appropriate for some of the housing dollars to be earmarked for residential care housing units as these could serve as an alternative to institutionalization in a nursing home. This could serve to provide care to seniors in the least restrictive setting possible and at a much lower cost.

Recommended by: M Dan Plotnick 1/30/80
M.D. Plotnick, Coordinator (DATE)
Office on Aging

Approved by: Helen D. Beirne 1/30/80
Helen D. Beirne, Commissioner (DATE)
Department of Health and Social Services

FISCAL NOTE

I. REQUEST

Bill/Resolution No. Senate Bill #325

Title Issuance of GOB-$15,000,000-cost of construction & development of senior housing.

Requested by Senate HESS Date 1/30/80

II. FISCAL DETAIL

Agency Affected Department of Health and Social Sevices

Program Category Affected Social Services for Aged

BRU, Program, or Subprogram(s) Affected Office on Aging

(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

		FY 80	FY 81	FY 82	FY 83	FY 84	FY 85
100	PERSONAL SERVICES	-0-	-0-	-0-	-0-	-0-	-0-
200	TRAVEL	-0-	-0-	-0-	-0-	-0-	-0-
300	CONTRACTUAL	-0-	-0-	-0-	-0-	-0-	-0-
400	COMMODITIES	-0-	-0-	-0-	-0-	-0-	-0-
500	EQUIPMENT	-0-	-0-	-0-	-0-	-0-	-0-
600	LAND & STRUCTURES	-0-	-0-	-0-	-0-	-0-	-0-
700	GRANTS, CLAIMS, ETC.	-0-	-0-	-0-	-0-	-0-	-0-
	TOTAL	-0-	-0-	-0-	-0-	-0-	-0-

FUNDING (Thousands of Dollars)

GENERAL FUND	-0-	-0-	-0-	-0-	-0-	-0-
FEDERAL FUNDS	-0-	-0-	-0-	-0-	-0-	-0-
OTHER (Specify Fund Source)	-0-	-0-	-0-	-0-	-0-	-0-

POSITIONS

FULL TIME	-0-	-0-	-0-	-0-	-0-	-0-
PART TIME	-0-	-0-	-0-	-0-	-0-	-0-
TEMPORARY	-0-	-0-	-0-	-0-	-0-	-0-

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

M.D. Plotnick

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)

Prepared by: M.D. Plotnick Date: 1/30/80
Office: Aging PH: 465-4904
Department of Health & Social Services

Approval DHSS Mgt. & Bdgt. Date: 1/30/80

33-001 (Rev. 12/79)
Modify by DHSS (11-8-79)

Introduced: 1/24/80
Referred: Health, Education & Social Services and Finance

BY THE RULES COMMITTEE BY REQUEST OF THE LEGISLATIVE COUNCIL (for the Interim Committee on Services for the Elderly)

IN THE HOUSE

HOUSE BILL NO. 617

IN THE LEGISLATURE OF THE STATE OF ALASKA

ELEVENTH LEGISLATURE - SECOND SESSION

A BILL

For an Act entitled: "An Act providing for the issuance of general obligation bonds in the amount of $15,000,000 for the purpose of paying the cost of construction and development of senior citizen housing; and providing for an effective date."

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

* Section 1. For the purpose of paying the cost of construction, ~~and~~ development, and planning of senior citizen housing, general obligation bonds of the state in the principal amount of not more than $15,000,000 shall be issued and sold. The full faith, credit and resources of the state are pledged to the payment of the principal of and interest and redemption premium, if any, on these bonds. These bonds shall be issued under the provisions of AS 37.15 as those provisions read at the time of issuance.

* Sec. 2. If the issuance of these bonds is authorized by the qualified voters of the state, a special fund of the state to be known as the "1980 Senior Citizen Housing Construction and Development Fund" shall be established, to which shall be credited the proceeds of the sale of the bonds described in sec. 1 of this Act except for the accrued interest and premiums. The amount of $15,000,000 is appropriated from the "1980 Senior Citizen Housing Construction and Development Fund" to the Department of Commerce and Economic Development, Alaska State Housing Authority, to be used for the purpose described in sec. 1 of this Act.

* Sec. 3. If the issuance of these bonds is authorized by the qualified voters of the state, the amount of $53,000 or as much of that amount as is

found necessary is appropriated from the general fund of the state to the state bond committee to carry out the provisions of this Act and to pay expenses incident to the sale and issuance of the bonds authorized in this Act. The amounts expended from the appropriation authorized by this section shall be reimbursed to the general fund from the proceeds of the sale of the bonds authorized by this Act.

* Sec. 4. The question whether the bonds authorized in this Act are to be issued shall be submitted to the qualified voters of the state at the next general election and shall read substantially as follows:

Proposition

State General Obligation Senior Citizen Housing Construction and Development Bonds $15,000,000

Shall the State of Alaska issue its general obligation bonds in the principal amount of not more than $15,000,000 for the purpose of paying the cost of construction and development of senior citizen housing?

Bonds Yes [ ]

Bonds No [ ]

* Sec. 5. This Act takes effect immediately in accordance with AS 01.10.-070(c).

STATE OF ALASKA

JAY S. HAMMOND
GOVERNOR

DEPARTMENT OF COMMERCE &
ECONOMIC DEVELOPMENT

OFFICE OF THE COMMISSIONER

POUCH D — JUNEAU 99811

February 28, 1980

The Honorable Thelma Buchholdt, Chairperson
House Committee on Health, Education and Social Services
Pouch V
Juneau, Alaska 99811

Dear Representative Buchholdt:

The following is in response to a request from the House Health, Education and Social Services Committee for a statement of position from the Alaska State Housing Authority (ASHA) regarding House Bill 617 entitled "An Act providing for the issuance of general obligation bonds in the amount of $15 for the purpose of paying the cost of construction and development of senior citizen housing; and providing for an effective date."

The Alaska State Housing Authority (ASHA) has been quite active in the construction and development of senior citizen housing in Alaska having produced within the last four years 360 units of housing for senior citizens in Anchorage, Fairbanks, Juneau, Ketchikan, Seward and Cordova. It is consistent with ASHA's enabling legislation to receive and administer the $15 million for the further development of senior citizen housing within the state.

The comments which follow should not be construed as opposition to the intent of HB 617 nor to the appropriation of funds to ASHA for the purpose stated. Our comments moreover simply concern the method of allocation of funds and their most efficient utilization for the development of senior citizen housing.

Section 1 of HB 617 authorizes the issuance of $15 million in general obligation bonds for the purpose of paying the cost of construction and development of senior citizen housing. Despite the past history of appropriation of funds to a corollary program of the Department of Community and Regional Affairs for the benefit of senior housing, the issuance of bonds, while consistent with prior actions, seems only to raise the cost of funds to the state and delay the utilization of those funds. The potential of direct appropriation rather than a general obligation bond issue might be considered.

Under Section 2 of HB 617, the provision is made for transfer of the funds from the "Senior Citizen Housing Construction and Development Fund" through the Department of Commerce and Economic Development to the Alaska State Housing Authority. There is a great potential for immediate benefit to the sponsors of elderly housing projects. After consultation with ASHA's bond counsel, we would therefore request the addition of the following

language to expedite the transfer and to more clearly state the intent of the legislation: "The entire sum of $15 million shall be disbursed upon request of the Alaska State Housing Authority after the adoption of regulations governing the use of the funds consistent with the purpose described in Section 1 of this act."

It is ASHA's esperience and our position that one of the most effective uses of the money is that it be used as "seed money" for attracting money available under Federal programs, or that it may be used in the form of direct grants or loans in order to pick up a commonly experienced "short fall" between the monies available for development and construction under federal programs and the actual cost of development and construction in the State of Alaska. Under this "seed money" mode of utilization, ASHA estimates that one state dollar shall attract approximately three to five federal dollars (or more) that might not otherwise be usable in the State of Alaska. Thus, ASHA would envision a program whereby loans and grants to the regional housing authorities or other nonprofit or municipal sponsors may be an appropriate method of utilizing these funds to most advantageously attract federal elderly housing dollars to the state, and address the needs of both the rural and urban communities.

Another issue to be addressed is a clear statement of legislative intent regarding any provisions for repayment. While the bill, on its face, appears to be a straight appropriations bill, questions regarding a requirement that the recipient agency of the funds eventually repay the money to the General Fund have arisen. Additionally, of concern to us is the question of whether the funds can be used to preserve failing projects.

To reiterate then, the appropriation of $15 million to the Alaska State Housing Authority can be utilized by ASHA and other nonprofit sponsors of senior citizen projects to further accommodate the housing needs of low and moderate income senior citizens in the urban and rural areas of the State of Alaska. It is appropriate to fully support the legislation. Subject to the concerns and suggestions stated in this position paper, we look forward to the bill's passage.

Sincerely,

ALASKA STATE HOUSING AUTHORITY

Harry F. Goldbar
Executive Director

By: David C. Creekman

David C. Creekman
Information Officer
Department of Commerce and Economic Development

cc: All House HESS committee members

House Health, Education & Social Services Committee — Meeting/Hearing on HB 617 — Date: 2/28/80

	Name	Address and Phone	Organization/Self	For/Against or Observing
1/	Dove Kull	326-4th Dr Hp 81010 / 586-2670	State Comm on Services to Elderly	for
2/	Marie O. Engberg	Route 3 Box 3851	AARP	for
3/	Mary E. Toof	326-4th St. Apt. 1205 5367 1104	AARP	for
4/	Rev. Mary Parsons	895 W. 12th St 586-1410	AJHA	
5/	A M Bair	P.O. Box 8 Anch 279-7643 99510	ASHA	for
6/	Marie Bigualberi	Pouch B Juno 99811	Community & Regional Affairs	observing
7/	Bronnie Bland	895 W. 12th St. # 214 586 3195	Self	for
8/	Elsie Hollingsworth	895 W. 12th # 311 586 1504	Self	for
9/	Esther Williamson	895 W. 12th # 308 586-1063	Self	for
10/	Ruth L Kallio	895 W 12th # 315 586 1256	Self	for
11/				
12/				
13/				

HB
618

Alaska State Legislature

TELECONFERENCE HEARINGS

DATE: ~~2/18~~ 2/21
LOCATION: Juneau H. HESS
SUBJECT: HB 618

NAME	REPRESENTING	ADDRESS	PHONE	HERE TO OBSERVE	HERE TO TESTIFY
(3) Jerry Gerardy	self				X
(5) Rose Palmquist	Anch Comm. for Senior Citizens	ANCHORAGE			X
(1) George Parker	Igloo 15				X
~~Renee Hoag~~	~~Comm. Senior Cit's Coalition~~				X
(2) Dorothy Sugg	N. Star Council on Aging	FAIRBANKS			X
(4) Loretta Wilhelm	Northern AK Health Resources Ass'n.				X
(6) Kerry Gabbert	OPAG - Exec Dir.				
(7) Florence Dan	Anch Pres of Bd of Dir. for Laverty Sen Cen				
Dennis Murray	Sen Cit. Center	Kodiak		X	

Alaska State Legislature

TELECONFERENCE HEARINGS

DATE: ~~2/18~~ 2/21
LOCATION: Juneau H. HESS
SUBJECT: HB 618

NAME	REPRESENTING	ADDRESS		PHONE	HERE TO OBSERVE	HERE TO TESTIFY
Jerry Gerardy	self					X
Rose Palmquist	Anch Comm. for Senior Citizens		ANCHORAGE			X
George Parkko	Igloo 15					X
Renee Hansey	Mun. Senior Cit. Office					X
Dorothy Sugg	N. Star Council on Aging		FAIRBANKS			X
Loretta Wilhelm	Northern AK Health Resources Ass'n.					X
Dennis Murray	Sen Cit. Center	Kodiak			X	

FISCAL NOTE

I. REQUEST
Bill/Resolution No. H.B. 618
Title: An Act Establishing an Older Alaskan Commission
Requested by _____ Date _____

II. FISCAL DETAIL
Agency Affected ~~Department of Health and Social Services~~ Department of Administration
Program Category Affected Social and Economic Assistance for the Aged
BRU, Program, or Subprogram(s) Affected Office on Aging
(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 80	FY 81	FY 82	FY 83	FY 84	FY 85
100 PERSONAL SERVICES		694.4				
200 TRAVEL		122.3				
300 CONTRACTUAL		158.3				
400 COMMODITIES		7.3				
500 EQUIPMENT		9.8				
600 L. ND & STRUCTURES						
700 GRANTS, CLAIMS, ETC.		5,292.9				
800 MISCELLANEOUS		9.6				
TOTAL		6,294.6				

FUNDING (Thousands of Dollars)

GENERAL FUND		628.9				
FEDERAL FUNDS		5,665.7				
OTHER (Specify Fund Source)						

POSITIONS

FULL TIME		19.0				
PART TIME						
TEMPORARY						

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

Transfer from Department of Health and Social Services to Department of Administration. An addition in cost in the travel component to cover the cost of transportation and perdiem for two more meetings for a total of six meetings of the Commission and an increase in the number of members from seven members to eleven members ($12,000).

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)

Prepared by: _____ Date: 1/29/80
Division/Office: _____ Ph: 465-4980
Department of Health & Social Services

33-001 (Rev. 12/79)
Modify by DHSS (11-28-79)

Approval DHSS Mgt & Bdgt: Michael Quiller Date: 1/29/80

House Health, Education & Social Services Committee — Meeting/Hearing on HB 618 — Date: 1/29/80

	Name	Address and Phone	Organization/Self	For/Against or Observing
1/	Florence Barnhardt	AARP/NRTA Alaska Joint Leg. Concern		
2/	John Mulholland Jr.	Work. DC Leg. Repr. ✓ ✓ ✓ — ✓		
(1) 3/	Bill Hudson		ADM&W	
(2) 4/	Comm Helen Beirne		H&SS	
Didn't want to testify 5/	Bill Cashen	AARP/NRTA		
6/	Mary Carde	✓ 1200 airport Heights Rd Anch-99504	NRTA-AARP Ak State Leg. Cir. Anchorage Mayor's Commission on 45 Retirees, Anch. Comm. for Senior Citizens; O.P.A.G. 3 Chapters N.C.&C-A.P.	
7/	Rose Palmquist			
8/	Lois Odsather	Wasilla - Anchorage	Pioneers of Alaska Grand Igloo, Pioneers of Alaska	concerned
9/	Bob GORE	119 Austin St. Ketchikan AK 99901		
10/	Dave M. Kull	326-4th St. Juneau, Ala 99801	Chairperson Sr. Cits Advisory Board for Juneau City & Borough	For — Members of Sen. & Comm. Services & the Elderly
11/	Lorena Showers	Anchorage NRTA-AARP Alaska Legislative Committee AARP Chapter # 533	Anchorage Mayors Commission National Council Senior Citizens	
W/O TESTIMONY 12/	Al Scott		Sr. Ferguson - Scott	Observing
13/	Lee McAnerney	Commissioner of C+KA		

POSITION PAPER/Department of Health & Social Services

POSITION PAPER
ON
HOUSE BILL NO. 618

"An Act establishing an Older Alaskans Commission; and providing for an effective date."

The Department of Health and Social Services strongly endorses the concept of a Commission to advise in planning and coordinating services for the elderly across all state departments to avoid duplication and service gaps. The Department of Health and Social Services has no objection to the Commission being placed in the Department of Administration if placement is acceptable to the Governor and the Department of Administration. To avoid management problems, though the staff should report to the Commissioner of the Department of Administration, and in turn to the Governor, who can require that recommendations be followed by the respective Commissioners.

The Department of Health and Social Services believes that the most appropriate purpose of that Commission as an initial step would be as an active functioning advisory board to recommend policy and administrative improvements. This Department cannot support at this time the Commission handling day to-day administrative functions, such as grant processing, contracting for services, and standard setting for levels of services.

The Department is also recommending changes to require that the Commission conform to all appropriate state and federal laws pertaining to the privacy and confidentiality of records and persons.

Our specific comments related to the bill are as follows:

Page 4 - Sec. 44.21.230 Powers and Duties (a)(1)-(7)

COMMENT: The Department believes the most appropriate purpose for this Commission is to advise, to recommend, and to inform about services to the elderly, rather than administer. We are also concerned about the executive director serving at the pleasure of a Commission and not reporting to the Commissioner of Administration and in turn to the Governor. We perceive possible management problems.

The following changes are therefore recommended:

Delete (4), (5), and (7).

Page 5 - Sec. 44.21.230 Power and Duties (b)

COMMENT: To bring the function of the Commission in line with our recommendations, the following changes are recommended:

POSITION PAPER/Department of Health & Social Services

Add a new subsection (2) and renumber accordingly:

(2) Request and receive audits from state agencies and local institutions concerned with the conditions and needs of older Alaskans.

(6) DELETE.

(7) Contract for consulting and research services to implement its advisory role. (necessary services)

(10) Recommend (set) standards for services for older Alaskans.

Page 5 - New Section:

We recommend that a new section be added prior to the Sec. 44.21.230 Definitions. That section would recognize that the Commission may have access to all records that are not protected by existing state or federal confidentiality and privacy laws and regulations.

Under Section 4 on bottom of page 5 and top of page 6, "ASSUMPTION OF PROGRAM RESPONSIBILITIES:"

As noted earlier, we do not think it appropriate that the Commission assume the responsibility for all programs, functions, and services now under the Office on Aging. We believe that removal of the Office on Aging at this time from the Department of Health and Social Services would fragment service delivery and hinder the provision of a continuum of care. We consider this to be counter-productive to the best interest of seniors and to the Commissioner's stated goals. Further, the bill is not explicit as to the disposition of current staff (employees) of the Office on Aging and Section 44.21.230(a)(4) pertaining to the employment of an executive director who serves at the pleasure of the Commission.

In conclusion, the Department of Health and Social Services recommends that H.B. 618 not be passed unless to above-stated amendments are included as language of the Act.

Approved by: Helen D. Beirne 1/29/80

Helen D. Beirne, Commissioner (DATE)
Department of Health and Social Services

The State of Alaska has been generous in the provision of services and benefits to its elderly population.

There is the Pioneers' Homes program for those older Alaskans who have lived in the state for longer than 15 years. It serves about 500 persons.

For those older Alaskans who have lived in the state for longer tha 25 years, there is the Alaska Longevity Bonus. This is worth $150 per month for about 7,500 persons.

There is the Property Tax Exemption for seniors who are homeowners, and a Renters' Rebate for seniors who rent. The homeowner program serves about 3,600 persons with an average benefit of $556; the renters' program serves about 1,050 persons with an average benefit of $268.

There is a Senior Housing program which has assisted in the construction of about 300 units of congregate housing with, perhaps, anothe 150 units soon to come on line. There's a Special Assessments program and a Winterization program.

The Office on Aging channels almost $6 million in Older Americans' Act monies into about two dozen local communities throughout the state for the benefit of older Alaskans. There is a Senior Community Employment Program which provides employment opportunities for about 91 persons over the age of 55.

There is a Homemakers program which assists about 350 persons; Medicaid which primarily is spent on about 400 persons in nursing homes; and General Relief Medical, of which seven percent of the budget is spent on the elderly.

For retired state employees and teachers, there is a good pension program. The University of Alaska offers free tuition to older Alaskans. Fish and Game provides free and permanent hunting and fishing licenses. The Marine Highway system offers free travel on the ferries for older Alaskans.

All totalled, in FY '80 the state plans to spend $57,917,156 for benefits and services for approximately 20,000 older Alaskans, half of whom are over the age of 65.

How is the money administered? Who makes the decisions affecting us older Alaskans? At present, we are in the hands of three or four different departments, half a dozen different divisions and at least 24 different program managers.

Why not a single agency - an Older Alaskans Commission to develop a coordinated, comprehensive plan to enhance all these programs? Why not take a step forward in kindness on behalf of the elderly who are frustrated by the fragmentation in the delivery of these services and the poor planning in the development of these benefits? Finding one's way around is exhausting.

And why not include on this commission informed, aggressive men and women over 60 and over 65 as knowledgeable advocates? Let older Alaskans monitor their own programs, not merely recommend.

Why not focus on quality care, standards and economical administration? All of us over 60 years of age have lived through the Great Depression and have learned how to cope. Who knows better than we, what we need?

Why not structure this Older Alaskans Commission to develop a community-based, home-centered network of services and benefits? We need a better delivery system, greater employment opportunities and more biomedical research on the aging process.

The state has been a great help to us, but why not let us help ourselves?

In December of 1979 President Carter stated, "It is very important that we recognize the need for the elderly people to have self-determination."

In November of 1979 Dr. Arthur Fleming (who is in his 70's) of the U.S. Commission on Civil Rights, decried the image of men and women considered "on the shelf" at age 60. He explained that non-involvement in the community and marketplace leads to physical, mental and spiritual deterioration. He predicted that legislation soon will remove all age barriers to employment.

Take advantage of us. Use us. Allow us to help you.

A majority of the 20,000 older Alaskans request our legislators and our governor to grant us self determination and our civil rights by creating an Older Alaskans Commission. Thank you.

Dove M. Kull

Dove M. Kull, M.S.W., A.C.S.W.

POSITION PAPER/HB 618: OLDER ALASKANS COMMISSION - Dove M. Kull, 1/29/80

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There is the Pioneers' Homes program for those older Alaskans who have lived in the state for longer than 15 years.

For those older Alaskans who have lived in the state for longer than 25 years there is the Alaska Longevity Bonus.

There is the Property Tax Exemption for seniors who are homeowners, and a Renters' Rebate for seniors who rent.

There is a Senior Housing program which the voters approved in 1976. There's a Special Assessments program and a Winterization program.

The Office on Aging channels federal dollars into local communities throughout the state for the benefit of older Alaskans. There is a Senior Community Employment program.

There is a Homemakers' program, Medicaid and General Relief Medical. There is a Para-Transit program.

For retired state employees and teachers there is a good pension program. The University of Alaska offers free tuition to older Alaskans. Fish and Game provides free and permanent hunting and fishing licenses. The Marine Highway system offers free travel on the ferries for older Alaskans.

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PROPOSAL: To establish an Older Alaskans Commission under the Office of the Governor.

* The commission would assume responsibility for all programs, functions and services of the Office on Aging and the Governor's Advisory Committee on Aging.

* Powers would include:

1) formulate a comprehensive state plan and annually analyze and evaluate services for older Alaskans;

2) make recommendations to the governor and the legislature;

3) aid in the development of local commissions; and

4) employ an executive director.

* To accomplish its duties, the commission would be able to do a number of things, the most important of which are:

1) review, evaluate and comment upon state programs concerned with the problems and needs of older Alaskans; and

2) set standards for levels of services for older Alaskans for programs administered by the commission.

* The commission would have 11 members: commissioners of Administration, Health & Social Services, and Community & Regional Affairs; the chairman of the Pioneers' Homes Advisory Board; and seven citizens, six of whom must be over the age of 60 and two of whom must be over the age of 65. Appointments would have to assure representation for low-income persons, minorities, urban, rural and geographic areas.

* The enabling legislation would also include a state policy in regard to older Alask

BACKGROUND:

* This commission is being proposed by the State Committee on Services to the Elderly a joint legislators/citizens committee established by the legislature during the 1979 interim. The committee's charge was to "consider the problems and make recommendations regarding improved delivery of benefits and services to elderly Alaskans."

* The assumptions upon which the committee acted are as follows:

1) the state presently provides more than 25 different services and benefits to senior citizens, administered by at least 11 different agencies;

2) the state presently spends over $50 million in General Fund monies for the benefit of approximately 20,000 Alaskans over the age of 60;

3) older Alaskans now facing the disabilities and financial limitations of their retirement years deserve the best the state can provide them; and

4) older Alaskans could perhaps be more conveniently, economically and effectively served by consolidating and coordinating the administration of these various state services and expenditures.

RATIONALE:

* Prior to the development of this proposal, the committee held four public hearings three meetings and two teleconferences. The committee had 96% attendence at the public hearings which drew 238 persons. (See summaries of public hearings for specific comments relating to the commission.)

* The committee has intentionally and continuously involved persons from the affected departments from the beginning of the developmental process, including Administration, Health & Social Services, Community & Regional Affairs, DOT/PF and the Office of the Governor

* The Older Alaskans Commission is intended to be the "single agency" responsible for policy development, planning and coordination of all state-operated services and benefits programs unique to citizens over the age of 60. To be effective in performing its duties - which reach across several departments - the committee believes the commission should be located under the Office of the Governor. To do otherwise would be to invite in-fighting between departments. Is it possible that the commissioner of one department would be happy to "take orders" from the commissioner of another department? The membership of the commission, and its placement, is designed to put everyone on an equal footing.

* Establishment of the commission would enable all departments involved to better coordinate and deliver services and benefits without causing any drastic shifts within the different administrative units. The only change in the staus quo would be the transfer of the Office on Aging from the Department of Health & Social Services to the commission under the Office of the Governor. The committee believes this is necessary for the following reasons:

1) To keep the commission and the Office on Aging separate would be duplicative since many of the functions of both would be identical. The idea is to reduce duplication and fragmentation of effort, not increase it. Older Alaskans want and need a "single agency" to whom to turn for information and assistance. The commission would be the focal pt

2) Including the Office on Aging's programs within the commission, under the Office of the Governor, would effectively remove any stigma of "welfare" which is presently associated with any and all programs within the Department of Health & Social Services.

3) The Department of Health & Social Services has not compiled a good record on programs for the aging. The Office on Aging is consistently given low budget priority, little direct support from the department, and interaction with the advisory committee has been effectively non-existent. If the department had been innovative with the Office on Aging, there would have been no need for our interim committee, much less the commission.

4) With the proposed abolition of the Governor's Advisory Committee on Aging, the commission would, because of the federal requirements of the Older Americans Act, have to have a special relationship with the Office on Aging anyway. In the past, the GACA has had responsibility for determining where and how the Older Americans Act monies are spent; this proposal would continue that practice of allowing citizen participation in the decision-making while enhancing the members' ability to do an effective job.

5) Under this proposal, the commissioner of Health & Social Services would have even greater involvement - as a member of the commission - with the functions of the Office on Aging than ever before.

6) Review of other states' statutes reveals that in those states which have some version of a Commission on Aging (Tennessee, Nebraska, Ohio, Alabama, Iowa, Indiana, Hawaii, California, West Virginia and Georgia), the majority of them are also designated as the state agency on aging.

7) In 1975 a bill similar to the one here proposed was before the legislature (SB 196). That bill would have created a Commission on Aging under the Office of the Governor. At that time, the position of the Department of Health & Social Services, according to the April 10, 1975 position paper signed by Commissioner Francis Williamson was:

> "This office recognizes the needs and desires to attempt to provide for the inclusion into a single new chapter within Alaska statutory law of a comprehensive and coordinated program pertaining to aging... positioning of the Commission on Aging in the Governor's Office will give this Commission visibility that the present Office on Aging lacks... Proposed Amendment 1: change title (from An Act creating the Commission on Aging) to 'Creating the Commission on Aging to replace the Office on Aging and transferring that Office to the Office of the Governor.' Rationale: This would remove the necessity of having two bodies...as the powers and duties of the Commission.., duplicate almost exclusively the work being performed presently by the staff of the Office on Aging."

I. TENNESSEE: (615) 741-2056/ talked to Ass't. Director Charles Durlind
- under the Governor
- * 13 members appointed by the Governor
- * created in 1963
- * policy-making body
- executive director chosen by commission with approval of Governor
- * 34 staff
- * meets 6 x's/year; "aren't rubber stamps"
- * heads of departments sit on commission as ex officio
- * makes recommendations to other agencies
- designated state agency for Older Americans Act
- there also exists an advisory committee; "rediculous" to have both; intend to try to do away with the advisory group; supposed to send me proposed legislation.

II. WEST VIRGINIA: (304) 348-3317/ talked to executive secretary of Executive Director (Marion Martin)
- * designated state agency for Older Americans Act
- * contracts for Title XX
- * heads of department sit on commission as ex officio - "very active; always come, in fact, one of those folks is the chairman of the commission; coordination is beautiful; the communication exists"
- * Executive Director is appointed by the commission
- under the Governor
- * meets four times/year
- * there also exists an advisory committee which is also quite active, but they don't have voting powers
- * suppossed to send 1978 Annual Plan; want me to keep in touch

III. NEBRASKA: (402) 471-2307/ talked with Sam Wareham, Coordinator of Programs
- * advisory; "not all that great"
- * 12 members appointed by the Governor
- * commission hires Executive Director; no final approval by Governor
- * there also exists an advisory committee and an interagency council; "too cumbersome"
- * designated state agency for Older Americans Act
- * under the Governor - "better than being under a department"
- * percent of elderly in Nebraska: 12%

IV. OHIO: (614) 466-5500/ talked to Martin Janis, Executive Director
- * designated state agency for Older Americans Act
- * genesis: started under Department of Mental Health, then became a commission, and next year will become a department
- * Executive Director is appointed by the Governor; has been a member of the cabinet for 13 years
- * 12 members meet once/month
- * there also exists an advisory committee which is responsible for making recommendations regarding OAA allocations; the commission then signs off on those recommendations
- * "the more participation by citizens the better"
- * commission administers, in addition to the OAA, other programs which have been funded to the commission by the legislature
- * commission doesn't run programs in other departments, but is charged with outreach for those programs which effect elderly
- * heads of departments sit on commission as non-voting members; generally send their designees
- * legislation requires all programs having impact on elderly to present new plans to commission

V. ALABAMA: (205) 832-6640/ talked with Frank Eliot, Deputy to Executive Director
* designated state agency for Older Americans Act
* Executive Director appointed by the Governor
* 16 members - advisory on everything but OAA; includes 4 legislators and heads of three departments
* there also exists an advisory committee, "but the commission could do it all"
* there also exists an Interagency Council - "doesn't do anything"
* under the Governor
* percent of elderly: 15%

VI. INDIANA: (317) 232-1190/ didn't get through; supposed to call back
* designated state agency for Older Americans Act

VII. IOWA: (515) 281-5187/ talked with Dr. Adams, Operations Manager
* 7 members and 4 legislators (non voting)
* designated state agency for Older Americans Act
* "policy-making"
* "be sure to clarify duties of Executive Director"
* there also exists an advisory committee which is "a frustration" because they also think they should be policy-making; "would like to gracefully do away with them"
* under the Governor
* policy-making to OAA, advisory to other departments, but "it works" because of good interpersonal interaction
* clout comes from other departments recognizing importance of annual report to the legislature
* is protesting requirement for additional advisory committee; says it is not required in 1978 Amendments to the Older Americans Act

VIII. HAWAII: (808) 548-2593/ talked with Charles Roylo, Grants Manager
* abolished commission in 1977; now is Executive Office on Aging under the Governor
* when they were a commission, heads of departments sat on the commission as ex officio, but it didn't work because they had no function
* appointees were "rubber stamps" for staff
* Executive Director appointed by the Governor
* primarily administers OAA
* supposed to send information to me

IX. GEORGIA: (404) 894-5333/ didn't get through
* designated state agency for Older Americans Act

X. CALIFORNIA: (916) 322-3887/ talked with John Riggle, Executive Director
* California also has a Department on Aging which is the designated state agency
* commission is the advisory committee for the OAA
* principle duty of commission is "principle advocate for older people"
* other duties - advise the Governor, legislature, other departments
* autonomous from the department on aging
* started out under Welfare, but independent
* Executive Director selected by the commission
* Interdepartmental Council on Aging meets regularly with Dep't and Comm.
* "Make sure your commission has staff; and that Executive Director is not administrat
* says there is a federal requirement for an advisory committee as well as commission
* Older Californians Act to be introduced in January
* supposed to send me information

1) Boards and Commissions with similarities to Older Alaskans Commission:

* Governor's Commission on the Administration of Justice - established in 1971, the commission is the state planning agency for a federal program (Criminal Justice Planning Agency). The AG selects the executive director with approval of governor. He may hire additional staff, all of whom are classified. The director is partially exempt. The commission administers $5.6 million, of which @ $400,000 is General Fund. There are about a dozen staff. It is presently in the governor's office, but is being mov into the Department of Law. It requires mandatory representatives from various agencies. (13 members - 7 public & 6 citizens) 44.19.746

* Alaska State Council on the Arts - established in 1966 under the Office of the Governor, members are appointed by the governor with consideration given to recommendatio of various civic groups. The governor designates the chairman and the vice-chairman. The chairman is the chief executive officer of the council. The chairman may employ additional personnel, for example, an executive director. It is the official agency of the state to receive and disburse funds made available through the National Endowment for the Arts. 44.19.900 (11 members - all citizens); receive @ $1 million in G.F.; (Governor @ $700,000 other funds (8 positions) find selects

* Alaska Coastal Policy Council - established in 1977 under the Office of the Governor, it has 16 members, including five commissioners. It has co-chairmen (one - works public and one state official), designated alternates, and uses the staff of DPDP for its own staff. It administers federal funds, develops standards even though the majori are public members. 44.19.891 (mets @ 12 times/yr) works well recommends legislation; good attendance of com. members administers $4.5 million ($200,000 G.F.)

* State Commission for Human Rights - established in 1963, it is a seven-member board appointed by the governor and confirmed by the legislature. The commission selects its own chairman and executive director. The latter must be approved by the governor. It is a $1 million operation with 24 positions. 18.80.010 all citizens

* Commission on the Conference of the Law of the Sea - The commission may hire an executive director without the approval of the governor. 44.19.789; est. 1972; com absorbed by fed

* State Board of Parole - five members appointed by the governor and confirmed by the legislature. The board picks its own executive director who serves at the pleasure of the governor. 33.15.010; under H&SS

* Alaska Commission on Post-secondary Education - established in 1974, the commission selects its own chairman and its own executive director, who serves at its pleasure. 14.40.903

* Alaska Public Broadcasting Commission - established in 1970, the commission selects its own chairman and hires the executive director. 14.58.010; confirmed by leg; regulatory

* Alaska Council on Science and Technology - seven-member council established in 1978, they hire executive director and staff. 44.19.191; all citizen

* Governor's Commission on the Status of Women - established in 1978, this nine-member commission selects its own chairman and hires its own executive director. 44.19.956 can administer federal grants; $150,000 budget

The Office of the Governor appears to have approximately 17 boards under it. 108

SENATE AMENDMENT

By Rodey

To: Older Alaskans Commission SENATE BILL No. #328

To: Older Alaskans Commission HOUSE BILL No. # 618

PAGE: 5 LINE: 29

CHANGE: After ASSUMPTION OF PROGRAM RESPONSIBILITIES: The Office on Aging shall be transferred from the Department of Health and Social Services to the Older Alaskans Commission, Department of Administration.

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ADD:

"The Pioneers' Homes program and the Alaska Longevity Bonus program shall remain under the authority of the ~~Commissioner of~~ Department of Administration."

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To: Older Alaskans Commission SENATE BILL No. # 328

To: Older Alaskans Commission HOUSE BILL No. # 618

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ADD: The governor shall solicit nominations from existing senior citizens' organizations prior to making the appointments.

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By Rodey

To: Older Alaskans Commission SENATE BILL No. #328

To: Older Aalskans Commission HOUSE BILL No. #618

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CHANGE: community-based programs to community-oriented programs

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"The Pioneers' Homes program and the Alaska Longevity Bonus program shall remain under the authority of the Commissioner of the Department of Administration. And these progs. shall not in any way be affected by the provisions of this bill.

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PLEASE NOTE

THE ORGINAL FILE CONTAINS AN OVERSIZED DOCUMENT THAT IS UNSUITABLE FOR FILMING. PLEASE REFER TO THE ALASKA STATE ARCHIVES TO VIEW THE ORIGINAL.

DESCRIPTION; OVERSIZE TABLOID "STATE COMMITTEE ON SERVICES TO THE ELDERLY" 8 PAGES

JANUARY 30,1980, POUCH V, JUNEAU, ALASKA 99811 465-3717

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a) Dept of Adm - appropriate for transfer... If prob w/ [redacted], let's not hide from it by moving to other depts... let's solve prob, throw baby out w/ bath water

b) Diff from Dr. Beine... strongly support Commission & legislation... Point =

3 of 4 Thes amends

SENATE BILL 328

DEPARTMENT OF ADMINISTRATION COMMENTS

General support for concept

A. Endorse efforts to coordinate activities and information dissemination

B. Encourage increased interdepartment work on issue and programs related to aging

C. Support involvement of commissioners for key agencies affecting aging programs

D. Believe commission can provide positive direction

Recommended changes

A. Retain Office of Aging operational function in Department of Health and Social Services

1. To maintain administrative accountability in line to Governor

2. To maintain maximum cohesiveness of funding and planning in relationship to all social and health services program

3. To emphasize the broad review and comprehensive commission role rather than the operational, and

4. To allow experience as a commission to develop in order to determine the advisability of removing the Office of Aging functions to an autonomous commission.

B. Or, the commission could be designed to serve the requirements of the advisory capacity now performed by the Advisory Council on Aging, with Office of Aging remaining in DH&SS.

C. Or, if the Office of Aging is under the commission, then the administrators should have direct line reporting responsibility to the Commissioner of the department into which it is placed.

Detailed comments and suggestions can be provided by Department of Health and Social Services, Department of Administration, and Department of Community and Regional Affairs as changes are studied.

FISCAL NOTE

I. REQUEST
Bill/Resolution No. S.B. 326/ H.B. 618
Title An Act Establishing an Older Alaskans Commission
Requested by Rules Committee Date 1/15 and 24/80

II. FISCAL DETAIL
Agency Affected Administration and Health and Social Services
Program Category Affected Social and Economic Assistance for the Aged
Budget Request Unit(s) Affected

EXPENDITURES (Thousands of Dollars)

		FY80	FY81	FY 82	FY83	FY84	FY 85
100	PERSONAL SERVICES		851.2	946.9	1,041.6	1,145.7	1,260.3
200	TRAVEL		133.8	147.2	161.9	178.1	195.9
300	CONTRACTUAL		169.3	186.2	204.9	225.3	247.9
400	COMMODITIES		9.8	10.8	11.9	13.1	14.4
500	EQUIPMENT		16.3	2.0	2.0	2.0	2.0
600	LAND & STRUCTURES						
700	GRANTS, CLAIMS, ETC.		6,292.9	6,922.2	7,614.4	8,375.9	9,213.4
			9.6	0	0	0	0
	TOTAL		7,482.9	8,215.3	9,036.7	9,940.1	10,933.9

FUNDING (Thousands of Dollars)

GENERAL FUND		1,817.2	2,549.6	3,371.0	4,274.4	5,268.2
FEDERAL FUNDS		5,665.7	5,665.7	5,665.7	5,665.7	5,665.7
OTHER (Specify)						

POSITIONS

FULL TIME		24	24	24	24	24
PART TIME						
TEMPORARY						

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)
The Older Alaskans Commission, which would be established by these bills, would provide statewide coordination for all efforts to provide services to the elderly of Alaska. As written, these bills would bring the Office on Aging into the Department of Administration as an agency directly operated by the Older Alaskans Commission. The Office on Aging is presently a part of the Department of Health and Social Services.

In order to accomplish the duties prescribed under Section 44.21.230, five new positions would be required:

Executive Director	(R24)
Clerk Typist III	(R8)
Accounting Clerk III	(R10)
Research Analyst III	(R18)
Planner IV	(R19)

IV. DATE 2/8/80 PREPARED BY George J. Michael
AGENCY Administration
PHONE 465-4401

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)

33-001 (Rev. 10/78)

Also, included in the above computation of costs is $1,000,000 in grant funds which is proposed for the Older Alaskans Commission by S.B. 327/H.B. 610. It is assumed that these additional grant funds will be handled by the present Office on Aging staff, except for the additional Accounting Clerk which is included above.

The Governor's Advisory Board on Aging would be abolished and replaced by the Commission. Therefore, travel and per diem expense is included in above costing for the 11 member commission, plus the Executive Director and 2 meetings for the Planner.

Inflation is computed at 10% per year for years beyond FY 81. Inflation is included in all categories, including grants, except for one time purchases of equipment items. Items of equipment for years beyond FY 81 are for replacement of worn out office furnishings only.

FY81

Older Alaskans Commission

Office on Aging (19 positions) — $6,282,600

State $616,900

Fed. 5,665,700

Additional staff: Salary and benefits (6 mo. @ 33%) — $156,811

- Executive Director (R24A) $49,822
- Clerk-Typist III (R8A) 17,718
- Accounting Clerk III (R10) 19,853
- Research Analyst III (R18) 33,474
- Planner IV (R19) 35,944

Total S & B. $156,811 — $100,000 (Approx.)

Travel & per diem: — $23,500

Executive Director $3,500

~~Planner~~ Research Analyst 2,000

Commission (11 members) 18,000 (additional cost above Travel for Aging Board) $23,500 — Michaels -

Contractual Services: — $11,000

Telephones $4,500

Postage & mailing 600

Advertising 750

Subscriptions 150

Copier 3,000

Printing & duplicating 2,000

$134,000 TOTAL

Commodities (office supplies)	$ 2,500
Equipment – desks, chairs, bookcases, filing cabinets, work tables, miscellaneous to outfit the five new positions	$ 6,500
~~Additional grants (SB 327 / HB 610)~~	~~$1,000,000~~
Total	$ 7,482,911

	POSITION TITLE				RANGE/STEP	BARG. UNIT.	LOCATION		APPROV.	DIS
1	Executive Director				24A	S	Juneau	GOV		
2	TYPE OF POSITION: PFT	STAFF MONTHS: 12	RP No.	PCN No.	PRIORITY: 1		FORM 12 PAGE/LINE	LEG.		

3	TYPE OF EXPENDITURE	1	2	AMOUNT 3
4	PERSONAL SERVICES: SALARY		40,228	
5	BENEFITS		6,095	
6	FICA		1,975	
7	HEALTH INS.		1,524	
8	TOTAL PERSONAL SERVICES			49,822
9	TRAVEL			3,500
10	CONTRACTUAL			4,200
11	COMMODITIES			500
12	EQUIPMENT			1,500
13	OTHER			
14	TOTAL COST			59,522

	CODE	FUNDING SOURCE	
15		FED RCPTS.	
16		GF MATCH.	
17		GEN. FUND	59,522
18		I-A RCPTS	
19		PGM RCPTS	
20		OTHER	
21	CONTINUATION		
22	ADDITION	X	

FOR B&M USE ONLY

4A KEY NUMBER _____ COLUMN NO. ____

JUSTIFICATION:

S.B. 328/H.B. 618 calls for an executive director to be employed by the Older Alaskans Commission, serving at the pleasure of the commission. The executive director will head the agency which has overall responsibility for coordination of all services to the elderly of Alaska, including but not limited to the following: 1) Review, evaluate and comment upon state programs; 2) Collect facts and statistic and make studies of conditions and problems pertaining to the employment, health, financial security, social welfare and other concerns which bear upon the well being of older Alaskans; 3) Provide information about public programs whic are of interest or benefit to older Alaskans; 4) Appoint special committees, including persons who are not members o the commission, to complete necessary studies; 5) Promote community education efforts; 6) Apply for and accept grants contributions and appropriations, including federal funds; 7) Contract for necessary services; 8) Consult and cooperat with persons, organizations, and groups interested in or concerned with programs of assistance to older Alaskans; 9) Set standards for levels of services for older Alaskans.

AGENCY Administration PROGRAM AREA Social & Economic Assistance for the Aged

BRU Older Alaskans Commission

COMPONENT _____

13 REQUEST FOR NEW POSITION.

REVISED DATE _____

FY 81

	POSITION TITLE				RANGE/STEP	BARG. UNIT	LOCATION		APPROV	DIS
1	Planner IV				19A	G	Juneau	GOV.		
2	TYPE OF POSITION	STAFF MONTHS	RP No.	PCN No.	PRIORITY		FORM 12 PAGE/LINE	LEG.		
	PFT	12			2					

3	TYPE OF EXPENDITURE		AMOUNT
	1	2	3
4	PERSONAL SERVICES: SALARY	28,260	
5	BENEFITS	4,281	
6	FICA	1,879	
7	HEALTH INS.	1,524	
8	TOTAL PERSONAL SERVICES		35,944
9	TRAVEL		2,000
10	CONTRACTUAL		2,500
11	COMMODITIES		500
12	EQUIPMENT		1,000
13	OTHER		
14	TOTAL COST		41,944

	CODE	FUNDING SOURCE	
15		FED RCPTS.	
16		GF MATCH.	
17		GEN. FUND	41,944
18		I-A RCPTS	
19		PGM RCPTS	
20		OTHER	
21	CONTINUATION		
22	ADDITION	XX	

FOR B&M USE ONLY

4A KEY NUMBER _____ COLUMN NO. _____

JUSTIFICATION:

This position is needed to oversee and plan for the orderly review and evaluation of State programs concerned with the problems and needs of older Alaskans, and for making recommendations for improvement in these programs. This position is also instrumental in formulating a State plan, which may increase federal participation in funding services to the elderly. The position will supervise a Research Analyst II in collecting and analyzing facts and statistics which bear upon the well being of older Alaskans.

AGENCY Administration PROGRAM AREA Social & Economic Assistance for the Aged

13 REQUEST FOR NEW POSITION.

BRU Older Alaskans Commission

COMPONENT _____

FY 81

REVISED DATE _____

1	POSITION TITLE Research Analyst III			RANGE/STEP 18A	BARG. UNIT G	LOCATION Juneau	GOV3	APPROV.	DI
2	TYPE OF POSITION PFT	STAFF MONTHS 12	RP No.	PCN No.	PRIORITY 3	FORM 12 PAGE/LINE	LEG		

	TYPE OF EXPENDITURE		AMOUNT
	1	2	3
4	PERSONAL SERVICES: SALARY	26,232	
5	BENEFITS	3,974	
6	FICA	1,744	
7	HEALTH INS.	1,524	
8	TOTAL PERSONAL SERVICES		33,474
9	TRAVEL		-0-
10	CONTRACTUAL		2.000
11	COMMODITIES		500
12	EQUIPMENT		1,000
13	OTHER		
14	TOTAL COST		36,974

	CODE	FUNDING SOURCE	
15		FED RCPTS.	
16		GF MATCH.	
17		GEN FUND	36,974
18		I-A RCPTS.	
19		PGM RCPTS	
20		OTHER	
21	CONTINUATION		
22	ADDITION	XX	

FOR O&M USE ONLY

1A KEY NUMBER _____ COLUMN NO _____

JUSTIFICATION:

This position is needed to compile facts and statistics, a make studies of conditions and problems pertaining to the employment, health, financial security, social welfare, an other concerns which bear upon the well being of older Alaskans. Gathering and analysis of pertinent data is essential to the proper evaluation and informed recommendations about programs affecting older Alaskans.

AGENCY Administration PROGRAM AREA Social & Economic Assistance for the Aged

BRU Older Alaskans Commission

COMPONENT _____

13 REQUEST FOR NEW POSITION

REVISED DATE _____

FY 81

	POSITION TITLE				RANGE/STEP	BARG. UNIT.	LOCATION		APPROV.	DI
1	Clerk Typist III				8A	G	Juneau	GOV		
2	TYPE OF POSITION	STAFF MONTHS	RP No.	PCN No.	PRIORITY		FORM 12 PAGE/LINE	LEG		
	PFT	12			4					

3	TYPE OF EXPENDITURE		AMOUNT
	1	2	3
4	PERSONAL SERVICES: SALARY	13,296	
5	BENEFITS	2,014	
6	FICA	884	
7	HEALTH INS.	1,524	
8	TOTAL PERSONAL SERVICES		17,718
9	TRAVEL		-0-
10	CONTRACTUAL		1,100
11	COMMODITIES		500
12	EQUIPMENT		2,000
13	OTHER		
14	TOTAL COST		21,318

	CODE	FUNDING SOURCE	
15		FED RCPTS	
16		GF MATCH	
17		GEN. FUND	21,318
18		I-A RCPTS	
19		PGM RCPTS	
20		OTHER	
21	CONTINUATION		
22	ADDITION	XX	

FOR B&M USE ONLY

4A KEY NUMBER _____ COLUMN NO. _____

JUSTIFICATION:

This position will serve as support to the Executive Direc and the 11 member Commission. Duties include acting as secretary receptionist, typing, filing, copying, processing travel and per diem claims, recording of Commission meeting making travel and meeting arrangements, etc.

AGENCY Administration PROGRAM AREA Social & Economic Assistance for the Aged

BRU Older Alaskans Commission

COMPONENT _____

13 REQUEST FOR NEW POSITION.

REVISED DATE _____

FY 81

	POSITION TITLE				RANGE/STEP	BARG. UNIT.	LOCATION		APPROV.	DIS.
1	Accounting Clerk III				10A	G	Juneau	GOV		
2	TYPE OF POSITION: PFT	STAFF MONTHS: 12	RP No.	PCN No.	PRIORITY: 5		FORM 12 PAGE/LINE	LEG.		

3	TYPE OF EXPENDITURE		AMOUNT
	1	2	3
4	PERSONAL SERVICES: SALARY	15,048	
5	BENEFITS	2,280	
6	FICA	1,001	
7	HEALTH INS.	1,524	
8	TOTAL PERSONAL SERVICES		19,853
9	TRAVEL		-0-
10	CONTRACTUAL		1,200
11	COMMODITIES		500
12	EQUIPMENT		1,000
13	OTHER		
14	TOTAL COST		22,553

	CODE	FUNDING SOURCE	
15		FED RCPTS.	
16		GF MATCH	
17		GEN. FUND	22,553
18		I-A RCPTS	
19		PGM RCPTS	
20		OTHER	
21	CONTINUATION		
22	ADDITION	XX	

FOR B&M USE ONLY

1A KEY NUMBER _____ COLUMN NO. _____

JUSTIFICATION:

This position is needed due to the additional administrati workload which will be brought on the Department of Admini- stration in its role of coordinating services to the elder $1,000,000 in additional grant funds will be administered I the Older Alaskans Commission under S.B. 327/H.B. 610, and sufficient fiscal staff does not exist in either the Offic on Aging or the Department of Administer these additional funds.

AGENCY Administration PROGRAM AREA Social & Economic Assistance for the Aged

BRU Older Alaskans Commission

COMPONENT _____

13 REQUEST FOR NEW POSITION.

REVISED DATE _____

FY 81

HB

620

Jerry Sheehan
KARLUK Advisory School Board
KARLUK, ALASKA
99608

Representative Thelma Buchholdt
chairperson HESS committee
Pouch V
JUNEAU, ALASKA
99811

Julie:
for Members'
files on 620
(which may
never get
heard, but just
in case)

March 5, 1980

The Honorable Alvin Osterback
House of Representatives
Pouch V - Mail Stop 3100
Juneau, Alaska 99811

Dear Representative Osterback:

The article I have enclosed was printed in the local newspaper yesterday. Please add it to your files on HB-620.

We hope that a hearing on HB-620 can be set up soon, so that the Bill may move thr ugh the legislative process and we may get a new school built soon.

Thank you.

Sincerely,

Jerry Sheehan
Chairman
Karluk Advisory School Board
Karluk, Alaska 99608

JS;ag

Enclosure: as stated

cc: The Honorable Thelma Bucholdt, House of Representatives
The Honorable Russ Meekins, House of Representatives
The Honorable Fred Zharoff, House of Representatives
The Honorable Bob Mulcahy, ~~United States~~ Senate
Jessie Dodson

KADIAK TIMES

VOLUME 4 - NUMBER 87 TUESDAY, MARCH 4, 1980 KODIAK, ALASKA 35 CENTS

Karluk residents push for school replacement

by MIKE ROSTAD
staff writer

Karluk residents Jerry Sheehan and Ron Lind say their children are going to school in a building that's "deteriorating and extremely overcrowded." The men were in town last week to sit in on a Kodiak Borough assembly meeting regarding OCS (outer continental shelf), but they also took advantage of several opportunities to express their concerns about the school where 26 children, grades kindergarten through seven, are somewhat limited by the crowded environment.

Sheehan, chairman of the Karluk Advisory School Board, told Kadiak Times "inadequate space prohibits the children from learning, making it difficult for them to concentrate on their work." In some cases, says Sheehan, the teachers, Doug and Cindy Glynn, end up taking students into their home for classes in order to alleviate the problem.

Additional space is needed so that children

(Continued on Page 9)

KARLUK REPRESENTATIVES – Jerry Sheehan, left, and Ron Lind of Karluk say their children are going to a school that's deteriorating.

KARLUK

(Continued from Page 2)

can utilize materials that are primary tools in the Kodiak School District's curriculum, says Sheehan. "HILS (high intensity learning system) reading course is required, but Karluk is unable to utilize it fully," says Sheehan, explaining that there isn't enough space to store all of the material, and when it is used, there isn't enough room for students to work with it. Sheehan added that the "extremely recommended math program, which will eventually be required, isn't used at all because of lack of space."

Village school principal Mary Ann Kendall agrees the school is "jammed," she says, and needs upgrading. Kendall told Kadiak Times the 24' by 58' ATCO structure sold to the Borough to accommodate Karluk students after the destructive storm of Jan. 1978 when the residents had to be relocated about a mile away was supposed to last for 15 years, but it appears it has a two or three year expectancy, she adds.

Sheehan, who was invited by Kendall to attend a Borough work session Saturday to express the needs of Karluk, says Karluk will likely have more students next year and no one is graduating. He added there are other problems in the school besides crowded conditions. "The ceiling doesn't leak water,it drops water," he says, noting that at times 10 buckets are set up to catch the dripping water. Lind says that the stinking fumes emitted from the drying carpet is also a burden to students and teachers are expected to put up with.

The men say the students have been writing letters to Juneau, describing their plight. But they're not alone in their crusade. Jerry himself has written letters, and the Board has received positive response, he says. "The letters from Juneau are sympathetic about our situation and they're doing something about it," he says, explaining a proposal calling for a new school building is in the House. "It was felt by the administration that we'd have a better chance if our request was on the Governor's bond proposal," adds Sheehan.

Sheehan also expresses his concern regarding OCS. He's been hired as a CETA employee to work with Wayne Marshall of Kodiak Area Natives' Association, KANA, to do research and develop testimony to be delivered in Anchorage and Kodiak during the OCS hearings in March. Along with Marshall and Bob Peterson, Sheehan will be speaking in behalf of KANA which recommends "no sale" on sale 46.

Lind, a member of Overall Economic Development Program, will represent the village council of Karluk at the hearings. Lind told Kadiak Times the draft environmental impact statement doesn't address the collective effects of proposed oil sales on both sides of Kodiak Island, but only regards the issue of sale 46 on the island's eastern side.

Ron says, "All of the sudden people are starting to get concerned about what happens in the future. It's pretty spooky. I wouldn't want to see any of Alaska destroyed like in places where oil rigs have been put in," he says.

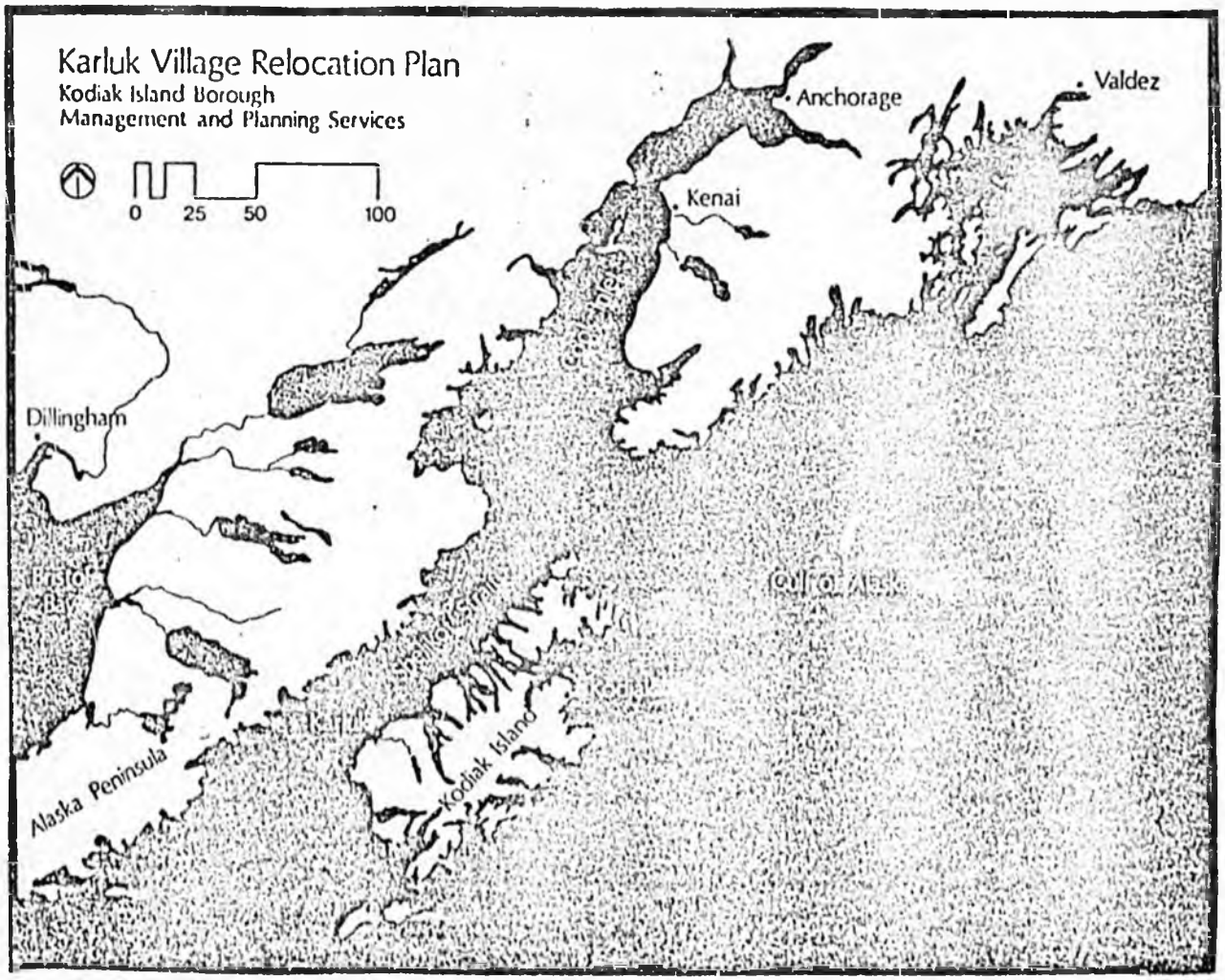
A Proposal for Funding of a Combined Elementary/Secondary School Facility in Karluk, Alaska

HB 620

For Consideration in the 1980 State Legislative Session

return

Proposal Written and Compiled by:
Mary Anne Kendall, Village Area Principal
Kodiak Island Borough School District
January, 1980


Karluk Village Relocation Plan
Kodiak Island Borough
Management and Planning Services
0 25 50 100
Anchorage
Valdez
Kenai
Dillingham
Alaska Peninsula
Kodiak Island

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RATIONALE FOR THIS PROPOSAL

Early in January of 1978, the village of Karluk on the west coast of Kodiak Island was struck by a storm which breached the protective spit, eliminating foot travel between the two portions of the village on either side of the Karluk Lagoon. This storm had an impact on the operation of the Karluk Elementary school, since prior to the storm, approximately 14 new Karluk students had walked across the spit to attend school in the Old Karluk school structure, along with 8 other students from Old Karluk.

Governor Hammond declared Karluk a disaster, but funds were not provided for rectifying the school situation. Consequently, the Kodiak Island Borough is still struggling with inadequate solutions to the problem.

The primary rationale for this combined elementary/secondary facility for Karluk originates partially from the storm disaster which has since caused the Kodiak Island Borough to set up a temporary ATCO school structure in new Karluk and to relocate the entire Karluk community. By fall of 1981 this structure will be hopelessly inadequate spacially, with the anticipated student population of 29 students, grades K-8. Within three years, it is also anticipated that there will be 14 secondary school students in Karluk. (Currently 5 high school students are either in correspondence or attending the high school program in town.

A secondary rationale for this proposal is based on the State's commitment to the Molly Hootch case consent decree and subsequent State Board of Education regulations which now require local school districts to provide educational programs for secondary students in small rural communities. The Kodiak Island Borough School District, in order to meet that mandate and challenge, has initiated a small high school program in five Kodiak Island Villages, with Karluk being the sixth.

Karluk emerges as an emergency priority facility within the KIBSD, because of the inadequate space of the current temporary ATCO facility 24' x 58' (which will be impacted by an additional six first grade students next year), and its total lack of secondary space to accomodate the fourteen secondary students anticipated within the next three years. Consequently, the District is seeking consideration of Karluk in a direct legislative appropriation for a combined elementary/secondary facility. The District cites the storm disaster and the Hootch consent decree as justification for this request.

I. STATEMENT OF NEED

A. Student Population Increase

In a formal resolution dated November, 1979, written by the Karluk Advisory Board to the Kodiak Island Borough Board, the Karluk parents requested a permanent elementary/secondary facility for their rapidly increasing student population. (See Appendix A) The increase was caused partially by their "bottom heavy" elementary population which is rapidly moving up into the secondary level, as well as the relocation and consolidation of the Karluk community in New Karluk. The existing 24' x 58' ATCO Unit is deficient for the twenty three students which it houses this year, and twenty nine students are anticipated next year.

B. Instructional Delivery System Needs

In addition to student population increases, the unique instructional delivery system of this small elementary secondary school must be taken into consideration when defining space needs for a permanent facility.

1. The elementary delivery system is mainly individualized or small group instruction, which necessitates a large array of instructional materials utilized in a resource lab format. This has been proven to be the most effective delivery system for small rural elementary schools, yet it does demand a certain degree of space for materials display and storage.

2. The secondary delivery system is more specialized and thus require more specific kinds of space (i.e.) Vocational Shop, Academic Space, Physical Education areas and Home Economics space. Moreover, State fire codes and building codes place further restrictions on space utilization. At this point, these areas simply do not exist in the present 24' x 58' Karluk school structure

   (Subject Area grid for Village High Schools - Appendix B)

   (Also, Kodiak Small High School Programs - General Space Implications - Appendix C)

3. Because of the multi grade classroom organization, many materials are used on a cyclical two or three year basis, thus placing an increased need on dry storage space. The current Karluk structure is seriously overcrowded with students, thus allowing little or no space for storage of instructional materials.

SUMMARY OF THE GOALS OF THIS PROPOSAL

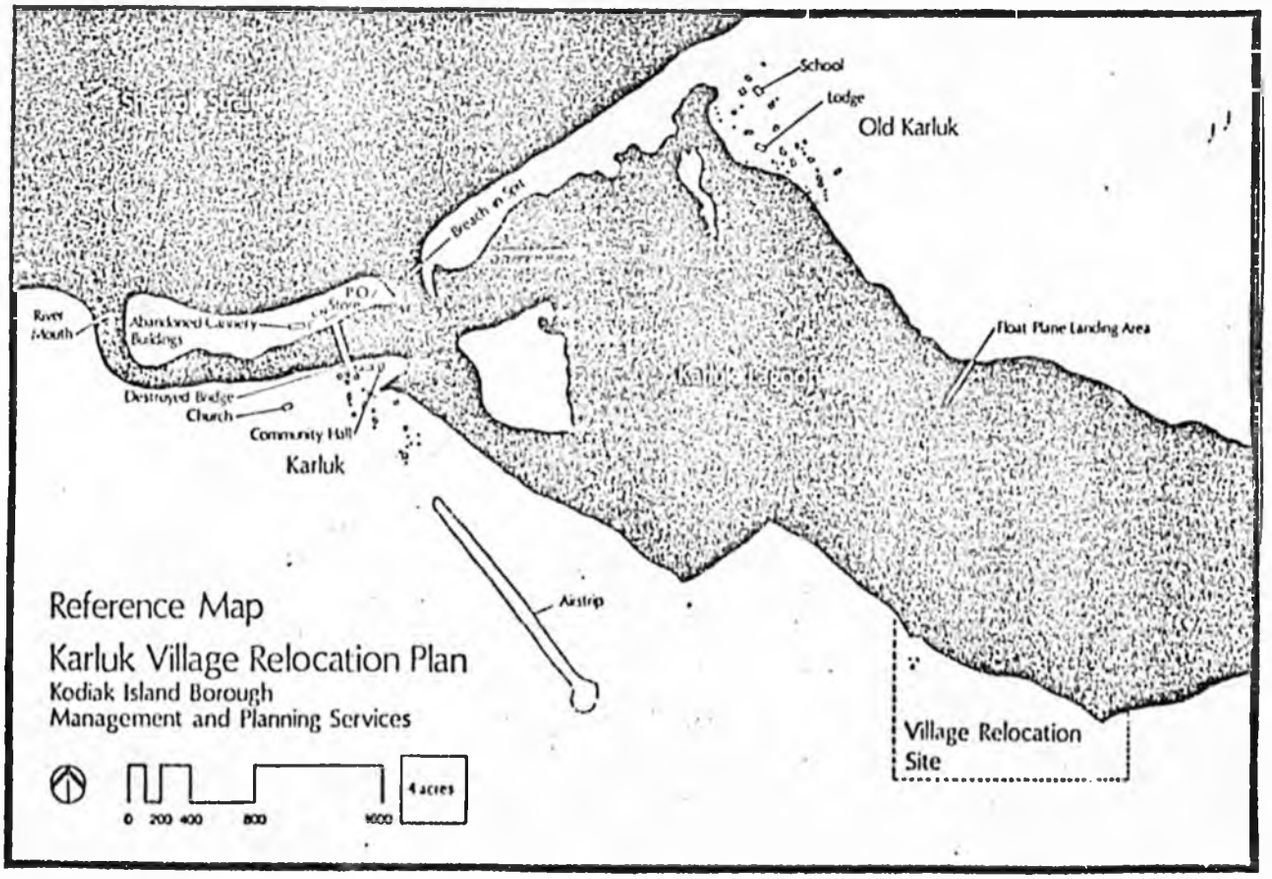
Major Goal

To seek financial assistance in providing adequate elementary and specific secondary space for Karluk school children.

1. Specifically, to have the Alaska State Legislature consider Karluk for a direct legislative appropriation.

2. To state and define the facility and instructional needs of the Karluk School and the KIBSD, and to offer cost estimates of these identified needs.

3. To provide additional relevant background information (e.g.) history of the Karluk school and the history of the small rural secondary curriculum project.


School
Lodge
Old Karluk
Breath n' Spa
PO
Store
River Mouth
Abandoned Cannery Buildings
Float Plane Landing Area
Destroyed Bridge
Church
Community Hall
Karluk
Airstrip
Village Relocation Site
Reference Map
Karluk Village Relocation Plan
Kodiak Island Borough
Management and Planning Services
0 200 400 800 1600
4 acres

II. THE HISTORY OF THE KARLUK SCHOOL AND KARLUK VILLAGE RELOCATION PLAN

A. History of Karluk School

(See Appendix D for maps representing each phase.)

PHASE 1

Prior to the disaster of January, 1978, there was one school in Old Karluk which was a BIA type structure - single classroom with a small group room adjoining, and a teacherage. All twenty three students attended this school until the storm washed away the adjoining spit, preventing the students from New Karluk from walking to the Old Karluk School. Strong currents and low tides made passage by the boat across the lagoon erratic at best.

PHASE 2

For the duration of the 1978 school year, a very deficient temporary school was set up in New Karluk in a small rented house. One teacher crossed the lagoon every day to conduct classes for approximately seven students. Eight students from New Karluk were sent to Kodiak for the remainder of the school year.

PHASE 3

In early August, 1978, the Karluk Advisory Board declared that all fourteen K-8 students who lived in New Karluk wished to attend school locally. Arrangements were made by the school district to rent the Karluk Community Hall until a more permanent school could be set up. Because of lack of predictability in transporting a teacher across the lagoon (tides and weather) and because the majority of students (18) were now attending school in New Karluk, the school district added a third teacher who lived in New Karluk and declared New Karluk as a seperate attendance area.

PHASE 4

In September of 1978, the Kodiak Island Borough appropriated funds ($113,000.00) for the purchase and installation of an ATCO Unit and a supporting sewer, water and electrical system. The unit was constructed and furnished in Anchorage and then barged to Larsen Bay. The Borough then sub-contracted with the Pleas Construction Company to utilize their smaller barge to transport the unit from Larsen Bay to Karluk. This was necesitated by low tides in Karluk and deteriorating weather.

Phase 4 (cont'd)

The district received a firm written committment from the parents of the eighteen students in New Karluk stating that they would attend the new school as soon as it could be opened. Twenty three new HUD housing units had been completed near the New Karluk school site, and when the ATCO Unit was completely installed, the parents moved into the new HUD units, and the majority of the community was relocated in New Karluk. The Old Karluk School was kept open until May, 1979, because those parents chose to wait until summer to move across to their HUD homes in New Karluk. One family chose to remain in Old Karluk and use the correspondence.

PHASE 5

The ATCO Unit, a Borough-purchased teacher housing unit and a small generator shed are the school facilities operating in New Karluk at present.

B. The Karluk Village Relocation Plan

After the storm of January, 1978, Karluk was declared a disaster by Governor Hammond (H.R.C. 110 Karluk Disaster Bill). Immediate measures were taken to assist the village. Food and fuel were barged in; the post office was set up in a private home, and eroding banks were sand bagged to protect the community hall and homes.

The timeline of the village relocation plan gives a summary of events.

February - The site selected for the new village by the Karluk Village Council was surveyed for Archeological resources by the U.S. Public Health Service.

March 8 - The Alaska State Senate passed H.R.C. 110, the Karluk Disaster Bill. The Karluk Planning and Redevelopment Committee med in Kodiak. Each group reported on progress to date.

March 13 - Management and Planning Services was contracted with by the Kodiak Island Borough to prepare a plan for the village relocation.

March 22 - The Karluk Planning and Redevelopment Committee met in Kodiak. Preliminary concepts of the plan were presented.

March 25 - Several members of the committee visited Karluk. The preliminary concepts of the plan were presented to the Village Council for their reaction and comments.

March 31 - Based on the Karluk Village Council's comments, a revised plan was submitted to the Kodiak Island Borough for review.

April 5 - Representatives of the village met with Kodiak Island Borough ro review the plan.

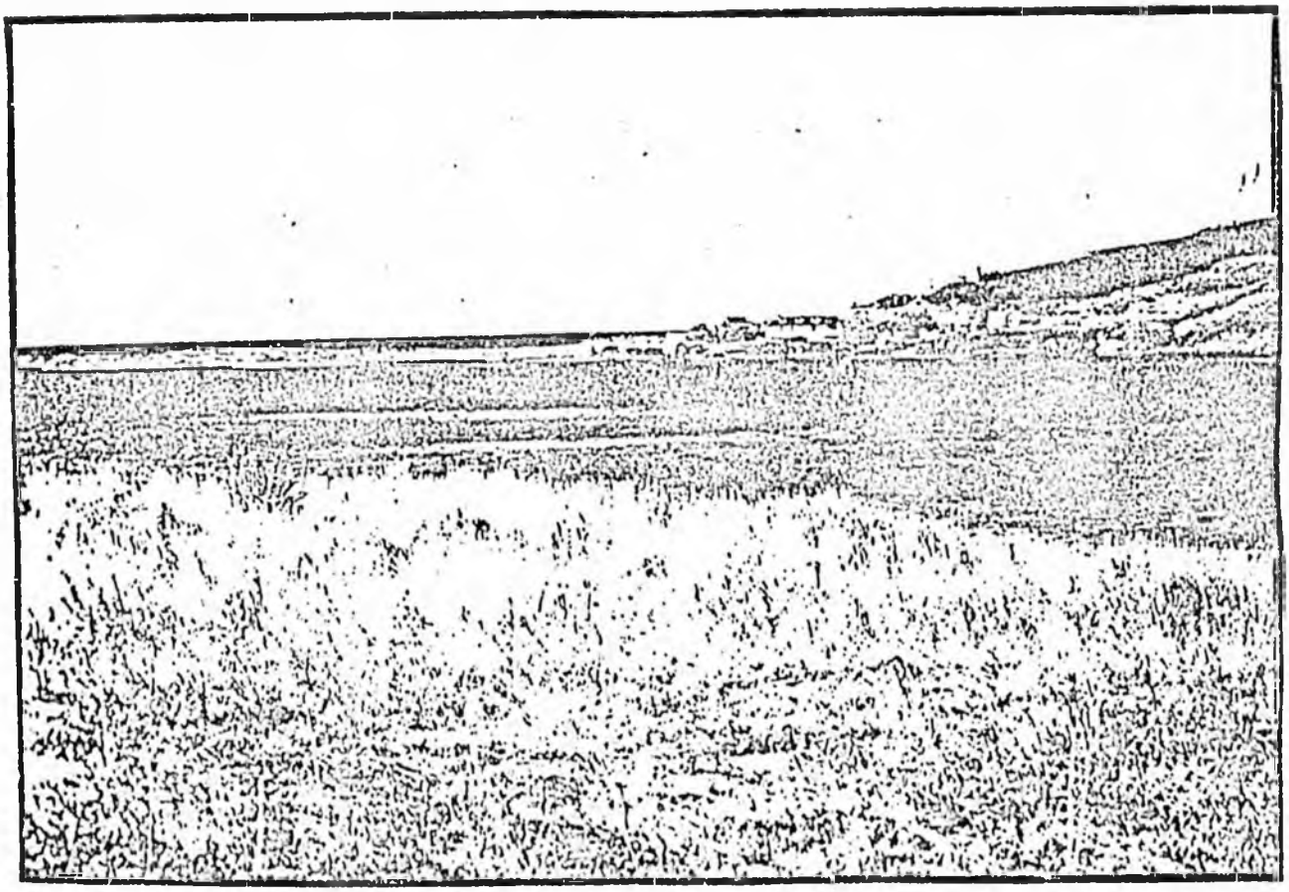
April 12 - The second version of the plan was presented to the Village Council at Karluk. They approved the plan which was then presented to the Kodiak Island Planning and Zoning Commission for their information.

The Karluk Village Subdivision Map shows a Tract reserved for the School, but no planning or facilities were provided through the Karluk Village Relocation Plan.

Page 23 of the Relocation Management Services Plan (1978) states:

"Funding for a new school at Karluk was not available this year. Until such funds are appropriated, the Kodiak Island Borough will provide relocatable units for a school facility at the new site."

The Kodiak Island Borough has been requested to provide a second ATCO Unit in Karluk to house the twenty nine students next year. There is still no indication of availability of funds for a permanent structure.



III. COMMUNITY PROFILE

A. Karluk Section

The village of Karluk is located at the mouth of the Karluk River on the west coast of Kodiak Island about 70 miles southwest of the City of Kodiak. The village of 100 people consists of two equally populated settlements lying on either side of the river: Old Karluk on the north and Karluk on the south. Before January 1978 the two Karluks were connected by a spit and a foot bridge.

Historical evidence indicates that the mouth of the river was populated several hundred years before the Russians arrived on Kodiak Island. Russian hunters established a trading post at Karluk in 1786. The abundance of salmon was undoubtedly one of the reasons for the original settlement; at one time the Karluk River had the largest red salmon run in the world. During the late 1800's and early 1900's a number of salmon processing plants were located on the Karluk spit. Over-fishing led to the closing of these facilities in the 1930's.

Fishing remains as the primary source of livelihood for the people at Karluk. As the Karluk Lagoon cannot accomodate larger commercial fishing vessels, the fishermen either fish out of small power boats and deliver their catch to floating processors, or go elsewhere and work on larger boats. Kodiak Island Seafoods, Inc. operates a major cannery at Larsen Bay to the east of Karluk. The Village Corporation of Karluk shares ownership of this facility with the village corporations of Larsen Bay and Old Harbor, and many Karluk residents either worth there or deliver fish to the cannery. The fishing season is short, lasting six to eight weeks. A small lodge in Old Karluk caters to sport fishermen who float the lake and river.

Development has been highly concentrated and consists mostly of houses - 17 in Old Karluk and 15 on the Karluk side. The condition of the houses ranges from excellent to poor; many houses are very old, having been occupied for generations. Some have been built from materials left from the Mutual Help Program. After the disaster the total was raised to 23 to replace threatened houses. These 23 units were completed by November, 1978, but without central electrification. A PHS sewer and water system is due to be completed by February, 1980. Most of the houses in Old and New Karluk are now deserted.

The deserted village had a combined grocery store and post office, a church, a community hall, and a school. The store and post office were located in an abandoned cannery building on the spit near the Karluk side. The church, built in 1888, is located on the bluff overlooking Karluk. The community hall, located in Karluk, had a large recreation room, and village's only telephone. Since the relocation the Karluk Community Hall has been closed down.

Karluk is most often reached by amphibious aircraft. there is a gravel and dirt airstrip on the south side of the lagoon; however, it is rarely used because of its poor condition. Karluk is due to receive a new airstrip this summer. Supply barges visit the village a few times a year, and occasional fishing boats stop.

Before the storm it was possible to walk between the two Karluks by foot bridge and spit. This was sometimes dangerous during high tides and storms, as driftwood would occasionally wash over the spit. Travel between the two villages now is by boat; and at low tide is difficult because of shallow, swift water and gravel bars.

Kodiak Island lies in the maritime climatic zone which is generally described as having "mild winters and cool summers". This description does not tell the whole truth.

Although the averages of Kodiak's weather do not appear unusually harsh, the extremes, variability, and unpredictability of the conditions can occur both in summer and winter. Wind speeds of 100 knots are not uncommon in intense storms. Although the variation between average winter and summer temperatures is only 25 degrees, temperatures of -12 degrees have been recorded. Precipitation varies between 40 and 80 inches a year and snowfall has been as low as 15.9 inches and as high as 178.1 inches. Foggy conditions occur between June and September. Kodiak Island's variable and extreme weather is a result of its location between the warm Japanese current and the colder Bering Sea.

B. Community Needs Assessment

Since the elementary and high school programs and general space implications for each school are the same, the only varients are the communities themselves, their own educational goals, and their particular needs. Therefore, this section describes the Karluk community.

In developing information for Karluk, public meetings were held to determine their overall educational goals and the growth they anticipated their community to experience. In short, the Karluk community developed much of this information. Other information was collected from the 1978 Needs Assessment conducted by Northwest Labs in every native village on Kodiak Island.

KARLUK
NEEDS ASSESSMENT

I. MEMBERS PRESENT

Jessie Shiehan
Jerry Shiehan
Hazel Balluta
Gery Pavaloff
Lidia Malutin
June Chya
Mary Reft
Nick Charliaga
Cindy Glynn
Doug Glynn
Phyllis Kaufman

II. BRAINSTORMING

English
Aleut
Russian
Journalism
Reading
Library Science Skills
Wood Shop
Mechanics
Boat Building
Ground School
Small Engine Repair
Welding
Diesel Mechanics
Home Economics
Navigation
Fisheries
Ham Radio
Typing
Speed Writing
Business Management
Office Machines
Economics
Accounting
Tax
Algebra
Geometry
Consumer Math
Native Land Claims
Alaska History
U.S. History
Government
Oral History
Music
Photography
Sculpture
Dancing
Painting
Drama (Theatre)
Drawing
Chemistry
Biology
Fisheries
Physiology
Nutrition
Child Care
First Aide
Survival Skills
Sex Education
Gun Safety
Writing Skills
Water Safety
Swimming
Dancing
Gynmastics
Organized Sports
Psychology
Sociology
World Religion
Communication Skills

III. TEN TOP PRIORITY PROGRAMS

A. Language Arts

1. English
2. Aleut
3. Russian
4. Journalism
5. Reading
6. Library Science Skills

B. Vocation Education

1. Wood Shop
2. Mechanics
3. Boat Building
4. Ground School
5. Small Engine Repair
6. Welding
7. Diesel Mechanics
8. Home Economics
9. Navigation
10. Fisheries
11. Ham Radio

Business Education

1. Typing
2. Speed Writing
3. Business Management
4. Office Machines
5. Computer Programming
6. Economics
7. Accounting
8. Tax

C. Math

1. Algebra
2. Geometry
3. Consumer Math

D. History/Political Science

1. Native Land Claims
2. Alaska History
3. World History
4. U.S. History
5. Oral History
5. Government:
   a. Village
   b. Regional
   c. State
   d. Federal

E. Arts

1. Music
   a. Vocal
   b. Instrumental
2. Photography
3. Sculpture
4. Dancing
5. Painting
6. Drama (Theatre)
7. Drawing

F. Sciences

1. Chemistry
2. Biology
3. Fisheries
4. Physiology

G. Health

1. Nutrition
2. Child Care
3. First Aide
4. Survival Skills
5. Sex Education
6. Gun Safety

Karluk Needs Assessment (cont')

H. College Prep

Writing Skills

I. Physical Education

1. Water Safety
2. Swimming
3. Dancing
4. Gymnastics
5. Organized Sports

J. Social Science

1. Psychology
2. Sociology
3. World Religion
4. Communication Skills

IV. SPACE NEEDS AND COSTS ESTIMATES FOR KARLUK ELEMENTARY/ SECONDARY PERMANENT FACILITY

This section outlines community growth and enrollment projections, along with current and future space needs for Karluk school. Gross cost estimates are presented which have been determined based on current building costs. (Estimates from Maynard and Partch Architectural Firm, Anchorage).

The Alaska State Guidelines for square footage estimates have been used in computing adequate space projections. Thus, this section attempts to give cost estimates that the Legislature should consider of this proposal is to be funded to meet the needs.

A. Community Growth and Enrollment Projections

As stated earlier in this proposal, Karluk had 23 new homes constructed in the fall of 1978. Along with the future economic plans of the Village Native Corporations, and with the possible impact of offshore oil development, this Kodiak Island Community is anticipated to grow. A new airstrip is scheduled to be built this summer which will really enhance the community's accessibility.

Village schools in general have experienced slight enrollment increases of the past few years, while urban areas, such as Kodiak, have declining enrollments. For these reasons, the growth rate of Karluk has been estimated at 22%. The growth and enrollment projections are displayed in Tables I and II. (See following pages for tables)

KARLUK

TABLE I, FUTURE COMMUNITY GROWTH AND ELEMENTARY AND HIGH SCHOOL ENROLLMENT PROJECTIONS

COMMUNITY GROWTH				ENROLLMENT HIGH SCHOOL			ENROLLMENT ELEMENTARY		
9-80 94	80-81* 102	83-84 115	% of Increase 22%	79-80 6	80-81* 8	83-84 14	79-80 26	80-81 29	83-84 31

KARLUK

TABLE II, ELEMENTARY AND SECONDARY COMBINED ENROLLMENT

Elementary and Secondary Combined Enrollment		
79-80 32	80-81 37	83-84 45

KARLUK - COMBINED ENROLLMENT: 1) 1978-79 32
2) 1979-80 37
3) 1983-84 45

TABLE III, COMPARISON OF PRESENT SPACE TO THE AMOUNT OF SPACE SUGGESTED BY THE ALASKA STATE DEPARTMENT OF EDUCATION (FOR BOTH PRESENT AND PROJECTED ENROLLMENT FIGURES)

ALASKA DEPARTMENT OF EDUCATION

COMBINED ELEM./SEC. SCHOOL SPACE GUIDELINES
(IN MAXIMUM GROSS SQUARE FEET OF FLOOR AREA) 1/

	PRESENT SPACE IN THE SCHOOL	SUGGESTED SPACE FOR CURRENT ENROLLMENT*	SUGGESTED SPACE FOR PROJECTED (1983-84) ENROLLMENT
ELEMENTARY CLASSROOM(S)	1392	1800	2400
SECONDARY CLASSROOM(S)	-0-	1200 2/	1500 3/
LIBRARY/MEDIA*	-0-	1100	1200
(%of individual study space)	-0-	70%	65%
SCIENCE CLASSROOM	-0-	-0-	800
INDUSTRIAL ED.	-0-	600	800
BUSINESS ED.	-0-	-0-	100
HOME SCIENCE	-0-	-0-	-0-
MULTI-PURPOSE SPACE*	-0-	2500	3500
SUPLEMENTARY SPACE*	-0-	35%	30%
TOTAL	1,392	10,595	13,390

*COMPUTED ON BASIS OF COMBINED ELEMENTARY AND SECONDARY ENROLLMENT.
1/ See Bibliography Reference #1 and Appendix A
2/ Include wet area for science/home economics
3/ Include wet area for home economics

IV-C. SUMMARY OF SPACE AND FINANCIAL NEEDS

IV-C-1. SPACE NEEDS SUMMARY

TABLE IV, SPACE SUGGESTED BY THE ALASKA STATE DEPARTMENT OF EDUCATION FOR BOTH PRESENT AND PROJECTED ENROLLMENT FIGURES

Village	Total Present Space (Unusable for Future Needs)	Total Suggested Space for Current Enrollment	Total Suggested Space for Projected (1983-84 Enrollment)
Karluk	1,392	10,595	13,390

IV-C-2. FINANCIAL NEEDS SUMMARY

Table V displays the financial needs of Karluk School in order to meet present and guture space needs. This table was derived by taking the total needed square feet and multiplying them by current estimated cost per square foot of public building on Kodiak Island. (Square foot estimates obtained from Maynard & Partch Architectural Firm) Because Karluk is the most inaccessible village on the island, the square footage cost is considerably increased. This gives us the actual dollars needed for construction which then must have 20% added on for design, State Public Works and administration fees to construct the buildings. The inflationary cost per year is estimated at 18% above the amount listed for current costs.

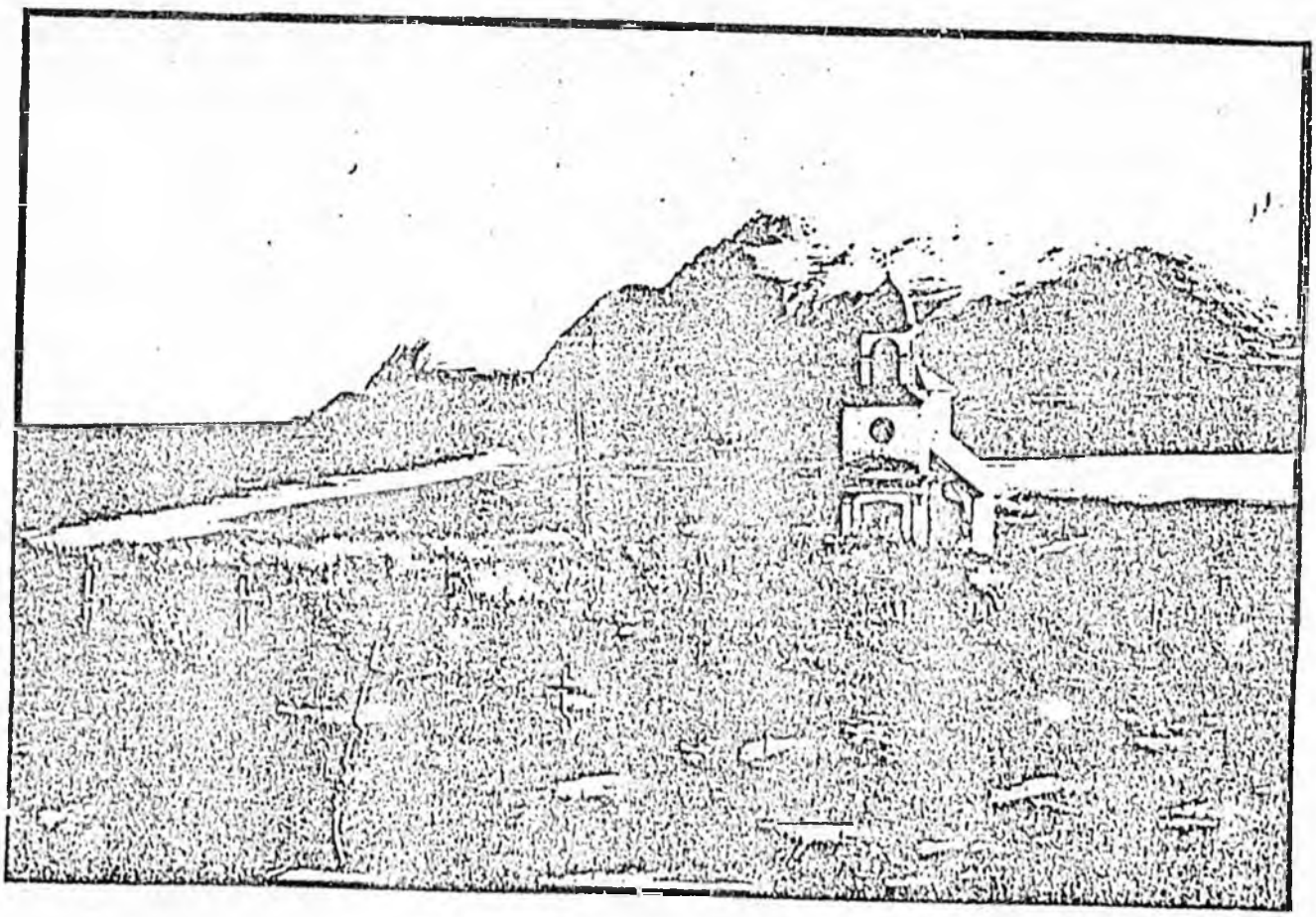
TABLE V, COSTS ESTIMATES FOR PRESENT AND PROJECTED SPACE BASED ON CURRENT ENROLLMENT

Present Square Feed Needed		Current Building Costs Per Square Foot		20% for Design & Administration Fees	Total Construction Plus Design & Administration
10,595	x	$188 = $1,991,860	x	20% = $398,372	$2,390,232
Projected Square Feed Needed					
13,390	x	$222 = $2,972,580	x	20% = $594,516	$3,567,096

**$188 per square foot plus 18% for 1 year inflationary costs = $222.

TABLE VI, TOTAL COST ESTIMATES FOR MEETING CURRENT AND FUTURE SPACE NEEDS IN KARLUK (ROUNDED OFF TO NEAREST $100,000)

FUNDS NEEDED TO MEET CURRENT SPACE NEEDS	FUNDS NEEDED TO MEET PROJECTED SPACE NEEDS
$2,400,000	$3,600,000



APPENDIX A

Karluk Advisory Board

RESOLUTION# _____ to the Kodiak Island School Board, made at the November 2nd meeting of the Karluk Advisory Board.

WHEREAS the Kodiak Island Borough School District has a commitment to equal educational opportunity in all of its K-12 programs; and

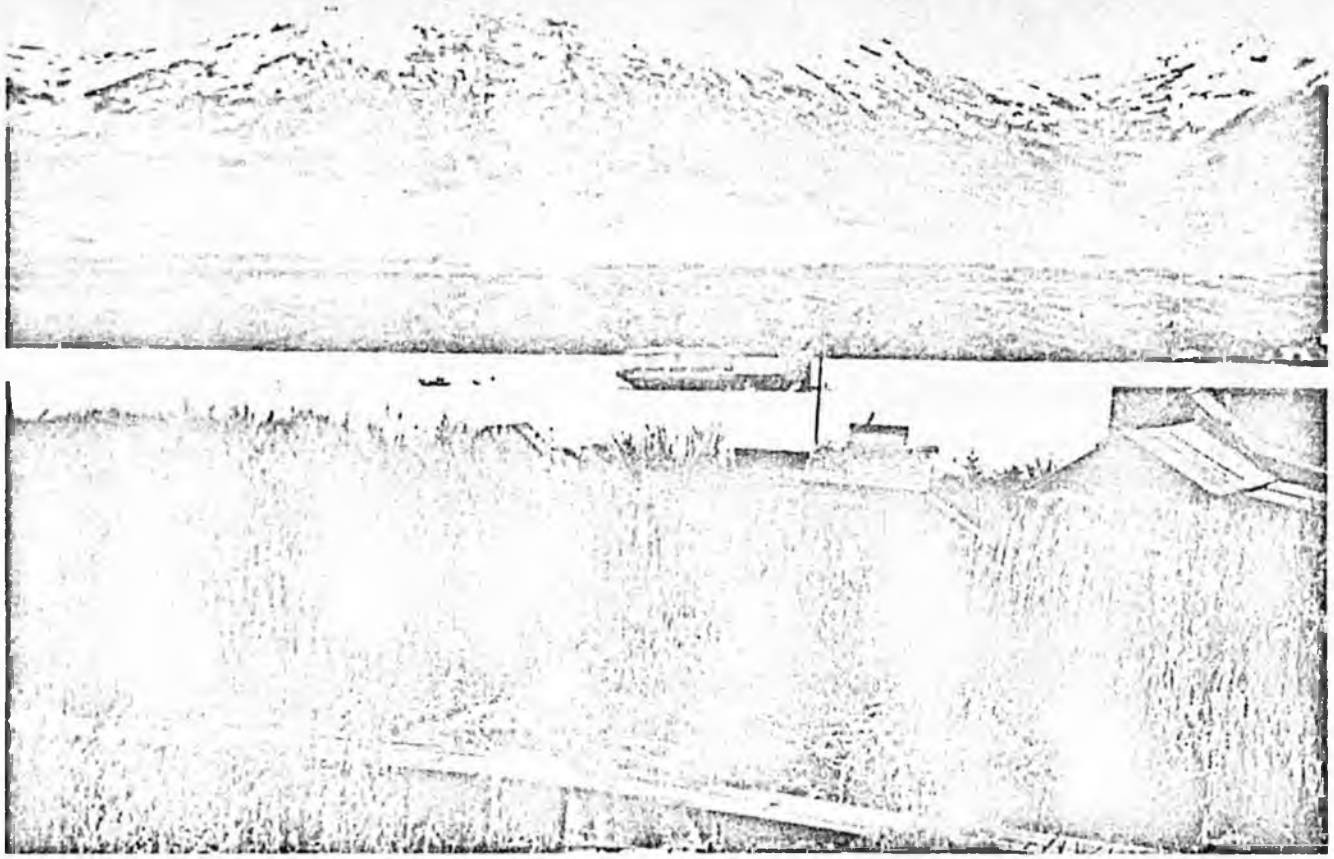
WHEREAS adequate school facilities constitute an essential component of any educational program; and

WHEREAS the Karluk school has been physically moved, divided and combined three times during the past two and one half years as a result of the Karluk bridge wash out and a relocated community; and

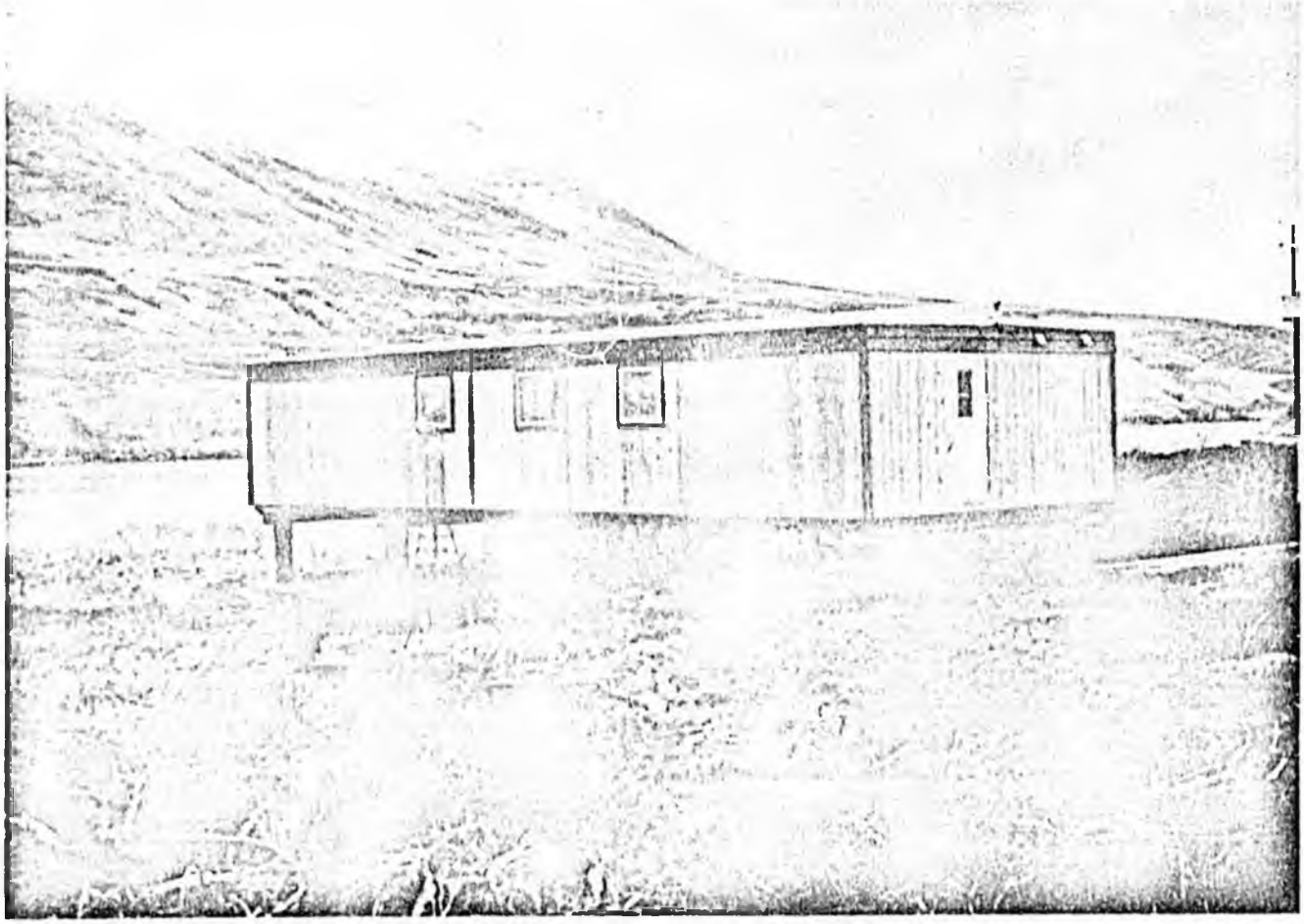
WHEREAS the Kodiak Island Borough School District and the Kodiak Island Borough Assembly did see fit to provide funding for the installation of a 20' X 42' temporary ATCO unit in December, 1978. From December of 1978 through May, 1979 this ATCO unit housed 18 students, while 8 students still attended school in the Old Karluk attendance area; and

WHEREAS the Kodiak Island Borough School District closed the Old Karluk school in May of 1979 and the Karluk parents all committed themselves to sending their children to the ATCO unit in the relocated village of Karluk; and

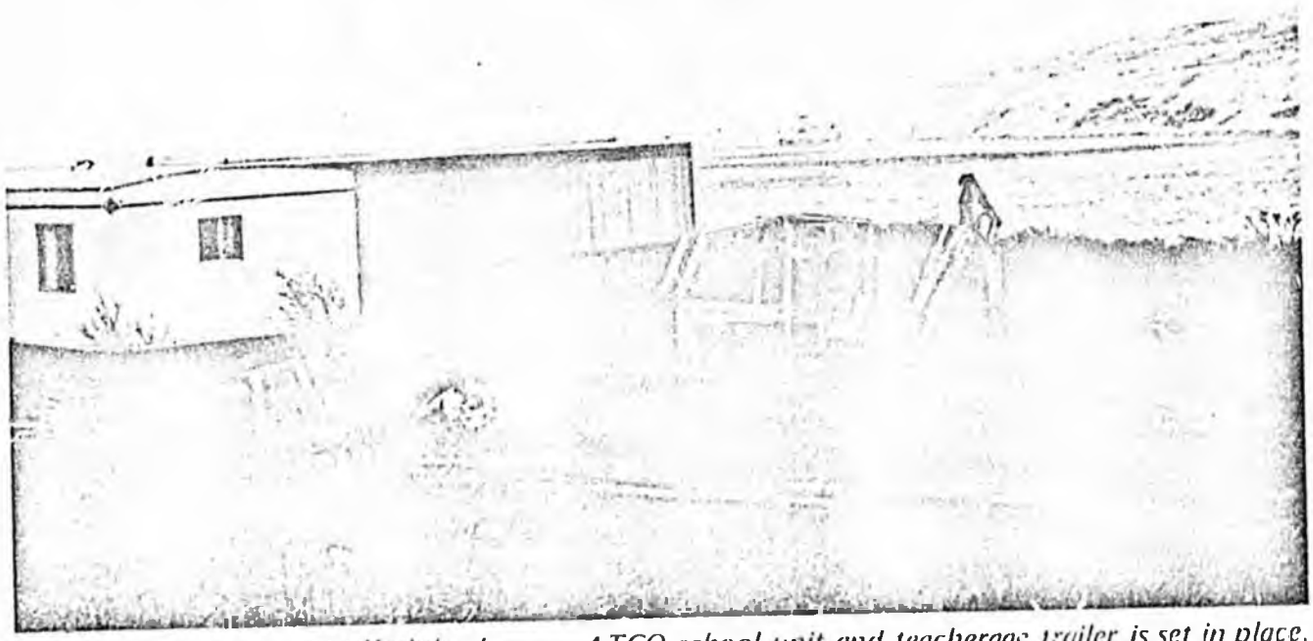
Whereas there are currently 26 students enrolled in the Karluk School, Grades K-8, with 6 of these students being Kindergarteners who attend school in a KANA rented facility, thus making teacher supervision difficult; and



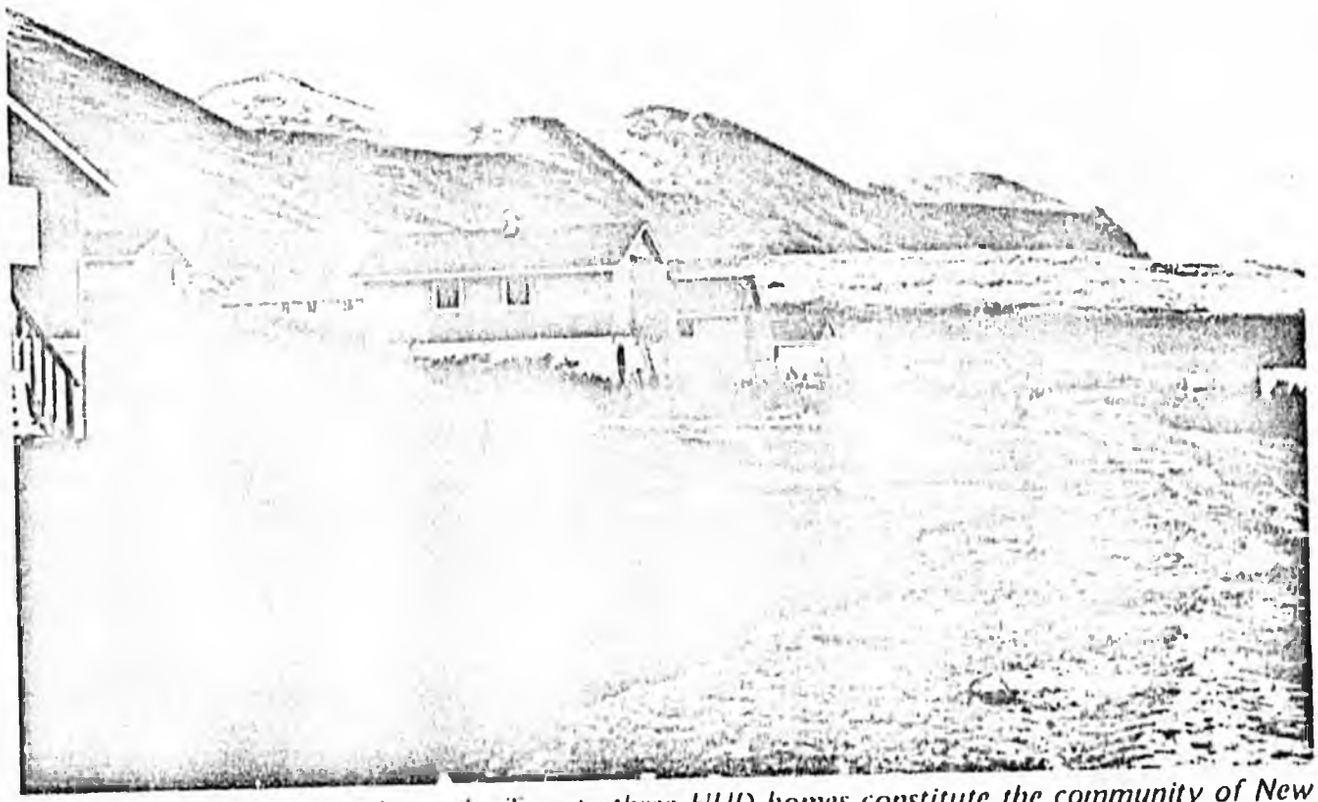
The Riley Pleas barge moves into the Karluk Lagoon loaded with the ATCO school unit. (October 1978)



The ATCO school unit is set on pilings at the New Karluk school site. (October 1978)



Looking out towards Old Karluk, the new ATCO school unit and teacherage trailer is set in place. (October 1978)



The village of Karluk is reloc d. Twenty-three HUD homes constitute the community of New Karluk. (November 1978)

WHEREAS in August of 1980, the projected enrollment for the ATCO unit is 29 (the 6 Kindergarteners will become first graders and 3 elementary correspondance students may plan to enter as regular students) and the square footage would be 18 sq. feet per student; and

WHEREAS the spacial deficiency and resulting noise problems would severly impede the delivery of an instructional program;

BE IT THEREFORE RESOLVED:

That the Kodiak Island Borough School District pursue funding for an additional temporary ATCO unit to meet Karluk students' emergency space needs for the 1980-81 school year and

That the Karluk School be assigned a high priority in the District's long range facilities planning document so that Karluk could expect a permanent elementary-secondary facility within the next 3 or 4 years, since the ATCO units provide a temporary solution only to our school space needs and since we anticipate 14 secondary students within those 3 or 4 years.

Karluk Advisory School Board

Jerry Sheehan, Chairman

Hilda Charliaga

Hazel Balluta

Betty Lind

Mary Kelly

APPENDIX B

II-D. SUBJECT AREAS FOR THE VILLAGE HIGH SCHOOL PROGRAM

A) Subject Area Grid: The subject area grid is presented as a brief diagram of the educational program.

9th Grade	10th Grade	11th Grade	12th Grade
English (Reading)	English (Reading)	English	English
General Math	General Math	U.S. History	U.S. Govern. / Consumer Ed.
General Sciences	General Sciences	Reading	Reading
Social Studies/ AK. Land Claims/ Alaska Geography	Social Studies/ AK. Land Claims/ Alaska Geography	P.E. / Elective	P.E. / Elective
Vocational Educ.	Vocational Educ.	Elective	Elective
Elective	Elective	Elective	Elective
These subjects are taught with programmed, basic skills materials that students must complete.		The required subjects above will be programmed. However, the electives will be left up to the students based on the areas or jobs they may be interested in.	

APPENDIX C

II-E. Kodiak Small High School Programs - General Space Implications

Any new high school building in Kodiak Small Rural Villages must be designed to accomodate and facilitate the high school program that community people have stated they want in this document. Moreover, the design must also reflect the delivery system of the program as outlined in this section. Therefore, the following conclusion can be drawn regarding the space needs of the new facilities:

1. All five types of instructional areas: academic studies, laboratory sciences, physical education, vocational education, and other electives must be included in the building.
2. Because of limited funding and small numbers of teachers and students, as many of the different kinds of areas and spaces for specific subjects in those areas as possible must be designed for shared space. Some areas will have to accomodate two or more categories or kinds of activities.
3. The individualized delivery system of the program requires that all areas accomodate individualized study needs.
4. Since the core of the program delivery system is individualization, the center of all activities must be an area containing the library media center, and individual and small group study spaces known

as a learning resource center. All areas must have access to this area so that students can seek and select information, study books, audio-visual tapes, and work in small groups or individually on information relating to all subject areas.

5. Instructional area requirements are listed below:

a. Academic Studies Space:

1) Must have individual student study places to accomodate all students.

2) Must have general purpose classroom(s).

3) Must have a learning resource center with several individual places for students to view filmstrips, film loops, movies, micro-fish, videotapes, television, and also, listen to and/or record cassette tapes and records.

4) Must have teacher station(s) and preparation areas.

5) Must have areas for small group work, perhaps isolated to reduce noise levels.

b. Laboratory Science Space:

1) Must have direct access to learning resource center.

2) Must have sinks, ventilation, and areas to display materials as well as secured area for storing certain chemicals and equipment.

c. Physical Education Space:

1) Must have access, but perhaps not direct access, to learning resource center.

2) Must have large area for student activities to be utilized by elementary students, as well as the entire community.

3) Must be able to be secured from rest of building for community use.

4) Must contain basketball and volleyball courts and storage area for equipment.

5) May have bleacher seating to seat 75% of the community. (Suggest bleachers on rollers).

6) May have storeaway stage area with curtain.

7) Must have showers and lockers.

d. Vocational Education Space:

1) Must have access, not necessarily direct, to learning center.

2) Must accomodate such diverse space needs as: home sciences, welding, wood-working, mechanics etc..

3) May have localized, secured tool area.

4) Must have appropriate ventilation and fire safety requirments.

5) May be able to be secured from rest of building for possible community use.

e. Other Elective Areas:

1) Must have access to learning resource center.

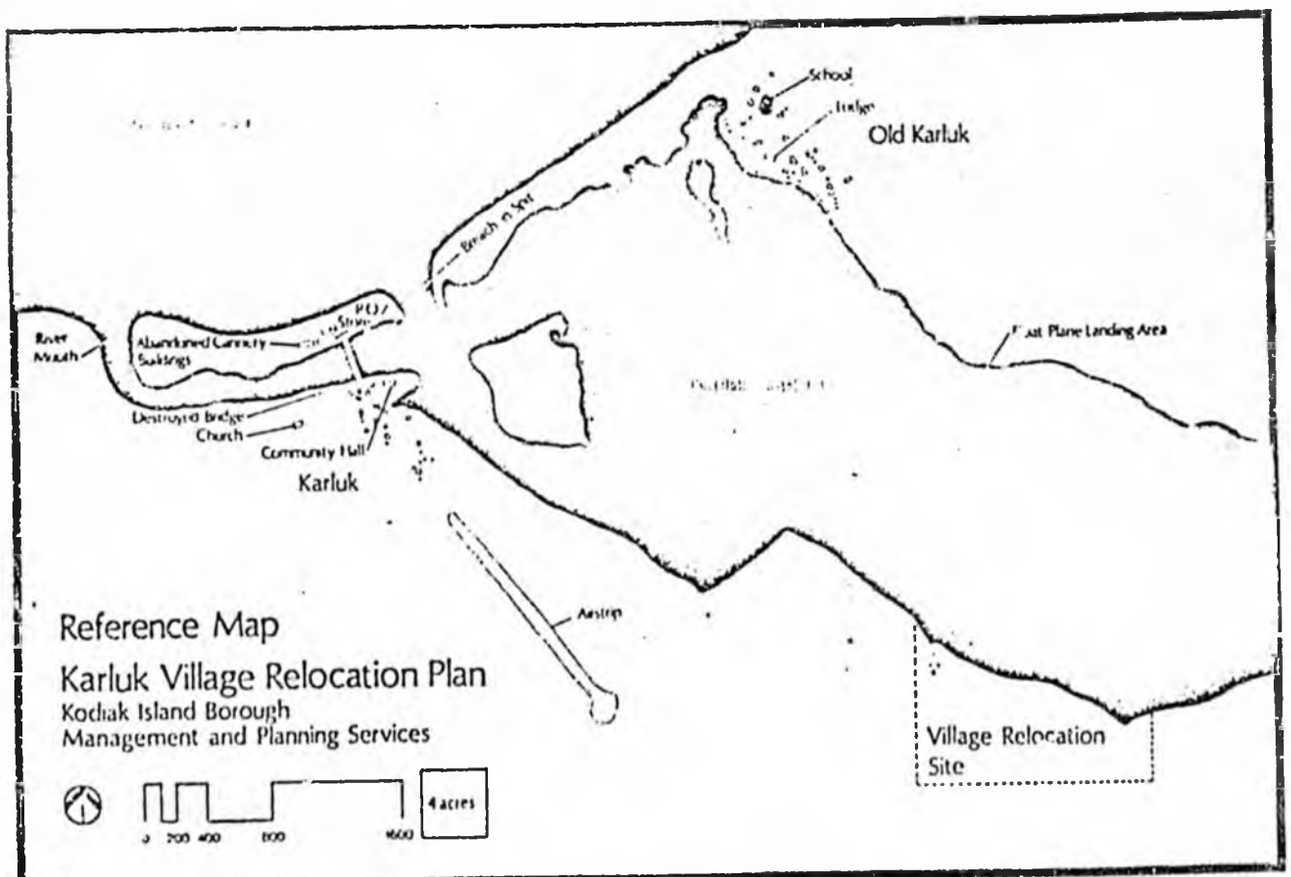
2) May accomodate such activities as music and art.

It should be emphasized that some of the above areas will have to be combined in some manner to provide space for all areas needed.

APPENDIX D

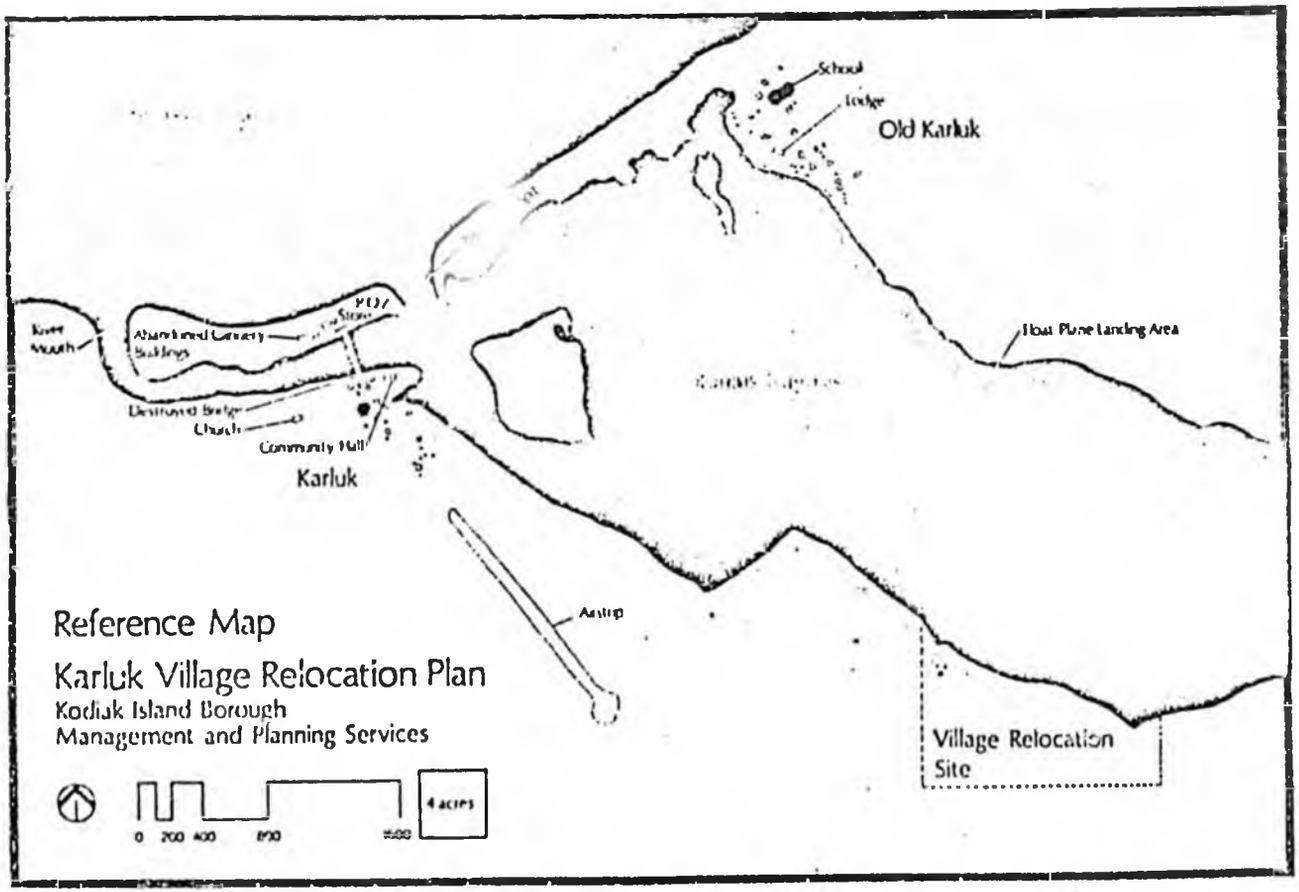
MAPS

PHASE I.



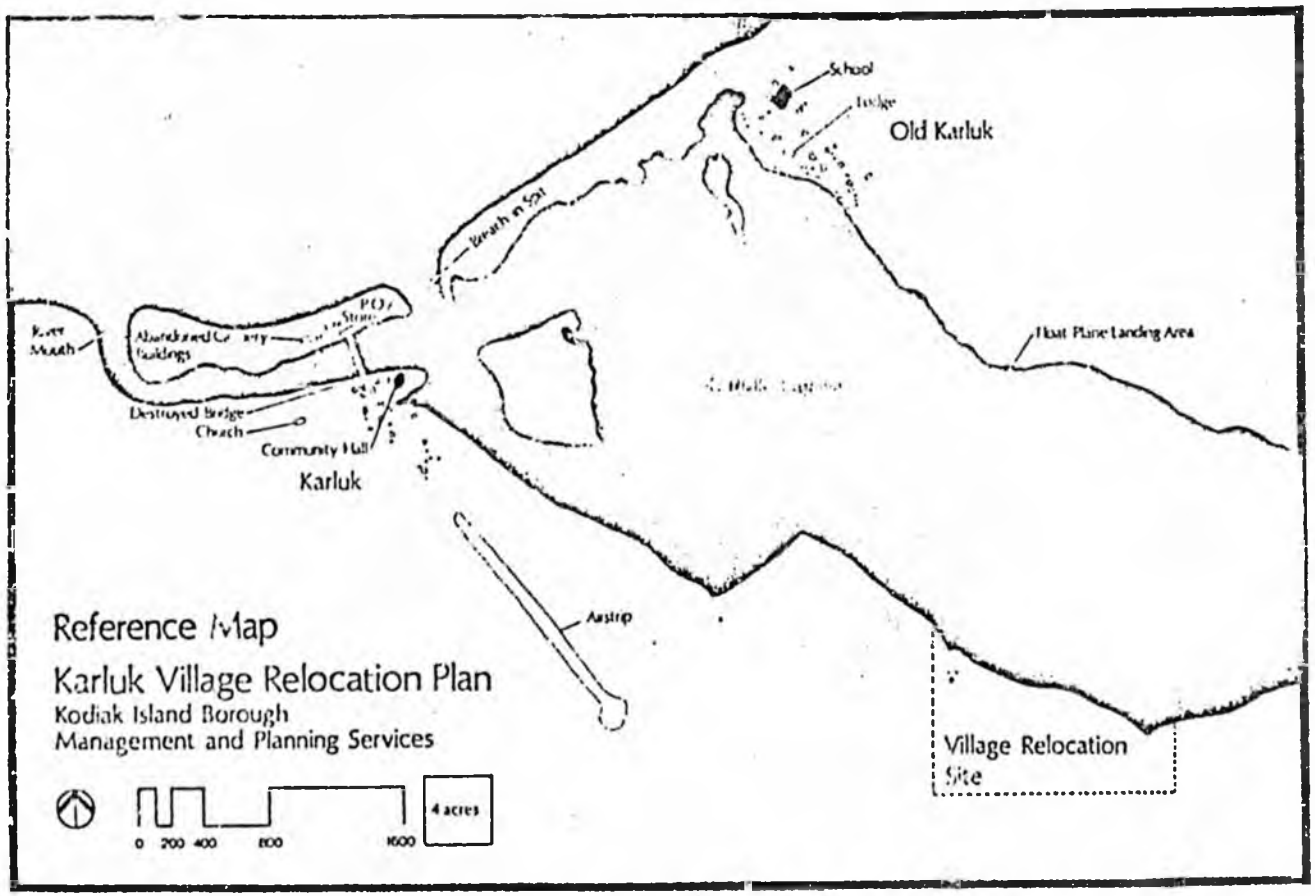
Sept. '77 - Feb. '78 - 1 School - Old Karluk

Phase 2.



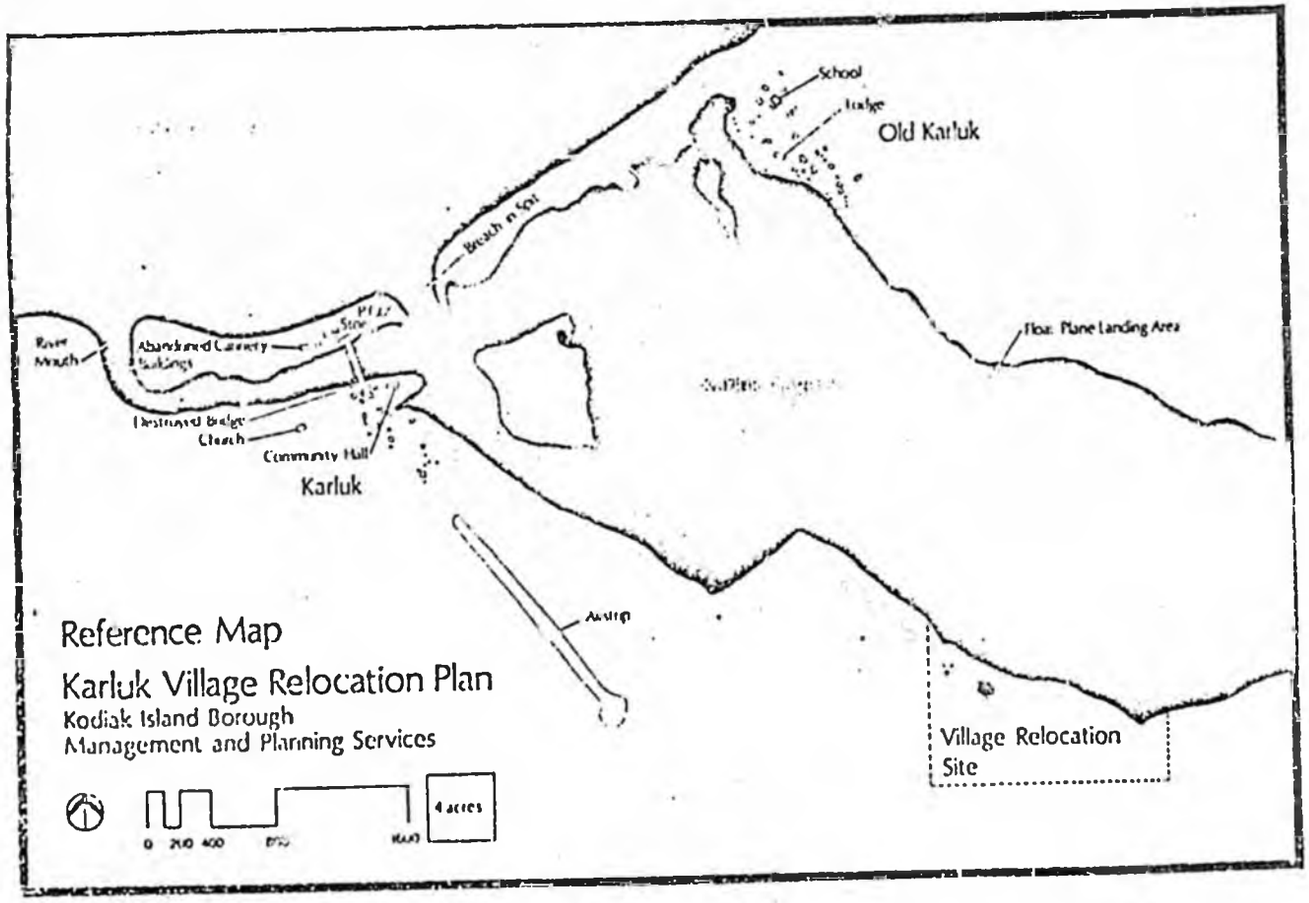
Feb. '78 - May '78 → 2 Schools
Old Karluk &
Rented House in New Karluk

Phase 3.



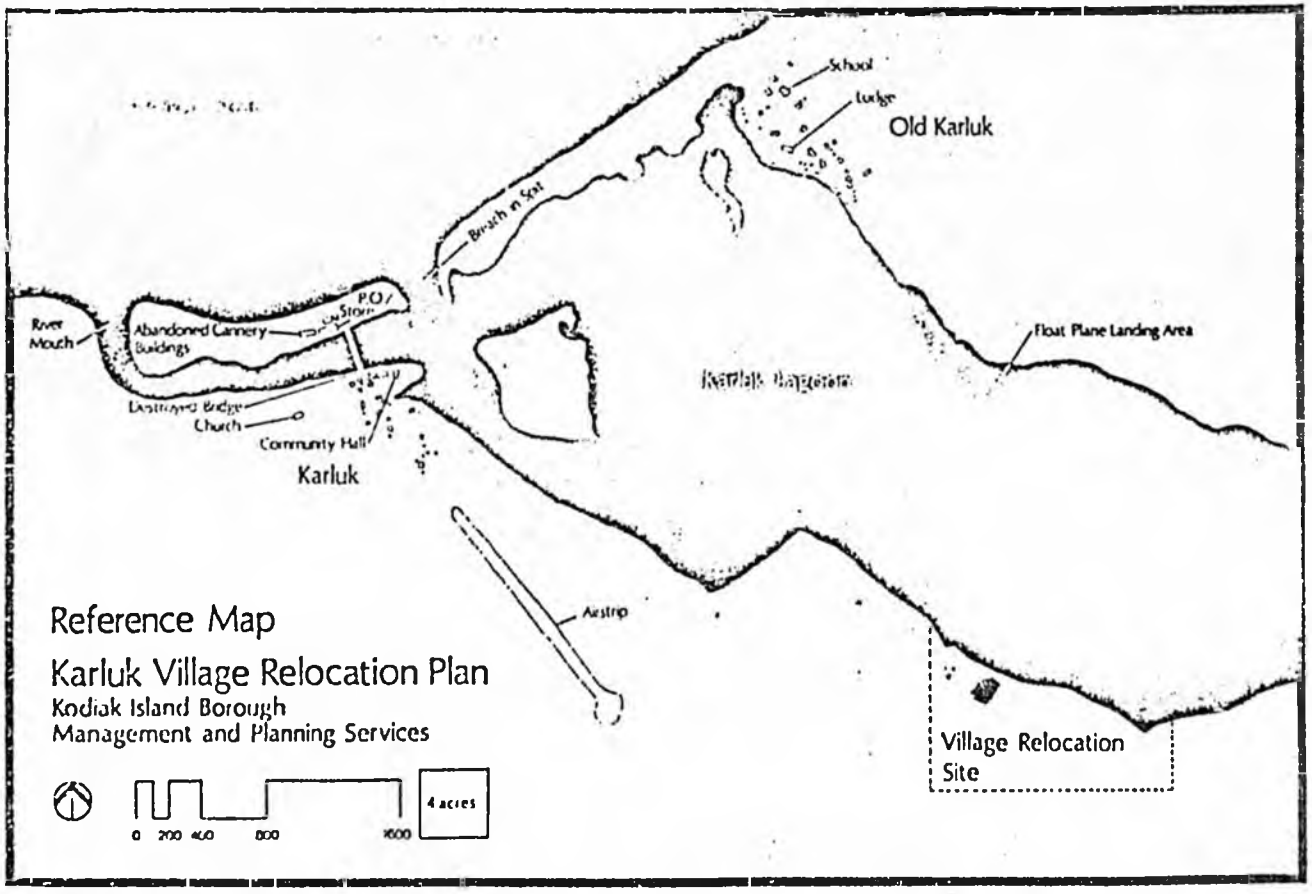
Aug '78 - Dec 4th, '78 - 2 Schools, Old Karluk & Community Hall

Phase 4.



Dec. 4th, 78 — May '79 - 2 Schools
Old Karluk
ATC 0 11 ...

Phase 5.



Aug '79 → Future — 1 School

ATCO Unit

TELEGRAM

ALASCOM, INC.
PHONE: 586-6442
JUNEAU, AK 99802

'80 FEB 11 PM 9 17

Karluk
HB 620

#

02172 NL ANCHORAGE ALASKA 68 02-11 355P AST

PMS REP ALVIN OSTERBACK

JUN 1990

WE WOULD LIKE TO EXPRESS OUR THANKS TO YOU FOR INTRODUCING HOUSE BILL 620 WHICH WOULD APPROPRIATE FUNDS TO THE DEPARTMENT OF TRANSPORTATION FOR CONSTRUCTION OF A SCHOOL AT KARLUK. WILL YOU BE TALKING TO THELMA BUCHHOLDT WITH THE INTENTION OF INCLUDING THIS INTO THE GOVERNORS BOND PROPOSAL PACKAGE? RECENT STORM DAMAGE TO THE TEMPORARY SCHOOL UNIT ROOF MAKES ACTION ON THE NEW SCHOOL PROPOSAL EVEN MORE CRITICAL.

KARLUK ADVISORY SCHOOL BOARD

Jerry Sheehan
Karluk Advisory School Board
Karluk, Alaska
99608

3/10/80

Dear Representative Buchholdt.

We hope that a hearing may be set up for HB 600 soon. We understand that Karluk is now on the Governors Bond Proposal also. We need a new school. If HB 600 can go through the legislative process, we can have a new school sooner than if the Governors Bond proposal is approved.

Enclosed are letters our children wrote to Juneau describing what they see, in their own words, as why we need a new school.

Also enclosed is a copy of the Kodiak Area Native Associations recent

(Rep. Thelma Buchholdt, pg)

newsletter, which endorses our school needs.

I will be in Juneau next week to attend the Citizens Participation Conference (Education) and I look forward to meeting you then.

Sincerely

Jerry Sheehan

Jerry Sheehan
Chairman Karluk Advisory
School Board

Karluk, Alaska
99608

THE FOLLOWING DOCUMENT(S) MAY NOT FILM LEGIBLY BECAUSE OF POOR QUALITY OF THE ORIGINAL.

Feb. 12 1980

Dear Alvin Osterback,

Greetings! How are you? I am just fine I am Tania Balleta I live in Kwajalein which is at the west side of Roi-Nam Island.

Kwajalein is made up of three separate islands you see Roi-Nam?

The bridge fell down during a storm two years ago! The church was built in 1888. There is 3 kids going to correspondence course and we not very happy being away from kids there our age.

I think you will be receiving a little from us. We do not like the lunches on the school!

I am in the sixth grade and would like to see Kwajalein get a new school and so would every body else. If you would like to see and see the school feel free!

Please Support us!

Turn this Paper over!

P.S.

Please Try To get the School in two more years!

Here is a poem for you!

What a School Means to Me!

Although I am just a sixth
grader with two more years to
go till I enter into high
school not knowing where I
will go.

I see high school student
passing off to school somewhere.
Most of them returning home again
mostly in disgrace.

I do not want to think of
the time to come for me to leave
home first to continue school elsewhere. The awful thought of returning
home in disgrace.

Love
Tonia Bolton

Please support the proposal for our school. The Elementary & Secondary Facility for Kenbridge. If we get it will surely help us out as to know we'll be attending there will be a comfortable thought!

Keep smiling
it makes people
wonder what you
been up to!

Feb. 6, 80

2-12-80

Dear

Hello, my name is Guy Balleto and I live in Karluk. Here we are in Karluk going to school in a box. We would really appreciate a new school. We would like to have a new school because in the last couple of years we moved to two different schools.

just in case you don't know, I reside on the island of Kodiak in Karluk. I sure wish we could get our new school next year sometime. If we are able to get it. will you please try to help us here in Karluk.

Guy Balleto

FeB.
2-12-80
Kar

Dear ,

I am Philip Mccormick.
I Live in Karluk Alaska. a village on
Kodiak Island. karluk is a nice place to Fish.
Karluk needs a new school. we use to
go to school across river. That school
Is Bigger Then this school. the
school that we are in Has Leaks
In it. The school That we are in now is to
small. we Do not Have no room in The school.
We want a new school next year.

Philip Mccormick

Feb, 2, 1980

Dear

How are you doing? My name is Derk Youvella I live on Kodiak Island in a village called Karluk We would appciate a new school. Because the school is to small and there are leaks in the school. And we would like the school next year.

By Derk

Feb. 12-1980

Dear ,

My name is Katharine Yeronne Left. I am in the 6th grade and 11 years old. I live in Kalskag which is on Kodiak Island. I wrote this letter to tell you we need a new school. Every day we go to conversation in the teachers trailer. The little kids are to noisy it's hard to learn. And next year we are getting more small kids. So please help us. We sure need help. I sure wish you could come out here and I will show you around. Thank you hope you could come.

Left Katharine Yeronne.

3-12-80
Karluk Ak.

Dear

I am Darryl Squartsoff.
I Live in Karluk Alaska in a blue house.
We would appreciate it you would
give us a new school. Our school
is to buse in. We always have a
class in our teachers house. If you
would get us a new school send
it as soon as posable. So we
won't be so crowded. In 1977
we had a brige and a store
but a storm started and our
big wood stor was distroyed. Our
brige was down by the time
the storm was over. Our Store keeper
quit his job and left. This happend
On my brothers birthday he was 1.
Now he is 3 years old. We are
going to have a lot of kids
next year in this small school.
I hope we dont have to go
to school out side next year.
Hope you can help

FEBRUARY 12 1980

2-12-80

Dear

Hello my name is Emil Sugak. we would like a new school. I live in Kodiak Island. I would like you to come over when you get a chance to. are school leaks all over the place. I am in 3th grade. and i am 9. are villiage is called Karluk. What is your names. where do you live. I have a friend name Robin he is in 3th grade and he is 9. I dont have anything else to say.

Bye

February 1980

Dear

"Hello my name is Roben Squisoff. "We would like a new school. We got a small school. "Please send us a new school. "I live on Kodiak. "Island. "We would like you to come over and visit one day. The school shakes. I am in 7th grade I am nine years old. Who is your name. We got a school that is 18x40.

By By

Feb. 12, 1980

Dear Fred Zharoff,

Hello my name is Alicia Lynn Reft. I live in Karluk, Alaska it is a small village of about 80 to 100 people. There are 20 kids in the morning in school and 26 in the afternoon and we could not work well because the school is noisy. The school is so small we have to go do Comprehension in the teacher's house. I would sure appreciate it if you could help us get a new school for next year because next year we are going to have about 30 to 32 kids in the school. We used to live on the other side of the village. Over there we went to school the school is nice and big but right now we are over here in the small school and on the other side three kids are taking Correspondence course and they are going to go to school over here next year. But we could barely fit them in

Dear _____ Feb.-12-80

Hello! My name is Joyce Elaine Reft. I live in Karluk. Karluk is on Kodiak Island Alaska. There are twenty kids in school and twenty six in the afternoon. We are going to school in a small Atco. We have to have Comprehension in the teachers trailer, because we don't have enough room in our school. We are asking you people to help us get a bigger and new school. I am 12 years old and in the 7th grade. My Teachers name is Mr. Craig Flynn. Every Tom it rains our school we have to put pans in the middle of our school. We don't have any place to go any where. We have to wear Rubber instant soups. We would like to have you out here and will show you our small school. When it storms hard the whole school shakes. Next year there going to be more kids.

THE PRECEDING DOCUMENT(S) MAY NOT FILM LEGIBLY BECAUSE OF POOR QUALITY OF THE ORIGINAL.

KANA NEWSLETTER

Volume 4- Number 3 FEBRUARY 1980

To promote pride on the part of the Natives of Alaska in their heritage & traditions; To preserve the customs, folklore & art of the Native races; To promote the physical, economic & social well-being of the Natives of Kodiak. To discourage & overcome racial prejudice & the inequities which such prejudice creates; To promote good government by reminding those who govern & those governed of their joint & mutual responsibilities.

THE VICE-PRESIDENT's VIEW

The residents of Kodiak Island should be well-aware of four bills presently before the Alaska State Legislature. All four will directly affect us. I urge your support of two of these bills - one providing for construction of a new school in Karluk and another providing for the installation of KMXT translators, and your active opposition to two other bills which repeal the limit seiner length and repeal prohibition of drum seining.

NEW SCHOOL FOR KARLUK

HB-620 was introduced in January by Representatives Osterback and Zharoff. This bill provides appropriation of $3,600,000 for construction of a new elementary-secondary school in Karluk. The funds would go directly to the Kodiak Island Borough for the construction project.

The village of Karluk needs your support. At this time, 27 students (Kindergarten through 8th grade) are attending classes in an ATCO unit. The conditions are very overcrowded and the various grade levels of the students make one-classroom teaching difficult.

Since Karluk is not included in the school construction bond issue this fall, legislative action is their only hope for a new school.

KMXT TO THE VILLAGES

In February, Representative Osterback introduced HB-548 to provide appropriation to install KMXT Radio translators between Kodiak and the villages of Old Harbor and Larsen Bay. The translators will extend KMXT's signal to these villages, bringing them public radio.

KMXT's staff and board have been working very hard for several years to extend their radio signal to all the Kodiak Island villages. This is the first of appropriating legislation to meet their goal and it needs our active support.

MORE GEAR, LARGER BOATS

Two bills before the Alaska State Legislature have the potential of adversely affecting salmon fishing on Kodiak Island and other areas of the states

HB-1, introduced by Representative Eliason, is an act relating to the length of salmon seine vessels. This bill repeals the maximum 58-foot keel. Allowing larger boats would have definite adverse effects on small boat fishing as practiced by the majority of Native fishermen on the Island. Larger vessels would result in increased cape fish-

(Continued on Page 2)

OIL - WHAT DO WE THINK

KANA and five villages are offering testimony this week at the Anchorage and Kodiak Public Hearings on the Draft Environmental Impact Statement (DEIS) for OCS Lease Sale No. 46.

KANA's testimony is supporting the No Sale option outlined in the DEIS statement. This formal position was reached by the KANA Board of Directors following staff and OEDP Committee analysis of the DEIS. The Board's support of the No Sale position was adopted for the following reasons: 1) The unavoidable adverse environmental impacts that will occur to the Island, particularly to its commercial fisheries, from the development and production of and/or natural gas from the sale area, 2) the adverse socio-economic effects that will occur, particularly to the subsistence/small boat rural lifestyle of the villages, 3) the non-compliance of conducting this sale in accordance with guidelines stated in the Bureau of Land Management/ Outer Continental Shelf Lands Act of 1953 as amended in 1978.

In addition, the villages of Akhiok, Karluk, Ouzinkie and Port Lions are supporting the No Sale options for similar reason. Old Harbor, however, is supporting the No Sale option prior to the lease sale occuring, but is requesting that it be considered as a potential location for the onshore facilities should oil development occur.

KANA's review process has focused on reviewing the numerous documents prepared in regard to Lease Sale No. 46, providing information to the Island's Native people on the probably impacts associated with the proposed sale, and to assist in advocating positions that the Island's villages have adopted. This effort has primarily occurred through working with the KANA Overall Economic Development and Planning Committee, a sub-committee comprised of one representative from each of the Island's six villages. The Committee's efforts have included meeting independently and with the Borough's OCS Advisory Council to become familiar with oil development.

NOTICE

The Eye Doctor from AMNC will be coming to Kodiak March 31st through April 4th. Anyone wishing to make an appointment, please contact Geraldine Squartsoff, the Kodiak Area Native Association Health Department, at 486-5725, extension 241.

KODIAK AREA NATIVE ASSOCIATION NEWSLETTER
P.O. Box 172 Kodiak, Alaska 99615 Phone 486-5725

From the office of the Vice - President

FRANK R. PETERSON - President
IONE M NORTON - Vice - President

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NEWS BRIEF

Budget Request Affects Alaska

The President sent Congress his budget request for FY 1981 which includes for Alaska: $25.2 million for military construction; $83.1 million for the Coast Guard; $98.3 million for the FAA; $124 million for highways; $11.5 million for the Alaska Railroad; $1.1 million for mass transportation; $38.9 million for the BLM; $30.8 million for the BIA; $76.5 million for Interior; $1.7 million for Bureau of Mines; $19.9 million for Fish and Wildlife; and $19.9 million for the National Park Service.

FUEL ASSISTANCE AVAILABLE NOW

The Federal Fuel Assistance Program is designed to provide up to $350 credit for fuel to households whose income falls within the prescribed guidelines. The program is available to help with fuel bills, paid or unpaid, incurred since October 1, 1979. The money goes directly to the fuel company with which you deal. When you send in your application, enclose your fuel and utility bills, paid or unpaid, since October 1, 1979.

Income guidelines are as follows:

HOUSEHOLD SIZE	MONTHLY GROSS INCOME
1	$445
2	558
3	730
4	873
5	1,016
6	1,158

Some income, such as the Longevity Bonus, is not "counted against you," so even if you are somewhat above the guidelines, apply anyway. You may be eligible.

In Kodiak, applications are available at the Food Stamp office in the old Hospital Building and at KANA Social Services office.

In the villages, the fee agents or Council have forms available.

WELCOME ABOARD!

Interest and enthusiasm is evident as Gene Sharratt talks about his new job at KANA. That is High School Counselor funded through the JOM program. Gene replaces Yvonne Zharoff who recently resigned to accompany here husband, Representative Fred Zharoff to Juneau.

Gene is located at the Counseling office in the High School and is available to any Native student for counseling, scheduling or just a friendly chat.

Gene has been in Kodiak off and on since 1965. He is married and he and his wife Carol have one child, Sarah. He comes to us with a Master's degree from the Pacific Lutheran Universit and a teaching background.

Welcome aboard, Gene!

(Continued from Page 1) MORE GEAR, LARGER BOATS

eries, increased gear lengths, lead to higher prices for entry permits and in general, favor "outside" fishermen who are engage in large boat salmon fisheries in other areas.

A House concurrent resolution (No. 54) has been introduced by Osterback, Gardener, and Zharoff which requests the Board of Fisheries to adopt special regulations for the Kodiak and Shumigan Islands and Alaska Peninsula. The resolution imposes a fifty-foot limit for these areas. Although the resolution is an attempt to save these areas from eliminating the present maximum keel length limit, it does not carry the weight of law.

HB-791, introduced by Representative Gardiner, reinstates the use of a drum or a reel as legal gear in the purse seine fishery. As would occur from the removal of the maximum keel length limit, this bill would favor "outside" fishermen who already use power reels or drums as legal gear in "lower 48" salmon fisheries. Overall, the most apparent effects would be less fish for the inland bay small boat fishermen and increasing pressures to reduce the number of entry permits available for the Kodiak Island area. Although the bill is being considered during this legislative session, it would not take effect until January 1, 1984.

I urge you to contact our legislators, Senator Mulcahy, Representative Zharoff and Osterback, to voice your concern on these bills. Petitions have or will be circulated in each village regarding HB-1 and HB-791.

AKHIOK MEN AMONG PUBLIC SAFETY OFFICER GRADUATES

Eighteen men and women completed four weeks of intensive training as Village Public Safety Officers with their graduation from the Department of Public Safety Academy in Sitka on February 8th. Among the graduates were Mitch Simeonoff and Robert Simeonoff of Akhiok.

This Village Public Safety Officer training course included two weeks of training as emergency medical technicians, the same course given to all Alaska State Troopers; and two weeks training in law enforcement, boating and water safety, search and rescue operations and preparation of village ordinances relating to public safety.

Later this spring, these Village Public Safety Officers will receive an additional one-week training in fire fighting and fire prevention. This will be conducted by the State Fire Service Training Program of the Department of Education at the new Regional Fire Training Center in Anchorage.

This will be followed by continued on-the-job training by Alaska State Troopers. As Village Public Safety Officers, these men and women will be responsible for providing a wide range of public safety services in their respective communities. This includes law enforcement, emergency medical treatment, fire fighting and the development of fire fighting skills and fire prevention programs in the villages, development of boating and water safety programs and enforcement of boating safety in cooperation with the U.S. Coast Guard, development of search and rescue programs within the villages and assistance to the village councils in the adoption of village ordinances.

KODIAK TEAMS HEAD FOR NATIVE YOUTH OLYMPICS

Although the first Native Youth Olympics was held in the spring of 1971, Kodiak youths did not participate until 1978. Now, as they enter their third year of competition, their interest and enthusiasm is stronger than ever. Twenty-two students from the Kodiak area are expected to participate in the state-wide competition in Anchorage on March 7 & 8. Island-wide local competition was held in February to create our All-Star team going to Anchorage. The Akhiok competitors were weather out during the island competition and consequently will be taking their own team to Anchorage.

The competition evolved from twelve teams in 1971 to over eighteen last year. This year's Native Youth Olympics promises to be even larger and more competitive. Students from Nome and Sitka will make the trip to Anchorage to compete for Gold, Silver and Bronze medals in eight different events.

These events include stick pull, head pull, leg wrestling, kneel jump, toe kick, two-foot high toe kick, one-foot high toe kick and seal hop.

The members of this year's Kodiak Island team include Walter and Paul Kewan, Vickie Delgado, Melody Inman, David Bourdon, Lloyd Ashouwak, Susan Panamaroff, Leona Haakanson, Elaine Smileoff, Barbara Squartsoff and Judy Inga. The team is being coached by Sue Bolling, a fifth-grade teacher at Main Elementary School, and Gene Sharratt, JOM Counselor at the high school. (Names of the Akhiok team members are not available.)

GOOD LUCK TO ALL!

INDIAN CHILD WELFARE ACT - HOW IT AFFECTS ADOPTIONS

When the Indian Child Welfare Act went into effect in May 1979, it brought about changes in adoption procedures all over the United States. Some of the procedures were already required under Alaska State Law. Other changes go beyond Alaska State Law and take precedence over Alaska State Law.

There are two routes to adoption: one, in which parents' rights to a child are terminated or ended permanently without their consent; and two, in which the parents voluntarily decide and agree to relinquish or give up their rights to their child.

I. In situations in which parents' rights are terminated or ended without their consent, the following rules apply.

1. The party seeking to terminate or end the parents' right must notify the child's parent, custodian, and the child's tribe of the court proceeding, and they must notify the parents and the tribe that they have a right to intervene and take a part in the court proceeding, at any point in the proceeding. After receiving notice, the parent, custodian, or the tribe or village have ten days, plus an additional 20 days upon request, to prepare for the court proceedings.

2. If the identity or location of the parent or Indian custodian and the tribe cannot be determined, the Secretary of the Interior shall be requested to notify the child's parent, Indian custodian, and tribe.

3. The child and his parent or Indian custodian shall have the right to court-appointed legal counsel.

4. Where state law makes no provision for court-appointed counsel in removal, placement, or termination proceedings, the Secretary of Interior shall pay for that service.

5. Any party seeking to terminate or end parental rights without parental consent must satisfy the court that active efforts have been made to provide remedial services and rehabilitative programs designed to prevent the breakup of the Indian family and that these efforts have proved unsuccessful.

6. Parental rights cannot be ended without parental consent unless the court determines, supported by evidence beyond a reasonable doubt, including testimony of qualified expert witnesses, that the continued custody of the child by the parent or Indian custodian is likely to result in serious emotional or physical damage to the child. Expert witnesses include people knowledgeable about tribal or village culture and customs.

(Continued on Page 6)

MANPOWER ON THE GO

Our ever-changing manpower program is gearing into the spring and summer seasons with completion of the carpentry programs and planning for the Summer Youth projects.

The Title IID Carpentry program in Kodiak and Ouzinkie drew to a close at the end of February with the completion of the Ouzinkie Health Clinic and the near completion of the Medical/Dental Clinic on the first floor of the Donnelly Building (KANA offices). After a little more finish work is taken care of in the Medical/Dental Clinic, an opening date will be announced.

Debbie Hunter, Manpower Program Manager, has already started planning for our summer youth projects. There will be employment for youths in the six villages and in Kodiak. Any ideas for meaningful projects are being accepted now. Contact Debbie at 486-5726.

Three of our newest in-town CETA participants are Peter Chichenoff, Laurie Ann Simeanoff and Loretta Shangin. All three are students at the Kodiak High school and are employed by the YETP program.

Peter is working at Alaska Legal Services as a para-legal trainee. His interests lie in this field of work and he enjoys his job.

Laurie Ann is working as a Nurse's Aide Trainee at the Kodiak Island Hospital. Laurie is interested in attending Sheldon Jackson College this fall to become a Registered Nurse.

Loretta's interests lie in the dental assistant field and she will be working in the Dental Clinic located in the Donnelly Building.

Two new participants in the CETA Title VI program are Vickie Leslie and Sue Lukin.

Vickie is working as a Court Clerk Trainee at the State Court System and find this a perfect opportunity to make herself more aware of this field.

Sue is working at the Harbormaster's Office in a clerical position. She was not available when pictures were taken.

Loretta Shangin

Peter Chichenoff

Vickie Leslie

Laurie Ann Simeanoff

NOBODY CALLS ME "DOCTOR"

If he walks like a Doctor, talks like a Doctor, sees you when you're sick like a Doctor, sews you up when you're cut, like a Doctor, why does he have the letters "P.A." after his name and not "M.D.". . .like a Doctor should? These are questions many people ask when they first come in contact with the newest breed of mid-level medical practitioner the profession refers to as "P.A." or Physician's Assistant.

The basic answer to the above question is "he's not called a Doctor because he isn't a Doctor, but a member of a relatively new professional class of mid-level practitioners which also includes Nurse Practitioners and Pediatric Nurse Practitioners". These new mid-level practitioners fill a much-needed role in the overall health care picture by serving the needs of medically under-served areas such as the Alaska bush country, often working with Native people in remote, isolated sites which could not afford the cost of a physician.

The first "P.A." graduated from Duke University School of Medicine's Physician's Assistant Program in 1965. There were four men in that pioneering class, and all had been Navy Corpsmen with independent duty experience during the Vietnam conflict. The initial Duke program consisted of two intense calendar years of medical training which prepared them to function in a medical practice with a physician supervisor—performing many of the tasks formerly restricted only to physicians themselves. Now there are over 40 P.A. programs throughout the United States and over 12,000 P.A.'s practicing, with 1200 new graduates each year.

The role of "P.A.'s" has grown during the short fifteen-year history of the profession. Now these mid-level practitioners serve in clinics and hospitals around the country, and their services are barely distinguishable from those of their physician supervisors. Yet, that is the major difference between a P.A. and a Doctor. The P.A. must always be a dependent practitioner, under the direct or indirect supervision of a sponsoring physician. The medical education of a P.A., while intensive and thorough, is not the equivalent to that of his physician supervisor, so the supervision is not only necessary but appropriate. This need for supervision is the protective edge the patient is guaranteed when he visits his community P.A., who always knows his limitations, and the appropriate time to ask for help when those limitations are reached.

In effect, then, a patient can be assured of receiving the same high level of care from the P.A. as he would from the physician himself. The difference is that if a patient's problems cannot be diagnosed by the P.A., he consults with his supervising physician or refers the patient to his own physician for appropriate, higher-level care. Thus the patient always receives the appropriate level of care needed for the situation, and never gets "second-class" medical care and treatment.

P.A.'s are licensed by the state in which they practice and must have graduated from an American Medical Association-approved Physician's Assistant Program, and have met other, tough State standards. P.A.'s now have prescription-writing privileges in 15 states with more states passing such enabling legislation each year. They often work for specialists such as Orthopedic Surgeons or Cardiologists, and have staff privileges at hospitals wherever they live and work, but again—those privileges are always tied in with the privileges of the supervising physician.

In Kodiak, there are three Physician's Assistants and one Nurse Practitioner currently practicing with their "back-up" physicians. Three of these are in private practice and the fourth works for KANA as a member of the Itinerant Health Care Team, under the KANA Health Director. He is Ken Miller, P.A. Ken's sponsoring physician is Dr. Rud Wasson of the Island Medical-Dental Center now under construction in Kodiak. When that facility opens in June, another medical staff member will be coming aboard", with the addition of a family practice physician, who will also act as KANA's Medical Director.

Interviewed at KANA this week, Ken Miller says he is constantly on the look-out for Native youth and young adults who may show an interest in the Physician's Assistant career field. "I envision that in ten or fifteen years, most of the Native Corporation jobs now held by non-Native P.A.'s in Alaska will be filled byNativeswho have left home for a few years to take the needed training and have come back to practice," he said. Ken feels that the P.A. profession is largely overlooked by many Native youth who are not aware of its existence. "The training and experience we give our CHA's should make them ideal candidates for a P.A. or Nurse Practitioner career if they would be interested," he added. He said he is willing to counsel any Native youth interested in more details about becoming a P.A. or Nurse Practitioner.

So, while you may call him "Doc". . .he may, in fact, be a member of the newest breed of medical practitioner. . . the P.A. And if you notice your local P.A. grinning the week of March 6th, it's because Governor Hammond has proclaimed the days of March 6, 7, & 8 as "Physician's Assistant Recognition Days." It's a long way from 1965, when the first four Duke graduates were constantly asked, "What's a P.A.?"

Kodiak Women's Resource Center

24-HOUR CRISIS LINE

486-3625 or 487-5086

ASSISTANCE:

- if your home is unsafe because of violence against you
- if you have been raped
- if you have been assaulted
- if you need help

INFORMATION KEPT CONFIDENTIAL

*Villages may call collect

Bus. Phone 486-5038

P.O. Box 2122
Kodiak, AK 99615

(Continued from Page 3)

II. In situations where parents Voluntarily Relinquish or give up their right to a child, the following rules apply.

1. The consent must be put in writing, and recorded before a judge of competent jurisdiction who will make sure that the parents understand exactly what they are doing.

2. No consent is valid for an infant until the infant is ten days old.

3. The consent of the parent or custodian can be withdrawn up until entry of the final decree of termination of rights or adoption.

4. After the entry of a final decree of adoption of an Indian Child in any State Court, the parent may withdraw consent upon the grounds that consent was obtained thru fraud or duress and may petition the court to overturn the decree. If the court finds that consent was obtained thru fraud or duress, the court shall overturn the decree and return the child to the parent. No adoption which has been effective for at least two years can be invalidated unless otherwise permitted by State Law.

III. Placement - Adoptive and Pre-Adoptive

The following placement preferences must be followed unless there is "good cause to the constrary." Good cause to the contrary means strong reasons not to follow the placement preferences in the law.

For the adoption placement, a preference will be given to:

1. a member of the child's extended family
2. other members of the Indian Child's tribe; or
3. other Indian families

For pre-adoptive placement (the waiting time before placement in the adoptive home), the child must be placed in the least restrictive setting which is most like a family and meets the child's needs. The child should also be placed reasonably close to his home.

The preferences for pre-adoptive placements are:

1. a member of the Indian child's extended family;

2. a foster home licensed, approved, or specified by the Indian child's tribe;

3. an Indian foster home licensed or approved by an authorized non-Indian licensing authority; or

4. an institution for children approved by an Indian tribe or operated by an Indian organization which has a program suitable to meet the Indian child's needs.

"Good cause" not to follow the placement preferences in the Law is based on one or more of the following considerations:

1. The request of the biological parents or the child when the child is of sufficient age.

2. The extraordinary physical or emotional needs of the child as established by testimony of a qualified expert witness.

3. The unavailability of suitable families for placement after a diligent search has been completed for families meeting the preference criteria.

4. The burden of establishing the existence of good cause not to follow the order of preferences, shall be on the party urging that the preferences not be followed.

The Child's tribe or village can establish a different order or preference by resolution, as long as the change is the least restrictive for the child and yet meets the child's needs.

The law says that, where appropriate, the preference of the parent and the child (if the child is of sufficient age) shall be considered. Also, if the parents' request confidentiality, this shall be taken into consideration.

A record of each such placement (pre-adoption), foster care, and adoption) shall be kept by the State showing how it made efforts to comply with the placement preferences. Such records shall be made available at any time at the request of the Secretary of the Interior or the Indian (Native) child's tribe (village).

When an Indian (Native) child who was adopted reaches the age of 18, the court shall inform him or her of his or her tribal affiliation and any such information as needed to protect the adopted child's right flowing from a tribal affiliation.

The provisions of the law do not apply to adoptions completed prior to May, 1979, except for an adopted child's right to find out about his or her tribal affiliation.

For any additional information or explanation on the Law, contact

John Johanson, KANA Social Services,
486-5726

K.A.N.A.
P.O. Box 172
Kodiak, Alaska 99615

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DRUG LEGISLATION

HESS COMMITTEE

SUMMARY

STATE OF ALASKA/ Jay S. Hammond
Governor

Title 17 contains our current drug statutes Chapt 12 enacted in 1968

SUMMARY OF PROPOSED REVISION TO ALASKA'S DRUG LAWS

I. INTRODUCTION

House Bill 628 comprehensively revises, consolidates and modernizes the drug laws of Alaska. The bill is patterned after the Federal Controlled Substances Act of 1970 and the Uniform Controlled Substances Act. The Federal and Uniform Acts have served as models for the forty-four states that have recently revised their outdated drug laws.

The bill has two related but distinct objectives regarding the problem of drug abuse. The first is to discourage the illicit trafficking in and use of drugs by establishing rational and enforceable penalties for the illegal distribution and possession of controlled substances. The second is to insure that the legitimate handling of controlled substances by persons such as pharmacists and manufacturers is properly regulated to prevent diversion of drugs into illegal channels.

II. CLASSIFICATION OF CONTROLLED SUBSTANCES

Following the lead of the Federal and Uniform Acts, House Bill 628 classifies all controlled substances into schedules based on the relative danger of the substance. Six schedules are used with schedule I containing the most dangerous controlled substances. Schedules II, III, IV, V, and VI list controlled substances in descending order of relative dangerousness.

Heroin, for example, is classified as a schedule I controlled substance while cocaine is classified as a schedule II controlled substance. Valium is classified as a schedule IV controlled substance while marijuana and alcohol are classified as schedule VI controlled substances. The specific penalty for the illicit manufacture, distribution and possession of a particular controlled substance is determined by the scheduling of the drug.

III. CONTROLLED SUBSTANCES ADVISORY COMMITTEE

Following the recommendation of the Uniform Controlled Substances Act, the proposed bill establishes a Controlled Substances Advisory Committee.

The Committee proposed under the bill would be comprised of nine members having special expertise in dealing with the problems of drug abuse. Included as members are the Director of the Division of Public Health, a pharmacist, the Commissioner of Public Safety, the Attorney General, a physician and a law enforcment officer. A public member is also appointed by the governor to insure maximum opportunity for citizen participation.

While all controlled substances are initially classified into one of the six schedules by the bill, the Committee is given primary responsibility for adding controlled substances after public hearings as new information becomes available concerning the abuse of drugs. If a drug is added to the federal schedules the committee must within 60 days consider adding the drug to Alaska's controlled substances schedules. Additionally, the committee is charged with the responsibility to determine whether the deletion or rescheduling of controlled substances is required and to report its findings to the governor and the legislature.

IV. CRIMINAL PENALTIES

House Bill 628 classifies all offenses involving the abuse of Controlled Substances into six degrees of the crime Promoting a Controlled Substance. The bill reserves its stiffest penalties for persons engaged in the large scale distribution of controlled substances and the distribution of drugs to minors.

A. Promoting a Controlled Substance in the First Degree

Promoting a Controlled Substance in the First Degree is the most serious crime under the bill and is punishable by a mandatory term of imprisonment of at least five years and a maximum term of imprisonment of ninety-nine years. This penalty is identical to the penalties authorized in the new criminal code for the crimes of Kidnapping and Murder in the Second Degree.

This statute covers the distribution of a schedule I controlled substance (e.g., heroin) to a minor as well as ongoing large scale criminal enterprises involving the distribution of any controlled substance.

B. Promoting a Controlled Substance in the Second Degree

Promoting a Controlled Substance in the Second Degree is a class A felony which under the new criminal code is punishable by a maximum of twenty years imprisonment. This penalty is identical to the penalties authorized in the new criminal code for Manslaughter, Armed Robbery, and Rape.

The statute prohibits the manufacture or distribution of schedule I controlled substances (e.g., heroin) to any person as well as the distribution of a schedule II or III controlled substance (e.g., cocaine, LSD and hashish) to a minor.

C. Promoting a Controlled Substance in the Third Degree

Promoting a Controlled Substance in the Third Degree is a class B felony, punishable by a maximum penalty of ten

years under the new criminal code. This penalty is identical to the punishment authorized in the new criminal code for the crimes of Perjury and Burglary of a Dwelling.

The statute covers the manufacture and delivery of a schedule II or III controlled substance (e.g., cocaine and hashish), the distribution of a schedule IV or V controlled substance (e.g., valium) or marijuana to a minor, and the possession by an adult of a schedule I or II controlled substance (e.g., heroin or cocaine) in a school.

D. Promoting a Controlled Substance in the Fourth Degree

Promoting a Controlled Substance in the Fourth Degree, a class C felony, carries the same five year maximum penalty as Criminally Negligent Homicide and Riot under the new criminal code.

The statute covers seven forms of conduct including the distribution of any amount of marijuana, the possession of schedule I or II controlled substances (e.g., heroin and cocaine), the possession by an adult of schedule III, IV or V controlled substances or marijuana within the grounds of a school and the possession of one pound or more of marijuana under any circumstances.

The specific prohibition against possession of one pound or more of marijuana is included to resolve ambiguities created by the Supreme Court's decision in Ravin v. State regarding possession of small amounts of marijuana for personal use in the home. This has been a particular problem in dealing with situations involving the cultivation of large amounts of marijuana plants. Under House Bill 628 the possession of one pound or more of marijuana is presumed not to be for personal use and is classified as a felony.

Also included in the fourth degree crime are aggravated instances of bootlegging. While bootlegging of intoxicating liquor is ordinarily a misdemeanor under both present law and House Bill 628, the bill makes it a felony if the defendant has been previously convicted of bootlegging or has attempted to sell the intoxicating liquor to a minor or to more than one person.

E. Promoting a Controlled Substance in the Fifth Degree

Promoting a Controlled Substance in the Fifth Degree is a class A misdemeanor punishable by a maximum of one year in jail. It carries the same penalties as Resisting Arrest and Assault and Battery under the new criminal code.

The statute covers the unlawful possession of schedule III, IV or V controlled substances (e.g., hashish and valium),

the furnishing of intoxicating liquor to a person under 19 years of age, non-aggravated instances of bootlegging and the furnishing of false or fraudulent information in application, reports or records pertaining to controlled substances.

F. Promoting a Controlled Substance in the Sixth Degree

Promoting a Controlled Substance in the Sixth Degree, a class B misdemeanor punishable by a maximum sentence of 90 days imprisonment, carries the same penalty as the theft of a $20 pair of gloves and Prostitution under the new criminal code.

The statute prohibits various forms of conduct involving the possession of marijuana that is punishable by a maximum $1,000 fine but no jail time today. It covers the possession of marijuana in public, the possession of marijuana while operating a motor vehicle and the possession of marijuana by persons under 19 years of age.

V. INCREASED PENALTIES FOR REPEAT OFFENDERS

Because the sentencing provisions of House Bill 628 are keyed into the presumptive sentencing provisions of the new criminal code, a judge's discretion in sentencing a defendant with a prior felony conviction is substantially restricted. For example, if a defendant is being sentenced for Promoting a Controlled Substance in the Second Degree (e.g., Sale of Heroin) and has prior felony convictions for Burglary and Aggravated Assault, the sentencing judge will be unable to reduce the sentence below 7 1/2 years. Additionally, once sentenced, the defendant may not be paroled.

VI. FORFEITURE

The proposed bill contains detailed provisions providing for the forfeiture of items such as automobiles, airplanes and firearms that are used to facilitate illegal drug transactions. While heavily penalizing persons engaged in criminal activity, the bill contains provisions allowing innocent parties, such as a bank holding a security interest in an automobile, to protect their interest in the property.

VII. BAIL

The bill also contains an amendment of the present statute concerning release on bail which provides that a defendant may not be released on bail after conviction if the offense was Promoting a Controlled Substance in the First Degree or otherwise involved the manufacture, delivery or possession with intent to deliver a Schedule I or II controlled substance (e.g., heroin, cocaine, LSD) under circumstances manifesting an intent to distribute the substance as part of an ongoing commercial enterprise. This adds these offenses to Murder, Kidnapping and Rape for which bail may not be granted after conviction.

VIII. REGULATORY PROVISIONS

To insure that drugs destined for legitimate distribution and possession by manufacturers, doctors, researchers and pharmacists are not diverted to illegal use, the bill requires registration with the state of all persons legitimately in possession of controlled substances. An identical scheme for monitoring legitimate use of controlled substances is provided for by federal law.

To insure that pharmacists, doctors, researchers and manufacturers of controlled substances are not subject to conflicting state and federal requirements concerning registration and record keeping requirements, order forms and prescriptions, the bill specifically provides that compliance with federal requirements satisfies state law.

IX. LABORATORY REPORTS

The bill additionally contains a provision for streamlining trials by allowing for the introduction of a certified laboratory report at the time of trial as evidence of the chemical nature of a suspected controlled substance. A defendant who has been properly notified that this procedure will be followed may for good cause object to such a procedure and require the presence of the chemist who performed the analysis of the drug. This procedure will allow the chemist to remain in his laboratory performing analysis rather than repeating in a court what he has already stated in his report.

MAJOR FEATURES OF PROPOSED DRUG LEGISLATION

I. EXPRESSION OF LEGISLATIVE INTENT - PURPOSE OF BILL

- A. CONSOLIDATE AND MODERNIZE ALASKA'S DRUG LAWS ELIMINATING INCONSISTENCIES AND LOOPHOLES
- B. PROVIDE FOR UNIFORM PENALTY PROVISIONS ON THE BASIS OF THE SERIOUSNESS OF SUBSTANCES IN TERMS OF PUBLIC HEALTH AND SAFETY

II. TITLE 17: CONTROLLED SUBSTANCES ACT

- A. CRITERIA FOR CLASSIFICATION OF DRUGS SPECIFICALLY SET OUT
- B. CONTROLLED SUBSTANCES COMMITTEE
- C. SIX SCHEDULES FOR ALL DRUGS CLASSIFIED ON BASIS OF A DRUG'S DANGER UNDER THE CRITERIA SPECIFIED IN THE BILL
- D LEGITIMATE HANDLER'S REQUIREMENTS
- E. ADMINISTRATIVE AND ENFORCEMENT PROVISIONS
  1. COOPERATIVE LAW ENFORCEMENT AGREEMENTS
  2. COMPREHENSIVE FORFEITURE PROVISIONS
  3. EDUCATIONAL AND RESEARCH PROGRAMS

III. TITLE 11: SPECIFIC CRIMINAL OFFENSES - REORGANIZES ALL OFFENSES INTO A SINGLE CHAPTER IN THE CRIMINAL CODE

- A. BROKEN DOWN INTO SIX DEGREES OF THE CRIME "PROMOTI'G A CONTROLLED SUBSTANCE."
- B. KEYED INTO THE CLASSIFICATION PROVISIONS OF THE REVISED CRIMINAL CODE
- C. KEYED INTO THE PRESUMPTIVE SENTENCING PROVISIONS OF THE REVISED CRIMINAL CODE

IV. AMENDMENT TO BAIL STATUTE DENYING BAIL AFTER CONVICTION FOR SERIOUS DRUG OFFENSES

SCHEDULING EXAMPLES

SCHEDULE I - HEROIN, OPIUM, OPIATES, METHADONE

SCHEDULE II - COCAINE, LSD, MESCALINE, PCP, AMPHETAMINES AND THE MORE SERIOUS DEPRESSANTS SUCH AS METHAQUALONE

SCHEDULE III - MODERATELY SERIOUS STIMULANTS AND DEPRESSANTS, BARBITURATES, HASHISH AND HASHISH OIL

SCHEDULE IV - LESS SERIOUS STIMULANTS AND PRESCRIPTION DEPRESSANTS (e.g. VALIUM)

SCHEDULE V - SMALL AMOUNT OF CODEINE AND OPIUM IN MIXTURES HAVING MEDICINAL QUALITIES

SCHEDULE VI - MARIJUANA AND INTOXICATING LIQUOR

CHARTS

COMPARISON WITH CLASSIFICATION OF OFFENSES UNDER THE REVISED CRIMINAL CODE

OFFENSE CLASSIFICATION	UNCLASSIFIED MAXIMUM 99 YR.	CLASS A FELONY 0-20 YR.	CLASS B FELONY 0-10 YR.	CLASS C FELONY 0-5 YR.	CLASS A MISDEMEANOR 0-1 YR.	CLASS B MISDEMEANOR 0-90 DAYS	VIOLATION MAXIMUM $200 FINE
DRUG LAW OFFENSES	PROMOTING A CONTROLLED SUBSTANCE IN THE FIRST DEGREE	PROMOTING A CONTROLLED SUBSTANCE IN THE SECOND DEGREE	PROMOTING A CONTROLLED SUBSTANCE IN THE THIRD DEGREE	PROMOTING A CONTROLLED SUBSTANCE IN THE FOURTH DEGREE	PROMOTING A CONTROLLED SUBSTANCE IN THE FIFTH DEGREE	PROMOTING A CONTROLLED SUBSTANCE IN THE SIXTH DEGREE	
EXAMPLES OF CRIMES INCLUDED IN DRUG OFFENSES	SALE OF HEROIN TO A MINOR DRUG OFFENSES COMMITTED AS PART OF A CONTINUING CRIMINAL ENTERPRISE	SALE OF HEROIN SALE OF COCAINE OR HASHISH TO A MINOR	SALE OF COCAINE SALE OF MARIJUANA TO A MINOR	SALE OF MARIJUANA POSSESSION OF HEROIN, COCAINE, LSD, ETC.	POSSESSION OF HASHISH FURNISHING LIQUOR TO A MINOR	POSSESSION OF MARIJUANA IN PUBLIC POSSESSION OF MARIJUANA OR INTOXICATING LIQUOR BY PERSON UNDER 19	
COMPARISON WITH OTHER OFFENSES IN SAME CLASSIFICATION	MURDER IN THE FIRST DEGREE MURDER IN THE SECOND DEGREE KIDNAPPING	MANSLAUGHTER RAPE ARMED ROBBERY	THEFT IN THE FIRST DEGREE ($25,000+) EXTORTION BURGLARY OF A DWELLING PERJURY	THEFT IN THE SECOND DEGREE ($500-25,000) BURGLARY OF A BUILDING RIOT	THEFT IN THE THIRD DEGREE ($50-$500) ASSAULT AND BATTERY CRIMINAL NON-SUPPORT RESISTING ARREST	THEFT IN THE FOURTH DEGREE ($50 or LESS) CARRYING A CONCEALED WEAPON DISORDERLY CONDUCT PROSTITUTION	LITTERING GAMBLING (1st OFFENSE) SELLING OR GIVING TOBACCO TO A MINOR

PRESUMPTIVE SENTENCING PROVISIONS

OF REVISED CRIMINAL CODE

CLASS A FELONY - 0-20 YEARS/$50,000
10 YEAR PRESUMPTIVE FOR SECOND FELONY CONVICTION
15 YEAR PRESUMPTIVE FOR THIRD FELONY CONVICTION

CLASS B FELONY - 0-10 YEARS/$50,000
4 YEAR PRESUMPTIVE FOR SECOND FELONY CONVICTION
6 YEAR PRESUMPTIVE FOR THIRD FELONY CONVICTION

CLASS C FELONY - 0-5 YEARS/$50,000
2 YEAR PRESUMPTIVE FOR SECOND FELONY CONVICTION
3 YEAR PRESUMPTIVE FOR THIRD FELONY CONVICTION

CLASS A MISDEMEANOR - 0-1 YEAR/$5,000

CLASS B MISDEMEANOR - 0-90 DAYS/$1,000

VIOLATION - FINE UP TO $300

TERMS OF IMPRISONMENT AND AUTHORIZED FINES IN REVISED CRIMINAL CODE

	FIRST FELONY CONVICTION	SECOND FELONY CONVICTION	THIRD FELONY CONVICTION
"A" Felony	0-20 3-[6]*-20	5-[10]-20	7 1/2-[15]-20
"B" Felony	0-10	0-[4]-10	3-[6]-10
"C" Felony	0-5	0-[2]-5	0-[3]-5

MAXIMUM FINES - PERSONS

Murder or kidnapping	- $75,000
A, B, or C Felony	- $50,000
A misdemeanor	- $ 5,000
B misdemeanor	- $ 1,000
Violation	- $ 300

MAXIMUM FINES - ORGANIZATIONS

All offenses - $100,000 or
3 X pecuniary gain
- whichever is greater

KEY

Number in bracket is presumptive sentence. Number to left is lowest mitigated sentence. Number to right is highest aggravated sentence.

* Six year presumptive term applies if first A felony conviction, other than manslaughter, and defendant used or possessed a firearm during the offense or caused serious physical injury.

MAXIMUM TERMS OF IMPRISONMENT FOR MISDEMEANORS

A misdemeanor - 1 year

B misdemeanor - 90 days

2-1

MAJOR FEATURES COMPARISON CHART

I. CLASSIFICATION RESPONSIBILTY AND CRITERIA

	HB 628 (1980)	SB 65 (1979) HB 10[illegible](1979)	HB 479 (1979)	FEDERAL CONTROLLED SUBSTANCES ACT	EXISTING LAW
RESPONSIBILITY FOR RESCHEDULING, DELETING, AND ADDING CONTROLLED SUBSTANCES	Commissioner of Health & Social Services upon advice of Controlled Substances Advisory Committee may add controlled substances. Legislature may add, delete or reschedule.	Legislature	Controlled Substance Committee created in Dept. of Law may by regulation add, delete or reschedule. Legislature may annul regulation of committee .	Attorney General upon recommendation of Secretary of HEW.	Legislature & Commissioner of Health & Social Services.
CRITERIA FOR DECIDING WHETHER A DRUG SHOULD BE CONTROLLED	Factors listed are basically identical to federal act but also include: (1) Relationship between use of a drug and other criminal activity; (2) Probable physical impact of widespread abuse of substance; and (3) The susceptibility of particular segments of the population.	Not Specified	Same factors as included under Federal Controlled Substances Act.	Eight Factors, including: (1) Potential for abuse; (2) Pharmacological effect; (3) Risk to public health; (4) Risk of psychic or physiological dependence.	Not Specified
CRITERIA FOR DECIDING IN WHICH SCHEDULE A DRUG SHOULD BE CLASSIFIED	The criteria for deciding whether a drug should be controlled are examined in determining the "danger or probable danger of a substance." Drugs with the highest degree are classified in the most serious schedule. Drugs with less danger are classified in correspondingly less serious schedules.	Not Specified	The criteria for deciding whether a drug should be controlled are examined in determining the "danger or probable danger" of a substance. Drugs with the highest degree are classified in the most serious schedule. Drugs with less danger are classified in correspondingly less serious schedules.	Schedule tests are specified and include: (1) Potential for abuse; (2) Accepted medical use; and (3) Physiological dependence.	Not Specified

MAJOR FEATURES COMPARISON CHART

II. PENALTIES: DISTRIBUTION OF CONTROLLED SUBSTANCES TO MINORS

	HB 628 (1980)	SB 65 (1979) HB 101(1979)	HB 479 (1979)	FEDERAL CONTROLLED SUBSTANCES ACT	EXISTING LAW
HEROIN	Unclassified Felony 5-99/$75,000	0-Life/$25,000	A Felony 0-20/$50,000 10 yr. presumptive if second felony conviction 15 yr. presumptive if third felony conviction	0-30/$50,000 - First Offense 0-45/$75,000 - Second Offense	10-30/$5,000-$10,000 First Offense 15-30/$5,000-$10,000 Second Offense
COCAINE	A Felony 0-20/$50,000 10 yr. presumptive if second felony conviction 15 yr. presumptive if third felony conviction	0-Life/$25,000	A Felony 0-20/$50,000 10 yr. presumptive if second felony conviction 15 yr. presumptive if third felony conviction	0-30/$50,000 - First Offense 0-45/$75,000 - Second Offense	Same penalties as for distribution of herion
MARIJUANA	B Felony 0-10/$50,000 4 Yr. presumptive if second felony conviction 6 yr. presumptive if third felony conviction	0-Life/$25,000	C Felony 0-5/$50,000 2 yr. presumptive if second felony conviction 3 yr. presumptive if third felony conviction	0-2/$10,000 - First Offense 0-4/$20,000 - Second Offense	0-Life/$25,000

MAJOR FEATURES COMPARISON CHART

III. PENALTIES: DISTRIBUTION OF CONTROLLED SUBSTANCES

	HB 628 (1980)	SB 65 (1979) HB 101 (1979)	HB 479 (1970)	FEDERAL CONTROLLED SUBSTANCES ACT	EXISTING LAW
HEROIN	A Felony 0-20, $50,000 10 yr. presumptive if second felony conviction 15 yr. presumptive if third felony conviction	2-25/$20,000-First Offense 4-Life/$25,000-Second Offense	A Felony 0-20/$50,000 if 50 or more capsules, tablets, ampules, syrettes or 1/8 oz or more B Felony if lesser amount Presumptive Sentencing for second and third felony	0-15/$25,000 - First Offense 0-30/$50,000 - Second Offense	Same penalties as provided for possession of heroin and cocaine: 2-10/$5,000-First Offense 10-20/$7,500 -Second Offense 20-30/$10,000-Third Offense
COCAINE & LSD	B Felony 0-10/$50,000 4 yr. presumptive if second felony conviction 6 yr. presumptive if third felony conviction	Cocaine: 2-25/$20,000 - First Offense 4-Life/$25,000 - Second Offense LSD: 0-15/$15,000 - First Offense 0-30/$30,000 - Second Offense	A Felony 0-20/$50,000 if 50 or more, capsules, tablets, ampules, syrettes or 1/2 oz or more B Felony if lesser amount Presumptive Sentence for second and third conviction	Cocaine: 0-15/$25,000 - First Offense 0-30/$50,000 - Second Offense	Cocaine: Same penalties as provided for possession of heroin and cocaine: 2-10/$5,000 -First Offense 10-20/$7,500 - Second Offense 20-40/$10,000 -Third Offense LSD: Same penalties as provided for distribution of marijuana as set out below
MARIJUANA	C Felony 0-5/$5,000 2 yr. presumptive if second felony conviction 3 yr. presumptive if third felony conviction	0-5/$5,000 - First Offense 0-10/$10,000 - Second Offense	C Felony 0-5/$50,000 if 2.2 lb. or more - presumptive sentencing for second and third offense Reduced C Felony 0-3/$10,000 if 1/2 lb. to 2.2 lbs. No presumptive sentencing A Misdemeanor 0-1/$5,000 if less than 1/2 lb. B Misdemeanor 0-90 days/$1,000 if one oz. or less and No Remuneration is Involved in a Sale to a person 18 years of age or older	0-5/$15,000 - First Offense 0-10/$30,000 - Second Offense If distribution is without remuneration; 0-1/$5,000 - First Offense 0-2/$10,000 - Second Offense	0-25/$20,000 - First Offense 0-Life/$25,000 - Second Offense

MAJOR FEATURES COMPARISON CHART

IV. PENALTIES: POSSESSION OF CONTROLLED SUBSTANCES

	HB 628 (1980)	SB 65 (1979) HB 101(1979)	HB 479 (1979)	FEDERAL CONTROLLED SUBSTANCES ACT	EXISTING LAW
HEROIN	C Felony 0-5/$50,000 2 yr. presumptive if second felony conviction 3 yr. presumptive if third felony conviction Unless Possession involves any amount by someone 18 yrs of age within school grounds which raises the offense to a B felony	Felony-0-5/$5,000	A Felony 0-20/$50,000 if 100 or more capsules, tablets, ampules, syrettes, or one oz. or more B Felony 0-10/$50,000 if 50 to 100 capsules, etc. or 1/4 to one oz. C Felony 0-5/$50,000 if 25 to 50 capsules, etc. or 1/8 to 1/4 oz. A Misdemeanor 0-1/$5,000 if 0 to 25 capsules etc. or 0 to 1/8 oz. Presumptive sentencing on second or third felony	0-1/$5,000-First Offense 0-2/$10,000-Second Offense	2-10/$5,000 - First Offense 10-20/$7,500 - Second Offense 20-40/$10,000 - Third Offense
COCAINE & LSD	Same penalties as provided for possession of heroin including provision pertaining to possession within school grounds	Cocaine: Felony: 0-5/$5,000 LSD: Misdemeanor - 0-1/$5,000	A Felony 0-20/$50,000 if 200 or more capsules, tablets, ampules, syrettes or 2 oz. or more B Felony: 0-10/$50,000 if 100 to 200 capsules, etc. or 1/2 oz. to 2 oz. C Felony: 0-5/$50,000 if 50 to 100 capsules, etc. or 1/4 oz. to 1/2 oz. A Misdemeanor: 0-1/$5,000 is lesser than above Presumptive sentencing on 2nd or 3rd felony.	Cocaine: 0-1/$5,000 - First Offense 0-2/410,000 - Second Offense	Cocaine: Same penalty as provided for possession of heroin LSD: Misdemeanor - 0-1/$1,000
MARIJUANA	Possession of one lb. or more of marijuana is classified as a class C felony punishable the same as possession of heroin & cocaine. Possession of any amount of marijuana by someone 18 yrs of age within school grounds is also classified as class C felony. Possession in public, or while operating a propelled vehicle or possession by minor: class B misdemeanor 0-90 days/$1,000	Does not change existing law	C Felony 0-3/$10,000 if 2.2 lb or more Not subject to presumptive sentencing A Misdemeanor if 1/2 lb to 2.2 lb - 0-90 days/$1,000 B Misdemeanor if any amount while operating motor vehicle Violation ($300) if possession of any amount in public	0-1/$5,000 - First Offense	(A) Misdemeanor with $1,000 fine being the maximum penalty: (1) Use of marijuana in public place; (2) Possession of one ounce or more in public places; (3) Possession while operating a motor vehicle or airplane; (4) Possession while under 18 yrs of age (B) Possession for own use in other than public place or possession of one oz. or less in public place - maximum civil fine of $100

BILL

Introduced: 1/28/80
Referred: Health,Education &
Social Services and Judiciary

IN THE HOUSE

BY THE RULES COMMITTEE BY
REQUEST OF THE GOVERNOR

HOUSE BILL NO. 628

IN THE LEGISLATURE OF THE STATE OF ALASKA

ELEVENTH LEGISLATURE - SECOND SESSION

A BILL

For an Act entitled: "An Act consolidating and revising the laws relating to drug abuse and prohibitions; and providing for an effective date."

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

* Section 1. DECLARATION OF LEGISLATIVE PURPOSE. (a) The purposes of this Act are to consolidate and revise Alaska's drug laws patterned after the Uniform Controlled Substances Act and the Federal Controlled Substances Act of 1970 and to enact uniform penalty provisions in conformity with the 1978 revision of Alaska's criminal code in order to more effectively combat illicit trafficking in controlled substances.

(b) Two distinct, but interrelated, concerns are addressed in this Act. The first concern is the detrimental effect on public safety created through illicit trafficking in and use of drugs. A second, but equally important, concern is the effect on public health created by the use and abuse of drugs. It is the intent of the legislature that, in addressing public safety concerns, uniform classification and penalty provisions be enacted which adopt an approach reflecting law enforcement problems unique to Alaska. It is also the intent of the legislature that in addressing public health concerns, a statutory scheme be enacted which is patterned after federal law and that the legitimate manufacture, distribution, prescription, and dispensing of controlled substances be subject to a regulatory scheme regarding registration, record keeping, order forms, and prescription requirements that is identical to that provided for under federal law.

* Sec. 2. AS 11 is amended by adding a new chapter to read:

CHAPTER 71. OFFENSES RELATING TO CONTROLLED SUBSTANCES.

Sec. 11.71.010. PROMOTING A CONTROLLED SUBSTANCE IN THE FIRST DEGREE. (a) Except as authorized in AS 17.30, a person commits the crime of promoting a controlled substance in the first degree if he

(1) delivers a schedule I controlled substance to a person under 18 years of age who is at least three years younger than he; or

(2) engages in a continuing criminal enterprise.

(b) For purposes of this section, a person is engaged in a "continuing criminal enterprise" if

(1) he commits a violation of this chapter which is punishable as a felony; and

(2) that violation is a part of a continuing series of violations of this chapter

(A) which he undertakes in concert with five or more other persons with respect to whom he occupies a position of organizer, supervisor, or any other position of management; and

(B) from which he obtains substantial income or resources.

(c) Promoting a controlled substance in the first degree is an unclassified felony and is punishable as provided in AS 12.55.

Sec. 11.71.020. PROMOTING A CONTROLLED SUBSTANCE IN THE SECOND DEGREE. (a) Except as authorized in AS 17.30, a person commits the crime of promoting a controlled substance in the second degree if he

(1) manufactures or delivers a schedule I controlled substance or possesses a schedule I controlled substance with intent to manufacture or deliver; or

(2) delivers a schedule II or III controlled substance to a person under 18 years of age who is at least three years younger than he.

(b) Promoting a controlled substance in the second degree is a class A felony.

Sec. 11.71.030. PROMOTING A CONTROLLED SUBSTANCE IN THE THIRD DEGREE. (a) Except as authorized in AS 17.30, a person commits the crime of promoting a controlled substance in the third degree if he

(1) manufactures or delivers a schedule II or III controlled substance or possesses a schedule II or III controlled substance with intent to manufacture or deliver;

(2) delivers a schedule IV or V controlled substance or marijuana to a person under 18 years of age who is at least three years younger than he; or

(3) being 18 years of age or older, knowingly possesses a schedule I or II controlled substance within the grounds of a public or private elementary, junior high, or secondary school.

(b) It is an affirmative defense to a prosecution under (a)(3) of this section that at the time of the possession the school was closed to any organized activity involving persons under 18 years of age. Nothing in this subsection precludes a prosecution under AS 11.71.040(a)(2).

(c) Promoting a controlled substance in the third degree is a class B felony.

Sec. 11.71.040. PROMOTING A CONTROLLED SUBSTANCE IN THE FOURTH DEGREE. (a) Except as authorized in AS 17.30, a person commits the crime of promoting a controlled substance in the fourth degree if he

(1) manufactures or delivers a schedule IV or V controlled substance or marijuana or possesses a schedule IV or V controlled substance or marijuana with intent to manufacture or deliver;

(2) knowingly possesses a schedule I or II controlled substance;

(3) being 18 years of age or older, knowingly possesses a schedule III, IV or V controlled substance or marijuana within the grounds of a public or private elementary, junior high, or secondary school;

(4) knowingly possesses one pound or more of marijuana under any circumstances;

(5) sells or offers for sale an intoxicating liquor in an area where a local option election has made these activities illegal, and

(A) has previously been convicted under AS 11.71.-050(a)(3);

(B) has engaged in conduct demonstrating an intent to sell or offer for sale intoxicating liquor to more than one person; or

(C) the sale or offer for sale was made to a person under 19 years of age or to an intoxicated person;

(6) knowingly keeps or maintains any store, shop, warehouse, dwelling, building, vehicle, boat, aircraft, or other structure or place which is used for keeping or selling controlled substances in violation of this chapter or AS 17.30;

(7) makes, delivers, or possesses any punch, die, plate, stone, or other thing designed to print, imprint, or reproduce the trademark, trade name, or other identifying mark, imprint, or device of another or any likeness of any of the foregoing upon any drug, drug container, or labeling so as to render the drug a counterfeit substance; or

(8) obtains possession of a controlled substance by deception

(b) It is an affirmative defense to a prosecution under (a)(3) of this section that at the time of the possession the school was closed

to any organized activity involving persons under 18 years of age. Nothing in this subsection precludes a prosecution under (a)(4) of this section or under AS 11.71.050(a)(1) or AS 11.71.060(a)(1) or (3).

(c) Promoting a controlled substance in the fourth degree is a class C felony.

Sec. 11.71.050. PROMOTING A CONTROLLED SUBSTANCE IN THE FIFTH DEGREE. (a) Except as authorized in AS 17.30, a person commits the crime of promoting a controlled substance in the fifth degree if he

(1) knowingly possesses a schedule III, IV, or V controlled substance under any circumstances except as otherwise provided in this chapter;

(2) delivers an intoxicating liquor to a person under 19 years of age who is at least three years younger than he;

(3) sells or offers to sell an intoxicating liquor in an area where a local option election has made these activities illegal;

(4) uses in the course of the manufacture or distribution of a controlled substance a registration number which is fictitious, revoked, suspended, or issued to another person; or

(5) furnishes false or fraudulent information in or omits material information from any application, report, record, or other document required to be kept or filed under AS 17.30.

(b) It is a defense to a prosecution under (a)(2) of this section that the defendant was the parent or guardian of the person under 19 years of age.

(c) Promoting a controlled substance in the fifth degree is a class A misdemeanor.

Sec. 11.71.060. PROMOTING A CONTROLLED SUBSTANCE IN THE SIXTH DEGREE. (a) Except as authorized in AS 17.30, a person commits the crime of promoting a controlled substance in the sixth degree if he

(1) uses, displays, or possesses marijuana on a public street or sidewalk or on the premises of a public carrier or business establishment or in any other public place;

(2) knowingly possesses marijuana within his immediate control while operating a propelled vehicle;

(3) being under 19 years of age, knowingly possesses marijuana or an intoxicating liquor;

(4) fails to make, keep, or furnish any record, notification, order form, statement, invoice, or information required under AS 17.30; or

(5) refuses entry into any premises for an inspection authorized under AS 17.30.

(b) Promoting a controlled substance in the sixth degree is a class B misdemeanor.

Sec. 11.71.080. PENALTIES UNDER OTHER LAWS. A penalty imposed for violation of this chapter is in addition to, and not in place of, any other civil or administrative penalty or sanction otherwise authorized by law.

Sec. 11.71.090. BAR TO PROSECUTION. If a violation of this chapter is a violation of a federal law or the law of another state, a conviction or acquittal under federal law or the law of another state for the same act is a bar to prosecution in this state.

Sec. 11.71.100. DEFENSE EXEMPTED. In a prosecution for the knowing possession of a controlled substance under this chapter, it is not a defense that the substance was possessed in less than a usable quantity. It is sufficient to support a conviction that there is a sufficient quantity of the substance to permit proper identification and the proof of a knowing possession.

Sec. 11.71.110. LIABILITY OF PUBLIC SERVANTS. No liability is

imposed by this chapter upon a public servant acting within the scope and authority of his employment.

Sec. 11.71.900. DEFINITIONS. As used in this chapter

(1) "controlled substance" means a drug, substance, or immediate precursor included in the schedules in AS 17.30.040 -- 17.30.090;

(2) "counterfeit substance" means a controlled substance or the container or labeling of a controlled substance which, without authorization, bears the trademark, trade name, or other identifying mark, imprint, number, or device of a manufacturer, distributor, or dispenser other than the person or persons who in fact manufactured, distributed, or dispensed the substance and which falsely purports or is represented to be the product of, or to have been distributed by, the other manufacturer, distributor, or dispenser;

(3) "cocaine" has the meaning ascribed to it in AS 17.30.-050(c);

(4) "deliver" or "delivery" means the actual, constructive, or attempted transfer from one person to another of a controlled substance whether or not there is an agency relationship;

(5) "drug" has the meaning ascribed to it in AS 17.30.-500(10);

(6) "hashish" means the dried, compressed, resinous product of the plant (genus) Cannabis;

(7) "hashish oil" means the viscous liquid concentrate of tetrahydrocannabinols extracted from the plant (genus) Cannabis;

(8) "immediate precursor" means a substance which is by statute or regulation designated as the principal compound commonly used or produced primarily for use, and which is an immediate chemical intermediary used or likely to be used in the manufacture of a con-

trolled substance, the control of which is necessary to prevent, curtail, or limit manufacture;

(9) "intoxicating liquor" includes whiskey, brandy, rum, gin, wine, ale, porter, beer, and all other spirituous, vinous, malt, and other fermented or distilled liquors intended for human consumption and containing more than one per cent alcohol by volume;

(10) "manufacture" has the meaning ascribed to it in AS 17.30.500(16);

(11) "marijuana" means the leaves, stems, flowers, and seeds of the plant (genus) Cannabis, whether growing or not; it does not include the resin or oil extracted from any part of the plant, or any compound, manufacture, salt, derivative, mixture, or preparation from the resin or oil, including hashish, hashish oil, and natural or synthetic tetrahydrocannabinol; it does not include the mature stalks of the plant, fiber produced from the stalks, oil or cake made from the seeds of the plant, any other compound, manufacture salt, derivative, mixture, or preparation of the mature stalks, fiber, oil or cake, or the sterilized seed of the plant which is incapable of germination;

(12) "schedule I controlled substance" means a controlled substance included in the schedule in AS 17.30.040;

(13) "schedule II controlled substance" means a controlled substance included in the schedule in AS 17.30.050;

(14) "schedule III controlled substance" means a controlled substance included in the schedule in AS 17.30.060;

(15) "schedule IV controlled substance" means a controlled substance included in the schedule in AS 17.30.070;

(16) "schedule V controlled substance" means a controlled substance included in the schedule in AS 17.30.080.

* Sec. 3. AS 12.30.040(b) is amended to read:

(b) Notwithstanding the provisions of (a) of this section, if the offense a person has been convicted of is murder in the first degree (as defined in AS 11.41.100), kidnapping (as defined in AS 11.41.300), sexual assault in the first degree (as defined in AS 11.41.410(a)(1) and (2)), robbery in the first degree (as defined in AS 11.41.500), or promoting a controlled substance in the first degree (as defined in AS 11.71.010), or an offense that involves the manufacture, delivery, or possession with intent to manufacture or deliver a schedule I or II controlled substance in violation of AS 11.71.020 or 11.71.030 under circumstances manifesting an intent to distribute the substance as part of a commercial enterprise [FIRST DEGREE MURDER, ARMED ROBBERY, KIDNAPPING, OR RAPE (AS DEFINED IN AS 11.15.130)], he may not be released on bail either before sentencing or pending appeal.

* Sec. 4. AS 12.45 is amended by adding a new section to read:

Sec. 12.45.155. LABORATORY REPORT OF CONTROLLED SUBSTANCE. (a) In a prosecution under AS 11.71.010 -- 11.71.060, a complete copy of an official laboratory report from the Department of Public Safety or a laboratory operated by another law enforcement agency is prima facie evidence of the content, identity, and weight of the substance. The report must be signed by the person performing the analysis and must state that the substance which is the basis of the alleged offense has been weighed and analyzed. It must also state with specificity findings as to the content, weight, and identity of the substance.

(b) A notarized statement executed by the signer of the report provided for in (a) of this section must be attached to the report. The statement must set out the identity of the signer and include a statement that he is an employee of the laboratory issuing the report and that performing the analysis is a part of his regular duties. The

statement must also include an outline of his education, training, and experience for performing an analysis. The signer shall attest that scientifically accepted tests were performed with due caution, and that the evidence was handled in accordance with established and accepted procedures while in the custody of the laboratory.

(c) The prosecuting attorney shall serve a copy of the report on the attorney of record for the accused, or on the defendant if he has no attorney, no later than 10 days before a proceeding in which the report is to be used against the accused. However, at a preliminary hearing or grand jury proceeding the report may be used without having been previously served upon the accused.

(d) The accused or his attorney may demand the testimony of the person signing the report, by serving a written demand showing cause, upon the prosecuting attorney within seven days from receipt of the report.

(e) Any report issued for use under this section must contain notice of the right of the accused to demand the testimony of the person signing the report.

* Sec. 5. AS 12.55.035(b)(1) is amended to read:

(1) $75,000 for murder in the first or second degree, [OR] kidnapping, or promoting a controlled substance in the first degree;

* Sec. 6. AS 12.55.125(b) is amended to read:

(b) A defendant convicted of murder in the second degree, [OR] kidnapping, or promoting a controlled substance in the first degree shall be sentenced to a definite term of imprisonment of at least five years but not more than 99 years.

* Sec. 7. AS 12.55.155(c) is amended by adding new paragraphs to read:

(15) the defendant is convicted of an offense specified in AS 11.71 and the offense involved the delivery of a controlled substance

under circumstances manifesting an intent to distribute the substance as part of a commercial enterprise;

(16) the defendant is convicted of an offense specified in AS 11.71 and the offense involved the smuggling of controlled substances into the state;

(17) the defendant is convicted of an offense specified in AS 11.71 and the offense involved large quantities of a controlled substance;

(18) the defendant is convicted of an offense specified in AS 11.71 and the offense involved the distribution of a controlled substance that had been adulterated with a toxic substance.

* Sec. 8. AS 12.55.155(d) is amended by adding new paragraphs to read:

(13) the defendant is convicted of an offense specified in AS 11.71 and the offense involved small quantities of a controlled substance;

(14) the defendant is convicted of an offense specified in AS 11.71 and the offense involved the distribution of a controlled substance, other than a schedule I controlled substance, to a personal acquaintance who is 19 years of age or older for no profit;

(15) the defendant is convicted of an offense specified in AS 11.71 and the offense involved the possession of a small amount of a controlled substance for personal use in the defendant's home.

* Sec. 9. AS 17 is amended by adding a new chapter to read:

CHAPTER 30. CONTROLLED SUBSTANCES ACT.

ARTICLE 1. STANDARDS AND SCHEDULES.

Sec. 17.30.010. AUTHORITY TO SCHEDULE CONTROLLED SUBSTANCES. Intro C.P. Bill

(a) The commissioner shall administer this Act and may by regulation adopted under the Administrative Procedure Act (AS 44.62) add substances to the schedules in AS 17.30.040 -- 17.30.090. Each addition may not rescind delete or

shall be in accordance with the advice and determination of the Controlled Substances Advisory Committee established in AS 17.30.020. In making a determination regarding the addition of a substance, the committee shall assess the danger or probable danger of the substance by considering the following:

(1) the actual or probable abuse of the substance including:

(A) its history and current pattern of abuse;

(B) the scope, duration, and significance of abuse;

(C) the degree of actual or probable detriment which may result from abuse of the substance;

(D) the probable physical and social impact of widespread abuse of the substance;

(2) the biomedical hazard of the substance including:

(A) its pharmacology: the effects and modifiers of effects of the substance;

(B) its toxicology: the acute and chronic toxicity, interaction with other substances, whether controlled or not, and liability to psychological or physiological dependence;

(C) its risk to public health and the particular susceptibility of segments of the population;

(3) whether the substance is an immediate precursor of a substance already controlled under this chapter;

(4) the current state of scientific knowledge regarding the substance;

(5) the relationship between the use of the substance and other criminal activity including:

(A) whether persons engaged in illicit trafficking of the substance are also engaged in other criminal activity;

(B) whether the nature and relative profitability of

the substance encourages illicit trafficking in the substance;

(C) whether the commission of other crimes is one of the effects of the use of the substance;

(D) whether addiction to the substance relates to the commission of crimes to support the continued use of the substance.

(b) If, after considering the factors enumerated in (a) of this section, the committee finds that a substance should be added, the commissioner shall adopt a regulation in accordance with the committee's findings.

(c) The committee shall advise the governor of the legislature as to the need to delete or reschedule substances in the schedules in AS 17.30.040 -- 17.30.090. In making recommendations regarding a substance, the committee shall assess the danger or probable danger of the substance by considering the factors enumerated in (a) of this section.

(d) If the committee designates a substance as an immediate precursor of a controlled substance, substances which are precursors of the controlled precursor are not subject to control solely because they are precursors of the controlled precursor.

(e) By the 30th day of each legislative session, the commissioner shall prepare and present to the governor and the legislature a report discussing the actions of the committee during the preceding year. If the commissioner has adopted a regulation adding a controlled substance, the report shall include the committee's findings of fact and other supporting information it considers appropriate.

Sec. 17.30.020. CONTROLLED SUBSTANCES ADVISORY COMMITTEE. (a) There is created within the department the Controlled Substances Advisory Committee, consisting of

(1) the director of the division of public health;

(2) the director of the office of drug abuse;

(3) the commissioner of public safety or his designee;

(4) the attorney general or his designee;

(5) a psychiatrist appointed by the governor;

(6) a physician appointed by the governor;

(7) a pharmacist appointed by the governor;

(8) a peace officer appointed by the governor after consultation with the Alaska Association of Chiefs of Police; and

(9) a public member appointed by the governor.

(b) Members of the committee specified in paragraphs (a)(5)-(9) of this section serve terms of four years; except that of the members first appointed, two shall be appointed for terms of two years, two for terms of three years, and one for a term of four years. Committee members are not entitled to receive a salary but are entitled to per diem and travel expenses authorized by law for boards and commissions.

(c) The committee shall meet at the call of the commissioner, but in no event less than twice a year. Five members constitute a quorum. The committee may adopt bylaws for its proceedings. Before making a determination regarding the addition of a substance under AS 17.30.010, the committee, together with the commissioner, shall hold public hearings as provided for under AS 44.62.210.

(d) If a substance is added as a controlled substance under federal law and notice of the designation is given to the department, or the addition of a substance has been published in the Code of Federal Regulations, the committee shall, within 60 days, meet and consider making a corresponding addition in the schedules specified in AS 17.30.040 -- 17.30.090. If the committee decides not to include the change, it shall publish the reasons for that decision and afford all interested parties an opportunity to be heard. Following the

hearing, the committee shall announce its final decision.

Sec. 17.30.030. NOMENCLATURE. The controlled substances listed in the schedules in AS 17.30.040 -- 17.30.090 are included by whatever official, common, chemical, or brand name is designated.

Sec. 17.30.040. SCHEDULE I. (a) A substance shall be placed in schedule I if it is found under AS 17.30.010(a) to have the highest degree of danger or probable danger.

(b) Schedule I includes, unless specifically excepted or listed in another schedule, any of the following substances whether produced directly or indirectly by extraction from substances of vegetable origin, or independently by means of chemical synthesis, or by a combination of extraction and chemical synthesis:

(1) opium and opiate, and any salt, compound, derivative, or preparation of opium or opiate, excluding apomorphine, dextrorphan, nalbuphine, naloxone, and naltrexone, and their respective salts, but including the following:

(A) raw opium;

(B) opium extracts;

(C) opium fluid extracts;

(D) powdered opium;

(E) granulated opium;

(F) tincture of opium;

(G) codeine;

(H) ethylmorphine;

(I) etorphine hydrochloride;

(J) hydrocodone;

(K) hydromorphone;

(L) metopon;

(M) morphine;

(N) oxycodone;

(O) oxymorphine;

(P) thebaine;

(2) any salt, compound, derivative, or preparation of a subincluded in (b)(1) of this section which is chemically equivalent or identical to any of the substances referred to in (b)(1) of this section, except that these substances do not include the isoquinoline alkaloids of opium;

( ) opium poppy and poppy straw;

( ) ncentrate of poppy straw which is the crude extract of poppy str n either liquid, solid, or powder form which contains the phennanth ne alkaloids of the opium poppy.

(c) Schedule I includes, unless specifically excepted or unless listed in another schedule, any of the following opiates, including their isomers, esters, ethers, salts, and salts of isomers, esters, and ethers, whenever the existence of such isomers, esters, ethers, and salts is possible within the specific chemical designation, dextrorphan excepted:

(1) acetylmethadol;

(2) allylprodine;

( ) alphacetylmethadol;

(4) alphameprodine;

(5) alphamethadol;

(6) alphaprodine;

(7) anileridine;

(8) benzethidine;

(9) betacetylmethadol;

(10) betameprodine;

(11) betamethadol;

(12) betaprodine;

(13) bezitramide;

(14) clonitazene;

(15) dextromoramide;

(16) diampromide;

(17) diethylthiambutene;

(18) difenoxin;

(19) dihydrocodeine;

(20) dimenoxadol;

(21) dimepheptanol;

(22) dimethylthiambutene;

(23) dioxaphetyl butyrate;

(24) diphenoxylate;

(25) dipipanone;

(26) ethylmethylthiambutene;

(27) etonitazene;

(28) etoxeridine;

(29) fentanyl;

(30) furethidine;

(31) hydroxpethidine;

(32) isomethadone;

(33) ketobemidone;

(34) levomethorphan;

(35) levomoramide;

(36) levorphanol;

(37) levophenacylmorphan;

(38) metazocine;

(39) methadone;

(40) methadone-intermediate, 4-cyano-2-dimethylamino-4, 4-

diphenyl butane;

(41) moramide-intermediate, 2-methyl-3-morpholinol, 1-diphenylpropane-carboxylic acid;

(42) morpheridine;

(43) noracymethadol;

(44) norlevorphanol;

(45) normethadone;

(46) norpipanone;

(47) pethidine, also known as meperidine;

(48) pethidine-intermediate-A, 4-cyano-1-methyl-4-phenyl-piperidine;

(49) pethidine-intermediate-B, ethyl-4-phenylpiperidine-4-carboxylate;

(50) pethidine-intermediate-C, 1-methyl-4-phenyl-piperidine-4-carboxylic acid;

(51) phenadoxone;

(52) phenampromide;

(53) phenazocine;

(54) phenomorphan;

(55) phenoperidine;

(56) piminodine;

(57) piritramide;

(58) proheptazine;

(59) properidine;

(60) propiram;

(61) racemethorphan;

(62) racemoramide;

(63) racemorphan;

(64) trimeperidine.

(d) Schedule I includes, unless specifically excepted or unless listed in another schedule, any of the following opium derivatives, their salts, isomers, and salts of isomers whenever the existence of these salts, isomers, and salts of isomers is possible within the specific chemical designation:

(1) acetorphine;

(2) acetyldihydrocodeine;

(3) benzylmorphine;

(4) codeine methylbromide;

(5) codeine-n-oxide;

(6) cyprenorphine;

(7) desomorphine;

(8) dihydromorphine;

(9) drotebanol;

(10) etorphine, except hydrochloride salt;

(11) heroin;

(12) hydromorphinol;

(13) methyldesorphine;

(14) methyldihydromorphine;

(15) morphine methylbromide;

(16) morphine methylsulfonate;

(17) morphine-n-oxide;

(18) myrophine;

(19) nicocodeine;

(20) nicomorphine;

(21) normorphine;

(22) pholcodine;

(23) thebacon

Sec. 17.30.050. SCHEDULE II. (a) A substance shall be placed

in schedule II if it is found under AS 17.30.010(a) to have a degree of danger or probable danger less than substances listed in schedule I, but higher than substances listed in schedule III.

(b) Schedule II includes, unless specifically excepted or unless listed in another schedule, any material, compound, mixture, or preparation, which contains any quantity of the following hallucinogenic substances, or which contains any of its salts, isomers, or salts of isomers whenever the existence of such salts, isomers, or salts of isomers is possible within the specific chemical designation:

(1) 4-bromo-2, 5-dimethoxy-amphetamine, also known as 4-bromo-2,5-dimethoxy-a-methylphenethylamine and 4-bromo-2, 5-DMA;

(2) 2,5-dimethoxyamphetamine, also known as 2,5-dimethoxy-a-methylphenethylamine and 2,5-DMA;

(3) 4-methoxyamphetamine, also known as 4-methoxy-a-methylphenethylamine and paramethoxyamphetamine, PMA;

(4) 5-methoxy-3,4-methylenedioxy-amphetamine;

(5) 4-methyl-2,5-dimethoxy-amphetamine, also known as 4-methyl-2,5 - dimethoxy-a - methylphenethylamine, "DOM" and "STP";

(6) 3,4-methylenedioxy amphetamine;

(7) 3,4,5-trimethoxy amphetamine;

(8) bufotenine, also known as 3-(B-dimethylaminoethyl)-5-hydroxyindole, 3-(2-dimethylaminoethyl)-5-indolol, N, N-dime -thylserotoain, 5-hydroxy-N, N-dimethyltryptamin , and mappine;

(9) diethyltryptamine, also known as N,N-diethyltryptamine and DET;

(10) dimethyltryptamine, also known as DMT;

(11) ibogaine, also known as 7-ethyl-6, 6B, 7,8,9,10,12, 13-octahydro-2-methoxy-6, 9-methano-5H-pyrido [1',2': 1,2] azepino

[5,4-b] indole and tabernanthe iboga;

(12) lysergic acid diethylamide;

(13) mescaline;

(14) peyote, meaning all parts of the plant presently classified botanically as lophophora williamsii lemaire, whether growing or not, the seeds of the plant, any extract from any part of the plant, and every compound, manufacture, salts, derivative, mixture, or preparation of the plant, its seeds, or extracts;

(15) n-ethyl-3-piperdyl benzilate;

(16) n-methyl-3-piperdyl benzilate;

(17) psilocybin;

(18) psilocyn;

(19) ethylamine analog of phencyclidine, also known by some trade or other names as follows: N-ethyl-1-phenylcyclohexylamine (1-phenylcyclohexy) ethylamine, N-(1-phenylcyclohexy) ethylamine, cyclohexamine, PCE;

(20) pyrrolidine analog of phencyclidine, also known by some trade or other names as follows: 1-(1-phenylcyclohexyl)-pyrrolidine PCPy, PHP;

(21) thiophene analog of phencyclidine, also known as 1-[1-(2-thienyl) cyclohexl] piperidine and 2-thienyl analog of phencyclindine and TPCP.

(c) For purposes of (b) of this section only, the term "isomer" includes the optical, position and geometric isomers.

(d) Schedule II includes cocaine and any compound, derivative, or preparation of coca leaves produced directly or indirectly by extraction from coca leaves, or independently by means of chemical synthesis, or by a combination of extraction and chemical synthesis, including the isomers, salts, and salts of isomers of cocaine and

other derivatives of coca leaves whenever the existance of such isomers and salts is possible, but does not include decocainized coca leaves or extractions of coca leaves which do not contain cocaine or ecgonine.

(e) Schedule II includes, unless specifically excepted or unless listed in another schedule, any material, compound, mixture, or preparation which contains any quantity of the following substances having a depressant effect on the central nervous system, including their salts, isomers, and salts of isomers whenever the existence of these salts, isomers, and salts of isomers is possible within the specific chemical designation:

(1) amobarbital;

(2) mecloqualone;

(3) methaqualone;

(4) pentobarbital;

(5) phencyclidine, also known as PCP;

(6) phencyclidine immediate precursors

(A) 1-phenylcyclohexylamine;

(B) 1-piperidinocyclohexanecarbonitrile, also known as PCC;

(7) secobarbital.

(f) Schedule II includes, unless specifically excepted or unless listed in another schedule, any material, compound, mixture, or preparation which contains any quantity of the following substances having a stimulant effect on the central nervous system:

(1) amphetamine, its salts, optical isomers, and salts of its optical isomers;

(2) methamphetamine, its salts, isomers, and salts of its isomers;

(3) phenmetrazine and its salts;

(4) methylphenidate.

Sec. 17.30.060. SCHEDULE III. (a) A substance shall be placed in schedule III if it is found under AS 17.30.010(a) to have a degree of danger or probable danger less than the substances listed in schedule II but higher than substances listed in schedule IV.

(b) Schedule III includes, unless specifically excepted or unless listed in another schedule, any material, compound, mixture, or preparation which contains any quantity of the following substances having a stimulant effect on the central nervous system, including their salts, isomers whether optical, position, or geometric, and salts of these isomers whenever the existence of such salts, isomers, and salts of isomers is possible within the specific chemical designation:

(1) benzphetamine;

(2) chlorphentermine;

(3) clortermine;

(4) mazindol;

(5) phendimetrazine.

(c) Schedule III includes, unless specifically excepted or unless listed in another schedule, any material, compound, mixture, or preparation which contains any quantity of the following substances having a depressant effect on the central nervous system:

(1) any compound, mixture, or preparation containing amobarbital, secobarbital, or pentobarbital or any salt of any of these substances combined with one or more other active medicinal ingredients which are not listed in AS 17.30.040 -- 17.30.090;

(2) any suppository dosage form containing amobarbital, secobarbital, or pentobarbital or any salt of any of these substances approved by the federal Food and Drug Administration for marketing

only as a suppository;

(3) any substance which contains any quantity of a derivative of barbituric acid or any salt of these substances;

(4) chlorhexadol;

(5) glutethimide;

(6) lysergic acid;

(7) lysergic acid amide;

(8) methyprylon;

(9) sulfondiethylmethane;

(10) sulfonethylmethane;

(11) sulfonmethane.

(d) Schedule III includes nalorphine.

(e) Schedule III includes, unless specifically excepted or unless listed in another schedule, any material, compound, mixture, or preparation containing limited quantities of any of the following narcotic drugs, or any of its salts:

(1) not more than 1.8 grams of codeine per 100 milliliters or not more than 90 milligrams per dosage unit, with an equal or greater quantity of an isoquinoline alkaloid of opium;

(2) not more than 1.8 grams of codeine per 100 milliliters or not more than 90 milligrams per dosage unit, with one or more active, nonnarcotic ingredients in recognized therapeutic amounts;

(3) not more than 300 milligrams of dihydrocodeinone per 100 milliliters or not more than 15 milligrams per dosage unit, with a fourfold or greater quantity of an isoquinoline alkaloid of opium;

(4) not more than 300 milligrams of dihydrocodeinone per 100 milliliters or not more than 15 milligrams per dosage unit, with one or more active nonnarcotic ingredients in recognized therapeutic amounts;

(5) not more than 1.8 grams of dihydrocodeine per 100 milliliters or not more than 90 milligrams per dosage unit, with one or more active nonnarcotic ingredients in recognized therapeutic amounts;

(6) not more than 300 milligrams of ethylmorphine per 100 milliliters or not more than 15 milligrams per dosage unit, with one or more active, nonnarcotic ingredients in recognized therapeutic amounts;

(7) not more than 500 milligrams of opium per 100 milliliters or per 100 grams or not more than 25 milligrams per dosage unit, with one or more active, nonnarcotic ingredients in recognized therapeutic amounts;

(8) not more than 50 milligrams of morphine per 100 milliliters or per 100 grams, with one or more active, nonnarcotic ingredients in recognized therapeutic amounts.

(f) Schedule III includes hashish, hashish oil, and tetrahydrocannabinols.

Sec. 17.30.070. SCHEDULE IV. (a) A substance shall be placed in schedule IV if it is found under AS 17.30.010(a) to have a degree of danger or probable danger less than the substances listed in schedule III, but higher than the substances listed in schedule V.

(b) Schedule IV includes, unless specifically excepted or unless listed in another schedule, any material, compound, mixture, or preparation which contains any quantity of the following substances, including their salts, isomers and salts of isomers whenever the existence of such salts, isomers, and salts of isomers is possible within the specific chemical designation:

(1) barbital;

(2) chloral betaine;

(3) chloral hydrate;

(4) chlordiazepoxide;

(5) clonazepam;

(6) clorazepate;

(7) diazepam;

(8) ethchlorvynol;

(9) ethinamate;

(10) flurazepam;

(11) lorazepan;

(12) mebutamate;

(13) meprobamate;

(14) methohexital;

(15) methylphenobarbital, also known as mephobarbital;

(16) oxazepam;

(17) paraldehyde;

(18) petrichloral;

(19) pentobarbital;

(20) prazepam.

(c) Schedule IV includes any material, compound, mixture, or preparation which contains any quantity of the following substances, including their salts, isomers whether optical, position, or geometric, and salts of these isomers, whenever the existence of these salts, isomers, and salts of isomers is possible: fenfluramine.

(d) Schedule IV includes, unless specifically excepted or unless listed in another schedule, any material, compound, mixture, or preparation which contains any quantity of the following substances having a stimulant effect on the central nervous system, including their salts, isomers whether optical, position, or geometric, and salts of these isomers whenever the existence of these salts, isomers,

and salts of isomers is possible within the specific chemical designation:

(1) diethlpropion;

(2) phentermine;

(3) pemoline, including organometallic complexes and chelates of this substance.

(e) Schedule IV includes, unless specifically excepted or unless listed in another schedule, any material, compound, mixture or preparation which contains any quantity of the following substances, including their salts:

(1) dextropropoxyphene (alpha-(+)-4-dimethylamino-1,2-diphenyl-3-methyl-2-propionoxybutane);

(2) phentazocine.

(f) Schedule IV includes, unless specifically excepted or unless listed in another schedule, any material, compound, mixture, or preparation containing limited quantities of any of the following substances or any salts of these substances: not more than 1 milligram of difenoxin and not less than 25 micrograms of atropine sulfate per dosage unit.

Sec. 17.30.080. SCHEDULE V. (a) A substance shall be placed in schedule V if it is found under AS 17.30.010(a) to have a degree of danger or probable danger less than substances listed in schedule IV, but higher than substances listed in schedule VI.

(b) Schedule V includes any compound, mixture, or preparation containing any of the following limited quantities of narcotic drugs or their salts which includes one or more nonnarcotic active medicinal ingredients in sufficient proportion to confer upon the compound, mixture, or preparation valuable medicinal qualities other than those possessed by schedule I substances alone:

(1) not more than 200 milligrams of codeine per 100 milliliters or per 100 grams;

(2) not more than 100 milligrams of dihydrocodeine per 100 milliliters or per 100 grams;

(3) not more than 100 milligrams of ethylmorphine per 100 milliliters or per 100 grams;

(4) not more than 2.5 milligrams of diphenoxylate and not less than 25 micrograms of atropine sulfate per dosage unit;

(5) not more than 100 milligrams of opium per 100 milliliters or per 100 grams;

(6) not more than 0.5 milligrams of difenoxin and not lesss than 25 micrograms of atropine sulfate per dosage unit.

(c) Schedule V includes loperamide.

Sec. 17.30.090. SCHEDULE VI. (a) A substance shall be placed in schedule VI if it is found under AS 17.30.010(a) to have the lowest degree of danger or probable danger.

(b) Schedule VI includes:

(1) marijuana;

(2) intoxicating liquors.

Sec. 17.30.095. EXEMPTED DRUGS. A controlled substance the manufacture, distribution, dispensing, or possession of which is explicitly exempt from criminal penalty under federal law is exempt from the application of this chapter and AS 11.71. This exemption includes any substances which may, under the federal Food, Drug, and Cosmetic Act (21 U.S.C. sec. 301 et seq.) be lawfully sold over the counter without a prescription.

ARTICLE 2. REGULATION OF MANUFACTURE, DISTRIBUTION, PRESCRIPTION, AND DISPENSING OF CONTROLLED SUBSTANCES.

Sec. 17.30.150. REGULATIONS. The commissioner shall adopt regu-

lations under the Administrative Procedure Act (AS 44.62) which are necessary for the administration of this chapter, and may charge reasonable fees relating to the registration and control of the manufacture, distribution, and dispensing of controlled substances within the state.

Sec. 17.30.160. REGISTRATION REQUIREMENTS. (a) A person who manufactures, distributes, dispenses, or conducts research with a controlled substance within the state or who proposes to engage in the manufacture, distribution, or dispensing of a controlled substance within the state, shall annually register with the commissioner in accordance with regulations adopted under AS 17.30.150.

(b) Persons registered under this chapter to manufacture, distribute, dispense, or conduct research with controlled substances may possess, manufacture, distribute, dispense, or conduct research with those substances to the extent authorized by their registration and in conformity with the other provisions of this chapter.

(c) The following persons need not register under this chapter:

(1) an agent or employee of a registered manufacturer, distributor, dispenser, or researcher of a controlled substance if the possession is incidental to the agent's or employee's acting in the usual course of his business or employment;

(2) a common or contract carrier or warehouseman, or his employee, whose possession of a controlled substance is in the usual course of his business or employment;

(3) a person in possession of a controlled substance under a lawful order of a registered practitioner or in lawful possession of a schedule V substance.

(d) The commissioner may, by regulation, waive the requirement for registration of certain manufacturers, distributors, or dispensers

if he finds it consistent with the public health and safety.

(e) A separate registration is required for each principal place of business or professional practice where the applicant manufactures, distributes, or dispenses controlled substances.

(f) The commissioner may inspect the establishment of a registrant or applicant for registration in accordance with regulations adopted by the commissioner.

Sec. 17.30.170. REGISTRATION. (a) The commissioner shall register an applicant to manufacture, distribute, or dispense controlled substances listed in the schedules in AS 17.30.040 -- 17.30.090 unless he finds that the registration would be inconsistent with the public interest. In determining the public interest, the commissioner shall consider the following factors:

(1) maintenance of effective controls against diversion of controlled substances into other than legitimate medical, scientific, or industrial channels;

(2) compliance with applicable state and local law;

(3) any conviction of the applicant under federal or state laws relating to controlled substances;

(4) past experience in the manufacture or distribution of controlled substances and the existence in the applicant's establishment of effective controls against diversion of controlled substances into other than legitimate medical, scientific, or industrial channels;

(5) furnishing by the applicant of false information in an application filed under this chapter;

(6) suspension or revocation of the applicant's federal registration to manufacture, distribute, or dispense controlled substances as authorized by federal law; and

(7) any other factors relevant to and consistent with the

public health and safety.

(b) Practitioners registered under federal law to conduct research with controlled substances shall be issued a registration to conduct research with these substances within the state upon furnishing the commissioner with evidence of the federal registration.

(c) Compliance by manufacturers and distributors with the provisions of federal law pertaining to registration requirements, excluding fees, entitles them to be registered under this chapter.

Sec. 17.30.180. REVOCATION AND SUSPENSION OF REGISTRATION. (a) A registration under AS 17.30.170 to manufacture, distribute, dispense, or conduct research with a controlled substance may be suspended or revoked by the commissioner upon a finding that the registrant:

(1) has furnished false or fraudulent material information in an application filed under this chapter;

(2) has been convicted of a felony under state or federal law relating to a controlled substance; or

(3) has had his federal registration to manufacture, distribute, dispense, or conduct research with controlled substances suspended or revoked.

(b) The commissioner may limit the revocation or suspension of a registration to the particular controlled substance with respect to which grounds for revocation or suspension exist.

(c) If the commissioner suspends or revokes a registration, all controlled substances owned or possessed by the registrant at the time of suspension or the effective date of the revocation order may be placed under seal and placed in the custody of the Department of Public Safety subject only to the orders and decrees of a court having jurisdiction over the property. No disposition may be made of substances under seal until the time for taking an appeal has elapsed or until

all appeals have been concluded unless a court, upon application, orders the sale of perishable substances and the deposit of the proceeds of the sale with the court. Upon a revocation order becoming final, all controlled substances are forfeited to the state.

(d) The commissioner shall promptly notify the Drug Enforcement Administration of all orders suspending or revoking registrations and of all forfeitures of controlled substances.

Sec. 17.30.190. ORDER TO SHOW CAUSE. (a) Before denying, suspending, or revoking a registration, or refusing a renewal of a registration, the commissioner shall serve upon the applicant or registrant an order to show cause why a registration should not be denied, revoked, or suspended, or why a renewal should not be refused. The order to show cause shall contain a statement of the basis for it and shall require the applicant or registrant to appear before the commissioner at a time and place not less than 30 days after the date of service of the order. In the case of a refusal of renewal of registration the show cause order must be served not later than 30 days before the expiration of the registration. These proceedings must be conducted in accordance with procedures for administrative adjudication under AS 44.62.330 -- 44.62.630 without regard to criminal prosecution or other proceeding. Proceedings to refuse renewal of registration do not abate the existing registration which remains in effect pending the outcome of the administrative hearing.

(b) The commissioner may, without an order to show cause, suspend a registration simultaneously with the institution of proceedings under AS 17.30.180 if he finds that there is an imminent danger to the public health or safety which warrants this action. The suspension continues in effect until the conclusion of the proceedings, including judicial review of the proceedings, unless sooner withdrawn by the com-

missioner or dissolved by a court of competent jurisdiction.

Sec. 17.30.200. RECORDS OF REGISTRANTS. Persons registered to manufacture, distribute, dispense, or conduct research with controlled substances under this chapter shall keep records and maintain inventories in conformance with the record-keeping and inventory requirements of federal law.

Sec. 17.30.210. ORDER FORMS: PRESCRIPTIONS. (a) Controlled substances may be distributed by one registrant to another registrant only if the distribution is in accordance with federal requirements for order forms.

(b) No controlled substance may be dispensed by a practitioner except in accordance with federal requirements regarding prescriptions for controlled substances.

(c) If a controlled substance is classified in a schedule set out in AS 17.30.040 -- 17.30.090, or through regulation adopted in accordance with this chapter, that is different from its corresponding classification under federal law, the requirements of (a) and (b) of this section are determined by the classification of the substance under federal law.

Sec. 17.30.220. EXCLUSION. For purposes of AS 17.30.150 -- 17.30.220, "controlled substance" does not include intoxicating liquors.

ARTICLE 3. ENFORCEMENT AND ADMINISTRATIVE PROVISIONS.

Sec. 17.30.300. COOPERATIVE ARRANGEMENTS. The commissioner of public safety shall cooperate with other state agencies and federal agencies in the discharge of their responsibilities pertaining to illicit traffic in controlled substances and in suppressing the abuse of controlled substances. Under this section, the commissioner of public safety's powers include but are not limited to the following:

(1) arranging for the exchange of information among govern-

mental officials concerning illicit traffic in and abuse of controlled substances;

(2) coordinating and cooperating in training programs pertaining to controlled substances at both local and state levels; and

(3) cooperating with the Drug Enforcement Administration of the United States Department of Justice through the establishment of a centralized unit to accept, catalogue, file, and collect statistics, including records of persons who have violated the provisions of this chapter or AS 11.71 within the state and make the information available for federal, state, and local law enforcement purposes; the commissioner may not furnish the name or identity of a patient or research subject whose identity could not be obtained under AS 17.30.350(b).

Sec. 17.30.310. FORFEITURES. (a) The following are subject to forfeiture to the state:

(1) any controlled substance which has been manufactured, distributed, dispensed, or possessed in violation of this chapter or AS 11.71;

(2) raw materials, products, and equipment which are used or intended for use in manufacturing, distributing, compounding, processing, delivering, importing, or exporting a controlled substance in violation of this chapter or AS 11.71;

(3) any property which is used or intended for use as a container for property described in (1) or (2) of this subsection;

(4) any conveyance, including but not limited to aircraft, vehicles or vessels which have been used to transport or in any manner to facilitate transportation for purpose of sale or receipt of property described in (1) or (2) of this subsection; however,

(A) no conveyance is subject to forfeiture under this section if the owner of the conveyance establishes, by a prepon-

derance of the evidence, at a hearing before the court as a trier of fact that its use in violation of this chapter or AS 11.71 was committed by another person and that the owner was not a consenting party nor privy to the violation and took all reasonable means to ensure that the conveyance would not be used, and that no person who operated it would use it in violation of this chapter or AS 11.71;

(B) a forfeiture of a conveyance encumbered by a bona fide security interest at the time of seizure is subject to the interest of the secured party if the secured party establishes, by a preponderance of the evidence, at a hearing before the court as a trier of fact that its use in violation of this chapter or AS 11.71 was committed by another person and that the secured party was not a consenting party nor privy to the violation and took all reasonable means to ensure that the conveyance would not be used and that no person who operated it would use it in violation of this chapter or AS 11.71;

(5) any books, records, and research products and materials, including formulas, microfilm, tapes, and data which are used in violation of this chapter or AS 11.71;

(6) any money or negotiable instrument derived from activity prohibited by this chapter or AS 11.71; and

(7) any firearm used during or in furtherance of a violation of this chapter or AS 11.71.

(b) Property listed in (a) of this section may be forfeited to the state either upon conviction of the defendant of a violation of this chapter or AS 11.71, or upon judgment of a court of competent jurisdiction in a separate civil proceeding in rem that an item specified in (a) of this section was used in or in aid of a violation of

this chapter or AS 11.71.

(c) It is not a defense in an in rem proceeding brought under this section that a criminal proceeding is pending or has resulted in a conviction or acquittal for a violation of this chapter or AS 11.71, or that a criminal proceeding has been dismissed, or that the item has not been forfeited in any criminal proceeding, or that multiple actions are pending.

(d) Property subject to forfeiture under this section may be seized by a peace officer upon an order issued by a court having jurisdiction over the property upon a showing of probable cause that the property is subject to forfeiture under (a) of this section. Seizure without a court order may be made if

(1) the seizure is incident to a valid arrest or a search under a valid search warrant;

(2) the property subject to seizure has been the subject of a prior judgment in favor of the state in a criminal proceeding or civil proceeding in rem based upon this chapter or AS 11.71; or

(3) there is probable cause that the property was or is being used in violation of this chapter or AS 11.71 and the property is easily movable; property seized under this paragraph may not be held for more than 48 hours or until an order continuing the seizure may be applied for and issued by a court, whichever is earlier.

(e) Property taken or detained under (b) of this section is in the custody of the Department of Public Safety subject only to the orders and decrees of the court having jurisdiction over the forfeiture proceedings. If property is seized under this chapter, the Department of Public Safety may:

(1) place the property under seal;

(2) remove the property to a place designated by the court;

or

(3) take custody of the property and remove it to an appropriate location for disposition in accordance with law.

(f) Within 10 days of any seizure under this section, the state shall inventory the property seized and its contents and appraise the value of the items seized.

(g) Within 20 days of any seizure under this section, the state shall, by certified mail, notify any person known to have an interest in an item with an appraised value of $500 or more, or who is ascertainable from official registration numbers, licenses or other state, federal or municipal numbers on the item. Additionally, the state shall publish notice of forfeiture action of an item valued at $500 or more in a newspaper of general circulation in the judicial district in which the seizure was made, or if no newspaper is published in that district, in a newspaper published in the state and distributed in that district, four times during four consecutive calendar weeks, once during each week. The requirements of this subsection do not apply to the forfeiture of controlled substances which have been manufactured, distributed, dispensed, or possessed in violation of this chapter or AS 11.71, regardless of their value.

(h) Upon service or publication of notice of commencement of an action under this section, a person claiming interest in the property shall file within 20 days from the service or publication, a notice of claim setting out the nature of his interest, the date it was acquired, the consideration paid, and an answer to the state's allegations. If no claim and answer is filed within the time specified, the property described in the state's allegation must be ordered forfeited to the state without further proceedings or showings.

(i) Questions of fact or law raised by a notice of claim and

answer of any claimant in an action commenced under this section must be determined by the court sitting without a jury. Such a proceeding may, in the court's discretion, be held in abeyance until conclusion of any pending criminal charges against the claimant under this chapter or AS 11.71.

(j) A claimant under (h) of this section may at any time petition for release of a seized item as follows:

(1) to a court in which a seizure warrant has been issued;

(2) to a court in which a criminal or civil action alleging forfeiture of the item has been filed; or

(3) before an action is filed, or if no seizure warrant was issued, to a court in the district in which the violation took place.

(k) An item may not be released by the court under (j) of this section except upon an adequate assurance from the claimant that the item will remain subject to the court's jurisdiction and within the constructive custody of the state and

(1) a finding that the release is in the best interests of the state; or

(2) the posting of a bond equal to twice the assessed value of the item or the posting of other valid and equivalent security.

(l) A claimant may petition the court for sale of an item before final disposition. The court shall grant a petition for sale upon a finding that the sale is in the best interests of the state and the preservation and maintenance of the item seized. Proceeds from the sale plus interest to the date of final disposition shall thereafter be treated as the subject of the forfeiture action.

(m) Property forfeited under this section must be disposed of according to court order. The court may order the Department of Public Safety to

(1) destroy property harmful to the public;

(2) sell the property and use the proceeds for payment of all proper expenses of the proceedings for forfeiture and sale, including expenses of seizure, custody, and court costs;

(3) take custody of the property and use it in the enforcement of this chapter or AS 11.71, or transfer it to another agency of the state for a use designated by the court in furtherance of the administration of justice;

(4) take custody of the property and remove it for disposition in accordance with law; or

(5) forward it to the Drug Enforcement Administration for disposition.

(n) Upon a showing that a claimant is entitled to remittance in accordance with the provisions of this section, the court shall order that

(1) if the item may be used for a valid state function, it shall be delivered to the Department of Administration and that department shall remit to the claimant the value of the claimant's interest at the time of seizure; or

(2) the item may be sold at public auction to the highest bidder, the claimant having a right of first refusal, with proceeds used to satisfy the claimant's interest at the time of seizure and the balance deposited in the general fund.

(o) An offender who used an item subject to remission in violation of this chapter or AS 11.71 shall be assessed a fine at least equal to the cost of any lien payment or remittance made by the state plus the reasonable costs of the seizure.

(p) Any controlled substance manufactured, possessed, transferred, sold, or offered for sale in violation of this chapter or AS 11.71 is

contraband and must be seized and summarily forfeited to the state.

(q) Plants from which controlled substances may be derived and which have been planted or cultivated in violation of this chapter or AS 11.71, or which are wild growths, may be seized and summarily forfeited to the state.

Sec. 17.30.320. BURDEN OF PROOF. It is not necessary for the state to negate an exemption or exception provided for in this chapter in a complaint, information, indictment or other pleading or at a trial, hearing, or other proceeding under this chapter or AS 11.71. The defendant has the burden of proving by a preponderance of the evidence any exemption or exception claimed by him.

Sec. 17.30.330. JUDICIAL REVIEW. All final determinations, findings, and conclusions of the commissioner under this chapter or regulations adopted under it are final decisions of the matters involved. A person aggrieved by a decision may obtain review of the decision in the superior court in accordance with AS 44.62.560 -- 44.62.570. A person is not, however, entitled to a hearing de novo in the superior court.

Sec. 17.30.340. EDUCATION AND RESEARCH. (a) The commissioner shall carry out educational programs designed to prevent and deter abuse of controlled substances. In connection with these programs, the commissioner may:

(1) promote better recognition of the problems surrounding abuse of controlled substances within the regulated industry and among interested groups and organizations;

(2) assist the regulated industry and interested groups and organizations in contributing to the reduction of abuse of controlled substances;

(3) consult with interested groups and organizations to aid

them in solving administrative and organizational problems;

(4) evaluate procedures, projects and techniques conducted or proposed as part of educational programs on abuse of controlled substances;

(5) disseminate the results of research on abuse of controlled substances to promote a better public understanding of the problems which exist and their solutions; and

(6) with the cooperation of the Department of Law, assist in the education and training of state and local law enforcement officials in their efforts to prevent illicit traffic in and abuse of controlled substances.

(b) The commissioner shall encourage research on controlled substances and may:

(1) establish methods to assess the effects of controlled substances and identify and characterize those with potential for abuse;

(2) make studies and undertake research to:

(A) develop new or improved approaches, techniques, systems, equipment and devices to strengthen the enforcement of this chapter;

(B) determine patterns of abuse of controlled substances and their social effects; and

(C) improve methods for preventing, predicting and understanding the abuse of controlled substances;

(3) enter into contracts with public agencies, institutions of higher education, and private organizations or individuals for conducting research, demonstrations, or special projects which bear directly on abuse of controlled substances and for related research and educational activities.

Sec. 17.30.350. CONFIDENTIALITY. (a) Results, information, and evidence received from the Drug Enforcement Administration of the United States Department of Justice relating to the regulatory functions of this chapter, including results of inspections conducted by it may be relied on and acted on by the commissioner in the exercise of his regulatory functions under this chapter.

(b) A practitioner engaged in medical practice or research may not furnish the name or identity of a patient or research subject to the commissioner, and the practitioner may not otherwise disclose the name or identity of an individual that he is obliged to keep confidential unless compelled to disclose it within the context of a criminal investigation or proceeding.

ARTICLE 4. DEFINITIONS.

Sec. 17.30.500. DEFINITIONS. As used in this chapter

(1) "administer" means the direct application of a controlled substance, whether by injection, inhalation, ingestion, or any other means into the body of a patient or research subject by

(A) a practitioner or, in the practitioner's presence, by his authorized agent, or

(B) the patient or research subject at the direction and in the presence of a practitioner;

(2) "agent" means an authorized person who acts on behalf of or at the direction of a manufacturer, distributor, or dispenser; it does not include a common or contract carrier, public warehouseman, or employee of the carrier or warehouseman;

(3) "commissioner" means the commissioner of health and social services;

(4) "committee" means the Controlled Substances Advisory Committee established in AS 17.30.020;

(5) "controlled substance" means a drug, substance, or immediate precursor included in the schedules set out in AS 17.30.040 -- 17.30.090;

(6) "deliver" or "delivery" means the actual, constructive, or attempted transfer from one person to another of a controlled substance whether or not there is an agency relationship;

(7) "department" means the Department of Health and Social Services;

(8) "dispense" means to deliver a controlled substance to an ultimate user or research subject by or under the lawful order of a practitioner, including the prescribing, administering, packaging, labeling, or compounding necessary to prepare the substance for that delivery; "dispenser" means a practitioner who dispenses;

(9) "distribute" means to deliver other than by administering or dispensing a controlled substance; "distributor" means a person who distributes;

(10) "drug"

(A) means

(i) substances recognized as drugs in the official United States Pharmacopoeia, official Homeopathic Pharmacopoeia of the United States, or official National Formulary, or any supplement to any of these publications;

(ii) substances intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease in humans or animals;

(iii) substances, other than food, intended to affect the structure or any function of the body of humans or animals; and

(iv) substances intended for use as a component

of any article specified in (i), (ii), or (iii) of this subparagraph;

(B) does not include devices or their components, parts, or accessories;

(11) "hashish" means the dried, compressed, resinous product of the plant (genus) Cannabis;

(12) "hashish oil" means the viscous liquid concentrate of tetrahydrocannabinols extracted from the plant (genus) Cannabis;

(13) "immediate precursor" means a substance which is by statute or regulation designated as the principal compound commonly used or produced primarily for use, and which is an immediate chemical intermediary used or likely to be used in the manufacture of a controlled substance, the control of which is necessary to prevent, curtail, or limit manufacture of that controlled substance;

(14) "judicial officer" means a justice of the supreme court, a judge of the superior court, a district judge, and a magistrate

(15) "intoxicating liquor" has the meaning ascribed to it in AS 11.71.200(9);

(16) "manufacture" means

(A) the production, preparation, propagation, compounding, conversion, growing, or processing of a controlled substance, either directly or indirectly by extraction from substances of natural origin, or independently by means of chemical synthesis, or by a combination of extraction and chemical synthesis; however, the growing of less than one pound of marijuana is not manufacturing; and

(B) any packaging or labeling of a controlled substance including but not limited to acts done

(i) by a practitioner as an incident to his ad-

ministering or dispensing of a controlled substance in the course of his professional practice; or

(ii) by a practitioner, or by his authorized agent under his supervision, for the purpose of, or as an incident to, research, teaching, or chemical analysis and not for sale;

(17) "marijuana" has the meaning ascribed to it in AS 11.-71.200(11);

(18) "opiate" means a substance having an addiction forming or addiction sustaining capability similar to morphine or being capable of conversion into a drug having addiction forming or addiction sustaining capability; it does not include, unless specifically designated as controlled under AS 17.30.010, the dextrorotatory isomer of 3-methoxy-n-methylmorphinan and its salts (dextromethorphan); it does include its racemic and levorotatory forms;

(19) "opium poppy" means the plant of the species Papaver somnifern L., except its seeds;

(20) "poppy straw" means all parts, except the seeds, of the opium poppy, after mowing;

(21) "practitioner" means:

(A) a physician, dentist, veterinarian, scientific investigator, or other person licensed, registered, or otherwise permitted to distribute, dispense, conduct research with respect to, or to administer a controlled substance in the course of professional practice or research in the state;

(B) a pharmacy, hospital or other institution licensed, registered, or otherwise permitted to distribute, dispense, conduct research with respect to or to administer a controlled substance in the course of professional practice or research in the

state;

(22) "production" includes the manufacture, planting, cultivation, growing, or harvesting of a controlled substance;

(23) "ultimate user" means a person who lawfully possesses a controlled substance for his own use or for the use of a member of his household or for administering to an animal owned by him or by a member of the household.

Sec. 17.30.600. SHORT TITLE. This chapter may be cited as the Alaska Controlled Substances Act.

* Sec. 9. AS 08.64.380(3)(B) is amended to read:

(B) habitual overuse of alcoholic beverages or <u>controlled substances</u> [DEPRESSANT, HALLUCINOGENIC OR STIMULANT DRUGS,] as defined in <u>AS 17.30</u> [AS 17.12.150(3), OR ADDICTION TO THE USE OF NARCOTIC DRUGS AS DEFINED IN AS 17.10.230(13)];

* Sec. 10. AS 08.80.260(2) is amended to read:

(2) selling, bartering, or making available <u>a controlled substance as defined in AS 17.30</u> [, MORPHINE, COCAINE OR OTHER, NARCOTIC] to a person addicted to the use of <u>a controlled substance</u> [DRUGS] except upon prescription issued by a licensed physician;

* Sec. 11. AS 08.80.260(9) is amended to read:

(9) violation of regulations pertaining to the provisions of adequate security for <u>controlled substances</u> [DANGEROUS DRUGS];

* Sec. 12. AS 08.80.470 is amended to read:

Sec. 08.80.470. CONSTRUCTION. Nothing in this chapter amends, modifies, repeals or otherwise changes any provision of the <u>Controlled Substances Act (AS 17.30)</u> [NARCOTIC DRUG ACT (AS 17.10)] or the Alaska Food, Drug and Cosmetic Act (AS 17.30).

* Sec. 13. AS 28.35.030(a) is amended to read:

(a) A person who, while under the influence of intoxicating

liquor, or other controlled substance listed [DEPRESSANT, HALLUCINOGENIC OR STIMULANT DRUGS OR NARCOTIC DRUGS AS DEFINED] in AS 17.30.040 -- 17.30.090 [AS 17.10.230(13) AND AS 17.12.150(3)] operates or drives an automobile, motorcycle or other motor vehicle in the state, upon conviction, is punishable by a fine of not more than $1,000, or by imprisonment for not more than one year, or by both and the court shall impose a minimum sentence of imprisonment of not less than three consecutive days. Upon a subsequent conviction within five years after a conviction under this section, the court shall impose a minimum sentence of imprisonment of not less than 10 consecutive days. The execution of sentence may not be suspended nor may probation or parole be granted until the minimum imprisonment provided in this section has been served, nor may imposition of sentence be suspended, except upon the condition that the defendant be imprisoned for no less than the minimum period provided in this section [, NOR MAY THE PUNISHMENT PROVIDED FOR IN THIS SECTION BE REDUCED UNDER AS 11.05.150]. In addition, his operator's license shall be revoked in accordance with AS 28.15.210(c). In addition, a person convicted under this statute shall undertake, for a term specified by the court, that program of alcohol education or rehabilitation which the court, after consideration of any information compiled under (b) of this section, finds appropriate.

* Sec. 14. AS 44.29.020 is amended to read:

Sec. 44.29.020. DUTIES OF DEPARTMENT. The Department of Health and Social Services shall administer the state programs of public health and welfare, including: (1) maternal and child health services; (2) preventive medical services; (3) public health nursing services; (4) sanitation and engineering services; (5) nutrition services; (6) health education; (7) laboratories; (8) mental health treatment and

diagnosis; (9) management of state institutions; (10) medical facilities; (11) old age assistance; (12) aid to dependent children; (13) aid to the blind; (14) child welfare services; (15) general relief; (16) licensing and supervision of child care facilities; [AND] (17) probation and parole supervision; and (18) the Alaska Controlled Substances Act (AS 17.30).

* Sec. 15. (a) Prosecution for a violation of law occurring before the effective date of this Act is not affected or abated by this Act. Violation of any law repealed by this Act may still be prosecuted and brought to a final determination in accordance with the laws and regulations in effect at the time of the violation.

(b) Civil seizures or forfeitures and injunctive proceedings commenced before the effective date of this Act are not affected by this Act.

(c) All administrative proceedings pending under prior laws which are superseded by this Act shall be continued and brought to a final determination in accordance with the laws and rules in effect before the effective date of this Act.

(d) The commissioner of health and social services shall initially permit persons to register who own or operate an establishment engaged in the manufacture, distribution, or dispensing of a controlled substance before the effective date of this Act and who are registered or licensed by the state.

(e) This Act applies to violations of law, seizures and forfeitures, injunctive proceedings, administrative proceedings and investigations which occur following its effective date.

* Sec. 16. Orders issued and regulations adopted under a law affected by this Act and in effect on the effective date of this Act and not in conflict with this Act continue until modified, superseded or repealed.

* Sec. 17. AS 04.15.080, 04.15.110, 17.10, 17.12, and 17.15 are repealed.

* Sec. 18. This Act takes effect on July 1, 1980.

DRUGS OF ABUSE

Narcotics

Opium
and opium derivatives or
synthetic substitutes

The term *narcotic* in its medical meaning refers to opium and opium derivatives or synthetic substitutes.*

Narcotics are indispensable in the practice of medicine: they are the most effective agents known for the relief of intense pain. They are also used as cough suppressants as well as a remedy centuries old for diarrhea.

Under medical supervision narcotics are administered orally or by intramuscular injection. As drugs of abuse, however, they may be sniffed, smoked, or self-administered by the more direct routes of subcutaneous ("skin-popping") and intravenous ("mainlining") injection.

The relief of suffering, whether of physical or psychological origin, may result in a short-lived state of euphoria. The initial effects, however, are often unpleasant, leading many to conclude that those who persist in their illicit use may have latent personality disturbances. Narcotics tend to induce pinpoint pupils and reduced vision, together with drowsiness, apathy, decreased physical activity, and constipation. A larger dose may induce sleep, but there is an increasing possibility of nausea, vomiting, and respiratory depression--the major toxic effect of the opiates. Except in cases of acute intoxication, there is no loss of motor coordination or slurred speech as in the case of the depressants.

To the extent that the response may be felt to be pleasurable, its intensity may be expected to increase with the amount of the dose administered. Repeated use, however, will result in increasing tolerance: the user must administer progressively larger doses to attain the desired effect, thereby reinforcing the compulsive behavior known as drug dependence.

Physical dependence refers to an alteration of the normal functions of the body that necessitates the continued presence of a drug in order to prevent the withdrawal or abstinence syndrome, which is characteristic of each class of ad-

* Cocaine, ecgonine, and coca leaves, classified as narcotics under the CSA, are discussed in the section on stimulants, beginning on page 24.

dictive drugs. The intensity of physical symptoms experienced during the withdrawal period is related directly to the amount of narcotic used each day. Deprivation of an addictive drug causes increased excitability of those same bodily functions that have been depressed by its habitual use.

With the deprivation of narcotics, the first withdrawal signs are usually experienced shortly before the time of the next scheduled dose. Complaints, pleas, and demands by the addict are prominent, increasing in intensity and peaking from 36 to 72 hours after the last dose, then gradually subsiding. Symptoms such as watery eyes, runny nose, yawning, and perspiration appear about 8 to 12 hours after the last dose. Thereafter, the addict may fall into a restless sleep. As the abstinence syndrome progresses, restlessness, irritability, loss of appetite, insomnia, goose flesh, tremors, and finally yawning and severe sneezing occur. These symptoms reach their peak at 48 to 72 hours. The patient is weak and depressed with nausea and vomiting. Stomach cramps and diarrhea are common. Heart rate and blood pressure are elevated. Chills alternating with flushing and excessive sweating are also characteristic symptoms. Pains in the bones and muscles of the back and extremities occur as do muscle spasms and kicking movements, which may be the source of the expression "kicking the habit." At this time an individual may become suicidal. Without treatment the syndrome eventually runs its course and most of the symptoms will disappear in 7 to 10 days. How long it takes to restore physiological and psychological equilibrium, however, is unpredictable. For a few weeks following withdrawal the addict will continue to think and talk about his use of drugs and be particularly susceptible to an urge to use them again.

The withdrawal syndrome may be avoided by reducing the dose of narcotic over a one-to-three-week period. Detoxification of an addict can be accomplished quite easily by substituting oral methadone for the illicit narcotic and gradually reducing the dose. However, the addict's entire pattern of life is built around drug taking and narcotic dependence is never entirely resolved by withdrawal alone.

Since addicts tend to become preoccupied with the daily round of obtaining and taking drugs, they often neglect themselves and may suffer from malnutrition, infections, and unattended diseases or injuries. Among the hazards of narcotic addiction are toxic reactions to contaminants, such as quinidine, sugars, and talcum powder, as well as unsterile needles and injection techniques, resulting in abscesses, blood poisoning, and hepatitis. Since there is no simple way to determine the purity of a drug that is sold on the street, the potency is unpredictable. A person with a mild overdose may be stuporous or asleep. Larger doses may induce a coma with slow shallow respiration. The skin becomes clammy cold, the body limp, and the jaw relaxed; there is a danger that the tongue may fall back, blocking the air passageway. If the condition is sufficiently severe, convulsions may occur, followed by respiratory arrest and death. Specific antidotes for narcotic poisoning are available at hospitals.

Narcotics of Natural Origin

The poppy *Papaver somniferum* is the main source of the nonsynthetic narcotics. It was grown in the Mediterranean region as early as 300 B.C. and has since been cultivated in countries around the world, including Hungary, Yugoslavia, Turkey, India, Burma, China, and Mexico.

The milky fluid that oozes from incisions in the unripe seedpod has since ancient times been scraped by hand and air dried to produce opium gum. A more modern method of harvesting is by the industrial poppy straw process of extracting alkaloids from the mature dried plant. The extract may be in either liquid, solid, or powder form. Most poppy straw concentrate made available commercially is a fine brownish powder with a distinct odor.

More than 400 tons of opium or its equivalent in poppy straw concentrate are legally imported annually into the United States.

Opium

There were no legal restrictions on the importation or use of opium until the early 1900's. In those days patent medicines often contained opium without any warning label.

Poppy field

Incised seedpod

Scraping raw opium

Today there are state, federal, and international laws governing the production and distribution of narcotic substances, and there is little abuse of opium in the United States.

At least 25 alkaloids can be extracted from opium. These fall into two general categories, each producing markedly different effects. The first, known as the phenanthrene alkaloids, represented by morphine and codeine, are used as analgesics and cough suppressants; the second, the isoquinoline alkaloids, represented by papaverine (an intestinal relaxant) and noscapine (a cough suppressant), have no significant influence on the central nervous system and are not regulated under the CSA.

Although a small amount of opium is used to make antidiarrheal preparations such as paregoric, virtually all the opium imported into this country is broken down into its alkaloid constituents, principally morphine and codeine.

Morphine

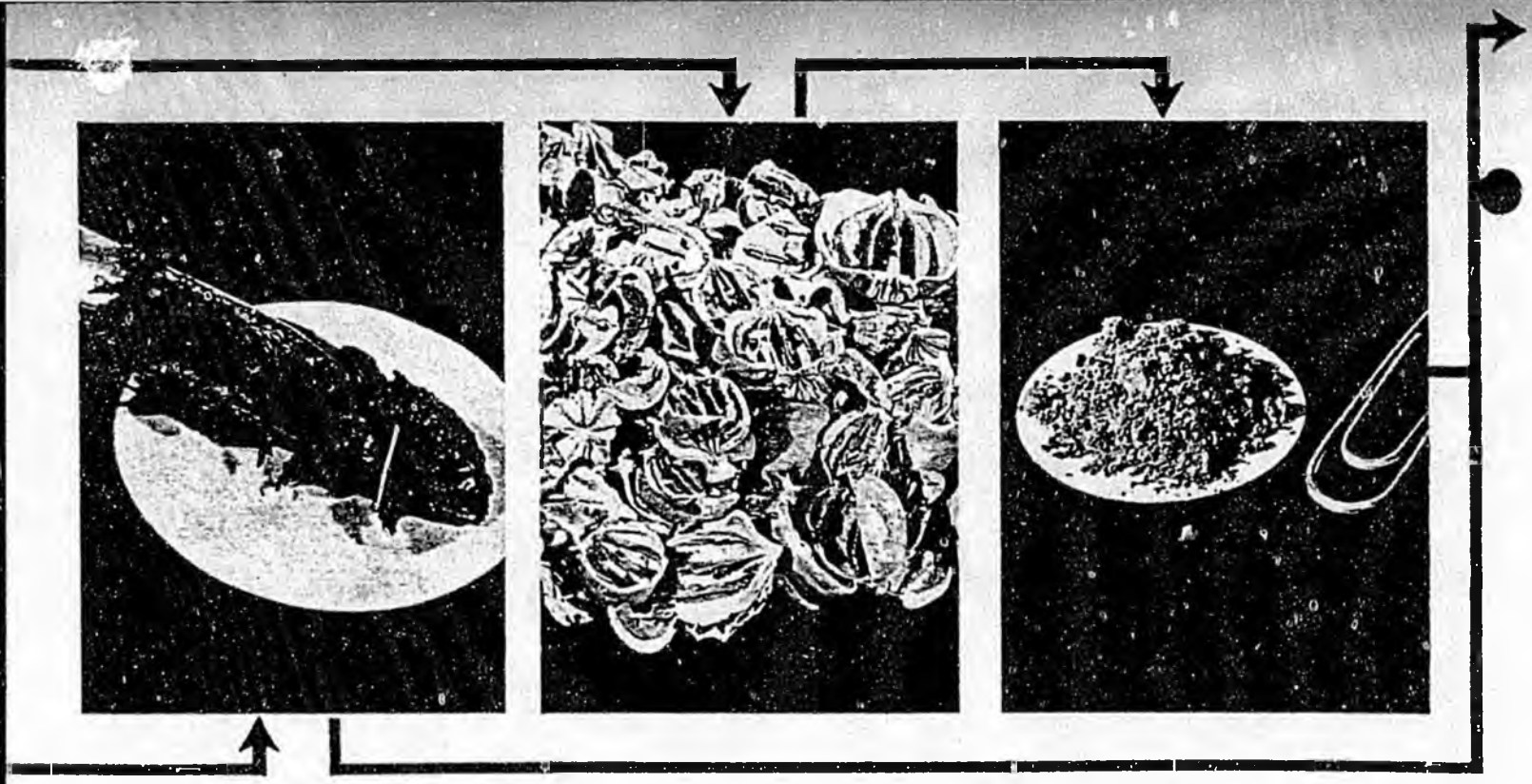
The principal constituent of opium, ranging in concentration from 4 to 21 percent, morphine is one of the most effective drugs known for the relief of pain. It is marketed in the form of white crystals, hypodermic tablets, and injectable preparations. Its licit use is restricted primarily to hospitals. Morphine is odorless, tastes bitter, and darkens with age. It may be administered subcutaneously, intramuscularly or intravenously, the latter method being the one most frequently resorted to by addicts. Tolerance and dependence develop rapidly in the user. Only a small part of the morphine obtained from opium is used medically. Most of it is converted to codeine and, secondarily, to hydromorphone.

Codeine

This alkaloid is found in raw opium in concentrations ranging from 0.7 to 2.5 percent. It was first isolated in 1832 as an impurity in a batch of morphine. Although it occurs naturally, most codeine is produced from morphine. As compared with morphine, codeine produces less analgesia, sedation, and respiratory depression. It is widely distributed in products of two general types. Codeine for the relief of moderate pain may consist of codeine tablets or be combined with other products such as aspirin or acetaminophen (Tylenol). Some examples of liquid codeine preparations for the relief of coughs (antitussives) are Robitussin AC, Cheracol, and elixir of terpin hydrate with codeine. Codeine is also manufactured to a lesser extent in injectable form for the relief of pain. It is by far the most widely used naturally occurring narcotic in medical treatment.

Thebaine

A minor constituent of opium, thebaine is the principal alkaloid



Opium gum *Poppy straw* *Poppy straw concentrate*

present in another species of poppy, *Papaver bracteatum*, which has been grown experimentally in the United States as well as in other parts of the world. Although chemically similar to both codeine and morphine, it produces stimulant rather than depressant effects. Thebaine is not used in this country for medical purposes, but it is converted into a variety of medically important compounds, including codeine, hydrocodone, oxycodone, oxymorphone, nalbuphine, naloxone, and the Bentley compounds. It is controlled in Schedule II of the CSA as well as under international law.

Semi-Synthetic Narcotics

The following narcotics are among the more significant synthetic substances that have been derived by modification of the chemicals contained in opium.

Heroin

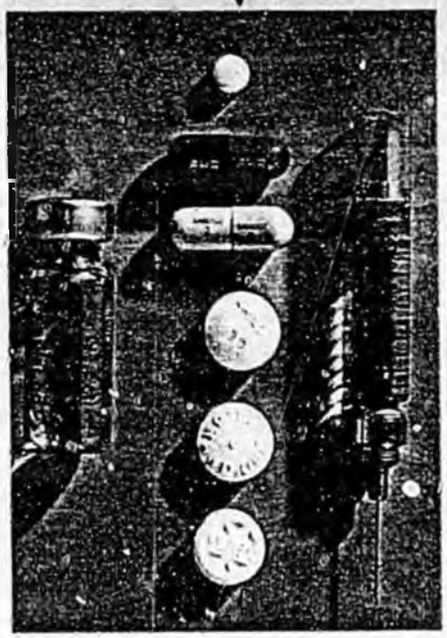
First synthesized from morphine in 1874, heroin was not extensively used in medicine until the beginning of this century. The Bayer Company in Germany first started commercial production of the new pain remedy in 1898. While it received widespread acceptance, the medical profession for years remained unaware of its potential for addiction. The first comprehensive control of heroin in the United States was established with the Harrison Narcotic Act of 1914. Pure heroin is a white powder with a bitter taste. Illicit heroin may vary in color from white to dark brown because of impurities left from the manufacturing process or the presence of additives such as food coloring, cocoa, or brown sugar. Pure heroin is rarely sold on the street. A "bag"—slang for a single dosage unit of heroin—may weigh about 100 mg, usually containing less than 5 percent heroin. To increase the bulk of the material sold to the addict, diluents are mixed with the heroin in ratios ranging from 9 to 1 to as much as 99 to 1. Sugars, starch, powdered milk, and quinine are among the diluents used.

Hydromorphone

Most commonly known as Dilaudid, hydromorphone is the second oldest semi-synthetic narcotic analgesic. Marketed both in tablet and injectable form, it is shorter acting and more sedative than morphine, but its potency is from two to eight times as great. It is therefore a highly abusable drug, much sought after by narcotic addicts, who usually obtain it through fraudulent prescription or theft. The tablets, stronger than available liquid forms, may be dissolved and injected.

Oxycodone

Oxycodone is synthesized from



Morphine

Codeine

Thebaine

Semi-Synthetic Narcotics

Heroin

Hydromorphone (Dilaudid)

thebaine. It is similar to codeine, but more potent and with a higher dependence potential. It is effective orally and is marketed in combination with other drugs such as Percodan for the relief of pain. Addicts take Percodan orally or dissolve tablets in water, filter out the insoluble material, and "mainline" the active drug.

Etorphine and Diprenorphine

Two of the Bentley compounds, these substances are both made from thebaine. Etorphine is more than a thousand times as potent as morphine in its analgesic, sedative and respiratory depressant effects. For human use its potency is a distinct disadvantage because of the danger of overdose. Etorphine hydrochloride (M99) is used by veterinarians to immobilize large wild animals. Diprenorphine hydrochloride (M50-50), acting as an antagonist, counteracts the effects of etorphine. The manufacture and distribution of both substances are strictly regulated under the CSA.

Synthetic Narcotics

In contrast to pharmaceutical products derived directly or indirectly from narcotics of natural origin, synthetic narcotics are produced entirely within the laboratory. A continuing search for a product that will retain the analgesic properties of morphine without the consequent dangers of tolerance and dependence has yet to yield a drug that is not susceptible to abuse. The two that are most widely available are meperidine and methadone.

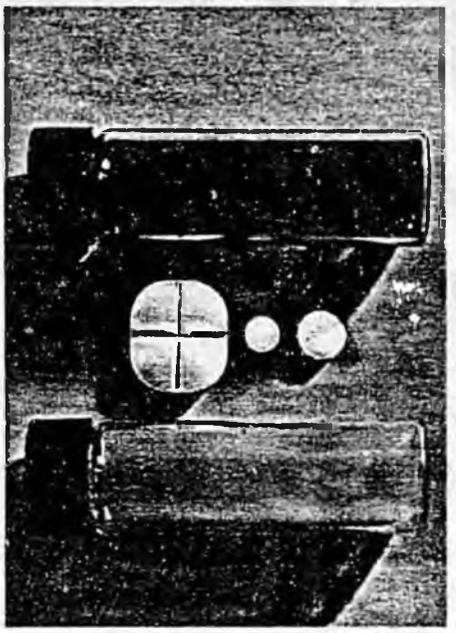
Meperidine (pethidine)

The first synthetic narcotic, produced originally a generation ago, meperidine is chemically dissimilar to morphine but resembles it in its analgesic potency. It is probably

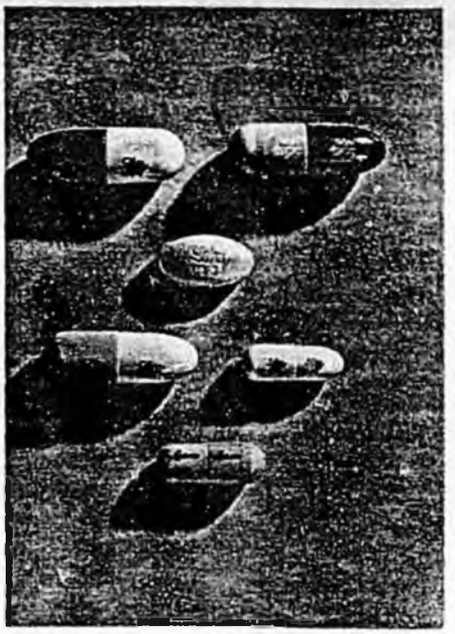
Thebaine derivatives

Diprenorphine (left) and etorphine

Meperidine



Methadone



Propoxyphene

the most widely used drug for the relief of moderate to severe pain. Available in pure form as well as in products containing other medicinal ingredients, it is administered either orally or by injection, the latter method being the most widely abused. Tolerance and dependence develop with chronic use, and large doses can result in convulsions.

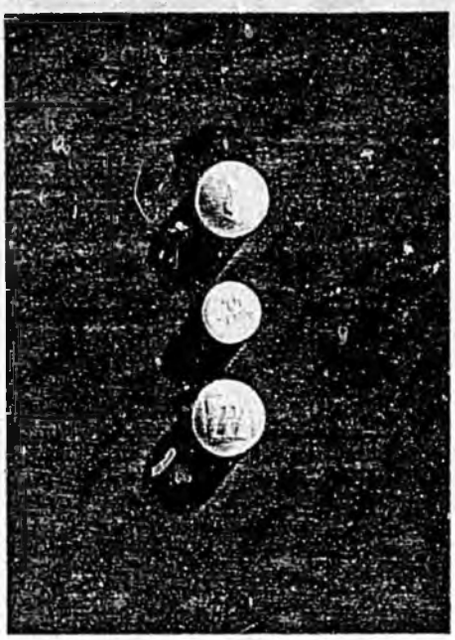
Methadone and Related Drugs

German scientists synthesized methadone during World War II because of a shortage of morphine. Although chemically unlike morphine or heroin, it produces many of the same effects. Introduced into the United States in 1947 as an analgesic and distributed under such names as Amidone, Dolophine, and Methadone, it became widely used in the 1960's in the treatment of narcotic addicts. The effects of methadone differ from morphine-based drugs in that they have a longer duration of action, lasting up to 24 hours, thereby permitting administration only once a day in heroin detoxification and maintenance programs. Moreover, methadone is almost as effective when administered orally as it is by injection. But tolerance and dependence may develop, and withdrawal symptoms, though they develop more slowly and are less severe, are more prolonged. Ironically, methadone, designed to control narcotic addiction, has emerged in some metropolitan areas as a major cause of overdose deaths.

Closely related chemically to methadone is the synthetic compound levo-alpha-acetylmethadol (LAAM), which has an even longer duration of action (from 48 to 72 hours), permitting a further reduction in clinic visits and the elimination of take-home medication. Its potential in the treatment of narcotic addicts is now under investigation. Another close relative of methadone is propoxyphene, first marketed in 1957 under the trade name of Darvon for the relief of mild to moderate pain. Less dependence-producing than the opiates, it is also less effective as an analgesic. Misuse of propoxyphene led to its placement in Schedule IV of the CSA in 1977.

Narcotic Antagonists

The deliberate effort to find an effective analgesic that is not dependence producing has led in recent years to the development of a class of compounds known as narcotic antagonists. These drugs, as the name implies, tend to block and reverse the effects of narcotics, and some of them may in future prove useful in checking recidivist tendencies of former addicts who have undergone treatment. Nalorphine, introduced into clinical medicine in 1951 and now under



Other synthetic narcotics: top to bottom, anileridine (Leritine), levorphanol (Levo-Dromoran), and pentazocine (Talwin)

Schedule III, is called a partial antagonist. In a drug-free individual, it produces morphine-like effects; whereas in an individual under the influence of narcotics, it counteracts these effects. Another partial antagonist is pentazocine (Talwin). Introduced as an analgesic in 1967, it was determined to be an abusable drug and placed under Schedule IV in 1979. Relatively pure antagonists have also been developed. Naloxone (Narcan), having no morphine-like effects, was removed from the CSA when introduced as a specific antidote for narcotic poisoning in 1971. A number of "pure" antagonists have since been developed that are longer lasting and effective when administered orally. One of them is Naltrexone, which was removed from control of the CSA in 1975, and which is now under evaluation to determine its utility in assisting post-narcotic addicts to remain drug free.

Drugs of Abuse

Substances regulated under the CSA as depressants have a high potential for abuse associated with both physical and psychological dependence.

Taken as prescribed by a physician, depressants may be beneficial for the relief of anxiety, irritability, and tension, and for the symptomatic treatment of insomnia. In excessive amounts, however, they produce a state of intoxication that is remarkably similar to that of alcohol.

As in the case of alcohol, these effects may vary not only from person to person but from time to time in the same individual. Low doses produce mild sedation. Higher doses, insofar as they relieve anxiety or stress, may produce a temporary sense of well-being; they may also produce mood depression and apathy. In marked contrast to the effects of narcotics, however, intoxicating doses invariably result in impaired judgment, slurred speech, and loss of motor coordination. In addition to the dangers of disorientation, resulting in a high incidence of highway accidents, recurrent users incur risks of long-term involvement with depressants.

Tolerance to the intoxicating effects develops rapidly, leading to a progressive narrowing of the margin of safety between an intoxicating and lethal dose. The person who is unaware of the dangers of increasing dependence will often increase the daily dose up to 10 or 20 times the recommended therapeutic level. The source of supply may be no further than the family medicine cabinet. Depressants are also frequently obtained by theft, illegal prescription, or purchase on the illicit market.

Members of the drug subculture often resort to the use of depressants as self-medication to soothe jangled nerves brought on by the use of stimulants, to quell the anxiety of "flashbacks" resulting from prior use of hallucinogens, or to ease their withdrawal from heroin. The dangers, it should be stressed, are compounded when depressants are used in combination with alcohol or other drugs. Chronic intoxication, though it affects every age group, is most common in middle age. The problem often remains unrecognized until

Depressants

In excessive amounts
they induce a state of intoxication
remarkably like that
of alcohol

the user exhibits recurrent confusion or an obvious inability to function. Depressants also serve as a means of suicide, a pattern particularly common among women.

As will be shown, the depressants vary with respect to their potential for overdose. Moderate depressant poisoning closely resembles alcoholic inebriation. The symptoms of severe depressant poisoning are coma, a cold clammy skin, a weak and rapid pulse, and a slow or rapid but shallow respiration. Death will follow if the reduced respiration and low blood pressure are not counteracted by proper medical treatment.

The abrupt cessation or reduction of high-dose depressant intake may result in a characteristic withdrawal syndrome, which should be recognized as a medical emergency more serious than that of any other drugs of abuse. An apparent improvement in the patient's condition may be the initial result of detoxification. Within 24 hours, however, minor withdrawal symptoms manifest themselves, among them anxiety and agitation, loss of appetite, nausea and vomiting, increased heart rate and excessive sweating, tremulousness and abdominal cramps. The symptoms usually peak during the second or third day of abstinence from the short-acting barbiturates or meprobamate; they may not be reached until the seventh or eighth day of abstinence from the long-acting barbiturates or benzodiazepines. It is during the peak period that the major withdrawal symptoms usually occur. The patient may experience convulsions indistinguishable from those occurring in grand mal epilepsy. More than half of those who experience convulsions will go on to develop delirium, often resulting in a psychotic state identical to the delirium tremens associated with the alcohol withdrawal syndrome. Detoxification and treatment must therefore be carried out under close medical supervision. While treatment techniques vary to some extent, they share common objectives: stabilization of the drug-dependent state to allay withdrawal symptoms followed by gradual withdrawal to prevent their recurrence.

Among the depressants that give rise to the general conditions described are chloral hydrate, a broad array of barbiturates, glutethimide, methaqualone, meprobamate, and the benzodiazepines.

Chloral Hydrate

The oldest of the hypnotic (sleep-inducing) drugs, chloral hydrate was first synthesized in 1862 and soon supplanted alcohol, opium, and cannabis preparations for inducing sedation and sleep. Its popularity declined after the introduction of the barbiturates, but chloral hydrate is still widely used. It has a penetrating, slightly acrid odor, and a bitter caustic taste. Its depressant effects, as well as resulting tolerance and dependence, are comparable to those of alcohol, and withdrawal symptoms resemble delirium tremens. Chloral hydrate is a liquid, marketed in the form of syrups and soft gelatin capsules. Cases of poisoning have occurred from mixing chloral hydrate with alcoholic drinks. Chloral hydrate is not a street drug of choice. Its main misuse is by older adults.

Barbiturates

Among the drugs most frequently prescribed to induce sedation and sleep by both physicians and veterinarians are the barbiturates. About 2,500 derivatives of barbituric acid have been synthesized, but of these only about 15 remain in medical use. Small therapeutic doses tend to calm nervous conditions, and larger doses cause sleep 20 to 60 minutes after oral administration. As in the case of alcohol, some individuals may experience a sense of excitement before sedation takes effect. If dosage is increased, however, the effects of the barbiturates may progress through successive stages of sedation, sleep, and coma to death from respiratory arrest and cardiovascular complications.

Barbiturates are classified as ultrashort, short, intermediate, and long-acting. The ultrashort-acting barbiturates produce anesthesia within one minute after intravenous administration. The rapid onset and brief duration of action make them undesirable for purposes of abuse. Those in current medical use are hexobarbital (Evipal), methohexital (Brevital), thiamylal (Surital), and thiopental (Pentothal).

Among the short-acting and intermediate-acting barbiturates are pentobarbital (Nembutal), secobarbital (Seconal), and amobarbital (Amytal)—three of the drugs in the depressant category most sought after by abusers. The group also

CONTROLLED SUB

	Drugs	Schedule	Trade or Other Names	Medical Uses	Physica Depen- dence
NARCOTICS	Opium	II, III, V	Dover's Powder, Paregoric, Parepectolin	Analgesic, antidiarrheal	High
	Morphine	II, III	Morphine, Pectoral Syrup	Analgesic, antitussive	
	Codeine	II, III, V	Codeine, Empirin Compound with Codeine, Robitussin A-C	Analgesic, antitussive	Moder
	Heroin	I	Diacetylmorphine, Horse, Smack	Under investigation	
	Hydromorphone	II	Dilaudid	Analgesic	High
	Meperidine (Pethidine)		Demerol, Pethadol	Analgesic	
	Methadone		Dolophine, Methadone, Methadose	Analgesic, heroin substitute	
	Other Narcotics	I, II, III, IV, V	LAAM, Leritine, Levo-Dromoran, Percodan, Tussionex, Fentanyl, Darvon*, Talwin*, Lomotil	Analgesic, antidiarrheal, antitussive	High-L
DEPRESSANTS	Chloral Hydrate	IV	Noctec, Somnos	Hypnotic	Moder
	Barbiturates	II, III, IV	Amobarbital, Phenobarbital, Butisol, Phenoxbarbital, Secobarbital, Tuinal	Anesthetic, anticonvulsant, sedative, hypnotic	High Moder
	Glutethimide	III	Doriden	Sedative, hypnotic	High
	Methaqualone	II	Optimil, Parest, Quaalude, Somnafac, Sopor		
	Benzodiazepines	IV	Ativan, Azene, Clonopin, Dalmane, Diazepam, Librium, Serax, Tranxene, Valium, Verstran	Anti-anxiety, anticonvulsant, sedative, hypnotic	Low
	Other Depressants	III, IV	Equanil, Miltown, Noludar Placidyl, Valmid	Anti-anxiety, sedative, hypnotic	Moder
STIMULANTS	Cocaine†	II	Coke, Flake, Snow	Local anesthetic	Possib
	Amphetamines	II, III	Biphetamine, Delcobese, Desoxyn, Dexedrine, Mediatric	Hyperkinesis, narcolepsy, weight control	
	Phenmetrazine	II	Preludin		
	Methylphenidate		Ritalin		
	Other Stimulants	III, IV	Adipex, Bacarate, Cylert, Didrex, Ionamin, Plegine, Pre-Sate, Sanorex, Tenuate, Tepanil, Voranil		
HALLUCINOGENS	LSD	I	Acid, Microdot	None	Non
	Mescaline and Peyote		Mesc, Buttons, Cactus		
	Amphetamine Variants		2,5-DMA, PMA, STP, MDA, MMDA, TMA, DOM, DOB		Unkno
	Phencyclidine	II	PCP, Angel Dust, Hog	Veterinary anesthetic	Degree unkno
	Phencyclidine Analogs	I	PCE, PCPy, TCP	None	
	Other Hallucinogens		Bufotenine, Ibogaine, DMT, DET, Psilocybin, Psilocyn		Non
CANNABIS	Marihuana	I	Pot, Acapulco Gold, Grass, Reefer, Sinsemilla, Thai Sticks	Under investigation	Degree unkno
	Tetrahydrocannabinol		THC		
	Hashish		Hash	None	
	Hashish Oil		Hash Oil		

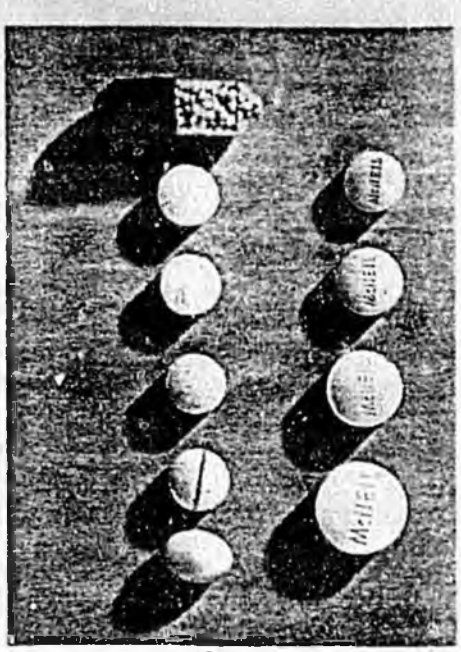
STANCES: USES & EFFECTS

Psychological Dependence	Tolerance	Duration of Effects (in hours)	Usual Methods of Administration	Possible Effects	Effects of Overdose	Withdrawal Syndrome
High	Yes	3 - 6	Oral, smoked	Euphoria, drowsiness, respiratory depression, constricted pupils, nausea	Slow and shallow breathing, clammy skin, convulsions, coma, possible death	Watery eyes, runny nose, yawning, loss of appetite, irritability, tremors, panic, chills and sweating, cramps, nausea
Moderate			Oral, injected, smoked			
High			Oral, injected			
			Injected, sniffed, smoked			
		12-24	Oral, injected			
High-Low		Variable				
Moderate	Possible	5 - 8	Oral	Slurred speech, disorientation, drunken behavior without odor of alcohol	Shallow respiration, cold and clammy skin, dilated pupils, weak and rapid pulse, coma, possible death	Anxiety, insomnia, tremors, delirium, convulsions, possible death
High-Moderate	Yes	1 - 16	Oral, injected			
High		4 - 8				
Low						
Moderate						
High	Possible	1 - 2	Sniffed, injected	Increased alertness, excitation, euphoria, increased pulse rate and blood pressure, insomnia, loss of appetite	Agitation, increase in body temperature, hallucinations, convulsions, possible death	Apathy, long periods of sleep, irritability, depression, disorientation
	Yes	2 - 4	Oral, injected			
			Oral			
Degree unknown	Yes	8 - 12	Oral	Illusions and hallucinations, poor perception of time and distance	Longer, more intense "trip" episodes, psychosis, possible death	Withdrawal syndrome not reported
			Oral, injected			
High		Up to days				
Degree unknown		Variable	Smoked, oral, injected			
	Possible		Oral, injected, smoked, sniffed			
Moderate	Yes	2 - 4	Smoked, oral	Euphoria, relaxed inhibitions, increased appetite, disoriented behavior	Fatigue, paranoia, possible psychosis	Insomnia, hyperactivity, and decreased appetite occasionally reported

*Not designated a narcotic under the CSA
†Designated a narcotic under the CSA

Chloral hydrate

Barbiturates: top row, amobarbital; middle row, pentobarbital (in combination with carbromal in the capsule at center); bottom row, secobarbital (in combination with amobarbital in the red and blue capsule at left).



Barbiturates: phenobarbital (left column) and butabarbital

includes butabarbital (Butisol), butalbital (Lotusate), allobarbital (Dial), aprobarbital (Alurate), and vinbarbital (Delvinal). After oral administration the onset time of action is from 15 to 40 minutes and duration of action is up to 6 hours. Physicians prescribe short-acting barbiturates to induce sedation or sleep. Veterinarians use pentobarbital for anesthesia and euthanasia.

Long-acting barbiturates, which include barbital (Veronal), phenobarbital (Luminal), mephobarbital or methylphenobarbital (Mebaral), and metharbital (Gemonil), have onset times of up to one hour and durations of action up to 16 hours. They are used medicinally as sedatives, hypnotics, and anticonvulsants. Their slow onset of action discourages their use for episodic intoxication, and they are not ordinarily distributed on the illicit market except when sold as something else. It should be emphasized, however, that all barbiturates result in a buildup of tolerance, and dependence on them is widespread.

Glutethimide

When glutethimide (Doriden) was introduced in 1954, it was said to be a safe barbiturate substitute without an addiction potential. But experience has shown glutethimide to be another CNS depressant, having no particular advantage over the barbiturates and several important disadvantages. The sedative effects of glutethimide begin about 30 minutes after oral administration and last for 4 to 8 hours. Glutethimide is marketed as Doriden in 125, 250, and 500 mg tablets. Because the effects of this drug are of long duration, it is exceptionally difficult to reverse overdoses, which often result in death.

Methaqualone

Methaqualone is a synthetic sedative chemically unrelated to the barbiturates, glutethimide, or chloral hydrate. It has been widely abused because it was once mistakenly thought to be non-addictive and effective as an aphrodisiac. Actually, methaqualone has caused many cases of serious poisoning. It is administered orally. Large doses cause coma, which may be accompanied by thrashing movements or convulsions. Continued heavy use of large doses leads to tolerance and dependence. Methaqualone has been marketed in the United States under various brand names such as Quaalude, Parest, Optimil, Somnafac, and Sopor. Counterfeit Quaalude tablets, which do not necessarily contain methaqualone, are prevalent on the U.S. illicit market, similar in appearance to the 300 mg tablet for-

Glutethimide (top row) and meprobamate

Methaqualone

Benzodiazepines: from top to bottom row, diazepam, chlordiazepoxide, flurazepam, clonazepam, clorazepate, lorazepam, and oxazepam

merly distributed by Rorer. Mandrax is a European brand name for methaqualone in combination with an antihistamine. Mecloqualone, a chemical similar to methaqualone in all significant respects, is not legally sold in the United States and is in Schedule I of the CSA.

Meprobamate

Meprobamate, first synthesized in 1950, introduced the era of mild or "minor" tranquilizers. In the United States today more than 200 tons of meprobamate are distributed annually under its generic name as well as under brand names such as Miltown, Equanil, Kesso-Bamate, and SK-Bamate. Meprobamate is prescribed primarily for the relief of anxiety, tension, and associated muscle spasms. Its onset and duration of action are like those of the intermediate-acting barbiturates; it differs from them in that it is a muscle relaxant, does not produce sleep at therapeutic doses, and is relatively less toxic. Excessive use, however, can result in psychological and physical dependence. Mebutamate (Dormate), a drug similar to meprobamate in its chemical makeup and effects, is also regulated under the CSA.

Benzodiazepines

The benzodiazepine family of depressants relieve anxiety, tension, and muscle spasms, produce sedation, and prevent convulsions. These substances are marketed as mild or minor tranquilizers, sedatives, hypnotics, or anticonvulsants. Their margin of safety is greater than that of other depressants. Eight members of the group are currently marketed in the United States. They are chlordiazepoxide (Librium), clonazepam (Clonopin), clorazepate (Tranxene, Azene), diazepam (Valium), flurazepam (Dalmane), lorazepam (Ativan), oxazepam (Serax), and prazepam (Verstran). Librium and Valium are among the drugs most widely prescribed in this country. These drugs have a relatively slow onset but long duration of action. Prolonged use of excessive doses may result in physical and psychological dependence. Withdrawal symptoms develop approximately one week to 10 days after continual high doses are abruptly discontinued. The delay in the appearance of the abstinence syndrome is due to the slow elimination of the drug from the body. When these drugs are used to obtain a "high," they are usually taken in conjunction with another drug such as alcohol or marihuana.

Stimulants

Of all abused drugs
the most powerfully reinforcing,
they can lead to increasingly compulsive behavior

The two most prevalent stimulants are nicotine in tobacco products and caffeine, the active ingredient of coffee, tea, and some bottled beverages that are sold in every supermarket. When used in moderation, these stimulants tend to relieve fatigue and increase alertness. They are an accepted part of our culture.

There are, however, more potent stimulants that because of their dependence-producing potential are under the regulatory control of the CSA. These controlled stimulants are available on prescription for medical purposes; they are also clandestinely manufactured in vast quantities for distribution on the illicit market.

Users tend to rely on stimulants to feel stronger, more decisive, and self-possessed. Because of the cumulative effects of the drugs, chronic users often follow a pattern of taking "uppers" in the morning and "downers" such as alcohol or sleeping pills at night. Such chemical manipulation interferes with normal body processes and can lead to mental and physical illness.

Young people who resort to stimulants for their euphoric effects consume large doses sporadically, over weekends or at night, often going on to experiment with other drugs of abuse. The consumption of stimulants may result in a temporary sense of exhilaration, superabundant energy, hyperactivity, extended wakefulness and a loss of appetite; it may also induce irritability, anxiety, and apprehension. These effects are greatly intensified with administration by intravenous injection, which may produce a sudden sensation known as a "flash" or "rush." The protracted use of stimulants is followed, however, by a period of depression known as "crashing" that is invariably described as unpleasant. Since the depression can be easily counteracted by a further injection of stimulant, this abuse pattern becomes increasingly difficult to break. Heavy users may inject themselves every few hours, a process sometimes continued to the point of delirium, psychosis, or physical exhaustion.

Tolerance develops rapidly to both the euphoric and appetite suppressant effects. Doses large

enough to overcome the insensitivity that develops may cause various mental aberrations, the early signs of which include repetitive grinding of the teeth, touching and picking the face and extremities, performing the same task over and over, a preoccupation with one's own thought processes, suspiciousness, and a sense of being watched. Paranoia with auditory and visual hallucinations characterizes the toxic syndrome resulting from continued high doses. Dizziness, tremor, agitation, hostility, panic, headache, flushed skin, chest pain with palpitations, excessive sweating, vomiting, and abdominal cramps are among the symptoms of a sublethal overdose. In the absence of medical intervention, high fever, convulsions, and cardiovascular collapse may precede the onset of death. It should be added that physical exertion increases the hazards of stimulant use since accidental death is due in part to their effects on the cardiovascular and body temperature regulating systems. Fatalities under conditions of extreme exertion have been reported among athletes who have taken stimulants in moderate amounts.

If withdrawn from stimulants, chronic high-dose users exhibit profound depression, apathy, fatigue, and disturbed sleep for up to 20 hours a day. The immediate withdrawal syndrome may last for several days. There may also be a lingering impairment of perception and thought processes. Anxiety, an incapacitating tenseness, and suicidal tendencies may persist for weeks or months. Many experts now interpret these symptoms as indicating that stimulant drugs are capable of producing physical dependence. Whether the withdrawal syndrome is physical or psychological in origin is in this instance academic since the stimulants are recognized as among the most potent agents of reward and reinforcement that underlie the problem of dependence.

Cocaine

The most potent stimulant of natural origin, cocaine is extracted from the leaves of the coca plant *(Erythroxylon coca)*, which has been cultivated in the Andean highlands of South America since prehistoric times. The leaves of the plant are chewed in the region for refreshment and relief from fatigue, much as North Americans once chewed tobacco.

Pure cocaine, the principal psychoactive ingredient, was first isolated in the 1880's. It was used as an anesthetic in eye surgery for which no previously known drug had been suitable; it became particularly useful in surgery of the nose and throat because of its ability to constrict blood vessels and thus limit bleeding. Although many of its therapeutic applications are now obsolete, the legal use of cocaine in the United States has in recent years been increased by the introduction of a morphine-cocaine elixir designed to relieve the suffering associated with terminal illness. In England, where this mixture was developed at the Brompton Chest Hospital, the use of cocaine in treatment of the terminally ill was largely abandoned after it was determined that it contributed to disquieting hallucinations and nightmares.

Illicit cocaine is distributed as a white crystalline powder, often adulterated to about half its volume by a variety of other ingredients, the most common of which are sugars such as lactose, inositol, mannitol, and local anesthetics such as lidocaine. Since the cost of illicit cocaine is high, there is a tendency to adulterate the product at each level of distribution. The drug is most commonly administered by being "snorted" through the nasal passages. Symptoms of repeated use in this manner may resemble the congested nose of a common cold. Less commonly, for heightened effect, the drug is injected directly into the bloodstream. Unlike such drugs as LSD and heroin, cocaine is popularly accepted as a recreational drug, facilitating social interaction. It is erroneously reputed to be relatively safe from undesirable side effects. Because of the intensity of its pleasurable effects, cocaine has the potential for extraordinary psychic dependency, which is all the more deceptive in view of its reputation as the recreational drug of choice.

Recurrent users may resort to larger doses at shorter intervals until their lives are largely committed to their habituation. Anxiety, restlessness, and extreme irritability may indicate the onset of a toxic psychosis similar to paranoid schizophrenia. Tactile hallucinations so afflict some chronic users that they injure themselves in attempting to remove imaginary in-

Coca plant

Coca processing

Cocaine

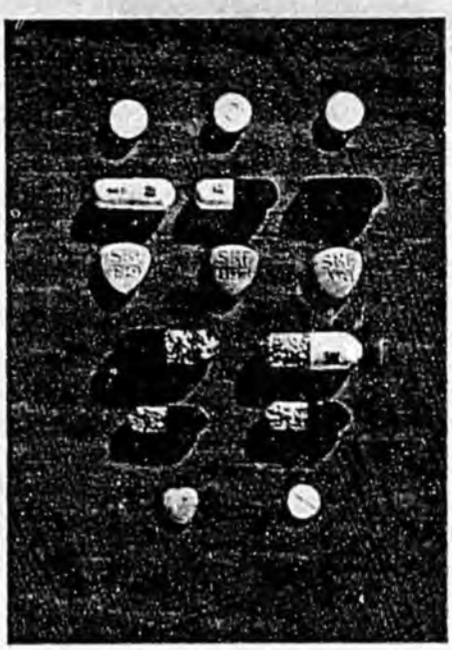
sects from under the skin. Others are persecuted by the fear of being watched and followed. Excessive doses of cocaine may cause seizures and death from respiratory failure.

Amphetamines

Amphetamine, dextroamphetamine, and methamphetamine are so similar in the effects they induce that they can be differentiated from one another only by laboratory analysis. Amphetamine was first used clinically in the mid-1930's to treat narcolepsy, a rare disorder resulting in an uncontrollable desire for sleep. After the introduction of the amphetamines into medical practice, the number of conditions for which they were prescribed multiplied as did the quantities made available. They were sold without prescription for a time in inhalers and other over-the-counter preparations. Abuse of the inhalers became popular among teenagers and prisoners. Housewives, students, and truck drivers were among those who used amphetamines orally in excessive amounts, and "speed freaks," who injected them, won notoriety in the drug culture for their bizarre and often violent behavior. Whereas a prescribed dose is between 2.5 and 15 mg per day, those on a "speed" binge have been known to inject as much as 1,000 mg every two or three hours. Recognition of the deleterious effects of these drugs and their limited therapeutic value has led to a marked reduction in their use by the medical profession. The medical use of amphetamines is now limited to narcolepsy, hyperkinetic behavioral disorders in children, and certain cases of obesity—as a short-term adjunct to a restricted diet for patients refractory to other forms of therapy. Their illicit use closely parallels that of cocaine in the range of its short-term and long-term effects. Despite broad recognition of the risks, clandestine laboratories produce vast quantities of amphetamines, particularly methamphetamine, for distribution on the illicit market.

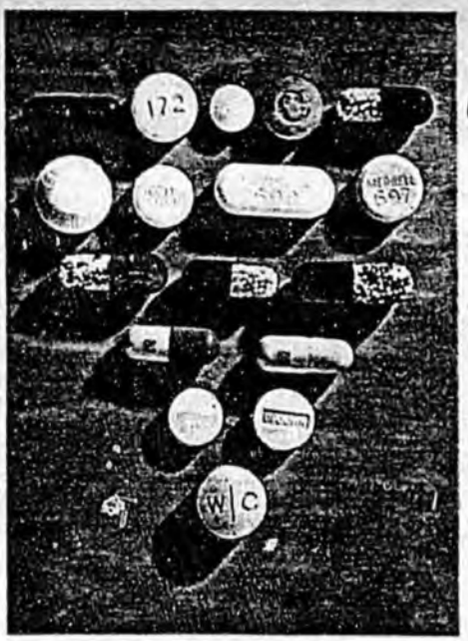
Phenmetrazine (Preludin) and Methylphenidate (Ritalin)

The medical indications, patterns of abuse, and adverse effects of phenmetrazine (Preludin) and methylphenidate (Ritalin) compare closely with those of the other stimulants. Phenmetrazine is medically used only as an appetite suppressant and methylphenidate mainly for treatment of hyperkinetic behavioral disorders in children. They have been subject to abuse in countries where freely available, as they are here in localities where medical practitioners write pre-



Methamphetamine (top row) and amphetamine. The tablets in the bottom row are of clandestine manufacture.

Phenmetrazine (left column) and methylphenidate



Other anorectic drugs: from top to bottom row, phendimetrazine, diethylpropion, phentermine (third and fourth rows), benzphetamine, and chlorphentermine

scriptions on demand. While the abuse of phenmetrazine involves both oral and intravenous use, most of that associated with methylphenidate results from injection after the drug in tablet form is dissolved in water. Complications arising from such use are common since the tablets contain insoluble materials which upon injection block small blood vessels and cause serious damage, especially in the lungs and retina of the eye.

Anorectic Drugs

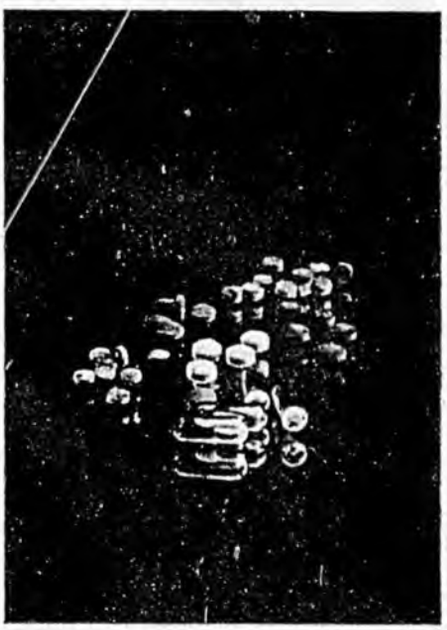
In recent years a number of drugs have been manufactured and marketed to replace amphetamines as appetite suppressants. These so-called anorectic drugs include benzphetamine (Didrex), chlorphentermine (Pre-Sate, etc.), clortermine (Voranil), diethylpropion (Tenuate, Tepanil, etc.), fenfluramine (Pondimin), mazindol (Sanorex), phendimetrazine (Plegine, Bacarate, Melfiat, Statobex, Tanorex, etc.), phentermine (Ionamin, Adipex-P, etc.). They produce many of the effects of the amphetamines but are generally less potent. Abuse patterns of some of them have not yet been established, but all are controlled because of the similarity of their effects to those of the amphetamines. Fenfluramine differs somewhat from the others in that at low doses it produces sedation.

Hallucinogens

Natural and synthetic substances that distort the perception of reality

Hallucinogenic drugs, both natural and synthetic, are substances that distort the perception of objective reality. They induce a state of excitation of the central nervous system, manifested by alterations of mood, usually euphoric, but sometimes severely depressive. Under the influence of hallucinogens, the pupils dilate, and body temperature and blood pressure rise. The senses of direction, distance, and time become disoriented. A user may speak of "seeing" sounds and "hearing" colors. If taken in a large enough dose, the drug produces delusions and visual hallucinations. Occasionally, depersonalization and depression are so severe that suicide is possible, but the most common danger is impaired judgment, leading to rash decisions and accidents. Persons in hallucinogenic states should therefore be closely supervised, and upset as little as possible, to keep them from harming themselves and others. Acute anxiety, restlessness, and sleeplessness are common until the drug wears off.

Long after hallucinogens are eliminated from the body, users may experience "flashbacks"—fragmentary recurrences of psychedelic effects—such as the intensification of a perceived color, the apparent motion of a fixed object, or the mistaking of one object for another. Recurrent use produces tolerance, which tends to encourage resorting to greater amounts. Although no evidence of physical dependence is detectable when the drugs are withdrawn, recurrent use tends to produce psychic dependence, varying according to the drug, the dose, and the individual user. It should be stressed that the hallucinogens are unpredictable in their effects each time they are used.



The abuse of hallucinogens in the United States reached a peak of popularity in the late 1960's, and a subsequent decline was attributed to broader awareness of their hazardous effects. Their abuse, however, re-emerged in the late 1970's.

Peyote and Mescaline

The primary active ingredient of the peyote cactus is the hallucinogen mescaline. It is derived

from the fleshy parts or buttons of this plant, which has been employed by Indians in Northern Mexico from the earliest recorded time as a part of traditional religious rites. The Native American Church, which uses peyote in religious ceremonies, has been exempted from certain provisions of the CSA. Peyote, or mescal buttons, and mescaline should not be confused with mescal, the colorless Mexican liquor distilled from the leaves of maguey plants. Usually ground into a powder, peyote is taken orally. Mescaline can also be produced synthetically. A dose of 350 to 500 mg of mescaline produces illusions and hallucinations lasting from 5 to 12 hours.

DOM, DOB, MDA, and MMDA

Many chemical variations of mescaline and amphetamine have been synthesized in the laboratory, certain of which at various times have won acceptance in the drug culture. DOM (4 -methyl -2, 5-dimethoxyamphetamine), synthesized in 1963, was introduced in 1967 into the Haight-Ashbury drug scene in San Francisco. At first named STP after a motor oil additive, the acronym was quickly reinterpreted to stand for "Serenity, Tranquility, and Peace." A host of related chemicals are illicitly manufactured, including DOB (4-bromo-2, 5-dimethoxyamphetamine), MDA (3, 4-methylenedioxyamphetamine), and MMDA (3-methoxy-4, 5-methylenedioxyamphetamine). These drugs differ from one another in their speed of onset, duration of action, potency, and capacity to modify mood with or without producing hallucinations. They are usually taken orally, sometimes "snorted," and rarely injected intravenously. Because they are produced in clandestine laboratories, they are seldom pure, and the dose in a tablet, in a capsule, or on a square of impregnated paper may be expected to vary considerably. The names of these drugs are sometimes used to misrepresent other chemicals.

Psilocybin and Psilocyn

Like the peyote cactus, Psilocybe mushrooms have been used for centuries in traditional Indian rites. When they are eaten, these "sacred" or "magic" mushrooms affect mood and perception in a manner similar to mescaline and LSD. Their active ingredients, psilocybin and psilocyn, are chemically related to LSD. They can now be made synthetically, but much of what is sold under these names on the illicit market consists of other chemical compounds.

LSD (LSD-25, lysergide)

LSD is an abbreviation of the German expression for lysergic acid diethylamide. It is produced from lysergic acid, a substance derived from the ergot fungus which grows on rye or from lysergic acid amide, a chemical found in morning glory seeds; both of these precursor chemicals are in Schedule III of the CSA. It was first synthesized in 1938. Its psychotomimetic effects were discovered in 1943 when a chemist accidentally took some LSD. As he began to experience the effects now known as a "trip," he was aware of vertigo and an intensification of light; closing his eyes, he saw a stream of fantastic images of extraordinary vividness accompanied by a kaleidoscopic play of colors. This condition lasted for about two hours.

Because of the extremely high potency of LSD, its structural relationship to a chemical which is present in the brain, and its similarity in effects to certain aspects of psychosis, LSD was used as a tool of research to study the mechanism of mental illness. It was later adopted by the drug culture. Although its popularity declined after the 1960's, there are indications that its illicit use is once again increasing.

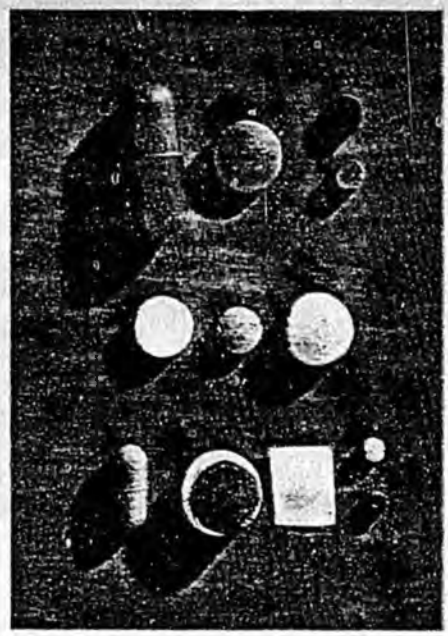
LSD is usually sold in the form of tablets, thin squares of gelatin ("window panes"), or impregnated paper ("blotter acid"). The average effective oral dose is from 30 to 50 micrograms, but the amount per dosage unit varies greatly. The effects of higher doses persist for 10 to 12 hours. Tolerance develops rapidly.

Phencyclidine (PCP) and Related Drugs

According to a consensus of drug treatment professionals, phencyclidine now poses greater risks to the user than any other drug of abuse.

Phencyclidine was investigated in the 1950's as a human anesthetic, but because of side effects of confusion and delerium its development for human use was discontinued. It became commercially available for use in veterinary medicine in the 1960's under the

Peyote cactus



Hallucinogens of clandestine manufacture

Psilocybe mushrooms

trade name Sernylan. In 1978, however, the manufacturer stopped production. That same year phencyclidine was transferred from Schedule III to Schedule II of the CSA, together with two previously unscheduled precursor chemicals.* Most if not all phencyclidine on the U.S. illicit market is produced in clandestine laboratories.

More commonly known as PCP, it is sold under at least fifty other names that reflect the range of its bizarre and volatile effects, including Angel Dust, Crystal, Supergrass, Killer Weed, Embalming Fluid, and Rocket Fuel; it is also frequently misrepresented as mescaline, LSD, or THC. In its pure form a white crystalline powder that readily dissolves in water, most PCP now contains contaminants resulting from its makeshift manufacture, causing the color to range from tan to brown and the consistency from a powder to a gummy mass. Although sold in tablets and capsules as well as in powder and liquid form, it is most commonly applied to a leafy material, such as parsley, mint, oregano or marihuana, and smoked.

The drug is as variable in its effects as it is in its appearance. A moderate amount often produces in the user a sense of detachment, distance, and estrangement from his surroundings. Numbness, slurred or blocked speech, and a loss of coordination may be accompanied by a sense of strength and invulnerability. A blank stare, rapid and involuntary eye movements, and an exaggerated gait are among the more common observable effects. Auditory hallucinations, image distortion as in a fun-house mirror, and severe mood disorders may also occur, producing in some acute anxiety and a feeling of impending doom, in others paranoi and violent hostility. PCP is uniqu among popular drugs of abuse i its power to produce psychoses ir distinguishable from schizophreni Although such extreme psychic re actions are usually associated wit repeated use of the drug, they hav been known to occur in some case after only one dose and to las or recur intermittently, long aft the drug has left the body.

Modification of the manufactu ing process may further yield chem ically related analogs, capable producing, so far as is known, sim lar psychic effects. Three of thes analogs have so far been encoun tered on the U.S. illicit marke where they have been sold PCP.* In view of the severe b havioral toxicity of phencyclidin

*The chemicals are 1-phenylcyclohexylamine and 1-piperidinocyclohexanecarbonitrile (PCC).

* The analogs are N-ethyl-1-phenylcycl hexylamine (PCE), 1-(1-phenylcyclohex pyrrolidine (PCPy; PHP), and 1-[1-(2-thien cyclohexyl]piperidine (TPCP, TCP).

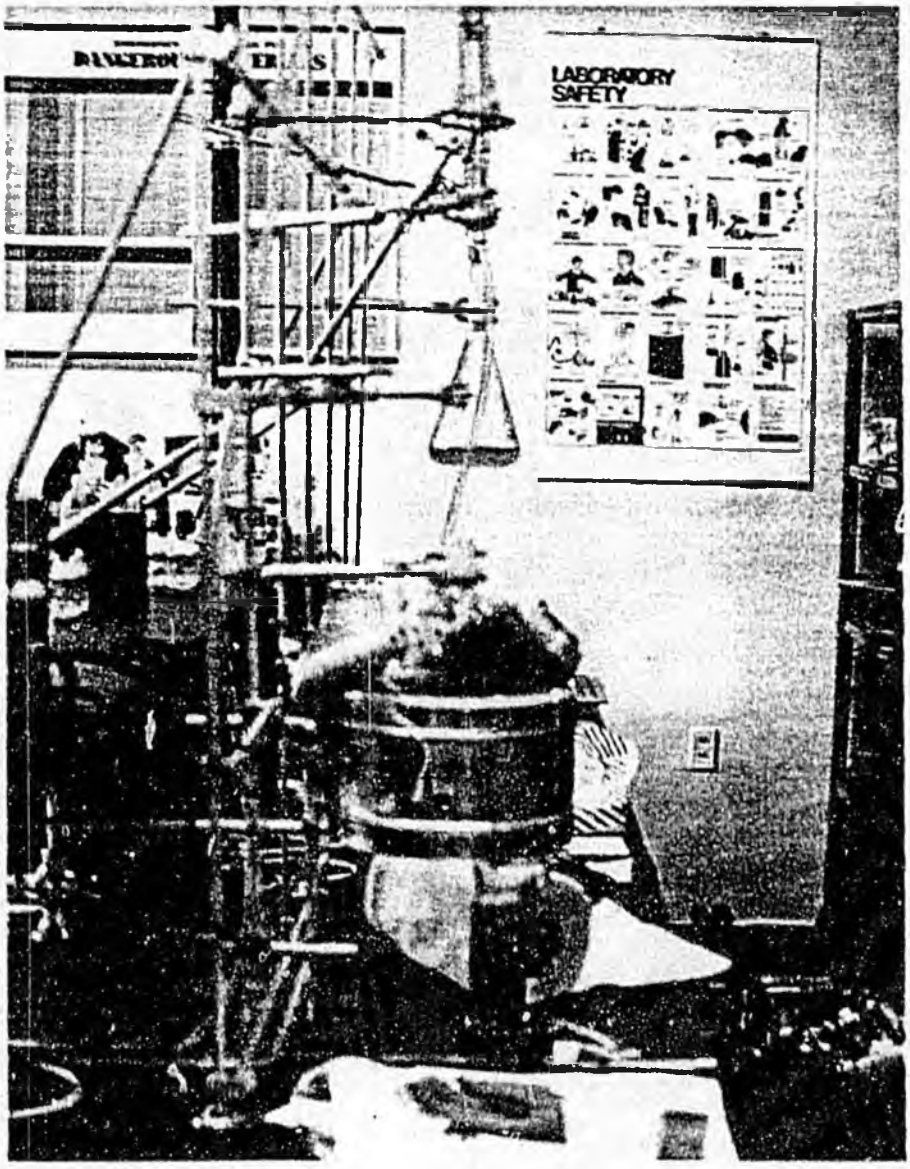
LSD

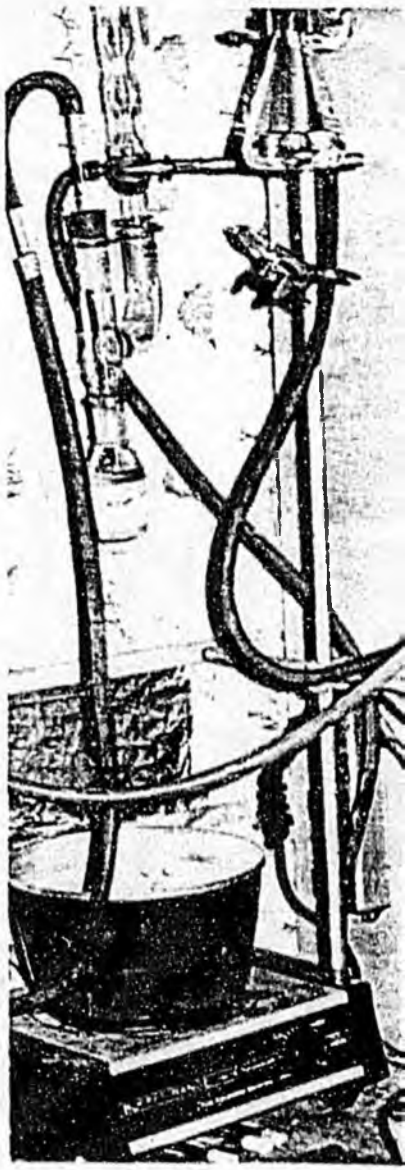
Phencyclidine (PCP)

and its analogs, the Congress in November 1978 passed legislation imposing penalties for the manufacture of these chemicals, or possession with intent to distribute them, more severe than for any other non-narcotic violation under the CSA. (For a first offense, a term of imprisonment of up to 10 years, a fine up to $25,000, or both; for a second offense, imprisonment up to 20 years, a fine of $50,000, or both.) Legislation was also passed which makes it mandatory to report all sales of the common precursor chemical piperidine, its salts, and acyl derivatives to the Drug Enforcement Administration.

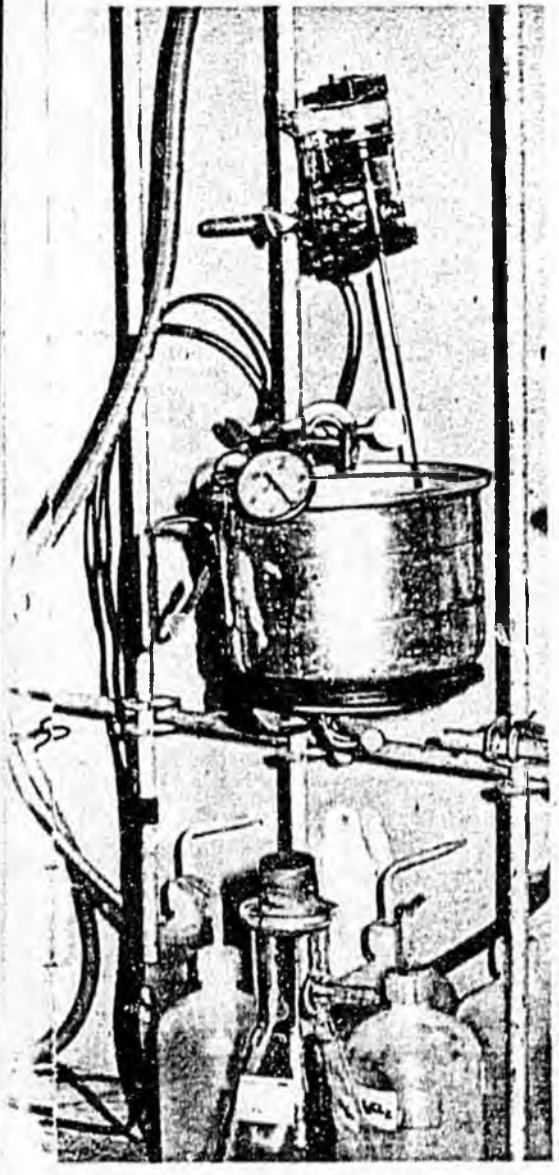
U.S. authorities seized a record number of clandestine drug laboratories in 1978. Seventy-eight of these laboratories were producing PCP. Methamphetamine was found in production at 69 others, one of which may be seen below in the photograph at the left. Despite the sophistication of equipment and easy availability of inexpensive chemicals obtainable through legitimate commercial channels, the clandestine drug industry is a high-risk enterprise, as the chart on the wall serves to remind the operator. This laboratory was

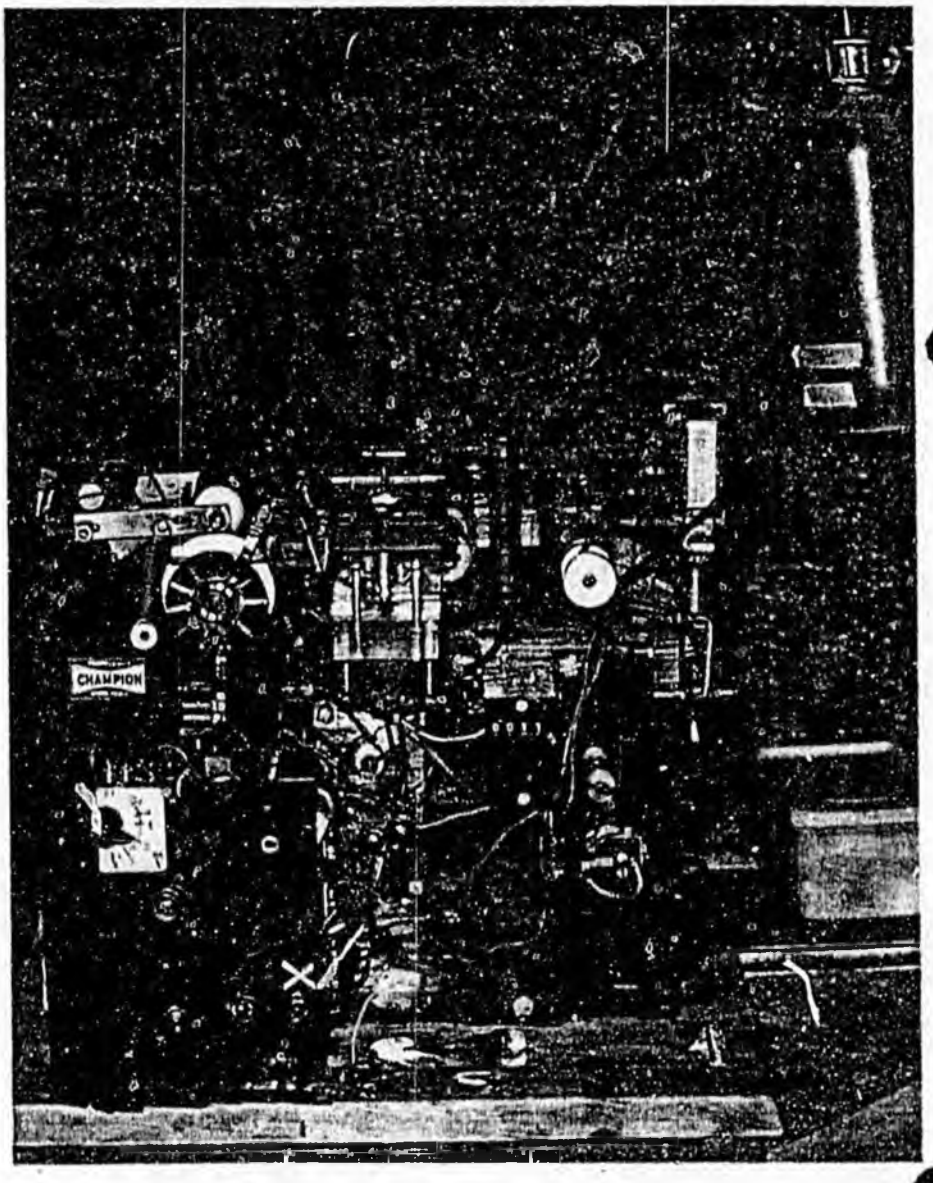
Clandestine Laboratories





seized by DEA in cooperation with the Cambridge, Massachusetts, Police Department. LSD was produced at the laboratory that is shown in the middle, located at a trailer park in Wappinger Falls, near Poughkeepsie, New York. Although the operator had no formal training in chemistry, his procedures were unusually efficient. All solvents were collected in cold traps and batched for later purification; all unreacted materials were removed for later use. The LSD was treated by a four-column chromatographic procedure, yielding a product of extremely high purity. An ingenious contraption, shown at the right, then processed it into precut strips of 100 dosage units of "blotter acid" apiece.





* Section 1. AS14.36.010 (b) is ammended to read:

(b) It is the intent of the legislature that

(1) a program of community school grants be established to provide assistance to local communities in the initial development, implementation and operation of community school programs;

(2) technical assistance, monitoring, training and coordination of statewide efforts to develop and operate community school programs be provided by the department;

(3) the community school program will become fully operational once a plan of operation has been approved by the commissioner; and

(4) evaluation of an approved plan of operation will be conducted by the department in cooperation with the school district. An annual report of all sites evaluated shall be presented by the Department of Education to the Legislature on or before the fifteenth day of the legislative session.

* Section 2. AS14.36.030 is repealed and re-enacted to read:

GRANTS FROM THE STATE. (a) A district operating a community school program under an approved plan of operation may receive an annual grant from the state of one percent of its public school foundation support or $10,000, whichever is greater.

(b) For each fiscal year beginning after June 30, 1980, a district operating an approved community school program under (a) of this section amy receive a further grant from the state equal to the amount allocated by the district to the support of the community school program from sources other than the grant provided under (a) of this section. Local match monies in the form of hard cash may come from any source the district deems appropriate. Local services or in-kind contributions which the district provides for the community schools program may consist

of district costs associated with energy, maintenance, administration, custodial services, telephone, postage and duplicating/ printing costs. Hard cash and in-kind contributions by the district shall be itemized under the community services section of the district's budget. The additional grant under this subsection may not exceed the amount received under (a) of this section.

Sec. 14.36.040. COMMUNITY SCHOOL PROGRAM, APPLICATION FOR GRANTS. Under regulations adopted by the state Board of Education, a district [LOCAL ATTENDANCE AREA] may submit to the commissioner [, THROUGH THE SCHOOL DISTRICT,] an application for a community school grant. An application shall include

(1) a comprehensive plan for the community school program, including, but not limited to, before and after school hours activities for both children and adults, continued education programs for children and adults, and cultural enrichment and recreational activities for citizens in the community;

(2) a provision for a community schools advisory council;

(3) provision for community school direction and coordination to include personnel requirements;

(4) an assurance that the community school program will be reasonably available to residents of all communities within the district [A STATEMENT AS TO THE NUMBER OF SCHOOLS TO BE OPERATED AS COMMUNITY SCHOOLS].

* Sec. 4. AS 14.36.050 is amended to read:

Sec. 14.36.050. APPLICATION REVIEW, DISPOSITION. The commissioner shall review and approve, disapprove or return to the [INITIATOR THROUGH THE] district [BOARD] for modification, an application for a community school program grant.

* Sec. 5. AS 14.36.070(5) is amended to read:

(5) "district" means a [SCHOOL] district of the state public school system as defined in AS 14.12.010 [OR THE STATE-OPERATED SCHOOLS];

* Sec. 6. AS 14.36.070(6) is repealed.

* Sec. 7. This Act takes effect July 1, 1980.

HB
629

THE LEGISLATURE OF THE STATE OF ALASKA
ELEVENTH LEGISLATURE

FISCAL NOTE

I. REQUEST
Bill/Resolution No. Committee Substitute for H.B. 629
Title An act relating to Community Schools
Requested by H.E.S.S. Committee Date February 28, 1980

II. FISCAL DETAIL
Agency Affected Education
Program Category Affected Foundation Support programs
BRU, Program, or Subprogram(s) Affected Community Schools
(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

		FY 80	FY 81	FY 82	FY 83	FY 84	FY 85
100	PERSONAL SERVICES		4.734.0	5065.4	5420.0	5799.4	6205.3
200	TRAVEL						
300	CONTRACTUAL						
400	COMMODITIES						
500	EQUIPMENT						
600	LAND & STRUCTURES						
700	GRANTS, CLAIMS, ETC.						
	TOTAL						

FUNDING (Thousands of Dollars)

GENERAL FUND		4.734.0	5065.4	5420.0	5799.4	6205.3
FEDERAL FUNDS						
OTHER (Specify Fund Source)						

POSITIONS

FULL TIME						
PART TIME						
TEMPORARY						

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

FY'81 cost reflects establishment of 10.0 base or one percent floor as contained in the proposed bill. For FY'82 and thereafter costs are reflected with a 7% inflationary cost factor.

The figures projected here do not take into consideration a possible change in the foundation support.

IV. DATE February 28, 1980 PREPARED BY William D. Brown
AGENCY Education
PHONE 465-2800

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)

33-001 (Rev. 12/79)

District/REAA	Found. Supp.	Found. Suppt. 10,000 Min.	Local Match	State Match
Anchorage	752,277	752,277	752,277	752,277
Bristol Bay	13,302	13,302	13,302	13,302
Cordova	18,706	18,706	18,706	18,706
Craig	7,137	10,000	10,000	10,000
Dillingham	20,416	20,416	20,416	20,416
Fairbanks	236,213	236,213	236,213	236,213
Galena	12,430	12,430	12,430	12,430
Haines	15,918	15,918	15,918	15,918
Hoonah	9,755	10,000	10,000	10,000
Hydaburg	5,643	10,000	10,000	10,000
Juneau	103,716	103,716	103,716	103,716
Kake	9,043	10,000	10,000	10,000
Kenai	174,464	174,464	174,464	174,464
Ketchikan	62,329	62,329	62,329	62,329
King Cove	7,296	10,000	10,000	10,000
Klawock	2,631	10,000	10,000	10,000
Kodiak	82,777	82,777	82,777	82,777
Mat-Su	126,281	126,281	126,281	126,281
Nenana	10,876	10,876	10,876	10,876
Nome	40,381	40,381	40,381	40,381
North Slope	93,678	93,678	93,678	93,678
Pelican	2,705	10,000	10,000	10,000
Petersburg	17,602	17,602	17,602	17,602
Sand Point	5,980	10,000	10,000	10,000
Sitka	45,346	45,346	45,346	45,346
Skagway	7,015	10,000	10,000	10,000
St. Mary's	9,189	10,000	10,000	10,000
Unalaska	11,364	11,364	11,364	11,364
Valdez	33,247	33,247	33,247	33,247
Wrangell	15,814	15,814	15,814	15,814
Yakutat	8,753	10,000	10,000	10,000
Total District	1,962,212	1,997,137	1,997,137	1,997,137
REAA				
Adak	9,716	10,000	10,000	10,000
Alaska Gateway	22,802	22,802	22,802	22,802
Aleutian Chain	15,196	15,916	15,916	15,916
Annette Island	5,254	10,000	10,000	10,000
Bering Strait	43,795	43,795	43,795	43,795
Chatham	8,000	10,000	10,000	10,000
Chugach	3,265	10,000	10,000	10,000
Copper River	24,090	24,090	24,090	24,090
Delta Greely	20,881	20,881	20,881	20,881
Iditarod	24,918	24,918	24,918	24,918
Kuspuk	29,859	29,859	29,859	29,859
Lake and Peninsula	36.199	36,199	36,199	36,199
Lower Kuskokwim	111,809	111,809	111,809	111,809
Lower Yukon	59,585	59,585	59,585	59,585
Northwest Arctic	80,125	80,125	80,125	80,125
Pribilof	8,470	10,000	10,000	10,000
Railbelt	18,075	18,075	18,075	18,075
Southeast Island	20,229	20,229	20,229	20,229
Southwest Region	39,648	39,648	39,648	39,648
Yukon Flats	29,672	29,672	29,672	29,672
Yukon Koyukuk	37,390	37,390	37,390	37,390
Total REAA's	648,978	664,273	664,273	664,273
Total All	2,611,190	2,661,410	2,661,410	2,661,410

#2

District/REAA	1% Found. Support	1% Found. Support with $10,00 Floor	1% Local Match	1% State Match
District				
Anchorage	$616,099	$616,099	$616,099	$616,099
Bristol Bay	10,185	10,185	10,185	10,185
Cordova	14,878	14,878	14,878	14,878
Craig	5,826	10,000	10,000	10,000
Dillingham	16,672	16,672	16,672	16,672
Fairbanks	191,637	191,637	191,637	191,637
Galena	8,880	10,000	10,000	10,000
Haines	13,059	13,059	13,059	13,059
Hoonah	7,834	10,000	10,000	10,000
Hydaburg	4,125	10,000	10,000	10,000
Juneau	87,538	87,538	87,538	87,538
Kake	7,223	10,000	10,000	10,000
Kenai	126,656	126,656	126,656	126,656
Ketchikan	53,405	53,405	53,405	53,405
King Cove	6,182	10,000	10,000	10,000
Klawock	2,751	10,000	10,000	10,000
Kodiak	69,228	69,228	69,228	69,228
Mat-Su	99,588	99,588	99,588	99,588
Nenana	8,398	10,000	10,000	10,000
ome	31,955	31,955	31,955	31,955
North Slope	67,147	67,147	67,147	67,147
Pelican	2,110	10,000	10,000	10,000
Petersburg	14,466	14,466	14,446	14,446
Sand Point	6,699	10,000	10,000	10,000
Sitka	38,832	38,832	38,832	38,832
Skagway	6,071	10,000	10,000	10,000
St. Mary's	7,894	10,000	10,000	10,000
Unalaska	7,049	10,000	10,000	10,000
Valdez	25,621	25,621	25,621	25,621
Wrangell	12,788	12,788	12,788	12,788
Yakutat	6,835	10,000	10,000	10,000
REAA				
Adak	22,733	22,733	22,733	22,733
Alaska Gateway	25,638	25,638	25,638	25,638
Aleutian	17,156	17,156	17,156	17,156
Annette	13,052	13,052	13,052	13,052
Bering Strait	38,774	38,774	38,774	38,774
Chatham	10,534	10,534	10,534	10,534
Chugach	3,400	10,000	10,000	10,000
Copper River	27,542	27,542	27,542	27,542
Delta/Greely	33,674	33,674	33,674	33,674
Iditarod	28,286	28,286	28,286	28,286
Kuspuk	34,109	34,109	34,109	34,109
Lake and Peninsula	38,672	38,672	38,672	38,672
Lower Kuskokwim	110,394	110,394	110,394	110,394
Lower Yukon	65,100	65,100	65,100	65,100
Northwest Arctic	89,585	89,585	89,585	89,585
Pribilof	11,684	11,684	11,684	11,684
Railbelt	19,336	19,336	19,336	19,336
Southeast Island	26,196	26,196	26,196	26,196
Southwest Region	38,112	38,112	38,112	38,112
Yukon Flats	30,413	30,413	30,413	30,413
Yukon Koyukuk	46,246	46,246	46,246	46,246
Total	$2,308,327	$2,366,990	$2,366,990	$2,366,990

MINUTES
House HESS Committee Meeting
2/14/80

Members present:

Buchholdt, Chair
Miles
Chatterton
Hurlburt
Barnes

The meeting consisted of a hearing and mark-up session on HB 629.

106 Linda Layfied, Director of the Juneau Community Schools program voiced her support for the bill and described some of the various courses that are offered through Community Schools in Juneau.

The Chair suggested that the Committtee members go over the bill and suggest possible ways of improving it.

There followed a discussion of how evaluation should be written into the bill. It was finally decided that the Committee would wait for the recommendations of the DOE auditors currently evaluating the Community Schools program.

There was then discussion of a proposal of Rep. Munson to require documentation of local matching funds sources. Joe McGill, of DOE, said that he would get the commissioner's clarification on whether or not this was currently required under statute.

There was a discussion of what could constitute in kind contributions to the local match part of the funding. Rep. Chatterton suggested that supplies, energy costs, janitorial costs and other such services should be included in the definition of in-kind contributions. It was generally agreed that this would be good.

There was then a discussion of how the legislature could implement its intent that travel outside of the community not be included in the definition of community school courses that state money could be spent on. It was genreally agreed that the existing Title was specific enough, but that an additional DOE regulation would take care of the travel problem.

551 Rep. Chatterton moved for unanimous consent that staff be asked to prepare the language for an additional section in the bill to fund evaluation of the program by DOE and localities. The amendment would include a provision stating that the report must be submitted to the 12 Legislature by the 15th day of the Session. The motion passed.

747 Rep. Chatterton suggested another amendment to raise the state's contribution from 2% to 3% and to provide that the state would never pay more than a locality contributed to the community schools program. There was much discussion of this amendment, and general disagreement among the other Committee members with Rep. Chatterton's amendment. Rep. Chatterton withdrew the second part of his amendment, and eventually withdrew the first half of the amendment as well.

The Chair noted, as the meeting was coming to a close, that by Monday, she would try to have the auditor's report, and the language for amendments dealing with evaluation and a definition for in-kind contributions.

Rep. Chatterton asked that clarification of the percentage given by the state to localities after the third year of program operation also be provided.

The meeting was adjourned.

MINUTES
House HESS Committee
2/13/80

Members present:

Buchholdt, Chair
Munson
Chatterton
Barnes

1096 The meeting consisted of a teleconference on HB 629, a bill relating to the funding of community schools.
The following people gave the following testimony:

Dia. Carpenter, Bethel City Council

Ms. Carpenter expressed her strong support for community schools because the system is greatly responsive to community needs. In Bethel, it is a welcome relief from the trials of a long winter without much other recreation for leisure time. Ms. Carpenter stated that there was a need for continued funding from the state. Rep. Munson asked if Ms. Carpenter thought there was any overlap between the community schools and the community college systems. Ms. Carpenter stated that each system served different functions within the community.

Paul Sterling, President, Nome School Board

Mr. Sterling voiced a "yes" to HB 629, stating that the community school system "greatly enhanced community environment". Mr. Sterling also noted that state funding was needed to continue the community schools program.

Leroy Owens, Asst. Superintendent, Southwest Regional Schools (Dillingham)

Mr. Owens suggested that districts, especially REAAs, be allowed to incorporate community school funds with other funds provided under the Foundation Program so that together, the total amount of funds could be used to provide program services, based on the individual community's needs. He advocated this approach, he stated, because of a need for coordination among the various programs, and a need for long-range planning and direction of programs.

Mr. Owens' testimony prompted discussion about whether community schools funding should be considered a part of basic education, as some of the other programs that Mr. Owens was referring to, would be.

Mellissa Strombe, Northwest Artic School District

Ms. Strombe stated that HB 629 was "financially inadequate" for her district's needs since there would be no substantial increase in state funding for localities.

The Chair responded that the idea behind community schools was that the locality should provide more money, not the state. This prompted discussion about what the original concept of community schools had been, and what it was today.

Dr. Doug Dralle, Sitka Parks and Recreation

Dr. Dralle supported community schools because of their wide variety of courses and the large numbers of people that they serve.

Dennis Daggett. Kenai Community School Advisory Board

Mr. Daggett expressed his support for the bill, and asked the legislature not to cut back funding for Kenai. Under questioning, he noted that although Kenai is not presently contributing to the funding of community schools, it will be contributing one third of the cost next year.

Jennifer Baggett, Big Lake Comm. School Advisory Council (Wasilla)

Ms. Baggett stated that the state should provide total funding for community schools.

Karl Pojhola, Asst. Superintendent, Kodiak School District

Mr. Pojhola noted that it was not always easy to figure out where local funding dollars came from. There was plenty of money in the Kodiak community schools from Kodiak, but it was not easy to figure out exactly how much came from each local source.

Lisa Menter, Andy Preston, Joy Winneston, Desmond Miller (Sitka)

Ms. Menter and her students expressed their support for the bill.

Daryl Hargraves, Superintendent, Nome public schools

Mr. Hargraves voiced his support for the bill because community schools help other community groups provide their services to a locality, without increasing their funds.

Harry Purdy, Superintendent, Dillingham City schools

Mr. Purdy suggested that the Committee amend the bill to provide total funding for those community without the necessary resources to provide the locality's portion of the funding necessary to run the community school system.

Dan Harman (Sitka)

Mr. Harman stated that the community schools provided several opportunities for new learning and social experiences.

Ken Kassner, Homer Community Schools

Mr. Kassner noted that the community schools were "a terrific umbrella organization". He further noted that they had "injected vitality" into the community college system.

Nel Fite, Big Lake Comm. Sch. Advisory Council (Wasilla)

Ms. Fite noted her support for HB 629.

Ian Fulk, Kodiak Parks & Recreation Director

Mr. Fulk detailed the various sports programs offered in the Kodiak community schools.

Pauline Chanel, Bethel Advisory Board

Ms. Chanel voiced her support for the bill because it would help people of all ages in the community.

Karen Dimond, Sitka

Ms. Dimond noted that she and her friends "love community schools", and that almost everyone she knows derives some benefit from them.

Beverly Kroner, Director, Kenai Comm. School

Ms. Kroner urged "longterm baseline funding" for community shcools.

Gary Stevens, Kodiak Community College

Mr. Stevens noted that the level of cooperation between Kodiak community schools and the Kodiak Community College was very high.

Nix Charles, Jr. (Bethel)

Mr. Nix noted that the community schools program provides a very important use of local tv and radio, and gives people access to these community services.

Mary Holden, Kodiak local arts council

Ms. Holden noted that without community schools, Kodiak would loose alot of "great programs".

Julie Gorham, Kuskokwim Comm. College (Bethel)

Ms. Gorham voiced her support for HB 629.

Leut. John Schoenz, Kodiak

Lieut. Schoenz voiced his support for the bill.

new tape

Chuck Evans, Kodiak

Mr. Evans stated that community schools were the best program that he had seen in his 28 years in the "education business". He stated that a "firm support base" was needed so that localities would not have to worry each year about where there funding was coming from.

The meeting was adjourned.

District/REAA	1% Found. Support	1% Found. Support with $10,00 Floor	1% Local Match	1% State Match	
#2					
District					
Anchorage	$616,099	$616,099	$616,099	$616,099	$1,848,297
Bristol Bay	10,185	10,185	10,185	10,185	30,555
Cordova	14,878	14,878	14,878	14,878	44,634
Craig	5,826	10,000	10,000	10,000	30,000
Dillingham	16,672	16,672	16,672	16,672	50,016
Fairbanks	191,637	191,637	191,637	191,637	574,911
Galena	8,880	10,000	10,000	10,000	30,000
Haines	13,059	13,059	13,059	13,059	39,177
Hoonah	7,834	10,000	10,000	10,000	30,000
Hydaburg	4,125	10,000	10,000	10,000	30,000
Juneau	87,538	87,538	87,538	87,538	262,614
Kake	7,223	10,000	10,000	10,000	30,000
Kenai	126,656	126,656	126,656	126,656	379,968
Ketchikan	53,405	53,405	53,405	53,405	160,215
King Cove	6,182	10,000	10,000	10,000	30,000
Klawock	2,751	10,000	10,000	10,000	30,000
Kodiak	69,228	69,228	69,228	69,228	207,684
Mat-Su	99,588	99,588	99,588	99,588	298,764
Nenana	8,398	10,000	10,000	10,000	30,000
Nome	31,955	31,955	31,955	31,955	95,865
North Slope	67,147	67,147	67,147	67,147	201,441
Pelican	2,110	10,000	10,000	10,000	30,000
Petersburg	14,466	14,466	14,446	14,446	43,398
Sand Point	6,699	10,000	10,000	10,000	30,000
Sitka	38,832	38,832	38,832	38,832	116,496
Skagway	6,071	10,000	10,000	10,000	30,000
St. Mary's	7,894	10,000	10,000	10,000	30,000
Unalaska	7,049	10,000	10,000	10,000	30,000
Valdez	25,621	25,621	25,621	25,621	76,863
Wrangell	12,788	12,788	12,788	12,788	38,364
Yakutat	6,835	10,000	10,000	10,000	30,000
REAA					
Adak	22,733	22,733	22,733	22,733	68,199
Alaska Gateway	25,638	25,638	25,638	25,638	76,914
Aleutian	17,156	17,156	17,156	17,156	51,468
Annette	13,052	13,052	13,052	13,052	39,156
Bering Strait	38,774	38,774	38,774	38,774	116,322
Chatham	10,534	10,534	10,534	10,534	31,602
Chugach	3,460	10,000	10,000	10,000	30,000
Copper River	27,542	27,542	27,542	27,542	82,626
Delta/Greely	33,674	33,674	33,674	33,674	101,022
Iditarod	28,286	28,286	28,286	28,286	84,858
Kuspuk	34,109	34,109	34,109	34,109	102,327
Lake and Peninsula	38,672	38,672	38,672	38,672	116,016
Lower Kuskokwim	110,394	110,394	110,394	110,394	331,182
Lower Yukon	65,100	65,100	65,100	65,100	195,300
Northwest Arctic	89,585	89,585	89,585	89,585	268,755
Pribilof	11,684	11,684	11,684	11,684	35,052
Railbelt	19,336	19,336	19,336	19,336	58,008
Southeast Island	26,196	26,196	26,196	26,196	78,588
Southwest Region	38,112	38,112	38,112	38,112	114,336
Yukon Flats	30,413	30,413	30,413	30,413	91,239
Yukon Koyukuk	46,246	46,246	46,246	46,246	138,738
Total	$2,308,327	$2,366,990	$2,366,990	$2,366,990	

THE LEGISLATURE OF THE STATE OF ALASKA
ELEVENTH LEGISLATURE

FISCAL NOTE

I. REQUEST

Bill/Resolution No. Committee Substitute for H.B. 629

Title An act relating to Community Schools

Requested by H.E.S.S. Committee Date April 21, 1980

II. FISCAL DETAIL

Agency Affected Education

Program Category Affected Foundation Support Programs

BRU, Program, or Subprogram(s) Affected Community Schools

(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 80	FY 81	FY 82	FY 83	FY 84	FY 85
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL						
400 COMMODITIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC.		3,021.3	3,281.3	3,511.0	3,756.8	$4,019.7
TOTAL						

FUNDING (Thousands of Dollars)

GENERAL FUND		3,021.3	3,281.3	3,511.0	3,756.8	$4,019.7
FEDERAL FUNDS						
OTHER (Specify Fund Source)						

POSITIONS

FULL TIME						
PART TIME						
TEMPORARY						

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

FY'81 cost reflects establishment of 10.0 base or .5 percent floor as contained in the proposed bill. FY'82 is based upon .5 percent of a 52 million dollar increase in the foundation support. FY'83, '84, '85, are based upon a 7% inflationary cost.

IV. DATE April 21, 1980 PREPARED BY William D Thomas

AGENCY Education

PHONE 465-2800

Original: Legislative Finance

cc: Budget and Management

Prime Sponsor (First Legislator Named)

District	.5% Found. Supp.	.5% Found. Supp. $10,000 Min.	.5% Local Match	.5% State Match
Anchorage	376,138	376,138	376,138	376,138
Bristol Bay	6,651	10,000	10,000	10,000
Cordova	9,353	10,000	10,000	10,000
Craig	3,568	10,000	10,000	10,000
Dillingham	10,208	10,208	10,208	10,208
Fairbanks	118,106	118,106	118,106	118,106
Galena	6,215	10,000	10,000	10,000
Haines	7,959	10,000	10,000	10,000
Hoonah	4,878	10,000	10,000	10,000
Hydaburg	2,821	10,000	10,000	10,000
Juneau	51,858	51,858	51,858	51,858
Kake	4,522	10,000	10,000	10,000
Kenai	87,232	87,232	87,232	87,232
Ketchikan	31,165	31,165	31,165	31,165
King Cove	3,648	10,000	10,000	10,000
Klawock	1,316	10,000	10,000	10,000
Kodiak	41,389	41,389	41,389	41,389
Mat-Su	63,140	63,140	63,140	63,140
Nenana	5,438	10,000	10,000	10,000
Nome	20,191	20,191	20,191	20,191
North Slope	46,839	46,839	46,839	46,839
Pelican	1,352	10,000	10,000	10,000
Petersburg	8,801	10,000	10,000	10,000
Sand Point	2,954	10,000	10,000	10,000
Sitka	22,673	22,673	22,673	22,673
Skagway	3,508	10,000	10,000	10,000
St. Mary's	4,594	10,000	10,000	10,000
Unalaska	5,682	10,000	10,000	10,000
Valdez	16,623	16,623	16,623	16,623
Wrangell	7,907	10,000	10,000	10,000
Yakutat	4,376	10,000	10,000	10,000
Total Districts	981,105	1,075,562	1,075,562	1,075,562
REAA				
Adak	11,141	11,141	11,141	11,141
Alaska Gateway	13,241	13,241	13,241	13,241
Aleutian Chain	8,556	10,000	10,000	10,000
Annette Island	6,532	10,000	10,000	10,000
Bering Strait	26,379	26,379	26,379	26,379
Chatham	5,688	10,000	10,000	10,000
Chugach	1,065	10,000	10,000	10,000
Copper River	13,703	13,703	13,703	13,703
Delta/Greely	16,028	16,028	16,028	16,028
Iditarod	15,175	15,175	15,175	15,175
Kuspuk	17,615	17,615	17,615	17,615
Lake and Peninsula	21,599	21,599	21,599	21,599
Lower Kuskokwim	67,902	67,902	67,902	67,902
Lower Yukon	39,426	39,426	39,426	39,426
Northwest Arctic	51,444	51,444	51,444	51,444
Pribilof	6,110	10,000	10,000	10,000
Railbelt	10,547	10,547	10,547	10,547
Southeast Island	13,971	13,971	13,971	13,971
Southwest Region	24,962	24,962	24,962	24,962
Yukon Flats	17,606	17,606	17,606	17,606
Yukon Koyukuk	24,370	24,370	24,370	24,370
Total REAA's	413,860	413,860	413,860	413,860
Total Dist. & REAA's	1,394,965	1,510,671	1,510,671	1,510,671

TRI-ANNUAL REPORT

Center: Alaska Department of Education

Report Period:
July-Oct. ____
Nov.-Feb. XXXXX
March-June ____

GOAL A TO DEVELOP A GREATER AWARENESS AND UNDERSTANDING OF COMMUNITY EDUCATION THROUGHOUT THE REGION

SA1. Present information about Community Education to different audiences upon request.

Verification: formal presentations about Community Education were made to the following audiences:

* Alaska Asscciation of School Administrators (10)
* Alaska School Boards Association (15)
* Mat-Su School Board (5)
* Copper River School Board (5)
* ACE Advisory Board

SA2. Present information about Community Education to university/community college classes, faculty members, and individual students at every opportunity.

Verification: Community Education information presented at:

* Sheldon Jackson College (1)
* University of Alaska, Juneau (2)
* Individual students (11)
* Alaska Pacific University (2)
* Copper River School District (15)

SA3. Assist in the development of conferences, seminars, or institutes to acquaint people with Community Education.

Verification: Assisted in planning and conducting:

* Inservice with Copper River School Board and Community

SA4. Distribute and/or display available Community Education materials as deemed appropriate.

Verification: The center has distributed some 425 individual pieces of written material pertaining to Community Education. Materials were also distributed at several Community Education workshops.

GOAL B TO PROVIDE CONSULTATION IN SUPPORT OF THE DEVELOPMENT AND/OR EXPANSION OF COMMUNITY EDUCATION PROGRAMS

SB1. Respond to requests for consultant assistance from communities, institutions, organizations, and agencies.

Verification: The center has answered requests for consultant services from nine (9) local communities and agencies/institutions.

Agencies/Institutions	Districts	
* Alaska Community Education Assoc.	* Fairbanks	* Sitka
* Alaska Pacific University	* Valdez	* Hydaburg
* University of Alaska	* Anchorage	
	* Cordova	
	* Copper River	
	* Mat-Su	
	* Klawock	

SB2. Assist in the development of new Community School programs.

Verification: Assisted in the development of Community School programs in the Bering Strait and Iditarod Districts.

SB3. Assist related agencies and organizations in the development of cooperative Community Education programs.

Verification: Assistance was given to:

* Delta/Greely District
* University of Alaska - Rural Education programs
* Fairbanks District
* Eagle River Community Schools
* Copper River District
* Prince William Sound Community College

SB4. Assist in the development and/or growth of the state Community Education Association.

* Continued provision of encouragement and/or direct assistance to the Alaska Community Education Association. Cooperation in production of state newsletter.

GOAL C TO DEVELOP, CONDUCT, AND/OR SUPPORT LOCAL, STATEWIDE, AND REGIONAL COMMUNITY EDUCATION TRAINING PROGRAMS AND RELATED NATIONAL TRAINING EFFORTS

SC1. Sponsor/co-sponsor inservice training sessions for practicing Community Educators in the state.

Verification: No activity this period.

SC2. Assist in the planning and implementation of training efforts facilitated by the Northwest Center as deemed appropriate.

Verification: No activity this period.

SC3. Provide special, individualized Community Education course offerings, including placements, readings, practicums, and internships for students as needed.

Verification: Assisted in course offerings:

* Through the University of Alaska
* Through Alaska Pacific University

SC4. Provide preservice training for Community School leaders.

Verification: Provided preservice training for:

* Community School Coordinators in Southwest REAA

SC5. Establish and/or maintain university/community college Community Education curricula.

Verification: Assisted in:

* Development of special topics at U. of A.
* Helped to maintain curricula at Alaska Pacific University

SC6. Disseminate information concerning state, regional, and national training opportunities.

Verification: Information for training opportunities was disseminated to:

* All Alaska Community Education personnel
* All Alaska Superintendents
* All Alaska Administrators
* All Alaska Community Education Association members

SC7. Provide a specialized training opportunity for a Center Trainee for a ~~3-9~~ 1-3 month period as deemed appropriate.

Verification: Facilitated the approval of traineeship for Robert Doyle, Supervisor of the Anchorage Community School program to spend two months at Alaska Center.

SC8. Provide other related orientation and training experiences as deemed appropriate.

Verification: Provided related orientation to:

* Alaska Department of Education personnel.

GOAL D TO PARTICIPATE IN COMMUNITY EDUCATION RELATED RESEARCH, EVALUATION, AND MATERIALS DEVELOPMENT ACTIVITIES

SD1. Assist in significant Community Education research, evaluation, and materials development efforts by students; independent research organizations; and, other Community Education affiliates.

Verification: Assisted in the Development of:

* Research activities of students at Alaska Pacific University

SD2. Conduct the annual Center evaluation.

Verification: No activity this period.

SD3. Respond to requests for Community Education evaluation assistance within the limits of available resources.

Verification: Assisted in the evaluation of the following programs:

* Mat-Su District
* Juneau
* Dillingham
* Kodiak
* Southwest
* Fairbanks
* Delta/Greely

SD4. Initiate and/or assist in the development of Community Education articles, booklets, and monographs for distribution.

Verification: Initiated the following:

* Prepared a pamphlet on Community Schools in Alaska.

SD5. Acquire pertinent media related to Community Education for addition to the Center's resource library.

Verification: Many articles, books and pamphlets for the center's resource library.

SD6. Assist the Northwest Center in assessing the Coalition's overall effectiveness for 1978-79.

Verification: The Alaska Representative has attended all formal coalition meetings.

SD7. Support those other research, evaluation, and materials development efforts which have a direct relationship to Community Education.

Verification: The Alaska Center has answered/responded to all assessment/inquiries from agencies/organization in Alaska and from the lower 48.

GOAL E TO ESTABLISH WORKING RELATIONSHIPS WITH OTHER AGENCIES TO EXTEND THE BASE FOR COMMUNITY EDUCATION OPERATIONS

SE1. Support the development and provision of Community Education related services in agencies/institutions within the state.

Verification: The following units in the Department have been provided support services:

* Adult Vocational Education
* Department of Public Information section
* Legislative Audit

SE2. Secure an increase in the dollar amount of local contributions to Center operations from all appropriate sources.

Verification: No change from last report. Center is currently seeking $4.7 million from the legislature for FY'81.

SE3. Become involved in activities of related groups as a member or resource person to strengthen cooperative relationships and improve mutual benefits.

Verification. Cooperative relationships were strengthened with:

* Alaska Community Education Association
* Anchorage Community College
* Alaska Adult Education Association

GOAL F TO MAINTAIN AND IMPROVE COMMUNICATIONS AND MANAGEMENT RELATED TO THE NORTHWEST COALITION

SF1. Prepare and submit appropriate articles on state Community Education developments to the Northwest Center for inclusion in the regional newsletter.

Verification: Appropriate articles have been submitted to the Northwest Center for issues of the "very latest".

SF2. Develop and/or assist in the distribution of a state Community Education newsletter.

Verification: Articles, information, resources, and state happenings have been submitted regularly to the State Association for inclusion in the PACE Setter newsletter, as well as the Southeast Alaska Community Education newsletter.

SF3. Prepare and submit tri-annual and annual reports to the Northwest Center within prescribed timelines.

Verification: Accomplished

SF4. Conduct the affairs of the Community Education Center in a manner consistent with its role as a representative of the state; Northwest Coalition; Charles Stewart Mott Foundation; and related national, state, and local agencies and/or organizations and the Community Education movement.

Verification: Process is continuous

SF5. Respond to all written, telephone, or walk-in inquiries and requests for information and/or assistance.

Verification: The center has responded to:

Written	Telephone	Walk-in Inquiries
All 36 Operational School Districts	Approximately 400 Calls	42 Walk-in individuals were supplied the information they requested

SF6. Develop and work with a Community Education Center Advisory Committee.

Verification: The Adult and Continuing Advisory Council serves as the State Community Education Advisory Committee. A major presentation was delivered to the council in January.

SF7. Co-sponsor the publication and distribution of a Directory of Community Education and Related Personnel Within the Northwest Coalition's Region.

Verification: Accomplished

GOAL G TO RESPOND TO REQUESTS FOR ASSISTANCE IN THE DEVELOPMENT AND/OR IMPROVEMENT OF SUPPORTIVE COMMUNITY EDUCATION LEGISLATION

SG1. Respond to all written requests for assistance in developing state and federal legislation supporting Community Education.

Verification: The Center has worked with the Alaska Association for Community Education, Representative Buchholdt's office, Senator Sackett's office and Legislative Affairs in preparation of the new Alaskan Bill. Testimony, at the request of the legislature, was given for H.B. 629.

SG2. Respond to all written requests to assist related agencies, organizations, and associations in the development of state legislation financially supporting Community Education.

Verification: Information concerning Alaska's legislation was sent to all states requesting it.

MOTT FOUNDATION STATISTICAL REPORT

This report covers:
1 (2) 3 period ending February 28, 1980
Grant # _____

Date Due March 28, 1980
Date Submitted March 26, 1980
Date Received by Mott Foundation _____

1. Alaska Department of Education
(Name of Grantee)

2. _____
(Division, Department, etc.)

3. _____
(Title of Program)

4. Joe Miguel
(Name of Director)

NOTE: Your financial section must be attached to this report.

	Total Projected at Year's End	Actual July 1	First Period	Second Period	Third Period	June 30 Year Total
1. Community School Programs (Buildings)*						
A. How many new community school programs (buildings) initiated during the grant period?	10	X	92	6		
B. How many community school programs (buildings) terminated during the grant period?	X	X	0	0		
C. How many community school programs (buildings) in existence?	164	62	154	160		
2. Community School Districts						
A. How many new community school districts initiated 1 or more community school (building) programs during the grant period?	2	X	20	3		
B. How many community school districts terminated all community school (building) programs within the district during the grant period?	X	X	0	0		
C. How many community school districts in existence?	35	13	33	36		
3. Community School Practitioners: How many community education practitioners devoting a minimum of 1/2 time to community school responsibilities?	180	65	160	168		

*As defined on the reverse hereof.

(Rev. 4/1/78)

	Total Projected at Year's End	Actual July 1	First Period	Second Period	Third Period	June 30 Year Total
4. Community Education Formal Training						
A. How many full-time students (interns) majoring in community education at all institutions in the state (area):						
1. Undergraduate level			0	0		
2. Master's level			0	0		
3. Doctoral level			0	0		
B. How many part-time students (interns) majoring in community education at all institutions in the state (area):						
1. Undergraduate level			0	0		
2 Master's level			0	11		
3. Doctoral level			0	0		
C. How many students enrolled in a formal community education course at all institutions in the state (area):						
1. Undergraduate level: # of courses:			0	0		
# of students:			0	0		
2. Graduate level: # of courses:			4	2		
# of students:			52	23		
5. Community Education Inservice Workshops (as described in your proposal only)						
A. How many workshops held during the grant period?			5	3		
B. How many participants attended workshops during the grant period?			72	35		
C. Cumulative total of # of workshops	14		5	8		
D. Cumulative total of # of participants attending workshops	202		72	107		

Financial Report - Mott Foundation Funds

Project Title Alaska Dept. of Educ. Grant _____

Period 2nd Months Ended _____

	A Original Budget Amount	B Line Item Transfers	C Adjusted Budget	D Cumulative Expenditures	E Payables (as defined)	F Balance (Column C Less Columns D & E)
Administration						
1 Professional staff salaries						
	0					
2. Other Salaries						
	0					
3. Fringe Benefits	0					
4. Telephone	0					
5. Travel - within Service Region	0					
6. Travel - outside Service Region	1,500.			1,500.		0
7. Office Supplies	0					
8. Furniture and Equipment-Office	0					
9. Food Expense	0					
10. TOTAL Administration	1,500.			1,500.		0

Form F (revised 4/1/78)

	A Original Budget Amount	B Line Item Transfers	C Adjusted Budget	D Cumulative Expenditures	E Payables (as defined)	F Balance (Column C Less Columns D & E
Seed Funding						
11. Public school district seed money	0					
12. Center seed money	0					
13. TOTAL Seed Funding	0					
Training/Inservice						
14. Fellowships						
Masters ( )	0					
Doctoral ( )	0					
Other (specify) ( )	0					
15. Travel-Training	2,000			1,474.18		525.82
16. Honoraria	0					
17. Food & Accommodations	1,500			1,000.00		500.00
18. Instructional supplies	500			35.69		464.31
19. Equipment-Training	0					
20. Other workshop & training program expenses	0					
21. TOTAL Training/Inservice	4,000					1,490.13
Media						
22. Audio Visual Materials	0					
23. Printing & Publishing	750			583.50		166.50
24. TOTAL Media	750					166.50

Research and Evaluation	A Original Budget Amount	B Line Item Transfers	C Adjusted Budget	D Cumulative Expenditures	E Payables (as defined)	F Balance (Column C less Columns D & E)
25. Salaries & Fringe	0					
26. Travel	0					
27. Telephone	0					
28. Materials & other expenses	0					
29. TOTAL Research and Evaluation	0					
30. Other Approved Project Budgets						
31. TOTAL BUDGET	6,250			4,593.37		1,656.63

Proposed Amendment to HB 629

Sec. 5. AS 14.36.070 is repealed and re-enacted to read:

AS 14.36.070. DEFINITIONS.

(1)"community school program" is the delivery system, via the local schools, that helps meet the local needs, wants and concerns;

(2)"commissioner" means the Commissioner of Education

(3)"department" means the Department of Education

(4)"district means a city or borough school district, or a regional educational attendance area.

The public schools of Alaska have served as a focal point for a wide range of community activities.

It has been demonstrated since the earliest days of public education in Alaska that the community school can function as a community center to meet needs of people of all ages.

The demands of our times require that public officials and private citizens alike give serious attnetion to increased educational, vocational, cultural, community development and human services delivered in an efficient, coordinated fashion at the neighborhood level.

The community school concept supports the maximum use of our existing neighborhoold school facilities as the focal point for activities and services.

The members of the Alaska Assocaition for Communtiy Education, the Alaska Adult Education Association, the Alaska Association for Physical Health, Education, Recreation and Dance and Alaska Parks and Recreation Association will be meeting in Anchorage, Alaska during the period of October 15, 16, 17, 1980, in a joint effort to provide coordinated services to Alaska's communities.

Education

COMMUNITY SCHOOL WEEK OFFICIALLY DECLARED

Official Memorandum

By

Jay Hammond

Governor of Alaska

GREETINGS: Juneau, Alaska

The public schools of Alaska have served as a focal point for a wide range of community activities.

It has been demonstrated since the earliest days of puolic education in Alaska that the community school can function as a community center to meet needs of people of all ages.

The demands of our times require that public officials and private citizens alike give serious attention to increased educational, vocational, cultural, community development and human services delivered in an efficient, coordinated fashion at the neighborhood level.

The community school concept supports the maximum use of our existing neighborhood school facilities as the focal point for activities and services.

The members of the Alaska Association for Community Education, Alaska Adult Education Association and ~~Texas~~ Community Education Association will be meeting in ~~Arlington, Texas~~ Anchorage, Alaska, during the period of ~~April 30-May 3~~ October 13-17, 1980, in a joint effort to promote coordinated services.

THEREFORE, I, as Governor of Alaska do hereby designate the week of October 13-17, 1980, as

COMMUNITY Education WEEK

in Alaska

Alaska Recreation & Parks Assn., Alaska Assn. for Physical Health Educ., Rec. & Dance

In official recognition whereof, I hereby affix my signature this ..... day of ....., 19.....

Governor of Alaska

vary theme of conf. as name of week

MEETINGS, MEETINGS, MEETINGS: ARE THEY WORTH IT?

Many things are implied by the statement, "that was a good meeting." The meeting leader presented his material so people understood what he was trying to communicate. He was concise, on time, transmitted information so it could be understood and left the audience with a feeling their time was not wasted, that something was accomplished. In a word, productivity!

Too often you're likely to hear the opposite: "What a waste of time. He didn't really have anything new to say. I know less now than when I went into the meeting. What does he really want?" Some meeting leaders are better than others--no question about that. Their meetings produce results. This productivity makes the difference between a good meeting leader and a poor one.

The following suggestions for more effective meetings are given by the 3M Company in a latest issue of the Leaders Digest.

When to hold meetings: A well-planned business meeting is a management tool that can encourage good communication in any organization. And growth--both of individuals and organizations--often goes hand in hand with successful business meetings. Here are some very good reasons to hold a meeting.

1. *Discuss goals, sell your ideas.* Meetings provide an excellent environment for the give and take of goal-setting and for pre-selling decisions to those people responsible for executing them.
2. *Discover or solve problems.* Meeting groups can bring together bits and pieces of experience which may lead to the discovery and/or solution of a specific problem. An interplay of ideas, experience, insights, contradictions and facts often is the best way to achieve quick analysis of problems.
3. *Handle reports.* A reporting meeting should stimulate both thinking and discussion. It can lead to a common understanding of mutual problems by everyone present. Group presentations also can prompt meeting participants to be thoughtful and organized.
4. *Tell people what they're supposed to do . . . and how.* Good communication helps turn plans into positive action. People need direction and a meeting lets them know what they're to do and how to do it. And team spirit is generated when everyone knows what their role is.
5. *Explain plans and programs.* Meetings are great places to provide information. Rather than being just so many words on a piece of paper, information can be enhanced by the presenter's personality and by visual displays or projections. Key parts of the message can be emphasized more effectively and leave a more lasting influence upon the audience.
6. *Gather opinions and reach a consensus.* There are many situations in business where a quick group response is necessary. A meeting is useful when the participation of such a group is needed for gathering opinions and making a decision.
7. *Train people.* Every meeting has some training value for all participants. But meetings also can be directed very effectively and specifically toward training. Training will make people more valuable to themselves and to their organization.
8. *Build morale and keep things moving.* Meetings can help keep a group's attention and interest in focus. And this usually is essential in maintaining efficiency and meeting deadlines.

When not to hold meetings: Meetings are only one method of communication, a method that sometimes is overdone. Before you call a meeting, think of why you're doing it, who will be there and what you want as a result. Don't call a meeting if phone calls or memos will do the job. If key people cannot be present, you're wasting everyone else's time in a meeting. Don't call a meeting if you don't have enough time to prepare. You'll undermine the very thing you're trying to accomplish. Personality conflicts or the plans of higher management may make the meeting a waste of time. And the cost of holding a meeting just may be prohibitive.

Planning: When you plan meetings, establish your specific purpose and allocate enough time for each topic. Prepare an orderly agenda, but don't hold to it so tightly that people feel they shouldn't participate. Before the meeting, let participants know what it's about, what they're expected to contribute and how long it will last. If you have others on the agenda, be sure to have a walk-through rehearsal--if not a dress rehearsal--so each message is on target and on time. Be sure to specify when, where and who is to be at the meeting. Make sure you invite those who can attend, who have to carry out what's decided, who have good ideas, who can o.k. results and who can represent divergent views. Remember your purpose is productivity . . . which you'll undermine if the right people are not present or if someone on your agenda rambles on, wasting everyone's time.

existing statute, 14.36 provides for 4 years of funding:

year 1:	up to 1/2%	foundation	support
year 2:	1%	"	"
year 3:	1 1/2%	"	"
year 4:	2%	"	"

the funding was tied to the number of community schools in operation the formula is:

$$\frac{\text{no. of community schools}}{\text{no. of schools in district}} \times \text{foundation support} \times \%\ \text{which district receives in that year}$$

Last year, CS HB 394 extended the programs on their 4th year for one more year, at at least the same level of funding the program received in its 4th year

There are currently 21 districts which will be dropping off as of June 30, 1980 due to the formula in the Community School Act of 1975. (list included)

CS HB 629 provides for a state grant of 1% of the foundation support money or $10,000, whichever is greater, to all districts operating community schools.

In addition, the state will match, up to 1% of the foundation support money or $10,000, local effort (cash or in-kind)

The grant application must include an assurance that the community school program will be reasonably accessible to residents of all communities within a district which express an interest in having such a program. (in an REAA, that might mean having a program in each village that has a school; in a city like Juneau, it might mean operating a program downtown, in the valley and in Douglas.)

Community school programs will be evaluated by the Department at least once every 4 years; a report will be submitted to the Legislature annually.

There may be a problem here, as the bill does not address funding to the Department of Education for conducting the evaluations. They would like about $50,000 to do this.

The Department must provide training of personell and help the programs develop an internal monitoring system.

The fiscal note reflects 2% of the foundation support.

Proposed Amendments to the Community School Regulations

Procedures

1. Community Education office reviewed present regulations and made tentative changes.

2. Tentative changes in regulations mailed to 25 Community Education personnel and Superintendents plus 15 members of the Advisory Committee.

3. Advisory Committee met in Anchorage on March 20 and 21 in order to review field input and draft proposed amendments.

4. Proposed amendments circulated in the Department of Education for input and forwarded to Attorney General's Office.

5. Proposed amendments to the Commmunity Schools regulations presented to the State Board of Education for promulgation.

Actions Taken

Prior to the Advisory Committee meeting to review the proposed amendments of the Community School Regulation, copies of the regulations were mailed to the following people in order to solicit their opinions.

District	Person
Lake and Peninsula	Charles White
Klawock	Bill Suss
Annette Island	Larrae Rocheleau
Bering Strait	Carol Aylard
Copper River	Al Krinke
Cordova	Tom Church
Craig	Charla Argo Wright
Delta/Greely	Marty Wells, Jerry Story
Fairbanks	Bob Degraw
Haines	Vivian March, Allen Heinrich
Hoonah	Ken Wicks
Juneau	Linda Layfield
Kake	David Dillman
Kenai	Beverly Cronen, Dennis Daggett
Kodiak	Chuck Evans, Carl Pohjola
Lower Kuskokwim	Judy Farley
Mat-Su	Mike Woodhead, Bruce DeMond, Cindy Woodings
Nome	Bill Karp, Darrol Hargraves
Northwest Arctic	Melissa Strom
Sitka	John Coffee
Southwest Region	Margery Wosiski
Valdez	Jean Kalish
Yakutat	Liz Boario
Yukon-Koyukuk	Colin Baxter

From the above list, thirteen people responded and their input was given to the committee in either verbal or written form.

On March 20th, 21st, an Advisory Committee comprised of the following people was convened in Anchorage in order to draft the proposed amendments to the Community School regulations.

In Attendance

Name	Yes	No	District
Vicki Malone		X	ACE/R2R Advisory Committee
Darroll Hargraves		X	Nome
Bill Suss		X	Klawock
Charles White		X	Lake and Peninsula
Allan Heinrich	X		Haines
Dennis Daggett	X		Kenai
Jerry Story		X	Delta/Greely
Carl Pohjola		X	Kodiak
Jill Waters	X		Municipality of Anchorage
Greg Jefferies	X		Municipality of Anchorage
Alecia Iden	X		Volunteer
Sally Oberstein		X	Municipality of Anchorage
Mike Woodhead	X		Mat-Su
Marty Wells	X		Delta/Greely
Tom Morgan	X		SCRRC
John Warden	X		Northern Institute
Lee Clune	X		Fairbanks
Lyle Marchant	X		Trainee
Liz Hudson	X		Municipality of Anchorage
Tom Healey	X		Anchorage Community College
Joe Miguel	X		Department of Education
Kim Ratz	X		Department of Education

Upon conveneing, the above group of fifteen people stated: their expectations of the meeting; possible additions to the regulations; possible deletions to the regulations; clarification/modifications in regulations; the criterian for match and what the in-kind/match allowances should be. The suggestions of the committee are following.

Initial Expectations of Advisory Committee

Clarification on terms ("matching" definitions)

Clarification/comments on dollar amounts of new bill

Find out other peoples concerns

Need to know "what's going on"

Get input on training, etc.

Revisions of conflicts between administration styles and structures around the state.

Come up with a good set of regulations

"Clean up" grant application process

Coordination of agencies to avoid duplication

Understand and work with regulations

Simplify things so others can understand

Get personal changes in regulations

Addit.ons to Regulations

Use of money for plan ing/training

How to address training
- Paid Staff
- Volunteers

Coordinator between Community Schools and Community College/related agencies

Standardized data collect/report procedures

Define match/in-kind contributions

Grant review process

What happens if funding is less than needed for 1% ± match? - Pro-ration?

Volunteer management

Block grants to districts

"Process" goals and objectives

Delete from Regulations

Planning money has been deleted

Excessive final reporting procedures/requirements

Repetition in Sections 1 and 2

.020B 1-A, 1-B, 1-C
1-B and 1-F/1-C, 1-D
Definition between .020B-1 and B-2

Obligation to Commissioner to provide reports (section B)

Use of word "program" - Section 6, 7, 8

Clarify/Modify in Regulations

New schools - 3 year comprehensive plan

How will a new school be funded? Program expansion?

Coordinator between Community School/Community Education related agency/organization

Definition of Community Education

Local/Department of Education evaluation/reporting

Short term goals for first year also

Long range plans - define/clarify

Standardize data collection/report procedures

In-kind/local contribution

Repitition at certain questions

Process for re-submitting timeline

Carryover funds

Most local level of community involve?

"Reasonable" access to community

Three year plan of service

Definition of Community Schools

What is an advisory council

Criterian for Match

Has to be auditable

Has to be in direct support of program (energy/maintenance)

Cash only

Split match; in-kind/cash

Local tuition/class fees for match, support not use of class fees, but would support use of local charges as match.

Reinforces local commitment

Funds from other programs related to Community Education.

Locally raised funds exclusive of class costs that earmarked force.

In lieu of formal economic income based local tuition funds should be allowed as in-kind dollar match.

In-kind/Match Allowances

In-kind

Energy
Maintenance
Administration
Telephone
Postage
Related agency contribution/services

Not Allowable

Facility rentals

Cash

Other Education programs

The advisory committee then proceeded to go through the current regulations. The final attachments to this report are the current regulations and the proposed amendments to the Community School regulations which the committee would like the State Board of Education to consider. A copy of the current regulations and the proposed amendments are attached for your perusal.

CHAPTER 32.
COMMUNITY SCHOOLS

Section
10. Scope of state-assisted projects
20. Community education grant application
30. Definitions

4 AAC 32.010. SCOPE OF STATE-ASSISTED PROJECTS. (a) Community school grants are made to school districts for planning, establishing, expanding, improving or maintaining community education programs. Two types of grants will be made:

(1) planning grants will be made to help districts and communities to develop comprehensive community education programs;

(2) operational grants will be made to help districts operate community education programs.

(b) Grants are for a period of up to one year. Subsequent applications must be submitted and will be evaluated in the same manner as initial grant applications. (Eff. 3/12/76, Reg. 57; am 12/4/76, Reg. 60)

Authority: AS 14.07.060
AS 14.36.040

4 AAC 32.020. COMMUNITY EDUCATION GRANT APPLICATION. (a) The commissioner will, in the exercise of his discretion, award a planning grant to a district upon an application submitted to him which contains, in narrative form, the following:

(1) objectives for the planning process;

(2) procedures, strategies, and activities for accomplishing the objectives;

(3) a time-line for accomplishing the objectives;

(4) an evaluation design providing for the collection, verification and analysis of data to measure the extent to which the objectives are accomplished by the program;

(5) a proposed budget, indicating the amount of grant funds requested; and

(6) a commitment to report to the commissioner the results of the planning effort.

(b) The commissioner will, in the exercise of his discretion, award a grant for operating a community education program to a district upon an application submitted to him which contains at least the following:

(1) an overall long-range plan which contains provisions to fulfill the following elements of a community education program:

(A) service to an identified community or local attendance area;

(B) potential for accommodation of all age groups as well as specific groups will special needs;

(C) concentration of activities in one or more public facilities;

(D) identification and utilization of cultural, recreational and other existing and planned resources located outside those public facilities in which the activities are to be concentrated;

(E) systematic procedures for identifying and documenting, on a continuing basis, the needs, interests and concerns of the community served and for responding to those needs, interests and concerns;

(F) programs and activities which reflect the array of needs, interests and concerns of the community; and

(G) creation of an active community education council whose members are representative of the community to be served;

(2) projections for expected long-range growth and development in regard to the following aspects of the community education program:

(A) the K-12 regular school program;

(B) facility and resource use;

(C) extended activities for children and youth;

(D) opportunities for the involvement of adults in the community education program;

(E) delivery of various human services at the most local community level; and

(F) community development in general;

(3) a short-range, detailed program plan which includes the following:

(A) program objectives which state specific and measurable outcomes of the selected program components;

(B) procedures, strategies, and activities for accomplishing the program objectives;

(C) a time-line for accomplishing the program objectives; and

(D) an evaluation design providing for the collection, verification and analysis of data to measure the extent to which the program objectives are accomplished by the program;

(4) documentation of the involvement of persons broadly representative of the community to be served by the program in the preparation of the application, and provision for indicating the continued involvement of such persons with the program;

(5) information regarding the administration of the program, including but not limited to

(A) proposed organizational arrangements for program administration and qualifications and roles of staff who will administer the program;

(B) provisions for securing appropriate training, where required, of a short-term, inservice or preservice nature for administrators, staff, community members, and others who will plan and carry out programs;

(C) an organizational chart indicating the relationship between individuals groups and agencies affected by the plan; and

(D) a statement as to the proportion of the total school district which operates as distinct administrative units for community education purposes;

(6) a commitment by the applicant to collect and make available information which may be required by the commissioner in accordance with those reasonable time constraints which he may establish, for purposes of carrying out program evaluations;

(7) letters from agencies and organizations affected by the program indicating affiliation or cooperation with the applicant as indicated in the program design; and

(8) a budget statement indicating money to be provided during the period of the requested grant by various agencies, organizations and individuals to support community education in the community to be served by the program.

(c) As necessary, incomplete or inadequate applications will be returned to the applicant for modification. Unfunded applications will be reviewed with comments provided by the department for future use by the applicant. (Eff. 3/12/76, Reg. 57; am 12/4/76 Reg. 60)

Authority: AS 14.07.060
AS 14.36.040

4 AAC 32.030. DEFINITIONS. In this chapter, unless the context requires otherwise

(1) "community education" means a "community school program" as defined in AS 14.36.070;

(2) "district" means a city or borough school district, or a regional educational attendance area;

(3) "program" means a community education program which meets the requirements set forth in sec. 20 of this chapter;

(4) "public facility" means a facility owned or operated by the state, or a political subdivision of the state. (Eff. 3/12/76, Reg. 57)

Authority: AS 14.07.060
AS 14.36.040

CHAPTER 32
COMMUNITY SCHOOLS

Section
10. Scope of state-assisted projects
20. Community education grant application
30. Definitions

4 AAC 32.010. SCOPE OF STATE-ASSISTED PROJECTS. (a) Community school grants are made to school districts for planning, establishing, expanding, improving or maintaining community education programs.

(b) The initial grant application will be comprehensive in nature and is for a three year period. During years two and three of the grant application, updated short term goals and objectives for that year's program activity will be evaluated in the same manner as initial grant applications. Grants are for a period of up to one year.

4 AAC 32.020. COMMUNITY EDUCATION GRANT APPLICATION (a) The commissioner, in the exercise of his discretion will award a grant for operating a community education program to a district upon an application submitted to him which contains at least the following:

(1) an overall, long range plan that contains provisions to:

(A) identify the community or local attendance area;

(B) accommodate all age groups and groups with special needs;

(C) concentrate activities in one or more public facilities;

(D) identify and utilize human and physical resources other than those public facilities in which activit.es are concentrated;

(E) develop a systematic procedure for identifying;

(F) provide programs and activities that respond to identified community interests and needs;

(G) continue utilizing an active community council whose members are representative of the community to be served; and

(H) attract, train and maintain a group of volunteers to implement programs and activities.

(2) new or expanding programs shall develop a plan of action that includes provisions that:

(A) develop community understanding of community education/community schools;

(B) initiate and train a local community education council;

(C) assist in the definition of local programs;

(D) provide for the selection and training of community school personnel; and

(E) integrate community education/community schools programs within total district programs and services.

(3) a three year plan of service which projects expected long-range growth in the following program components:

(A) the K-12 regular school program;

(B) facility and resource use;

(C) extended activities for children and youth;

(D) opportunities for the involvement of adults in the community school program;

(E) delivery of various human resources at the most appropriate community level; and

(F) community development in general.

(4) an annual short range detailed program plan for each year of the three year plan which includes the following:

(A) specific and measurable objectives in each component area listed under number (3) above.

(B) the methods for accomplishing the objectives;

(C) a timeline for accomplishing the objectives; and

(D) an evaluation process which measures that the objectives were accomplished.

(5) documentation of how community representatives are involved in the preparation of the grant application and how community members continue to be involved in the program.

(6) information regarding the administration of the program:

(A) proposed organizational arrangements for program administration and qualifications and roles of staff who will administer the program;

(B) provisions for securing appropriate training, where required, of a short-term, inservice or preservice nature for administrators, staff, community members, and others who will plan and carry out programs;

(C) an organizational chart indicating the relationship between individuals, groups and agencies affected by the plan; and

(D) an assurance that the community school program will be reasonably available at the local level to all residents of the community who wish to be involved.

(7) a commitment by the applicant to collect and make available appropriate information which is required by the commissioner in accordance with those reasonable time constraints which he may establish, for purposes of carrying out evaluations;

(8) letters from community agencies and organizations with responsibilities to the same population indicating affiliation and the degree of present and planned cooperation with the applicant as indicated in the program design.

(9) (A) a budget statement indicating income from:

(1) basic community school state grant funds;

(2) funds in the form of local cash and/or inkind services used to match the receipt of additional state funds;

(3) additional community school state funds (items (6)B and C above are required only of the local district applies for matching funds); and

(4) a budget of planned expenditures for the grant period.

(B) at the discretion of the commissioner, grant applications shall be annually reviewed by a committee of community educators. Those districts which have an incomplete or an inadequate application shall have a minimum of three months to write and submit a revised application for approval.

4 AAC 42.030. DEFINITIONS. In this chapter, unless the context requires otherwise

(1) "community education" is the philosophical concept where a community maximizes its own potential to meet its needs, wants and concerns;

(2) "community school program" is the delivery system, via the local schools, that helps meet the local needs, wants and concerns;

(3) "district" means a city or borough school district, or a regional educational attendance area;

(4) "program" means a community education program which meets the requirements set forth in section 20 of this chapter;

(5) "public facility" means a facility owned or operated by the state, or a political subdivision of the state;

(6) "community development" means an ongoing process of community improvements, which includes both individual development as well as the promotion of the health, safety and well being of the community and its residents;

(7) "resources" means physical, financial and human contributions (paid and volunteer);

(8) "community council" means a group broadly representative of the community served, whose members may include program participants (e.g., youth, young adults, adults and senior citizens) and cooperating agencies and organizations;

(8) "in-kind monies" means for purposes of budget preparation, those district expenditures which are directly related to the operation of the community school. These in-kind monies will come from:

(A) energy;

(B) administration;

(C) custodial;

(D) maintenance;

(E) postage; and

(F) duplicating costs.

to cash - foundation $
JOM
PL 874
in lieu of
Indian Educ Act

receive, in addition to funds provided under (a) of this section, a further grant of up to one per cent of that public school foundation support or their flat grant amount, whichever is the greater amount on an equal matching basis with the amount of match provided by them from state and local sources in support of the program. In the event that the Legislature does not appropriate the full amount the department shall prorate the grants on a proportional basis.

(c) Pursuant to section 1. AS14.36.010 (b) (4), the legislat · shall appropriate to the State Department of Education a sum equal to one per cent of the total state appropriation granted under section 2. AS14.36.030 (a) and (b)

(c) optional Pursuant to section 1. AS14.36.010 (b) (4), the State Department of Education shall retain and hold in abeyance a sum equal to one per cent of the total state appropriation granted under section 2, AS14.36.030 (a) and (b).

Sec. 14.36.040. COMMUNITY SCHOOL PROGRAM, APPLICATION FOR GRANTS. Under regulations adopted by the State Board of Education, a school district may submit to the commissioner an application for a community school grant.

Sec. 14.36.050 DEFINITIONS. In this chapter

(1) "board" means the governing body of a school district;

(2) "commissioner" means the commissioner of education;

(3) "community school program" means the composite of those educational, cultural, social and recreational services provided the citizens of a community, except those services normally provided through the regular instructional program;

(4) "department" means the Department of Education;

(5) "district" means a district of the state publ school system as defined in AS 14.12.010;

(6) This Act takes effect July 1, 1980

BACKUP

HB 629

Funding levels based on new foundation support figures

Fiscal note based on new foundation support figures

FY79 grant / # of participants in each district / cost per partic.

FY79 - local + State support

FY80 - local + state support

Community schools whose grants will drop off in June 1980

breakdown of Community schools + # of participants FY79 funding levels FY 80 and anticipated funding levels for FY81 at time of HESS hearings (considerably less than SB199 figures)

SB 199

Legislative Audit on Community Schools Program

STATE OF ALASKA

A SPECIAL REVIEW OF THE DEPARTMENT OF EDUCATION COMMUNITY SCHOOLS PROGRAM

July 1, 1978 - June 30, 1979

DIVISION OF LEGISLATIVE AUDIT
Juneau, Alaska

A SPECIAL REVIEW OF THE DEPARTMENT OF EDUCATION COMMUNITY SCHOOLS PROGRAM

July 1, 1978 - June 30, 1979

Commissioner, Department of Education	Marshall L. Lind
Deputy Commissioner, Department of Education	Wm. D. Thomson

STATE OF ALASKA

DIVISION OF LEGISLATIVE AUDIT

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PURPOSE AND SCOPE OF THE REVIEW

Purpose

In accordance with the provisions of Title 24 of the Alaska Statutes and a special request of the Legislative Budget and Audit Committee, a review was conducted of the Department of Education's Community Schools Program to determine:

1. if the financial statements appearing in the State Annual Financial Report for Fiscal Year 1979 are fairly presented;

2. the compliance by the Department of Education with applicable State statutes and regulations governing fiscal activities and program operations; and

3. if the program was operated in an effective, efficient and economical manner.

Scope

The major areas reviewed were the agency's operations and management of the program. Our review consisted of analyzing and evaluating the following:

1. applicable statutes and regulations;
2. agency policies and procedures;
3. interviews with agency and other State personnel;
4. interviews with school district personnel - superintendents, Community Schools coordinators, teachers, etc.;
5. questionnaires sent to district community school coordinators, superintendents and school board members;
6. tests of records and documents of the Department of Education (DOE);
7. on-site visitations at two school districts.

Scope Constraint

Prior to FY '79, DOE had not collected, recorded and maintained pertinent files and statistics relating to the program.

ORGANIZATION AND FUNCTION

On June 3, 1975, the Alaska State Legislature passed the Community Schools Act, AS 14.36, to provide State leadership and financial support to encourage and assist local school districts in establishing community school programs. Community Schools is operated by the Department of Education as one component of the Adult Education and Vocational Training Program, and provides local community school programs with financial support through foundation program grants.

The Community Schools Program is designed to involve the citizens of the community and to make the school facilities available to all Alaskans for academic, cultural, recreational and social enrichment endeavors. The Program promotes a more efficient use of school facilities by utilizing school buildings and equipment beyond the normal school day.

FINDINGS AND RECOMMENDATIONS

Recommendation No. 1

The Department of Education (DOE) should issue operating community schools grant funds in accordance with AS 14.36.030.

DOE was approving community schools grant funds based on the number of students in school sites with community school programs rather than the number of schools used for community school programs as specified in AS 14.36.030. As a result, approximately $268,000 were allocated to nine school districts in excess of their proper entitlement for FY '79 (see Schedule below).

DOE did use the proper formula (based on school sites) in calculating FY '80 district allocations. However, since DOE was directed to fund school district grants at or above the FY '79 funding level, four districts received a total of $200,000 above the calculated allotment for FY '80.

DOE should comply with the funding formula specified in AS 14.36.030 in awarding future community schools grants.

SCHEDULE OF DISTRICTS FUNDED IN EXCESS OF ENTITLEMENT

District/REAA	FY '79	FY '80
Anchorage	$ 74,509	$ 74,509
Fairbanks	73,282	68,404
Kenai	53,410	53,410
Mat-Su	5,282	-0-
Chatham	4,175	3,677
Delta Greeley	10,613	-0-
Kodiak	2,946	-0-
North Slope	18,474	-0-
Northwest Arctic	25,309	-0-
Total	$268,000	$200,000

Recommendation No. 2

DOE should strengthen grant reimbursement review procedures.

DOE paid school districts for reported community school expenditures even though the reimbursement requests showed violations of DOE established reimbursement criteria. We found:

1) a reimbursement for a line item expenditure exceeding the budgeted amount by $22,000;
2) a reimbursement based on purchase orders rather than actual disbursements;
3) fourteen (14) reimbursement requests signed by school district employees who were not on the authorized signature list of DOE. However, by contacting the districts involved, we learned that all but one of the employees were actually authorized by their local school boards.

In addition, a review of several school districts' audit reports showed that community school expenditures reimbursed did not agree to audited expenditures. For example, one school district had been reimbursed $20,531 more than the expenditures per the audit report. This was due, in part, to reimbursement procedures that allowed the school district to submit a detailed list of expenditures without requiring financial statements supporting the charges. It was also due to the school district not having established a separate fund for the community school grant.

Therefore, we recommend that DOE make a more thorough review of reimbursement requests. We also recommend that a review of the annual audit reports of the school districts be included as a part of the grant closeout procedure.

Recommendation No. 3

DOE should comply with Alaska Statutes by approving only one planning grant to establish a community school program in an attendance area.

DOE approved planning grants for attendance areas that had an established operating community school program. Some of these areas were in their third and fourth year of operating grants. However, AS 14.36.010 states, in part ". . . the community school program will become fully operational at the beginning of the second fiscal year following its authorization", and, in the opinion of our legal counsel, Legislative Affairs Agency, Division of Legal Services, the intent of the Legislature was to limit planning grants to the first year only.

Approving planning grants to districts with operating programs reduces the available planning grant funds for districts attempting to establish a community school program.

DOE should award future planning grants only for the purpose of establishing a community school program in attendance areas that have no operational program.

Recommendation No. 4

DOE should collect, record and maintain statistics of the community schools program.

DOE needs relevant facts and statistics for evaluating the effectiveness and progress of the community schools program. Many past statistics have not been collected and maintained, for both before and after State funding, such as:

1. number of attendance areas/school districts with community school programs;
2. amount of community resident involvement;
3. local and other funding involved; and
4. number of applications reviewed.

DOE should keep these and other records in order to support its budget request, evaluate its personnel and determine areas of need.

Recommendation No. 5

DOE should perform on-site evaluations of district community school programs.

DOE has not performed any on-site evaluations of the various districts' community school programs since 1977. These evaluations are necessary to properly manage the community schools program. The information generated points out the effectiveness, efficiency and economy of the program.

In addition, it provides monitoring of information submitted to DOE by the districts. For example, several school districts submitted grant applications indicating that all the schools in their district were being used for community school sites; however, the questionnaires returned by the community school coordinators showed less than 100% were being used for community school sites. Since the number of school sites used for community schools is the basis for funding, it is essential that information be accurate. On-site evaluations would provide information needed to evaluate the accuracy of the districts' reports. Therefore, we recommend the establishment of an on-site evaluation program.

STATE OF ALASKA

THE LEGISLATURE

BUDGET AND AUDIT COMMITTEE

AUDIT DIVISION
POUCH W—ALASKA OFFICE BUILDING

FINANCE DIVISION
POUCH WF—STATE CAPITOL

JUNEAU, ALASKA 99811

February 13, 1980

Members of the
Legislative Budget and Audit Committee:

We have examined the Statement of Expenditures and Encumbrances Compared with Appropriations for Operating Programs for the State of Alaska, Department of Education, Community Schools Program, for the fiscal year ended June 30, 1979. Our examination was made in accordance with generally accepted auditing standards and, accordingly, included such tests of the accounting records and such other auditing procedures as we considered necessary in the circumstances.

In our opinion, the Statement of Expenditures and Encumbrances Compared with Appropriations for Operating Programs presents fairly the appropriations, expenditures, encumbrances, and closing balance of the State of Alaska, Department of Education, Community Schools Program, for the fiscal year ended June 30, 1979, in accordance with the accounting policies as stated in Note 1 on a basis consistent with the preceding year.

Gerald L. Wilkerson

Gerald L. Wilkerson, CPA
Legislative Auditor
Division of Legislative Audit

STATE OF ALASKA
DEPARTMENT OF EDUCATION
COMMUNITY SCHOOLS PROGRAM
STATEMENT OF EXPENDITURES AND ENCUMBRANCES
COMPARED WITH APPROPRIATIONS FOR OPERATING PROGRAMS
July 1, 1978 - June 30, 1979

Budget Category	1978-1979 Budget Act Appropriations	Continuations Supplementals and Revisions	Total Authorizations	Expenditures	Encumbrances at Close of Year	Lapsed Balance
Education Category						
Foundation Program Components						
Community Schools Adjustment	$1,212,700	$ -0-	$1,212,700	$650,446	$542,215	$20,039
Source of Funds	General Fund					
Appropriation Act	$1,212,700					

See Accompanying Notes to the Financial Statements.

STATE OF ALASKA
DIVISION OF LEGISLATIVE AUDIT

STATE OF ALASKA
DEPARTMENT OF EDUCATION
COMMUNITY SCHOOLS PROGRAM
NOTES TO THE FINANCIAL STATEMENT
July 1, 1978 - June 30, 1979

Note 1 - Summary of Significant Accounting Policies

Alaska Statute 37.05.150 requires the accounting policies of the State of Alaska to conform to generally accepted accounting principles. The following is a summary of the significant policies.

Basis of Accounting. The General Fund utilizes the modified accrual basis of accounting. Modifications in such method from the accrual basis are as follows:

1. Revenues are recorded as received in cash except for:

   (a) revenues susceptible to accrual; and

   (b) material revenues that are not received at the normal time of receipt.

2. Expenditures are recorded on accrual basis except for:

   (a) Certain types of expenses which are considered expenditures at time of purchase:

      (1) inventory type items;

      (2) prepaid expenses, such as insurance; and

      (3) interest on long-term debts.

   (b) Encumbrances which represent:

      (1) valid obligations accrued at June 30, 1979 and paid during the reappropriation period; and

      (2) purchase order and contract commitments at June 30, 1979, which were recorded by August 31, 1979.

General Fixed Assets. General fixed assets purchased are recorded as expenditures in the general or capital project fund at time of purchase. Such assets are capitalized at cost in the general fixed assets group of accounts. No depreciation has been provided on general fixed assets.

Note 2 - Community Schools Adjustment

This is the account for the grants awarded to the school districts for planning and operating community school programs. There are no costs included here for the State's administration of the program.

SUPPLEMENTAL INFORMATION

STATE OF ALASKA

THE LEGISLATURE

BUDGET AND AUDIT COMMITTEE

AUDIT DIVISION
POUCH W—ALASKA OFFICE BUILDING

FINANCE DIVISION
POUCH WF—STATE CAPITOL

JUNEAU, ALASKA 99811

February 13, 1980

Members of the
Legislative Budget and Audit committee:

Our examination of the financial statements presented in the preceding section of this report was made primarily to form an opinion on such financial statements. The supplementary information, contained in the following pages, is not considered necessary for the fair presentation of the financial statements of the State of Alaska, Department of Education, Community Schools Program, but is presented as additional analytical data. However, the following information has not been audited by us, but was taken from records of the Department of Education, and, accordingly, we do not express an opinion on it.

Gerald L. Wilkerson, CPA
Legislative Auditor
Division of Legislative Audit

STATE OF ALASKA
DEPARTMENT OF EDUCATION
SCHEDULE OF COMMUNITY SCHOOLS GRANTS BY DISTRICT
For the Fiscal Years Ended June 30, 1976, 1977, 1978, 1979 and 1980
(UNAUDITED)

	Actual Expenditures							Grant Amount
	FY '76	FY '77		FY '78		FY'79 (1)		FY '80
District	Operation	Operation	Planning	Operation	Planning	Operation	Planning	Operation
Anchorage	$ 39,740	$140,182	$ 5,387	$289,487	$ 9,127	$243,066	$12,981	$ 256,646
Bristol Bay	6,480	8,546	-0-	9,509	-0-	9,790	-0-	10,246
Cordova	3,200	-0-	-0-	-0-	-0-	3,203	3,404	6,487
Craig	-0-	-0-	5,688	2,637	-0-	2,992	-0-	4,014
Dillingham	965	12,048	1,500	13,734	2,630	10,427	1,871	12,169
Fairbanks	2,229	47,564	-0-	55,042	-0-	85,228	-0-	96,803
Haines	3,748	9,833	12,200	10,982	2,195	13,408	2,012	11,958
Hoonah	-0-	-0-	-0-	7,808	-0-	8,072	-0-	8,497
Hydaburg	-0-	1,734	1,969	1,833	-0-	-0-	-0-	-0-
Juneau	7,090	64,156	8,159	63,796	3,560	46,583	5,286	71,274
Kake	-0-	2,325	10,749	2,930	-0-	4,764	-0-	4,861
Kenai	6,205	87,025	5,539	59,543	3,195	94,739	2,983	106,570
Ketchikan	-0-	-0-	971	-0-	-0-	-0-	-0-	-0-
King Cove	-0-	4,310	-0-	5,641	-0-	6,701	-0-	5,251
[illegible]ck	-0-	1,600	1,800	1,116	-0-	4,834	2,500	5,200
Kodiak	9,492	-0-	-0-	22,402	-0-	43,727	-0-	61,517
Mat-Su	7,600	53,657	3,237	35,327	3,962	55,116	6,020	69,197
Nome	8,385	22,978	11,250	25,499	1,885	23,093	3,521	30,670
North Slope	6,772	35,168	2,600	10,000	-0-	41,607	-0-	-0-
Petersburg	-0-	4,500	1,350	6,074	1,365	7,090	-0-	10,602
Sitka	-0-	31,864	6,479	31,615	-0-	30,232	-0-	35,922
Skagway	-0-	-0-	-0-	1,753	-0-	2,728	-0-	6,322
St. Mary's	600	-0-	-0-	-0-	-0-	-0-	-0-	1,311
Valdez	3,000	22,943	2,500	25,683	2,277	21,050	-0-	26,445
Wrangell	-0-	-0-	-0-	-0-	20,000	-0-	-0-	-0-
Yakutat	-0-	-0-	-0-	5,234	-0-	5,227	-0-	6,623
Total District	105,506	550,433	81,377	687,645	50,196	763,077	40,578	849,085
Total REAA	4,388	99,786	39,815	143,347	38,878	220,070	54,716	380,815
Grand Total Community Schools Grants	$109,894	$650,219	$120,192	$830,992	$89,074	$983,747	$95,294	$1,229,900

(1) FY '79 expenditures are disbursements per DOE records as of February 13, 1980, and do not include outstanding encumbrances of $35,810.

STATE OF ALASKA
DEPARTMENT OF EDUCATION
SCHEDULE OF COMMUNITY SCHOOLS GRANTS BY REAA
For the Fiscal Years Ended June 30, 1976, 1977, 1978, 1979 and 1980
(UNAUDITED)

	Actual Expenditures							Grant Amount
	FY '76	FY '77		FY '78		FY '79 (1)		FY '80
REAA	Operation	Operation	Planning	Operation	Planning	Operation	Planning	Operation
Adak	$ -0-	$18,225	$ 8,790	$ 19,728	$ -0-	$ 16,746	$ 4,350	$ 20,396
AUBSD	4,388	-0-	-0-	-0-	-0-	-0-	-0-	-0-
Aleutian	-0-	-0-	-0-	-0-	557	-0-	-0-	-0-
Annette	-0-	-0-	3,500	5,458	-0-	7,015	3,576	8,576
Bering Strait	-0-	7,050	-0-	5,103	-0-	19,519	6,800	34,727
Chatham	-0-	-0-	3,855	2,809	-0-	2,442	-0-	5,567
Copper River	-0-	-0-	-0-	-0-	4,766	13,416	1,704	19,361
Delta Greeley	-0-	8,958	3,102	23,982	-0-	21,226	-0-	30,903
Iditarod	-0-	-0-	4,578	8,652	8,193	6,165	4,496	20,564
Kuspuk	-0-	17,998	-0-	11,484	-0-	-0-	-0-	-0-
Lake & Peninsula	-0-	22,000	2,077	23,483	9,748	18,338	-0-	-0-
Lower Kuskokwim	-0-	-0-	3,220	17,650	-0-	36,316	-0-	72,982
Lower Yukon	-0-	-0-	-0-	-0-	-0-	6,558	4,380	35,758
Northwest Arctic	-0-	-0-	-0-	-0-	11,929	24,889	-0-	63,916
Pribilof	-0-	-0-	-0-	4,951	-0-	7,120	23,455	8,380
Selawik	-0-	2,332	-0-	-0-	-0-	-0-	-0-	-0-
Southeast Island	-0-	-0-	5,000	5,966	-0-	-0-	-0-	-0-
Southwest Region	-0-	23,223	4,250	10,857	3,685	28,934	5,955	40,755
Yukon Flats	-0-	-0-	443	3,244	-0-	11,386	-0-	18,930
Total REAA	$4,388	$99,786	$38,815	$143,347	$38,878	$220,070	$54,716	$380,815

(1) FY '79 expenditures are disbursements per DOE records as of February 13, 1980, and do not include outstanding encumbrances of $35,810.

QUESTIONNAIRE SENT TO
COMMUNITY SCHOOL COORDINATORS

Name of Grantee: 34 School Districts

Type of Grant, July 1, 1978 - June 30, 1979

Planning [16]

Operational:
3 1st yr 10 2nd yr 10 3rd yr 11 4th yr

Background Information

1. How many schools are in your district? 292

2. How many schools are used as community education sites? 189 (64.7%) 25 districts use 100% of district schools.

3. How many community school coordinators do you have in your school district?

   a. Full-time 52

   b. Part-time 73

   c. How many hours per week (average)? 2-40 hrs

4. How many students (K-12) were enrolled in your school district in Fall of 1978?

   a. Elementary 44,232 b. Secondary 36,833 c. Total 81,065

5. What is the overall population of the community (or communities) within your district? 410,841

6. What are the major objectives of the community education program in your district? (Please check all that apply and place a "1" to the left of the most important.)

Applies	"1"	
33	9	Expanding the use of schools beyond normal school hours.
31	2	Providing educational services/programs to out-of-school youth and adults.
33	9	Providing low-cost cultural, recreational and social opportunities for all community members.
28	4	Increasing social interaction, ethnic intergration, and participation in school and other public decision-making processes.
33	4	Utilizing more fully human resources and community agencies for broad community purposes.
29	0	Providing additional benefits to regular instructional programs (K-12).
		Other(s) (specify):
3	1	a. Provide/develop advisory councils
8	0	b. Various other objectives

Facilities Used for Community Education (C.E.)

A. School Facilities

Type of Facility	No. In District	No. Used for C.E.	Most Frequent Response: Type of Program (Refer to Pg. 4 for Types)	Number Hours Used: Per Week	Per Year
1. Multi-purpose classroom	3003	407	Recreation - 21	1,700	65,534
2. Specialized classroom	375	186	Education Enrich.-21	1,827	33,873
3. Playground	191	99	Recreation - 21	688	17,018
4. Gymnasium	118	79	Recreation - 30	1,103	39,103
5. Shops (wood, auto, etc.)	126	62	Voc. Training - 18	297	5,388
6. Library	199	82	Education Enrich.-19	270	8,343
7. Auditorium	30	18	Social/Cultural - 8	44	561
8. Cafeteria	95	53	Social/Cultural - 12	179	3,116
9. Other	127	66	Recreation - 10	1,396	24,268

Please list the top ten groups who use the school facilities for community education activities (Examples include: Boy Scouts, senior citizen clubs, social clubs, religious groups, clinics, etc.):

1. City/Borough Parks & Recreation
2. Basketball Leagues
3. Scouting Organizations
4. Public Health Services;Red Cross
5. Native Organizations
6. Civic Organizations; Lions Club, etc.
7. PTA
8. State Agencies
9. Senior Citizens Groups
10. Miscellaneous

B. Other Community Facilities

Type of Facility	No. Used for C.E.	Most Frequent Response: Type of Program (Refer to Pg. 4 for Types)	Number Hours Used: Per Month	Per Year
1. Government Non-Recreational	78	Education-10 Social-10	540	4,376
Recreational	52	Recreation-16	592	10,377
2. Business	38	Education-5 Recrea.-5	247	1,805
3. Service Club	11	Recreation-4	54	538
4. Social Club	17	Recreation-6	347	3,393
5. Other (specify):	132	Recreation-10	1,403	14,707

Please list the top ten groups who use the above non-school facilities for community education activities:

1. City Borough Parks & Recreation
2. Native Organizations
3. Miscellaneous
4.
5.
6.
7.
8.
9.
10.

IMPACT ON K-12 PROGRAM

Is the community education program providing resources to the K-12 education program?

☐ Yes ☐ No

Activity	Elementary Students		Secondary Students		Total K-12 Students	
	#Activities	#Involved	#Activities	#Involved	#Activities	#Involved
1. Field Trips	95	2,979	22	574	117	3,553
2. Volunteer Aides	62	2,481	31	536	93	3,017
3. Tutorial Service	16	705	20	87	36	792
4. Volunteer Instructors	187	3,053	66	1,746	253	4,799
5. Other (specify):	120	6,242	77	3,186	197	9,428

PROGRAMS

Indicate below which types of programs are offered to each age group and how many persons participate (P = number of programs; S = number of students).

Community Education Programs Offered by School District	Children (Pre-School through Elementary)		Youth (Secondary)		Adults (Ages 18 through 60)		Senior Citizens (Over 60)		Mixed Ages (Children through Seniors)		Total All Age Groups	
	P	S	P	S	P	S	P	S	P	S	P	S
Education/Curriculum Enrichment	250	5,217	184	2,589	528	6,644	63	113	73	2,013	1,098	16,576
Recreation	519	7,545	331	5,980	806	11,871	34	206	242	8,043	1,932	33,645
Vocational Training	11	161	23	220	97	1,338	1	24	34	450	166	2,393
Social/Cultural	117	5,420	58	2,151	207	4,065	33	417	114	7,166	569	19,221
Academic Credit Bearing	-0-	-0-	17	162	221	2,481	18	32	7	181	283	2,956
Speical Activity (1 Time Only)	84	4,411	69	4,164	117	3,456	45	652	120	15,415	455	28,098
Other (specify):	3	80	2	10	10	1,244	1	1	26	1,260	62	3,163
Total All Programs	1,004	22,836	704	15,286	2,026	31,099	197	1,447	636	35,036	4,567	105,747

What innovative programs have been offered through your community school program (i.e., activities for the handicapped or senior citizens, etc.)? _____

Community Agencies' Involvement

Please list the community agencies which organized and/or sponsored the community education activities listed under PROGRAMS above, and indicate how the agency was involved.

Type of Agency	Most Frequent Response Type of Program(s) Organized/Sponsored		Did the Agency (please check): Make Facilities Available?	Make Instructors Available?	Contribute Money?	Contribute Material?
Health-Related Agencies	Education	17	10	14	1	13
Parks and Recreation Depts	Recreation	8	7	8	3	6
Legal Assistance	Education	4	1	4	0	3
Community/ Civic Groups	Social	11	5	6	9	7
Business and Industry	Social	6	2	4	2	1
Other Government Agencies	Education	11	8	7	1	8
Other (Specify):	Education	11	6	5	5	6

Community Residents' Involvement

The following question is designed to tell us how and in what areas community residents provide input to community education programs.

For example, assume the following: 1) The Community Schools Advisory Council is the primary vehicle (source) of input to setting priorities, and is the secondary input to program development; 2) the PTA is the primary vehicle for needs assessment and tertiary (third) for other support. Using P = primary vehicle for input, S = secondary vehicle for input, and T = tertiary vehicle for input, your answer would be marked as follows:

Vehicle for Community Residents' Input	Program Development	Needs Assessment	Program Evaluation	Setting Priorities	Other Support
Community Schools Advisory Council	S		P		
PTA		P			T

Using the above example, please indicate how the residents in your community provide input to the community education program:

Vehicle for Community Residents' Input	Program Development P	S	T	Needs Assessment P	S	T	Program Evaluation P	S	T	Setting Priorities P	S	T	Other Support P	S	T
Community Schools Advisory Council	21	8	2	20	5	1	23	4	2	25	3	1	8	4	4
PTA	1	2	3		1	1	0	3	1	1	3	3	0	2	2
Other Parent Advisory Groups	2	7	1	5	7	1	1	8	1	1	9	1	1	3	3
Block Clubs	1	2	1	1	0	1	0	1	2	0	1	1	0	1	1
Telephone Tree	0	5	2	1	2	2	2	1	1	0	2	1	2	2	4
Community Associations	6	10	3	3	6	3	4	5	2	2	9	2	5	3	2
Informal Network	7	12	3	9	8	4	4	11	4	2	14	5	2	4	6
Other (specify):	5	3	1	5	3	2	3	4	1	1	4	2	1	1	1

Technical Assistance and Funding

1. Have you asked for technical assistance from the State Department of Education?

23 Yes

In what areas (please check):	
Establishing program goals and objectives.	11
Local needs assessment.	6
Identification of existing resources.	4
Staffing patterns.	6
Budgeting.	13
Establishing methods of community feedback.	7
Preparation and filing of grant application.	20
Maintaining financial records.	4
Establishing communication and cooperative planning mechanisms.	10
Other (specify): Training, Planning Grant Assistance, Regulations Interpretation.	5

10 No

From what source(s) do you obtain technical assistance (please check where applicable)?	Paid	Non Paid
Direct contacts	9	7
Talent banks	1	7
Other agencies (please specify):	4	10

2. Did you receive technical assistance from the State Department of Education?

25 Yes 8 No

What was the quality of assistance (Check one)?	Excellent	Good	Fair	Poor
Establishing program goals and objectives.	15	6	1	0
Local needs assessment.	0	5	2	0
Identification of existing resources.	1	3	1	1
Staffing patterns.	1	2	4	0
Budgeting.	4	7	0	0
Establishing methods of community feedback.	3	3	1	0
Preparation and filing of grant application.	13	6	3	0
Maintaining financial records.	0	3	2	0
Establishing communication and cooperative planning mechanisms between districts.	6	4	4	0
Other (specify):	0	0	1	0

3. What program areas have suffered in the past because of cutbacks in State funding? Please specify:

Inadequate personnel to administer programs. Unable to expand and add programs where interest is shown.

4. What were the sources of funding for your community education program in Fiscal Years 1978 and 1979? (Enter dollar amount where applicable.)

Source	FY 1978	FY 1979
State Community School grant	$ 858,915	$ 1,137,099
Federal Community School grant	-0-	-0-
School District	486,053	517,300
Community Organizations	102,000	126,000
Other (specify): _____	650,289	851,016
_____		
_____		
Total Community Education Funding	$ 2,097,257	$ 2,631,415

5. Has an on-site evaluation of your community schools program been done by a representative of the State Department of Education?

3 Yes 31 No

When? 1977

Name of representative _____

Title of representative _____

6. Have your community school program accounting records been reviewed on-site by a representative of the State Department of Education? (Do not include annual audits by CPA firms.)

Yes 34 No

When? _____

Name of representative _____

What were the results of your audit or review? _____

7. What direction do you think the community education program in your district should take during the next few years? (Check all that apply.)

a. 4 Continue as it is now.

b. 24 Add new programs.

c. 1 Offer fewer programs.

d. 25 Serve more members of the community.

e. 0 Serve fewer members of the community.

f. 15 Other (please specify): _____

Comments: _____

QUESTIONNAIRE SENT TO SUPERINTENDENTS

Respondent Name: District Superintendents

School District: 26 School Districts

Telephone: _____

FOR SUPERINTENDENTS ONLY

Background Information

1. How many schools are in your district? 173

2. How many schools are used as community education sites? 136 (78.6%)

3. How many students (K-12) were enrolled in your school district in Fall of 1978?

   a. Elementary 13,539 b. Secondary 10,082 c. Total 23,621

4. What is the overall population of the community (or communities) within your district? 106,402

5. How closely have you supervised the Community Education Program in your district during the past years? (Please check the statement that best describes your actions.)

   3 Close supervision. Community Education was one of the programs I was most involved in. I attended most meetings and participated in all levels of decision-making.

   13 Moderate supervision. I provided general oversight of this project to about the same extent as I supervise other special programs in the district. I participated in many decisions, but delegated lesser decisions and activities to others.

   9 Indirect supervision. Community Education was not one of my major concerns last year. I delegated most decisions to appropriate personnel and participated only in overall matters of policy if they came up. Helps write grant application.

   1 Other (specify) Helps write grant application.

FOR ALL RESPONDENTS

6. How familiar are you with the State funded community schools program?

0	2	13	10
Not Familiar	Very Limited Familiarity	Moderately Familiar	Quite Familiar

1
No Respons

7. What are the major objectives of the community education program in your district? (Please check all that apply and place a "1" to the left of the most important.)

Applies	"1"	
23	4	Expanding the use of schools beyond normal school hours.
24	4	Providing educational services/programs to out-of-school youth and adults.
23	3	Providing low-cost cultural, recreational and social opportunities for all community members.
17	2	Increasing social interaction, ethnic integration, and participation in school and other public decision-making processes.
22	1	Utilizing more fully human resources and community agencies for broad community purposes.
17	0	Providing additional benefits to regular instructional programs (K-12).
		Other(s) (specify):
3	0	a. Promote School Usage-2; Mobilize Community-1;
		b. _____

8. Has the School Board made any policies relating to the community school program?

3 No

If no, have any policy changes ever been proposed?

0 Don't know

2 No

0 Yes

23 Yes

If yes, what have they done?

18 An official motion was passed endorsing the concept of Community Education (when passed? _____)

4 The School Board approved the present project, but is not on record as endorsing Community Education generally.

1 Other (specify)

Addressed in Policy

9. How actively did the following participate in conceiving or preparing the most recent (1979-1980) Community Education proposal?

	Don't know	Not active	Slightly active	Moderately active	Very active
a. School superintendent	0	2	6	8	10
b. School board	0	5	9	9	3

10. How actively did the following participate in the actual operation of the Community Education Program in 1978-1979?

	Don't know	Not active	Slightly active	Moderately active	Very active
a. School superintendent	2	4	5	10	5
b. School board	2	7	7	9	0

11. Both POSITIVE and NEGATIVE changes may result from the implementation of a Community Education Program. Changes, if any, will be realized to different extents in each community.

Please indicate how much change, either positive or negative, has occurred in your school district which you feel can be attributed to the Community Education Program.

The scale ranges from: +4 to -4 with 0 representing none. Then on both sides. 1 = a little change; 2 = moderate change; 3 = significant change; 4 = very significant change.

Circle the number which applies.

		NEGATIVE CHANGE	Average of Responses	POSITIVE CHANGE
a.	Community support for schools		+2.2	
b.	Attitudes of teachers and administrative staff toward community		+1.6	
c.	Self-help activities undertaken by the community		+1.3	
d.	Cooperation between schools and non-school governmental agencies		+2.4	
e.	Cooperation of schools with private agencies		+1.8	
f.	Services to the elderly		+0.9	
g.	School vandalism		+1.5	
h.	Participation of citizens in school decision-making		+1.6	
i.	Participation of citizens in non-school community decision-making		+1.2	
j.	Drug abuse		+0.9	

12. What is your overall impression of the community schools program?

Very Negative	Negative	No Opinion	Positive	Very Positive
0	2	0	12	12
-2	-1	0	+1	+2

Education program?

Very Negative	Negative	Neutral	Positive	Very Positive
0	0	3	13	10
-2	-1	0	+1	+2

14. How involved do you think citizens should be in the following?

Categories of Involvement	Not involved	Slightly involved	Moderately involved	Very involved
a. Developing school/district educational policy	2	3	9	12
b. Designing new courses, including goals and content	1	8	11	6
C. Serving as volunteers in the daily program	0	5	9	12
d. Assisting in district evaluation of programs	2	1	12	11

Have your attitudes toward any of the above changed in the past two years?

20 No

6 Yes. If yes, please circle the area of change and explain: _____

15. If state funding were terminated next year, to what extent do you think the Community Education Program would continue to operate?

6 Don't know

6 Program (and its services/activities) would be discontinued

13 Program would exist but would operate at reduced levels in terms of decreased numbers of areas served or decreased services/activities (With what funds? _____

_____)
(specify)

1 Program would operate in the same manner and to the same degree as it has operated (With what funds? _____

_____)
(specify)

0 Program would expand to include a larger service area or more services/activities (With what funds? _____

_____).
(specify)

16. Have you ever attended any community school conferences, workshops, or training sessions?

a. 12 No 13 Yes

If yes:

b. Was it in the past two years? 3 No 10 Yes

If yes:

c. Who was/were the sponsor(s)? Various Agencies

d. How valuable was/were the sessions?

0	0	3	5	2
of no value	of little value	of some value	quite helpful	critical to my efforts

e. Can you cite any specific examples of having done anything differently because of the training/assistance received?

1 No 8 Yes

If yes, what? (1) Policy Changes

(2) Use Community Surveys to Develop Program

(3) Utilize Volunteers

(4)

17. What suggestions can you make to the Alaska Legislature that would improve the effectiveness of Community Education programs?

Increase funding levels/change funding methods- 16

Provide continuous funding from year to year - 7

Reduce paperwork - 2

ADDITIONAL COMMENTS:

STATE OF ALASKA

JAY S. HAMMOND
GOVERNOR

DEPARTMENT OF EDUCATION

OFFICE OF THE COMMISSIONER
POUCH F-ALASKA OFFICE BUILDING
JUNEAU 99811

RECEIVED
MAR 10 1980
LEGISLATIVE
AUDIT

March 7, 1980

Mr. Gerald L. Wilkerson, CPA
Legislative Auditor
Division of Legislative Audit
Pouch W
Juneau, AK 99811

Dear Mr. Wilkerson:

Reference: Response to the Preliminary Audit of the Community School Program

The Department of Education staff and I have reviewed the above referenced report and offer the following commentary. First, under the Scope Constraint, the Department of Education has collected data on the FY'79 operational grants and will continue to do so in each subsequent year. Please see attachment A.

Recommendation #1

The Department of Education (DOE) should issue operating Community School grant funds in accordance with AS 14.36.030.

The Department of Education agrees with this recommendation. This specific recommendation was brought to the attention of the Department of Education prior to the issuance of the FY'80 grants. Hence the Department of Education has issued FY'80 grant monies in accordance with this recommendation.

Recommendation #2

DOE should strengthen the grant reimbursement procedures.

The Department of Education agrees with the audit recommendation; however, since the FY'78 grant reimbursements, the Department has strengthened the grant reimbursement process. The process of reimbursement requires the program manager to review all reimbursement requests. The administrative assistant to the Adult and Continuing Education Unit and the unit administrator review the requests, and the division accountant reviews the request before it is forwarded to fiscal for payment. During these reviews, line item expenditures, authorized signatures and other points are checked for compliance.

School Districts are not allowed to overexpend their line item budgets unless line item transfers are approved by the Department.

An effort will be made to review the annual district reports with the Community School reimbursement file. However, the annual district reports generally do not arrive in the Department of Education until December and January, while the Community School operational grants should be closed by December.

Recommendation #3

Department of Education should comply with Alaska Statutes by approving one planning grant to establish a Community School program in an attendance area.

The Department of Education does not agree with recommendation #3. Section 4 AAC 32.101. Scope of State Assisted Projects, published in Register 60, January 1977, p. 4-24, part A, (see attachment B), stipulates that Community School grants are made to school districts for planning, establishing, expanding, improving or maintaining community education programs.

While it is true that a "Community School program becomes fully operational at the beginning of the second fiscal year following its authorization," this does not take into account "expanding and improving" their programs.

Those districts which received planning grants during their third and fourth year of operation utilized said funds for expanding and improving their programs.

Recommendation #4

Department of Education should collect, record and maintain statistics on Community School programs.

The Department of Education agrees partly with recommendation #4. A systematic process of the collection of data relevant to the Community School programs in Alaska was begun in FY'79. (See attachment A, C & D). The figures on these attachments are not standardized.

Since the completion of the FY'79 operations grants, the districts which have operational grants now have to submit a narrative report and a statistical report with their final reimbursement request. The procedures for standardization of statistics is being finalized for FY'80.

Recommendation #5

Department of Education should perform on-site evaluations of district Community School programs.

The Department of Education concurs with recommendation #5. Although it is true that the Department of Education did not perform official

on-site monitoring trips during the period of time stated in the preliminary audit report; each technical assistance visitation was also an unofficial monitoring trip. We have now formalized the procedure beginning with FY'80 grant applications, a three year rotational schedule has been established. During FY'80, eleven (11) sites will be monitored. With the additional two (2) sites that the audit committee reviewed, thirteen (13) sites have been monitored. The remaining sites will be monitored during the next two years.

Finally we would clarify that the questionnaire, sent to community school coordinators and superintendents in the Supplemental Information Section, was not taken from the records of the Department of Education, Community School program, but was a survey which was conducted by legislative audit personnel.

I would like to thank you for the fine professional manner in which the members of your staff conducted themselves during the course of this audit.

Sincerely,

Marshall L. Lind
Commissioner

ALASKA COMMUNITY INVOLVEMENT
IN COMMUNITY EDUCATION
FY79

Attachment A

City	School System	Total No. Of Schools In System	No. of School Designated Community Schools			Citizen Involvement		Total * Involvement
			Elementary	Secondary	TOTALS	Youth	Adult	
1. Anchorage	Anchorage School System	66	20	1	21	9,761	9,051	18,812
2. Metlakatla	Annette Island City Schools	2	1	1	2	149	117	266
3. Agnoon	Chu[illegible]m Schools	4	----------4----------		4	did not submit final report		
4. Glennallen	Copper River Schools	5	----------5----------		5	372	286	658
5. Delta Jun.	Delta/Greely Schools	3	2	1	3	191	197	388
6. Haines	Haines Borough Schools	2	1	1	2			967
7. Kake	Kake City Schools	2	1	1	2	226	75	301
8. King Cove	King Cove City Schools	2	1	1	2	did not submit final report		
9. Kodiak	Kodiak Island Borough Schools	13	8	2	10	603	870	1,473
10. Bethel	Lower Kuskokwim Schools	10	---------8---------		8	798	1,015	1,813
11. Palmer	Matanuska/Susitna Borough Schools	11	8	3	11	2,741	3,472	6,213
12. Nome	Nome City Schools	2	1	1	2	610	777	1,387
13. Petersburg	Petersburg City Schools	2	1	1	2	submitted narrative only		
14. St. Paul Is.	Pribilof Schools	2	1	1	2	submitted narrative only		
15. Sitka	Sitka Borough Schools	10	4	2	6	410	445	855
16. Skagway	Skagway City Schools	1	---------1---------		1	107	135	242
17. Dillingham	Southwest Region Schools	11	---------7---------		7	443	294	737
18. Valdez	Valdez City Schools	4	2	2	4	126	250	376

ALASKAN COMMUNITY INVOLVMENT
IN COMMUNITY EDUCATION
FY79

City	School System	Total No. Of Schools In System	No. of Schools Designated Community Schools			Citizen Involvement		Total Involvement
			Elementary	Secondary	TOTALS	Youth	Adult	
19. Fairbanks	Northstar Borough Schools	28	5	2	7	Did not submit final report		
20. McGrath	Iditarod Area Schools	9	---------9----------		9	Did not submit final report		
21. Juneau	Juneau Borough School District	9	5	2	7	2,434	5,419	7,853
22. Soldotna	Kenai Peninsula Borg. Schools	26	9	8	17	626	3,770	4,396
23. Kotzebue	Northwest Arctic School Dist.	12	---------7----------		7	Submitted narrative only		
24. Dillingham	Dillingham City Schools	1	---------1----------		1	Did not submit final report		
25. Adak	Adak Region Schools	2	1	1	2	Submitted narrative only		
26. Naknek	Bristol Bay Borough Schools	3	2	1	3	78	163	241
27. Craig	Criag City Schools	2	1	1	2	65	175	240
28. Hoonah	Hoonah City Schools	2	1	1	2	Submitted narrative only		
29. Naknek	Lake and Peninsula	12	--------10 ----------		10	Did not submit final report		
30. Barrow	North Slope Borough Schools	7	---------5----------		5	Submitted narrative only		
31. Ft. Yukon	Yukon Flats Schools	8	---------1----------		1	Did not submit final report		
32. Yakutat	Yakutat City Schools	2	1	1	2	100	113	213
33. Cordova	Cordova City Schools	2	1	1	2	494	308	802
34. Klawock	Klawock City Schools	1	---------1----------		1	140	62	202
			20 Districts submitting statistics		TOTALS	20,474	26,994	47,468

* Total involvement on these sheets are a one-time registration of each participant, however, many participants are involved in more that one class so that this figure does not ascertain the level of involvement for each individual.

CHAPTER 32. COMMUNITY SCHOOLS

Section
10. Scope of state-assisted projects
20. Community education grant application
30. Definitions

4 AAC 32.010. SCOPE OF STATE-ASSISTED PROJECTS. (a) Community school grants are made to school districts for planning, establishing, expanding, improving or maintaining community education programs. Two types of grants will be made

(1) planning grants will be made to help districts and communities to develop comprehensive community education programs;

(2) operational grants will be made to help districts operate community education programs.

(b) Grants are for a period of up to one year. Subsequent applications must be submitted and will be evaluated in the same manner as initial grant applications. (Eff. 3/12/76, Reg. 57; am 2/4/76, Reg. 60)

Authority: AS 14.07.060
AS 14.36.040

4 AAC 32.020. COMMUNITY EDUCATION GRANT APPLICATION. (a) The commissioner will, in the exercise of his discretion, award a planning grant to a district upon an application submitted to him which contains, in narrative form, the following:

(1) objectives for the planning process;

(2) procedures, strategies, and activities for accomplishing the objectives;

(3) a time-line for accomplishing the objectives;

(4) an evaluation design providing for the collection, verification and analysis of data to measure the extent to which the objectives are accomplished by the program;

(5) a proposed budget, indicating the amount of grant funds requested; and

(6) a commitment to report to the commissioner the results of the planning effort.

(b) The commissioner will, in the exercise of his discretion, award a grant for operating a community education program to a district upon an application submitted to him which contains at least the following:

(1) an overall long-range plan which contains provisions to fulfill the following elements of a community education program:

(A) service to an identified community or local attendance area;

(B) potential for accommodation of all age groups as well as specific groups with special needs;

(C) concentration of activities in one or more public facilities;

(D) identification and utilization of cultural, recreational and other existing and planned resources located outside those public facilities in which the activities are to be concentrated;

(E) systematic procedures for identifying and documenting, on a continuing basis, the needs, interests and concerns of the community served and for responding to those needs, interests and concerns;

(F) programs and activities which reflect the array of needs, interests and concerns of the community; and

(G) creation of an active community education council whose members are representative of the community to be served;

(2) projections for expected long-range growth and development in regard to the following aspects of the community education program:

(A) the K–12 regular school program;

(B) facility and resource use;

(C) extended activities for children and youth;

(D) opportunities for the involvement of adults in the community education program;

(E) delivery of various human services at the most local community level; and

(F) community development in general;

(3) a short-range, detailed program plan which includes the following:

(A) program objectives which state specific and measurable outcomes of the selected program components;

(B) procedures, strategies, and activities for accomplishing the program objectives;

(C) a time-line for accomplishing the program objectives; and

(D) an evaluation design providing for the collection, verification and analysis of data to measure the extent to which the program objectives are accomplished by the program;

(4) documentation of the involvement of persons broadly representative of the community to be served by the program in the preparation of the application, and provision for indicating the continued involvement of such persons with the program;

(5) information regarding the administration of the program, including but not limited to

(A) proposed organizational arrangements for program administration and qualifications and roles of staff who will administer the program;

(B) provisions for securing appropriate training, where required, of a short-term, in-service or preservice nature for administrators, staff, community members, and others who will plan and carry out programs;

(C) an organizational chart indicating the relationship between individuals, groups and agencies affected by the plan; and

(D) a statement as to the proportion of the total school district which operates as distinct administrative units for community education purposes;

(6) a commitment by the applicant to collect and make available information which may be required by the commissioner in accordance with those reasonable time constraints which he may establish, for purposes of carrying out program evaluations;

(7) letters from agencies and organizations affected by the program indicating affiliation or cooperation with the applicant as indicated in the program design; and

(8) a budget statement indicating money to be provided during the period of the requested grant by various agencies, organizations and individuals to support community education in the community to be served by the program.

(c) As necessary, incomplete or inadequate applications will be returned to the applicant for modification. Unfunded applications will be reviewed with comments provided by the department for future use by the applicant. (Eff. 3/12/76, Reg. 57; am. 12/4/76, Reg. 60)

Authority: AS 14.07.060
AS 14.36.040

4 AAC 32.030. DEFINITIONS. In this chapter, unless the context requires otherwise

(1) "community education" means a "community school program" as defined in AS 14.36.070;

(2) "district" means a city or borough school district, or a regional educational attendance area;

(3) "program" means a community education program which meets the requirements set forth in sec. 20 of this chapter;

(4) "public facility" means a facility owned or operated by the state, or a political subdivision of the state. (Eff. 3/12/76, Reg. 57)

Authority: AS 14.07.060
AS 14.36.040

Attachment C

Community Education

FY'79

District	Local Contribution	State Support
Anchorage/Eagle River	$978,646.00	$256,646.00
Adak	Not Listed	17,932.00
Annette Islands	Not Listed	7,015.00
Bering Straits	8,100.00	26,885.00
Bristol Bay	Not Listed	9,790.00
Chatham Straits	5,720.00	5,567.00
Copper River	Not Listed	14,227.00
Cordova	25,025.00	3,536.00
Craig	12,249.20	2,992.00
Delta Junction	5,000.00	21,226.00
Dillingham	Not Listed	12,169.00
Fairbanks	11,481	96,803.00
Haines	Not Listed	13,408.00
Hoonah	1,773.00	8,072.00
Juneau	Not Listed under total	46,583.00
Kake	7,935.00	4,764.00
Kenai	Not Listed	101,114.00
King Cove	2,390.00	6,701.00
Klawock	3,250.00	5,200.00
Kodiak	25,145.00	43,964.00
Lake & Peninsula	Not Listed	27,376.00
Lower Kuskokwim	19,767.00	38,130.00
Lower Yukon	Not Listed	10,722.00
Mat-Su	Not Listed	53,666.00
Nome	37,427.00	23,093.00
North Slope Borough	14,521.00	41,607.00
N.W. Arctic	Not Listed	39,794.00
Petersburg	Not Listed	7,090.00
Pribilof	16,126.00	5,670.00
Sitka	Not listed	30,232.00
Skagway	3,000.00	3,097.00
Southwest Region	Not Listed	30,887.00
Valdez	97,938.00	21,050.00
Yakutat	5,227.00	5,227.00
Yukon Flats	16,450.00	12,382.00
Iditarod	Not Listed	12,557.00
Totals	$1,397,170.20	$1,067,174.00

ATTACHMENT D

District/REAA	FY79 State Grant	# of Participant	Cost/Participant
District			
Anchorage	$256,646	18,812	$13.64
Bristol Bay	8,340	241	34.60
Cordova	3,533	802	4.40
Craig	2,992	240	12.46
Dillingham	12,169	Figures not available	Figures not avail.
Fairbanks	96,803	Figures not available	Figures not avail.
Haines	11,958	967	12.36
Hoonah	6,622	Narrative report	Narrative report
Juneau	46,583	7,853	5.93
Kake	3,314	301	11.00
Kenai	106,570	4,396	24.24
King Cove	5,251	Figures not available	Figures not avail.
Klawok	5,200	202	25,74
Kodiak	43,964	1,473	29.84
Mat-Su	53.666	6,213	8.47
Nome	21,643	1,387	15.60
North Slope	41,607	Narrative Report	Narrative Report
Petersburg	7,094	Narrative Report	Narrative Report
Sitka	28,782	855	33.66
Skagway	3,097	242	12.79
Valdez	19,600	376	52.12
Yakutat	5,227	213	24.53
REAA			
Adak	16,482	Figures not available	Figures not avail.
Annette Island	5,565	266	20.92
Bering Strait	26,885	Narrative Report	Narrative Report
Chatham	5,567	Figures not available	Figures not avail.
Cooper River	14,227	658	21,62
Delta/Greely	21,226	388	54.70
Iditarod	12,557	Figures not available	Figures not avail.
Lake and Peninsula	27,376	Figures not available	Figures not avail.
Lower Kuskokwim	38,130	1,813	21,03
Lower Yukon	9,272	183	50.66
Northwest Arctic	39,794	Figures not available	igures not avail.
Pribilof	5,670	Narrative Report	Narrative Report
Southwest Region	29,437	737	39.94
Yukon Flats	10,932	Figures not available	Figures not avail.
Total	$1,087,979	48,618	$ 22.37

STATE OF ALASKA

THE LEGISLATURE

BUDGET AND AUDIT COMMITTEE

AUDIT DIVISION
POUCH W —ALASKA OFFICE BUILDING

FINANCE DIVISION
POUCH WF—STATE CAPITOL

JUNEAU, ALASKA 99811

March 12, 1980

Members of the
Legislative Budget and Audit Committee:

We have reviewed the Department of Education's response to our Preliminary Report. Our comments follow:

Recommendation No. 3

The Department disagreed with our recommendation, and stated that the Community Schools' planning grants may be made to school districts for expanding and improving their programs whether they are in their first year or their fourth year of operation. However, the following is a quote from a letter dated January 2, 1980, from our legal counsel, Legislative Affairs Agency, Division of Legal Services:

> While conceding the community schools "planners" their due, I would caution that planning money is limited to one grant per "local attendance area." Neither the statute nor the department's regulations are clear on the point. However, the "Statement of intent" codified at AS 14.36.010(b) indicates legislative resolve that the "community school program will become fully operational at the beginning of the second fiscal year following its authorization." (Emphasis added.) A "local attendance area" may submit an application for a community schools grant, to include a request for support of a comprehensive plan for the community school program. . . ." If each local attendance area within a district may seek financial support for the development of the comprehensive plan for a community school program, where the legislation so clearly recognizes planning as a requisite to successful implementation and administration of a program and the legislature has taken the position that a supported program move into operation at the beginning of the second fiscal year, the net effect must be to limit the number of planning grants per "local attendance area" to one.

The House HESS Committee eliminated the requirement of initiation of an operational program at the start of the second fiscal year in its committee substitute. The House Finance Committee restored the provision, evidence that, while program planning was essential, it was the support of the development and implementation of an operating program which the legislature was seeking to support.

Gerald L. Wilkerson, CPA
Legislative Auditor
Division of Legislative Audit

Districts	1% Foundation Support $10,000 min.	1% Foundation Support Plus State Match	0.75% Foundation Support $10,000 min.	0.75% Foundation Support Plus State Match	0.5% Foundation Support $10,000 min.	0.5% Foundation Support Plus State Match
Anchorage	$ 752,277	$1,504,554	$ 564,208	$1,128,416	$ 376,138	$ 752,276
Bristol Bay	13,302	26,604	10,000	20,000	10,000	20,000
Cordova	18,706	37,412	14,030	28,060	10,000	20,000
Craig	10,000	20,000	10,000	20,000	10,000	20,000
Dillingham	20,416	40,832	15,312	30,624	10,208	20,416
Fairbanks	236,213	472,426	177,160	354,320	118,106	236,212
Galena	12,430	24,860	10,000	20,000	10,000	20,000
Haines	15,918	31,836	11,938	23,876	10,000	20,000
Hoonah	10,000	20,000	10,000	20,000	10,000	20,000
Hydaburg	10,000	20,000	10,000	20,000	10,000	20,000
Juneau	103,716	207,432	77,787	155,574	51,858	103,716
Kake	10,000	20,000	10,000	20,000	10,000	20,000
Kenai	174,464	348,928	130,848	261,696	87,232	174,464
Ketchikan	62,329	124,658	46,747	93,494	31,165	62,330
King Cove	10,000	20,000	10,000	20,000	10,000	20,000
Klawock	10,000	20,000	10,000	20,000	10,000	20,000
Kodiak	82,777	165,554	62,083	124,166	41,389	82,778
Mat-Su	126,281	252,562	94,711	189,422	63,140	126,280
Nenana	10,876	21,752	10,000	20,000	10,000	20,000
Nome	40,381	80,762	30,286	60,572	20,191	40,382
North Slope	93,678	187,356	70,258	140,516	46,839	93,678
Pelican	10,000	20,000	10,000	20,000	10,000	20,000
Petersburg	17,602	35,204	13,202	26,404	10,000	20,000
Sand Point	10,000	20,000	10,000	20,000	10,000	20,000
Sitka	45,346	90,692	34,010	68,020	22,673	45,346
Skagway	10,000	20,000	10,000	20,000	10,000	20,000
St. Mary's	10,000	20,000	10,000	20,000	10,000	20,000
Unalaska	11,364	22,728	10,000	20,000	10,000	20,000
Valdez	33,247	66,494	24,935	49,870	16,623	33,246
Wrangell	15,814	31,628	11,860	23,720	10,000	20,000
Yakutat	10,000	20,000	10,000	20,000	10,000	20,000
Total Districts	$1,997,137	$3,994,274	$1,529,375	$3,058,750	$1,075,562	$2,151,124

	1% Foundation Support $10,000 min.	1% Foundation Support Plus State Match	0.75% Foundation Support $10,000 min.	0.75% Foundation Support Plus State Match	0.5% Foundation Support $10,000 min.	0.5% Foundation Support Plus State Match
REAA						
Adak	$ 22,281	$ 44,562	$ 16,711	$ 33,422	$ 11,141	$ 22,282
Alaska Gateway	26,481	52,962	19,861	39,722	13,241	26,482
Aleutian Chain	17,111	34,222	12,834	25,668	10,000	20,000
Annette Island	13,064	26,128	10,000	20,000	10,000	20,000
Bering Strait	52,757	105,514	39,568	79,136	26,379	52,758
Chatham	11,376	22,752	10,000	20,000	10,000	20,000
Chugach	10,000	20,000	10,000	20,000	10,000	20,000
Copper River	27,407	54,814	20,555	41,110	13,703	27,406
Delta Greely	32,056	64,112	24,042	48,084	16,028	32,056
Iditarod	30,350	60,700	22,762	45,524	15,175	30,350
Kuspuk	35,229	70,458	26,422	52,844	17,615	34,230 ←
Lake & Peninsula	43,197	86,394	32,398	64,796	21,599	43,198
Lower Kuskokwim	135,804	271,608	101,853	203,706	67,902	135,804
Lower Yukon	78,852	157,704	59,139	118,278	39,426	78,852
Northwest Arctic	102,888	205,776	77,166	154,332	51,444	102,888
Pribilof	12,220	24,440	10,000	20,000	10,000	20,000
Railbelt	21,094	42,188	15,820	31,640	10,547	21,094
Southeast Island	27,942	55,884	20,956	41,912	13,971	27,942
Southwest Region	49,925	99,850	37,444	74,888	24,962	49,924
Yukon Flats	35,213	70,426	26,410	52,820	17,606	35,212
Yukon Koyukuk	48,740	97,480	36,555	73,110	24,370	48,740
Total REAA	$ 833,987	$1,667,974	$ 630,496	$1,260,992	$ 435,109	$ 870,218
Total District and REAA	$2,831,124	$5,662,248	$2,159,871	$4,319,743	$1,510,671	$3,021,342

Community Education FY80

District	Amount Local Contribution	Amount State Support
Anchorage and Eagle River	$882,689.60	$256,646.00
Bristol Bay	7,084.00	10,246.00
Adak	9,739.00	20,396.00
Annette Island	Not Listed	8,576.00
Bering Straits	Not Listed	34,727.00
Copper River	Not Listed	19,361.00
Cordova	24,618.34	6,487.00
Craig	12,000.00	4.014.00
Delta Junction	6,000.00	30,903.00
Dillingham	Not Listed	12,169.00
Fairbanks	14,585.00	96,803.00
Haines	19,050.00	11,958.00
Hoonah	10,298.00	8,497.00
Juneau	Not Listed	71,274.00
Kake	13,728.00	4,861.00
Kenai	Not Listed	106,570.00
King Cove	1,952.00	5,251.00
Klawock	9,725.00	5,200.00
Kodiak	15,743.00	61,517.00
Lower Kuskokwim	19,767.00	72.982.00
Lower Yukon	61,060.00	35,758.00
Mat-Su	Not Listed	69,197.00
Nome	44,780.00	30,670.00
N.W. Arctic	Not Listed	63,916.00
Petersburg	Not Listed	10,602.00
Pribilof	16,657.00	8,380.00
Sitka	45,977.00	35,922.00
Skagway	12,206.00	6,322.00
Southwest Region	Not Listed	40,755.00
St. Mary	Not Listed	4,442.00
Valdez	40,870.00	26,445.00
Yakutat	16,040.00	6,623.00
Yukon Flats	26,030.00	18,930.00
Iditarod	188,000.00	20,564.00
Totals	$1,484,013.94	$1,226,964.00

Community Education

FY'79

District	Local Contribution	State Support
Anchorage/Eagle River	$978,646.00	$256,646.00
Adak	Not Listed	17,932.00
Annette Islands	Not Listed	7,015.00
Bering Straits	8,100.00	26,885.00
Bristol Bay	Not Listed	9,790.00
Chatham Straits	5,720.00	5,567.00
Copper River	Not Listed	14,227.00
Cordova	25,025.00	3,536.00
Craig	12,249.20	2,992.00
Delta Junction	5,000.00	21,226.00
Dillingham	Not Listed	12,169.00
Fairbanks	11,481	96,803.00
Haines	Not Listed	13,408.00
Hoonah	1,773.00	8,072.00
Juneau	Not Listed under total	46,583.00
Kake	7,935.00	4,764.00
Kenai	Not Listed	101,114.00
King Cove	2,390.00	6,701.00
Klawock	3,250.00	5,200.00
Kodiak	25,145.00	43,964.00
Lake & Peninsula	Not Listed	27,376.00
Lower Kuskokwim	19,767.00	38,130.00
Lower Yukon	Not Listed	10,722.00
Mat-Su	Not Listed	53,666.00
Nome	37,427.00	23,093.00
North Slope Borough	14,521.00	41,607.00
N.W. Arctic	Not Listed	39,794.00
Petersburg	Not Listed	7,090.00
Pribilof	16,126.00	5,670.00
Sitka	Not listed	30,232.00
Skagway	3,000.00	3,097.00
Southwest Region	Not Listed	30,887.00
Valdez	97,938.00	21,050.00
Yakutat	5,227.00	5,227.00
Yukon Flats	16,450.00	12,382.00
Iditarod	Not Listed	12,557.00
Totals	$1,397,170.20	$1,067,174.00

District				
Anchorage	$256,646	$458,530	$328,264	$1,232,199
Bristol Bay	10,246	22,336	5,427	20,370
Cordova	6,487	14,141	7,927	29,756
Craig	4,014	8,749	3,104	11,651
Dillingham	12,169	20,885	8,883	33,345
Fairbanks	96,803	74,909	102,106	383,274
Galena	0	0	4,731	17,760
Haines	11,958	25,584	6,958	26,117
Hoonah	8,497	18,523	4,174	15,668
Hydaburg	0	0	2,198	8,250
Juneau	71,274	155,367	46,641	175,077
Kake	4,861	10,834	3,849	14,446
Kenai	106,570	106,242	67,484	253,312
Ketchikan	0	0	28,454	106,809
King Cove	5,251	13,301	3,294	12,364
Klawok	5,200	5,502	1,466	5,502
Kodiak	61,517	134,097	36,885	138,455
Mat-Su	69,197	150,839	53,062	199,177
Nenana	0	0	4,475	16,796
Nome	30,670	66,856	17,026	63,911
North Slope	0	0	35,776	134,293
Pelican	0	0	1,125	4,221
Petersburg	10,602	23,112	7,708	28,932
Sand Point	0	0	3,569	13,398
Sitka	35,922	78,303	20,690	77,664
Skagway	6,322	13,781	3,234	12,141
St. Mary's	1,811	3,948	4,206	15,788
Unalaska	0	0	3,756	14,099
Valdez	26,445	57,647	13,651	51,242
Wrangell	0	0	6,814	25,576
Yakutat	6,623	14,438	3,641	13,669
REAA				
Adak	20,396	44,460	12,112	45,466
Alaska Gateway	0	0	13,660	51,276
Aleutian	0	0	9,141	34,313
Annette	8,576	18,695	6,954	26,103
Bering Strait	34,727	75,698	20,659	77,548
Chatham	5,567	4,988	5,613	21,068
Chugach	0	0	1,844	6,920
Copper River	19,361	42,204	14,675	55,084
Delta/Greely	30,903	67,365	17,942	67,349
Iditarod	20,564	44,825	15,071	56,572
Kuspuk	0	0	18,173	68,217
Lake and Peninsula	0	0	20,605	77,344
Lower Kuskokwim	72,982	159,091	58,819	220,789
Lower Yukon	35,758	77,946	34,686	130,200
Northwest Arctic	63,916	139,327	47,732	179,169
Pribilof	8,380	18,266	6,226	23,369
Railbelt	0	0	10,302	38,671
Southeast Island	0	0	13,958	52,393
Southwest Region	40,755	88,838	20,306	76,224
Yukon Flats	18,930	41,265	16,204	60,826
Yukon Koyukuk	0	0	24,640	92,491
Totals	$1,229,900	$2,300,692	$1,229,900	$4,616,654

STATE OF ALASKA

MEMORANDUM

TO: The Honorable Thelma Bucholdt
The House of Representatives
Alaska State Legislature

DATE: January 28, 1980

FILE NO:

THRU: Commissioner Lind
Department of Education

TELEPHONE NO:

FROM: Joe Miguel, Supervisor
Community Education
Department of Education

SUBJECT: List of currently funded Operational Community School Districts which will not be funded in FY'80

At your reqeust, I am supplying your office with a list of school districts which are currently receiving grants from the State, but will be dropping off as of June 30, 1980, due to the formula in the Community School Act of 1975.

District	Funding Level	Year of Operation
Anchorage	256,646	5
Bristol Bay	8,465	4
Dillingham City	12,169	4
Fairbanks	96,803	4
Haines	11,958	5
Hoonah	7,020	4
Juneau	58,884	4
Kenai	106,570	5
King Cove	5,251	4
Klawock	5,200	4
Kodiak	50,823	4
Matanuska-Susitna	57,168	4
Nome	25,338	4
North Slope	50,535	4
Sitka	29,677	4
Valdez	21,848	4
Yakutat	5,472	4
Adak	16,850	4
Bering Straits	28,690	4
Delta/Greely	25,531	4
Southwest Region	33,670	4

MEMORANDUM State of Alaska

TO: Jan Sorice, Legislative Aide
Representative Buchholdt's Office

DATE: May 2, 1980

FILE NO:

TELEPHONE NO: 465-2800

FROM: Marshall L. Lind, Commissioner
Department of Education

SUBJECT: House Bill 629

In the event that the legislature does not fully fund House Bill 629, the Department of Education recommends the following methods for dispersal of funds to those districts with approved plans of service:

1. If less than 1% of the total foundation support is given to the bill for sections a and b, then .5% will be used in section a and the remaining amount will be prorated to the districts in section b.

2. If 1% of the total foundation support is given to the bill for sections a and b, then .5% will be used in section a and .5% in section b.

3. If 1.5% of the total foundation support is given to the bill for sections a and b, then section a will be fully funded at the 1% level and section b will be prorated at the .5% level.

4. If 2% of the total foundation support is given to the bill for sections a and b, then section a will be fully funded at the 1% level and section b will also be fully funded at the 1% level.

ALASKA COMMUNITY INVOLVEMENT
IN COMMUNITY EDUCATION
FY79

ity	School System	Total No. Of Schools In System	No. of School Designated Community Schools			Citizen Involvement		Total Involveme
			Elementary	Secondary	TOTALS	Youth	Adult	
Anchorage	Anchorage School System	66	20	1	21	9,761	9,051	18,812
Metlakatla	Annette Island City Schools	2	1	1	2	149	117	266
Agnoon	Chatham Schools	4	----------4----------		4	did not submit final report		
Glennallen	Copper River Schools	5	----------5----------		5	372	286	658
Delta Jun.	Delta/Greely Schools	3	2	1	3	191	197	388
Haines	Haines Borough Schools	2	1	1	2	did not submit final report		
Kake	Kake City Schools	2	1	1	2	226	75	301
King Cove	King Cove City Schools	2	1	1	2	did not submit final report		
Kodiak	Kodiak Island Borough Schools	13	8	2	10	603	870	1,473
. Bethel	Lower Kuskokwim Schools	10	---------8----------		8	798	1,015	1,813
. Palmer	Matanuska/Susitna Borough Schools	11	8	3	11	2,741	3,472	,213
. Nome	Nome City Schools	2	1	1	2	610	777	1,387
. Petersburg	Petersburg City Schools	2	1	1	2	submitted narrative only		
. St. Paul Is.	Pribilof Schools	2	1	1	2	submitted narrative only		
. Sitka	Sitka Borough Schools	10	4	2	6	410	445	855
. Skagway	Skagway City Schools	1	---------1----------		1	107	135	242
. Dillingham	Southwest Region Schools	11	---------7----------		7	443	294	737
. Valdez	Valdez City Schools	4	2	2	4	126	250	376

ALASKAN COMMUNITY INVOLVEMENT IN COMMUNITY EDUCATION FY79

ty	School System	Total No. Of Schools In System	No. of Schools Designated Community Schools			Citizen Involvement		Total Involvement
			Elementary	Secondary	TOTALS	Youth	Adult	
. Fairbanks	Northstar Borough Schools	28	5	2	7	Did not submit final report		
. McGrath	Iditarod Area Schools	9	--------9----------		9	Did not submit final report		
. Juneau	Juneau Borough School District	9	5	2	7	2,434	5,419	7,853
. Soldotna	Kenai Peninsula Borg. Schools	26	9	8	17	626	3,770	4,396
. Kotzebue	Northwest Arctic School Dist.	12	--------7----------		7	Submitted narrative only		
. Dillingham	Dillingham City Schools	1	--------1-------- --		1	Did not submit final report		
. Adak	Adak Region Schools	2	1	1	2	Submitted narrative only		
. Naknek	Bristol Bay Borough Schools	3	2	1	3	78	163	241
. Craig	Criag City Schools	2	1	1	2	65	175	240
. Hoonah	Hoonah City Schools	2	1	1	2	Submitted narrative only		
. Naknek	Lake and Peninsula	12	-------10----------		10	Did not submit final report		
. Barrow	North Slope Borough Schools	7	--------5----------		[illegible]	Submitted narrative only		
. Ft. Yukon	Yukon Flats Schools	8	--------1----------		1	Did not submit final report		
. Yakutat	Yakutat City Schools	2	1	1	2	100	113	213
. Cordova	Cordova City Schools	2	1	1	2	494	308	802
. Klawock	Klawock City Schools	1	--------1----------		1	140	62	202
			20 Districts submitting statistics		TOTALS	20,474	26,994	47,468

Total involvement on these sheets are a one-time registration of each participant, however, many participants are involved in more that one class so that this figure does not ascertain the level of involvement for each individual.

THE LEGISLATURE OF THE STATE OF ALASKA
ELEVENTH LEGISLATURE

FISCAL NOTE

I. REQUEST

Bill/Resolution No. Committee Substitute for H.B. 629

Title An act relating to Community Schools

Requested by H.E.S.S. Committee Date April 21, 1980

II. FISCAL DETAIL

Agency Affected Education

Program Category Affected Foundation Support Programs

BRU, Program, or Subprogram(s) Affected Community Schools

(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 80	FY 81	FY 82	FY 83	FY 84	FY 85
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL						
400 COMMODITIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC.		5,323.	5,843.	6,252.	6,689.	7,157.
TOTAL						

FUNDING (Thousands of Dollars)

GENERAL FUND		5,323.	5,843.	6,252.	6,689.	7,157.
FEDERAL FUNDS						
OTHER (Specify Fund Source)						

POSITIONS

FULL TIME						
PART TIME						
TEMPORARY						

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

FY'81 cost reflects establishment of 10.0 base or one percent floor as contained in the proposed bill. For FY'82 upon a 52 million dollar increase in the foundation support. FY'83, '84, and '85, are based upon a 7% inflationary cost.

IV. DATE April 21, 1980 PREPARED BY [signature]

AGENCY Education

Original: Legislative Finance PHONE 465-2800

cc: Budget and Management

THE LEGISLATURE OF THE STATE OF ALASKA
ELEVENTH LEGISLATURE

FISCAL NOTE

I. REQUEST

Bill/Resolution No. Committee Substitute for H.B. 629
Title An act relating to Community Schools
Requested by H.E.S.S. Committee Date April 21, 1980

II. FISCAL DETAIL

Agency Affected Education
Program Category Affected Foundation Support Programs
BRU, Program, or Subprogram(s) Affected Community Schools
(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 80	FY 81	FY 82	FY 83	FY 84	FY 85
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL						
400 COMMODITIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC.		3,021.3	3,281.3	3,511.0	3,756.8	$4,019.7
TOTAL						

FUNDING (Thousands of Dollars)

GENERAL FUND		3,021.3	3,281.3	3,511.0	3,756.8	$4,019.7
FEDERAL FUNDS						
OTHER (Specify Fund Source)						

POSITIONS

FULL TIME						
PART TIME						
TEMPORARY						

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

FY'81 cost reflects establishment of 10.0 base or .5 percent floor as contained in the proposed bill. FY'82 is based upon .5 percent of a 52 million dollar increase in the foundation support. FY'83, '84, '85, are based upon a 7% inflationary cost.

IV. DATE April 21, 1980 PREPARED BY William D Thomas
AGENCY Education
PHONE 465-2800

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)

District/REAA	FY 80 Actual .43	FY80 Full	FY81 Gov. App. 266+	FY81 Full 2%
District				
Anchorage	$256,646	$458,530	$328,264	$1,232,199
Bristol Bay	10,246	22,336	5,427	20,370
Cordova	6,487	14,141	7,927	29,756
Craig	4,014	8,749	3,104	11,651
Dillingham	12,169	20,885	8,883	33,345
Fairbanks	96,803	74,909	102,106	383,274
Galena	0	0	4,731	17,760
Haines	11,958	25,384	6,958	26,117
Hoonah	8,497	18,523	4,174	15,668
Hydaburg	0	0	2,198	8,250
Juneau	71,274	155,367	46,641	175,077
Kake	4,861	10,834	3,849	14,446
Kenai	106,570	106,242	67,484	253,312
Ketchikan	0	0	28,454	106,809
King Cove	5,251	13,301	3,294	12,364
Klawok	5,200	5,502	1,466	5,502
Kodiak	61,517	134,097	36,885	138,455
Mat-Su	69,197	150,839	53,062	199,177
Nenana	0	0	4,475	16,796
Nome	30,670	66,856	17,026	63,911
North Slope	0	0	35,776	134,293
Pelican	0	0	1,125	4,221
Petersburg	10,602	23,112	7,708	28,932
Sand Point	0	0	3,569	13,398
Sitka	35,922	78,303	20,690	77,664
Skagway	6,322	13,781	3,234	12,141
St. Mary's	1,811	3,948	4,206	15,788
Unalaska	0	0	3,756	14,099
Valdez	26,445	57,647	13,651	51,242
Wrangell	0	0	6,814	25,576
Yakutat	6,623	14,438	3,641	13,669
REAA				
Adak	20,396	44,460	12,112	45,466
Alaska Gateway	0	0	13,660	51,276
Aleutian	0	0	9,141	34,313
Annette	8,576	18,695	6,954	26,103
Bering Strait	34,727	75,698	20,659	77,548
Chatham	5,567	4,988	5,613	21,068
Chugach	0	0	1,844	6,920
Copper River	19,361	42,204	14,675	55,084
Delta/Greely	30,903	67,365	17,942	67,349
Iditarod	20,564	44,825	15,071	56,572
Kuspuk	0	0	18,173	68,217
Lake and Peninsula	0	0	20,605	77,344
Lower Kuskokwim	72,982	159,091	58,819	220,789
Lower Yukon	35,758	77,946	34,686	130,200
Northwest Arctic	63,916	139,327	47,732	179,169
Pribilof	8,380	18,266	6,225	23,369
Railbelt	0	0	10,302	38,671
Southeast Island	0	0	13,958	52,393
Southwest Region	40,755	88,838	20,306	76,224
Yukon Flats	18,930	41,265	16,204	60,826
Yukon Koyukuk	0	0	24,640	92,491
Totals	$1,229,900	$2,300,692	$1,229,900	$4,616,654

District/REAA	FY 80 Actual .43	FY80 Full	FY81 Gov. App. 266+	FY81 Full 2%
District				
Anchorage	$256,646	$458,530	$328,264	$1,232,109
Bristol Bay	10,246	22,336	5,427	20 0
Cordova	6,487	14,141	7,927	29,756
Craig	4,014	8,749	3,104	11,651
Dillingham	12,169	20,885	8,883	33,345
Fairbanks	96,803	74,909	102,106	383,274
Galena	0	0	4,731	17,760
Haines	11,958	25,384	6,958	26,117
Hoonah	8,497	18,523	4,174	15,668
Hydaburg	0	0	2,198	8,250
Juneau	71,274	155,367	46,641	175,077
Kake	4,861	10,834	3,849	14,446
Kenai	106,570	106,242	67,484	253,312
Ketchikan	0	0	28,454	106,809
King Cove	5,251	13,301	3,294	12,364
Klawok	5,200	5,502	1,466	5,502
Kodiak	61,517	134,097	36,885	138,455
Mat-Su	69,197	150,839	53,062	199,177
Nenana	0	0	4,475	16,796
Nome	30,670	66,856	17,026	63,911
North Slope	0	0	35,776	134,293
Pelican	0	0	1,125	4,221
Petersburg	10,602	23,112	7,708	28,932
Sand Point	0	0	3,569	13,398
Sitka	35,922	78,303	20,690	77,664
Skagway	6,322	13,781	3,234	12,141
St. Mary's	1,811	3,948	4,206	15,788
Unalaska	0	0	3,756	14,099
Valdez	26,445	57,647	13,651	51,242
Wrangell	0	0	6,814	25,576
Yakutat	6,623	14,438	3,641	13,669
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Alaska Gateway	0	0	13,660	51,276
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Yukon Koyukuk	0	0	24,640	92,491
Totals	$1,229,900	$2,300,692	$1,229,900	$4,616,654

District/REAA	FY79 State Grant	# of Participant	Cost/Participant
District			
Anchorage	$256,646	18,812	$13.64
Bristol Bay	8,340	241	34.60
Cordova	3,533	802	4.40
Craig	2,992	240	12.46
Dillingham	12,169	Figures not available	Figures not avail.
Fairbanks	96,803	Figures not available	Figures not avail.
Haines	11,958	967	12.36
Hoonah	6,622	Narrative report	Narrative report
Juneau	46,583	7,853	5.93
Kake	3,314	301	11.00
Kenai	106,570	4,396	24.24
King Cove	5,251	Figures not available	Figures not avail.
Klawok	5,200	202	25,74
Kodiak	43,964	1,473	29.84
Mat-Su	53,666	6,213	8.47
Nome	21,643	1,387	15.60
North Slope	41,607	Narrative Report	Narrative Report
Petersburg	7,094	Narrative Report	Narrative Report
Sitka	28,782	855	33.66
Skagway	3,097	242	12.79
Valdez	19,600	376	52.12
Yakatat	5,227	213	24.53
REAA			
Adak	16,482	Figures not available	Figures not avail.
Annette Island	5,565	266	20.92
Bering Strait	26,885	Narrative Report	Narrative Report
Chatham	5,567	Figures not available	Figures not avail.
Cooper River	14,227	658	21,62
Delta/Greely	21,226	388	54.70
Iditarod	12,557	Figures not available	Figures not avail.
Lake and Peninsula	27,376	Figures not available	Figures not avail.
Lower Kuskokwim	38,130	1,813	21,03
Lower Yukon	9,272	183	50.66
Northwest Arctic	39,794	Figures not available	Figures not avail.
Pribilof	5,670	Narrative Report	Narrative Report
Southwest Region	29,437	737	39.94
Yukon Flats	10,932	Figures not available	Figures not avail.
Total	$1,087,979	48,618	$ 22.37

District/REAA	FY79 State Grant	# of Participant	Cost/Participant
District			
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Bristol Bay	8,340	241	34.60
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Kodiak	43,964	1,473	29.84
Mat-Su	53,666	6,213	8.47
Nome	21,643	1,387	15.60
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Southwest Region	29,437	737	39.94
Yukon Flats	10,932	Figures not available	Figures not avail.
Total	$1,087,979	48,618	$ 22.37

AACE Recommended House Bill No. 204

Amended

An Act

"An Act relating to community schools; and providing for an effective date."

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

CHAPTER 36. COMMUNITY SCHOOLS

Sec. 14.36.010. PURPOSE, INTENT. (a) The community school is an expression of the philosophy that the school, as the prime educational institution of the community, is most effective when it involves the people of that community in a program designed to fulfill their educational needs. The community school promotes a more efficient use of school facilities through an extension of buildings and equipment beyond the normal school day. The purpose of this chapter is to provide state leadership and financial support to encourage and assist local school districts in the establishment of community schools.

(b) It is the intent of the legislature that

(1) a program of community school grants be established to provide assistance to local communities in the initial development, implementation, and operation of community school programs;

(2) technical assistance, monitoring, training and coordination of statewide efforts to develop and operate community school programs be provided by the department; and

(3) the community school program will become fully operational once a plan of service has been approved by the commissioner.

(4) evaluation of approved programs and data collection will be conducted by the department.

Chapter 103

Sec. 14.36.020. COMMUNITY SCHOOLS GRANT FUND CREATED: LIMITATIONS ON USE. There is created a community schools grant fund as an account in the general fund. The fund shall be used to make community school grants to local attendance areas or school districts under this chapter. Legislative appropriations for community school grants shall be deposited in this fund.

Sec. 14.36.030. GRANTS (a) A district operating an approved community school program may elect to receive a grant of one per cent of its total public school foundation support or a flat grant, the amount of which is to be determined by the department.

(b) For fiscal years beginning after June 30, 1980, those districts may

NOV 26 1979

TO: REPS. BUCHHOLDT, BARNES, AND CHATTERTON

PETITION

We the undersigned members of Baxter Community School Association support the passage of House Bill 204 which provides for state grants to local community schools. We are convinced that HB 204 is critical to the continued operation of community schools in Anchorage and the rest of the state.

	Name	Address
1	Alice Allen	6419 Tolhurst Ct Anch.
2	Jon D Ribieski	6448 Tolhurst Ct. Anc
3	Miles Loverdale	2357 N. Elias Drive
4	Deborah L. White	3429 Jade Circle
5	Barbara K. Breneman	6435 Eastwood Ct.
6	Kathleen L. Mackie	2519 Kensington Dr.
7	Dave Hammond	2632 Cannon Cir.
8	Marianne Blackwelder	6019 Camden Ct.
9	[illegible]	6449 Tolhurst Ct.
10	Cheryl R. Volpert	6459 Tolhurst Ct.
11	Roberta G. Thomas	6457 Tolhurst Ct. Anchorage
12	W. W. Daily	6458 Tolhurst Ct. Anchorage
13	Debbie L. Lind	6458 Tolhurst Ct Anchorage
14	[illegible]	6448 Tolhurst Ct.
15	[illegible]	6435 Cache Ct Anch. 99504
16	[illegible]	4[illegible] Carlo Ct Anch 99507
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PETITION

We the undersigned members of Baxter Community School Association support the passage of House Bill 204 which provides for state grants to local community schools. We are convinced that HB 204 is critical to the continued opperation of community schools in Anchorage and the rest of the state.

	Name	Address
1	JAMES E. THOMAS	P.O. Box 638 GUNNALLEN, ALASKA 99588
2	Helen Applegate	4503 Lamplighter Anchorage, Alaska 99503
3	James C. Applegate	4503 Diamond Valley Anch. AK. 99503
4	Kelly Dilright	3141 Diamond Blvd Anch AK 99502
5	[illegible]	[illegible]
6	Charles L. [illegible]	3038 North Circle Anch. AK 99507
7	Rick Nelms	SRA 15615 Anch AK 99507
8	Susan Barlow	1130 B St. Anchorage 99501
9	Richard Lemon	SRA Box 1413 Anchorage AK 99502
10	Carol Cole	4407 Sunbeam Dr Anchorage AK 99507
11	Carol Lee	3700 Bonifacio #A Anchorage AK 99504
12	Thomas Wells	3323 Wesleyan Anchorage AK 99504
13	Craig A Valentine	3838 Westminster Way Anchorage AK 99504
14	Lisa Lawton	2541 Nile St. Anchorage AK 99504
15	Catherine D. Crockett	371 Checkmate Drive Anchorage AK 99
16	Margie M Hill	3713 Lynn Dr #3 Anch AK 99504
17	Sylvia Marchand	2991 BAXTER RD Anch. AK 99504
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PETITION

We the undersigned members of Baxter Community School Association support the passage of House Bill 204 which provides for state grants to local community schools. We are convinced that HB 204 is critical to the continued operation of community schools in Anchorage and the rest of the state.

	Name	Address
1	Spring Boling	9426 E 5th Ave
2	Kathy Boling	500 Bolin St Anch Ak
3	Sharon Boling	500 Bolin St. Anch
4	[illegible]	[illegible]
5	David DeWam	6900 Foothill Dr. Anch.
6	Mike McCormick	Box 8504, Anchorage, 99508
7	Barbara Jaworski	3423 Admiral Wayne Anch, AK 995
8	Barbara Hansel	1047 San Ernesto Anch., Ak. 99504
9	Anne Bennett	SRA Box 4015C Anch 99507
10	Ann Jaramillo	SRA Box 394-B Anch 99507
11	Cathie Welch	PO Box 10348 Eagle River, Alaska 99577
12	Sharon Campbell	SRA Box 132 Anch AK 99507
13	Kathleen O'Leary	SRA Box 15872 Anch, Ak. 99507
14	Cathie Agnew	872 Tanalian Dr. Anch AK 9950
15	Daniel Cheyn	8411 Birch Hills Dr. #12 Anch AK 995
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PETITION

We the undersigned members of Baxter Community School Association support the passage of House Bill 204 which provides for state grants to local community schools. We are convinced that HB 204 is critical to the continued operation of community schools in Anchorage and the rest of the state.

	Name	Address
1	Agnes M. Johnson	7111-Eleventh Dr Anch. AK.
2	Jessie K. Baby	3307 Bourbon Anch AK.
3	Peggy Hazel	5535 Kenyhill Anch 99504
4	[illegible]	7720 E 21st #3
5	Mary Hurley	7720 E 21st #3
6	Betty Lehman	3213 Glendenning Anchorage
7	Carol Wigate	4123 E 21st 99504
8	Shaja Coates	4944 Barat Circle 99504
9	Esther Eschholz	1737 Wickersham Dr. 995
10	Gordon Ingebretsen	4430 Channing Creek Cr.
11	Mary Kay Dunbar	6607 E 35TH ST. 99504
12	Celeste Long	8930 Hillcrest Anch AK 9950
13	[illegible]	5120 N. Trudeau, Anch. AK. 995
14	Sharon Dymond	6405 Colgate Drive Anch AK 99504
15	Carol Ware	3135 Tamarack Circle Anch. 99504
16	Nina M Bartoff	231 Wyoming #21 Anch AK 99504
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PETITION

We the undersigned members of Baxter Community School Association support the Passage of House Bill 204 which provides for state grants to local community schools. We are convinced that HB 204 is critical to the continued operation of community schools in Anchorage and the rest of the state.

	Name	Address
1	Kathryn J. Brandt	3432 Chelsea Rd,
2	Linda L. Wiederhoft	1900 W. 42nd Ave.
3	Howard Clay	[illegible] Dr.
4	John H. Hoole	4020 Hoodike Ave
5	Chris Judy	2535 Kinberg Circle
6	Kathie Chilcott	1605 Sprucewood Circle
7	Margaret Rader	5812 Box 73R
8	Bernard R. Johnson	5944 Lancaster Dr Anch AK
9	James A. Sandstedt	3307 Sonique Cir.
10	Karen B. Lee	2205 Kennedy Way
11	Gary Chilcott	1605 Sprucewood Circle
12	Michael Klaslus	5605 Shellie Ave
13	Betty Jackson	3953 James Dr. Anch. AK.
14	Murrell Fagg	4137 Jane Dr.
15	Sandra L. McHowan	5072 Bellaire Circle
16	Marilyn Chavez	5589 Sample Drive
17	Linda Kielhorn	3441 A Pineywillow
18	Diana J. Burgess	3324 Lee St #4
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PETITION

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	Name	Address
1	Clifford Hatch	4113 Chesa Dr.
2	Barbara Edwards	3010 Glacier
3	David Wm Ebb	5051 Bryn Mawr
4	Marie Deane	5420 Avila Ct
5	John Bagley	5512 Harlequin
6	Suzanne Bagley	5512 Harlequin Dr.
7	Myra Vaughn	5524 Fairmont Dr.
8	J A Vaughn	5524 Fairmont Dr.
9	L W Shaver	5420 Avila Ct.
10	E. H. Walters	2939 Glacier
11	Mary J Walters	2939 Glacier
12	Donald Bennett	2928 Sunflower
13	Wm. N. Gooby	5224 Emmanuel Ave., Anch., Ak.
14	Carol A. Bennett	2928 Sunflower
15	Lexie L Bagley	5524 Emmanuel Anchorage
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PETITION

We the undersigned members of Baxter Community School Association support the passage of House Bill 204 which provides for state grants to local community schools. We are convinced that HB 204 is critical to the continued operation of community schools in Anchorage and the rest of the state.

	Name	Address
1	Marian Hollingsworth	421 Baxter Circle Anch AK 99503
2	Margaret Wakefield	6441 Lucile St. Anch. 99504
3	Joaquin Thomas	6615 Nottingham Dr. Anch. 99504
4	Sherry Hallman	6416 E 35th Anchorage 99504
5	Barbara Buckman	1501 Oxford Anch 99503
6	Stephanie Stepp	3201 Upland Dr. Anch 99504
7	Lillian E Wells	3516 Edinburgh Lane Anch. 99504
8	Connie L Meadow	6321 Regent Dr. Anch 99504
9	GARRETT TATSUMI	2451 BENTZEN CIR ANCH 99503
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HB 204

STATE
of ALASKA

MEMORANDUM

TO: Honorable Thelma Buchholdt, Chairperson
H.E.S.S. Committee
Alaska State Legislature

DATE: March 20, 1979

FILE NO:

TELEPHONE NO:

Thru: William Thomson
Deputy Director
XXXX Department of Education

XXXXX

From: Joe Miguel, Supervisor
Community Education
Department of Education

Subject: Community Education Files

In order to avoid some areas of possible confusion when your committee reviews the Community Education files, I would like to bring the follcw-ing points to your attention:

1. When the districts apply for funds in early May of each year, they complete their budget sections utilizing the figure they would receive if they were fully funded.

   When the actual allocations are established, they are notified as to the pro-rated amount. They then complete a budget sheet re-flecting the correct amount.

   We have seen this as a duplication of effort. This year, the districts will only submit a budget sheet when they know the correct funding level.

   It is possible that more than one budget sheet will be found on the left hand side of the folders. The budget sheet which is signed off is the one which is currently being used.

2. It appears that the committee was interested in the travel section of the budgets. Please note that on the instructions to the review committee that they were asked to be very critical of large travel budgets.

3. When looking over the individual budget sheets please refer to the budget explanation section for a breakdown of each area of concern.

   The budget explanation section is usually following the budget line item sheet.

   If concerns are still voiced after reviewing the budget explanation section, it may be necessary to refer to the goals and objectives section of each individual grant.

4. The grant application process has been reviewed/evaluated by the department and individuals in the field. It was decided from this review to produce a new application form. This new form was sent to you with the Community Education files for FY79.

Please note that each of the items asked for on the new application form is an item from the Community Education regulations of the Law of 1975.

5. The piece of green shorthand notebook paper on the left hand side of the folder is meant to help keep me abreast of the payments that a district receives.

   The administrative assistant has a ledger of all Community Education grant payments which I check my records against and, of course, fiscal keeps the master sheets for both of us to check against. In this manner there are three sets of records to insure accuracy.

6. There should be a master review sheet on the left hand side of each folder. Please note that:

   a) The number of x's after pass/fail is not indicative of how strong or weak the application was.

   b) There is a difference between administrative support and community support.

   c) These are a compilation of comments made by the review committee members.

7. When reviewing the grant applications you will notice that there are approximately nine grants which are marked "fail."

   These (nine) grants are the ones that were not originally accepted by the review committee and were rewritten by the districts to correct the noted areas of deficiency.

   Once the areas of deficiency were corrected, the applications were approved and funded. Three other grant applications were not accepted, or corrected satisfactorily, and hence did not receive funding.

We hope these points clarify some questions you might have. If we can be of any assistance, please do not hesitate to contact us.

Name	Address	Organization	Bill No.
Blake Kazama	P.O. Box 808 Douglas, AK	Comm. Educ.	HB 204
Blanche Wilson	K-1 655 University Fairbanks	Coalition of Economic Justice	HB 125
John Coffee	Box 808, Douglas, AK.	Juneau Schools	HB 204
Elizabeth McKinnon	POUCH H 05	DHSS	HB125
Marie Kessler	8944 Blackberry, Anchorage	Coalition of Ec. Justice	HB 125
Cheryl Robinson	1545 South West ap 63 Anchorage 99504	Comm. Educ.	HB 204
Steve Hole	Pouch F	DOC	HB 54
Kim Ratz	DOE Pouch F Juneau	Comm ED.	HB 204
Joe Miguel	DOE	Com. ED.	HB 204

Name	Organization	Address	Bill No
Tony Ommer	Community Schools	428 W. 6th (6-6449)	HB-204
Joe Miguel	Dept. of Ed Program Community School Program	Pouch F Juneau	HB-204
Blake Kazama	Dir. of Comm. Educ. / Juneau	P.O. Box 808 Douglas, AK	HB-204
Conrad Hizon	D.O.E.	P. F	
Marilou Madden	Director, Division of Ed Program Support	Pouch F Juneau	HB 204

PLEASE SIGN IN

Community Education FY80

District	Amount Local Contribution	Amount State Support
Anchorage and Eagle River	$882,689.60	$256,646.00
Bristol Bay	7,084.00	10,246.00
Adak	9,739.00	20,396.00
Annette Island	Not Listed	8,576.00
Bering Straits	Not Listed	34,727.00
Copper River	Not Listed	19,361.00
Cordova	24,618.34	6,487.00
Craig	12,000.00	4,014.00
Delta Junction	6,000.00	30,903.00
Dillingham	Not Listed	12,169.00
Fairbanks	14,585.00	96,803 00
Haines	19,050.00	11,958.00
Hoonah	10,298.00	8,497.00
Juneau	Not Listed	71,274.00
Kake	13,728.00	4,861.00
Kenai	Not Listed	106,570.00
King Cove	1,952.00	5,251.00
Klawock	9,725.00	5,200.00
Kodiak	15,743.00	61,517.00
Lower Kuskokwim	19,767.00	72.982.00
Lower Yukon	61,060.00	35,758.00
Mat-Su	Not Listed	69,197.00
Nome	44,780.00	30,670.00
N.W. Arctic	Not Listed	63,916.00
Petersburg	Not Listed	10,602.00
Pribilof	16,657.00	8,380.00
Sitka	45,977.00	35,922.00
Skagway	12,206.00	6,322.00
Southwest Region	Not Listed	40,755.00
St. Mary	Not Listed	4,442.00
Valdez	40,870.00	26,445.00
Yakutat	16,040.00	6,623.00
Yukon Flats	26,030.00	18,930.00
Iditarod	188,000.00	20,564.00
Totals	$1,484,013.94	$1,226,964.00

Community Education

FY'79

District	Local Contribution	State Support
Anchorage/Eagle River	$978,646.00	$256,646.00
Adak	Not Listed	17,932.00
Annette Islands	Not Listed	7,015.00
Bering Straits	8,100.00	26,885.00
Bristol Bay	Not Listed	9,790.00
Chatham Straits	5,720.00	5,567.00
Copper River	Not Listed	14,227.00
Cordova	25,025.00	3,536.00
Craig	12,249.20	2,992.00
Delta Junction	5,000.00	21,226.00
Dillingham	Not Listed	12,169.00
Fairbanks	11,481	96,803.00
Haines	Not Listed	13,408.00
Hoonah	1,773.00	8,072.00
Juneau	Not Listed under total	46,583.00
Kake	7,935.00	4,764.00
Kenai	Not Listed	101,114.00
King Cove	2,390.00	6,701.00
Klawock	3,250.00	5,200.00
Kodiak	25,145.00	43,964.00
Lake & Peninsula	Not Listed	27,376.00
Lower Kuskokwim	19,767.00	38,130.00
Lower Yukon	Not Listed	10,722.00
Mat-Su	Not Listed	53,666.00
Nome	37,427.00	23,093.00
North Slope Borough	14,521.00	41,607.00
N.W. Arctic	Not Listed	39,794.00
Petersburg	Not Listed	7,090.00
Pribilof	16,126.00	5,670.00
Sitka	Not listed	30,232.00
Skagway	3,000.00	3,097.00
Southwest Region	Not Listed	30,887.00
Valdez	97,938.00	21,050.00
Yakutat	5,227.00	5,227.00
Yukon Flats	16,450.00	12,382.00
Iditarod	Not Listed	12,557.00
Totals	$1,397,170.20	$1,067,174.00

Funding pattern under H.B. 394 relating to Community Schools

	FY'79 Allocation .51	FY'80 Governor's Budget .435	Full FY'80
Adak	$ 16,482	$ 18,745	$ 43,091
Railbelt	-0-	4,165	9,574
Aleutian	-0-	-0-	-0-
Gateway	-0-	-0-	-0-
Annette-Metlakatla	5,565	7,381	16,967
Bering Straits	26,885	30,575	70,287
Chattam	5,567	7,122	16,372
Chugach	-0-	-0-	-0-
Copper River	14,227	18,202	41,844
Delta Greely	21,226	24,139	55,491
Iditarod	12,557	16,066	39,933
Kuspuk	-0-	16,128	37,076
Lake & Peninsula	27,376	31,133	71,571
Lower Kuskokwim	38,130	48,784	112,148
Lower Yukon	9,272	20,044	46,078
Northwest Arctic	39,794	50,513	117,041
Pribilof	5,670	7,254	16,677
Southeast	-0-	-0-	-0-
Southwest	29,437	33,478	76,961
Yukon Flats	10,932	13,987	32,154
Yukon Koyukuk	21,592	27,625	63,505
Anchorage	256,647	218,904	503,227
Bristol Bay	8,340	9,485	21,804
Cordova	3,536	6,031	13,864
Craig	2,992	3,828	8,799

	FY'79 Allocation .51	FY'80 Governor's Budget .435	Full FY'80
Dillingham	12,169	13,839	31,814
Fairbanks	96,083	110,089	253,079
Galena	-0-	-0-	-0-
Haines	11,958	10,200	23,448
Hoonah	6,622	7,531	17,312
Hydaburg	2,683	3,433	7,891
Juneau	46,583	52,977	121,786
Kake	3,314	4,241	9,749
Kenai	106,570	90,898	208,967
Ketchikan	-0-	-0-	-0-
King Cove	5,251	8,585	19,730
Klawock	-0-	2,501	5,011
Kodiak	43,964	45,998	114,937
Matunuska-Susitna	53,666	61,031	140,302
Nenana	-0-	-0-	-0-
Nome	21,643	24,614	56,584
North Slope	41,607	47,318	108,777
Pelican	-0-	-0-	-0-
Petersburg	7,094	9,076	20,864
Sitka	28,782	32,733	75,248
Skagway	3,097	3,962	9,108
St. Mary's	-0-	-0-	-0-
Unalaska	-0-	-0-	-0-
Valdez	19,600	22,308	51,282
Wrangell	-0-	-0-	-0-
Yakutat	5,227	5,945	13,666
Totals	$1,096,033	$1,170,866	$2,704,319

#1

District/REAA	FY81 1%	FY81 2%
District		
Anchorage	$616,099	$1,232,199
Bristol Bay	10,185	20,370
Cordova	14,878	29,756
Craig	5,826	11,651
Dillingham	16,672	33,345
Fairbanks	191,637	383,274
Galena	8,880	17,760
Haines	13,059	26,117
Hoonah	7,834	15,668
Hydaburg	4,125	8,250
Juneau	87,538	175,077
Kake	7,223	14,446
Kenai	126,656	253,312
Ketchikan	53,405	106,809
King Cove	6,182	12,364
Klawock	2,751	5,502
Kodiak	69,228	138,455
Mat-Su	99,588	199,177
Nenana	8,398	16,796
Nome	31,955	63,911
North Slope	67,147	134,293
Pelican	2,110	4,221
Petersburg	14,466	28,932
Sand Point	6,699	13,398
Sitka	38,832	77,664
Skagway	6,071	12,141
St. Mary's	7,894	15,788
Unalaska	7,049	14,099
Valdez	25,621	51,242
Wrangell	12,788	25,576
Yakutat	6,835	13,669
REAA		
Adak	22,733	45,466
Alaska Gateway	25,638	51,276
Aleutian	17,156	34,313
Annette	13,052	26,103
Bering Strait	38,774	77,548
Chatham	10,534	21,068
Chugach	3,460	6,920
Copper River	27,542	55,084
Delta/Greely	33,674	67,349
Iditarod	28,286	56,572
Kuspuk	34,109	68,217
Lake and Peninsula	38,672	77,344
Lower Kuskokwim	110,394	220,789
Lower Yukon	65,100	130,200
Northwest Arctic	89,585	179,169
Pribilof	11,684	23,369
Railbelt	19,336	38,671
Southeast Island	26,196	52,393
Southwest Region	38,112	76,224
Yukon Flats	30,413	60,826
Yukon Koyukuk	46,246	92,491
Totals	$2,308,327	$4,616,654

#2

District	1% Found. Support	Found. Support OR $10,00 Floor	1% Local Match	1% State Match
Anchorage	$616,099	$616,099	$616,099	$616,099
Bristol Bay	10,185	10,185	10,185	10,185
Cordova	14,878	14,878	14,878	14,878
Craig	5,826	10,000	10,000	10,000
Dillingham	16,672	16,672	16,672	16,672
Fairbanks	191,637	191,637	191,637	191,637
Galena	8,880	10,000	10,000	10,000
Haines	13,059	13,059	13,059	13,059
Hoonah	7,834	10,000	10,000	10,000
Hydaburg	4,125	10,000	10,000	10,000
Juneau	87,538	87,538	87,538	87,538
Kake	7,223	10,000	10,000	10,000
Kenai	126,656	126,656	126,656	126,656
Ketchikan	53,405	53,405	53,405	53,405
King Cove	6,182	10,000	10,000	10,000
Klawock	2,751	10,000	10,000	10,000
Kodiak	69,228	69,228	69,228	69,228
Mat-Su	99,588	99,588	99,588	99,588
Nenana	8,398	10,000	10,000	10,000
Nome	31,955	31,955	31,955	31,955
North Slope	67,147	67,147	67,147	67,147
Pelican	2,110	10,000	10,000	10,000
Petersburg	14,466	14,466	14,446	14,446
Sand Point	6,699	10,000	10,000	10,000
Sitka	38,832	38,832	38,832	38,832
Skagway	6,071	10,000	10,000	10,000
St. Mary's	7,894	10,000	10,000	10,000
Unalaska	7,049	10,000	10,000	10,000
Valdez	25,621	25,621	25,621	25,621
Wrangell	12,788	12,788	12,788	12,788
Yakutat	6,835	10,000	10,000	10,000
REAA				
Adak	22,733	22,733	22,733	22,733
Alaska Gateway	25,638	25,638	25,638	25,638
Aleutian	17,156	17,156	17,156	17,156
Annette	13,052	13,052	13,052	13,052
Bering Strait	38,774	38,774	38,774	38,774
Chatham	10,534	10,534	10,534	10,534
Chugach	3,460	10,000	10,000	10,000
Copper River	27,542	27,542	27,542	27,542
Delta/Greely	33,674	33,674	33,674	33,674
Iditarod	28,286	28,286	28,286	28,286
Kuspuk	34,109	34,109	34,109	34,109
Lake and Peninsula	38,672	38,672	38,672	38,672
Lower Kuskokwim	110,394	110,394	110,394	110,394
Lower Yukon	65,100	65,100	65,100	65,100
Northwest Arctic	89,585	89,585	89,585	89,585
Pribilof	11,684	11,684	11,684	11,684
Railbelt	19,336	19,336	19,336	19,336
Southeast Island	26,196	26,196	26,196	26,196
Southwest Region	38,112	38,112	38,112	38,112
Yukon Flats	30,413	30,413	30,413	30,413
Yukon Koyukuk	46,246	46,246	46,246	46,246
Total	$2,308,327	$2,366,990	$2,366,990	$2,366,990

ALASKA COMMUNITY INVOLVEMENT
IN COMMUNITY EDUCATION
FY79

ty	School System	Total No. Of Schools In System	No. of School Designated Community Schools			Citizen Involvement		Total
			Elementary	Secondary	TOTALS	Youth	Adult	Involveme
Anchorage	Anchorage School System	66	20	1	21	9,761	9,051	18,812
Metlakatla	Annette Island City Schools	2	1	1	2	149	117	266
Agnoon	Chatham Schools	4	----------4----------		4	did not submit final report		
Glennallen	Copper River Schools	5	----------5----------		5	372	286	658
Delta Jun.	Delta/Greely Schools	3	2	1	3	191	197	388
Haines	Haines Borough Schools	2	1	1	2	did not submit final report		
Kake	Kake City Schools	2	1	1	2	226	75	301
King Cove	King Cove City Schools	2	1	1	2	did not submit final report		
Kodiak	Kodiak Island Borough Schools	13	8	2	10	603	870	1,473
0. Bethel	Lower Kuskokwim Schools	10	---------8----------		8	798	1,015	1,813
1. Palmer	Matanuska/Susitna Borough Schools	11	8	3	11	2,741	3,472	6,213
2. Nome	Nome City Schools	2	1	1	2	610	777	1,387
3. Petersburg	Petersburg City Schools	2	1	1	2	submitted narrative only		
4. St. Paul Is.	Pribilof Schools	2	1	1	2	submitted narrative only		
5. Sitka	Sitka Borough Schools	10	4	2	6	410	445	855
6. Skagway	Skagway City Schools	1	---------1----------		1	107	135	242
7. Dillingham	Southwest Region Schools	11	---------7----------		7	443	294	737
8. Valdez	Valdez City Schools	4	2	2	4	126	250	376

ALASKAN COMMUNITY INVOLVEMENT IN COMMUNITY EDUCATION FY79

ity	School System	Total No. Of Schools In System	No. of Schools Designated Community Schools			Citizen Involvement		Total Involvement
			Elementary	Secondary	TOTALS	Youth	Adult	
. Fairbanks	Northstar Borough Schools	28	5	2	7	Did not submit final report		
. McGrath	Iditarod Area Schools	9	--------9----------		9	Did not submit final report		
. Juneau	Juneau Borough School District	9	5	2	7	2,434	5,419	7,853
. Soldotna	Kenai Peninsula Borg. Schools	26	9	8	17	626	3,770	4,396
. Kotzebue	Northwest Arctic School Dist.	12	--------7------	-	7	Submitted narrative only		
. Dillingham	Dillingham City Schools	1	--------1----------		1	Did not submit final report		
dak	Adak Region Schools	2	1	1	2	Submitted narrative only		
. Naknek	Bristol Bay Borough Schools	3	2	1	3	78	163	241
. Craig	Criag City Schools	2	1	1	2	65	175	240
. Hoonah	Hoonah City Schools	2	1	1	2	Submitted narrative only		
. Naknek	Lake and Peninsula	12	-------10----------		10	Did not submit final report		
. Barrow	North Slope Borough Schools	7	--------5----------		5	Submitted narrative only		
. Ft. Yukon	Yukon Flats Schools	8	--------1----------		1	Did not submit final report		
. Yakutat	Yakutat City Schools	2	1	1	2	100	113	213
. Cordova	Cordova City Schools	2	1	1	2	494	308	802
. Klawock	Klawock City Schools	1	--------1----------		1	140	62	202
			20 Districts submitting statistics		TOTALS	20,474	26,994	47,468

Total involvement on these sheets are a one-time registration of each participant, however, many participants are involved in more that one class so that this figure does not ascertain the level of involvement for each individual.

District/REAA	FY 80 Actual .43	FY80 Full	FY81 Gov. App. 266+	FY81 Full 2%
District				
Anchorage	$256,646	$458,530	$328,264	$1,232,199
Bristol Bay	10,246	22,336	5,427	20,370
Cordova	6,487	14,141	7,927	29,756
Craig	4,014	8,749	3,104	11,651
Dillingham	12,169	20,885	8,883	33,345
Fairbanks	96,803	74,909	102,106	383,274
Galena	0	0	4,731	17,760
Haines	11,958	25,384	6,958	26,117
Hoonah	8,497	18,523	4,174	15,668
Hydaburg	0	0	2,198	8,250
Juneau	71,274	155,367	46,641	175,077
Kake	4,861	10,834	3,849	14,446
Kenai	106,570	106,242	67,484	253,312
Ketchikan	0	0	28,454	106,809
King Cove	5,251	13,301	3,294	12,364
Klawok	5,200	5,502	1,466	5,502
Kodiak	61,517	134,097	36,885	138,455
Mat-Su	69,197	150,839	53,062	199,177
Nenana	0	0	4,475	16,796
Nome	30,670	66,856	17,026	63,911
North Slope	0	0	35,776	134,293
Pelican	0	0	1,125	4,221
Petersburg	10,602	23,112	7,708	28,932
Sand Point	0	0	3,559	13,398
Sitka	35,922	78,303	20,690	77,664
Skagway	6,322	13,781	3,234	12,141
St. Mary's	1,811	3,948	4,206	15,788
Unalaska	0	0	3,756	14,099
Valdez	26,445	57,647	13,651	51,242
Wrangell	0	0	6,814	25,576
Yakutat	6,623	14,438	3,641	13,669
REAA				
Adak	20,396	44,460	12,112	45,466
Alaska Gateway	0	0	13,660	51,276
Aleutian	0	0	9,141	34,313
Annette	8,576	18,695	6,954	26,103
Bering Strait	34,727	75,698	20,659	77,548
Chatham	5,567	4,988	5,613	21,068
Chugach	0	0	1,844	6,920
Copper River	19,361	42,204	14,675	55,084
Delta/Greely	30,903	67,365	17,942	67,349
Iditarod	20,564	44,825	15,071	56,572
Kuspuk	0	0	18,173	68,217
Lake and Peninsula	0	0	20,605	77,344
Lower Kuskokwim	72,982	159,091	58,819	220,789
Lower Yukon	35,758	77,946	34,686	130,200
Northwest Arctic	63,916	139,327	47,732	179,169
Pribilof	8,380	18,266	6,226	23,369
Railbelt	0	0	10,302	38,671
Southeast Island	0	0	13,958	52,393
Southwest Region	40,755	88,838	20,306	76,224
Yukon Flats	18,930	41,265	16,204	60,826
Yukon Koyukuk	0	0	24,640	92,491
Totals	$1,229,900	$2,300,692	$1,229,900	$4,616,654

District/REAA	FY79 State Grant	# of Participant	Cost/Participant
District			
Anchorage	$256,646	18,812	$13.64
Bristol Bay	8,340	241	34.60
Cordova	3,533	802	4.40
Craig	2,992	240	12.46
Dillingham	12,169	Figures not available	Figures not avail.
Fairbanks	96,803	Figures not available	Figures not avail.
Haines	11,958	967	12.36
Hoonah	6,622	Narrative report	Narrative report
Juneau	46,583	7,853	5.93
Kake	3,314	301	11.00
Kenai	106,570	4,396	24.24
King Cove	5,251	Figures not available	Figures not avail.
Klawok	5,200	202	25,74
Kodiak	43,964	1,473	29.84
Mat-Su	53,666	6,213	8.47
Nome	21,643	1,387	15.60
North Slope	41,607	Narrative Report	Narrative Report
Petersburg	7,094	Narrative Report	Narrative Report
Sitka	28,782	855	33.66
Skagway	3,097	242	12.79
Valdez	19,600	376	52.12
Yakatat	5,227	213	24.53
REAA			
Adak	16,482	Figures not available	Figures not avail.
Annette Island	5,565	266	20.92
Bering Strait	26,885	Narrative Report	Narrative Report
Chatham	5,567	Figures not available	Figures not avail.
Cooper River	14,227	658	21,62
Delta/Greely	21,226	388	54.70
Iditarod	12,557	Figures not available	Figures not avail.
Lake and Peninsula	27,376	Figures not available	Figures not avail.
Lower Kuskokwim	38,130	1,813	21,03
Lower Yukon	9,272	183	50.66
Northwest Arctic	39,794	Figures not available	Figures not avail.
Pribilof	5,670	Narrative Report	Narrative Report
Southwest Region	29,437	737	39.94
Yukon Flats	10,932	Figures not available	Figures not avail.
Total	$1,087,979	48,618	$ 22.37

STATE
of ALASKA

MEMORANDUM

TO: The Honorable Thelma Buchholdt,
Chairperson
Health, Education and Social Services
Committee
House of Representatives
Alaska State Legislature

DATE: March 15, 1979

FILE NO:

TELEPHONE NO:

SUBJECT: FY'79 Community Education Grant Folders

XXXX

Thru: Marshall L. Lind, Commissioner
Department of Education

From: Joe Miguel, Supervisor
Community Education
Division of Educational Program Support
Department of Education

In accordance with the request of the H.E.S.S. Committee, I am forwarding to you the FY'79 Community Education operational grant folders for your perusal. As each folder is opened, you will notice the review sheets of the grant review committee on the left hand side, immediately followed by a letter of acceptance or rejection to the district. The review sheets objectively state the strengths and weaknesses of each grant request as they were reviewed by the committee of practitioners.

Also, on the left hand side are the actual grant applications, encumbrance sheets and report and records of local expenditures. It is important to note that the budget sheets need to be correlated with the budget explanation and the goals and objectives of the grant. The budget line item sheets do not give a true picture of why the monies are placed in each category.

When the Community Schools Act of 1975 was passed, there were no provisions for the handling of local education agency grants other than the procedures which were outlined by the Department of Education. In FY'78 the grant process was finalized and a yearly grant review committee was established. I have attached a list of the past review committee members for your perusal (attachment 1).

During FY'79 the actual grant application has been revised into a concise packet (attachment 2). The grant review committee will be chosen by April 1, and will review the grant applications for FY'80 on May 15 and 16.

Attachment

JM:vaw

4 AAC 05.070. PROGRAM PLANNING AND EVALUATION. (a) The chief school administrator of a school district shall develop and have approved by the governing body of that district, annually and no later than that body's first meeting in October, an education plan for each of the three years of operation after the effective date of this section: (i) for each school established under section 40 of this chapter, and (ii) for each school or partial program established on or after the commencement of the 1976-77 school year in communities not having a preexisting school or partial program of the same grades.

(b) An educational plan shall include as a minimum the following:

(1) A description of the process used by the school to secure community participation in program development and evaluation;

(2) A statement of philosophy and goals of the school;

(3) The program goals for each subject area;

(4) A description of each course or subject area, which shall include the following information:

(i) Course or subject area title;
(ii) Credit toward graduation awarded upon completion;
(iii) Whether course or subject area is required or elective;
(iv) General outline of topics to be covered;
(v) General description of types of teaching materials and instructional methods;
(vi) certificate type of instructor or supervisor;

(5) The number of instructional personnel of the school (including part-time);

(6) The operational budget for the school;

(7) The projected enrollment, by grade;

(8) The planned ~~term~~ time schedule for courses to be offered; and

(9) Such other information as the commissioner may from time-to-time require.

(c) As near as practicable to the close of each school year for which an educational plan must be developed under (a) of this section, but no later than the governing body's last meeting in the fiscal year, the chief school administrator shall prepare and submit to the governing body of the school district an evaluation of each new school operated by the district.

(d) The evaluation shall include a survey of parents in the community and students and teachers at the school, who shall be asked, at a minimum, whether they believe the school program as a whole is performing adequately, and whether they have suggestions for improving the school. All comments received shall accompany the evaluation. The evaluation shall specify each aspect of the school program which differed from the plan for the period evaluated and shall include such other information as the commissioner may from time-to-time require.

(e) The chief school administrator shall assure maximum ongoing local community participation in the development and preparation of each educational plan and evaluation required by this section. The chief school administrator or his/her designee shall involve local citizens (including members of the local school committee and students) during the initial drafting of the educational plan and evaluation. Local citizens shall be provided access to adequate information and materials to enable them to participate in the development of the plan and evaluation.

The chief school administrator or his/her designee shall conduct in the local community a public meeting on the draft plan for the school in that community after reasonable notice of the meeting has been given. The chief school administrator shall prepare the final plan taking into account the evaluation required by this section and the record of the public meeting. The chief school administrator shall submit a report to the governing body explaining any significant changes made in the draft plan, shall notify the local school committee of any such changes, and shall afford members of the community the opportunity to be heard by the governing body on the final plan.

(f) A copy of each plan and evaluation developed under this section must be maintained on file for public inspection in the school district office. No later than ten (10) days after (i) an educational plan has been approved by the governing body of the district, or (ii) an evaluation has been submitted to the governing body of the district, a copy of such plan or evaluation must be filed with the commissioner, Pouch F, Juneau, Alaska 99811 and furnished to the local school committee of the community to which the plan or evaluation relates.

(g) A school shall be operated to the extent practicable in conformity with the educational plan, provided that where significant departures from the plan appear to be necessary the plan may be modified during the school year in accordance with the procedures set forth in subsection (e).

(h) The commissioner will return incomplete or inadequate plans under this section to the chief school administrator for further development. After November 15, following adoption of this section, no public school foundation monies available under AS 14.17 will be distributed to a school district having a school for which a plan must be developed under (a) of this section if the school district is in material non-compliance with this section. "Material non-compliance" includes, but is not limited to, failure by the district to submit an educational plan which meets the criteria set forth in this section for each school for which a plan must be developed under subsection (a); failure to submit an evaluation; and failure to involve the local community in the development of the plan and evaluation.

(i) The chief school administrator may apply to the commissioner to shorten the period for compliance set forth in (a) of this section by one, two, or three years with respect to each school, upon a showing that the district has previously developed with local community participation as set forth in (e) of this section, an educational plan which meets the criteria in (b) of this section; has implemented such plan in the school; and has conducted with local community participation as set forth in (e) of this section an evaluation which meets the requirements in (d) of this section.

STATE
of ALASKA

MEMORANDUM

TO: Thelma Buchholdt, Chairperson
House Health Education and Social Services

DATE: March 5, 1979

FILE NO:

Through: Bill Thomson, Deputy Commissioner
Department of Education

TELEPHONE NO:

FROM: Wanda J. Cooksey, Administrator
Correspondence Study

SUBJECT:

Following is the information you requested regarding Correspondence Study.

School Districts with C/S Programs in FY 79	Number of Students in Local C/S Programs	Number of Districts' Students in CC/S
Alaska Gateway	54	12
Bering Straits	8	0
Cooper River	81	5
Delta/Greely	35	1
Fairbanks	157	37
Iditarod	9	9
Juneau	9	16
Kenai	105	35
Ketchikan	76	2
Kodiak	27	1
Lake and Peninsula	11	2
Matanuska/Susitna	202	35
North Slope	5	2
Northwest Arctic	7	3
Sitka	11	8
Southeast Islands	76	22
Southwest Region	16	5
Yukon Flats	37	9
Yukon Kaykuk	81	4
Total	1,077	208

Alaska State Legislature

House of Representatives

Committee on

Health, Education & Social Services

Official Business

Pouch V
State Capitol
Juneau, Alaska 99811

March 5, 1979

Ms. Lou Ann Gagne
400 W. 11th, Apt. 16
Anchorage, Alaska 99501

Dear Ms. Gagne:

This is in response to your recent telegram in which you expressed concern regarding HB-204.

The House HESS Committee did hold a hearing on the bill on February 23, 1979. At that time, Representative Buchholdt was called out of town on a family emergency, so was not present for our hearing.

HB-204 will be heard again in this committee. When it was heard, we received excellent testimony in support of the bill. There were question raised though, by committee members, as to the original intent of establishing community schools in 1975. Several committee members expressed their continued support for community schools, but until such time as we can reschedule the bill, we are holding it in committee.

Again, thank you for writing to let us know of your support.

Sincerely,

Cynthia L. Hill

Cynthia L. Hill
for THELMA BUCHHOLDT

LA11 2673 16.01 JA01 0048 16.10 02/27/79

TO REPS. BUCHHOLDT, MUNSON, HURLBERT, MILES, BARNES, BEIRNE, CHATTERTON, MEEKINS, AND PARKER

FROM: LOU ANN GAGNE, 400 W. 11TH, APT. 16, ANCHORAGE 99501 273-2561

I WOULD LIKE TO URGE YOU TO RECONSIDER THE KILLING OF HB 204 WHICH DEALS WITH COMMUNITY EDUCATION. THE ABSENCE OF THIS PROGRAM WILL BE DEEPLY FELT AND THE IMPACT TO STUDENTS PRESENT AND POTENTIAL CANNOT BE ADEQUATELY DETERMINED WITHOUT FURTHER INPUT. PLEASE RECONSIDER.

CD EOM/

CHUGIAK-EAGLE RIVER COMMUNITY SCHOOLS
Post Office Box [illegible] / Chugiak, Alaska 99567

February 22, 1979

Randy Phillips
House of Representatives
Pouch V
Juneau, Alaska 99811

Dear Randy,

As members of the Chugiak/Eagle River Community School Association and as private citizens, we would like to express our thanks for your thoughtfulness in sending us information concerning HB 204.

In our opinion HB 204 would solve a great many inequities found in the communities in bush Alaska. For too long these communities have not had the financial resources necessary for Community Education.

We are generally pleased with this proposed legislation (HB 204). Since our operation is 100% State funded, any legislation would have to be, in our opinion, fair, responsive and viable. It must be noted that while being funded 100% by State money we have had and continue to have the largest volunteer program in the Anchorage Bowl or the Mat/Su Valley area.

There are however certain additions we would like to see made (Our additions are double underlined).

* Sec 2. AS 14.36.030 Grants
  (b) For fiscal years beginning after June 30, 1980, and succeeding years, those districts which elect to a grant of one half of one percent of their total public school foundation support may receive.....

We would like the legislation to be explicit concerning future funding.

AND

* Sec 3. AS 14.36.040 Community Schools Program Application For Grants
  Under regulations adopted by the State Board of Education, a school district (local attendance), or service areas presently designated Community School by the Commissioner may submit to the Commissioner (through the school district) an application for a Community School grant....

Original sponsor:

(((must be on all CS's)))

BY PHILLIPS

IN THE HOUSE ~~SENATE~~

HOUSE BILL NO.

IN THE LEGISLATURE OF THE STATE OF ALASKA

Second ~~THIRTY-FIRST~~ LEGISLATURE - First ~~SECOND~~ SESSION

A BILL

For an Act entitled: " An Act relating to grants for community schools programs; and providing for an effective date."

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

* Section 1. AS 14.36.030 is amended to read:

Sec. 14.36.030. GRANTS. A district operating an approved community school program may receive a first-year grant up to one-half of one per cent of its public school foundation support, a second-year grant of up to one per cent of that support, a third-year grant of up to one and one-half per cent of that support, and a [FOURTH-YEAR] grant during the fourth and subsequent years of up to two per cent of that support. The support provided shall be in the proportion that the number of schools in each district that are operated as community schools is to the total number of schools in the district.

* Sec. 2. This Act takes effect July 1, 1979.

Alaska State Legislature

House of Representatives

Committee on

Health, Education & Social Services

Official Business

Pouch V
State Capitol
Juneau, Alaska 99811

March 1, 1979

Ms. Rebecca Graham
629 W. 9th Avenue
Anchorage, Alaska 99501

Dear Ms. Graham:

This is in response to our recent telegram in which you expressed concern regarding HB204.

The House HESS Committee did hold a hearing on the bill on February 23, 1979. At that time, Representative Buchholdt was called out of town on a family emergency, so was not present for our hearing.

HB204 will be heard again in this committee. When it was heard, we received excellent testimony in support of the bill. There were question raised though, by committee members, as to the original intent of establishing community schools in 1975. Several committee members expressed their continued support for community schools, but until such time as we can reschedule the bill, we are holding it in committee.

Again, thank you for writing to let us know of your support.

Sincerely,

Cynthia L. Hill

Cynthia L. Hill
for THELMA BUCHHOLDT
House HESS Committee

LA11 2092 14.22 JA01 0034 14.22 02/27/79

TO REP BUCHHOLDT, CHAIRPERSON, H. HESS COMMITTEE
AND ALL COMMITTEE MEMBERS

TO REPS. MEEKINS AND PARKER

FROM REBECCA GRAHAM
629 N 9TH AVE
ANCH., AK 99501
TEL: 278-9934

"I WOULD LIKE TO EXPRESS SUPPORT FOR HB 204 (COMMUNITY SCHOOLS) AND I ASK THAT H. HESS RECONSIDER THEIR DECISION.

COMMUNITY EDUCATION IS AN IMPORTANT PART OF LIFE IN ANCHORAGE AND ONE THAT WOULD BE SORELY MISSED. TO DISCONTINUE THIS PROGRAM AT THIS TIME WOULD BE A MISTAKE." S/ REBECCA GRAHAM EOM

hb 204

February 13, 1979

The Honorable Terry Gardiner
Speaker of the House
Alaska State Legislature
Juneau, Alaska 99811

Dear Mr. Speaker:

Under the authority of art. III, sec. 18 of the Alaska Constitution, I am transmitting a bill relating to community schools. The bill would make a number of changes in AS 14.36 which deals with the community school program. Most of the proposed changes (secs. 1, 3, 4, 5, and 6) are relatively minor in nature and are designed to clarify or streamline the existing statutory program.

Section 2 of the bill proposes a new approach to state funding of community school programs by repealing and re-enacting AS 14.36.030 which deals with state grants for those programs. Under the proposed changes, a district could elect to receive either one-half of one per cent of its public school foundation support for the year or $10,000, effective with the beginning of FY 80. Additionally, districts electing the one-half of one per cent grant could also receive, effective with the beginning of FY 81, up to an additional one-half of one per cent on a dollar-for-dollar matching basis with funds allocated to the community school program by the district.

Sincerely,

5/JSH

Jay S. Hammond
Governor

THE LEGISLATURE OF THE STATE OF ALASKA
ELEVENTH LEGISLATURE

FISCAL NOTE

I. REQUEST — HOUSE BILL NO. 204

Bill/Resolution No. Attorney General File: J-77-136-79

Title Revised Bill Relating to Community Schools

Requested by Office of the Governor Date 2-13-79

II. FISCAL DETAIL

Agency Affected Education

Program Category Affected Foundation Support Programs

Budget Request Unit(s) Affected Community Schools

EXPENDITURES (Thousands of Dollars)

		FY 79	FY 80	FY 81	FY 82	FY 83	FY 84
100	PERSONAL SERVICES						
200	TRAVEL						
300	CONTRACTUAL						
400	COMMODITIES						
500	EQUIPMENT						
600	LAND & STRUCTURES						
700	GRANTS, CLAIMS, ETC.		24.0	1,481.8*	1,570.7*	1,664.9*	1,764.8*
	TOTAL						

FUNDING (Thousands of Dollars)

GENERAL FUND		24.0	1,481.8	1,570.7	1,664.9	1,764.8
FEDERAL FUNDS						
OTHER (Specify)						

POSITIONS

FULL TIME		-0-	-0-	-0-	-0-	-0-
PART TIME						
TEMPORARY						

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

See attached table.

FY 80 cost reflects establishment of 10.0 floor contained in AS 14.36.030(a) of proposed bill; for FY 81 and thereafter costs reflect 1/2 of 1% match provision contained in subsection (b) of AS 14.36.030.

* Assumes 6% inflation beginning in 1981

IV. DATE February 13, 1979 PREPARED BY William O. Thomson

AGENCY Education

PHONE 465-2802

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)

(Rev. 10/78)

District	FY'79 Allocation	FY'80 1/2 of 1% or Floor of $10,000	Difference Between FY'79 and New Legislation	Under This Bill 1/2 or 1% or Floor of 10,000 in FY'81	Under This Bill State Match FY'81	FY'81 Total State Monies
Yukon Flats	$ 10,932	$ 10,827	$ 105 (-)	$ 14,490	$ 14,490	$ 28,980
Yukon Koyukuk	21,592	21,383	209 (-)	23,319	23,319	46,638
Anchorage	256,646	304,907	48,261	354,570	354,570	709,140
Bristol Bay	8,340	10,000	1,660	5,544	5,544	11,088
Cordova	3,536	10,000	6,464	7,562	7,562	15,124
Craig	2,992	10,000	7,008	10,000	-0-	10,000
Dillingham	12,169	10,000	2,169 (-)	8,663	8,663	17,326
Fairbanks	96,083	90,096	5,987 (-)	105,724	105,724	211,448
Galena	-0-	10,000	10,000	9,021	9,021	18,042
Haines	11,958	10,000	1,958 (-)	6,677	6,677	13,354
Hoonah	6,622	10,000	3,378	5,212	5,212	10,424
Hydaburg	2,683	10,000	7,317	10,000	-0-	10,000
Juneau	46,583	42,075	4,058 (-)	49,691	49,691	99,382
Kake	3,314	10,000	6,686	10,000	-0-	10,000
Kenai	106,570	67,293	39,277	76,938	76,938	153,876
Ketchikan	-0-	25,092	25,092	29,136	29,136	58,272
King Cove	5,251	10,000	4,749	10,000	-0-	10,000
Klawock	-0-	10,000	10,000	10,000	-0-	10,000
Kodiak	43,964	29,025	14,939 (-)	37,674	37,674	75,348
Matanuska-Susitna	53,666	43,587	10,079 (-)	55,313	55,313	110,626

District	FY'79 Allocation	FY'80 1/2 of 1% or Floor of $10,000	Difference Between FY'79 and New Legislation	Under This Bill: 1/2 or 1% or Floor of 10,000 in FY'81	Under This Bill: State Match FY'81	FY'81 Total State Monies
Adak	$ 16,482	$ 10,882	$ 5,600 (-)	$ 10,651	$ 10,651	$ 21,302
Railbelt	- 0 -	10,000	10,000	10,125	10,125	20,250
Aleutian	- 0 -	10,918	10,918	12,105	12,105	24,210
Gateway	- 0 -	10,000	10,000	12,896	12,896	25,792
Annette Metlakatla	5,565	10,000	4,435	5,919	5,919	11,838
Bering Straits	26,885	17,750	9,135 (-)	19,902	19,902	39,804
Chatham	5,567	10,000	4,433	10,000	- 0 -	10,000
Chugach	- 0 -	10,000	10,000	10,000	- 0 -	10,000
Copper River	14,227	14,089	138 (-)	13,517	13,517	27,034
Delta Greely	21,226	14,013	7,213 (-)	16,071	16,071	32,142
Iditarod	12,557	12,436	121 (-)	15,921	15,921	31,842
Kuspuk	12,606	12,484	122 (-)	19,353	19,353	38,706
Lake and Peninsula	27,376	18,074	9,302 (-)	20,755	20,755	41,510
Lower Kuskokwim	38,130	37,761	369 (-)	53,734	53,734	107,468
Lower Yukon	9,272	23,272	14,000	40,088	40,088	80,176
Northwest Arctic	39,794	39,408	386 (-)	47,195	47,195	94,390
Pribilof	5,670	10,000	4,330	6,328	6,328	12,656
Southeast	10,568	10,465	103 (-)	12,576	12,576	25,152
Southwest	29,437	19,435	10,002	23,598	23,598	47,196

District	FY'79 Allocation	FY'80 1/2 of 1% or Floor of $10,000	Difference Between FY'79 and New Legislation	Under This Bill: 1/2 or 1% or Floor of 10,000 in FY'81	Under This Bill: State Match FY'81	FY'81 Total State Monies
Nenana	$ -0-	$ 10,000	$ 10,000	$ 10,000	$ -0-	$ 10,000
Nome	21,643	14,289	7,354 (-)	18,333	18,333	36,666
North Slope	41,607	27,469	14,138 (-)	33,505	33,505	67,010
Pelican	-0-	10,000	10,000	10,000	-0-	10,000
Petersburg	7,094	10,000	2,906	8,334	8,334	16,668
Sitka	28,782	19,002	9,780 (-)	21,419	21,419	42,838
Skagway	3,097	10,000	6,903	10,000	-0-	10,000
St. Mary's	-0-	10,000	10,000	10,000	-0-	10,000
Unalaska	-0-	10,000	10,000	10,000	-0-	10,000
Valdez	19,600	12,940	6,660 (-)	14,486	14,486	28,972
Wrangell	-0-	10,000	10,000	7,087	7,087	14,174
Yakutat	5,227	10,000	4,773	10,000	-0-	10,000
TOTALS	$1,096,033	$1,198,972		$1,363,432	$1,233,432	$2,596,864

FY'80 Total for Proposed Legislation $1,198,972
FY'80 Governor's Appropriation 1,174,900
Need to fund Part I of Legislation $ 24,072

Total FY'81 Part I of Legislation $1,363,432
Total FY'81 Part II of Legislation 1,233,432
Combined total Parts I & II $2,596,864

ALASKA COMMUNITY INVOLVEMENT
IN COMMUNITY EDUCATION
FY79

ity	School System	Total No. Of Schools In System	No. of School Designated Community Schools			Citizen Involvement		Total Involvem
			Elementary	Secondary	TOTALS	Youth	Adult	
Anchorage	Anchorage School System	66	20	1	21	9,761	9,051	18,812
Metlakatla	Annette Island City Schools	2	1	1	2	149	117	266
Agnoon	Chatham Schools	4	----------4----------		4	did not submit final report		
Glennallen	Copper River Schools	5	----------5----------		5	372	286	658
Delta Jun.	Delta/Greely Schools	3	2	1	3	191	197	388
Haines	Haines Borough Schools	2	1	1	2	did not submit final report		
Kake	Kake City Schools	2	1	1	2	226	75	301
King Cove	King Cove City Schools	2	1	1	2	did not submit final report		
Kodiak	Kodiak Island Borough Schools	13	8	2	10	603	870	1,473
Bethel	Lower Kuskokwim Schools	10	---------8----------		8	798	1,015	1,813
Palmer	Matanuska/Susitna Borough Schools	11	8	3	11	2,741	3,472	6,213
Nome	Nome City Schools	2	1	1	2	610	777	1,387
Petersburg	Petersburg City Schools	2	1	1	2	submitted narrative only		
St. Paul Is.	Pribilof Schools	2	1	1	2	submitted narrative only		
Sitka	Sitka Borough Schools	10	4	2	6	410	445	855
Skagway	Skagway City Schools	1	---------1----------		1	107	135	242
Dillingham	Southwest Region Schools	11	---------7----------		7	443	294	737
Valdez	Valdez City Schools	4	2	2	4	126	250	376

ALASKAN COMMUNITY INVOLVEMENT
IN COMMUNITY EDUCATION
FY79

ty	School System	Total No. Of Schools In System	No. of Schools Designated Community Schools			Citizen Involvement		Total Involvement
			Elementary	Secondary	TOTALS	Youth	Adult	
. Fairbanks	Northstar Borough Schools	28	5	2	7		Did not submit final report	
. McGrath	Iditarod Area Schools	9	--------9----------		9		Did not submit final report	
. Juneau	Juneau Borough School District	9	5	2	7	2,434	5,419	7,853
. Soldotna	Kenai Peninsula Borg. Schools	26	9	8	17	626	3,770	4,396
. Kotzebue	Northwest Arctic School Dist.	12	--------7----------		7		Submitted narrative only	
. Dillingham	Dillingham City Schools	1	--------1----------		1		Did not submit final report	
. Adak	Adak Region Schools	2	1	1	2		Submitted narrative only	
. Naknek	Bristol Bay Borough Schools	3	2	1	3	78	163	241
. Craig	Criag City Schools	2	1	1	2	65	175	240
. Hoonah	Hoonah City Schools	2	1	1	2		Submitted narrative only	
. Naknek	Lake and Peninsula	12	-------10----------		10		Did not submit final report	
. Barrow	North Slope Borough Schools	7	--------5----------		5		Submitted narrative only	
. Ft. Yukon	Yukon Flats Schools	8	--------1----------		1		Did not submit final report	
. Yakutat	Yakutat City Schools	2	1	1	2	100	113	213
. Cordova	Cordova City Schools	2	1	1	2	494	308	802
. Klawock	Klawock City Schools	1	--------1----------		1	140	62	202
			20 Districts submitting statistics		TOTALS	20,474	26,994	47,468

Total involvement on these sheets are a one-time registration of each participant, however, many participants are involved in more that one class so that this figure does not ascertain the level of involvement for each individual.

Back up
179

Put in my
HB 304
file
Thanks
Thelma

March 12, 1979

Hon. Jay Hammond
Governor of Alaska

Dear Sir:

In support of HB204, I would request that you include an amendment to the bill as follows:

Implement part B of Section 14.36.030 in FY80.

This inclusion would provide eligibility for local districts to receive State matching funds in 1980.

Unless the proposed amendment is implemented, 23 Districts throughout the State would suffer a severe set-back in FY80 funding. To maintain the level of service and involvement Community Education must have full funding.

The Community of Sutton is fully in support of the Community Education process and to uphold the present level of programming such an amendment is necessary.

Sincerely,

Virginia Gallant

Virginia Gallant
P.O. Box 73
Sutton, Alaska 99674

cc:
Thelma Buchholt, Chairperson
Representative Munson
Representative Hulbert
Representative Miles
Representataive Barnes
Representative Beierne
Representative Chatterton

TO REP. THELMA BUCHHOLDT

FROM: RALPH AHGUTUK, 3230 PETERKIN STREET, APT. 1, ANCH. 99504

I SUPPORT HB 204.

CD EOM/

LA11 3210 18.56 JA01 0077 18.56 03/14/79

Thelma -- can you let me know what's happening so far with this bill? Thanks, Stella

TO STELLA FROM CAROL

DIDN'T REALIZE YOU WERE STILL THERE...HAVE SEVERAL PEOPLE VERY ANXIOUS TO KNOW IF HOUSE HESS DID ANYTHING ON HB 204. THANKS. EOM/

Thelma -

TO: REP. BUCHHOLDT
FROM: ANCH LIO

THE FOLLOWING PEOPLE HAVE CALLED IN IN SUPPORT OF HB 204:

HENRIETTA MCCRADY (PH:333-6897)
7605 E 17TH, ANCHORAGE, AK 99504

THOMAS & EDITH TAYLOR (PH:337-2266) (NORTHEAST COMM. COUNCIL)
2310 TATALAK, ANCHORAGE, AK 99504

TO REP. THELMA BUCHHOLDT

THE FOLLOWING PEOPLE HAVE PHONED IN THEIR SUPPORT FOR HB 204 - COMMUNITY SCHOOLS:

MARY LYNN KADLETZ, 2507 EIDE, #5, ANCHORAGE 99503 - 278-1197
FRANCES WESLEY, 3444 E. 16TH, ANCHORAGE 99504 - 274-4319
ERWIN V. AND VIVIAN KURTZ, 2900 E. 15TH, ANCHORAGE 99504 - 279-4902

CD EOM/

TO REPRESENTATIVE BUCHHOLDT

THE FOLLOWING PEOPLE HAVE PHONED IN INDICATING SUPPORT FOR HB 204:

MARY HELLEN, 3228 ILIAMNA, ANCHORAGE 99503
DOROTHY WARD, 7211 EAST 20TH, ANCHORAGE 99504 333-1165

JUDY ANCHORAGE

EOM/

TO REP. THELMA BUCHHOLDT, CHAIRPERSON, HOUSE HESS COMMITTEE
FROM: ANCHORAGE LIO

THE FOLLOWING PEOPLE HAVE PHONED IN THEIR SUPPORT OF HB 204 - COMMUNITY SCHOOLS:

DENNIS THOMASON, L200 W. DIMOND, #1010, ANCHORAGE 99502 - 344-4656
CANDACE OLSON, 6425 CARLOS COURT, ANCHORAGE 99504 - 333-5095
STEVE MOSS, 1555 NELCHINA, APT. 7, ANCHORAGE 99501 - 276-6513

CD EOM/

LA11 0670 10.45 JA01 0007 10.45 03/16/79

TO REPRESENTATIVE BUCHHOLDT

WE REQUEST HB 204, CONTAINING COMMUNITY EDUCATION LEGISLATION, BE PASSED THROUGH THE HESS COMMITTEE. THIS LEGISLATION IS VITAL TO COMMUNITY EDUCATION IN OUR AREA.

BONNIE MURPHY, JUNE NEWMAN, JAMES SANFORD, FRED AND PATRICIA AGREE, PATRICIA HUNSICKER, HRRY AND TERRY CRAVIOTTO, DEXTER AND LINDA BLANCHARD,MARJORIE CONN, SHIRLEY PETERSON, JEANNE TWETEN

TO REP. THELMA BUCHHOLDT, CHAIRMAN, HOUSE HESS COMMITTEE

THE FOLLOWING PEOPLE HAVE PHONED IN THEIR SUPPORT FOR HB 204 - COMMUNITY SCHOOLS:

JACKIE THOMASON, 1200 W. DIMOND, #1010, ANCHORAGE, - 344-4658
PATRICIA BOW ., 1315 W. 12TH, ANCHORAGE 99501 - 276-5550
CHERYL AND LARRY VOLMERT, 6459 TOLHURST, ANCHORAGE 99504 - 333-5640

CD EOM

LA11 1344 12.05 JA01 0027 12.05 03/14/79

TO REPRESENTATIVE THELMA BUCHHOLDT

THE FOLLOWING PEOPLE HAVE TELEPHONED IN THEIR SUPPORT FOR HB 204 - COMMUNITY SCHOOLS:

CHERRILL BROWN, 6824 TIMOTHY, #2, ANCHORAGE 99502 243-1041
SALLY FARAHER, 3754 STRAWBERRY ROAD, ANCHORAGE - 243-2838
BEATRICE LA PLANTE, 7161 TALL SPRUCE DRIVE, ANCHORAGE 99502
MARY ELEN MCGLOTHLIN, 1725 SKILAK CIRCLE, ANCHORAGE - 333-7104
PEGGY SANEL, SRA BOX 6-2W, ANCHORAGE 99507 - 344-1410

LA11 1394 12.12 JA01 0028 12.12 03/14/79

TO REP. THELMA BUCHHOLDT
FROM: CAROL, ANCH. LIO

THE FOLLOWING PEOPLE HAVE PHONED IN THEIR SUPPORT FOR HB 204 - COMMUNITY SCHOOLS:

CATHERINE INICOLAS, 800 W. 56TH, #4, ANCHORAGE 99502 - 277-5183
JENNIFER MACKENZIE, 3813 ARKANSAS DRIVE, #1, ANCHORAGE - 243-3583
LOREAN BRASSARD, 5444 LANCELOT CIRCLE, #6, ANCHORAGE
CAROL EATON, 7541 BELUGA, ANCHORAGE 99504 - 333-6212
REBECCA KURTZ, 7500 JEWELL LAKE ROAD, ANCHORAGE 99502 - 243-2319
LYNNE ONURA, 616 SO. PINE, ANCHORAGE 99504 - 337-6769
HELEN AND BOB MOTHERSHEAD, 827 NORMAN STREET, ANCHORAGE 99504 - 337-2061
HOBART HYATT, 1344 WEST 11TH, ANCHORAGE 99501 - 277-1361

CD EOM/

LA11 3306 18.49 03/15/79 JA01 0002 08.09 03/16/79

TO: WARREN FROM: BARBARA

THE FOLLOWING LIST OF MANES WAS PHONED IN FROM PALMER
AND THEY ASKED THAT THE LEGISLATORS GET THEM AS SOON
AS POSSIBLE--DOESN'T EVERYONE!!

****

TO: REP. CARNEY & MEMBERS OF HOUSE HESS COMMITTEE

THE FOLLOWING PEOPLE ARE IN SUPPORT OF HB 204*

CYNTHIA WOODINGS, BOX 1386, PALMER
BRADLEY SNODGRASS, CAREER ED DIRECTOR
JEAN GOODWIN, DIRECTOR, FEDERAL PROGRAMS
DR. NORMAN ROUSEY, SUPT. OF SCHOOLS, BOX 140, PALMER
BRUCE DE MOND, ASST. SUPT. OF SCHOOLS, BOX 713, WASILLA
DELBERT SMITH, DIRECTOR, SPECIAL ED
LARRY CRAIG, DIRECTOR OF OPERATIONS, BOX 353, PALMER
WILDA BOGGS, BOX 296, PALMER
HELEN WOODINGS, BOX 1386, PALMER
GEAN MARSH, PRES, MAT-SU SCHOOL BD., ON BEHALF OF BOARD,
    STAR RTE. B BOX S 886
RODNEY COTTLE, WASILLA
CHARLES AKERS, BOX 1, PALMER
)PRINCIPAL, WASILLA JR. HIGH)
GORDON PEPPERD, BOX 1420, WASILLA
DIANNE JOHNSON, BOX 344, WASILLA
SANDRA C. SLOAN, BOX 372, WASILLA
MARILYN PHOM, STAR RTE A, BOX 5, PALMER
PAMELA TWITCHELL, DIRECTOR, COMMUNITY SCHOOLS
    BOX 1164, PALMER
NANCY LEE SHAW, BOX 2245, PALMER
GLENDA LOVELL, BOX 1086, PALMER
GLEO HUYCK
SANDRA E. LARSEN, STAR RTE BOX 2325E, WASILLA
SHIRLEY PENNINGTON, BOX 22, SUTTON
ROGER SHEPHERD, TALKEETNA

EOM/

BLANK MOORE BUSINESS FORMS, INC.

IDITAROD
Area School District

POST OFFICE BOX 105 • McGRATH, ALASKA 99627 • (907) 524-3599

April 2, 1979

Representative Vernon L. Hurlbert
1648 Court Building
Juneau, Alaska 99811

Dear Rep. Hurlbert:

Recently, when I was in the capitol for a few hours, I contacted several people in regard to Community Education Legislation. I was there with other people from this District. Unfortunately, you were in a committee meeting at the time and we could not make contact with you. When I was visiting with Representative Buchholdt about the Community Schools Legislation, she informed me that you were on the committee that is presently considering the Community Education Legislation.

She also said that you had information from areas of your constituency which caused you to question whether community school funds were being utilized for community school purposes. We want to assure you that in Iditarod Area School District, all community education funds which we have received have been spent directly to the intent of community education.

In fact, we have found state funding for community school activities very inadequate for carrying out any kind of meaningful program unless the funding is supplemented by other sources. We have been able to develop community school activities in each of the villages of our school district through the creative use of CETA funds. If it were not for CETA, we would only be able to afford a small amount of district level administrative promotion of the community school concept. However, with CETA we have successfully employed Native Community School Coordinators in the villages and we have conducted a number of local adult education activities. I am enclosing a summary of our adult education activities in this district. When you review the summary, please bear in mind our school district population is approximately 1200 people (all ages) and that our services are scattered among nine villages.

So, you might ask, "Why do we need [illegible] community school money?" For us, the answer is that CETA funding is short term and indirect. Four of our Community Education Coordinators have been in those positions since the fall of 1977. In the beginning of this coming school year, these four individuals will no longer be eligible for CETA funds and we will be required to lay them off or pay them with non-CETA funds. As you know, CETA is a tenuous program having undergone much national criticism.

We talk a lot about the necessity for good education for rural residents. From your own experience in the bush, I expect that you will agree with me that there is a need to <u>demonstrate</u> how education can really benefit rural residents. Community Schools are a way to respond to what people <u>want</u>. Too often schools try to tell people what they need. I believe that adult education and adult involvement in local schools is the best way to generate a positive and practical educational climate in the villages.

Please give strong support to fully funded Community School Legislation. Community education should be considered a basic and required component of education in rural Alaska. Thank you.

Sincerely,

Francis Mitchell

Francis Mitchell
Programs and Personnel Development Coordinator

P.S. We met when you personally campaigned in McGrath. I was working on a storm entry to my cabin when you stopped by.

cc: James Zuelow
Superintendent

Rep. Thelma Buchholdt

Joe Miguel

FM:fp

STATE
of ALASKA

MEMORANDUM

TO: The Honorable Thelma Bucholdt
The House of Representatives
Alaska State Legislature

DATE: January 28, 1980

FILE NO:

THRU: Commissioner Lind
Department of Education

TELEPHONE NO:

FROM:
Joe Miguel, Supervisor
Community Education
Department of Education

SUBJECT: List of currently funded Operational Community School Districts which will not be funded in FY'80

At your reqeust, I am supplying your office with a list of school districts which are currently receiving grants from the State, but will be dropping off as of June 30, 1980, due to the formula in the Community School Act of 1975.

District	Funding Level	Year of Operation
Anchorage	256,646	5
Bristol Bay	8,465	4
Dillingham City	12,169	4
Fairbanks	96,803	4
Haines	11,958	5
Hoonah	7,020	4
Juneau	58,884	4
Kenai	106,570	5
King Cove	5,251	4
Klawock	5,200	4
Kodiak	50,823	4
Matanuska-Susitna	57,168	4
Nome	25,338	4
North Slope	50,533	4
Sitka	29,677	4
Valdez	21,848	4
Yakutat	5,472	4
Adak	16,850	4
Bering Straits	28,690	4
Delta/Greely	25,531	4
Southwest Region	33,670	4

Community Education

FY'79

District	Local Contribution	State Support
Anchorage/Eagle River	$978,646.00	$256,646.00
Adak	Not Listed	17,932.00
Annette Islands	Not Listed	7,015.00
Bering Straits	8,100.00	26,885.00
Bristol Bay	Not Listed	9,790.00
Chatham Straits	5,720.00	5,567.00
Copper River	Not Listed	14,227.00
Cordova	25,025.00	3,536.00
Craig	12,249.20	2,992.00
Delta Junction	5,000.00	21,226.00
Dillingham	Not Listed	12,169.00
Fairbanks	11,481	96,803.00
Haines	Not Listed	13,408.00
Hoonah	1,773.00	8,072.00
Juneau	Not Listed under total	46,583.00
Kake	7,935.00	4,764.00
Kenai	Not Listed	101,114.00
King Cove	2,390.00	6,701.00
Klawock	3,250.00	5,200.00
Kodiak	25,145.00	43,964.00
Lake & Peninsula	Not Listed	27,376.00
Lower Kuskokwim	19,767.00	38,130.00
Lower Yukon	Not Listed	10,722.00
Mat-Su	Not Listed	53,666.00
Nome	37,427.00	23,093.00
North Slope Borough	14,521.00	41,607.00
N.W. Arctic	Not Listed	39,794.00
Petersburg	Not Listed	7,090.00
Pribilof	16,126.00	5,670.00
Sitka	Not listed	30,232.00
Skagway	3,000.00	3,097.00
Southwest Region	Not Listed	30,887.00
Valdez	97,938.00	21,050.00
Yakutat	5,227.00	5,227.00
Yukon Flats	16,450.00	12,382.00
Iditarod	Not Listed	12,557.00
Totals	$1,397,170.20	$1,067,174.00

Community Education FY80

District	Amount Local Contribution	Amount State Support
Anchorage and Eagle River	$882,689.60	$256,646.00
Bristol Bay	7,084.00	10,246.00
Adak	9,739.00	20,396.00
Annette Island	Not Listed	8,576.00
Bering Straits	Not Listed	34,727.00
Copper River	Not Listed	19,361.00
Cordova	24,618.34	6,487.00
Craig	12,000.00	4,014.00
Delta Junction	6,000.00	30,903.00
Dillingham	Not Listed	12,169.00
Fairbanks	14,585.00	96,803.00
Haines	19,050.00	11,958.00
Hoonah	10,298.00	8,497.00
Juneau	Not Listed	71,274.00
Kake	13,728.00	4,861.00
Kenai	Not Listed	106,570.00
King Cove	1,952.00	5,251.00
Klawock	9,725.00	5,200.00
Kodiak	15,743.00	61,517.00
Lower Kuskokwim	19,767.00	72.982.00
Lower Yukon	61,060.00	35,758.00
Mat-Su	Not Listed	69,197.00
Nome	44,780.00	30,670.00
N.W. Arctic	Not Listed	63,916.00
Petersburg	Not Listed	10,602.00
Pribilof	16,657.00	8,380.00
Sitka	45,977.00	35,922.00
Skagway	12,206.00	6,322.00
Southwest Region	Not Listed	40,755.00
St. Mary	Not Listed	4,442.00
Valdez	40,870.00	26,445.00
Yakutat	16,040.00	6,623.00
Yukon Flats	26,030.00	18,930.00
Iditarod	188,000.00	20,564.00
Totals	$1,484,013.94	$1,226,964.00

Funding pattern under H.B. 394 relating to Community Schools

	FY'79 Allocation .51	FY'80 Governor's Budget .435	Full FY'80
Adak	$ 16,482	$ 18,745	$ 43,091
Railbelt	-0-	4,165	9,574
Aleutian	-0-	-0-	-0-
Gateway	-0-	-0-	-0-
Annette-Metlakatla	5,565	7,381	16,967
Bering Straits	26,885	30,575	70,287
Chattam	5,567	7,122	16,372
Chugach	-0-	-0-	-0-
Copper River	14,227	18,202	41,844
Delta Greely	21,226	24,139	55,491
Iditarod	12,557	16,066	39,933
Kuspuk	-0-	16,128	37,076
Lake & Peninsula	27,376	31,133	71,571
Lower Kuskokwim	38,130	48,784	112,148
Lower Yukon	9,272	20,044	46,078
Northwest Arctic	39,794	50,513	117,041
Pribilof	5,670	7,254	16,677
Southeast	-0-	-0-	-0-
Southwest	29,437	33,478	76,961
Yukon Flats	10,932	13,987	32,154
Yukon Koyukuk	21,592	27,625	63,505
Anchorage	256,647	218,904	503,227
Bristol Bay	3,340	9,485	21,804
Cordova	3,536	6,031	13,864
Craig	2,992	3,828	8,799

	FY'79 Allocation .51	FY'80 Governor's Budget .435	Full FY'80
Dillingham	12,169	13,839	31,814
Fairbanks	96,083	110,089	253,079
Galena	-0-	-0-	-0-
Haines	11,958	10,200	23,448
Homer	6,622	7,531	17,312
Hydaburg	2,683	3,433	7,891
Juneau	46,583	52,977	121,786
Kake	3,314	4,241	9,749
Kenai	106,570	90,898	208,967
Ketchikan	-0-	-0-	-0-
King Cove	5,251	8,583	19,730
Klawock	-0-	2,501	5,011
Kodiak	43,964	45,998	114,937
Matunuska-Susitna	53,666	61,031	140,302
Nenana	-0-	-0-	-0-
Nome	21,643	24,614	56,584
North Slope	41,607	47,318	108,777
Pelican	-0-	-0-	-0-
Petersburg	7,094	9,076	20,864
Sitka	28,782	32,733	75,248
Skagway	3,097	3,962	9,108
St. Mary's	-0-	-0-	-0-
Unalaska	-0-	-0-	-0-
Valdez	19,600	22,308	51,282
Wrangell	-0-	-0-	-0-
Yakutat	5,227	5,945	13,666
Totals	$1,096,033	$1,170,866	$2,704,319

#1

District/REAA	FY81 1%	FY81 2%
District		
Anchorage	$616,099	$1,232,199
Bristol Bay	10,185	20,370
Cordova	14,878	29,756
Craig	5,826	11,651
Dillingham	16,672	33,345
Fairbanks	191,637	383,274
Galena	8,880	17,760
Haines	13,059	26,117
Hoonah	7,834	15,668
Hydaburg	4,125	8,250
Juneau	87,538	175,077
Kake	7,223	14,446
Kenai	126,656	253,312
Ketchikan	53,405	106,809
King Cove	6,182	12,364
Klawock	2,751	5,502
Kodiak	69,228	138,455
Mat-Su	99,588	199,177
Nenana	8,398	16,796
Nome	31,955	63,911
North Slope	67,147	134,293
Pelican	2,110	4,221
Petersburg	14,466	28,932
Sand Point	6,699	13,398
Sitka	38,832	77,664
Skagway	6,071	12,141
St. Mary's	7,894	15,788
Unalaska	7,049	14,099
Valdez	25,621	51,242
Wrangell	12,788	25,576
Yakutat	6,835	13,669
REAA		
Adak	22,733	45,466
Alaska Gateway	25,638	51,276
Aleutian	17,156	34,313
Annette	13,052	26,103
Bering Strait	38,774	77,548
Chatham	10,534	21,068
Chugach	3,460	6,920
Copper River	27,542	55,084
Delta/Greely	33,674	67,349
Iditarod	28,286	56,572
Kuspuk	34,109	68,217
Lake and Peninsula	38,672	77,344
Lower Kuskokwim	110,394	220,789
Lower Yukon	65,100	130,200
Northwest Arctic	89,585	179,169
Pribilof	11,684	23,369
Railbelt	19,336	38,671
Southeast Island	26,196	52,393
Southwest Region	38,112	76,224
Yukon Flats	30,413	60,826
Yukon Koyukuk	46,246	92,491
Totals	$2,308,327	$4,616,654

#2

District/REAA	1% Found. Support	1% Found. Support OR with $10,00 Floor	1% Local Match	1% State Match
District				
Anchorage	$616,099	$616,099	$616,099	$616,099
Bristol Bay	10,185	10,185	10,185	10,185
Cordova	14,878	14,878	14,878	14,878
Craig	5,826	10,000	10,000	10,000
Dillingham	16,672	16,672	16,672	16,672
Fairbanks	191,637	191,637	191,637	191,637
Galena	8,880	10,000	10,000	10,000
Haines	13,059	13,059	13,059	13,059
Hoonah	7,834	10,000	10,000	10,000
Hydaburg	4,125	10,000	10,000	10,000
Juneau	87,538	87,538	87,538	87,538
Kake	7,223	10,000	10,000	10,000
Kenai	126,656	126,656	126,656	126,656
Ketchikan	53,405	53,405	53,405	53,405
King Cove	6,182	10,000	10,000	10,000
Klawock	2,751	10,000	10,000	10,000
Kodiak	69,228	69,228	69,228	69,228
Mat-Su	99,588	99,588	99,588	99,588
Nenana	8,398	10,000	10,000	10,000
Nome	31,955	31,955	31,955	31,955
North Slope	67,147	67,147	67,147	67,147
Pelican	2,110	10,000	10,000	10,000
Petersburg	14,466	14,466	14,446	14,446
Sand Point	6,699	10,000	10,000	10,000
Sitka	38,832	38,832	38,832	38,832
Skagway	6,071	10,000	10,000	10,000
St. Mary's	7,894	10,000	10,000	10,000
Unalaska	7,049	10,000	10,000	10,000
Valdez	25,621	25,621	25,621	25,621
Wrangell	12,788	12,788	12,788	12,788
Yakutat	6,835	10,000	10,000	10,000
REAA				
Adak	22,733	22,733	22,733	22,733
Alaska Gateway	25,638	25,638	25,638	25,638
Aleutian	17,156	17,156	17,156	17,156
Annette	13,052	13,052	13,052	13,052
Bering Strait	38,774	38,774	38,774	38,774
Chatham	10,534	10,534	10,534	10,534
Chugach	3,460	10,000	10,000	10,000
Copper River	27,542	27,542	27,542	27,542
Delta/Greely	33,674	33,674	33,674	33,674
Iditarod	28,286	28,286	28,286	28,286
Kuspuk	34,109	34,109	34,109	34,109
Lake and Peninsula	38,672	38,672	38,672	38,672
Lower Kuskokwim	110,394	110,394	110,394	110,394
Lower Yukon	65,100	65,100	65,100	65,100
Northwest Arctic	89,585	89,585	89,585	89,585
Pribilof	11,684	11,684	11,684	11,684
Railbelt	19,336	19,336	19,336	19,336
Southeast Island	26,196	26,196	26,196	26,196
Southwest Region	38,112	38,112	38,112	38,112
Yukon Flats	30,413	30,413	30,413	30,413
Yukon Koyukuk	46,246	46,246	46,246	46,246
Total	$2,308,327	$2,366,990	$2,366,990	$2,366,990

STATE OF ALASKA

Inter-Department Route Slip

TO:
MAIL STATION NUMBER 3100

DEPARTMENT Health, Education & Social Se

ATTENTION Shannon Garrett

- ☐ Approval
- ☐ Signature
- ☐ Comment
- ☐ Contact Me
- ☐ Prepare Reply
- ☐ For Your File
- ☐ Note & Return
- ☐ Initial & Return
- ☐ Return As Requested
- ☐ Return For Approval
- ☐ Necessary Action
- ☐ Your Information

Remarks:

FROM:
MAIL STATION NUMBER 0500

DEPARTMENT Education

BY dlm DATE 2-22

J2-002 (REV.10/73)

BILL ANALYSIS

ASSIGNMENT DATE_____

UNASSIGNED_____

DEPARTMENT	SPONSOR (PRINCIPAL)	BILL NO.
Education	Governor	HB-204

DEPARTMENT POSITION

Support

DIVISION DIRECTOR	DATE	COMMISSIONER	DATE
William D. Thomson	2-22-79	Marshall L. Lind	2-22-79

GOVERNOR'S OFFICE USE

☐ POSITION NOTED ☐ POSITION APPROVED ☐ POSITION DISAPPROVED

BY: DATE:

SUMMARY

(1) RELATED BILLS (SIMILAR OR CONFLICTING) None

(2) OTHER AGENCIES AFFECTED BY BILL Local School Districts

(2) a. ORGANIZATIONAL SUPPORT FOR BILL		(2) b. ORGANIZATIONAL OPPOSITION TO BILL
Not Known		Not Known

(3) PROGRAM EFFECTS OF BILL

Provides for base level support of FY'80 programs; provides for additional state funds on a dollar for dollar match for FY'81.

(4) FISCAL IMPACT: ☐ NONE ☐ FISCAL ANALYSIS ATTACHED (already submitted)

(5) AMENDMENTS PROPOSED:

None

(6) COMMENTS:

If HB-204 passes, it will provide the impetus for local support of district programs.

As you will note from the fiscal note which is attached to the bill, many districts will receive less money in FY'80 under the new bill than they did in FY'79. However, FY'81, the effect of 14.30.030(b) of the bill will enable the districts to utilize state and local match monies to bring the level of services to their communities up to the level which was intended.

The Department of Education is in support of both the FY'80 base level of support and the FY'81 matching concepts of HB-204.

District				
Anchorage	$256,646	$458,530	$328,264	$1,232,199
Bristol Bay	10,246	22,336	5,427	20,370
Cordova	6,487	14,141	7,927	29,756
Craig	4,014	8,749	3,104	11,651
Dillingham	12,169	20,885	8,883	33,345
Fairbanks	96,803	74,909	102,106	383,274
Galena	0	0	4,731	17,760
Haines	11,958	25,384	6,958	26,117
Hoonah	8,497	18,523	4,174	15,668
Hydaburg	0	0	2,198	8,250
Juneau	71,274	155,367	46,641	175,077
Kake	4,861	10,834	3,849	14,446
Kenai	106,570	106,242	67,484	253,312
Ketchikan	0	0	28,454	106,809
King Cove	5,251	13,301	3,294	12,364
Klawok	5,200	5,502	1,466	5,502
Kodiak	61,517	134,097	36,885	138,455
Mat-Su	69,197	150,839	53,062	199,177
Nenana	0	0	4,475	16,796
Nome	30,670	66,856	17,026	63,911
North Slope	0	0	35,776	134,293
Pelican	0	0	1,125	4,221
Petersburg	10,602	23,112	7,708	28,932
Sand Point	0	0	3,569	13,398
Sitka	35,922	78,303	20,690	77,664
Skagway	6,322	13,781	3,234	12,141
St. Mary's	1,811	3,948	4,206	15,788
Unalaska	0	0	3,756	14,099
Valdez	26,445	57,647	13,651	51,242
Wrangell	0	0	6,814	25,576
Yakutat	6,623	14,438	3,641	13,669
REAA				
Adak	20,396	44,460	12,112	45,466
Alaska Gateway	0	0	13,660	51,276
Aleutian	0	0	9,141	34,313
Annette	8,576	18,695	6,954	26,103
Bering Strait	34,727	75,698	20,659	77,548
Chatham	5,567	4,988	5,613	21,068
Chugach	0	0	1,844	6,920
Copper River	19,361	42,204	14,675	55,084
Delta/Greely	30,903	67,365	17,942	67,349
Iditarod	20,564	44,825	15,071	56,572
Kuspuk	0	0	18,173	68,217
Lake and Peninsula	0	0	20,605	77,344
Lower Kuskokwim	72,982	159,091	58,819	220,789
Lower Yukon	35,758	77,946	34,686	130,200
Northwest Arctic	63,916	139,327	47,732	179,169
Pribilof	8,380	18,266	6,226	23,369
Railbelt	0	0	10,302	38,671
Southeast Island	0	0	13,958	52,393
Southwest Region	40,755	88,838	20,306	76,224
Yukon Flats	18,930	41,265	16,204	60,826
Yukon Koyukuk	0	0	24,640	92,491
Totals	$1,229,900	$2,300,692	$1,229,900	$4,616,654

District/REAA	FY79 State Grant	# of Participant	Cost/Participant
District			
Anchorage	$256,646	18,812	$13.64
Bristol Bay	8,340	241	34.60
Cordova	3,533	802	4.40
Craig	2,992	240	12.46
Dillingham	12,169	Figures not available	Figures not avail.
Fairbanks	96,803	Figures not available	Figures not avail.
Haines	11,958	967	12.36
Hoonah	6,622	Narrative report	Narrative report
Juneau	46,583	7,853	5.93
Kake	3,314	301	11.00
Kenai	106,570	4,396	24.24
King Cove	5,251	Figures not available	Figures not avail.
Klawok	5,200	202	25.74
Kodiak	43,964	1,473	29.84
Mat-Su	53,666	6,213	8.47
Nome	21,643	1,387	15.60
North Slope	41,607	Narrative Report	Narrative Report
Petersburg	7,094	Narrative Report	Narrative Report
Sitka	28,782	855	33.66
Skagway	3,097	242	12.79
Valdez	19,600	376	52.12
Yakatat	5,227	213	24.53
REAA			
Adak	16,482	Figures not available	Figures not avail.
Annette Island	5,565	266	20.92
Bering Strait	26,885	Narrative Report	Narrative Report
Chatham	5,567	Figures not available	Figures not avail.
Cooper River	14,227	658	21,62
Delta/Greely	21,226	388	54.70
Iditarod	12,557	Figures not available	Figures not avail.
Lake and Peninsula	27,376	Figures not available	Figures not avail.
Lower Kuskokwim	38,130	1,813	21,03
Lower Yukon	9,272	183	50.66
Northwest Arctic	39,794	Figures not available	Figures not avail.
Pribilof	5,670	Narrative Report	Narrative Report
Southwest Region	29,437	737	39.94
Yukon Flats	10,932	Figures not available	Figures not avail.
Total	$1,087,979	48,618	$ 22.37

STATE OF ALASKA

MEMORANDUM

TO: The Honorable Thelma Bucholdt
The House of Representatives
Alaska State Legislature

DATE: January 28, 1980

FILE NO:

THRU: Commissioner Lind
Department of Education

TELEPHONE NO:

FROM: Joe Miguel, Supervisor
Community Education
Department of Education

SUBJECT: List of currently funded Operational Community School Districts which will not be funded in FY'80

At your reqeust, I am supplying your office with a list of school districts which are currently receiving grants from the State, but will be dropping off as of June 30, 1980, due to the formula in the Community School Act of 1975.

District	Funding Level	Year of Operation
Anchorage	256,646	5
Bristol Bay	8,465	4
Dillingham City	12,169	4
Fairbanks	96,803	4
Haines	11,958	5
Hoonah	7,020	4
Juneau	58,884	4
Kenai	106,570	5
King Cove	5,251	4
Klawock	5,200	4
Kodiak	50,823	4
Matanuska-Susitna	57,168	4
Nome	25,338	4
North Slope	50,533	4
Sitka	29,677	4
Valdez	21,848	4
Yakutat	5,472	4
Adak	16,850	4
Bering Straits	28,690	4
Delta/Greely	25,531	4
Southwest Region	33,670	4

MEMORANDUM State of Alaska

TO: Jan Sorice, Legislative Aide
Representative Buchholdt's Office

DATE: May 2, 1980

FILE NO:

TELEPHONE NO: 465-2800

FROM: Marshall L. Lind, Commissioner
Department of Education

SUBJECT: House Bill 629

In the event that the legislature does not fully fund House Bill 629, the Department of Education recommends the following methods for dispersal of funds to those districts with approved plans of service:

1. If less than 1% of the total foundation support is given to the bill for sections a and b, then .5% will be used in section a and the remaining amount will be prorated to the districts in section b.

2. If 1% of the total foundation support is given to the bill for sections a and b, then .5% will be used in section a and .5% in section b.

3. If 1.5% of the total foundation support is given to the bill for sections a and b, then section a will be fully funded at the 1% level and section b will be prorated at the .5% level.

4. If 2% of the total foundation support is given to the bill for sections a and b, then section a will be fully funded at the 1% level and section b will also be fully funded at the 1% level.

District/REAA	FY 80 Actual .43	FY80 Full	FY81 Gov. App. 266+	FY81 Full .9%
District				
Anchorage	$256,646	$458,530	$328,264	$1,232,199
Bristol Bay	10,246	22,336	5,427	20,370
Cordova	6,487	14,141	7,927	29,756
Craig	4,014	8,749	3,104	11,651
Dillingham	12,169	20,885	8,883	33,345
Fairbanks	96,803	74,909	102,106	383,274
Galena	0	0	4,731	17,760
Haines	11,958	25,384	6,958	26,117
Hoonah	8,497	18,523	4,174	15,668
Hydaburg	0	0	2,198	8,250
Juneau	71,274	155,367	46,641	175,077
Kake	4,861	10,834	3,849	14,446
Kenai	106,570	106,242	67,484	253,312
Ketchikan	0	0	28,454	106,809
King Cove	5,251	13,301	3,294	12,364
Klawok	5,200	5,502	1,466	5,502
Kodiak	61,517	134,097	36,885	138,455
Mat-Su	69,197	150,839	53,062	199,177
Nenana	0	0	4,475	16,796
Nome	30,670	66,856	17,026	63,911
North Slope	0	0	35,776	134,293
Pelican	0	0	1,125	4,221
Petersburg	10,602	23,112	7,708	28,932
Sand Point	0	0	3,569	13,398
Sitka	35,922	78,303	20,690	77,664
Skagway	6,322	13,781	3,234	12,141
St. Mary's	1,811	3,948	4,206	15,788
Unalaska	0	0	3,756	14,099
Valdez	26,445	57,647	13,651	51,242
Wrangell	0	0	6,814	25,576
Yakutat	6,623	14,438	3,641	13,669
REAA				
Adak	20,396	44,460	12,112	45,466
Alaska Gateway	0	0	13,660	51,276
Aleutian	0	0	9,141	34,313
Annette	8,576	18,695	6,954	26,103
Bering Strait	34,727	75,698	20,659	77,548
Chatham	5,567	4,988	5,613	21,068
Chugach	0	0	1,844	6,920
Copper River	19,361	42,204	14,675	55,084
Delta/Greely	30,903	67,365	17,942	67,349
Iditarod	20,564	44,825	15,071	56,572
Kuspuk	0	0	18,173	68,217
Lake and Peninsula	0	0	20,605	77,344
Lower Kuskokwim	72,982	159,091	58,819	220,789
Lower Yukon	35,758	77,946	34,686	130,200
Northwest Arctic	63,916	139,327	47,732	179,169
Pribilof	8,380	18,266	6,226	23,369
Railbelt	0	0	10,302	38,671
Southeast Island	0	0	13,958	52,393
Southwest Region	40,755	83,838	20,306	76,224
Yukon Flats	18,930	41,265	16,204	60,826
Yukon Koyukuk	0	0	24,640	92,491
Totals	$1,229,900	$2,300,692	$1,229,900	$4,616,654

Community Education FY80

District	Amount Local Contribution	Amount State Support
Anchorage and Eagle River	$882,689.60	256,646.00
Bristol Bay	7,084.00	10,246.00
Adak	9,739.00	20,396.00
Annette Island	Not Listed	8,576.00
Bering Straits	Not Listed	34,727.00
Copper River	Not Listed	19,361.00
Cordova	24,618.34	6,487.00
Craig	12,000.00	4,014.00
Delta Junction	6,000.00	30,903.00
Dillingham	Not Listed	12,169.00
Fairbanks	14,585.00	96,803.00
Haines	19,050.00	11,958.00
Hoonah	10,298.00	8,497.00
Juneau	Not Listed	71,274.00
Kake	13,728.00	4,861.00
Kenai	Not Listed	106,570.00
King Cove	1,952.00	5,251.00
Klawock	9,725.00	5,200.00
Kodiak	15,743.00	61,517.00
Lower Kuskokwim	19,767.00	72.982.00
Lower Yukon	61,060.00	35,758.00
Mat-Su	Not Listed	69,197.00
Nome	44,780.00	30,670.00
N.W. Arctic	Not Listed	63,916.00
Petersburg	Not Listed	10,602.00
Pribilof	16,657.00	8,380.00
Sitka	45,977.00	35,922.00
Skagway	12,206.00	6,322.00
Southwest Region	Not Listed	40,755.00
St. Mary	Not Listed	4,442.00
Valdez	40,870.00	26,445.00
Yakutat	16,040.00	6,623.00
Yukon Flats	25,030.00	18,930.00
Iditarod	186,000.00	20,564.00
Totals	$1,484,013.94	$1,226,964.00

Community Education

FY'79

District	Local Contribution	State Support
Anchorage/Eagle River	$978,646.00	$256,646.00
Adak	Not Listed	17,932.00
Annette Islands	Not Listed	7,015.00
Bering Straits	8,100.00	26,885.00
Bristol Bay	Not Listed	9,790.00
Chatham Straits	5,720.00	5,567.00
Copper River	Not Listed	14,227.00
Cordova	25,025.00	3,536.00
Craig	12,249.20	2,992.00
Delta Junction	5,000.00	21,226.00
Dillingham	Not Listed	12,169.00
Fairbanks	11,481	96,803.00
Haines	Not Listed	13,408.00
Hoonah	1,773.00	8,072.00
Juneau	Not Listed under total	46,583.00
Kake	7,935.00	4,764.00
Kenai	Not Listed	101,114.00
King Cove	2,390.00	6,701.00
Klawock	3,250.00	5,200.00
Kodiak	25,145.00	43,964.00
Lake & Peninsula	Not Listed	27,376.00
Lower Kuskokwim	19,767.00	38,130.00
Lower Yukon	Not Listed	10,722.00
Mat-Su	Not Listed	53,666.00
Nome	37,427.00	23,093.00
North Slope Borough	14,521.00	41,607.00
N.W. Arctic	Not Listed	39,794.00
Petersburg	Not Listed	7,090.00
Pribilof	16,126.00	5,670.00
Sitka	Not Listed	30,232.00
Skagway	3,000.00	3,097.00
Southwest Region	Not Listed	30,887.00
Valdez	97,938.00	21,050.00
Yakutat	5,227.00	5,227.00
Yukon Flats	16,450.00	12,382.00
Iditarod	Not Listed	12,557.00
Totals	$1,397,170.20	$1,067,174.00

	1% Foundation Support $10,000 min.	1% Foundation Support Plus State Match	0.75% Foundation Support $10,000 min.	0.75% Foundation Support Plus State Match	0.5% Foundation Support $10,000 min.	0.5% Foundation Support Plus State Match
REAA						
Adak	$ 22,281	$ 44,562	$ 16,711	$ 33,422	$ 11,141	$ 22,282
Alaska Gateway	26,481	52,962	19,861	39,722	13,241	26,482
Aleutian Chain	17,111	34,222	12,834	25,668	10,000	20,000
Annette Island	13,064	26,128	10.000	20,000	10,000	20,000
Bering Strait	52,757	105,514	39,568	79,136	26,379	52,758
Chatham	11,376	22,752	10,000	20,000	10,000	20,000
Chugach	10,000	20,000	10,000	20,000	10,000	20,000
Copper River	27,407	54,814	20,555	41,110	13,703	27,406
Delta Greely	32,056	64,112	24,042	48,084	16,028	32,056
Iditarod	30,350	60,700	22,762	45,524	15,175	30,350
Kuspuk	35,229	70,458	26,422	52,844	17,615	34,230 ←
Lake & Peninsula	43,197	86,394	32,398	64,796	21,599	43,198
Lower Kuskokwim	135,804	271,608	101,853	203,706	67,902	135,804
Lower Yukon	78,852	157,704	59,139	118,278	39,426	78,852
Northwest Arctic	102,888	205,776	77,166	154,332	51,444	102,888
Pribilof	12,220	24,440	10,000	20,000	10,000	20,000
Railbelt	21,094	42,188	15,820	31,640	10,547	21,094
Southeast Island	27,942	55,884	20,956	41,912	13,971	27,942
Southwest Region	49,925	99,850	37,444	74,888	24,962	49,924
Yukon Flats	35,213	70,426	26,410	52,820	17,606	35,212
Yukon Koyukuk	48,740	97,480	36,555	73,110	24,370	48,740
Total REAA	$ 833,287	$1,667,974	$ 630,496	$1,260,992	$ 435,109	$ 870,218
Total District and REAA	$2,831,124	$5,662,248	$2,159,871	$4,319,743	$1,510,671	$3,021,342

Districts	1% Foundation Support $10,000 min.	1% Foundation Support Plus State Match	0.75% Foundation Support $10,000 min.	0.75% Foundation Support Plus State Match	0.5% Foundation Support $10,000 min.	0.5% Foundation Support Plus State Match
Anchorage	$ 752,277	$1,504,554	$ 564,208	$1,128,416	$ 376,138	$ 752,276
Bristol Bay	13,302	26,604	10,000	20,000	10,000	20,000
Cordova	18,706	37,412	14,030	28,060	10,000	20,000
Craig	10,000	20,000	10,000	20,000	10,000	20,000
Dillingham	20,416	40,832	15,312	30,624	10,208	20,416
Fairbanks	236,213	472,426	177,160	354,320	118,106	236,212
Galena	12,430	24,860	10,000	20,000	10,000	20,000
Haines	15,918	31,836	11,938	23,876	10,000	20,000
Hoonah	10,000	20,000	10,000	20,000	10,000	20,000
Hydaburg	10,000	20,000	10,000	20,000	10,000	20,000
Juneau	103,716	207,432	77,787	155,574	51,858	103,716
Kake	10,000	20,000	10,000	20,000	10,000	20,000
Kenai	174,464	348,928	130,848	261,696	87,232	174,464
Ketchikan	62,329	124,658	46,747	93,494	31,165	62,330
King Cove	10,000	20,000	10,000	20,000	10,000	20,000
Klawock	10,000	20,000	10,000	20,000	10,000	20,000
Kodiak	82,777	165,554	62,083	124,166	41,389	82,778
Mat-Su	126,281	252,552	94,711	189,422	63,140	126,280
Nenana	10,876	21,752	10,000	20,000	10,000	20,000
Nome	40,381	80,762	30,286	60,572	20,191	40,382
North Slope	93,678	187,356	70,258	140,516	46,839	93,678
Pelican	10,000	20,000	10,000	20,000	10,000	20,000
Petersburg	17,602	35,204	13,202	26,404	10,000	20,000
Sand Point	10,000	20,000	10,000	20,000	10,000	20,000
Sitka	45,346	90,692	34,010	68,020	22,673	45,346
Skagway	10,000	20,000	10,000	20,000	10,000	20,000
St. Mary's	10,000	20,000	10,000	20,000	10,000	20,000
Unalaska	11,364	22,728	10,000	20,000	10,000	20,000
Valdez	33,247	66,494	24,935	49,870	16,623	33,246
Wrangell	15,814	31,628	11,860	23,720	10,000	20,000
Yakutat	10,000	20,000	10,000	20,000	10,000	20,000
Total Districts	$1,997,137	$3,994,274	$1,529,375	$3,058,750	$1,075,562	$2,151,124

ALASKA COMMUNITY INVOLVEMENT
IN COMMUNITY EDUCATION
FY79

ity	School System	Total No. Of Schools In System	No. of School Designated Community Schools			Citizen Involvement		Total Involvement
			Elementary	Secondary	TOTALS	Youth	Adult	
Anchorage	Anchorage School System	66	20	1	21	9,761	9,051	18,812
Metlakatla	Annette Island City Schools	2	1	1	2	149	117	266
Agnoon	Chatham Schools	4	----------4----------		4	did not submit final report		
Glennallen	Copper River Schools	5	----------5----------		5	372	286	658
Delta Jun.	Delta/Greely Schools	3	2	1	3	191	197	388
Haines	Haines Borough Schools	2	1	1	2	did not submit final report		
Kake	Kake City Schools	2	1	1	2	226	75	301
King Cove	King Cove City Schools	2	1	1	2	did not submit final report		
Kodiak	Kodiak Island Borough Schools	13	8	2	10	603	870	1,473
Bethel	Lower Kuskokwim Schools	10	---------8----------		8	798	1,015	1,813
Palmer	Matanuska/Susitna Borough Schools	11	8	3	11	2,741	3,472	6,213
Nome	Nome City Schools	2	1	1	2	610	777	1,387
Petersburg	Petersburg City Schools	2	1	1	2	submitted narrative only		
St. Paul Is.	Pribilof Schools	2	1	1	2	submitted narrative only		
Sitka	Sitka Borough Schools	10	4	2	6	410	445	855
Skagway	Skagway City Schools	1	---------1----------		1	107	135	242
Dillingham	Southwest Region Schools	11	---------7----------		7	443	294	737
Valdez	Valdez City Schools	4	2	2	4	126	250	376

ALASKAN COMMUNITY INVOLVEMENT IN COMMUNITY EDUCATION FY79

ty	School System	Total No. Of Schools In System	No. of Schools Designated Community Schools			Citizen Involvement		Total Involvement
			Elementary	Secondary	TOTALS	Youth	Adult	
. Fairbanks	Northstar Borough Schools	28	5	2	7	Did not submit final report		
. McGrath	Iditarod Area Schools	9	--------9----------		9	Did not submit final report		
. Juneau	Juneau Borough School District	9	5	2	7	2,434	5,419	7,853
. Soldotna	Kenai Peninsula Borg. Schools	26	9	8	17	626	3,770	4,396
. Kotzebue	Northwest Arctic School Dist.	12	--------7----------		7	Submitted narrative only		
. Dillingham	Dillingham City Schools	1	------- 1----------		1	Did not submit final report		
. Adak	Adak Region Schools	2	1	1	2	Submitted narrative only		
. Naknek	Bristol Bay Borough Schools	3	2	1	3	78	163	241
. Craig	Criag City Schools	2	1	1	2	65	175	240
. Hoonah	Hoonah City Schools	2	1	1	2	Submitted narrative only		
. Naknek	Lake and Peninsula	12	-------10----------		10	Did not submit final report		
. Barrow	North Slope Borough Schools	7	--------5----------		5	Submitted narrative only		
. Ft. Yukon	Yukon Flats Schools	8	--------1----------		1	Did not submit final report		
. Yakutat	Yakutat City Schools	2	1	1	2	100	113	213
. Cordova	Cordova City Schools	2	1	1	2	494	308	802
. Klawock	Klawock City Schools	1	--------1----------		1	140	62	202
			20 Districts submitting statistics		TOTALS	20,474	26,994	47,468

Total involvement on these sheets are a one-time registration of each participant, however, many participants are involved in more that one class so that this figure does not ascertain the level of involvement for each individual.

THE LEGISLATURE OF THE STATE OF ALASKA
ELEVENTH LEGISLATURE

FISCAL NOTE

I. REQUEST

Bill/Resolution No. Committee Substitute for H.B. 629

Title An act relating to Community Schools

Requested by H.E.S.S. Committee Date April 21, 1980

II. FISCAL DETAIL

Agency Affected Education

Program Category Affected Foundation Support Programs

BRU, Program, or Subprogram(s) Affected Community Schools

(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 80	FY 81	FY 82	FY 83	FY 84	FY 85
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL						
400 COMMODITIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC.		5,323.	5,843.	6,252	6,689.	7,157
TOTAL						

FUNDING (Thousands of Dollars)

GENERAL FUND		5,323.	5,843.	6,252.	6,689.	7,157.
FEDERAL FUNDS						
OTHER (Specify Fund Source)						

POSITIONS

FULL TIME						
PART TIME						
TEMPORARY						

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

FY'81 cost reflects establishment of 10.0 base or one percent floor as contained in the proposed bill. For FY'82 upon a 2 million dollar increase in the foundation support. FY'83, '84, and '85, are based upon a 7% inflationary cost.

IV. DATE April 21, 1980 PREPARED BY [signature]

AGENCY Education

PHONE 465-2800

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)

MEMORANDUM State of Alaska

TO: Alephe Morris, Administrative Assistant
Senator Sackett's Office
Alaska State Legislature

DATE: May 20, 1980

FILE NO:

TELEPHONE NO: 465-2800

FROM: Marshall L. Lind, Commissioner
Department of Education

SUBJECT: CSHB 629

Due to the changing of basic formulas for the Community Schools grants and the appropriation which the House gave the new bill, you will notice on the attached sheet that many districts will take a substantial cut in the amount they receive for FY'81.

The Department urges the Senate to place the following verbage into the intent of CSHB 629, "that no district will receive less in FY'81 than it received in FY'80."

Along with this intent, we also urge the sum of $179,000 be added to the bill to insure the above intent.

District/REAA

District	FY'80 Actual .43	FY'81 .5% Foundation Support or $10,000 Floor
Anchorage	$ 256,646	$ 376,138
Bristol Bay	10,246	10,000
Cordova	6,487	10,000
Craig	4,014	10,000
Dillingham	12,169	10,208
Fairbanks	96,803	118,106
Galena	-0-	-0-
Haines	11,958	10,000
Hoonah	8,497	10,000
Hydaburg	-0-	10,000
Juneau	71,274	51,858
Kake	4,861	10,000
Kenai	106,570	87,232
Ketchikan	-0-	-0-
King Cove	5,251	10,000
Klawok	5,200	10,000
Kodiak	61,517	41,389
Mat-Su	69,197	63,140
Nenana	-0-	10,000
Nome	30,670	20,191
North Slope	-0-	46,839
Pelican	-0-	-0-
Petersburg	10,602	10,000
Sand Point	-0-	-0-
Sitka	35,922	22,673
Skagway	6,322	10,000
St. Mary's	1,811	10,000
Unalaska	-0-	-0-
Valdez	26,445	16,623
Wrangell	-0-	-0-
Yakutat	6,623	10,000
REAA		
Adak	20,396	11,141
Alaska Gateway	-0-	-0-
Aleutian	-0-	-0-
Annette	8,576	10,000
Bering Strait	34,727	-0-
Chatham	5,567	10,000
Chugach	-0-	-0-
Copper River	19,361	13,703
Delta/Greely	30,903	16,028
Iditarod	20,564	15,175
Kuspuk	-0-	-0-
Lake and Peninsula	-0-	-0-
Lower Kuskokwim	72,982	67,902
Lower Yukon	35,758	-0-
Northwest Arctic	63,916	51,444
Pribilof	8,380	10,000
Railbelt	-0-	-0-
Southeast Island	-0-	-0-
Southwest Region	40,755	24,962
Yukon Flats	18,930	17,606
Yukon Koyukuk	-0-	-0-
TOTALS	$1,229,900	$1,242,358

MEMORANDUM State of Alaska

TO: Alephe Morris, Administrative Assistant
Senator Sackett's Office
Alaska State Legislature

DATE: May 20, 19[illegible]

FILE NO:

TELEPHONE NO: 465-2800

FROM: Marshall L. Lind, Commissioner
Department of Education

SUBJECT: CSHB 629

Due to the changing of basic formulas for the Community Schools grants and the appropriation which the House gave the new bill, you will notice on the attached sheet that many districts will take a substantial cut in the amount they receive for FY'81.

The Department urges the Senate to place the following verbage into the intent of CSHB 629, "that no district will receive less in FY'81 than it received in FY'80."

Along with this intent, we also urge the sum of $179,000 be added to the bill to insure the above intent.

1,204
added by
Senate finance

02-001A(Rev.10/79)

District/REAA

District	FY'80 Actual .43	FY'81 .5% Foundation Support or $10,000 Floor
Anchorage	$ 256,646	$ 376,138
Bristol Bay	10,246	10,000
Cordova	6,487	10,000
Craig	4,014	10,000
Dillingham	12,169	10,208
Fairbanks	96,803	118,106
Galena	-0-	-0-
Haines	11,958	10,000
Hoonah	8,497	10,000
Hydaburg	-0-	10,000
Juneau	71,274	51,858
Kake	4,861	10,000
Kenai	106,570	87,232
Ketchikan	-0-	-0-
King Cove	5,251	10,000
Klawok	5,200	10,000
Kodiak	61,517	41,389
Mat-Su	59,197	63,140
Nenana	-0-	10,000
Nome	30,670	20,191
North Slope	-0-	46,839
Pelican	-0-	-0-
Petersburg	10,602	10,000
Sand Point	-0-	-0-
Sitka	35,922	22,673
Skagway	6,322	10,000
St. Mary's	1,811	10,000
Unalaska	-0-	-0-
Valdez	26,445	16,623
Wrangell	-0-	-0-
Yakutat	6,623	10,000
REAA		
Adak	20,396	11,141
Alaska Gateway	-0-	-0-
Aleutian	-0-	-0-
Annette	8,576	10,000
Bering Strait	34,727	-0-
Chatham	5,567	10,000
Chugach	-0-	-0-
Copper River	19,361	13,703
Delta/Greely	30,903	16,028
Iditarod	20,564	15,175
Kuspuk	-0-	-0-
Lake and Peninsula	-0-	-0-
Lower Kuskokwim	72,982	67,902
Lower Yukon	35,758	-0-
Northwest Arctic	63,916	51,444
Pribilof	8,380	10,000
Railbelt	-0-	-0-
Southeast Island	-0-	-0-
Southwest Region	40,755	24,962
Yukon Flats	18,930	17,606
Yukon Koyukuk	-0-	-0-
TOTALS	$1,229,900	$1,242,358

LETTER OF INTENT

It is the intent of the Senate Finance Committee that $1.006 million be added to the governor's appropriation of $1.229 million and the House appropriation of $.250 million for the support of the community schools program.

It is the further intent of the Senate Finance Committee that $18,000 be added to the Department of Education's Adult and Continuing Education BRU for the sole purpose of conducting on-site monitoring and evaluation of operational community school programs, as required in Section 14.36.010(b)(4). Accounting of the expenditure of these funds shall be included in the annual report to the Legislature as mandated in the the same section.

2.4
250
2.250

1.229 gov.
1.204 Senate
2.433

Senate CS changes 1% to 12%

People that came in to testify;

- Carol Welsh - School Board
- Karen Guymon - School Board
- Doug Dralle - Park + Rec.
- Dan Harnam - High School st.
- Janet Leekly - State Parks
- Cheryl Brangren - Teen Club
- Teri Gatavas - Ass. Director
- Ralph Piepkow - Director

House Health, Education & Social Services Committee Meeting/Hearing on HB 629 Date: 2/12/90

	Name	Address and Phone	Organization/Self	For/Against or Observing
1/	CLIFF HARTMAN	1433 W. 13 279 8176	Council of Sch Adm	for
2/	Linda Layfield	Rt. 6, Box 3530	Juneau Community Schools	for
3/	Brenda Wilbur	R 3 Box 3587 Juneau AK 586-6257	Juneau Community Schools Coordinator	for
4/	Patricia A. Cooper	RR6 Box 3491-H	Juneau Community Schools	for
5/	Tom K. Gillespie	540 Calhoun #4	Juneau Community Schools	for
6/	Joe Miguel	Box 37 Auke Bay	AK. Dept. of Ed.	for
7/	Bruce W. Kruger	924 A St. Juneau	Juneau Parks + Recreation	for
8/				
9/				
10/				
11/				
12/				
13/				

GREATER SITKA BOROUGH SCHOOL DISTRICT
ACCREDITED BY THE NORTHWEST ASSOCIATION OF SECONDARY SCHOOLS & COLLEGES

P. O. BOX 179 SITKA, ALASKA 99835

JOHN E. COFFEE
SUPERINTENDENT

February 15, 1980

Honorable Representative Thelma Buchholdt:

I want to make a few comments on our Telecommunications conservation February 13th regarding House Bill 629.

It was taken very well by the seven people we had in to testify. I just wish we would have had more time for discussion. It would have been nice if we could have asked some questions to the legislators.

Enclosed are the letters people wrote supporting the Community School concept here in Sitka. Also the list of people we had in to testify and our last brochure that went out to all boxholders of Sitka.

We sure appreciate your efforts in helping us keep the Community Education process going here in Sitka. If I can be of any assistance to you feel free to contact me at your convenience.

Yours for a Better Community!

Sincerely,

Ralph B. Piepkow

Ralph Piepkow, Director
Sitka Community School

CAROL WALSH

I wish to speak on behalf of Community Schools across the State of Alaska as well as for the active + viable Community School program that exists in Sitka.

As a board member for the Greater Sitka Borough School District, it has been heartening for me to see the Sitka program exhibit great effectiveness in opening our school facilities to the entire public - giving a diverse cross-section of the community the opportunity to participate in new learning + social experiences.

As an advocate for exceptional children, I have been greatly pleased to see the Special olympics program enhanced and strengthened [redacted] by that group's activities inclusion in the Community School setting.

As a parent, I have seen first-hand how such a program can offer exciting opportunities for the younger members of our community.

The track & field competitions, for example, generated a great deal of interest among some of our junior high

students - my daughter included. Their high enthusiasm for such activities and awareness & good physical fitness has been directly affected by the Community School support and encouragement of such activities. As a result, four Sitka girls represented the entire State of Alaska at a national track and field competition in West Virginia. Such a healthy & edating venture would not have been possible without Community School initiative and interest in

providing community
activity and involvement.

Thank you.

Carol Welsh
Sitka

February 13, 1980

To the Committee:

I have served on the Sitka Community School Committee from the day of its conception five years ago. I am a firm believer in the fact that the impact the program has had on our community has been nothing but positive. The quality of life has been greatly enhanced because of the programs' scope and depth. It has made available outlets for recreational, cultural and educational interests that a town of our size could not do on its' own. It has opened the public school facilities for their maximum use that could only be matched by a very substantial capitol outlay for a multi-use facility. In short. the Community Education Program does a very fine job in serving the maximum amount of citizens, with a wide variety of programs, for a minimum amount of money.

I wish to thank you for this opportunity to state my feelings and voice my support for the on-going Community Education Program.

Sincerely,

David Winters
Chairman

13 February 1980

The Community Schools program in Sitka is a most important part of our Total Community. People of all ages, from pre-school to adult, are involved in the varied programs offered by the Community Schools. I strongly urge continued funding of this program for Sitka.

Carol Wheeler

Carol Wheeler

The Community Schools program at Blatchley Junior High School, Sitka, has become for our family a "family center" during the evenings of the winter months.

Judy instruction for children has offered a fine father-son activity with Ed offering supervision support for the class.

Other children have felt comfortable to visit parents classes, simultaneously taking recreational swim at the school.

The quality of instruction has been superior and the very reasonable fees have encouraged all ofus to choose a class each semester.

I have done calligraphy for twelve years and have taken instruction in California from a university art professor and an artist who taught in adult education evening classes. In these twelve years of classes and workshops, the best teacher ofcalligraphy I found in the Community Schools program in 1979.

Certainly we as a family will continue each semester to select classes from thewide range of offerings for all ages.

Sincerely,

Barbara A. Soukup

Barbara A. Soukup
Box 562
Sitka, Alaska 99835

Feb. 13, 1980

to the Committee.

Our family moved to Sitka three years ago. Shortly after we settled in this rather isolated community we discovered the Sitka School District had a Community Schools Program. There are programs for every member of our family from age 6 to adult.

Because of the Community Schools year around programs we are no longer isolated from opportunities to be involved in a wide range of educational and physical activities.

At present funding for the Sitka School District's "Community Schools Program is being maintained. I urge you to continue support of the Community School Program in Sitka.

Respectively
Sandy Hackett

13 February

To Whom it May Concern:

I, Susan Johnson, being a concerned citizen of this community, wish to show my concern and support for our Community Schools.

This program is a vital part of our community. It provides the means for many of us to further ourselves in numerous ways! It also gives us a place to go and meet other people with similar interests and goals. And, it provides education along with self-improvement in mental ~~and~~ physical and many other areas.

I feel we use and need our Community School system and hope the State support can be maintained.

Sincerely,

Susan Johnson

- HB 629
- Summary
- fiscal note + district breakdown based on 1% foundation formula (SB 199)
- fiscal note + district breakdown based on .5% foundation formula (SB 199)
- FY 79 grant / # participants in each district / cost per participa
- FY 79 state + local contribution
- FY 80 state + local contribution
- Community schools whose grants will drop off June 1980
- funding levels FY 80 actual + full + anticipated FY 81 levels (at time of hearings)
- breakdown of programs + involvement
- HB 394
- legislative audit

36 ~~334~~ school districts w/ a Community schools program w/ 47,468 enrolled

District/REAA	Found. Supp.	Found. Suppt. 10,000 Min.	Local Match	State Match
Anchorage	752,277	752,277	752,277	752,277
Bristol Bay	13,302	13,302	13,302	13,302
Cordova	18,706	18,706	18,706	18,706
Craig	7,137	10,000	10,000	10,000
Dillingham	20,416	20,416	20,416	20,416
Fairbanks	236,213	236,213	236,213	236,213
Galena	12,430	12,430	12,430	12,430
Haines	15,918	15,918	15,918	15,918
Hoonah	9,755	10,000	10,000	10,000
Hydaburg	5,643	10,000	10,000	10,000
Juneau	103,716	103,716	103,716	103,716
Kake	9,143	10,000	10,000	10,000
Kenai	174,464	174,464	174,464	174,464
Ketchikan	62,329	62,329	62,329	62,329
King Cove	7,296	10,000	10,000	10,000
Klawock	2,631	10,000	10,000	10,000
Kodiak	82,777	82,777	82,777	82,777
Mat-Su	126,281	126,281	126,281	126,281
Nenana	10,876	10,876	10,876	10,876
Nome	40,381	40,381	40,381	40,381
North Slope	93,678	93,678	93,678	93,678
Pelican	2,705	10,000	10,000	10,000
Petersburg	17,602	17,602	17,602	17,602
Sand Point	5,980	10,000	10,000	10,000
Sitka	45,346	45,346	45,346	45,346
Skagway	7,015	10,000	10,000	10,000
St. Mary's	9,189	10,000	10,000	10,000
Unalaska	11,364	11,364	11,364	11,364
Valdez	33,247	33,247	33,247	33,247
Wrangell	15,814	15,814	15,814	15,814
Yakutat	8,753	10,000	10,000	10,000
Total District	1,962,212	1,997,137	1,997,137	1,997,137
REAA				
Adak	9,716	10,000	10,000	10,000
Alaska Gateway	22,802	22,802	22,802	22,802
Aleutian Chain	15,196	15,916	15,916	15,916
Annette Island	5,254	10,000	10,000	10,000
Bering Strait	43,795	43,795	43,795	43,795
Chatham	8,000	10,000	10,000	10,000
Chugach	3,265	10,000	10,000	10,000
Copper River	24,090	24,090	24,090	24,090
Delta Greely	20,881	20,881	20,881	20,881
Iditarod	24,918	24,918	24,918	24,918
Kuspuk	29,859	29,859	29,859	29,859
Lake and Peninsula	36.199	36,199	36,199	36,199
Lower Kuskokwim	111,809	111,809	111,809	111,809
Lower Yukon	59,585	59,585	59,585	59,585
Northwest Arctic	80,125	80,125	80,125	80,125
Pribilof	8,470	10,000	10,000	10,000
Railbelt	18,075	18,075	18,075	18,075
Southeast Island	20,229	20,229	20,229	20,229
Southwest Region	39,648	39,648	39,648	39,648
Yukon Flats	29,672	29,672	29,672	29,672
Yukon Koyukuk	37,390	37,390	37,390	37,390
Total REAA's	648,978	664,273	664,273	664,273
Total All	2,611,190	2,661,410	2,661,410	2,661,410

District	Found. Supp.	Found. Supp. $10,000 Min.	Local Match	State Match
Anchorage	376,138	376,138	376,138	376,138
Bristol Bay	6,651	10,000	10,000	10,000
Cordova	9,353	10,000	10,000	10,000
Craig	3,568	10,000	10,000	10,000
Dillingham	10,208	10,208	10,208	10,208
Fairbanks	118,106	118,106	118,106	118,106
Galena	6,215	10,000	10,000	10,000
Haines	7,959	10,000	10,000	10,000
Hoonah	4,878	10,000	10,000	10,000
Hydaburg	2,821	10,000	10,000	10,000
Juneau	51,858	51,858	51,858	51,858
Kake	4,522	10,000	10,000	10,000
Kenai	87,232	87,232	87,232	87,232
Ketchikan	31,165	31,165	31,165	31,165
King Cove	3,648	10,000	10,000	10,000
Klawock	1,316	10,000	10,000	10,000
Kodiak	41,389	41,389	41,389	41,389
Mat-Su	63,140	63,140	63,140	63,140
Nenana	5,436	10,000	10,000	10,000
Nome	20,191	20,191	20,191	20,191
North Slope	46,839	46,839	46,839	46,839
Pelican	1,352	10,000	10,000	10,000
Petersburg	8,801	10,000	10,000	10,000
Sand Point	2,954	10,000	10,000	10,000
Sitka	22,673	22,673	22,673	22,673
Skagway	3,508	10,000	10,000	10,000
St. Mary's	4,594	10,000	10,000	10,000
Unalaska	5,682	10,000	10,000	10,000
Valdez	16,623	16,623	16,623	16,623
Wrangell	7,907	10,000	10,000	10,000
Yakutat	4,376	10,000	10,000	10,000
Total Districts	981,105	1,075,562	1,075,562	1,075,562
REAA				
Adak	11,141	11,141	11,141	11,141
Alaska Gateway	13,241	13,241	13,241	13,241
Aleutian Chain	8,556	10,000	10,000	10,000
Annette Island	6,532	10,000	10,000	10,000
Bering Strait	26,379	26,379	26,379	26,379
Chatham	5,688	10,000	10,000	10,000
Chugach	1,865	10,000	10,000	10,000
Copper River	13,703	13,703	13,703	13,703
Delta/Greely	16,028	16,028	16,028	16,028
Iditarod	15,175	15,175	15,175	15,175
Kuspuk	17,615	17,615	17,615	17,615
Lake and Peninsula	21,599	21,599	21,599	21,599
Lower Kuskokwim	67,902	67,902	67,902	67,902
Lower Yukon	39,426	39,426	39,426	39,426
Northwest Arctic	51,444	51,444	51,444	51,444
Pribilof	6,110	10,000	10,000	10,000
Railbelt	10,547	10,547	10,547	10,547
Southeast Island	13,971	13,971	13,971	13,971
Southwest Region	24,962	24,962	24,962	24,962
Yukon Flats	17,606	17,606	17,606	17,606
Yukon Koyukuk	24,370	24,370	24,370	24,370
Total REAA's	413,860	413,860	413,860	413,860
Total Dist. & REAA's	1,394,965	1,510,671	1,510,671	1,510,671

Community Education FY80

District	Amount Local Contribution	Amount State Support
Anchorage and Eagle River	$882,689.60	$256,646.00
Bristol Bay	7,084.00	10,246.00
Adak	9,739.00	20,396.00
Annette Island	Not Listed	8,576.00
Bering Straits	Not Listed	34,727.00
Copper River	Not Listed	19,361.00
Cordova	24,618.34	6,487.00
Craig	12,000.00	4,014.00
Delta Junction	6,000.00	30,903.00
Dillingham	Not Listed	12,169.00
Fairbanks	14,585.00	96,803.00
Haines	19,050.00	11,958.00
Hoonah	10,298.00	8,497.00
Juneau	Not Listed	71,274.00
Kake	13,728.00	4,861.00
Kenai	Not Listed	106,570.00
King Cove	1,952.00	5,251.00
Klawock	9,725.00	5,200.00
Kodiak	15,743.00	61,517.00
Lower Kuskokwim	19,767.00	72.982.00
Lower Yukon	61,060.00	35,758.00
Mat-Su	Not Listed	69,197.00
Nome	44,780.00	30,670.00
N.W. Arctic	Not Listed	63,916.00
Petersburg	Not Listed	10,602.00
Pribilof	16,657.00	3,380.00
Sitka	45,977.00	35,922.00
Skagway	12,206.00	6,322.00
Southwest Region	Not Listed	40,755.00
St. Mary	Not Listed	4,442.00
Valdez	40,870.00	26,445.00
Yakutat	16,040.00	6,623.00
Yukon Flats	26,030.00	18,930.00
Iditarod	188,000.00	20,564.00
Totals	$1,484,013.94	$1,226,964.00

Community Education

FY'79

District	Local Contribution	State Support
Anchorage/Eagle River	$978,646.00	$256,646.00
Adak	Not Listed	17,932.00
Annette Islands	Not Listed	7,015.00
Bering Straits	8,100.00	26,885.00
Bristol Bay	Not Listed	9,790.00
Chatham Straits	5,720.00	5,567.00
Copper River	Not Listed	14,227.00
Cordova	25,025.00	3,536.00
Craig	12,249.20	2,992.00
Delta Junction	5,000.00	21,226.00
Dillingham	Not Listed	12,169.00
Fairbanks	11,481	96,803.00
Haines	Not Listed	13,408.00
Hoonah	1,773.00	8,072.00
Juneau	Not Listed under total	46,583.00
Kake	7,935.00	4,764.00
Kenai	Not Listed	101,114.00
King Cove	2,390.00	6,701.00
Klawock	3,250.00	5,200.00
Kodiak	25,145.00	43,964.00
Lake & Peninsula	Not Listed	27,376.00
Lower Kuskokwim	19,767.00	38,130.00
Lower Yukon	Not Listed	10,722.00
Mat-Su	Not Listed	53,666.00
Nome	37,427.00	23,093.00
North Slope Borough	14,521.00	41,607.00
N.W. Arctic	Not Listed	39,794.00
Petersburg	Not Listed	7,090.00
Pribilof	16,126.00	5,670.00
Sitka	Not listed	30,232.00
Skagway	3,000.00	3,097.00
Southwest Region	Not Listed	30,887.00
Valdez	97,938.00	21,050.00
Yakutat	5,227.00	5,227.00
Yukon Flats	16,450.00	12,382.00
Iditarod	Not Listed	12,557.00
Totals	$1,397,170.20	$1,067,174.00

District/REAA	Found. Supp.	Found. Suppt. 10,000 Min.	Local Match	State Match
Anchorage	752,277	752,277	752,277	752,277
Bristol Bay	13,302	13,302	13,302	13,302
Cordova	18,706	18,706	18,706	18,706
Craig	7,137	10,000	10,000	10,000
Dillingham	20,416	20,416	20,416	20,416
Fairbanks	236,213	236,213	236,213	236,213
Galena	12,430	12,430	12,430	12,430
Haines	15,918	15,918	15,918	15,918
Hoonah	9,755	10,000	10,000	10,000
Hydaburg	5,643	10,000	10,000	10,000
Juneau	103,716	10 ,716	103,716	103,716
Kake	9,043	1 ,000	10,000	10,000
Kenai	174,464	174,464	174,464	174,464
Ketchikan	62,329	62,329	62,329	62,329
King Cove	7,296	10,000	10,000	10,000
Klawock	2,631	10,000	10,000	10,000
Kodiak	82,777	82,777	82,777	82,777
Mat-Su	126,281	126,281	126,281	126,281
Nenana	10,876	10,876	10,876	10,876
Nome	40,381	40,381	40,381	40,381
North Slope	93,678	93,678	93,678	93,678
Pelican	2,705	10,000	10,000	10,000
Petersburg	17,602	17,602	17,602	17,602
Sand Point	5,980	10,000	10,000	10,000
Sitka	45,346	45,346	45,346	45,346
Skagway	7,015	10,000	10,000	10,000
St. Mary's	9,189	10,000	10,000	10,000
Unalaska	11,364	11,364	11,364	11,364
Valdez	33,247	33,247	33,247	33,247
Wrangell	15,814	15,814	15,814	15,814
Yakutat	8,753	10,000	10,000	10,000
Total District	1,962,212	1,997,137	1,997,137	1,997,137
REAA				
Adak	9,716	10,000	10,000	10,000
Alaska Gateway	22,802	22,802	22,802	22,802
Aleutian Chain	15,196	15,916	15,916	15,916
Annette Island	5,254	10,000	10,000	10,000
Bering Strait	43,795	43,795	43,795	43,795
Chatham	8,000	10,000	10,000	10,000
Chugach	3,265	10,000	10,000	10,000
Copper River	24,090	24,090	24,090	24,090
Delta Greely	20,881	20,881	20,881	20,881
Iditarod	24,918	24,918	24,918	24,918
Kuspuk	29,859	29,859	29,859	29,859
Lake and Peninsula	36.199	36,199	36,199	36,199
Lower Kuskokwim	111,809	111,809	111,809	111,809
Lower Yukon	59,585	59,585	59,585	59,585
Northwest Arctic	80,125	80,125	80,125	80,125
Pribilof	8,470	10,000	10,000	10,000
Railbelt	18,075	18,075	18,075	18,075
Southeast Island	20,229	20,229	20,229	20,229
Southwest Region	39,648	39,648	39,648	39,648
Yukon Flats	29,672	29,672	29,672	29,672
Yukon Koyukuk	37,390	37,390	37,390	37,390
Total REAA's	648,978	664,273	664,273	664,273
Total All	2,611,190	2,661,410	2,661,410	2,661,410

District	Found. Supp.	Found. Supp. $10,000 Min.	Local Match	State Match
Anchorage	376,138	376,138	376,138	376,138
Bristol Bay	6,651	10,000	10,000	10,000
Cordova	9,353	10,000	10,000	10,000
Craig	3,568	10,000	10,000	10,000
Dillingham	10,208	10,208	10,208	10,208
Fairbanks	118,106	118,106	118,106	118,106
Galena	6,215	10,000	10,000	10,000
Haines	7,959	10,000	10,000	10,000
Hoonah	4,878	10,000	10,000	10,000
Hydaburg	2,821	10,000	10,000	10,000
Juneau	51,858	51,858	51,858	51,858
Kake	4,522	10,000	10,000	10,000
Kenai	87,232	87,232	87,232	87,232
Ketchikan	3[illegible]	31,165	31,165	31,165
King Cove		10,000	10,000	10,000
Klawock		10,000	10,000	10,000
Kodiak	,389	41,389	41,389	41,389
Mat-Su	3,140	63,140	63,140	63,140
Nenana	5,438	10,000	10,000	10,000
Nome	20,191	20,191	20,191	20,191
North Slope	46,839	46,839	46,839	46,839
Pelican	1,352	10,000	10,000	10,000
Petersburg	8,801	10,000	10,000	10,000
Sand Point	2,954	10,000	10,000	10,000
Sitka	22,673	22,673	22,673	22,673
Skagway	3,508	10,000	10,000	10,000
St. Mary's	4,594	10,000	10,000	10,000
Unalaska	5,632	10,000	10,000	10,000
Valdez	16,623	16,623	16,623	16,623
Wrangell	7,907	10,000	10,000	10,000
Yakutat	4,376	10,000	10,000	10,000
Total Districts	981,105	1,075,562	1,075,562	1,075,562
REAA				
Adak	11,141	11,141	11,141	11,141
Alaska Gateway	13,241	13,241	13,241	13,241
Aleutian Chain	8,556	10,000	10,000	10,000
Annette Island	6,532	10,000	10,000	10,000
Bering Strait	26,379	26,379	26,379	26,379
Chatham	5,688	10,000	10,000	10,000
Chugach	1,865	10,000	10,000	10,000
Copper River	13,703	13,703	13,703	13,703
Delta/Greely	16,028	16,028	16,028	16,028
Iditarod	15,175	15,175	15,175	15,175
Kuspuk	17,615	17,615	17,615	17,615
Lake and Peninsula	21,599	21,599	21,599	21,599
Lower Kuskokwim	67,902	67,902	67,902	67,902
Lower Yukon	39,426	39,426	39,426	39,426
Northwest Arctic	51,444	51,444	51,444	51,444
Pribilof	6,110	10,000	10,000	10,000
Railbelt	10,547	10,547	10,547	10,547
Southeast Island	13,971	13,971	13,971	13,971
Southwest Region	24,962	24,962	24,962	24,962
Yukon Flats	17,606	17,606	17,606	17,606
Yukon Koyukuk	24,370	24,370	24,370	24,370
Total REAA's	413,860	413,860	413,860	413,860
Total Dist. & REAA's	1,394,965	1,510,671	1,510,671	1,510,671

Community Education F.30

District	Amount Local Contribution	Amount State Support
Anchorage and Eagle River	$882,689.60	$256,646.00
Bristol Bay	7,084.00	10,246.00
Adak	9,739.00	20,396.00
Annette Island	Not Listed	8,576.00
Bering Straits	Not Listed	34,727.00
Copper River	Not Listed	19,361.00
Cordova	24,618.34	6,487.00
Craig	12,000.00	4,014.00
Delta Junction	6,000.00	30,903.00
Dillingham	Not Listed	12,169.00
Fairbanks	14,585.00	96,803.00
Haines	19,050.00	11,958.00
Hoonah	10,298.00	8,497.00
Juneau	Not Listed	71,274.00
Kake	13,728.00	4,861.00
Kenai	Not Listed	106,570.00
King Cove	1,952.00	5,251.00
Klawock	9,725.00	5,200.00
Kodiak	15,743.00	61,517.00
Lower Kuskokwim	19,767.00	72.982.00
Lower Yukon	61,060.00	35,758.00
Mat-Su	Not Listed	69,197.00
Nome	44,780.00	30,670.00
N.W. Arctic	Not Listed	63,916.00
Petersburg	Not Listed	10,602.00
Pribilof	16,657.00	8,380.00
Sitka	45,977.00	35,922.00
Skagway	12,206.00	6,322.00
Southwest Region	Not Listed	40,755.00
St. Mary	Not Listed	4,442.00
Valdez	40,870.00	26,445.00
Yakutat	16,040.00	6,623.00
Yukon Flats	26,030.00	18.930.00
Iditarod	188,000.00	20,564.00
Totals	$1,484,013.94	$1,226,964.00

Community Education

FY'79

District	Local Contribution	State Support
Anchorage/Eagle River	$978,646.00	$256,646.00
Adak	Not Listed	17,932.00
Annette Islands	Not Listed	7,015.00
Bering Straits	8,100.00	26,885.00
Bristol Bay	Not Listed	9,790.00
Chatham Straits	5,720.00	5,567.00
Copper River	Not Listed	14,227.00
Cordova	25,025.00	3,536.00
Craig	12,249.20	2,992.00
Delta Junction	5,000.00	21,226.00
Dillingham	Not Listed	12,169.00
Fairbanks	11,481	96,803.00
Haines	Not Listed	13,408.00
Hoonah	1,773.00	8,072.00
Juneau	Not Listed under total	46,583.00
Kake	7,935.00	4,764.00
Kenai	Not Listed	101,114.00
King Cove	2,390.00	6,701.00
Klawock	3,250.00	5,200.00
Kodiak	25,145.00	43,964.00
Lake & Peninsula	Not Listed	27,376.00
Lower Kuskokwim	19,767.00	38,130.00
Lower Yukon	Not Listed	10,722.00
Mat-Su	Not Listed	53,666.00
Nome	37,427.00	23,093.00
North Slope Borough	14,521.00	41,607.00
N.W. Arctic	Not Listed	39,794.00
Petersburg	Not Listed	7,090.00
Pribilof	16,126.00	5,670.00
Sitka	Not listed	30,232.00
Skagway	3,000.00	3,097.00
Southwest Region	Not Listed	30,887.00
Valdez	97,938.00	21,050.00
Yakutat	5,227.00	5,227.00
Yukon Flats	16,450.00	12,382.00
Iditarod	Not Listed	12,557.00
Totals	$1,397,170.20	$1,067,174.00

Community Education FY80

District	Amount Local Contribution	Amount State Support
Anchorage and Eagle River	$882,689.60	$256,646.00
Bristol Bay	7,084.00	10,246.00
Adak	9,739.00	20,396.00
Annette Island	Not Listed	8,576.00
Bering Straits	Not Listed	34,727.00
Copper River	Not Listed	19,361.00
Cordova	24,618.34	6,487.00
Craig	12,000.00	4,014.00
Delta Junction	6,000.00	30,903.00
Dillingham	Not Listed	12,169.00
Fairbanks	14,585.00	96,803.00
Haines	19,050.00	11,958.00
Hoonah	10,298.00	8,497.00
Juneau	Not Listed	71,274.00
Kake	13,728.00	4,861.00
Kenai	Not Listed	106,570.00
King Cove	1,952.00	5,251.00
Klawock	9,725.00	5,200.00
Kodiak	15,743.00	61,517.00
Lower Kuskokwim	19,767.00	72.982.00
Lower Yukon	61,060.00	35,758.00
Mat-Su	Not Listed	69,197.00
Nome	44,780.00	30,670.00
N.W. Arctic	Not Listed	63,916.00
Petersburg	Not Listed	10,602.00
Pribilof	16,657.00	8,380.00
Sitka	45,977.00	35,922.00
Skagway	12,206.00	5,322.00
Southwest Region	Not Listed	40,755.00
St. Mary	Not Listed	4,442.00
Valdez	40,870.00	26,445.00
Yakutat	16,040.00	6,623.00
Yukon Flats	26,030.00	18,930.00
Iditarod	188,000.00	20,564.00
Totals	$1,484,013.94	$1,226,964.00

Community Education

FY'79

District	Local Contribution	State Support
Anchorage/Eagle River	$978,646.00	$256,646.00
Adak	Not Listed	17,932.00
Annette Islands	Not Listed	7,015.00
Bering Straits	8,100.00	26,885.00
Bristol Bay	Not Listed	9,790.00
Chatham Straits	5,720.00	5,567.00
Copper River	Not Listed	14,227.00
Cordova	25,025.00	3,536.00
Craig	12,249.20	2,992.00
Delta Junction	5,000.00	21,226.00
Dillingham	Not Listed	12,169.00
Fairbanks	11,481	96,803.00
Haines	Not Listed	13,408.00
Hoonah	1,773.00	8,072.00
Juneau	Not Listed under total	46,583.00
Kake	7,935.00	4,764.00
Kenai	Not Listed	101,114.00
King Cove	2,390.00	6,701.00
Klawock	3,250.00	5,200.00
Kodiak	25,145.00	43,964.00
Lake & Peninsula	Not Listed	27,376.00
Lower Kuskokwim	19,767.00	38,130.00
Lower Yukon	Not Listed	10,722.00
Mat-Su	Not Listed	53,666.00
Nome	37,427.00	23,093.00
North Slope Borough	14,521.00	41,607.00
N.W. Arctic	Not Listed	39,794.00
Petersburg	Not Listed	7,090.00
Pribilof	16,126.00	5,670.00
Sitka	Not listed	30,232.00
Skagway	3,000.00	3,097.00
Southwest Region	Not Listed	30,887.00
Valdez	97,938.00	21,050.00
Yakutat	5,227.00	5,227.00
Yukon Flats	16,450.00	12,382.00
Iditarod	Not Listed	12,557.00
Totals	$1,397,170.20	$1,067,174.00

District/REAA	FY79 State Grant	# of Participant	Cost/Participant
District			
Anchorage	$256,646	18,812	$13.64
Bristol Bay	8,340	241	34.60
Cordova	3,533	802	4.40
Craig	2,992	240	12.46
Dillingham	12,169	Figures not available	Figures not avail.
Fairbanks	96,803	Figures not available	Figures not avail.
Haines	11,958	967	12.36
Hoonah	6,622	Narrative report	Narrative report
Juneau	46,583	7,853	5.93
Kake	3,314	301	11.00
Kenai	106,570	4,396	24.24
King Cove	5,251	Figures not available	Figures not avail.
Klawok	5,200	202	25,74
Kodiak	43,964	1,473	29.84
Mat-Su	53,666	6,213	8.47
Nome	21,643	1,387	15.60
North Slope	41,607	Narrative Report	Narrative Report
Petersburg	7,094	Narrative Report	Narrative Report
Sitka	28,782	855	33.66
Skagway	3,097	242	12.79
Valdez	19,600	376	52.12
Yakatat	5,227	213	24.53
REAA			
Adak	16,482	Figures not available	Figures not avail.
Annette Island	5,565	266	20.92
Bering Strait	26,685	Narrative Report	Narrative Report
Chatham	5,567	Figures not available	Figures not avail.
Cooper River	14,227	658	21,62
Delta/Greely	21,225	388	54.70
Iditarod	12,557	Figures not available	Figures not avail.
Lake and Peninsula	27,376	Figures not available	Figures not avail.
Lower Kuskokwim	38,130	1,813	21,03
Lower Yukon	9,272	183	50.66
Northwest Arctic	39,794	Figures not available	Figures not avail.
Pribilof	5,670	Narrative Report	Narrative Report
Southwest Region	29,437	737	39.94
Yukon Flats	10,932	Figures not available	Figures not avail.
Total	$1,087,979	48,618	$ 22.37

Community Education FY80

District	Amount Local Contribution	Amount State Support
Anchorage and Eagle River	$882,689.60	$256,646.00
Bristol Bay	7,084.00	10,246.00
Adak	9,739.00	20,396.00
Annette Island	Not Listed	8,576.00
Bering Straits	Not Listed	34,727.00
Copper River	Not Listed	19,361.00
Cordova	24,618.34	6,487.00
Craig	12,000.00	4,014.00
Delta Junction	6,000.00	30,903.00
Dillingham	Not Listed	12,169.00
Fairbanks	14,585.00	96,803.00
Haines	19,050.00	11,958.00
Hoonah	10,298.00	8,497.00
Juneau	Not Listed	71,274.00
Kake	13,728.00	4,861.00
Kenai	Not Listed	106,570.00
King Cove	1,952.00	5,251.00
Klawock	9,725.00	5,200.00
Kodiak	15,743.00	61,517.00
Lower Kuskokwim	19,767.00	72[illegible]92.00
Lower Yukon	61,060.00	[illegible]8.00
Mat-Su	Not Listed	6[illegible]7.00
Nome	44,780.00	70.00
N.W. Arctic	Not Listed	63, 6.00
Petersburg	Not Listed	10,602.00
Pribilof	16,657.00	8,380.00
Sitka	45,977.00	35,922.00
Skagway	12,206.00	6,322.00
Southwest Region	Not Listed	40,755.00
St. Mary	Not Listed	4,442.00
Valdez	40,870.00	26,445.00
Yakutat	16,040.00	6,623.00
Yukon Flats	26,030.00	18,930.00
Iditarod	188,000.00	20,564.00
Totals	$1,484,013.94	$1,226,964.00

Community Education

FY'79

District	Local Contribution	State Support
Anchorage/Eagle River	$978,646.00	$256,646.00
Adak	Not Listed	17,932.00
Annette Islands	Not Listed	7,015.00
Bering Straits	8,100.00	26,885.00
Bristol Bay	Not Listed	9,790.00
Chatham Straits	5,720.00	5,567.00
Copper River	Not Listed	14,227.00
Cordova	25,025.00	3,536.00
Craig	12,249.20	2,992.00
Delta Junction	5,000.00	21,226.00
Dillingham	Not Listed	12,169.00
Fairbanks	11,481	96,803.00
Haines	Not Listed	13,408.00
Hoonah	1,773.00	8,072.00
Juneau	Not Listed under total	46,583.00
Kake	7,935.00	4,764.00
Kenai	Not Listed	101,114.00
King Cove	2,390.00	6,701.00
Klawock	3,250.00	5,200.00
Kodiak	25,145.00	43,964.00
Lake & Peninsula	Not Listed	27,376.00
Lower Kuskokwim	19,767.00	38,130.00
Lower Yukon	Not Listed	10,722.00
Mat-Su	Not Listed	53,666.00
Nome	37,427.00	23,093.00
North Slope Borough	14,521.00	41,607.00
N.W. Arctic	Not Listed	39,794.00
Petersburg	Not Listed	7,090.00
Pribilof	16,126.00	5,670.00
Sitka	Not listed	30,232.00
Skagway	3,000.00	3,097.00
Southwest Region	Not Listed	30,887.00
Valdez	97,38.00	21,050.00
Yakutat	5,227.00	5,227.00
Yukon Flats	16,450.00	12,382.00
Iditarod	Not Listed	12,557.00
Totals	$1,397,170.20	$1,067,174.00

existing statute, 14.36 provides for 4 years of funding:

year 1:	up to 1/2%	foundation	support
year 2:	1%	"	"
year 3:	1 1/2%	"	"
year 4:	2%	"	"

the funding was tied to the number of community schools in operation
the formula is:

$$\frac{\text{no. of community schools}}{\text{no. of schools in district}} \times \text{foundation support} \times \%\ \text{which district receives in that year}$$

Last year, CS HB 394 extended the programs on their 4th year for one more year, at at least the same level of funding the program received in its 4th year

There are currently 21 districts which will be dropping off as of June 30, 1980 due to the formula in the Community School Act of 1975. (list included)

CS HB 629 provides for a state grant of 1% of the foundation support money or $10,000, whichever is greater, to all districts operating community schools.

In addition, the state will match, up to 1% of the foundation support money or $10,000, local effort (cash or in-kind)

The grant application must include an assurance that the community school program will be reasonably accessible to residents of all communities within a district which express an interest in having such a program.
(in an REAA, that might mean having a program in each village that has a school; in a city like Juneau, it might mean operating a program downtown, in the valley and in Douglas.)

Community school programs will be evaluated by the Department at least once every 4 years; a report will be submitted to the Legislature annually.

There may be a problem here, as the bill does not address funding to the Department of Education for conducting the evaluations. They would like about $50,000 to do this.

The Department must provide training of personell and help the programs develop an internal monitoring system.

They can get this as a supplemental next year if it can't get on the FY81 operating budget.

District	.5% Found. Supp.	.5% Found. Supp. $10,000 Min.	.5% Local Match	.5% State Match
Anchorage	376,138	376,138	376,138	376,138
Bristol Bay	6,651	10,000	10,000	10,000
Cordova	9,353	10,000	10,000	10,000
Craig	3,568	10,000	10,000	10,000
Dillingham	10,208	10,208	10,208	10,208
Fairbanks	118,106	118,106	118,106	118,106
Galena	6,215	10,000	10,000	10,000
Haines	7,959	10,000	10,000	10,000
Hoonah	4,878	10,000	10,000	10,000
Hydaburg	2,821	10,000	10,000	10,000
Juneau	51,858	51,858	51,858	51,858
Kake	4,522	10,000	10,000	10,000
Kenai	87,232	87,232	87,232	87,232
Ketchikan	31,165	31,165	31,165	31,165
King Cove	3,648	10,000	10,000	10,000
Klawock	1,316	10,000	10,000	10,000
Kodiak	41,389	41,389	41,389	41,389
Mat-Su	63,140	63,140	63,140	63,140
Nenana	5,438	10,000	10,000	10,000
Nome	20,191	20,191	20,191	20,191
North Slope	46,839	46,839	46,839	46,839
Pelican	1,352	10,000	10,000	10,000
Petersburg	8,801	10,000	10,000	10,000
Sand Point	2,954	10,000	10,000	10,000
Sitka	22,673	22,673	22,673	22,673
Skagway	3,508	10,000	10,000	10,000
St. Mary's	4,594	10,000	10,000	10,000
Unalaska	5,682	10,000	10,000	10,000
Valdez	16,623	16,623	16,623	16,623
Wrangell	7,907	10,000	10,000	10,000
Yakutat	4,376	10,000	10,000	10,00
Total Districts	981,105	1,075,562	1,075,562	1,075,562
REAA				
Adak	11,141	11,141	11,141	11,141
Alaska Gateway	13,241	13,241	13,241	13,241
Aleutian Chain	8,556	10,000	10,000	10,000
Annette Island	6,532	10,000	10,000	10,000
Bering Strait	26,379	26,379	26,379	26,379
Chatham	5,688	10,000	10,000	10,000
Chugach	1,865	10,000	10,000	10,000
Copper River	13,703	13,703	13,703	13,703
Delta/Greely	16,028	16,028	16,028	16,028
Iditarod	15,175	15,175	15,175	15,175
Kuspuk	17,615	17,615	17,615	17,615
Lake and Peninsula	21,599	21,599	21,599	21,599
Lower Kuskokwim	67,902	67,902	67,902	67,902
Lower Yukon	39,426	39,426	39,426	39,426
Northwest Arctic	51,444	51,444	51,444	51,444
Pribilof	6,110	10,000	10,000	10,000
Railbelt	10,547	10,547	10,547	10,547
Southeast Island	13,971	13,971	13,971	13,971
Southwest Region	24,962	24,962	24,962	24,962
Yukon Flats	17,606	17,606	17,606	17,606
Yukon Koyukuk	24,370	24,370	24,370	24,370
Total REAA's	413,860	413,860	413,860	413,860
Total Dist. & REAA's	1,394,965	1,510,671	1,510,671	1,510,671

District/REAA	FY79 State Grant	# of Participant	Cost/Participant
District			
Anchorage	$256,646	18,812	$13.64
Bristol Bay	8,340	241	34.60
Cordova	3,533	802	4.40
Craig	2,992	240	12.46
Dillingham	12,169	Figures not available	Figures not avail
Fairbanks	96,803	Figures not available	Figures not avail
Haines	11,958	967	12.36
Hoonah	6,622	Narrative report	Narrative report
Juneau	46,583	7,853	5.93
Kake	3,314	301	11.00
Kenai	106,570	4,396	24.24
King Cove	5,251	Figures not available	Figures not avail
Klawok	5,200	202	25,74
Kodiak	43,964	1,473	29.84
Mat-Su	53,666	6,213	8.47
Nome	21,643	1,387	15.60
North Slope	41,607	Narrative Report	Narrative Report
Petersburg	7,094	Narrative Report	Narrative Report
Sitka	28,782	855	33.66
Skagway	3,097	242	12.79
Valdez	19,600	376	52.12
Yakatat	5,227	213	24.53
REAA			
Adak	16,482	Figures not available	Figures not avail
Annette Island	5,565	266	20.92
Bering Strait	26,885	Narrative Report	Narrative Report
Chatham	5,567	Figures not available	Figures not avail
Cooper River	14,227	658	21,62
Delta/Greely	21,226	388	54.70
Iditarod	12,557	Figures not available	Figures not avail
Lake and Peninsula	27,376	Figures not available	Figures not avail
Lower Kuskokwim	38,130	1,813	21,03
Lower Yukon	9,272	183	50.66
Northwest Arctic	39,794	Figures not available	Figures not avail
Pribilof	5,670	Narrative Report	Narrative Report
Southwest Region	29,437	737	39.94
Yukon Flats	10,932	Figures not available	Figures not avail
Total	$1,087,979	48,618	$ 22.37

STATE of ALASKA

MEMORANDUM

TO: The Honorable Thelma Bucholdt
The House of Representatives
Alaska State Legislature

DATE January 28, 1980

FILE NO

THRU: Commissioner Lind
Department of Education

TELEPHONE NO

FROM Joe Miguel, Supervisor
Community Education
Department of Education

SUBJECT: List of currently funded Operational Community School Districts which will not be funded in FY'80

At your reqeust, I am supplying your office with a list of school districts which are currently receiving grants from the State, but will be dropping off as of June 30, 1980, due to the formula in the Community School Act of 1975.

District	Funding Level	Year of Operation
Anchorage	256,646	5
Bristol Bay	8,465	4
Dillingham City	12,169	4
Fairbanks	96,803	4
Haines	11,958	5
Hoonah	7,020	4
Juneau	58,884	4
Kenai	106,570	5
King Cove	5,251	4
Klawock	5,200	4
Kodiak	50,823	4
Matanuska-Susitna	57,168	4
Nome	25,338	4
North Slope	50,533	4
Sitka	29,677	4
Valdez	21,848	4
Yakutat	5,472	4
Adak	16,850	4
Bering Straits	28,690	4
Delta/Greely	25,531	4
Southwest Region	33,670	4

Community Education FY80

District	Amount Local Contribution	Amount State Support
Anchorage and Eagle River	$882,689.60	$256,646.00
Bristol Bay	7,084.00	10,246.00
Adak	9,739.00	20,396.00
Annette Island	Not Listed	8,576.00
Bering Straits	Not Listed	34,727.00
Copper River	Not Listed	19,361.00
Cordova	24,618.34	6,487.00
Craig	12,000.00	4,014.00
Delta Junction	6,000.00	30,903.00
Dillingham	Not Listed	12,169.00
Fairbanks	14,585.00	96,803.00
Haines	19,050.00	11,958.00
Hoonah	10,298.00	8,497.00
Juneau	Not Listed	71,274.00
Kake	13,728.00	4,861.00
Kenai	Not Listed	106,570.00
King Cove	1,952.00	5,251.00
Klawock	9,725.00	5,200.00
Kodiak	15,743.00	61,517.00
Lower Kuskokwim	19,767.00	72.982.00
Lower Yukon	61,060.00	35,758.00
Mat-Su	Not Listed	69,197.00
Nome	44,780.00	30,670.00
N.W. Arctic	Not Listed	63,916.00
Petersburg	Not Listed	10,602.00
Pribilof	16,657.00	8,380.00
Sitka	45,977.00	35,922.00
Skagway	12,206.00	6,322.00
Southwest Region	Not Listed	40,755.00
St. Mary	Not Listed	4,442.00
Valdez	40,870.00	26,445.00
Yakutat	16,040.00	6,623.00
Yukon Flats	26,030.00	18,930.00
Iditarod	188,000.00	20,564.00
Totals	$1,484,013.94	$1,226,964.00

Community Education

FY'79

District	Local Contribution	State Support
Anchorage/Eagle River	$978,646.00	$256,646.00
Adak	Not Listed	17,932.00
Annette Islands	Not Listed	7,015.00
Bering Straits	8,100.00	26,885.00
Bristol Bay	Not Listed	9,790.00
Chatham Straits	5,720.00	5,567.00
Copper River	Not Listed	14,227.00
Cordova	25,025.00	3,536.00
Craig	12,249.20	2,992.00
Delta Junction	5,000.00	21,226.00
Dillingham	Not Listed	12,169.00
Fairbanks	11,481	96,803.00
Haines	Not Listed	13,408.00
Hoonah	1,773.00	8,072.00
Juneau	Not Listed under total	46,583.00
Kake	7,935.00	4,764.00
Kenai	Not Listed	101,114.00
King Cove	2,390.00	6,701.00
Klawock	3,250.00	5,200.00
Kodiak	25,145.00	43,964.00
Lake & Peninsula	Not Listed	27,376.00
Lower Kuskokwim	19,767.00	38,130.00
Lower Yukon	Not Listed	10,722.00
Mat-Su	Not Listed	53,666.00
Nome	37,427.00	23,093.00
North Slope Borough	14,521.00	41,607.00
N.W. Arctic	Not Listed	39,794.00
Petersburg	Not Listed	7,090.00
Pribilof	16,126.00	5,670.00
Sitka	Not listed	30,232.00
Skagway	3,000.00	3,097.00
Southwest Region	Not Listed	30,887.00
Valdez	97,938.00	21,050.00
Yakutat	5,227.00	5,227.00
Yukon Flats	16,450.00	12,382.00
Iditarod	Not Listed	12,557.00
Totals	$1,397,170.20	$1,067,174.00

	1% Foundation Support $10,000 min.	1% Foundation Support Plus State Match	0.75% Foundation Support $10,000 min.	0.75% Foundation Support Plus State Match	0.5% Foundation Support $10,000 min.	0.5% Foundation Support Plus State Match
REAA						
Adak	$ 22,281	$ 44,562	$ 16,711	$ 33,422	$ 11,141	$ 22,282
Alaska Gateway	26,481	52,962	19,861	39,722	13,241	26,482
Aleutian Chain	17,111	34,222	12,834	25,668	10,000	20,000
Annette Island	13,064	26,128	10,000	20,000	10,000	20,000
Bering Strait	52,757	105,514	39,568	79,136	26,379	52,758
Chatham	11,376	22,752	10,000	20,000	10,000	20,000
Chugach	10,000	20,000	10,000	20,000	10,000	20,000
Copper River	27,407	54,814	20,555	41,110	13,703	27,406
Delta Greely	32,056	64,112	24,042	48,084	16,028	32,056
Iditarod	30,350	60,700	22,762	45,524	15,175	30,350
Kuspuk	35,229	70,458	26,422	52,844	17,615	34,230 ←
Lake & Peninsula	43,197	86,394	32,398	64,796	21,599	43,198
Lower Kuskokwim	135,804	271,608	101,853	203,706	67,902	135,804
Lower Yukon	78,852	157,704	59,139	118,278	39,426	78,852
Northwest Arctic	102,888	205,776	77,166	154,332	51,444	102,888
Pribilof	12,220	24,440	10,000	20,000	10,000	20,000
Railbelt	21,094	42,188	15,820	31,640	10,547	21,094
Southeast Island	27,942	55,884	20,956	41,912	13,971	27,942
Southwest Region	49,925	99,850	37,444	74,888	24,962	49,924
Yukon Flats	35,213	70,426	26,410	52,820	17,606	35,212
Yukon Koyukuk	48,740	97,480	36,555	73,110	24,370	48,740
Total REAA	$ 833,987	$1,667,974	$ 630,496	$1,260,992	$ 435,109	$ 870,218
Total District and REAA	$2,831,124	$5,662,248	$2,159,871	$4,319,743	$1,510,671	$3,021,342

Districts	1% Foundation Support $10,000 min.	1% Foundation Support Plus State Match	0.75% Foundation Support $10,000 min.	0.75% Foundation Support Plus State Match	0.5% Foundation Support $10,000 min.	0.5% Foundation Support Plus State Match
Anchorage	$ 752,277	$1,504,554	$ 564,208	$1,128,416	$ 376,138	$ 752,276
Bristol Bay	13,302	26,604	10,000	20,000	10,000	20,000
Cordova	18,706	37,412	14,030	28,060	10,000	20,000
Craig	10,000	20,000	10,000	20,000	10,000	20,000
Dillingham	20,416	40,832	15,312	30,624	10,208	20,416
Fairbanks	236,213	472,426	177,160	354,320	118,106	236,212
Galena	12,430	24,860	10,000	20,000	10,000	20,000
Haines	15,918	31,836	11,938	23,876	10,000	20,000
Hoonah	10,000	20,000	10,000	20,000	10,000	20,000
Hydaburg	10,000	20,000	10,000	20,000	10,000	20,000
Juneau	103,716	207,432	77,787	155,574	51,858	103,716
Kake	10,000	20,000	10,000	20,000	10,000	20,000
Kenai	174,464	348,928	130,848	261,696	87,232	174,464
Ketchikan	62,329	124,658	46,747	93,494	31,165	62,330
King Cove	10,000	20,000	10,000	20,000	10,000	20,000
Klawock	10,000	20,000	10,000	20,000	10,000	20,000
Kodiak	82,777	165,554	62,083	124,166	41,389	82,778
Mat-Su	126,281	252,562	94,711	189,422	63,140	126,280
Nenana	10,876	21,752	10,000	20,000	10,000	20,000
Nome	40,381	80,762	30,286	60,572	20,191	40,382
North Slope	93,678	187,356	70,258	140,516	46,839	93,678
Pelican	10,000	20,000	10,000	20,000	10,000	20,000
Petersburg	17,602	35,204	13,202	26,404	10,000	20,000
Sand Point	10,000	20,000	10,000	20,000	10,000	20,000
Sitka	45,346	90,692	34,010	68,020	22,673	45,346
Skagway	10,000	20,000	10,000	20,000	10,000	20,000
St. Mary's	10,000	20,000	10,000	20,000	10,000	20,000
Unalaska	11,364	22,728	10,000	20,000	10,000	20,000
Valdez	33,247	66,494	24,935	49,870	16,623	33,246
Wrangell	15,814	31,628	11,860	23,720	10,000	20,000
Yakutat	10,000	20,000	10,000	20,000	10,000	20,000
Total Districts	$1,997,137	$3,994,274	$1,529,375	$3,058,750	$1,075,562	$2,151,124

ALASKA COMMUNITY INVOLVEMENT
IN COMMUNITY EDUCATION
FY79

City	School System	Total No. Of Schools In System	No. of School Designated Community Schools			Citizen Involvement		Total * Involvement
			Elementary	Secondary	TOTALS	Youth	Adult	
1. Anchorage	Anchorage School System	66	20	1	21	9,761	9,051	18,812
2. Metlakatla	Annette Island City Schools	2	1	1	2	149	117	266
3. Agnoon	Chatham Schools	4	----------4----------		4	did not submit final report		
4. Glennallen	Copper River Schools	5	----------5----------		5	372	286	658
5. Delta Jun.	Delta/Greely Schools	3	2	1	3	191	197	388
6. Haines	Haines Borough Schools	2	1	1	2	did not submit final report		
7. Kake	Kake City Schools	2	1	1	2	226	75	301
8. King Cove	King Cove City Schools	2	1	1	2	did no	ubmit final report	
9. Kodiak	Kodiak Island Borough Schools	13	8	2	10	603	870	1,473
10. Bethel	Lower Kuskokwim Schools	10	---------8----------		8	798	1,015	1,813
11. Palmer	Matanuska/Susitna Borough Schools	11	8	3	11	2,741	3,472	6,213
12. Nome	Nome City Schools	2	1	1	2	610	777	1,387
13. Petersburg	Petersburg City Schools	2	1	1	2	submitted narrative only		
14. St. Paul Is.	Pribilof Schools	2	1	1	2	submitted narrative only		
15. Sitka	Sitka Borough Schools	10	4	2	6	410	445	855
16. Skagway	Skagway City Schools	1	---------1----------		1	107	135	242
17. Dillingham	Southwest Region Schools	11	----------7----------		7	443	294	737
18. Valdez	Valdez City Schools	4	2	2	4	126	250	376

ALASKAN COMMUNITY INVOLVEMENT
IN COMMUNITY EDUCATION
FY79

City	School System	Total No. Of Schools In System	No. of Schools Designated Community Schools			Citizen Involvement		Total Involvement
			Elementary	Secondary	TOTALS	Youth	Adult	
19. Fairbanks	Northstar Borough Schools	28	5	2	7	Did not submit final report		
20. McGrath	Iditarod Area Schools	9	--------9----------		9	Did not submit final report		
21. Juneau	Juneau Borough School District	9	5	2	7	2,434	5,419	7,853
22. Soldotna	Kenai Peninsula Borg. Schools	26	9	8	17	626	3,770	4,396
23. Kotzebue	Northwest Arctic School Dist.	12	--------7----------		7	Submitted narrative only		
24. Dillingham	Dillingham City Schools	1	--------1----------		1	Did not submit final report		
25. Adak	Adak Region Schools	2	1	1	2	Submitted narrative only		
26. Naknek	Bristol Bay Borough Schools	3	2	1	3	78	163	241
27. Craig	Criag City Schools	2	1	1	2	65	175	240
28. Hoonah	Hoonah City Schools	2	1	1	2	Submitted narrative only		
29. Naknek	Lake and Peninsula	12	-------10----------		10	Did not submit final report		
30. Barrow	North Slope Borough Schools	7	--------5----------		5	Submitted narrative only		
31. Ft. Yukon	Yukon Flats Schools	8	--------1----------		1	Did not submit final report		
32. Yakutat	Yakutat City Schools	2	1	1	2	100	113	213
33. Cordova	Cordova City Schools	2	1	1	2	494	308	802
34. Klawock	Klawock City Schools	1	--------1----------		1	140	62	202
			20 Districts submitting statistics		TOTALS	20,474	26,994	47,468

* Total involvement on these sheets are a one-time registration of each participant, however, many participants are involved in more that one class so that this figure does not ascertain the level of involvement for each individual.

THE LEGISLATURE OF THE STATE OF ALASKA
ELEVENTH LEGISLATURE

FISCAL NOTE

I. REQUEST

Bill/Resolution No. Committee Substitute for H.B. 629
Title An act relating to Community Schools
Requested by H.E.S.S. Committee Date April 21, 1980

II. FISCAL DETAIL

Agency Affected Education
Program Category Affected Foundation Support Programs
BRU, Program, or Subprogram(s) Affected Community Schools
(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

		FY 80	FY 81	FY 82	FY 83	FY 84	FY 85
100	PERSONAL SERVICES						
200	TRAVEL						
300	CONTRACTUAL						
400	COMMODITIES						
500	EQUIPMENT						
600	LAND & STRUCTURES						
700	GRANTS, CLAIMS, ETC.		5,323.	5,843.	6,252	6,689.	7,157.
	TOTAL						

FUNDING (Thousands of Dollars)

GENERAL FUND		5,323.	5,843.	6,252.	6,689.	7,157.
FEDERAL FUNDS						
OTHER (Specify Fund Source)						

POSITIONS

FULL TIME						
PART TIME						
TEMPORARY						

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

FY'81 cost reflects establishment of 10.0 base or one percent floor as contained in the proposed bill. For FY'82 upon a 52 million dollar increase in the foundation support. FY'83, '84, and '85, are based upon a 7% inflationary cost.

IV. DATE April 21, 1980 PREPARED BY

District/REAA		10,000 Min.		
Anchorage	752,277	752,277	752,277	752,277
Bristol Bay	13,302	13,302	13,302	13,302
Cordova	18,706	18,706	18,706	18,706
Craig	7,137	10,000	10,000	10,000
Dillingham	20,416	20,416	20,416	20,416
Fairbanks	236,213	236,213	236,213	236,213
Galena	12,430	12,430	12,430	12,430
Haines	15,918	15,918	15,918	15,918
Hoonah	9,755	10,000	10,000	10,000
Hydaburg	5,643	10,000	10,000	10,000
Juneau	103,716	103,716	103,716	103,716
Kake	9,043	10,000	10,000	10,000
Kenai	174,464	174,464	174,464	174,464
Ketchikan	62,329	62,329	62,329	62,329
King Cove	7,296	10,000	10,000	10,000
Klawock	2,631	10,000	10,000	10,000
Kodiak	82,777	82,777	82,777	82,777
Mat-Su	126,281	126,281	126,281	126,281
Nenana	10,876	10,876	10,876	10,876
Nome	40,381	40,381	40,381	40,381
North Slope	93,678	93,678	93,678	93,678
Pelican	2,705	10,000	10,000	10,000
Petersburg	17,602	17,602	17,602	17,602
Sand Point	5,980	10,000	10,000	10,000
Sitka	45,346	45,346	45,346	45,346
Skagway	7,015	10,000	10,000	10,000
St. Mary's	9,189	10,000	10,000	10,000
Unalaska	11,364	11,364	11,364	11,364
Valdez	33,247	33,247	33,247	33,247
Wrangell	15,814	15,814	15,814	15,814
Yakutat	8,753	10,000	10,000	10,000
Total District	1,962,212	1,997,137	1,997,137	1,997,137
REAA				
Adak	9,716	10,000	10,000	10,000
Alaska Gateway	22,802	22,802	22,802	22,802
Aleutian Chain	15,196	15,916	15,916	15,916
Annette Island	5,254	10,000	10,000	10,000
Bering Strait	43,795	43,795	43,795	43,795
Chatham	8,000	10,000	10,000	10,000
Chugach	3,265	10,000	10,000	10,000
Copper River	24,090	24,090	24,090	24,090
Delta Greely	20,881	20,881	20,881	20,881
Iditarod	24,918	24,918	24,918	24,918
Kuspuk	29,859	29,859	29,859	29,859
Lake and Peninsula	36.199	36,199	36,199	36,199
Lower Kuskokwim	111,809	111,809	111,809	111,809
Lower Yukon	59,585	59,585	59,585	59,585
Northwest Arctic	80,125	80,125	80,125	80,125
Pribilof	8,470	10,000	10,000	10,000
Railbelt	18,075	18,075	18,075	18,075
Southeast Island	20,229	20,229	20,229	20,229
Southwest Region	39,648	39,648	39,648	39,648
Yukon Flats	29,672	29,672	29,672	29,672
Yukon Koyukuk	37,390	37,390	37,390	37,390
Total REAA's	648,978	664,273	664,273	664,273
Total All	2,611,190	2,661,410	2,661,410	2,661,410

THE LEGISLATURE OF THE STATE OF ALASKA
ELEVENTH LEGISLATURE

FISCAL NOTE

I. REQUEST

Bill/Resolution No. Committee Substitute for H.B. 629

Title An act relating to Community Schools

Requested by H.E.S.S. Committee Date April 21, 1980

II. FISCAL DETAIL

Agency Affected Education

Program Category Affected Foundation Support Programs

BRU, Program, or Subprogram(s) Affected Community Schools

(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

		FY 80	FY 81	FY 82	FY 83	FY 84	FY 85
100	PERSONAL SERVICES						
200	TRAVEL						
300	CONTRACTUAL						
400	COMMODITIES						
500	EQUIPMENT						
600	LAND & STRUCTURES						
700	GRANTS, CLAIMS, ETC.		3,021.3	3,281.3	3,511.0	3,756.8	$4,019.7
	TOTAL						

FUNDING (Thousands of Dollars)

GENERAL FUND		3,021.3	3,281.3	3,511.0	3,756.8	$4,019.7
FEDERAL FUNDS						
OTHER (Specify Fund Source)						

POSITIONS

FULL TIME						
PART TIME						
TEMPORARY						

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

FY'81 cost reflects establishment of 10.0 base or .5 percent floor as contained in the proposed bill. FY'82 is based upon .5 percent of a 52 million dollar increase in the foundation support. FY'83, '84, '85, are based upon a 7% inflationary cost.

IV. DATE April 21, 1980 PREPARED BY William D. Thomas

AGENCY Education

PHONE 465-2800

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)

33-001 (Rev. 12/79)

District	.5% Found. Supp.	.5% Found. Supp. $10,000 Min.	.5% Local Match	.5% State Match
Anchorage	376,138	376,138	376,138	376,138
Bristol Bay	6,651	10,000	10,000	10,000
Cordova	9,353	10,000	10,000	10,000
Craig	3,568	10,000	10,000	10,000
Dillingham	10,208	10,208	10,208	10,208
Fairbanks	118,106	118,106	118,106	118,106
Galena	6,215	10,000	10,000	10,000
Haines	7,959	10,000	10,000	10,000
Hoonah	4,878	10,000	10,000	10,000
Hydaburg	2,821	10,000	10,000	10,000
Juneau	51,858	51,858	51,858	51,858
Kake	4,522	10,000	10,000	10,000
Kenai	87,232	87,232	87,232	87,232
Ketchikan	31,165	31,165	31,165	31,165
King Cove	3,648	10,000	10,000	10,000
Klawock	1,316	10,000	10,000	10,000
Kodiak	41,389	41,389	41,389	41,389
Mat-Su	63,140	63,140	63,140	63,140
Nenana	5,438	10,000	10,000	10,000
Nome	20,191	20,191	20,191	20,191
North Slope	46,839	46,839	46,839	46,839
Pelican	1,352	10,000	10,000	10,000
Petersburg	8,801	10,000	10,000	10,000
Sand Point	2,954	10,000	10,000	10,000
Sitka	22,673	22,673	22,673	22,673
Skagway	3,508	10,000	10,000	10,000
St. Mary's	4,594	10,000	10,000	10,000
Unalaska	5,682	10,000	10,000	10,000
Valdez	16,623	16,623	16,623	16,623
Wrangell	7,907	10,000	10,000	10,000
Yakutat	4,376	10,000	10,000	10,000
Total Districts	981,105	1,075,562	1,075,562	1,075,562
REAA				
Adak	11,141	11,141	11,141	11,141
Alaska Gateway	13,241	13,241	13,241	13,241
Aleutian Chain	8,556	10,000	10,000	10,000
Annette Island	6,532	10,000	10,000	10,000
Bering Strait	26,379	26,379	26,379	26,379
Chatham	5,688	10,000	10,000	10,000
Chugach	1,865	10,000	10,000	10,000
Copper River	13,703	13,703	13,703	13,703
Delta/Greely	16,028	16,028	16,028	16,028
Iditarod	15,175	15,175	15,175	15,175
Kuspuk	17,615	17,615	17,615	17,615
Lake and Peninsula	21,599	21,599	21,599	21,599
Lower Kuskokwim	67,902	67,902	67,902	67,902
Lower Yukon	39,426	39,426	39,426	39,426
Northwest Arctic	51,444	51,444	51,444	51,444
Pribilof	6,110	10,000	10,000	10,000
Railbelt	10,547	10,547	10,547	10,547
Southeast Island	13,971	13,971	13,971	13,971
Southwest Region	24,962	24,962	24,962	24,962
Yukon Flats	17,606	17,606	17,606	17,606
Yukon Koyukuk	24,370	24,370	24,370	24,370
Total REAA's	413,860	413,860	413,860	413,860
Total Dist. & REAA's	1,394,965	1,510,671	1,510,671	1,510,671

THE LEGISLATURE OF THE STATE OF ALASKA
ELEVENTH LEGISLATURE

FISCAL NOTE

I. REQUEST

Bill/Resolution No. Committee Substitute for H.B. 629
Title An act relating to Community Schools
Requested by H.E.S.S. Committee Date April 21, 1980

II. FISCAL DETAIL

Agency Affected Education
Program Category Affected Foundation Support Programs
BRU, Program, or Subprogram(s) Affected Community Schools
(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 80	FY 81	FY 82	FY 83	FY 84	FY 85
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL						
400 COMMODITIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC.		5,323.	5,843.	6,252.	6,689.	7,157.
TOTAL						

FUNDING (Thousands of Dollars)

GENERAL FUND		5,323.	5,843.	6,252.	6,689.	7,157.
FEDERAL FUNDS						
OTHER (Specify Fund Source)						

POSITIONS

FULL TIME						
PART TIME						
TEMPORARY						

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

FY'81 cost reflects establishment of 10.0 base or one percent floor as contained in the proposed bill. For FY'82 upon a 52 million dollar increase in the foundation support. FY'83, '84, and '85, are based upon a 7% inflationary cost.

IV. DATE April 21, 1980 PREPARED BY [signature]
AGENCY Education
PHONE 465-2800

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)

District/REAA	1% Found. Supp.	1% Found. Suppt. 10,000 Min.	1% Local Match	1% State Match
Anchorage	752,277	752,277	752,277	752,277
Bristol Bay	13,302	13,302	13,302	13,302
Cordova	18,706	18,706	18,706	18,706
Craig	7,137	10,000	10,000	10,000
Dillingham	20,416	20,416	20,416	20,416
Fairbanks	236,213	236,213	236,213	236,213
Galena	12,430	12,430	12,430	12,430
Haines	15,918	15,918	15,918	15,918
Hoonah	9,755	10,000	10,000	10,000
Hydaburg	5,643	10,000	10,000	10,000
Juneau	103,716	103,716	103,716	103,716
Kake	9,043	10,000	10,000	10,000
Kenai	174,464	174,464	174,464	174,464
Ketchikan	62,329	62,329	62,329	62,329
King Cove	7,296	10,000	10,000	10,000
Klawock	2,631	10,000	10,000	10,000
Kodiak	82,777	82,777	82,777	82,777
Mat-Su	126,281	126,281	126,281	126,281
Nenana	10,876	10,876	10,876	10,876
Nome	40,381	40,381	40,381	40,381
North Slope	93,678	93,678	93,678	93,678
Pelican	2,705	10,000	10,000	10,000
Petersburg	17,602	17,602	17,602	17,602
Sand Point	5,980	10,000	10,000	10,000
Sitka	45,346	45,346	45,346	45,346
Skagway	7,015	10,000	10,000	10,000
St. Mary's	9,189	10,000	10,000	10,000
Unalaska	11,364	11,364	11,364	11,364
Valdez	33,247	33,247	33,247	33,247
Wrangell	15,814	15,814	15,814	15,814
Yakutat	8,753	10,000	10,000	10,000
Total District	1,962,212	1,997,137	1,997,137	1,997,137
REAA				
Adak	9,716	10,000	10,000	10,000
Alaska Gateway	22,802	22,802	22,802	22,802
Aleutian Chain	15,196	15,916	15,916	15,916
Annette Island	5,254	10,000	10,000	10,000
Bering Strait	43,795	43,795	43,795	43,795
Chatham	8,000	10,000	10,000	10,000
Chugach	3,265	10,000	10,000	10,000
Copper River	24,090	24,090	24,090	24,090
Delta Greely	20,881	20,881	20,881	20,881
Iditarod	24,918	24,918	24,918	24,918
Kuspuk	29,859	29,859	29,859	29,859
Lake and Peninsula	36.199	36,199	36,199	36,199
Lower Kuskokwim	111,809	111,809	111,809	111,809
Lower Yukon	59,585	59,585	59,585	59,585
Northwest Arctic	80,125	80,125	80,125	80,125
Pribilof	8,470	10,000	10,000	10,000
Railbelt	18,075	18,075	18,075	18,075
Southeast Island	20,229	20,229	20,229	20,229
Southwest Region	39,648	39,648	39,648	39,648
Yukon Flats	29,672	29,672	29,672	29,672
Yukon Koyukuk	37,390	37,390	37,390	37,390
Total REAA's	648,978	664,273	664,273	664,273
Total All	2,611,190	2,661,410	2,661,410	2,661,410

Community Education FY80

District	Amount Local Contribution	Amount State Support
Anchorage and Eagle River	$882,689.60	$256,646.00
Bristol Bay	7,084.00	10,246.00
Adak	9,739.00	20,396.00
Annette Island	Not Listed	8,576.00
Bering Straits	Not Listed	34,727.00
Copper River	Not Listed	19,361.00
Cordova	24,618.34	6,487.00
Craig	12,000.00	4,014.00
Delta Junction	6,000.00	30,903.00
Dillingham	Not Listed	12,169.00
Fairbanks	14,585.00	96,803.00
Haines	19,050.00	11,958.00
Hoonah	10,298.00	8,497.00
Juneau	Not Listed	71,274.00
Kake	13,728.00	4,861.00
Kenai	Not Listed	106,570.00
King Cove	1,952.00	5,251.00
Klawock	9,725.00	5,200.00
Kodiak	15,743.00	61,517.00
Lower Kuskokwim	19,767.00	72.982.00
Lower Yukon	61,060.00	35,758.00
Mat-Su	Not Listed	69,197.00
Nome	44,780.00	30,670.00
N.W. Arctic	Not Listed	63,916.00
Petersburg	Not Listed	10,602.00
Pribilof	16,657.00	8,380.00
Sitka	45,977.00	35,922.00
Skagway	12,206.00	6,322.00
Southwest Region	Not Listed	40,755.00
St. Mary	Not Listed	4,442.00
Valdez	40,870.00	26,445.00
Yakutat	16,040.00	6,623.00
Yukon Flats	26,030.00	18,930.00
Iditarod	188,000.00	20,564.00
Totals	$1,484,013.94	$1,226,964.00

Community Education

FY'79

District	Local Contribution	State Support
Anchorage/Eagle River	$978,646.00	$256,646.00
Adak	Not Listed	17,932.00
Annette Islands	Not Listed	7,015.00
Bering Straits	8,100.00	26,885.00
Bristol Bay	Not Listed	9,790.00
Chatham Straits	5,720.00	5,567.00
Copper River	Not Listed	14,227.00
Cordova	25,025.00	3,536.00
Craig	12,249.20	2,992.00
Delta Junction	5,000.00	21,226.00
Dillingham	Not Listed	12,169.00
Fairbanks	11,481	96,803.00
Haines	Not Listed	13,408.00
Hoonah	1,773.00	8,072.00
Juneau	Not Listed under total	46,583.00
Kake	7,935.00	4,764.00
Kenai	Not Listed	101,114.00
King Cove	2,390.00	6,701.00
Klawock	3,250.00	5,200.00
Kodiak	25,145.00	43,964.00
Lake & Peninsula	Not Listed	27,376.00
Lower Kuskokwim	19,767.00	38,130.00
Lower Yukon	Not Listed	10,722.00
Mat-Su	Not Listed	53,666.00
Nome	37,427.00	23,093.00
North Slope Borough	14,521.00	41,607.00
N.W. Arctic	Not Listed	39,794.00
Petersburg	Not Listed	7,090.00
Pribilof	16,126.00	5,670.00
Sitka	Not listed	30,232.00
Skagway	3,000.00	3,097.00
Southwest Region	Not Listed	30,887.00
Valdez	97,938.00	21,050.00
Yakutat	5,227.00	5,227.00
Yukon Flats	16,450.00	12,382.00
Iditarod	Not Listed	12,557.00
Totals	$1,397,170.20	$1,067,174.00

District/REAA	FY79 State Grant	# of Participant	Cost/Participant
District			
Anchorage	$256,646	18,812	$13.64
Bristol Bay	8,340	241	34.60
Cordova	3,533	802	4.40
Craig	2,992	240	12.46
Dillingham	12,169	Figures not available	Figures not avail
Fairbanks	96,803	Figures not available	Figures not avail
Haines	11,958	967	12.36
Hoonah	6,622	Narrative report	Narrative report
Juneau	46,583	7,853	5.93
Kake	3,314	301	11.00
Kenai	106,570	4,396	24.24
King Cove	5,251	Figures not available	Figures not avail
Klawok	5,200	202	25.74
Kodiak	43,964	1,473	29.84
Mat-Su	53,666	6,213	8.47
Nome	21,643	1,387	15.60
North Slope	41,607	Narrative Report	Narrative Report
Petersburg	7,094	Narrative Report	Narrative Report
Sitka	28,782	855	33.66
Skagway	3,097	242	12.79
Valdez	19,600	376	52.12
Yakatat	5,227	213	24.53
REAA			
Adak	16,482	Figures not available	Figures not avail
Annette Island	5,565	266	20.92
Bering Strait	26,885	Narrative Report	Narrative Report
Chatham	5,567	Figures not available	Figures not avail
Cooper River	14,227	658	21.62
Delta/Greely	21,226	388	54.70
Iditarod	12,557	Figures not available	Figures not avail
Lake and Peninsula	27,376	Figures not available	Figures not avail
Lower Kuskokwim	38,130	1,813	21.03
Lower Yukon	9,272	183	50.66
Northwest Arctic	39,794	Figures not available	Figures not avail
Pribilof	5,670	Narrative Report	Narrative Report
Southwest Region	29,437	737	39.94
Yukon Flats	10,932	Figures not available	Figures not avail
Total	$1,087,979	48,618	$ 22.37

ALASKA ASSOCIATION OF COMMUNITY EDUCATION

Legislation Position Paper

1.0 Definition

The Act should define a community education program as "a program in which a public building, including but not limited to a public elementary or secondary school, or a community or junior college (or a related extension center), is used as a community center operated in conjunction with other groups in the community, community organizations, and local governmental agencies, to provide educational, recreational, health care, cultural, and other related community and human services for the community that the center serves in accordance with the needs, interests and concerns of that community."

1.1 The Local Education Agency may elect to function as a prime sponsor in order to subcontract the operational funds to other agencies. (such as municipal goverments, community colleges, extension centers, etc.)

1.2 An LEA is considered to be one of the 53 public school districts in Alaska.

2.0 Need

Community Education has captured the imagination of both educational and lay leaders throughout the United States. The growth of community education has arisen from three significant factors. These factors are:

2.1 Schools must discharge their presently accepted responsibilities with a greater degree of community accountability.

2.2 Schools must extend their traditional service to all members of the community - not just the traditional student population.

2.3 Alternatives must be found for reducing duplication of effort so that improved services are provided at a lower overall cost.

Because of the potential which Community Education holds for recognizing and addressing these factors the Alaska State Legislature will assume responsible leadership in fostering Community Education. This will be accomplished by providing financial and technical assistance within the limitations of the Alaska State Department of Education's allocated resources to those LEAs requesting funding and services related to Community Education. Technical assistance may be provided to subcontractors at the request of the LEA.

3.0 Program Description

The proposed law and accompanying regulations should limit eligible activities to the leadership, administrative, and coordinating activities involved in planning, establishing, expanding, or operating a community education program. The program should not pay for cost directly related to the provision of services or activities.

This approach reflects the associations judgment that while a community education program may encompass virtually any type of educational or other

social service, the State Program was not meant to pay for these services but, rather, for the processes of organizing and coordinating these services in a community education program. These proposed limits distinguish community education, elementary and secondary education, and recreational and social services.

4.0 Position Statement

Because of the uniqueness of each local situation and/or community, Community Education cannot be considered a uniform, state-mandated, or prescribed set of activities, classes or programs. It should be the position of the State Legislature to encourage educators and the community at large to:

4.1 Explore the possibility of initiating Community Education.
4.2 Consider Community Education when new facilities are being developed or existing facilities are being remodeled.
4.3 Consider the use of Community Education to effect participation of local citizenry in the education decision-making process.
4.4 Explore the possibility of using Community Education to eliminate duplicated effort and coordinate education and community programs.
4.5 Consider how Community Education will be evaluated to insure community and educational accountability.
4.6 Consider Community Education's potential for extending the school's traditional services to all members of the community.

5.0 Position Strengths

Consideration of Community Education should reveal the following strengths:

5.1 Community Education can be generally accomplished through improved coordination of existing resources at minimal additional cost.
5.2 Community Education maximizes the use of public facilities and services, thus increasing program and service cost-effectiveness.
5.3 Community Education assists the citizenry to a greater awareness of the needs of the total community.
5.4 The greater awareness created by Community Education maximizes the possibility of meeting the self-defined needs of the total community.
5.5 The involvement of the citizenry in meeting their own needs generally develops a more positive outlook toward education and the community.
5.6 The positive outlook toward education and the community which develops through Community Education usually increases community support for education.
5.7 The positive outlook and support gained through Community Education fosters individual concern for both family and neighbors, thereby strengthening the family and the community structure.

6.0 Position Constraints

It should be recognized that a number of existent factors could hinder or deter the successful implementation of the Community Education process.

6.1 There is a need for additional qualified personnel available for the purpose of providing technical assistance to those inaugurating or strengthening Community Education.

6.2 Presently, technical assistance and evaluation assistance to those developing or operating community education is hindered by financial limitations.

6.3 Financial resources currently designated for Community Education can not adequately support programs in Alaska's 53 school districts.

6.4 If community and educational agencies cannot work together effectively, the following constraints may result:

- a. Duplication of programs and services.
- b. Competition between agencies for resources and patrons.
- c. Increased expense to the citizenry.
- d. Poor Community Eduction accountability.

6.5 Community Educational opportunities for training leaders in key community and education leadership positions should be supported by the legislation.

6.6 Community Education can run the risk of being just another add-on program.

6.7 Community Education should never be inaugurated solely to improve the schools image or public relations with the community.

6.8 Initiating Community Education through administrative decree alone should never occur, but administrative leadership and support are imperative.

6.9 Care should be exerted so as not to limit or eliminate the involvement of the citizenry in the education decision-making process associated with Community Education.

6.10 Care should be exerted to insure that control of Community Education remains with the local community, where individuals interacting with each other can insure that the greatest good results for the greatest number.

7.0 Minimum Elements

The association recommends that minimum elements should apply to each Community Education program to be assisted under the State formula program within the State Foundation support system. These minimum elements are:

7.1 Educational Institution Involvement -- The extent to which an LEA is involved in program administration policies development, financial resources, and their commitment to the support and improvement of the program should be defined.

7.2 Community To Be Served -- The geographic area which the program is designed to serve as well as the populations which exist in the community should be defined.

7.3 Community Education Council -- A community council should be in existence to provide for the active and continuous involvement of individuals, groups, and institutions broadly representative of the community served.

7.4 Community Needs -- The program should provide a systematic procedure for identifying community needs, interests, and concerns.

7.5 Interagency Cooperation -- Community Education should promote, encourage, and facilitate interagency cooperation through such activities as coordinating councils, joint use agreements, public relations, cooperative facility planning and joint funding arrangements.

7.6 Identification of Community Resources -- Community resources in the following areas should be identified:
a. Physical b. Fiscal c. Human d. Services

7.7 Public Facility As A Community Center -- Program services for the community should be identified in specific public facilities although satellite or mobile facilities may be utilized.

7.8 Scope of Activities and Services -- Community Education programs are based upon needs identified in each community and should contain a balance between enrichment, recreational, vocational, cultural and social activities. The Community Education program should make provisions for social and health agencies to provide services in community education facilities, Community Education should provide for the awareness, discussion, and analysis of topics of contemporary community interest and concern.

Community Education

FY'79

District	Local Contribution	State Support
Anchorage/Eagle River	$978,646.00	$256,646.00
Adak	Not Listed	17,932.00
Annette Islands	Not Listed	7,015.00
Bering Straits	8,100.00	26,885.00
Bristol Bay	Not Listed	9,790.00
Chatham Straits	5,720.00	5,567.00
Copper River	Not Listed	14,227.00
Cordova	25,025.00	3,536.00
Craig	12,249.20	2,992.00
Delta Junction	5,000.00	21,226.00
Dillingham	Not Listed	12,169.00
Fairbanks	11,481	96,803.00
Haines	Not Listed	13,408.00
Hoonah	1,773.00	8,072.00
Juneau	Not Listed under total	46,583.00
Kake	7,935.00	4,764.00
Kenai	Not Listed	101,114.00
King Cove	2,390.00	6,701.00
Klawock	3,250.00	5,200.00
Kodiak	25,145.00	43,964.00
Lake & Peninsula	Not Listed	27,376.00
Lower Kuskokwim	19,767.00	38,130.00
Lower Yukon	Not Listed	10,722.00
Mat-Su	Not Listed	53,666.00
Nome	37,427.00	23,093.00
North Slope Borough	14,521.00	41,607.00
N.W. Arctic	Not Listed	39,794.00
Petersburg	Not Listed	7,090.00
Pribilof	16,126.00	5,670.00
Sitka	Not listed	30,232.00
Skagway	3,000.00	3,097.00
Southwest Region	Not Listed	30,887.00
Valdez	97,938.00	21,050.00
Yakutat	5,227.00	5,227.00
Yukon Flats	16,450.00	12,382.00
Iditarod	Not Listed	12,557.00
Totals	$1,397,170.20	$1,067,174.00

HB
637

STATE OF ALASKA
THE LEGISLATURE

LEGISLATIVE AFFAIRS AGENCY

POUCH Y - STATE CAPITOL
JUNEAU, ALASKA 99811
907-465-3800

M E M O R A N D U M

January 29, 1980

SUBJECT: ost settling for social services, etc.
Work Order Number 7795)

TO: Representative Charles H. Parr

FROM: David T. Walker
Co-Revisor of Statutes

Your request for reintroduction of CSHB 432 gave me the opportunity to do some "clean-up" work on the bill. I do not believe any of my changes are substantive - mostly they relate to use of the technique of repealing and reenacting and to clarifying that the cost settling technique is applicable to the purchase of services for all persons under the state's responsibility, not just to child care agencies.

I hope that these changes meet with your approval.

DTW:ljb

Enclosure

September 19, 1979

Representative Charles H. Parr
SR Box 50599
Fairbanks, Alaska 99701

Dear Representative Parr:

<u>You are one of our State's leading legislators and we need your help!</u>

Alaska Children's Services (ACS) is committed to providing quality residential childcare to our State's most troubled children. In fiscal year 1979 we provided more than 23,000 days and nights of tender loving care and professional treatment for 956 unwanted, abused, neglected and delinquent children and youth. Some of these children are from the district you represent in the State Legislature. More than 95% of the children we serve are in the custody of the State's Department of Health and Social Services through either the Division of Corrections or the Division of Social Services.

Alaska has some of the most stringent childcare, health, safety and fire codes in the nation. Our statutes were written to be in the best interest of children. For this you and our other law makers are to be commended. However, it costs a great deal to implement these statutes and regulations. Providing adequate funds to do this is also a legislative responsibility.

We at ACS want to work hand in hand with the Legislature and the Department of Health and Social Services in providing the very best care and treatment possible for these unfortunate and troubled children and youth. Even though we have a so called "full cost of care statute", AS 47.40, it falls far short of reimbursing agencies for the full cost of caring for state placed children. In 1979 our agency had to raise $143,000 from private contributions to subsidize state placed children. Many of our employees -- who are the real substitute parents for these children -- worked for less than the minimum wage simply because our request for adequate reimbursement rates have consistently been denied by the State. One such former employee is now suing us for back wages charging that we were in violation of Alaska Statute 21.10.

We need your help to change some of the laws that place heavy fiscal burdens on our childcare agencies and we need your help in obtaining adequate reimbursement for the full implementation of those laws and regulations which are in the best interest of children. Meanwhile, we need your help in getting adequate legislative appropriations for those line items in the State budget from which we are reimbursed for taking care of, and providing treatment for children the state places with us.

Alaska Children's Services

1200 East 27th Avenue
Anchorage, AK 99504
(907) 276-4515

Serving Alaska's Children through:

- Jesse Lee Home
- Group Homes:
  - Aquarius House
  - Collett House
  - North Star House
  - Mary Johnson House*
- Emergency Shelter Services*

(*located on the Anchorage Children's Christian Home Campus)

Jointly founded by the American Baptist, American Lutheran and United Methodist Churches

Member:
United Way of Anchorage
Child Welfare League of America

Specifically, the problems are as follows:

1. The Division of Corrections owes ACS in excess of $35,000 for services provided in FY 1979. We have been informed that we will not likely receive payment for this until a supplemental appropriation is approved by the Legislature. This, of course, cannot occur until next spring. Last year we waited 11 months to be paid $17,000 carried over by the Division of Corrections from FY 1978. How can we collect what the State owes us now for FY 1979?

2. Because of FY 1980 budget constraints the Division of Corrections has decided not to place any additional children in our care. This will have the long run effect of increasing the cost of care rate for next year since fixed expenses remain relatively the same whether the occupancy rate is 75% or 100% of state licensed capacity. What is going to happen to the Division of Correction's youth who need residential treatment? Will they not be "on the street" only to get into more serious difficulty with the law and ultimately require more extensive and expensive treatment and/or incarceration? How can we keep our rates reasonable without full placement utilization?

3. The Commissioner of the Department of Health and Social Services has determined not to grant any cost of living increase with our current reimbursement rates due to FY 1980 budget constraints. Inflation has increased our cost at least 10%. For July and August this has resulted in a $30,000 short fall, which will grow to more than $150,000 by the end of the fiscal year. How can this agency fiscally survive the year? Does not AS 47.40.040 state that cost of care rates shall include a proportionate share of anticipated cost of living and staff salary increment increases for the fiscal year for which the cost of services is being determined?

4. To curb expenditures sufficiently to stay within the current reimbursement rates we would have to terminate several staff members. We cannot legally provide the coverage necessary for the supervision and treatment of the troubled and unwanted children now in our care should this be done. Most normal families do not want to become foster parents for "these kind of children and teenagers." They either have no homes or families to which they can be returned or the ones they have are not safe or viable. What is going to happen to the children in our care and treatment programs if we are forced to terminate staff?

5. During the 1980 legislative budget process the Administration requested $6,989,833 for institutional childcare. The Legislature reduced this by nearly one half million dollars. The Commissioner states that she is committed and legally responsible to keep the Department of Health and Social Services expenditures within this reduced appropriation. ACS which has a long history, 90 years,

of providing quality care for Alaska's needy children cannot fiscally survive on the reimbursement rates established by the Department within the Legislature's appropriation. How can the Department's request of $6,989,883 be restored in order that they may be able to reimburse us more adequately?

1979 has been designated "The year of the child." ACS is stretching to its maximum ability to provide the very best residential childcare and treatment for Alaska's most troubled and needy children. We cannot do it alone. We and the children of our state need your help in finding a solution to our fiscal crisis. At your earliest convenience I, or one of our Board members, would welcome the opportunity to meet with you to discuss this pressing matter. Please call me at 276-4515 or let me know what additional information is needed. Can we count on you and the next session of the Alaska State Legislature to provide the resources necessary to keep serving Alaska's "troubled kids?"

Respectfully yours,

John C. Garvin, Ph.D.
Executive Director

JCG/rv

POSITION PAPER/Department of Health & Social Services

POSITION PAPER
ON
HOUSE BILL NO. 637

"An Act relating to the purchase of services by the state for persons under its responsibility; and providing for an effective date."

House Bill 637 redefines the procedures and policies for care purchased by the State from private institutions, group homes or foster care homes for children and young adults under the Department's supervision or custody.

The bill would require that the Department adopt regulations within one year from the effective date of the Act governing standards of reasonable and allowable costs for purchase of such services. The Department would be required to pay interim daily rates using "standard industrial cost-accounting principles" plus a cost-of-living increase. At the end of the fiscal year, a cost settlement between provider and the Department is made based on the actual costs incurred compared to the amount the provider has received from the State. Another major change is the allowance of depreciation and replacement costs of major property and equipment in determining reimburseable costs by the State.

Current Situation

The Department presently purchases care for these children under 47.40 of the Alaska law which is titled "Purchase of Service," but is more commonly referred to as "Full Cost of Care." Both the Department and providers of care have expressed dissatisfaction with the present law and its lack of flexibility to respond to current changing situations in a timely manner. In response to this, the Department has asked the Governor to introduce legislation which would allow us the flexibility to design such a system through negotiating contract procedures. This bill was introduced as House Bill 704.

The "Full Cost of Care" law now provides funds for the maintenance of the child (food, clothing, allowances, heat, light, transportation, etc.) as well as the program provided by each individual institution. The program costs are reflected in staff salaries. Costs specifically excluded by the law include fund raising, construction, major equipment, and other capital expenditures, depreciation, religious training and education, and services provided which are substandard to, or exceed, the requirement of the Department. Section 47.40.040(a) describes how the rate shall be set based on the previous years expenditures and days of service provided by the individual agencies. The method of rate computation has caused a great deal of dissatisfaction with the child care agencies and the State in that it is inflexible and based on year old conditions and costs.

POSITION PAPER/Department of Health & Social Services

Discussion Items

1. All reference to "full" cost in the "purchase of services" statute should be changed to reasonable or allowable in accordance with regulations. The statute stating it pays full cost of care, yet excludes many expenses has been a source of confusion and litigation. Since H.B. 637 would permit the Department to define by regulation standards of "allowable cost which are reasonable and necessary," it is likely that the Department may not pay for all costs associated with the child's care as certain items such as religious training will continue to be excluded from reimbursement. The same confusing situation will exist. Such reference to payment of "full cost" in the bill are on:

   a. Page 1, line 18.

   b. Page 1, line 28.

   c. Page 2, line 8.

2. Page 2, line 1 and 2 - We are unaware of any standard accepted "industry cost-accounting principles for fixed and variable costs" for the purchase of care for children. We interpret this to mean cost-accounting principles accepted by the AICPA (American Institute of Certified Public Accountants). We support the use of generally accepted cost-accounting principles utilized by the profession in the State.

3. Page 2, line 1 - We would recommend modifying the "per-person, per-day costs" to be based on total beds being maintained and available and not based on occupancy. The Department has found itself under the current law paying for the cost of vacant beds.

4. Page 2, line 4 - The bill states that the inflation increase is based on the Department of Labor cost-of-living index. In checking with the Department of Labor, we found that the appropriate title for this index is the United State Department of Labor, Bureau of Labor Statistics Consumer Price Index. The Bureau provides an index for both Anchorage and Fairbanks, Alaska. We would recommend a change reflecting the formal title of this index.

5. Page 2, line 5 - We recommend that the definition of salary increases include benefits. We have found that although base salaries in many child care institutions are low, many institutions provide free lodging, meals, and transportation in lieu of additional salary, which often brings their total compensation in line with salaries in the current market.

6. Page 2, line 14 - We would recommend that replacement costs continue not to be reimburseable under the purchase of services statutes. Since the bill would already be covering depreciation, we believe this would be duplicative. Also, it may serve as an

POSITION PAPER/Department of Health & Social Services

avenue of potential abuse for institutions who received their building through donations could as well bill the State for costs necessary to replace the building if became antiquated and needed replacement.

7. Page 2, line 15 - It would be extremely useful to clearly state that depreciation may not be claimed for buildings acquired by donation, rather than purchase. The public may be paying for the cost of the building twice - once through charity donations and again through tax dollars for the care purchase by the State provided in that institution.

8. Page 2, line 20 - We would recommend that the rates be based on reasonable and allowable costs as defined by regulations, rather than on actual cost incurred. This may avoid confusion in the future, when an institution provides services beyond which the State normally provides or cares to purchase (i.e., swimming pool). The State would pay only up to the level defined by regulation and not all dollars spent by the provider to care for the child.

9. Page 2, line 26 - We would recommend that the effective date be changed to July 1, 1981. We believe we could do a better job administratively if we had one year to prepare for the new process. We would have to write and issue new regulations; hold public hearings; revise forms and manuals; hold training sessions for providers and department staff; and advise provider groups accordingly. If this recommendation is accepted, we would see no objection to the regulations becoming due shortly (90 days) after the bill becomes effective, rather than one year later.

Department Position

Although the Department believes that the contracting approach to purchase of services found in H.B. 704 is preferable, we could support H.B. 637 if the changes noted in this position paper are accepted. We, too, recognize the need to revise Alaska "purchase of services" law in order to make it more responsive to current situations and to make reimbursement more cost-effective and appropriate.

Approved by: Helen D. Beirne 3/21/80

Helen D. Beirne, Commissioner (DATE)
Department of Health and Social Services

(10) "intoxicated person" means a person whose mental or physical functioning is substantially impaired as a result of the use of alcohol;

(11) "office" means the office of alcoholism within the Department of Health and Social Services;

(12) "treatment" means the broad range of emergency, outpatient, intermediate, and inpatient services and care which may be extended to alcoholics and intoxicated persons, including diagnostic evaluation, medical, psychiatric, psychological, and social service care, vocational rehabilitation and career counseling. (§ 1 ch 207 SLA 1972; am § 4 ch 116 SLA 1978)

Effect of amendment. — The 1978 amendment inserted "or through a grant awarded under AS 47.30.475" in paragraph (3).

Quoted in Peter v. State, Sup. Ct. Op. No. 1112 (File No. 2185), 531 P.2d 1263 (1975).

Chapter 40. Purchase of Services.

Section	Section
10. Purchase of services	50. Services
20. Licensing and supervision	60 — 70. [Repealed]
30. Required accounting procedures	80. Definitions
40. Determination of full cost of services	

Sec. 47.40.010. Purchase of services. (a) When the department purchases services for persons for whom the state has assumed responsibility under the laws of the state, the department shall

(1) adopt regulations establishing the levels of care to be provided;

(2) determine the rates of payment for the full cost of services required;

(3) pay all expenses related directly to the full cost of services at the levels of care required;

(4) make the placement of persons in accordance with the levels of care provided for in the regulations.

(b) Services of jails and other penal institutions may not be included in services purchased by the state in this chapter. (§ 1 ch 136 SLA 197

Sec. 47.40.020. Licensing and supervision. Anyone providing services which are purchased by the department under this chapter shall, if required by the department, be licensed and supervised in the same manner as boarding homes, foster homes and other institutions provided for in AS 47.35.010 — 47.35.080. (§ 1 ch 136 SLA 1970)

Sec. 47.40.030. Required accounting procedures. Anyone who solicits or receives funds from the department for the cost of services provided under this chapter shall

(1) meet accepted standards of fiscal accountability for public funds and shall, upon request, submit a complete financial statement by an independent, certified public accountant to the department and to the division of legislative audit;

THE FOLLOWING DOCUMENT(S) MAY NOT FILM LEGIBLY BECAUSE OF POOR QUALITY OF THE ORIGINAL.

(2) upon request before the meetings provided for in AS 47.05.010 (10) demonstrate the actual cost of services offered using cost accounting procedures as provided for by the department;

(3) upon request, furnish the division of legislative audit all fiscal information, books, records, and accounts pertaining to services paid for under this chapter. (§ 1 ch 136 SLA 1970)

Sec. 47.40.010. Determination of full cost of services. (a) In this chapter, "full cost" of services shall be determined by the per person, per day cost in the preceding fiscal year plus a proportionate share of anticipated cost of living and staff salary increment increases for the fiscal year for which the full cost of services, determined to be necessary by the department, is being determined. Child care costs for foster homes shall be computed in the same manner as for child care and nursing home institutions except that no salary costs may be considered.

(b) Full cost of services does not include the following:

(1) expenses, including salaries and fees, incurred in raising funds;

(2) funds expended for construction, major equipment and other capital expenditures;

(3) depreciation and replacement costs of, and costs of additions to, major property and equipment;

(4) religious training and education; and

(5) services provided which are substandard to, or exceed, the requirements of the department. (§ 1 ch 136 SLA 1970)

Sec. [illegible].050. Services. When determining the levels of service to be [illegible] department shall consider program services as outlined in the Catalogue of Functional or Program Service Categories published by the United Funds and Councils of America, September [illegible] (§ 1 ch 136 SLA 1970)

Sec. 47.40.060. Temporary placement. Repealed by § 1 ch 210 SLA 1970.

Revisor's note. — The repealed section derived from § 1, ch. 136, SLA 1970.

Sec. 47.40.070. Permanent placement. Repealed by § 1 ch 210 SLA 1970.

Revisor's note. — The repealed section derived from § 1, ch. 136, SLA 1970.

Sec. 47.40.080. Definitions. In this chapter

(1) "anyone" means any person, city, organized borough and private voluntary institution or agency;

(2) "services" means family, child welfare and nonprofit nursing home services but does not include health, hospital, profit-making nursing homes or medical services,

Supplement

(3) "department" means the Department of Health and Social Services. (§ 1 ch 136 SLA 1970; am § 2 ch 210 SLA 1970; am § 55 ch 71 SLA 1972)

Legislative history report. — For report on ch. 71, SLA 1972 (HCSSB 383 am H), see 1972 House Journal, p. 898.

Chapter 45. Alaska Longevity Bonus.

Section

10. Persons who may qualify for longevity bonus
20. Continuous eligibility procedures
30. Absence from the state
40. Disqualification
50. Department hearing
60. Legal remedy
70. Unqualified persons
80. Accrual of bonuses
90. Alaska longevity bonus fund
100. Powers and duties of the administrator
110. Custody of funds
120. Exemption from taxation and process
130. Death or cessation of residency
140. Penalty for false statements
150. Definitions
160. Applicability of Administrative Procedure Act
170. Purpose

Editor's note. — Section 2, ch. 205, SLA 1972, provides: "AS 01.10.030 does not apply to this Act. If any provision of this Act, or the application of a provision of this Act to any person or circumstance is held invalid, this entire Act shall be considered invalid."

Legislative history report. — For report on ch. 205, SLA 1972 (FCCS HCS CSSB 211), see 1972 House Journal, p. 751.

Sec. 47.45.010. Persons who may qualify for longevity bonus. (a) A person who is 65 years of age or over, who was domiciled in the territory on or before January 3, 1959 and who has maintained a continuous domicile in the territory or state for 25 years may apply to the commissioner of administration for qualification to receive a monthly bonus of $150.

(b) When the commissioner of administration determines that an applicant qualifies under this chapter he shall immediately begin payment of the bonus.

(c) A person who otherwise qualifies to receive a bonus provided for in this chapter may continue to do so only as long as he continuously retains a domicile in the state. (§ 1 ch 205 SLA 1972; am § 1 ch 33 SLA 1976; am § 1 ch 89 SLA 1978)

Effect of amendments. — The 1976 amendment increased the monthly bonus in subsection (a) from $100.00 to $125.00.

The 1978 amendment increased the monthly bonus in subsection (a) from $125.00 to $150.00.

Legislative history report. — For report on ch. 33, SLA 1976 (SB 476 am), see 1976 Senate Journal, p. 160.

THE PRECEDING DOCUMENT(S) MAY NOT FILM LEGIBLY BECAUSE OF POOR QUALITY OF THE ORIGINAL.

THE LEGISLATURE OF THE STATE OF ALASKA
ELEVENTH LEGISLATURE

FISCAL NOTE

I. REQUEST
Bill/Resolution No. House Bill 637
Title "An Act relating to the purchase of services by the state for persons under its
Requested by House HESS Date 4/16/80
Title cont.
responsibility; and providing for an effective date."

II. FISCAL DETAIL
Agency Affected Department of Health and Social Services
Program Category Affected Social Services, Justice, Health
BRU, Program, or Subprogram(s) Affected Admin. and Support - Audit
(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

		FY 80	FY 81	FY 82	FY 83	FY 84	FY 85
100	PERSONAL SERVICES		125.8	98.0	111.0	124.0	140.0
200	TRAVEL		20.1	10.0	21.0	23.0	25.0
300	CONTRACTUAL		.9	1.1	1.3	1.4	1.6
400	COMMODITIES		1.0	.8	.9	1.0	1.1
500	EQUIPMENT		2.5				
600	LAND & STRUCTURES						
700	GRANTS, CLAIMS, ETC.		1) See Note 1 below				
	TOTAL		150.3 *	118.9 *	134.2 *	149.4 *	167.7 *

*Does not include costs in 700 lines as result of cost settling.

FUNDING (Thousands of Dollars)

GENERAL FUND		150.3*	118.9*	134.2*	149.4*	167.7*
FEDERAL FUNDS						
OTHER (Specify Fund Source)						

POSITIONS

FULL TIME		3	2	2	2	2
PART TIME						
TEMPORARY						

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

Note 1:

During 1978 rate hearings were held for "full-cost-of-care" as required in AS 47.40.70. Inflationary rate increases were established and the costs for the first six months of that year were reviewed. Based on that information rates were believed to be sufficient to pay for the full-cost-of-care. A review of FY 1979 provider costs revealed costs exceeded actual payments by $352,723.81. It may be reasonable to assume that the FY 81 cost settlement would be at least equal and probably greater.

Assumptions:

1. Actual impact cannot be estimated for expenditures related to costs to be allowed under this bill, as no data base exists. Other line items reflect 7% inflation.

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)

Prepared by: Deborah Bliss Date: April 16, 1980
Division/Office: PH:
Department of Health & Social Services

Approval DHSS Mgt. & Bdgt: Date: 4/16/80

33-001 (Rev. 12/79)
Modify by DHSS (11-28-79)

2. Costs above reflect increase in administrative expense only.
3. All positions full year budgeted.
4. Salaries reflect current contracts plus 7% increase in calendar year 1982.

Program:

1. Personal Services

   a. Two range 18 Field Auditors
      Salary FY 81
      2465 increases to 2640 1-1-81

      FY 82
      2736 increases to 2928 1-1-82
      Benefits total 28%

Program:

   b. Social Worker IV Position for FY 81 only.

      This position is needed to enable the Department to promulgate regulations this fiscal year, including levels of care and standards of allowable costs. The position would also carry out an implementation plan including developing facility forms, guidelines, and information packets. Finally, the position would provide ongoing expertise in residential child care and develop strategies to enable providers to upgrade the quality of their treatment programs.

2. Program Plan

   These additional auditors will be required to perform lengthy and complex fiscal audits to establish and revise rates of reimbursement for contract providers of service.

   The complex financial arrangements made by some current providers include holding companies, lease back agreements, donated property and similar complications, all of which preclude an accurate cost estimate.

State of Alaska						
ification	Minimum Qualifications	Salary(3)	Classification	Minimum Qualifications	Salary(4)	Difference*
Asst I Asst II	High School graduation/or GED 6 months at Nurs. Asst I level	$1140mo 1277mo	Houseparent (live in position) (2)	High school graduation or GED	$3.60hr (5)	NA I - 83% NA II- 106%
unselor I	High school graduation plus 1 yr college or 1 yr casework	$1533mo	Youth Worker	High school graduation plus 2 yrs college or 2 yrs exp. in residential care facility	$5.45 (6)	62%
unselor III	High school graduation plus 3 yrs college or 3 years case-work	$22,200 year	Unit Supervisor	Bachelor degree in behavioral sciences plus 2 years of experience	$13,860 year	60%
orker II	M.S.W.	$22,200 year	Social Worker	M.S.W.	$17,640 year	26%
eatment Supervisor	Bachelor degree in social sci. plus 2 years admin superv. in group living--corr. facility	$29,580 year	Program Director	M.S.W. or Masters in Couns. Psych plus 2 yrs experience	$21,420 year	38%
Services rator	Masters in clinical psych, couns. soc. wk + 4 yr diagnostic wk in clinical setting	$32,472 year	Director, Clinical Services	M.S.W. plus 4 years experience	$23,940 year	36%
endent	Experience required varies & is dependent upon type of institution up through masters work	$34,140 year	Executive Director	M.S.W. plus 5 years superv. or management experience	$35,000-38,000 (7)	(3% higher)
l Officer I	Bachelor's degree	$23,088 year	Director, Personnel	Bachelor degree plus 2 yrs experience	$17,640 year	31%
pist III	High school graduation plus 1 yr cler exper.	$15,324 year	Word Processing	High school graduation plus 2 years prog resp. clerical experience	$11,340 year	35%
pist II	High school graduation plus 6 mo clerical experience	$14,484 year	Receptionist/Typist	High School plus 6 month experience	$11,340 year	28%
ng Clerk III	High school graduation plus 3 yr exp., 1 at Acct Clk II level	$17,280 year	Computer Operator/ Bookkeeper	High school graduation plus 3 yrs experience	$13,860 year	25%
nce Man	Journeyman level w/several skill specialities	$9.52 hour	Maintenance Leadman	3 years experience; journey-man level; 3 specialities	$6.66 hour	43%
Custodian	Qualified level, but not journey man	$7.94 hour	Maintenance Worker	High school graduation plus 2 yrs exper.--1 speciality	$5.45 hour	46%
ping Aide v Wkr WG X	Ability to perform work	$6.94 hour	House Manager (cook/housekeeper)	Family housekeeping	$3.60 hour	93%

*Approximate percentage increase required to bring residential care rates to same pay level as State.

HB
651

STATE OF ALASKA
THE LEGISLATURE

POUCH Y - STATE CAPITOL
JUNEAU, ALASKA 99811
907 465-3800

LEGISLATIVE AFFAIRS AGENCY

M E M O R A N D U M March 11, 1980

SUBJECT: Effect on land and land grant assistance of establishment of a separate Alaska Community College System, HB 651

TO: Representative Thelma Buchholdt, Chairman
House Health, Education and Social Services Committee

FROM: John B. Chenoweth
Legislative Counsel

At the committee hearing of March 10th, members of the committee posed two questions, both bearing on the effect of establishment of a separate community college system on lands now held by or for the benefit of the University of Alaska.

The first question concerned the propriety of the legislature's designation of a second educational institution and the receipt by it of a portion of federal land grant assistance. In a 1976 memo, prepared in conjunction with an earlier version of community college legislation, the Agency suggested that it saw no problem in establishing institutions of higher education in addition to the land grant college originally designated:

> "Federal land grant aid is based upon the Morrill Act and subsequent legislation incorporated under 7 U.S.C. 301-349. Under the Morrill Act federal land or land script was donated to the states and the proceeds from the sale of the land or script was placed in a trust fund to be used 'to the endowment, support and maintenance of at least one college where the leading object shall be, without excluding other scientific and classical studies and including military tactics, to teach such branches of learning as are related to agriculture and the mechanic arts in such manner as the legislatures of the states may respectively prescribe, in order to promote the liberal and practical education of the industrial classes in the several pursuits and professions of life.' (7 U.S.C. 304).

"The Morrill Act applied only to states and did not provide federal aid for territorial colleges. Consequently, the University of Alaska originated from a land grant enacted by Congress in 1915. The Act provided for the donation of certain federal lands to be leased by the Territory to provide operating expenses for 'the support of a territorial agricultural college and school of mines when established by the Legislature of Alaska' (P.L. 63-181, section 1). Section 2 of that 1915 Act of Congress provided federal lands as a site for the territorial college and school of mines. The original territorial college, therefore, was not created under the same conditions and procedures as were state colleges under the Morrill Act. Nevertheless, the successor to the original territorial college and school of mines has been and still is treated by the federal government as if it were a land grant college under the Morrill Act.

"Assuming then that the University of Alaska is a 'land grant' college as that term has been used in relation to the Morrill Act, the first question to be addressed is whether a state which already has an existing land grant college can create a separate postsecondary educational institution which could also be classified as a land grant college for purposes of receiving federal land grant aid. This question has been specifically answered by the courts. In State of Wyoming ex rel Wyoming Agricultural College v. Irvine 206 U.S. 278 (1906), the Wyoming Agricultural College, which was that state's original land grant college, contested the appropriation of federal land grant monies to the University of Wyoming, which was established several years after the Wyoming Agricultural College was founded. The plaintiff claimed that federal land grant monies were appropriated directly to land grant colleges and, as such, the state could not reallocate these monies to different educational institutions. The Supreme Court disagreed. It held that federal land grant monies are appropriated to the states - not to specific institutions - and the states, acting through the legislatures, could create additional institutions which could qualify for aid (206 U.S. at 283). The court's ruling was codified under the agricultural extension act which provided that if a state had two or more land grant colleges, federal land grant aid for extension programs 'shall be administered by such . . . colleges as the legislature of such state [or] territory . . . may direct' (7 U.S.C. 341)."

The Committee members' second question concerned particular parcels or tracts of land held by the University.

A 1976 study for the University, prepared by Charles E. Tulin and Dale Tubbs and published as a "Manual of University of Alaska Lands" identifies the University lands by parcel and catalogs the holdings into seven categories

(1) "Site lands", the lands within the Tanana Valley, the site of the principal campus of the system at Fairbanks, conveyed to the Territory of Alaska by the Act of March 4, 1915, 48 U.S.C. 354;

(2) Section 33 lands, reserved from townships 33 for the benefit of the University by the 1915 Act, 48 U.S.C. 353, and granted to the State by the Statehood Act;

(3) 100,000 acre lands, authorized by the Act of January 21, 1929, 48 U.S.C. 354a, providing that the University might select up to 100,000 acres of vacant non-mineral, surveyed, unreserved public lands;

(4) Experiment Station lands, withdrawn by the U. S. Department of Agriculture for experimental station purposes, and subsequently conveyed to the University by the United States Government;

(5) Gift lands, provided by private gifts and endowments;

(6) Purchased lands, acquired through purchase from private and public sources; and

(7) Leased lands, held by the University under lease-purchase or similar arrangement.

The report indicates that the various categories of lands are subject to differing restraints on alienation. Since committee members limited expressions of concern only to tracts or parcels which clearly related back to the original federal acts providing for conveyance of these lands, the first three categories of the preceding paragraph, I will limit discussion to these.

"Site lands", by the Act of 1915, are required to be "forever reserved and dedicated to use as a site for an agricultural college and school of mines," and constitute a revocable

grant. The 1915 Act does not authorize disposition of the lands, thus the four sections included in the Fairbanks campus site may not be reconveyed from University ownership.

Section 33 lands, that is, the various sections 33 of townships in the Tanana Valley, were reserved to the territory for the benefit of an agricultural college and school of mines by the same 1915 Act, but subject to different strictures. The original statute precluded "sale or settlement," but specifically permitted the lease of these lands, with use of the proceeds or income from these lands to be invested and the income to be expended "for the exclusive use and benefit of . . . the agricultural college and school of mines, . . . in such manner as the Legislature of Alaska may by law direct." The Statehood Act, P.L. 85-508, sec. 6(k), repealed provisions of the 1915 Act, granted to the State the lands previously reserved to the Territory, but imposed the additional condition that the Statehood Act land grant was "for the purposes for which [the lands] were reserved [under the 1915 Act, §353]." Thus, the state received title to the Section 33 lands as the corpus of a trust for the benefit of the state's university system.1/

The 100,000 Acre lands were originally granted by a 1929 Act, codified as 48 U.S.C. 354(a), and were subject to extensive limitations and conditions. Sale or disposal of these lands was, however, permitted, with the principal stipulation that sale proceeds be deposited into an account in the state treasury for the benefit of the University. The parallel state statute is AS 14.40.400, amended in secs. 3 - 5 of HB 651 to recognize the proposed community college system.

1/ Whether Section 33 lands may be sold or otherwise disposed of is an unresolved question. Relying on the provision in 48 U.S.C. 353 prohibiting sale or settlement of these lands as surviving repeal of that section by the Statehood Act, the Tulin-Tubbs report concludes that sale or disposal is precluded. In a 1978 memo, this Agency reached the opposite conclusion, suggesting that the repeal of §353 by the Statehood Act removed the impediment. However, the latter determination is without legal effect in that the legislature has specifically authorized only lease of these lands, with income to go for the benefit of the University under AS 14.40.360. HB 651 recognizes the applicability of the community college system's sharing in this income: see AS 14.42.300.

I suggest that, with respect to both Section 33 lands and those which derive from the so-called 100,000 acre category, the state legislature has latitude to determine that these lands may benefit a separate community college system as well as the University of Alaska corporation. The decision in Irvine earlier cited suggests that the legislature has discretion in the expenditure of land grant funds. There is no comparable court decision that considers the discretion which the legislature enjoys with respect to land when it authorizes establishment of a separate institutional system. But policy arguments, when coupled with reference to the land grant enabling legislation, 7 U.S.C. 301 - 308, suggest that, where, as with HB 651, the legislature is proposing to establish a community college system "as part of a comprehensive statewide system of degree and nondegree programs," where the course work offered by the community colleges provides both "practical education . . . in the several pursuits and professions of life," and a liberal education that does not exclude "other scientific and classical studies," -- the tests of the "rounded education" required to be provided by a land grant college, 7 U.S.C. 304 -- and where Congress has not required that land grant colleges provide a full course of instruction at only one location, the legislature may establish a community college system as an extension of the state's university system, to introduce postsecondary education to students at locations closer to their homes, without sacrificing the benefits received by the state's land grant status.

The matter of title to lands is admittedly not entirely clear. The committee may wish to consider additional language, to be added in sec. 18(a), to the effect that, where title to property may not be conveyed to a community college because of restrictions or limitations included in the grant of lands used for the benefit of a unit of the community college system, the Board of Regents shall enter into a long-term lease with the Board of Trustees of the Community College System by which the latter may have exclusive use of the facility or parcel for a period of years specified by statute.

JBC:ljb

THE BOARD OF REGENTS

UNIVERSITY OF ALASKA
FAIRBANKS, ALASKA 99701

March 7, 1980

Representative Thelma Buchholdt, Chairperson
House HESS Committee
112 State Capitol
Pouch V
Juneau, Alaska 99811

Dear Representative Buchholdt & Committee Members:

House Bill 651, which you are now considering, would separate the Community College system from the University of Alaska. As Vice President of the Board of Regents and as an Alaskan citizen, I wish to bring your attention to four of the many issues that arise relative to the proposed split.

First, the University of Alaska is an integrated system of senior colleges, community colleges, Rural and Cooperative Extension Service Centers, fisheries and agricultural programs and many other services reaching every corner of the State. We cannot draw lines that would neatly put Community Colleges on one side and the University of Alaska on the other. There must continue to be full mutual access between the University and the people of Alaska. The constitutional mandate of the University and the proposed mandate of the Community Colleges would overlap in far too many areas. House Bill 651 would not create two complementary systems, but rather would invite duplications and confrontations on boundaries that are not and cannot easily be defined. We believe that would not be in the interests of the people of Alaska.

Second, we see immense potential in the present structure to provide integrated, coordinated educational services to the people of Alaska. No one is more aware than the Board of Regents is of the painful growth and development we have experienced to achieve this potential. House Bill 651 would dismantle that structure just as it is prepared to prove itself to be one of the great assets of the people of Alaska.

Third, the University of Alaska, in its entirety, is a small University. Seattle University, Portland State, Chico State and many other schools of modest size are larger than the University of Alaska. Providing maximum benefit from our capital, human and educational resources for a widely scattered population, is already our foremost challenge. Dividing those resources under two separate Boards and two separate Administrations is not the best use of resources, nor is it sound educational development.

And finally, House Bill 651 cannot relieve the Board of Regents of its constitutional responsibility to make the educational resources of the State University available to all citizens of the State. The Community Colleges are vital to the mission we accepted. Their removal would leave us with the same task, but with a drastically reduced capacity to respond.

To: Representative Thelma Buchholdt
From: Regent Jeffry J. Cook
Re: House Bill 651
Date: March 7, 1980

Many Legislators have expressed satisfaction with the tremendous strides that the University has made in the development of educational services. We now ask your support for continuation of a unified system of public higher education in Alaska.

Sincerely,

Jeffry J. Cook, Vice President
Board of Regents

JJC:hr

CC: Jay Barton
Edward B. Rasmuson
Members of the Board of Regents
Representative Joyce Munson, Vice Chairman - House HESS
Representative Vernon L. Hurlbert
Representative Bill Miles
Representative Ramona L. Barnes
Representative M. F. Beirne
Representative C. V. Chatterton

THE LEGISLATURE OF THE STATE OF ALASKA
ELEVENTH LEGISLATURE

FISCAL NOTE

I. REQUEST
Bill/Resolution No. HB 651 (introduced 1/31/80)
Title An Act establishing the Alaska Community College System
Requested by Representative Buchholdt Date 3/11/80

II. FISCAL DETAIL
Agency Affected University of Alaska
Program Category Affected Education
BRU, Program, or Subprogram(s) Affected All University of Alaska
(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

		FY 80	FY 81	FY 82	FY 83	FY 84	FY 85
100	PERSONAL SERVICES						
200	TRAVEL						
300	CONTRACTUAL						
400	COMMODITIES						
500	EQUIPMENT						
600	LAND & STRUCTURES						
700	GRANTS, CLAIMS, ETC.						
800	MISCELLANEOUS	-0-	5,450.0	5,995.0	6,594.0	7,254.0	7,979.0
	TOTAL	-0-	5,450.0	5,995.0	6,594.0	7,254.0	7,979.0

FUNDING (Thousands of Dollars)

GENERAL FUND	-0-	5,450.0	5,995.0	6,594.0	7,254.0	7,979.0
FEDERAL FUNDS						
OTHER (Specify Fund Source)						

POSITIONS

FULL TIME	0	60	60	60	60	60
PART TIME						
TEMPORARY						

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

See Attachment.

IV. DATE 3/11/1 PREPARED BY [signature]
AGENCY University of Alaska
PHONE 479-7593

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)

[illegible] (Rev. 12/79)

A. Assumptions:

1. 10% inflation per year following FY81.
2. All support functions under the proposed Community College System would be totally independent and separate from the current University of Alaska system.
3. No program expansions or reductions are included in the fiscal data.
4. The Community College System Statewide offices would be based in Anchorage.

B. Program Summary:

1. Positions - An estimated 60 new positions would need to be added to perform all the functions presently being performed by the University of Alaska system. A few of these positions (approx. 15%), could be transferred from the University of Alaska. It is impossible to be precise without several months of detailed planning when the bill is enacted.

2. Types of Expenditures - The following table identifies, by function, the level of expenditure required to create a separate administrative structure for the proposed Community College System.

a. Board of Trustees expenses	$150,000
b. Data Processing Network	1,400,000
c. Financial Administration/Purchasing	333,000
d. Payroll	275,000
e. Institutional Studies	180,000
f. Admissions and Records	370,000
g. Financial Aid Administration	360,000
h. Facilities Planning/Construction	408,000
i. Rural Facility Maintenance	111,000
j. Public Information Office	118,000
k. Student Services	360,000
l. Legal Services	250,000
m. Risk Management	750,000
n. Property Control	65,000
o. Additional Leased Office Space	150,000
p. Labor Relations Management	80,000
q. External Audit	90,000
Total	$5,450,000
Approximately $800,000 could be transferred from UA	(800,000)
Net Increase to State (GF)	$4,650,000

3. Exclusions - The above data does not attempt to assess the fiscal impact on other institutions which presently deal with one university system. Other institutions include the Alaska Commission on Postsecondary Education, Alaska Department of Administration, and Alaska Department of Revenue.

C. Agency Comments: The University of Alaska is not in favor of the proposed HB 651. The principal reasons include:

1. When dealing with two entirely separate institutions, students attending the Community College System would have significantly greater problems with the transfer of credits than at present.
2. Dividing the University of Alaska at a time when the State's policies with respect to postsecondary education are not clearly defined would result in:
   a. further confusion about the allocation of resources for post secondary education;
   b. greatly expand the competition for resources dedicated to education; and
   c. result in costly and needless duplication of programs within the state.
3. The creation of the Community College System would necessitate a costly, duplicative, and unneeded bureaucracy in higher education.

4. While more populous states (such as California) have multiple systems of higher education Alaska still has one of the lowest population levels in the nation. Accordingly, the University of Alaska feels that the small population base does not warrant more than one public system of higher education.

5. A division of the University of Alaska would result in substantial amounts of litigation for a number of years. At present, many contracts are in force which affect multiple institutions. Lands, buildings, and property would need to be divided, and many federal grants and contracts would need to be renegotiated.

6. The currently pooled resources of the University of Alaska would be divided into fractional components, which would diminish the effectiveness of either institution in solving many of the state's problems, especially in rural education and crosscultural educational programs.

HB 651
file in
H+SS 2/80

STATE OF ALASKA

ALASKA COMMISSION ON POSTSECONDARY EDUCATION

JAY S. HAMMOND, GOVERNOR

POUCH F - STATE OFFICE BUILDING
JUNEAU, ALASKA 99811
(907) 465-2855

M E M O R A N D U M

TO: Members of the House HESS Committee

Thelma Buchholdt, Chairman
Ramona Barnes
~~H.~~ F. "Mike" Beirne
C. V. "Chat" Chatterton
Vernon L. Hurlbert
Bill Miles
Joyce Munson

FROM: Kerry D. Romesburg, Executive Director
Alaska Commission on Postsecondary Education

DATE: February 28, 1980

HB 651, an act establishing the Alaska Community College System, is before your committee for consideration. In your deliberations it may be useful to have available some general background information. Much of this information may have already been submitted through various testimonies, but I felt it might be beneficial to have it summarized in one place.

A. Community College Structures

In examining the governance structures for community colleges in the fifty states, one finds a variety of approaches. These can be categorized into six basic types for summary purposes, but it should be remembered that a great deal of variation may exist between approaches included under one category. The most important point to be made is that no one type is always successful or always a failure. There are strengths and weaknesses to each, and there are advocates and critics of each. No single approach can be held up as the only, or best approach for other than subjective reasons.

Structure	Number of States	
No community colleges	2	(SD and IN)
CC's part of university	4	(AK, HI, KY, NY)
Separate CC board - no coord. board	7	
Separate boards with a coord. board	28	
One statewide ed. bd. for all educ.	5	
CC's divided between bd's.	4	
	50	

B. Transfer of Credits

Transferability of credit is not a product of the governance structure, or at least, it should not be. A student attending a public institution should be given the information as to exactly which credits will or will not transfer to other in-state public institutions; and further, if the credits do transfer, the student should know if the credits apply toward major degree requirements. This can be achieved with a single system or a totally independent system, with or without a statewide coordinating board.

C. Accreditation

If accreditation problems exist currently, they would probably continue to exist under a different structure. Each institution is presently seeking its own accreditation, so creating a new separate system should not adversely affect this process. In other words, accreditation should not be a prime determinate in the current deliberations.

D. Educational Goals

The goals of a community college are different from the goals of a university. This is well-established. In fact, a nationwide study of over 1,000 persons, conducted in 1976 by Dr. Leonard Romney of the National Center for Higher Education Management Systems, documented, or attempted to document, these differences. Trustees, administrators, and faculty were asked to rank twenty goal areas for their institution. Those goals ranked highest by community college representatives were quite different from those ranked highest by doctorate-granting universities. For example: trustees, administrators, and faculty in community colleges ranked "meeting local needs: as 2nd, 1st, and 2nd, respectively; while those doctorate-granting university representatives ranked it as 16th, 15th, and 15th, respectively. Conversely, doctorate-granting univeristy trustees, administrators, and faculty ranked "academic development" as 2nd, 1st, and 1st, respectively; while community college representatives ranked it 13th, 7th, and 9th, respectively.

Whether or not a single administration and single board can encompass these divergent philosophies is of course at the center of the current issue. As with so many of these questions, the answer may be people-dependent rather than structure-dependent. Within some states a single board and administration is both lauded and criticized. The same is true for those states with separate boards. The decision as to which structure is the best for which state is a question for the Legislature, and ultimately, the people to answer.

E. Administrative Efficiency

Efficiency is usually measured as a relationship between cost and output. In education this becomes extremely difficult to measure, especially in any objective fashion. Costs, of course, can be readily identified, and there are few who would argue that two separate systems will not require additional costs.

Output, in an educational sense, relates to actual changes in the lives of people. To simply quantify outputs in terms of credit hours produced or degrees granted is a disservice. If this is recognized, the question then becomes one of whether or not the educational outputs and services would be better under one structure than another. This is also a philosophical issue which must be addressed on a state by state level. Would one structure or the other be educationally better for Alaska? Would one structure or the other better promote the services and programs of community colleges in Alaska? These are the questions to be answered.

F. Enrollment Data

Enrollments in Alaska's community colleges have expanded by more than 400 percent in the last eight years. Some if this increase is attributable to expansion of the community college system, but the majority of the increase is an absolute increase in the percentage of the population receiving educational services from the community college system. In terms of headcount, in 1978-79, the community colleges accounted for 62.6% of the students enrolled for credit in the University of Alaska. This headcount relationship is presented in Figure 1.

Peak semester enrollments are used to reflect the most individuals served at one time (semester) throughout the academic year.

Figure 2 contains data on student credit hours produced within the University of Alaska system. In 1978-79, the community colleges produced 55.2% of the total student credit hours. From these comparisons it is readily seen that Alaska's community colleges represent a large and vital portion of the public postsecondary educational resources of the State.

Full-time equivalent enrollments, those calculated by converting student credit hours to a full-time student equivalent, are presented in Figure 3.

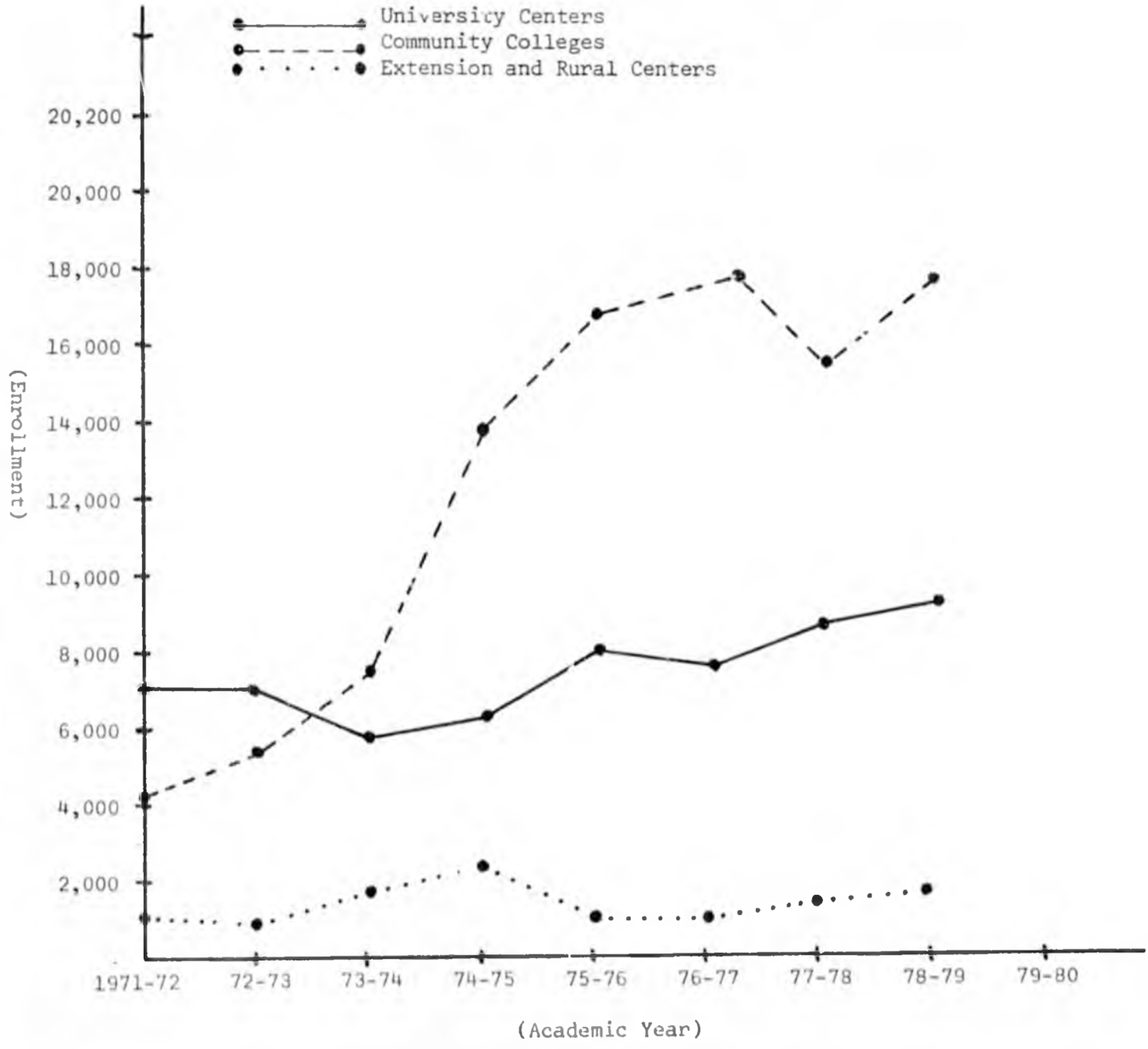


Figure 1
Headcount Enrollments, Peak Semester
1971-72 through 1978-79

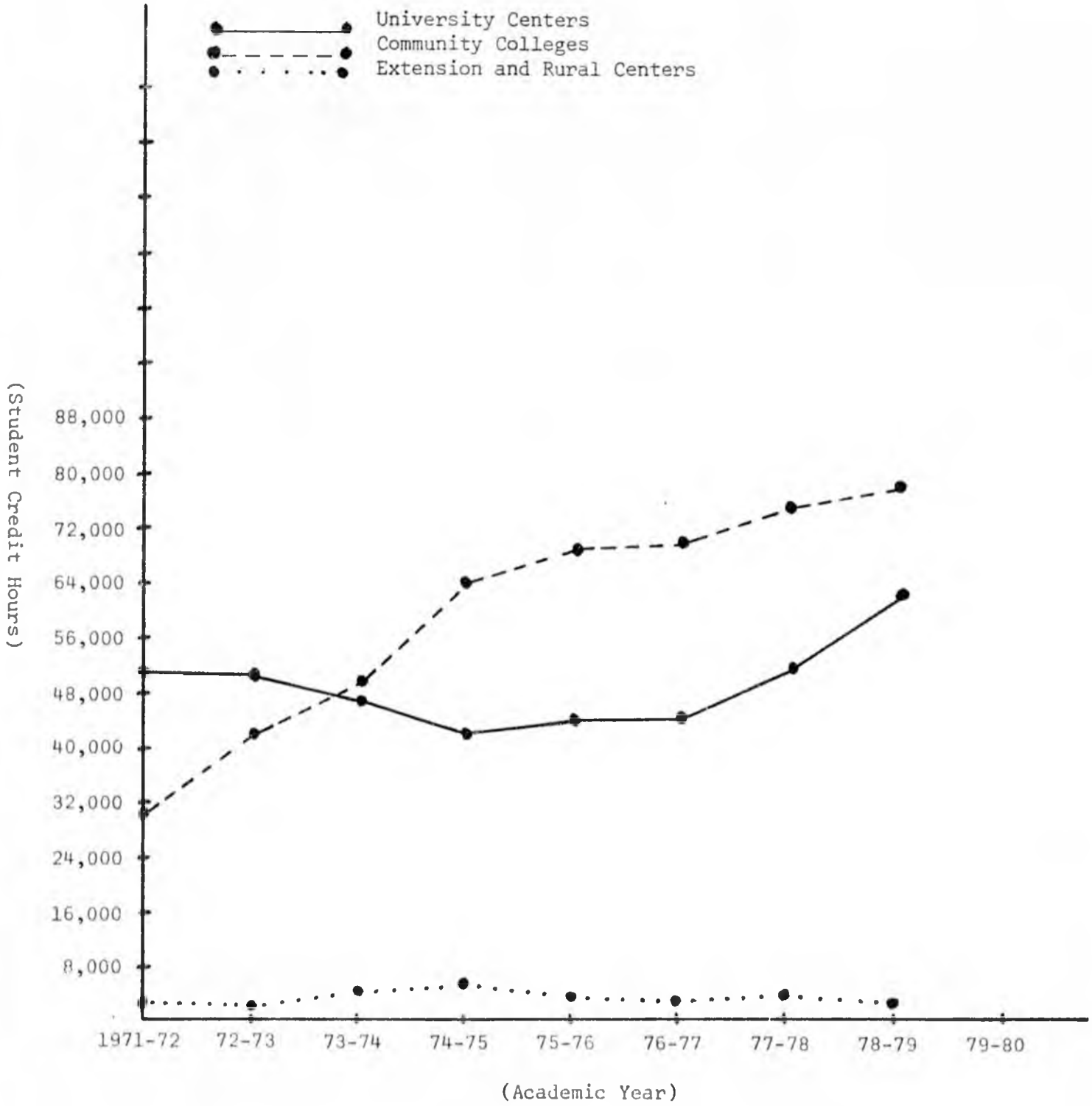


Figure 2
Student Credit Hour Production, Peak Semester
1971-72 through 1978-79

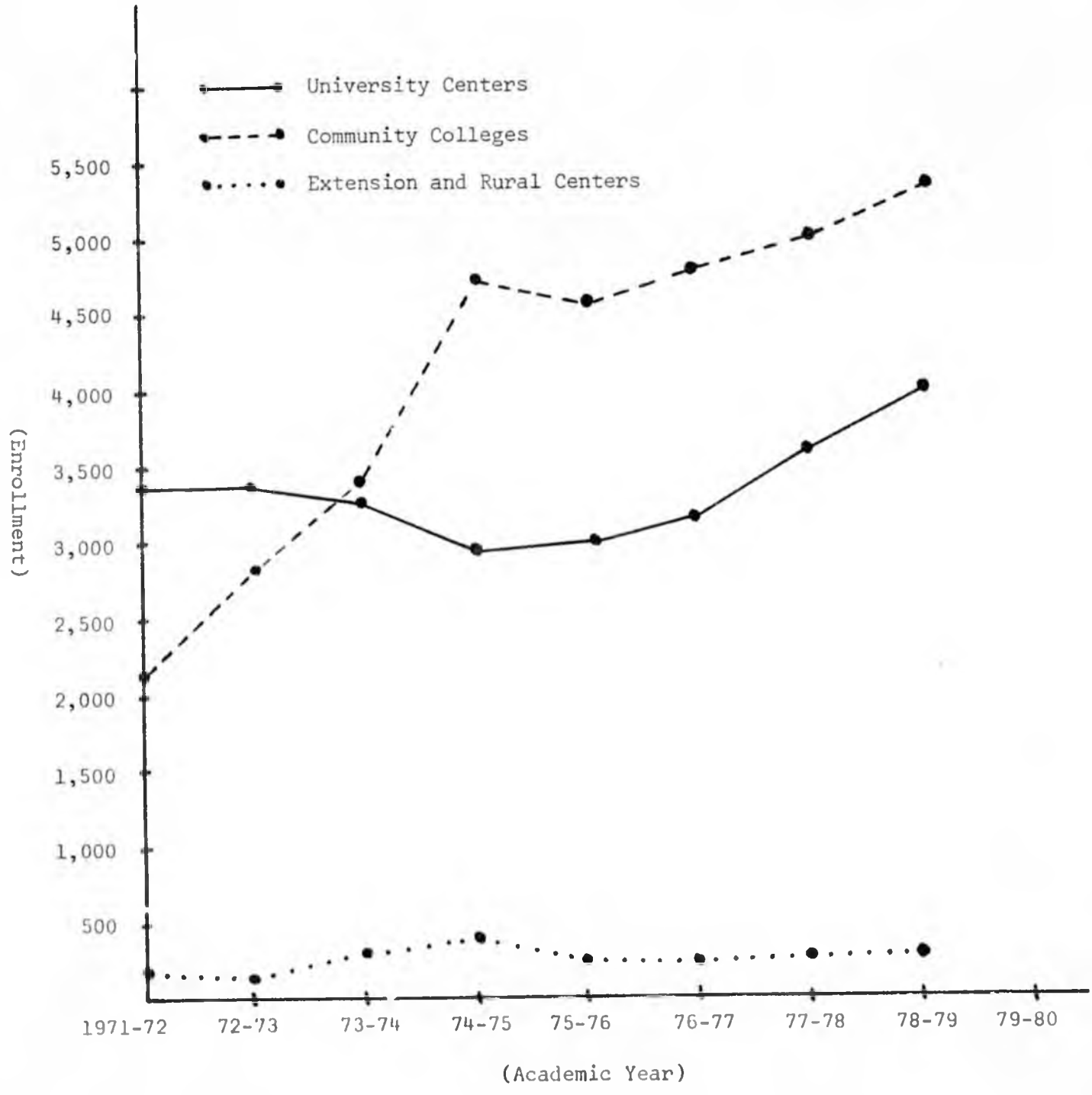


Figure 3
Full-Time Equivalent Enrollment, Peak Semester
1971-72 through 1978-79

Alaska State Legislature

House of Representatives

Committee on

Health, Education & Social Services

Official Business

Pouch V
State Capitol
Juneau, Alaska 99811

March 26, 1980

David E. Johnson, M.D.
Ketchikan Medical Clinic, Inc.
3612 Tongass
Ketchikan, Alaska 99901

Dear Dr. Johnson:

I have received your letter expressing the opposition of the Ketchikan Community College Policy Advisory Council to HB 651. Your opposition will be noted in the official record of the next public hearing that the House HESS Committee holds on the bill.

Thank you for expressing the view of your PAC about separating community colleges from the state university system.

Sincerely,

Thelma

Thelma Buchholdt
State Representative
District 9 (Spenard);
Chair, House HESS Committee

Ketchikan Medical Clinic, Inc.

3612 TONGASS
KETCHIKAN, ALASKA 99901

H.J. Henrickson, M.D.
D.E. Johnson, M.D.
T.L. Conley, M.D.

Phone 225-5144
Phone 225-5145

March 19, 1980

Honorable Thelma Buchholdt
Pouch "V"
Juneau, Alaska 99811

Dear Representative Buchholdt:

I am writing to follow-up my personal testimony on the teleconference on HB 651, held sometime ago. At our regular meeting last night, the Ketchikan Community College Policy Advisory Council discussed this bill in particular, and the issue of separation in general, at some length. Following careful consideration, it is our considered position that we oppose enactment of HB 651.

While there are changes in the community colleges that could be helpful, we believe that they are most effective as part of the University of Alaska. We are impressed with the information gathering that Dr. Jay Barton has done, and would prefer to continue the current relationship at this time, rather than embark upon a new organizational structure.

Thank you for providing the opportunity to us to testify on this legislation. We will continue to study this issue, and would be glad to respond further, should that be helpful in your deliberations.

Yours truly,

D E Johnson

David E. Johnson, M.D., Chairman
Ketchikan Community College Policy Advisory Council

cc: Honorable Terry Gardiner

Honorable Oral Freeman

UNIVERSITY OF ALASKA, FAIRBANKS
Fairbanks, Alaska 99701

March 25, 1980

Representative Thelma Bucholdt, Chairperson
House HESS Committee
112 State Capitol
Pouch V
Juneau, Alaska 99811

Dear Representative Bucholdt & Committee Members,

The papers on which you requested a response all discuss matters related to the debt service on bonds for student centers in Fairbanks and Anchorage. One paper also discusses the budget of the ACC Electronic Technology Program.

The paper entitled "History of Student Center Bonds" is correct in saying that the University initially could not sell bonds for the Anchorage center. It was necessary to agree to earmark 35% of tuition for debt service in order to sell the bonds. Enclosed are letters which explain the bond requirements relative to the student centers.

As you will see, the University has little latitude in the management of debt service. The alternatives are spelled out on page two of Sherman Carter's letter to Bill Hogan, dated February 2.

In regard to the Electronic Technology Program budget, a 47% cut was made across the instructional budgets of all ACC disciplines when the ACC tuition shortfall became apparent. The Board of Regents submitted a supplemental request for $350,000 to cover the shortfall. SB426 proposes to fully fund the request while CSHB60 proposes to fund it at $250,000. If the supplemental appropriation is funded -- preferably to the amount requested -- we can alleviate some of the problems brought to your attention.

The Electronics Technology Program at ACC is a strong program for which both the Community College Chancellor and the ACC President expect to provide the fullest support possible as funds are made available. By the same token, other programs should receive the same fair consideration that the Electronics Technology Program will receive.

We would be happy to provide any additional information you require.

Sincerely,

Dennis Demmert

Dennis Demmert
Staff Assistant to the President

Enclosures
cc: Don Abel
Jay Barton
Sherman Carter
Pat O'Rourke

UNIVERSITY OF ALASKA
Statewide System of Higher Education
Fairbanks, Alaska 99701
March 17, 1980

TO: Dennis Demmert
Staff Assistant to the President

FROM: Ashok K. Dhingra
Associate Vice President for Finance

In reference to the papers that you gave me last week relating to Anchorage Community College, statements made in the said papers are not fully accurate. On the subject of Debt Service Requirements, enclosed find a copy of the letter that was recently sent to Bill Hogan. The information in this attachment responds to the concerns expressed in the papers that you provided to me.

As to the Electronic Technology program, the paper on this outlined the budget fairly accurately for this program. The above is based on information confirmed by Anchorage Community College Staff, Larry Kingry, who is the head of this division. He has provided us the following observations pertaining to the said paper.

1. FY79 travel funds were allocated to several Electronic Technology faculty but those funds were distributed from the Director's office control account.

2. Several cost saving devices were used in FY79 and FY80 by consolidating program budgets and purchasing a dry copier thus saving contractual services expenditures.

3. Travel funds for FY79 and FY80 were reduced by the legislature.

4. FY80 equipment funds were cut entirely from program budgets by the legislature. Funds allocated to the chancellor were sufficient only to cover emergency needs.

5. True inflation rate over the last several years has been greater than that funded by the legislature. As commodity prices rose, funds had to be redistributed to programs in critical areas. FY80 reductions in the 4001 and 3001 line items to some programs are the result of this redistribution.

AKD/dr

attachment

UNIVERSITY OF ALASKA
Statewide System of Higher Education
Fairbanks, Alaska 99701

February 27, 1980

Mr. Bill Hogan
Aide to Senator John Sackett
Alaska State Senate
Pouch V
Juneau, Alaska 99811

Dear Bill:

This letter is to provide information which you requested from Ashok Dhingra regarding debt service requirements for student centers at Anchorage and Fairbanks.

Undergraduate resident students on both campuses pay $170 per semester tuition. Additionally, at UAF, students are charged $15 per semester for covering part of the debt service on the Wood Center. On both campuses, students pay some additional fees for different things, such as their own student organizations; but, no charge on the Anchorage campus compares with the $15 per semester charge made to UAF students to retire debt on their student center. Additional monies as necessary, up to 25% of the fulltime student tuition, are pledged to cover the total debt service requirement on the Wood Center. At Anchorage, debt service on the student center is covered totally from part of the aforementioned $170 per semester student tuition which these students pay.

Data concerning indebtedness on student centers is summarized below:

Anchorage student center

Original debt: $5,000.0

Amount outstanding: $5,000.0

Interest rate: 8.00%

Type: revenue bonds, non-registered, payable to bearer

Maturity date: May 1, 2000

Prepayment: no prepayment is allowed until 5/1/85; after that, any prepayment is subject to a 2% penalty.

Faribanks student center

Original debt: $4,000.0

Amount outstanding: $3,076.0

Interest rate: 5.00%

Type: "Special Obligation Installment Note" with State of Alaska

Maturity date: June 31, 1995

Prepayment: no prepayment penalty

A paper which I wrote earlier this month concerning the debt service requirement on the Anchorage student center is attached. However, there are some additional related points which should be made. For FY80 and FY81, collections from the 35% tuition mentioned in the attachment are now budgeted to be used as follows:

UAA Administration and Plant	$125.3
UAA Student Services	125.3
ACC Student Services	39.8
Operation of the Student Center	252.7

We are now using more money than is being collected from the 35% of student tuition to retire debt, since we have a past accumulation of funds. Starting in FY82, however, the only money which will be available from this source, in addition to debt service, will be the above-listed $252.7 for operation of the student center. The other charges listed above, for the administration and plant and for student services, will need to be covered from the general fund.

To summarize--

(1) It is not possible to prepay the indebtedness on the Anchorage student center until May 1, 1985; then, if this indebtedness is to be prepaid there will be a 2% penalty.

(2) The indebtedness on the student center at UAF could be prepaid at any time.

(3) The university has no money in hand or in sight to prepay indebtedness on either student center. If the state wishes to provide the university money to prepay such indebtedness, that would be fine as far as the university is concerned.

(4) UAF students are now being required to pay $15 per semester extra to retire indebtedness on their student center while debt service on the Anchorage student center is paid from tuition paid by students attending UAA and ACC.

(5) Because of this disparity and because the debt on the Anchorage student center cannot be paid until 1985, the state may wish now to consider covering indebtedness on the Fairbanks student center.

(6) Since this debt is owed to the state, I assume that the legislature could simply arrange to waive or forgive this debt, rather than going through the process of appropriating the money to the university for use to repay the state.

(7) If the legislature were now to cover outstanding indebtedness on the Wood Center, (a) UAF students would no longer need to be assessed the special $15 per semester student fee, and also (b) the university's budget request for general fund money for FY81 could be reduced by $210.8. This represents the amount of the $170 per semester tuition at UAF being used for Wood Center debt service. If the above-cited debt for UAF is retired, a general fund offset in the amount of $210.8 thus can be made in the UAF instruction component.

To keep interested persons informed about these matters, because of student lobbying with respect to prepayment of indebtedness on the student centers, and because some points in this paper differ slightly from information previously presented, I shall now send copies of this letter to the persons listed below.

Sincerely,

Sherman Carter

SFC:nba

cc: Board of Regents
President Jay Barton
Chancellors Cutler, Harrison and O'Rourke
Mr. Ron Lehr
Representative Brian Rogers

UNIVERSITY OF ALASKA
Statewide System of Higher Education
Fairbanks, Alaska 99701

February 4, 1980

TO: Chancellor O'Rourke

FROM: Sherman Carter

SUBJECT: Debt Service Requirements

This is to respond to a paper which you wrote to me dated 22 January regarding the requirement to set aside 35% of student fee collections for debt service. We previously made the interpretation that special fees such as lab fees and any receipts which might eventually be collected for such things as dormitory rentals or operating a housing system are excluded. And, it now may be possible further to expand somewhat exceptions to the 35% requirement.

Provisions to cover indebtedness on the student center are somewhat complicated. The annual debt service requirement is about $502.0. However, the bond indenture requires that the university collect about $754.8, that is, about 1½ times the annual debt coverage which is required. This amount must be collected and segregated. Then the amount in excess of what is needed to cover the debt service during any fiscal year may be used on the Anchorage campus, by UAA and ACC, the next year. For the current year, the state specified how that money was to be used. If the state does not so specify this in the future, we will make an equitable distribution of that money to UAA and ACC based upon the amount which each has contributed.

Stating again points made above, in FY80 we must collect about $754.8 to service debt on the student center on the Anchorage campus. However, only about $502.0 will actually be used to service this debt in FY80. The $252.8 then can be used by UAA and ACC in FY81. Any collections over the $754.8 in FY80 may be used in FY80. However, this year in order to do that, we must clear that with the legislative budget and audit committee.

The situation as I understand it, is that self-supporting courses could be given at Elmendorf AFB and Fort Richardson if the 35% debt service requirement were not involved, but with this requirement, charges cannot be such that the courses will be self-supporting. So, with the 35% debt service requirement, some such courses cannot be conducted. If this is true, and if and when we are certain of being able to cover the $754.8 from student collections which are made in FY80, it will be permissible for all courses which are set up on a self-support basis which are conducted off campus by ACC and UAA to be excluded from the requirement to set aside 35% of collections from students to service debt on buildings on the campus. I suppose that most "self-support" courses which are conducted off campus will be by ACC rather than UAA; however, to ensure that both ACC and UAA are following the same rules, I shall send a copy of this paper to Chancellor Frank Harrison.

In FY79, student fees collected against the 35% requirement totaled $787.397--$339.437 came from UAA and $447.960 came from ACC. I do not know how much, if any of this came from self-support courses conducted off campus. I assure that

more fees will be collected in FY80 than in FY79. But, I must continue to emphasize that before instituting the change mentioned above (i.e., excluding the 35% requirement for self-supporting courses conducted off the Anchorage campus by UAA and ACC) conservative projections must indicate that the $754.8 will be collected this year from the 35% of student tuition which is set aside. I do not yet know the financial impact of making the change underlined above, and it is not to be implemented until we can eliminate any doubt about being able to collect at least the $754.8 in FY80.

Your paper to me asked if the legal requirement for covering bonded indebtedness was to attain only some specific dollar amount. No, it unfortunately does not simply provide for that. We must go through the drill of initially setting aside the 35% collection for debt services and then redistributing the excess collections as explained above. And, I do not want even to consider the interpretation described above with regard to self-supporting courses conducted off campus unless UAA and ACC will collect over the $754.8. If they will, the interpretation is reasonable, in the university's best interests, permits presenting courses that would not otherwise be conducted, and does not jeopardize in any way the position of the holders of this debt.

In conclusion, Pat, I shall help you get in place the provisions underlined on the previous page, as soon as possible. To proceed to do this, please send me conservatively prepared financial projections for FY80 indicating the amount of fees to be collected by ACC in FY80 which compare with the $447.960 cited above. Please have this information presented two ways—under procedures now in effect and under the procedure specified by the underlined provisions on the previous page. By sending a copy of this paper to Chancellor Harrison I shall ask him please to send me this same data for UAA, that is, considering that UAA contributed $339.437 toward student center debt service in FY79, how much is UAA projected to contribute in FY80, assuming (a) current procedures remain in effect, and (b) procedure gets changed as specified by the underlined provisions on the previous page? If possible, I would like to get this data from UAA and ACC within two weeks. Then, we can see where we are. If we cannot be sure of collecting enough money for debt service in FY80 to institute the new procedure, perhaps we can fix things in another way to solve the problem for the year starting July 1, 1980.

SFC:nba

cc: President Jay Barton
Vice President Thrombley
Chancellor Frank Harrison
President Ed Biggerstaff
Vice Chancellor Stan Vaughn
Mr. Gerry Bomotti
Mr. Bob Maloney

February 26, 1980

Rep. Thelma Buchholdt
Chairperson House Health Education
& Social Services Committee
Pouch V
Juneau, AK 99811

Dear Thelma,

As mentioned in my earlier letter the Committee for Autonomy has some concern with page 24 of HB651. We had hoped to clear proposed changes with the ACCFT legal counsel, but he has been unavailable. Since I realize you may be marking up the bill in the near future I am writing to give you our suggestions and would also like to ask that they be cleared with Legislative Counsel.

We suggest that page 24 line 9 and 10 read as follows: "... and who were employed for 1979-80 shall be offered equivalent employment by the Alaska Community College system. The..."

We suggest that page 24 line 25 read: "... the University of Alaska during 1979-80, shall be assumed by the..."

While these changes seem minor, to us they represent a much greater protection both for employees of the community colleges and the community college programs, and we feel it extremely important that they he made. We are especially concerned about the impact of these provisions on Juneau Douglas.

Thank you again for your community college efforts.

Mim Carlson

Mim Carlson

February 26, 1980

Rep. Thelma Buchholdt
Chairperson House Health
Education & Social Services Committee
Pouch V
Juneau, AK 99811

Dear Thelma,

The committee for Community College Autonomy reviewed HB651 and the comments made by John Chenoweth, Legislative Counsel. We wholeheartedly endorse the bill. We did have several suggestions of minor changes which I communicated verbally to your assistant. The following is to give you written confirmation of those suggestions.

1. Our suggested draft included the following in Sec. 14.42.230(a)

> Sec. 14.42.230. FINANCE. (a) The state is basically responsible for the funding for all community college, extension center or outreach programs and activities.
>
> However, nothing in this chapter prohibits a school district, municipality, federal agency or nonprofit corporation or association from providing funds for additional courses and programs which may be considered appropriate under Sec. 210(a)(3) of this chapter.

We feel that it is important to retain this statement in the bill. Mr. Chenoweth felt this was a philosophical statement that might better be included in a purpose or intent clause. We suggest incorporating this statement on page 2 line 8 as item (c)..

On page 17 add the word <u>same</u> on line 21 to read as follows: "Alaska, the <u>same</u> shared or joint use of these facilities..." After line 26 add the following: <u>Subsequent changes are subject to mutual agreement of both boards.</u>

These suggestions are made because there was fear that in the transition period there might be an attempt on the part of the University to preempt community college use of facilities. These two changes would insure status quo in the transition and provide for future flexibility.

On page 18 line 2 we suggest changing shall to may, so that it reads "...the two boards may enter into a contract ..."

It was our feeling that it would allow for more flexibility in the future if this were made a permissive rather than a mandatory statement.

We have some concerns about page 24 line 5-13. We are awaiting a legal opinion as to whether this fully protects the employment rights of all present community college staff. We will notify your office immediately if our counsel suggests any change.

On behalf of the committee I would like to express our appreciation for your efforts on our behalf.

Thank you,

Miriam Carlson

Miriam Carlson

KENAI PENINSULA COMMUNITY COLLEGE

of the University of Alaska in cooperation with the Kenai Peninsula Borough School District

P.O. Box 848 ★ Soldotna, Alaska 99669 ★ 262-5801

February 27, 1980

Representative Thelma Buchholdt
Chairman, House HESS Committee
Pouch V
Juneau, Alaska 99811

Dear HESS Committee:

On Tuesday, February 19 I appeared in a teleconference committee hearing as a witness on the subject of House Bill 651. A quite accurate transcription of my remarks is attached. The analysis would have been more extensive and in-depth except that we mistakenly thought the testimony of each person would be limited to about 2-5 minutes.

During the course of the testimony, Policy Advisory Committee Chairman Donnis Thompson remarked that a meeting would be held and the subject of separation discussed on Thursday, February 21. A copy of the minutes of that meeting are attached. A digest of the discussion on House Bill 651 is included on the second page of the minutes.

Again we thank you for allowing us to present our testimony. In the event that further testimony would be in order, I am sure that the other members of our Policy Advisory Council would be glad to bear witness.

Very truly yours,

John G. Wilsey, Ed.D.
Campus President

JGW:gdf

Attachments: 2

attach

TESTIMONY TO THE HEALTH, EDUCATION & SOCIAL SERVICES COMMITTEE OF THE HOUSE OF REPRESENTATIVES, STATE OF ALASKA

REPRESENTATIVE THELMA BUCHHOLDT, CHAIRMAN

CHAIRMAN BUCHHOLDT AND MEMBERS OF THE HESS COMMITTEE, I AM JOHN WILSEY, PRESIDENT OF THE KENAI PENINSULA COMMUNITY COLLEGE. ALL OF US IN THE ALASKA COMMUNITY COLLEGE SYSTEM ARE VITALLY INTERESTED IN HOUSE BILL 651 AND OTHER LEGISLATIVE ACTIONS THAT WOULD AFFECT OUR ACTIVITIES. AND IT IS COMFORTING TO KNOW THAT THE LEGISLATURE IS INDEED INTERESTED IN THE COMMUNITY COLLEGES THIS STATE.

BUT MAY I ADDRESS HB-651 NEITHER AS AN ADVOCATE NOR AS AN OPPONENT BUT RATHER AS A NEUTRAL? I WOULD SPEAK ONLY TO CERTAIN FEATURES, ASPECTS AND IMPLICATIONS OF THE BILL. IT IS A FAR RANGING DOCUMENT IN WHICH MUCH THOUGHT HAS BEEN PLACED BUT READING IT RAISES QUESTIONS FOR ME. HOUSE BILL 651 COULD CREATE A VERY HIGHLY BUREAUCRATIZED CENTRAL AUTHORITY. AS IT IS WRITTEN THE STATE COULD END UP WITH A SINGLE COMMUNITY COLLEGE AND EXTENSIONS OR BRANCHES LOCATED AROUND THE STATE. ASSUMING THAT THE PURPOSE IS INCREASED AUTONOMY TO ALLOW FOR THE FLEXIBILITY SO VITAL TO ANSWER COMMUNITY NEEDS, THIS BILL PLAYS A STRONG EMPHASIS ON A TIGHT HIERARCHY WHICH COULD PROVE MOST BENEFICIAL OR COULD STYMIE HIGHER EDUCATION IN COMMUNITY COLLEGES. MANY STATES OPERATE SUCCESSFULLY WITH A BOARD OF TRUSTEES, AN EXECUTIVE DIRECTOR OR CHANCELLOR WHO PRESIDES OVER A SMALL CENTRAL OFFICE, LOCAL BOARDS OF GOVERNORS OR SOME SUCH, AND LOCAL PRESIDENTS.

THERE IS MUCH TO BE SAID FOR THIS WHICH FOLLOWS THE NATIONAL PATTERN YOU MIGHT CONSIDER.

THE EXTREME PROBLEM OF EQUITABLE FUNDING IS NOT ADDRESSED SPECIFICALLY IN HB-651. COMMUNITY COLLEGES MUST BE ABLE TO GAUGE REVENUES ACCURATELY ALLOWING FOR BASIC COSTS, GROWTH OR SHRINKAGE, AND DISCRETIONARY FUNDS RATHER THAN AN ANNUAL PERHAPS CONGENIAL BUT FIERCLY COMPETITIVE CONFRONTATION. THE PUBLIC SCHOOLS OFFER A GOOD EXAMPLE.

THE COMPOSITION OF THE CRITICALLY IMPORTANT BOARD OF TRUSTEES CAUSES DISCOMFITURES. A FACULTY MEMBER IS NAMED; HE WOULD SEEM TO HAVE THE GROSSEST KIND OF CONFLICT OF INTEREST BECAUSE HE WOULD HELP DETERMINE HIS OWN SALARY. ALSO, UNDER THE ACT NO COMMUNITY COLLEGE STUDENT COULD EVER BECOME ELIGIBLE FOR MEMBERSHIP ON THE BOARD. AND IF THE FACULTY AND STUDENT ARE NAMED WHY NOT ADD A CAMPUS PRESIDENT, A BUSINESSMAN, A HOUSEWIFE OR OTHER CATEGORIES? HERE IS WHERE A LA BOARD MIGHT OPERATE BEST AND MOST EFFECTIVELY.

LOCAL CONTROL WOULD SEEM A MUST FOR AN AUTONOMOUS COMMUNITY COLLEGE SYSTEM TO WORK. LOCALLY ELECTED BOARDS OF GOVERNORS SHOULD GIVE REAL ATTENTION TO LOCAL NEEDS AND MAKE POLICY UNDER THE UMBRELLA OF THE STATE BOARD. A BOARD ELECTED IN A DEMOCRATIC MANNER COULD BE EXPECIALLY EFFECTIVE IF ACCOMPANIED BY LEGALIZED TAX BASE OR ITS BOROUGH EQUIVALENT.

ONE PROBLEM TO BE CONSIDERED HAS TO DO WITH THE TRANSFERABILITY OF CREDIT IN A STATE ARTICULATED PROGRAM. TO ASSURE TRANSFER STUDENTS THAT THEIR TIME HAS NOT BEEN WASTED WOULD SEEM TO BE AN IMPORTANT ITEM TO CONSIDER AS IT IS IN THE FLORIDA PLAN.

RELATED TO THIS, WHAT OF INTRUSION INTO THE HOMEGROUND OF THE COMMUNITY COLLEGES? HOUSE BILL 651 SAYS THAT COMMUNITY COLLEGES "MAY" COORDINATE UPPER LEVEL AND GRADUATE COURSES. WHAT IF THEY CHOOSE NOT TO DO SO? THIS PROBLEM MIGHT BE APPROACHED BENEFICIALLY THROUGH SUCH AN ORGANIZATION AS THE RURAL EDUCATION DEPARTMENT OF THE PRESENT COMMUNITY COLLEGE DIVISION.

COMMITTEE MEMBERS, THIS BILL ADDRESSES MORE THAN SEPARATION. I AM SURE YOU COULD ANSWER THIS BUT I CANNOT. WHY ARE SCHOLARSHIPS INCLUDED IN THE SEPARATION BILL? COULD SCHOLARSHIPS BE TAKEN CARE OF UNDER A SEPARATE ACT?

OTHERS WILL HAVE TO ADDRESS THE MANY STICKY ISSUES NOT SPOKEN TO HERE: COMPREHENSIVENESS, HOUSING, DIVISION OF PROPERTY AND EQUIPMENT, LAND GRANT LEGALITIES, STUDENT FEES, TERMINATION AND TRANSFER OF STAFF AND FACULTY, AND OTHER RELATED ITEMS. BUT IT IS MY GUESS THAT TO SERVE A MAXIMUM NUMBER OF CITIZEN-STUDENTS IN A MANNER THAT ADDRESSES THE VARIED NEEDS OF EACH COMMUNITY IN A WIDELY DIVERSIFIED STATE, YOU ALREADY HAVE TASK FORCES ON THIS BILL AT THIS MOMENT.

TO ME IT IS MOST GRATIFYING JUST TO KNOW THAT THE LEGISLATURE IS CONCERNED ABOUT ITS HIGHER EDUCATION SYSTEM. AND IN THIS TESTIMONY I HAVE SPOKEN ONLY TO FEATURES OF THE BILL RATHER THAN SEPARATION ITSELF, BUT IF SEPARATION WOULD BECOME A FACT, PLEASE GIVE US 15 MINUTES AND WATCH OUR SMOKE.

I THANK YOU FOR ALLOWING ME TO TESTIFY TODAY.

KENAI PENINSULA COMMUNITY COLLEGE POLICY ADVISORY COUNCIL
Minutes, Meeting of February 21, 1980

Meeting called to order at 7:10 P.M. by Chairman Thompson.

MEMBERS PRESENT: Donnis Thompson, Chairman, George Day, Marion Hylen, Hazel Heath, John Monfor, Walter Ward, John Wilsey.

MEMBERS ABSENT: Earl Mundell, Linda O'Brien.

MOTION: By Day, second Heath, passed unanimously.

That the Minutes of meeting of November 29, 1979 be accepted as read.

AGENDA APPROVAL: By concensus, Chairman Thompson was given permission to rearrange the Schedule as required due to the expected appearance of Dr. Pat O'Rourke about 8:00 P.M.

GUESTS, STAFF AND VISITORS: Dave Forbes, Jim Morrison, Chris Butzen, Dayne Clark, Margo Zuelow, Tom Wagoner, Dennis Steffy, John Williams.

REPORTS: President Wilsey reported on a meeting of Campus Presidents in Anchorage.

Dean of Instruction, Margo Zuelow, presented three Grant Proposals for approval by the PAC.

MOTION: By Heath, second Hylen, passed unanimously.

That the Policy Advisory Council of the Kenai Peninsula Community College hereby recommends final approval of the proposal, NETWORK: PHASE II to be funded by ALASKA COMMISSION ON POSTSECONDARY EDUCATION: HIGHER EDUCATION FUNDS. The Policy Advisory Council commends the administration, faculty, and staff for seeking funding for activities such as represented here.

By Day, second Hylen, passed unanimously.

That the Policy Advisory Council of the Kenai Peninsula Community College hereby recommends final approval of the proposal, STATE OF ALASKA: PETROLEUM EXTENSION SERVICE to be funded by ALASKA DEPARTMENT OF EDUCATION, CAREER AND VOCATIONAL EDUCATION UNIT. The Policy Advisory Council commends the administration, faculty and staff for seeking funding for activities such as represented here.

By Ward, second Hylen, passed unanimously.

That the Policy Advisory Council of the Kenai Peninsula Community College hereby recommends final approval of the proposal, KPCC DEVELOPMENTAL STUDIES PROJECT to be funded by NATIONAL BASIC SKILLS IMPROVEMENT PROJECT. The Policy Advisory Council commends the administration, faculty and staff for seeking funding for activities such as represented here.

REPORTS: Business Manager, Tom Wagoner, explained the problems caused by accrued leave. Budget margins are thin but KPCC is staying within its requirements.

REQUEST BY LEGISLATORS: The prioritized lists themselves and related communications were distributed to PAC members. At this time Dr. O'Rourke arrived. After brief discussion, it was agreed that the Chancellor and Campus President should meet to discuss the matter.

SEPARATION OF C.C. FROM U.A.: House Bill 651 was mentioned although not reviewed. In Dr. Wilsey's opinion the Bill has serious deficiencies and his Testimony to HESS on the Bill was distributed. Dr. O'Rourke pointed out that HB-651 and SB-483 were exactly the same and if passed in the present form an FCC would not be necessary. Opinions by the PAC members on the matter varied. Day spoke for separation perhaps not through this Bill. Hylen spoke for separation possibly going to a Borough college. Heath felt that whatever would benefit all areas of the Kenai Peninsula would be best. Monfor spoke for separation. Ward suggested looking at aiternatives such as SB-190 which sponsors Grades 13 and 14 in the public schools. Chairman Thompson did not take a stand.

FUTURE MEETINGS: As the time was growing late a number of Agenda items were held over to the next meeting. Chairman Thompson spoke to the need for monthly meetings until the great mass of backed up work due to having bi-monthly meetings be taken care of. Hylen pointed to the desirability of workshops and the inability to make informed decisions without more time for study. All agreed that it is impossible to make sound decisions without more time for preparation.

The next meeting was scheduled for March 13, 1980 at 7:00 P.M.

MEETING ADJOURNED: 10:07 P.M.

KETCHIKAN COMMUNITY COLLEGE
7th and Madison
KETCHIKAN, ALASKA 99901
907-225-6177

February 20, 1980

Representative Thelma Buchholdt
Pouch V
Juneau, Alaska 99811

Dear Representative Buchholdt:

I appreciated the opportunity to speak on House Bill 651 last evening, but feel that I should write relative to my concerns as I did not mention all of them last night as they had been previously mentioned by other people testifying.

As I stated, I had worked for three different systems while engaged in community college education and those systems being the K-12 system, a statewide community college system, and then the statewide system of higher education as we have here in Alaska. I see advantages and disadvantages of each system, but have concluded that different systems work better and more efficiently in different states depending on their geographic size and their administrative structure.

I read the bill as a mixture of educational delivery systems and not once specifically relating to community colleges and its accepted philosophy and objectives for providing educational opportunities of lower division offerings in a local geographical area at a reasonable cost to students. My major question relative to the intent of the bill is whether it is establishing a community college system or separating out that portion of the Univeristy of Alaska now in the Division of Community College, Rural Education and Extension under Chancellor O'Rourke. Rural education and cooperative extension have different objectives than community colleges and I am wondering in this bill if we are mixing a number of different ingredients as to philosophy and objectives.

Some of the specific items in the bill that I considered were concerns are as follows:

Section 1, Paragraph 4 - Educational delivery system that may or may not lead to baccalaureate and advanced degrees. The question is whether this is opening up the possibility that the community college system being created by this bill would, therefore, open the doors for community colleges to offer upper-division and graduate courses.

Article I, Section 14.42.030 - Faculty member of a community college being on the Board of Trustees. This could create a situation where there could be a conflict of interest with the collective bargaining faculty serving on the Board of Trustees in having a voice in determining the policies and making the decisions relative to governance.

Article I, Section 14.42.040 - The method of determining a student member to the Board of Trustees. The bill states that a person must be a full-time student for at least one year before appointment, then the student would be appointed for a two-year term. Traditionally, students in community colleges usually attend only a maximum of two years so, therefore, most of the terms for students would only be one year or less.

If there are going to be faculty members and students on the Board of Trustees, consideration might be given to putting on an administrator and a classified staff member as they are a part of the total community college.

Section 14.42.140 - It states that the principal administrative officer of each community college campus will be responsible directly to the president and to the community college council, however, it does not specify what the community college councils are responsible and accountable for. This also relates to Section 14.42.170 where it states that the community college council will act in a policy making capacity and also in an advisory capacity, but again the responsibilities are not specifically listed and I believe that this could cause some conflict between the chief executive officer of the board and the local community college councils.

Section 14.42.150 - It states that regional service centers also may be established to administer the outreach programs and to provide postsecondary education services. In reading this, this would appear that it would probably be an opportunity for the community college to offer upper-division and graduate courses which has not been a community college objective or function in the past. Again, if this is supposed to be a function of the rural education outreach programs, it comes back to my original statement relative to a difference of philosophy and objectives of the areas to be included in the community college system.

Section 14.42.170 - With the establishment of the community college council, again it refers of having faculty and student representation as well as representatives from other agencies in the area. Again, why not include an administrator and a classified staff member if these councils are established.

Section 14.42.200 - This section again refers to the establishing of the extension centers and outreach programs that may or may not include upper-division and graduate courses in-so-far as the community college determines demand for postsecondary education. This could cause some conflicts and duplications in-so-far as cooperative agreements may be made with one university, but would not prohibit another university from coming in and offering parallel or similar courses on their own initiative.

Section 14.42.230 - It states that the board shall prepare a complete budget for each community college including all courses, programs and activities. This would make a very cumbersome and expansive budget proposal if all courses and activities had to be included and it would also put limitations on community colleges of offering courses that were requested during the year after the budget was put together. I am assuming that this does not mean listing every individual course and every individual activity that is sponsored or offered by a community college.

Section 14.42.240 - The question arises as to the constitutiorality of community colleges being land-grant institutions when not associated with the state four-year university.

Section 14.42.310 - It states a person may not be deprived of the privileges and services of the system because of age, sex, color or nationality. In a question relative to age, it would appear that the bill would allow community colleges to serve anyone regardless of age. This could cause much concern in the secondary level with students wanting to drop out of high school and attend community colleges. Community colleges have not had as one of its objectives that of providing secondary education except for adults.

Section 14.40.460 - This relates to scholarships for high school students which I believe would be a good idea, however, it states that the scholarship would include dormitory rent for a period of two years or four years, however, this would be very limiting to community colleges as most community colleges do not have dormitory facilities.

Under Section 18 - Transition. It states that the Board of Regents of the University of Alaska shall redistribute or transfer property assets, etc. to the Alaska Community College System. The question arises as to the legality of the transfer of property from the University of Alaska to the community college system as the University of Alaska is constitutionally created.

Under the same section, it states that faculty, staff and officers in the community colleges shall be terminated by the University of Alaska and shall be rehired by the community college system, however, it goes on to say that the Alaska Commission on Postsecondary Education shall assist those community college faculty and staff and its officers and employees, who are not transferred, in finding positions. This appears to be a conflicting statement within the same section of the bill.

Under Section 20, it states this act will be effective July 1, 1980. This appears to be a very short timetable to do many of the things that this bill encompasses and feel that we would probably create a massive chaos trying to implement this in such a short space of time.

The community colleges have come a long way in the past two years under the reorganization within the University of Alaska of placing the community colleges into a separate division with its own chancellor. I don't feel that this bill would be in the best interest of the community colleges and the local communities in the state of Alaska as relating to community college objectives and philosophies.

I feel that the community colleges should continue to operate as it is today under the chancellor instead of under this bill.

Sincerely,

Rod Enos

Rodney Enos
Campus President

RE:sl

cc: Senator Robert Ziegler
Speaker Terry Gardiner
Representative Oral Freeman
Chancellor Patrick O'Rourke

Statement of Richard Whittaker
Regarding legislation to separate community colleges from the University of Alaska system, HB 651

In years past I have favored anything which would disrupt the stepchild status between the University and the Community Colleges. The University has had little or no interest in bringing education to the people of our state which, of course, is one of the significant roles of Community Colleges.

My view has radically changed in the past year. With the coming of University of Alaska president, Jay Barton, we have a vastly different University, a University which sees the Community Colleges as a means of bringing the services of the total university system to the people of the state.

Separating the two institutions would limit the ability of Dr. Barton to give the University the needed guidance to accomplish this change. He has indicated his first priority as rural education, which basically means Community College and similar approaches.

I, having studied the matter, as a member and chairman of the Ketchikan Community College Advisory Board, and prior to that as a legislator, strongly believe the best thing we can do in higher education in Alaska at this time, is to give our support to Dr. Barton to give him a change to correct these long standing inequities.

STATE OF ALASKA
THE LEGISLATURE

LEGISLATIVE AFFAIRS AGENCY

POUCH Y - STATE CAPITOL
JUNEAU ALASKA 99811
907 465-3800

M E M O R A N D U M

February 16, 1980

SUBJECT: Sectional analysis, legislation establishing a separate Community College System (HB 651) [Work Order No. 7988]

TO: Representative Thelma Buchholdt, Chairman
House Health, Education and Social Services Committee

FROM: John B. Chenoweth
Legislative Counsel

The legislation relies extensively on earlier bills by which the community colleges, extension centers, and outreach programs of the University of Alaska would have been removed from the University's jurisdiction and constituted a separate Community College System.

Section 1, an uncodified section in keeping with current drafting practice, describes a purpose for the bill and the general philosophy of a separate comprehensive community college system for the state.

Section 2 adds a new chapter to AS 14 and describes the "Alaska Community College System." The System is established as a state corporation (AS 14.42.010), under control of a seven member board of trustees, each of whom is appointed by the governor; an appointee be a resident of a community containing a unit of the community college system (AS 14.42.020(a) and (b)). Five board members are appointed from designated geographic regions (AS 14.42.020(c)); a sixth member must be a member of the faculty of a unit of the System (AS 14.42.-020(c)(5)); the seventh must be a student enrolled in a unit of the System (AS 14.42.020(c)(6)). Specific procedures are described for the nomination and selection of the faculty appointee (AS 14.42.030) and for the student appointee (AS 14.42.040), and limitations are placed on their service as members of the board of trustees of the corporation expressed in terms of their continuing appointment to faculty

status and continuing association with a unit of the system as a student. The term of office of the "public" members of the board is five years (AS 14.42.050(a)); for the faculty and student board member, the term is two years (AS 14.42.-050(b)). The legislation contemplates a staggering of terms: see section 19 for manner and duration of initial appointments. The legislation requires election by the board of certain officers, and authorizes the board to select others, limiting terms of officers to one year and setting a two-term limit on a person's service as chairman (AS 14.42.060). The legislation requires the board to prepare rules for its procedures (AS 14.42.070(a)), determines a quorum and the minimum vote necessary for action by the board -- both set at four of seven votes (AS 14.42.070(b))) -- and precludes use of proxies (AS 14.42.070(c)). The legislation requires, at minimum, quarterly board meetings, rotating through the various community college campuses over a five-year cycle (AS 14.42.080(a) and (b)), authorizes special meetings, prescribes meeting notice requirements (AS 14.42.080(a)), and generally restates "open meeting" provisions of the Administrative Procedure Act (AS 14.42.080(c)). The bill authorizes reimbursement for travel and per diem at state rates (AS 14.42.090).

The powers and duties of the board of trustees are enumerated in AS 14.42.100 and 14.42.110. Key provisions are designated as paragraph (7) in each: establishment of management policies applicable to units of the System and determination of the courses of instruction at the units of the System define the policy-making nature of the corporation's board of trustees.

The board's chief executive officer is the System's president. The bill describes his primary responsibility as the administration of the System. (AS 14.42.110(a)). In addition to the on-campus programs, he is charged with development and administration of an effective rural and off-campus program (AS 14.42.110(b)). The corporation president may, with the approval of the board, appoint administrative officers for community colleges and extension centers (AS 14.42.120(b)(1)) and, with the recommendation of the latter, appoint -- or delegate authority to appoint -- members of the faculty of units of the System (AS 14.42.120(a)). He must supervise the work of the people he appoints (AS 14.42.120(b)(2), and give general direction to, and coordinate the work of, the several units of the System (AS 14.42.120(b)(3) and (4)). Student discipline -- exercised through suspension or expulsion -- is the responsibility of the president (AS 14.-42.130).

Community college campus administration is made the responsibility of a chancellor; other units of the System are headed by a director. The manner of appointment of each is described in AS 14.42.140.

The bill authorizes the board to establish and maintain centralized and regional service centers to supplement activities involving units of the System (AS 14.42.150). The bill provides minimal direction relating to appointment of and service by faculty (AS 14.42.160(a) and (b)). A unit of the Community College System is given authority to "coordinate and facilitate all public postsecondary and continuing education in the area it serves," including coordination of course work offered through the University of Alaska and other universities (AS 14.42.160(c)).

The establishment of a community college council for a community college is mandated; a council may be established for other units of the System (AS 14.42.170(a)). The determination of the size, manner of selection, terms, officers and comparable provisions concerning community college councils is the responsibility of the board of trustees (AS 14.42.170(b)). The bill distinguishes between the "policy-making" role of a council and its "advisory" role (AS 14.42.170(e)), and gives a community council significant authority with respect to making and securing implementation of recommendations with respect to operation of the campus or unit for which the council is responsible (AS 14.42.170(f)).

The bill describes the manner of establishment of new community colleges: nomination (AS 14.42.180); determination of feasibility (AS 14.42.190); establishment of a different form (i.e. "extension center or outreach program" where a community college does not meet standards (AS 14.42.200). While legislative nomination of new campuses is made a part of the process, the process does not preclude the legislature from establishing a new college through appropriation.

Specific provision is made by which the relationship between a unit of the System and a second party may cooperate in the formation and operation of a community college (AS 14.42.210): the college is given, under the bill, "complete operational authority . . . subject to periodic reviews" by the cooperating party, and title to those facilities financed or constructed with System funds.

The board of trustees is given specific duties under AS 14.-42.220 by which to assure expanding educational opportunity for community college System course work.

Finance, fiscal and property management, and related provisions generally follow requirements imposed by the state on operations of its secondary education programs, though the manner of administration of funds received is committed to the discretion of the board of trustees by regulation (AS 14.42.230(b)). The budget process is made the responsibility of the board (AS 14.42.230(a)), and requires preparation of a program budget subject to the review and recommendations of a community college council for a particular campus (see AS 14.42.170(f)(2)). Fund management and the acquisition and holding of property are committed to the board (AS 14.42.240), and the board may act as trustee for property as necessary (AS 14.42.250). Monetary gifts and endowments for the benefit of the System are transferrable to the Department of Revenue for investment and management (AS 14.42.260); other properties, real or personal, are taken by the System and made part of the permanent property inventory (AS 14.42.270). Specific provision is made for a working capital fund to receive legislative appropriations for construction of capital improvements of benefit to the Community College System (AS 14.42.290). The state's Fiscal Procedures Act (AS 37.05) is imposed on the corporation (AS 14.42.280); federal laws applicable to the University of Alaska as a land grant college are made applicable also to the System corporation in its capacity as an anticipated recipient of federal funds and lands (AS 14.-42.300).

The remaining newly-codified provisions generally address the manner of operation or function of the system. General civil rights provisions are made applicable (AS 14.42.310(a)); political and religious sectarian instruction is prohibited (AS 14.42.310(b)). Cooperative use of facilities brought into the System from the University of Alaska as a result of this Act, or otherwise subsequently constructed for the benefit of the System or for the University, is mandated (AS 14.42.320). Open library services are made mandatory for community college campuses; at extension centers and outreach program offices, they are discretionary (AS 14.42.-330). An annual report of the work of the corporation is required (AS 14.42.340).

The manner of operation of a unit of the System, where not specifically described in the legislation, is committed to the authority of the System in accordance with regulations prescribed by the board of trustees (AS 14.42.350).

Sections 3 - 11 amend existing provisions of law applicable to the University of Alaska to incorporate reference to the "community colleges" or "the Alaska Community College System", as applicable. Section 12 adds membership from the System on the state's Postsecondary Education Commission; section 13 authorizes that Commission to designate the board of trustees of the Community College System corporation as its advisory council on community colleges where an advisory council is required by federal Higher Education Acts.

By section 14 the commissioner of administration is authorized to delegate any of his responsibilities under the state's Fiscal Procedures Act to the System's board of trustees by "[setting] out the criteria and guidelines which shall be followed." Section 15 places officers, employees, and faculty of the System in the state's exempt service; section 16 requires the members of the System's board of trustees to file necessary disclosure reports in accordance with the state's so-called "Conflict of Interest" statutes. Section 17 repeals current provisions, part of the University of Alaska chapter, pertaining to community colleges as part of the University.

Transitional provisions -- to accommodate the separation and separate establishment of an Alaska Community College System -- are collected in section 18: asset redistribution occurs under the direction of the state's Postsecondary Education Commission; continuance of litigation, contracts, other proceedings, and courses of study and related services is addressed; faculty, staff, officers and employees of the University whose work involves them with the community college system are terminated and must be rehired by the Alaska Community College System; where the latter proves impossible, the Postsecondary Education Commission is directed to assist in securing positions for which these persons are qualified.

JBC:jdn

Mr. Robert F. Leach
4010 Merrill Drive
Anchorage, AK 99503
February 28, 1980

Ms. Thelma Buchholdt
Health, Education and
Social Services
Pouch V
Juneau, AK 99811

Dear Ms. Buchholdt:

The enclosed information is documentation to backup my testimony on Tuesday, February 26, 1980. This documentation demonstrates the University makes decisions which greatly impact the Community College without consulting the Community College. Later, when it is shown to them that there is adverse reaction, they take no action to correct the problem. They simply appear to just walk away from the problem and do not address it.

Attachment 1: History of Student Center Bonds, outlines a decision made by the University in which the Community College was committed to 35% of its tuitions to pay for the Student Center.

Attachment 2: Effects of 35% Tuitior Loading on Anchorage Community College, briefly outlines the financial burden that this decision has had on the Community College.

Attachment 3: This item shows the effects that this decision has on self-support, night-time programs.

Attachment 4: Anchorage Community College major fiscal problem areas shows that additional incidents in which the University of Alaska through its decisions have adversely affected the Anchorage Community College operation.

For all of the above reasons, I find it necessary to support the Autonomy Bill which would separate the Community Colleges from the University of Alaska.

Sincerely,

Robert F Leach

Robert F. Leach

Robert Leach

HISTORY OF STUDENT CENTER BONDS

The Board of Regents decided to build a complex at the Anchorage Campus. The Student Center was one part of the complex. They went to the legislature requesting permission to sell six million dollars in revenue bonds to pay for the student center. The revenue was to come from 25 percent of tuitions paid in the Anchorage area. The legislators authorized the sale of the revenue bonds.

The University marketed the bonds but could not sell the bonds. They then successfully lobbied the legislature to increase the authorization to 35 percent of the Anchorage tuition. Only five million of the six million dollar bonds authorized were sold; and then only after an agreement that the 35 percent of Anchorage's tuitions had to be assessed each year. Also that a minimum of $754,800.00 had to be raised by tuition monies or the Board of Regents would be required to make a special assessment to each student to make up the difference. The annual payment is $500,000.00 for twenty years.

The bond money was invested to earn interest during construction. Also, the excess monies from two years of collecting the 35 percent were invested. The five million dollars did not pay to complete the Student Center. Central administration now decided to use part of the interest on the invested monies and the excess raised by the 35 percent of tuition to complete the Student Center. These monies went mainly into food service equipment.

The next major event was when Max Hullinger's replacement found approximately $600,000.00 in unused interest monies. The legislators thought that the University of Alaska had "rat holed" this money and directed that $290,000.00 be transferred to the Physical Education Plant and withdrew a like amount from appropriations.

The combined operating costs of the Physical Education facility and the Student Center is $540,000.00. The 35 percent of tuition has been producing $250,000.00 excess monies each year over the $500,000.00 annual payment. These excess monies and the found monies were combined to operate the two facilities. As of January, 1980, funds for operating these two facilities ~~has~~ will have been depleted and a plan for obtaining funds in the future has not be stated.

Robert Leach

EFFECTS OF 35% TUITION LOADING ON ACC

The Board of Regents had a plan to cover the Anchorage Community College and the University of Alaska Anchorage's (one unit at this time) 35 percent tuition load by increasing the requested funds from the legislature by a like amount.

The FY77 ACC budget reflected an increase to cover the losses incurred by the 35 percent tuition loading. But the anticipated tuition income for ACC for FY78 and FY79 were over estimated by some large amount. As of this writing time, I have been unable to determine which office or person made the over estimation. Because of the over estimation of income for ACC, ACC was unable to raise all of its tuition income. The budget had been absorbing the 35 percent loading on the self-support classes. It could not now absorb the 35 percent loading and classes had to be cut. Cutting classes meant fewer tuitions. Fewer tuitions further compounded the original problem of having over estimated the tuition income.

At this point, ACC finances started a downward spiral. Fewer tuitions meant fewer classes. Fewer classes meant fewer tuitions.

Possible solutions must address two problems. First, how to reduce the 35 percent loading of Anchorage's tuitions. Second, how to raise the operational monies needed to keep the Physical Education facility and Student Center operating.

If the remainder of the bond indebtedness were to immediately be paid off, this would stop the 35 percent of tuition loading. At the same time, it would eliminate a $250,000.00 source of operating funds for the Physical Education facility and for the Student Center.

The shortage of operational monies will be further compounded when the ice hockey rink comes on line. Additional personnel will be needed and larger utility bills incurred.

Robert Leak

The Electronic Technology Department can not operate a serious night program because the University Regent's change in self-support financing. At first I could operate self-support classes by charging the student twenty dollars per credit. The student could not obtain self-support classes under the consolidated fee schedule. Of this tuition money, I received eighty percent to pay the instructor and to pay for consumables. Twenty percent was for overhead such as: utilities, janitorial services, registration office, accounting office, and administration at all levels to include the President's office for the University of Alaska. Under this system I started to build up the night program.

The Board of Regents then changed the self-support fee structure so that a student could use the consolidated fee schedule for self-support classes. This dictated that ACC move instructional monies into a separate account to cover the self-support class whenever a student uses the consolidated fee schedule to pay for the self-support class.

Next came the Student Center. I was now told that an additional 35 percent of the tuition paid to self-support classes would be withdrawn to meet the bond retirement indebtedness. This now meant the most monies I could realize for self-support was 45 percent of the tuition paid by the student. The difference between the 45 percent of the tuition and the costs of the self-support class had to be made up from the instructional budget. That drain was too large unless the Electronic Technology Program had more than 45 students in a class. For a technology class using equipment under tight supervision to insure personal safety, these numbers are unrealistic.

Because of the above administrative decisions the Electronic Technology Program will be unable to offer night classes. I have to tell those students who must work days and can attend classes only at night there will be no night program for them.

SELF-SUPPORT MONIES DISTRIBUTION FOR A 3 CREDIT CLASS

	Cost per Credit	3 credits	Number of Students	Total Tuition	20% for Adminis.	80% for Program	35% for Bonds	45% for Program
Original Financing	$20	$60	20	$1200	$240	$960		
Change in Financing	$20	$60	20	$1200	$240		$420	$540
Current Change in Financing	$21	$63	20	$1260	$252		$441	$567

Program now receives $567.00 to pay instructor for 15 weeks of two nights a week and to cover all expendables. If the instructor received all of the $567.00, he would only receive, before taxes, $18.90 per night. The instructor has 90 minutes of instruction, 15 minutes set-up, 15 minutes breakdown, travel to and from the college, prep time, grading papers. The instructor makes approximately $6.30 an hour. Also, we have had double digit inflation in the last three years yet the total monies the Electronic Technology Program has received to run these self-support classes has gone down, not up. It is not possible to attract quality people at these rates.

Robert Leach

ACC'S MAJOR FISCAL PROBLEM AREAS

I. Projected tuition and fee income shortfall

Presently the ACC Administration is projecting a tuition and fee income shortfall for FY'80 of approximately $300,000 (rounded from $289.900) for the following reasons:

A. Income has been overstated since FY'78;

B. Income projection for FY'79 was increased by $494,100, with a corresponding General Fund increase (in hard dollars) of only $57,000;

C. It was UAA, not ACC, who projected the incomes and controlled the budgets in both FY'78 and 79. No explanation at this time is available as to why UAA estimated such a large increase in tuition and fee revenues;

D. The FY'80 Governor's budget included a tuition increase item of 20%(removing this amount from the General Fund dollars). This amounted to $339,300. However, the Board of Regents refused to approve such a tuition increase, approving only a 7% increase. The Free Conference Committee restored $249,400 of this revenue, leaving the shortfall of $89,900 which represents the difference between the Governor's 20% increase and the actual 7% increase allowed.

II. Reduction of tuition income for debt service

By law, the Anchorage Community College must apply 35% of all credit tuition to the retirement of revenue bonds on the new Student Center. Apparently, income projections since FY'78 have been based on 100% tuition income and not the actual 65% income, even though UAA has told ACC that there was an initial adjustment made for this difference.

III. Leave Accrual

Annual leave accrual for teachers has until this year been handled by the University of Alaska Statewide Administration. The cumulative leave accrual liability has been estimated at $450,000, which Vice-President Sherman Carter is implying now must be paid off totally by ACC during FY'80.

ACC was never given budget instructions to budget for this liability, and all ledgers on the local campus were in the black until June 23rd, when ACC was told the leave accrual was immediately due and payable.

Attached are copies of the Electronic Technology Program's budgets for the last five years. This will give you the picture of the monies the Electronics Technology Program has had in the past and the monies it now has.

While the upper levels of the University administration have their disputes over the question: Are there enough funds? Are the funds allocated properly? Are the present funds being spent wisely?; We at the teaching/first line supervision level do not have enough monies to properly operate our classrooms. The Electronic Technology Program is a four semester Associate Degree program whose purpose is to take in unskilled men and women and properly train them to become Electronic Technicians. This September, 1979, we expect to have 16 to 20 individual classes taught in the day program. In January, 1980, we are scheduled to have 24 classes. This summer we are operating four classes. For all of the above classes the Electronic Technology Program's budget is as follows:

Pay for seven full-time instructors
3001-Contractual has $1500
4001-Commodities has $3000
5001-Equipment is zero
8001-Miscellaneous is zero

The above shows that to operate 44 technical classes the Electronic Technology Program has $3,000 to purchase all of our consumables. Besides chalk, grade books, paper, writing materials, postage, program advertisement, subscriptions, telephone bills, leases and reproduction costs for handouts, this $3,000 must also cover purchase of resistors, capacitors, transistors, wire,hardware to repair test leads, integrated circuit chips, printed circuit boards, replacements for tools and other items that wear out due to fair-wear-and-tear. The $1,500 in code 3001 for contractual maintenance cannot be used for commodity items. Code 3001 monies can only be used for maintenance agreements to maintain or to repair equipment. Included are items such as, xerox machine, our two typewriters, five microcomputers with peripheral equipment and all of our test equipment. We have over one hundred items of test equipment.

As I stated earlier, the upper levels of the University are arguing and pointing their fingers at each other as to who is at fault. I as a first line teacher/supervisor have no quarrel with the President of the Anchorage Community Colleges on down. I have no idea who is at fault in the upper levels of administration, I only know that I do not have the proper amount of monies to properly operate the Electronic Technology Program.

BUDGET SUMMARY

	FY 74	FY 75	FY 76
200 Travel	-----	-----	1,140
300 Supplies	3,911	5,420	1,978
400 Services	1,100	1,275	1,275
500 Student Aid	-----	-----	-----
600 Other	320	320	320
700 Equipment	9,000	13,280	1,713
TOTAL	$14,331	$20,295	$6,420

	FY 77	FY 78	*FY 79	FY 80
2001 Travel	1,273	900	-----	-----
3001 Contract & Repair	1,923	1,900	2,000	1,500
4001 Expendables(commodities)	2,420	9,200	4,100	3,000
5001 Equipment	9,356	4,000	11,000	-----
TOTAL	$14,927	$16,000	$17,100	$4,500

*FY 79 - The voters approved a bond for the University of Alaska. The Electronics Technology Program received $31,867.70. This was in addition to the $11,000 shown in 5001.

February 26, 1980

Rep. Thelma Buchholdt
Chairperson House Health
Education & Social Services Committee
Pouch V
Juneau, AK 99811

Dear Thelma,

The committee for Community College Autonomy reviewed HB651 and the comments made by John Chenoweth, Legislative Counsel. We wholeheartedly endorse the bill. We did have several suggestions of minor changes which I communicated verbally to your assistant. The following is to give you written confirmation of those suggestions.

1. Our suggested draft included the following in Sec. 14.42.230(a)

> Sec. 14.42.230. FINANCE. (a) The state is basically responsible for the funding for all community college, extension center or outreach programs and activities.
>
> However, nothing in this chapter prohibits a school district, municipality, federal agency or nonprofit corporation or association from providing funds for additional courses and programs which may be considered appropriate under Sec. 210(a)(3) of this chapter.

We feel that it is important to retain this statement in the bill. Mr. Chenoweth felt this was a philosophical statement that might better be included in a purpose or intent clause. We suggest incorporating this statement on page 2 line 8 as item (c).

On page 17 add the word <u>same</u> on line 21 to read as follows: "Alaska, the <u>same</u> shared or joint use of these facilities..." After line 26 add the following: <u>Subsequent changes are subject to mutual agreement of both boards.</u>

These suggestions are made because there was fear that in the transition period there might be an attempt on the part of the University to preempt community college use of facilities. These two changes would insure status quo in the transition and provide for future flexibility.

On page 18 line 2 we suggest changing shall to may, so that it reads "...the two boards may enter into a contract ..."

It was our feeling that it would allow for more flexibility in the future if this were made a permissive rather than a mandatory statement.

We have some concerns about page 24 line 5-13. We are awaiting a legal opinion as to whether this fully protects the employment rights of all present community college staff. We will notify your office immediately if our counsel suggests any change.

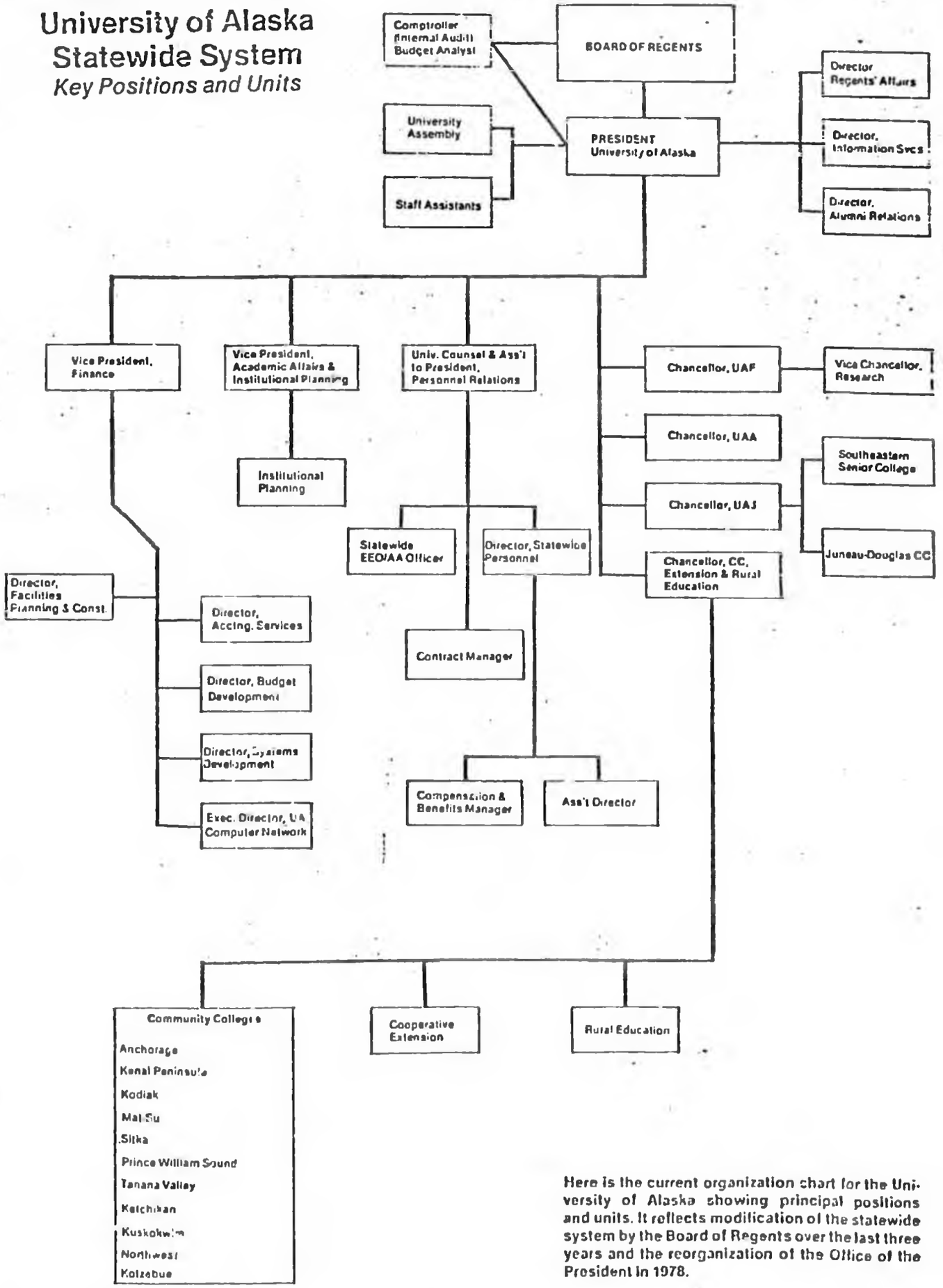
On behalf of the committee I would like to express our appreciation for your efforts on our behalf.

Thank you,

Miriam Carlson

University of Alaska Statewide System

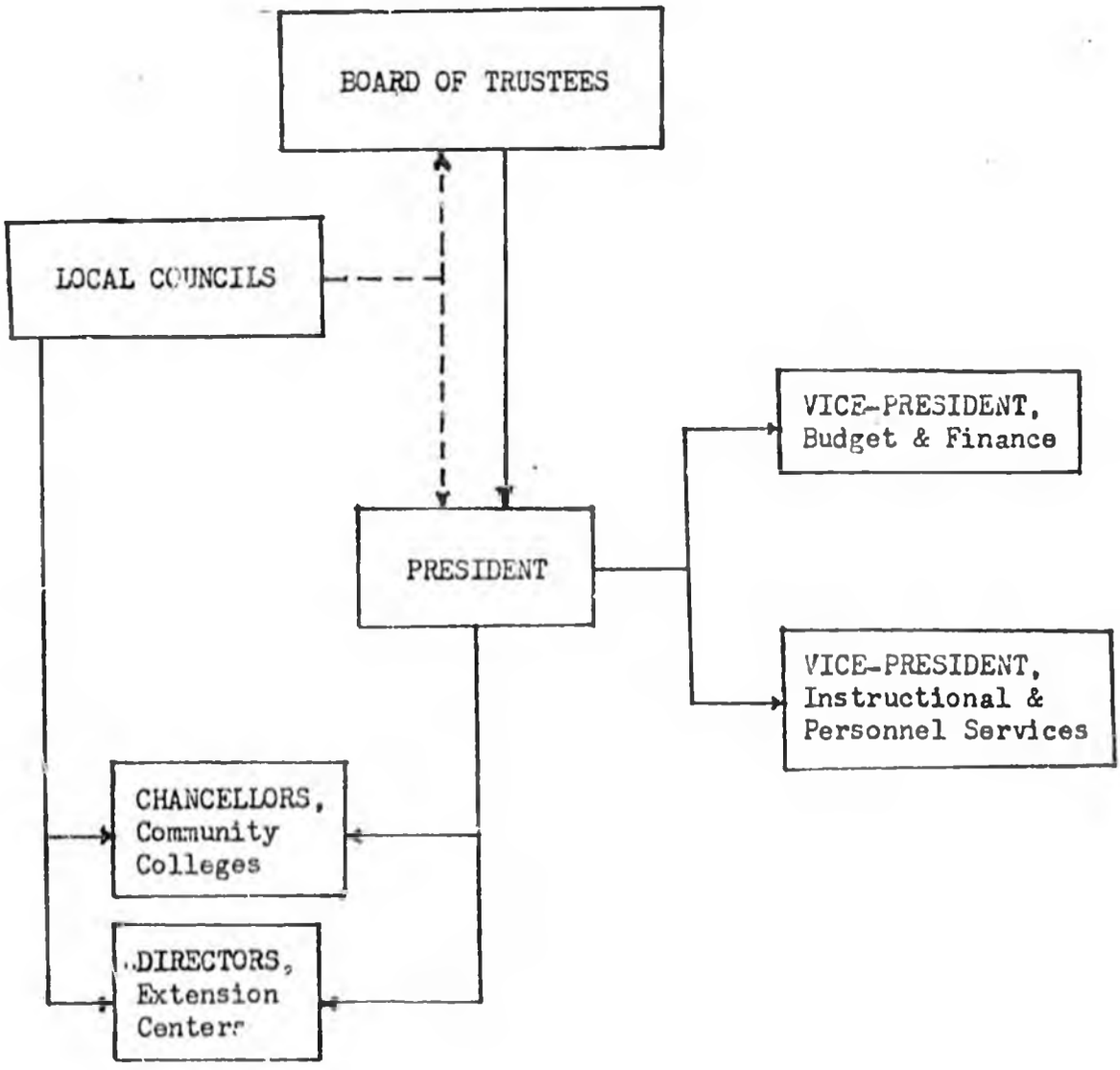
Key Positions and Units



Here is the current organization chart for the University of Alaska showing principal positions and units. It reflects modification of the statewide system by the Board of Regents over the last three years and the reorganization of the Office of the President in 1978.

ALASKA COMMUNITY COLLEGE SYSTEM

Proposed Organization Chart



Direct ———

Advisory - - - -

February 26, 1980

Representative Buchholdt
Chairperson, House H.E.S.S. Committee

Dear Chairperson Buchholdt and Members of the Committee:

I regret that I am unable to appear in person to testify in support of HB 651 and the establishment of a statewide community college system. I have a very large class tonight that requires advance preparation during the hours that the teleconference is scheduled. I do hope that this written statement will suffice.

I am a teacher of history and geography at Anchorage Community College. Since my initial hire in 1972, I have been involved in a number of programs at A.C.C. I am probably best known for the numerous film series and film classes offered on campus, but I have also been actively involved in organization and promotion of study tours; in fact, this year we are offering our sixth study tour to the Hawaiian Islands. I am presently serving as faculty advisor for the soon-to-be-organized Anchorage Community College Student Association and was a member of the University Assembly and chairperson for the Student Affairs Committee in 1975-76.

I must be quite candid and say that I have supported autonomy for the community colleges of Alaska ever since I have been at A.C.C. I came to Alaska from the state of California where the role of the community colleges in higher education is clearly defined and actively supported by individual communities throughout the state. In California, the community colleges are viewed as the foundation of the state's educational system, offering a number of courses and programs of interest to the respective community, as well as serving as a source of students for the University of California and the California State University and College system.

In Alaska, the situation is not quite so clearly defined. Despite the existence of a statewide network of community colleges, they are all under the monolithic control of the University of Alaska system, an organization which does not seem certain as to the role it wishes the community colleges to play. The history of Anchorage Community College (the largest community college in the system) certainly demonstrates this confusion.

When I first arrived, A.C.C. was administered under the "Southcentral Region" office of the University. Within two years, it was decided that A.C.C. and the Senior College of this Southcentral Region were to be merged into a single entity, the University of Alaska-Anchorage. A.C.C's identity was soon lost as we became a "happy family" under the U.A.A. logo.

The attempt to merge two educational institutions with differing educational goals and purposes was, as you are hopefully aware, an outright disaster. Yet the uneasy "marriage" of A.C.C. and U.A.A. continued for nearly three years until the Board of Regents declared a "divorce" in 1977. The impact of this marriage on the respective institutions was one from which we are still trying to recover today, yet it appears as though such mistakes can be repeated. Within the past year, the same situation that was forced upon A.C.C. has now been placed upon Juneau-Douglas Community College. Worse than the A.C.C.-U.A.A. situation, J.D.C.C. has had its academic programs placed under the banner of the University of Alaska-Juneau, leaving the community college as little more than a "voc-tech" school.

These actions by the University administration and the Board of Regents are particularly astonishing in light of the fact that community colleges are increasing in importance nationwide while the traditional four-year institutions are facing stabilizing (if not declining) enrollments and, in some cases, fiscal problems of major proportions.

I don't wish to argue for the discontinuance of the University of Alaska system. Indeed, their programs of research and degree-oriented courses should be allowed to continue and grow. However, this should not be at the expense of the community colleges. Community colleges have their place and purpose in higher education in serving transfer students (those in pursuit of a bachelor's degree), vocational and technical training, and community interest programs. Under the present system, this growth and development has not been allowed to take place to the full potential of which Alaska's community colleges are capable. It is my firm belief that the community colleges can successfully serve the educational goals and needs of the people of the state of Alaska only through the creation and the active support of a separate community college system.

Sincerely,

Ron Crawford

Ron Crawford
History/Geography Teacher
Anchorage Community College

March 25, 1980

Rep. Thelma Buchholdt, Chairperson
Committee on Health, Education and Social Services
House of Representatives
Pouch V
Juneau, Alaska 99811

Dear Thelma,

Mim Carlson and I appreciated the opportunity to meet with you and Kerry Romesburg regarding HB651. We're happy that you both were supportive of our proposal for a joint legislative interim study of higher education needs in Alaska. While we continue to support the provisions of HB651, we do understand the reluctance of the Legislature to take such a significant step as separation of the community colleges from the University system without further inquiry into the effects of such a move. We feel that an interim study would clarify the issues which have been raised.

Our recommendation is that a joint legislative committee be established consisting of two members from each house of the Legislature, with the Executive Director of the Postsecondary Commission on Higher Education serving in an ex-officio capacity. The committee would employ a Director for the study and other staff support. The committee would be charged to examine, review and report on the structure of higher education in Alaska, with the following goals in mind:.

1. Review of missions, goals and objectives of the University of Alaska and its component parts.

2. Comparison of the structure of public higher education in Alaska with structures in other states.

3. To make recommendations regarding structuring public higher education in Alaska to fulfill missions with emphasis on maximum responsiveness to community needs and cost effectiveness.

We feel that the committee should provide every opportunity for interested persons throughout the State to express their views on this vital subject, and we would urge that sufficient hearings be held to accomplish this. The committee should also avail itself of all possible expert opinions in all phases of higher education. We would hope that sufficient funding to accomplish these objectives would be made available.

We deeply appreciate the concern of yourself and your Committee for the community college programs in Alaska. If we can be of further assistance please call on us.

Sincerely,

Pat Spartz
Faculty Autonomy Committee
Anchorage Community College

P.S. I've taken the liberty of sending copies of this to George Hohman and Terry Stimson, cosponsors of SB483. Both expressed their support of an interim study.

c: Kerry Romesburg, Postsecondary Education Commission
Senator George Hohman
Senator Terry Stimson

THE LEGISLATURE OF THE STATE OF ALASKA
ELEVENTH LEGISLATURE

FISCAL NOTE

I. REQUEST
Bill/Resolution No. CSHB 651
Title Study of Community College System
Requested by House HESS Date 4/4/80

II. FISCAL DETAIL
Agency Affected EDUCATION
Program Category Affected Alaska Commission on Postsecondary Education
BRU, Program, or Subprogram(s) Affected Commission on Postsecondary Education
(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 79	FY 80	FY 81	FY 82	FY 83	FY 84
100 PERSONAL SERVICES			16.0			
200 TRAVEL			48.9			
300 CONTRACTUAL			10.1			
400 COMMODITIES			.5			
500 EQUIPMENT			Ø			
600 LAND & STRUCTURES			Ø			
700 GRANTS, CLAIMS, ETC.			Ø			
TOTAL	Ø	Ø	75.5	Ø	Ø	Ø

FUNDING (Thousands of Dollars)

GENERAL FUND	N.A.	N.A.	75.5	N.A.	N.A.	N.A.
FEDERAL FUNDS			Ø			
OTHER (Specify Fund Source)						

POSITIONS

FULL TIME	N.A.	N.A.	Ø	N.A.	N.A.	N.A.
PART TIME			Ø			
TEMPORARY			2.0			

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

Personal Services:

1 Research Analyst 6 mos. @ 2132 plus fringe

Contractual:

(a) Consultant 12 days @ $300/day 3,600
(b) Printing, copying, etc. 3,000
(c) State Computer Time and system support. . . 3,500

TRAVEL:

See attached sheets.

IV. DATE April 4, 1980 PREPARED BY Kenny D. Romesburg
AGENCY Commission on Postsecondary Education
PHONE 465-2854

Original: Legislative Finance
: Budget and Management
Prime Sponsor (First Legislator Named)

TABLE 1: IN-STATE TRAVEL COST ANALYSIS
FOR SPECIAL STUDY OF ALASKA COMMUNITY COLLEGES

Member/Representing	Residence	ANCHORAGE Per Diem	ANCHORAGE Travel	BETHEL Per Diem	BETHEL Travel	FAIRBANKS Per Diem	FAIRBANKS Travel
Senate	Anchorage	55	Ø	160	192	55	128
Senate	Fairbanks	55	128	160	325	55	Ø
House	Anchorage	55	Ø	160	192	55	128
House	Fairbanks	55	128	160	325	55	Ø
Commission	Kenai	55	45	160	370	55	173
Commission	Anchorage	55	Ø	160	192	55	128
Commission	Nome	110	350	160	184	110	222
Commission	Juneau	55	212	160	404	110	340
Staff	Juneau	55	212	160	404	110	340
Staff	Juneau	55	212	160	404	110	340
Staff	Juneau	55	212	160	404	110	340
TOTAL		$ 660	$1,499	$1,760	$3,396	$ 880	$2,139

Member/Representing	Residence	KENAI Per Diem	KENAI Travel	KETCHIKAN Per Diem	KETCHIKAN Travel	KODIAK Per Diem	KODIAK Travel
Senate	Anchorage	68	45	52	280	136	122
Senate	Fairbanks	136	173	104	398	136	165
House	Anchorage	68	45	52	280	136	122
House	Fairbanks	136	173	104	398	136	165
Commission	Kenai	68	Ø	104	325	136	167
Commission	Anchorage	68	45	52	280	136	122
Commission	Nome	136	395	104	538	136	472
Commission	Juneau	136	514	104	125	136	334
Staff	Juneau	136	514	104	125	136	334
Staff	Juneau	136	514	104	125	136	334
Staff	Juneau	136	514	104	125	136	334
TOTAL		$1,224	$2,932	$ 988	$2,999	$1,496	$2,522

TABLE 1 (Continued)

Member/Representing	Residence	KOTZEBUE Per Diem	KOTZEBUE Travel	NOME Per Diem	NOME Travel	PALMER Per Diem	PALMER Travel
Senate	Anchorage	192	224	168	350	62	60
Senate	Fairbanks	192	232	168	222	62	173
House	Anchorage	192	224	168	350	62	60
House	Fairbanks	192	232	168	222	62	173
Commission	Kenai	192	269	168	395	62	105
Commission	Anchorage	192	224	168	350	62	60
Commission	Nome	192	122	84	¢	124	268
Commission	Juneau	192	436	168	562	62	272
Staff	Juneau	192	436	168	562	62	272
Staff	Juneau	192	436	168	562	62	272
Staff	Juneau	192	436	168	562	62	272
TOTAL		$2,112	$3,271	$1,764	$4,137	$ 774	$1,987

Member/Representing	Residence	SITKA Per Diem	SITKA Travel	VALDEZ Per Diem	VALDEZ Travel
Senate	Anchorage	124	220	60	80
Senate	Fairbanks	124	322	60	241
House	Anchorage	124	220	60	80
House	Fairbanks	124	322	60	241
Commission	Kenai	124	265	60	125
Commission	Anchorage	124	220	60	80
Commission	Nome	124	514	120	368
Commission	Juneau	62	95	120	292
Staff	Juneau	62	95	120	292
Staff	Juneau	62	95	120	292
Staff	Juneau	62	95	120	292
TOTAL		$1,116	$2,463	$ 960	$2,383

TABLE 2: IN-STATE TRAVEL COST ANALYSIS FOR
COMMUNITY COLLEGE UNIT COST OF INSTRUCTION STUDY

Representing	Residence	ANCHORAGE Per Diem	ANCHORAGE Travel	FAIRBANKS Per Diem	FAIRBANKS Travel
Staff	Juneau	330	636	110	340
Staff	Juneau	330	636	110	340
University	Anchorage	165	Ø	55	128
University	Fairbanks	220	384	55	Ø
TOTAL		$1,045	$1,656	$ 330	$ 808

TABLE 3: OUT-OF-STATE TRAVEL COST FOR
ONE CONSULTANT (TWO TRIPS TO ALASKA)

		JUNEAU Per Diem	JUNEAU Travel
Consultant	Denver (est.)	$ 804	$ 820

HB
664

Funding Information
General Fund $22,250,500
Other Funds -0-
$22,250,500

Introduced: 2/4/80
Referred: Health, Education & Social Services and Finance

IN THE HOUSE

BY ANDERSON AND OSTERBACK

HOUSE BILL NO. 664

IN THE LEGISLATURE OF THE STATE OF ALASKA

ELEVENTH LEGISLATURE - SECOND SESSION

A BILL

For an Act entitled: "An Act making a special appropriation to the Department of Transportation and Public Facilities for school construction and upgrade at various locations; and providing for an effective date."

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

* Section 1. The sum of ~~$1,200,000~~ 3,629,525 is appropriated from the general fund to the Department of Transportation and Public Facilities for payment as a grant to the Dillingham City school district for school construction and upgrade.

* Sec. 2. The sum of $1,200,000 is appropriated from the general fund to the Department of Transportation and Public Facilities for payment as a grant to the Bristol Bay borough school district for school construction and upgrade.

* Sec. 3. The sum of $19,850,500 is appropriated from the general fund to the Department of Transportation and Public Facilities for school construction and upgrade in the following amounts in the following regional educational attendance areas:

Southwest regional educational attendance area	$12,094,000
Lake-Peninsula regional educational attendance area	7,756,500

* Sec. 4. This Act takes effect immediately in accordance with AS 01.10.-070(c).

DILLINGHAM CITY SCHOOL DISTRICT
POST OFFICE BOX 202
DILLINGHAM, ALASKA 99576

PHONE: 842-3624
HERBERT OBA
SUPERINTENDENT OF SCHOOLS
HARRY E. PURDY
ASSISTANT SUPERINTENDENT

February 25, 1980

The Honorable Nels Anderson, Jr.
House of Representatives
Pouch V - State Capitol Building
Juneau, AK 99811

RE: Remodeling of Dillingham High School

Dear Representative Anderson:

Let me start by thanking you for all of your hard work in the past in helping to provide Dillingham with new showers, gym and the funds to begin and complete a new elementary building. For your information the plans will be going out to bid on the third of March.

As you will recall during the last session we were also looking for funds to remodel the current high school. That need is still with use and is more apparent than ever as the Fire Marshall's office in the person of Ray C. Isenberg, has issued the District a notification of fire hazards and an order to correct. There are some which are not difficult to comply with. Enclosed please find the four (4) page report. I have circled the items which will be costly and difficult to comply with from the finance point of view.

To continue you have a number of copies of the "Dillingham Secondary School Facilities Analysis" which was prepared in January, 1978. That document deals with our needs. However, to review page 44 with you, we have completed the shwer and locker rooms. Still needed under "A" are the Public Toilets and Hallway between new gym and old building. The rejected bid for the toilets and hallway was $366,000.

B.	Science Lab	477,200
C.	Learning Resource Center	759.400
D.	Music	302,100
E.	Art	251,800
F.	Home Economics	201,500
G.	Health Clinic	75,600
H.	Classrooms	465,500
	Jan. 1978 est.	$2,899,100
	Inflation 10.5 (1979) 8.9 (1980) = 19.4%	562,425
		$3,461,525
	Additionally from a safety stand point and financial savings a sprinkler system would be needed.	168,000
		$3,629,525

We have asked that a sprinkler system be installed as an add-on in the bids for the new elementary and have looked into the cost. For the building which is about one-half the square foot of the high school is about $56,000 and since adding the system to the high school which is about 44,000 square feet the cost would be three times the cost for the new elementary. The savings on insurance is great, (for example: the cost for $1,000 of insurance without the system is $1.25 and with the system $.50 for $1,000 of insurance or a savings of $.75 per $1,000 of insurance.) The high school, not counting the gym and showers, is valued at $4,000,000. As you can see there is a great deal of savings.

The District could get by with $3,629,000. It would be greatly appreciated by the community, board and administration of the District if you could secure the funds to complete our school construction and remodeling program.

Please let us know in what ways we would be of help.

Thank you again for your help.

Sincerely,

Harry E. Purdy
Assistant Superintendent

HEP:mkt

Enclosure: 2

PAGE #1

STATE OF ALASKA

JAY S. HAMMOND, GOVERNOR

DEPARTMENT OF PUBLIC SAFETY

DIVISION OF FIRE PREVENTION

P. O. BOX 6188, ANNEX
ANCHORAGE, ALASKA 99502

NOTIFICATION OF FIRE HAZARDS AND AN ORDER TO CORRECT

To: MR. HERBERT COE
SUPERINTENDENT
DILLINGHAM School Dist
P.O. BOX 902
DILLINGHAM AK 99576

Occupancy Name: DILLINGHAM High School
Location: DILLINGHAM
Survey Date: 1-15-80
UBC Classification: E-1
Surveyor: ISENBERG

The following deficiencies were noted and are required to be corrected as indicated:

	Deficiencies	Corrective action required	Correct by
1.	PARTITIONS & FEET IN HEIGHT FORMING CORRIDORS	PERMANENT PARTITIONS (WALLS) IN THIS CLASS ROOMS ARE REQUIRED TO EXTEND FROM FLOOR TO CEILING W/O OPENINGS AT TOP OF WALL. UBC SECTION 3304 (d)	MARCH 15, 1980
2.	CLASS ROOM DOORS HALLWAY CORE:	DOORS TO CLASS ROOMS ARE REQUIRED TO BE 20 MINUTE RATED SMOKE STOP DOORS UBC SECTION 3304 (4)(h)	MARCH 15, 1980

A LETTER CERTIFYING THAT THE LISTED DEFICIENCIES HAVE BEEN CORRECTED SHALL BE SENT TO THIS OFFICE WITHIN TEN (10) DAYS FOLLOWING THE DATE (S) SPECIFIED IN COLUMN THREE.

Recieved by: Herbert Coe

Relation to Property _____

Please reply to: _____

ORDER OF THE STATE FIRE MARSHALL

By: Roy C. Isenberg
(Surveyor)

Date: Jan 15, 1980

*Indicates deficiency pending from previous survey.

Authority: AS 18.70.070
AS 18.70.080
AS 18.70.090

12-L11LH

DEFICIENCIES	CORRECTIVE ACTION REQUIRED	CORRECT BY
3. Opening into corridor - old Radio Room Plain Glass -	Install 1/4" thick wired glass set in steel frames UBC Sec. 3304 (h)	March 15, 1980
4 West exit door obstructed by desk	Remove obstruction from exit door and maintain required width UBC Sec. 3301 (e)	Upon receipt of this notice
5. Portable fire extinguishers through out school require checking	Have all fire extinguishers checked and serviced if needed. NFPA 10 & 10A	March 15, 1980
6. Radio Room and class rooms	Remove all styrofoam from top of partitions and complete construction of wall to ceiling 13 AAC - 50.070 (1)(a)	March 15, 1980
7. Radio Room storage	Lower storage and maintain 18" clearence from ceiling	March 15, 1980

D.D.D. — Owner/Operator (Initial)

Surveyor (Initial)

March 15, 1980 — Date

Dillingham High School — Occupancy (Name)

	DEFICIENCIES	CORRECTIVE ACTION REQUIRED	CORRECT BY
8.	CEILING TILE MISSING THROUGH-OUT SCHOOL	REPLACE ALL CEILING TILE WHERE MISSING	MARCH 15, 1980
9.	FLAME SPREAD REQUIREMENTS OF CORRIDOR WOOD PANELS - LETTER REQUIRED CERTIFYING PANEL MEET CODE.	WOOD PANEL WORK IN CORRIDOR REQUIRED TO HAVE FLAME SPREAD RATING (B) FLAME SPREAD CLASSIFICATION 26-75- UBC SEC. 4203 TABLE 42-A.	MARCH 15, 1980
10	OLD BOILER ROOM.	REPLACE ELECTRICAL PANEL BOX COVER. NEC.	MARCH 15, 1980
11	MAINTS SHOP DOOR.	INSTALL SELF CLOSING DEVICE ON MAINTS SHOP DOOR	MARCH 15, 1980
12.	EMERGENCY EXIT LIGHT BY OLD GYM NOT WORKING PROPERLY.	REPAIR OR REPLACE BATTERY IN EMERGENCY LIGHT UBC SECTION 3312(a)	MARCH 15, 1980

H.H.O'Ian — Owner/Operator (Initial)

Ike — Surveyor (Initial)

JAN 15, 1980 — Date

Dicciny RPM High School — Occupancy (Name)

	DEFICIENCIES	CORRECTIVE ACTION REQUIRED	CORRECT BY
13.	EXIT LIGHTS THROUGHOUT	REPLACE EXIT LIGHT BULBS WHERE NEEDED UBC SECTION 3312 (c)	UPON RECEIPT OF THIS NOTICE
14.	METAL SHOP OXYGEN BOTTLES	OXYGEN BOTTLES ARE REQUIRED TO BE CHAINED TO WALL	MARCH 15, 1980
15.	DRAFTING ROOM 2ND FLOOR REQUIRES SECOND EXIT	INSTALL EXIT DIRECT TO EXTERIOR OF BLDG EXIT FROM DRAFTING ROOM NOT TO PASS THROUGH METAL SHOP OR WOOD WORKING SHOP. UBC 3302 (a) UBC SECTION 3302 (e)	MARCH 15, 1980
16.	SEPARATION REQUIRED BETWEEN WOOD WORKING AND METAL SHOPS.	WALL BETWEEN WOOD AND METAL SHOPS IS REQUIRED TO BE 5/8 TYPE X GYPSUM WALLBOARD TO BOTH SIDES OF 2"X 4" 16" ON CENTER TAPED & FINISHED UBC SEC. 803(b)	MARCH 15, 1980

W. W. Allen
Owner/Operator (Initial)

Surveyor (Initial)

JAN 15, 1980
Date

DILLINGHAM High
Occupancy (Name)

HB

672

CHUGIAK-EAGLE RIVER
REPUBLICAN WOMEN'S CLUB
P. O. Box 144
Chugiak, Alaska 99567

February 18, 1980

Honorable Nels Anderson
Alaska State House of Representatives
Pouch V
Juneau, Alaska 99811

Dear Mr. Anderson:

The Chugiak-Eagle River Republican Women's Club supports House Bill No. 672.

Sincerely,

Barbara Franklin

Barbara Franklin
President

rcvd 2/22/80

UNIVERSITY OF ALASKA, RURAL EDUCATION

Dillingham Extension Center
Box 10206
Dillingham, Alaska 99576

February 12, 1980

Representative Nels A. Anderson, Jr.
Pouch V
Juneau, Alaska 99811

Dear Representative Anderson:

Per your suggestion at last evening's Constituent Teleconference, I am forwarding to you my remarks in behalf of the Dillingham Extension Center and its Policy Advisory Council addressed to you and Sen. Hohman in support of HB 672.

"We are here this evening (Trish Dorey, President, PAC, and I) to urge the passage of House Bill 672 allocating funds for Adult Basic Education (ABE) to DOE.

"Various agencies and individuals in the Dillingham Community have over the past five years submitted proposals to bring ABE to the Bristol Bay region. These proposals were never funded and our region is still without an ABE program to serve the needs of more that 5000 people of the 30+ villages in the area.

"I am here as one representative of education in this community to urge passage of HB 672 for the following reasons:

"1. The Bristol Bay region needs an ABE program--as Coordinator of the Dillingham Extension Center I have had the opportunity to travel extensively in the region and ABE is an unmet need which I receive most question about. It is unquestionably, in my opinion, the number one educational priority of the region.

"2. We believe that passage of HB 672, in its present form will finally result in the release of a portion of the total ABE funds ($617,500) for a program in this region.

"3. The Dillingham Extension Center is in a position vis-a-vis the Bristol Bay Regional Resource Center and its Director, Mr. Bob Brown, to train teachers using models developed by the Northern Institute. I have talked with Mr. Dave Alexander of

rec'd 2/18/80

TNI who has assured us of assistance in the development of a training program for ABE teachers. We will however, need funds to assist our teacher trainees once they are recruited, as well as funds to support them as they work in the villages training adults in basic literacy skills.

"4. Finally, and perhaps most importantly, we believe that a successful ABE program in the Bristol Bay region will go a long way toward insuring the success of other programs in the region. The University of Alaska as it attempts to extend education to all the people of the Bristol Bay area through its Extension Center is acutely aware of the need to impact people at all educational levels if its own programs are to succeed."

Sincerely,

Charles A. Blood, Jr.

Charles A. Blood, Jr.
Coordinator
Dillingham Extension Center

CB/jm
cc-Bob Brown
Trish Dorey

A PROPOSAL FOR EDUCATION LEGISLATION TO SERVE SEVEN REGIONS IN ALASKA

INTRODUCTION

This state offers a free education to every member of its varied society. Even so, there are many adults among us who either could not or would not finish (or, in some cases, even start) their elementary or secondary education. Because these adults are poorly educated, they have, throughout an entire lifetime, held some of the least rewarding jobs in our society. Frequently, they have held no jobs at all. They find themselves on the welfare roles, and each generation begets yet another generation of those who are uneducated, unskilled, and unemployed.

There are men and women in the state who cannot fill out job applications, who cannot read labels on prescriptions or prices at the grocery store, and who cannot help their children with even the simplest homework. They are people who need Adult Basic Education.

On the other hand, there are men and women among us who have recently applied for and received either their first job or a better job. We have adults who no longer must depend upon others to read for them on shopping trips. We have people who take new pride in helping their children learn, who pass that pride in education along to their formerly indifferent families. These are men and women who have received and are now demonstrating the benefits of Adult Basic Education.

DEFINITION

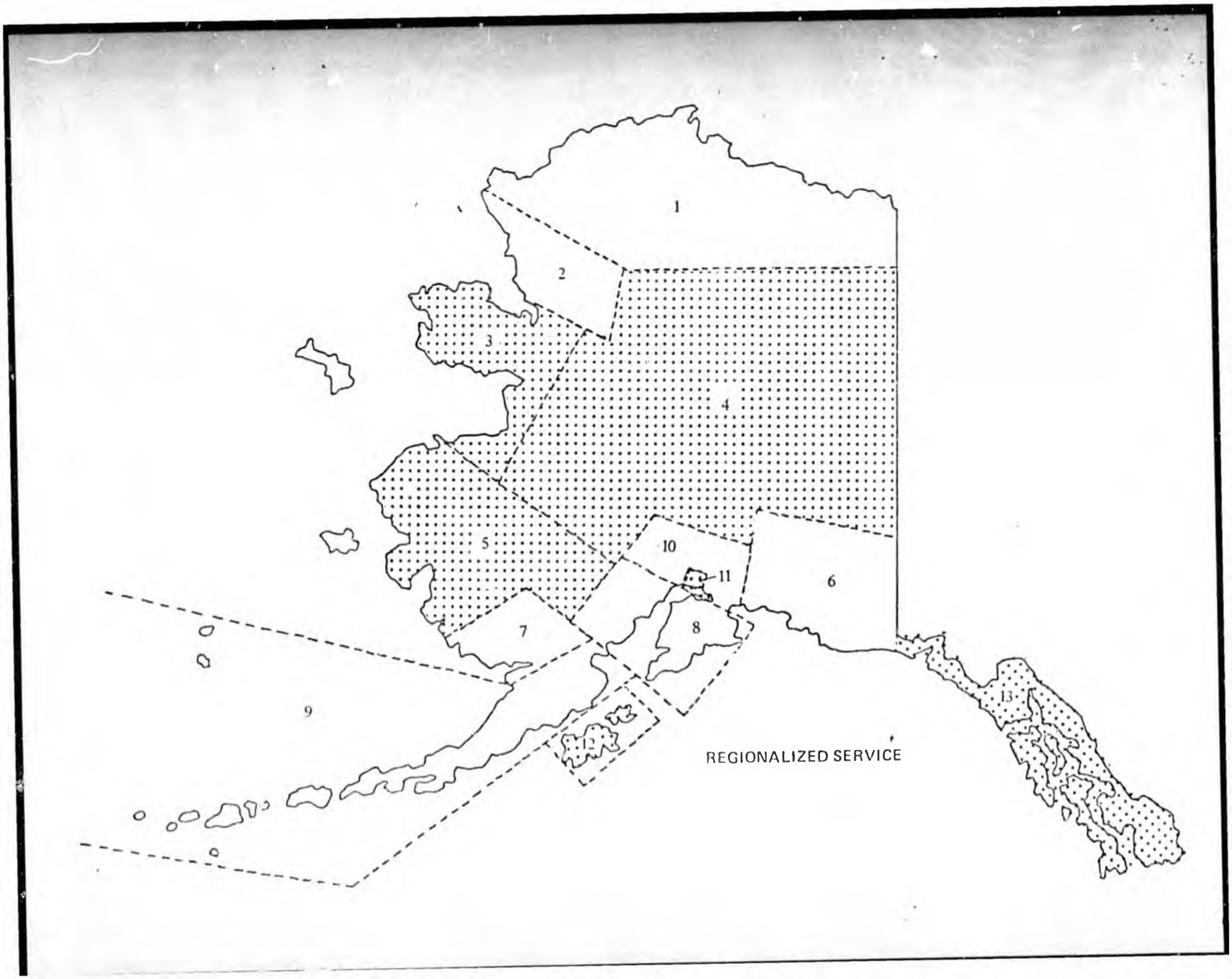
Adult — A person sixteen years of age or older who is not enrolled in a regular public or private school program and who is in need of basic literacy skills, English Language instruction, life skills instruction or other assistance up to secondary school completion.

STATEMENT OF NEED

The goals of Alaska Adult Basic Education are:

> ...to provide the best possible educational opportunities for all undereducated adults in Alaska ... to provide adults opportunities to continue their education to at least the level ... of secondary school ... (to make these) opportunities available for adults who have not completed secondary training as well as adults who have received a certificate of graduation from a school providing a secondary education but are functioning at less than a secondary competency.

There are presently seven geographic regions in the state receiving little or no instructional money for Adult Basic Education. The North Slope, Northwest Arctic, Aleutian/Pribilof Islands and Bristol Bay and Rural Anchorage Regions receive no funding. The Kenai Region receives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REGIONALIZED SERVICE

funding for two part-time classes and Valdez is funded for one teacher. This means that approximately 68,000 Alaskans are being denied access to the advantages of adult education.

At current funding level options are limited. Programs could be drawn out of one region and relocated in another region, but this would cause the loss of experienced staff in whom the state has a considerable investment in training. This would further cause the discontinuation of programs for many students who have had a long term commitment and are in the advanced stages of completion.

A second alternative would be to trim a percentage of money from existing programs and put into the unserved regions. Once again this would cause many people to lose service and take away from programs which already operate at only a minimal level. A case in point is the Kuskokwim Region which serves fourteen out of fifty-three villages now.

The third alternative and that being suggested by this proposal is to leave present funding in place and add minimum funds necessary to complete the network. The state is already in the unfortunate position of denying many of its citizens equal access to educational opportunity. To reduce or remove the programs currently thinly spread over the state would be a denial to our responsibility.

Great social pressure is being exerted upon the Native populations of the state. With Indian Self Determination, the advent of Native Land Claims and localization of the schools people with little education are being required to sit on boards of directors of corporations making decisions with great environmental and financial impact, sitting on school boards making decisions in hiring and firing professional staff as well as judgements on quality of education.

This press for educated adults cannot depend strictly upon the new young graduates to fill the need. Every effort must be made to tap the knowledge and experience of the mature adult in the older geneations. This can be done only through basic education.

The following statistics corroborate the need for basic education in the proposed regions to be served.

REGIONAL NEEDS STATEMENTS

1. Bristol Bay:

"In a special report prepared by Robert Natham and Associates for the Federal Government, a number of statistics were identified relative to the well being of Alaska Natives. For Bristol Bay, the figures are indeed stark:

The Median education ... school years completed by
Alaska Native (as a whole) is:.....7.4
For Bristol Bay.....3.5

Further, the studies identified 50.3% of the population 25 years of age or older as having an educational attainment of 0-4 years of formal schooling. In this same population group, only 8.6% have

completed four years of high school or have an equivalent high school diploma. There is an immediate need for Adult Basic Education Courses in virtually all Bristol Bay villages."

No Adult Basic Education courses are currently being taught, therefore, there is no existing program or vehicle for adults within the villages to obtain the basic skills necessary to even apply for and pass the five sub-tests for a General Education Diploma (GED). An Adult Basic Education program would not only provide this service but would help provide for equal educational and growth opportunities for those adults who have been and are still being neglected.

2. Northwest Arctic:

An active, comprehensive program of adult education, based on the conceptual framework of Adult Performance Levels, is a prime requisite for growth of political, social, personal, and economic skills of NANA Region residents. In a recent (December 1978) survey, it was found that 42% of respondents had attended school to eighth grade of less. Another 13% attended between nine and eleven years. 45% were at least high school graduates. Teachers and other relatively transient professionals were included in the random sample and contributed to this last category. The indigenous, stable population is primarily of Inupiaq Eskimo heritage and fewer of this group have completed high school than the survey results suggest. Complicated further by multilingualism, the adult populations thus has a high rate of functional illiteracy. The region's people also suffer a high rate of unemployment. Inuit respondents, 52% had not had a job for the past year. An additional 41% were employed part-time. Only 7% had fulltime jobs. Besides unemployment, alcoholism, high prices, and lack of something to do, were seen by the respondents as the region's major problems.

The above statistics would in themselves suggest a need for an adult basic education/adult education program. But there is further evidence as well. When asked the question, "If a school for adults was available here, would you be likely to go?", 73% replied they would. And 90% said they would attend workshops or classes to teach people self-health care.

In follow-up interviews by school district personnel (April 1979), Ambler adults indicated that an average of 36% of respondents would attend each of sixteen (16) vocationally oriented classes. An average of 61% would enroll in each of two (2) consumer education classes, and in each of four (4) health and safety classes. Three (3) ABE courses would each have an enrollment of 10% of the adult population of this village, and a GED preparation course 32%. If extrapolated to the region's adult residents (approximately 2,500 people in eleven villages), one could anticipate about 150 people interested in a ABE program, 800 in a GED program, 900 in job skills, and 1,525 in other life skills program. Of course, many people indicated interest in several programs, and actual attendance would be well below the level of interest, but the need for an adult education program is apparent.

MEDIAN YEARS OF SCHOOL COMPLETED BY REGIONAL POPULATIONS

The following chart was compiled in an effort to show both the educational services needs and the income levels of the target area populations the A.S.H.E.S. Talent Search Project would be aimed at.

Region	Median Years School Completed		Highest Grade Completed by largest % of population				Eligible youth age 14-24 (17.4% of poverty population	Total below poverty pop.		Total Pop.
	Native	Non-Native	Native	%	Non-N.	%				
ALUET	7.2	12.7	5-6	23.9	12	46.7	73	419	9.6	4359
ARCTIC SLOPE	5.6	18.0	5-6	23.9	12	35.9	154	887	28.8	3079
CALISTA	3.0	13.5	0	33.9	12	33.6	1378	7889	65.5	12040
BERING STRAITS	7.0	13.8	1-4	21.8	12	28.5	387	1938	35.3	5497
BRISTOL BAY	3.9	12.6	1-4	29.9	12	38.3	256	1471	33.1	4446
CHUGACH	8.2	12.5	1-4	17.1	12	41.3	146	839	14.5	5794
COOK INLET	10.2	12.6	12	24.8	12	48.3	1791	10292	7.0	140823
ATHNA	5.8	12.4	0	22.9	12	46.2	42	240	18.0	1336
KOMIAG	8.6	12.5	8	28.8	12	41.9	135	773	9.3	8338
NANA	6.2	13.5	1-4	29.2	12	34.2	238	1369	37.2	3684
NOTON	6.7	12.6	1-4	21.4	12	42.4	892	5127	10.4	49233
SEALASKA	10.3	12.5	9-11	25.3	12	38.1	760	4370	10.4	41957
OTAL	7.5	12.6					6197	35614	12.7	280536

Data compiled from 2(c) Report, Task I. Excerpt from 2(c) Report, Task II, "The lack of basic statistical information prevents educational agencies from evaluating current educational efforts and identifying unmet needs."

3. Aleutian/Pribilof

Due to limited educational opportunities in the past, the people of the Aleutian/Pribilof region have faced many difficulties coping with 20th Century corporate life thrust upon them by the Native Claims Settlement Act. Leadership has been developing with incredible rapidity and effectiveness, but the heavy pressures involved in rapid change have caused frustrations resulting in social disorganization. Village corporations, councils, school committees and school boards have all been forced into leadership decisions for which they often lack basic training and experience. According to the 1970 U.S. Census in the Aleut Corporation area, 15% of the Native people 25 years or older completed grades 1-4; 25% grades 5-6; and 16% grades 7-8. Unless educational needs are met, the following will continue to occur:

A. Village and city governments will fail or falter or will be dominated by non-Natives.
B. School boards will be dominated by non-Natives, and Native parents will have little to say about education of their children.
C. Village corporations will not function at their full potential.
D. Outside investors will reap fortunes in the Aleutian/Pribilof area while the majority of Aleut people will subsist virtually at poverty level.
E. The Aleut cultural heritage will be overrun and lost, leaving behind the vicious circle of poverty, alcoholism, drug abuse, family disintegration and loss of identity.

4. Matanuska-Susitna

Matanuska-Susitna Community College identified 4,600 adults having less than a secondary education in the Matanuska-Susitna service area. Bureau of Labor statistics revealed a July unemployment rate of 15.1 percent and November 23.3 percent combined with Decembers 24.9 percent are symptomatic of the need for basic education and life coping skills training.

5. North Slope

The native residents of the North Slope have a median school completion level of 5.6 years. This lack of education has significant impact upon the ability of natives to compete for and maintain jobs in the now technologically oriented North Slope Region. Additionlly, a bank of educated persons is necessary to train for the roles necessary if the new affluence introduced by massive oil revenues is to remain under control of its rightful owners. The few individuals represented in the leadership need many more trained, educated people to take on the many emerging roles in business, education, industry and arctic leadership.

6. Kenai Region

During the summer of 1979, an assessment of the available educational resources and needs of the adult client population was done under a federally funded program named NETWORK. (Network of Education, Training and work Opportunity Resources Knowledge Bank). The final report will not be in this office until October 30, however, preliminary analysis indicates that the statistics presented last year were in the ball park. Thus, they are repeated here.

The population of the Kenai Peninsula is approximately 25,000 with most of the people living in the Kenai-Soldotna area. In Level I (1-9), it is estimated that 1,500 adults could be served. Additional estimates are that there are approximately 3,000 adults in Level II and 150 needing ESL training.

7. Valdez/Copper River

The Valdez/Copper River Region encompases a population of nearly ten thousand people. Of this ten thousand an estimated 2,400 have less than a high school education. The Native adult population has a median school completion level of 5.8 years. With the pipeline terminal, pumping and maintenance stations throughout the region it is apparent that employment opportunities are fast appearing, but they are at a level which demand solid-scholastic background. Unless the region is given the benefit of ABE services, these opportunities will once again fall to outsiders.

PROPOSED SERVICES

Services shall include instruction in basic literacy, English as a Second Language, life coping skills and vocational counseling in the form of:

an "individualized educational program" a written statement jointly developed by a qualified instructor and by the person, to include:

- present achievement level analysis
- short range and long range goals
- identification of specific services that will be provided toward meeting those goals
- when and where these services will be provided and how long they will last
- a schedule for checking progress achieved under the plan and for rating necessary revisions

These services shall take place in the towns and villages of the respective regions as selected by the educational institution providing the service. Curriculum shall be determined by the student, local educational institution in concert with their local advisory council and the citizens participatory planning process used by the state ABE program.

PROGRAM IMPLEMENTATION

Organization for Delivery of Services

State Organization: In an effort to prevent proliferation of state bureacracy, these funds should be located in the Alaska Department of Education, Adult Basic Education Section.

This section already has in place the mechanisms for granting and administering funds. A statewide network of curriculum assistance, technical assistance and staff development. The addition of this program to the present network could achieve maximum benefit at minimum cost.

LOCAL DELIVERY

Local/Regional delivery is currently conducted throughout the state by a variety of organizations. These organizations include school districts, community colleges, Native Non-profits, private non-profits and public non-profit agencies. The funds are placed on a competitive basis to the organization offering the most service for the available dollars. Programs in most regions reflect cooperation between two or more agencies for delivery of service. The competition between agencies has been very effective in holding down costs without causing instability in the program. In the case of similar bids the program operator with the proven history of performance is always funded.

Program operators not performing will have historically been given one year grace to upgrade and it has been necessary to null only a program in six years.

FUNDS NECESSARY TO IMPLEMENT NEW REGIONS

North Slope	$80,000
Northwest Arctic	80,000
Bristol Bay	75,000
Aleutian/Pribilof Islands	85,000
Kenai Peninsula	75,000
Rural Anchorage (Mat-Su)	75,000
Valdez/Copper River	75,000
Total Program	$545,000
Staff Development @ 10%	54,500
Support Services - 1 clerk typist III @ 18,000 including fringe, etc.	18,000
Total Cost	$617,500

Justification:

Regional Allotments

North Slope, Northwest Arctic and Aleutian/Pribilof Islands Regions are suggested at a higher level of support due to unusual travel costs. Although travel will be much cheaper in the Kenai and Rur Anchorage regions extra funds are justified due to the population density they must serve.

Staff development is a vital compontent to ABE. Rural teachers are taken from the indigenous population and trained as ABE instructors. This training is a rich source of leaders in the rural areas. Attached find statements of what have happened to many of the ex-instructors once the role of ABE instructor gave them responsibility in the political/social process.

Furthermore, staff development is inherent in quality instruction, particularly when dealing with people who have never taught before or even experienced teachers dealing for the first time with adult students.

Support services are necessary if reasonable service is to be available to the new regions. Although ABE is funded over three times as high as four years ago and is offering many more services to field programs, the present administrative staff need not be expanded but the present 1/2 time secretarial clerical arrangement simply cannot keep up with present volume let alone be expected to handle nearly double the number of contracts currently served.

Matching funds are available from many sources including C.E.T.A., B.I.A., Indian Education, Labor, Social Services, boroughs, etc., once a knowedgable organize services and negotiate contracts. It is anticipated that the first fiscal year funds at least equally the inital grant will be generated by and the third year they would be generating as much as three dolllars per state dollar.

The money being generated tends to be dollars that previsously created overlap programs or furnish ancillary services which, though useful, were not coordinated with ABE, therefore seldom used.

United States Council of State Directors

Adult Education Economic Impact Survey
Alaska - FY79

A. Public Assistance

1. List the number of Adult Education Learners removed from public assistance in FY77 (as reported in Table 5, Item 12 in Annual Report). 24

2. Average annual cost per adult for public assistance in your state. Households average 1 adult and 2 dependents nationally and FY77 statistics from USOE reveal Alaska costs to be 12,948 per household including case work, etc. 12,948

3. Total projected savings per year. (Multiply answer in number one times the answer in number two.) 310,752

B. Employment

1. List the number of Adult Education learners who became employed in FY77 as a result of Adult Education (as reported in Table 5, Item 13 in Annual Report). 112

2. Projected income earned by adults who became employed. Take the number of adults receiving jobs as a direct or indirect result of attending Adult Education class: Multiply this number by the minimum hourly rate (now $2.30) times 40 X 52. If the actual income is known, then use this instead of minimum rate. 1,397,760

Minimum average in Alaska is just over $6.00

EXAMPLE: 112 persons who became employed X $6.00 per hour = $672.00 per hour X 40 hours per week = $26,880 X 52 weeks = $1,397,760 per year new income.

C. Job Promotions

1. List the number of adults who were promoted as a result of Adult Education (as reported in Table 5, Item 14 in Annual Report). 222

2. Using Employers State salary scale minim is 18¢ per hour. Projected additional money earned by adults who were promoted as a result of Adult Education. Multiply the number of adults receiving a promotion by .10 per hour (which is a minimal figure) X 40 hours X 52. 230,880

EXAMPLE: 222 promotions X .50 per hour = $111.00 per hour X 40 hours per week = $4,440 per week X 52 weeks = 230,880 per year.

House Health, Education & Social Services Committee

Meeting/Hearing on HB 672

Date: 3/18/70

	Name	Address and Phone	Organization/Self	For/Against or Observing
1/	Clark Jones	Pouch F 465-4685	DOE	For
2/				
3/				
4/				
5/				
6/				
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8/				
9/				
10/				
11/				
12/				
13/				

Southwest Region Schools

P.O. Box 196
Dillingham, Alaska 99576
Phone (907) 842-5288

January 10, 1980

The Honorable Nels Anderson, Jr.
Member, Alaska State Legislature
Pouch V
Juneau, Alaska 99811

Dear Nels:

We have reviewed our capital improvement needs and find them to be as follows:

1.	Aleknagik South Shore		
	Diking of oil tanks and doing code required work.	$ 50,000	$ 50,000
2.	Aleknagik North Shore		
	Additional funds needed to provide complete K-12 school, including space fo industrial arts, kindergarten, specialized secondary classroom, instructional materials center, and support space for a total of 4,600 square feet.	1,350,000	1,350,000
3.	Clarks Point		
	Diking of oil tanks and doing code required work.	75,000	
	Additional space for industrial arts, multipurpose activities and support space, totaling 4,200 square feet.	1,120,000	
	Remodel existing space to provide specialized secondary classroom.	150,000	1,345,000
4.	Ekwok		
	Additional funds needed to provide complete K-12 school including specialized secondary space, an instructional materials center, industrial arts and support space for a total of 3,900 square feet.	1,144,000	1,144,000

5. Koliganek		
Funds for a 1,200 square foot industrial arts building.	$ 370,000	
Oil tank diking and life safety upgrade of original building.	250,000	$ 620,000
6. Levelock		
Funds for one elementary classroom, one specialized secondary classroom, an industrial arts room, an instructional materials center, plus supplemental space for a total of 4,700 square feet.	1,300,000	
Furnace replacement and waste heat recovery.	100,000	1,400,000
7. Manokotak		
Remodel existing space to provide an instructional materials center.	125,000	
Dike oil tanks and perform code required work.	150.000	
Upgrade gym floor and improve safety of building.	150,000	425,000
8. New Stuyahok		
Convert existing space to an instructional materials center and remodel kitchen.	200,000	
Dike oil tanks and perform code required work.	100,000	
Furnace replacement and waste heat recovery.	200,000	500,000
9. Portage Creek (Ohgsenakale)		
Furnace replacement and waste heat recovery.	75,000	
Dike oil tanks and perform required work.	50,000	125,000

10.	Togiak		
	Construct and equip a 2,400 square foot industrial arts building.	$ 720,000	
	Heating system replacement and waste heat recovery.	300,000	
	Dike oil tanks and perform code required work.	75,000	
	Replace relocatable classrooms, 3,600 square feet.	960,000	2,055,000
11.	Twin Hills		
	Dike oil tanks and perform code required work.	30,000	30,000
12.	District Office		
	Perform code required work and connect to Dillingham City Water.	50,000	50,000
13.	Swimming Pools		
	Construct 20 x 50 x 4 ft. deep pools, plus mechanical systems, lockers and showers in order to improve building life safety and provide swimming instruction to students at Manokotak, New Stuyahok and Togiak.	3,000,000	3,000,000
	Larger pools with capability for diving could be constructed at the three sites at a cost of $1,500,000 each or a total of $4,500,000.		
	To date we have been unable to secure a rate quotation for fire insurance that would be lower than present rates by using the pools as reservoirs for the sprinkler systems. However, a sprinkler system would definitely improve life safety protection at Manokotak and New Stuyahok where there are no sprinkler systems.		
		TOTAL	$12,094,000

We have appreciated your past efforts on behalf of the students of the District, and know that you will do your very best for them during this session.

Should you need additional information, please do not hesitate to call.

Sincerely,

Bob

Robert Van Slyke
Superintendent

RVS:ct

HB
690

FY81 CAPITAL BUDGET REQUEST

1. Instructional Equipment. (Various Units)

   This is a six-year program which will maintain a continuous supply of instructional equipment for teaching purposes for the entire University. Most of the needs are determined or based on the existing program needs, the deterioration of the current equipment and projected needs.

2. Seward Marine Education Center. (UA/Fairbanks)

   This will be a new facility and will provide conference rooms, library spaces, office and reception areas for marine advisory agent, a public display area, aquarium, etc. This will be located in Seward. This facility will be built on the land that is currently owned by the City of Seward, which has extended the lease agreement with the University for the next two to three years, within which time this project can be implemented.

3. Handicapped Barrier Removal. (Various Units)

   This item is in response to the requirement of Section 504 which requires removal of handicapped barriers within the University buildings and campuses.

4. Campus Development Plan. (Statewide Administration)

   This project, if approved, would provide a resource to properly develop the expansion and growth of the physical aspects of the University. It would also afford coordination between the academic master plan, physical master plan and land management. It would provide basis and document from which the requests for capital projects in the future could be extracted and coordinated. It will provide a general plan document which is necessary not only for the development of the major campuses, but also the community college campuses as well as coordination of the entire University system.

5. General Building Upgrade and Replacement. (Various Units)

   This is a six-year program that will keep vigilence and maintenance over the buildings within the University system, providing continuously good quality space for educational needs, resulting in a lower maintenance cost.

6. Roads, Streets and Parking. (Various Units)

   This project is part of the six-year schedule within the capital projects program. It is intended to serve as a maintenance type of project to prevent deterioration of streets, roads and parking, and will therefore result in an economical way of maintaining the vehicular communication lines within the campus.

7. Classroom Building. (UA/Anchorage)

   Because of lack of large space the department is currently located in a variety of sites which is not conducive to proper educational development. Enrollment has increased to such a level that it is difficult to handle program needs in current facilities. Therefore, it is proposed that a new classroom building will provide for Departments of Music, Theatre and Art.

8. Galena Learning Center. (Rural Education)

This request will provide space facilities for the Rural Education needs. The student population and interests in technical education are growing, and at this point there is no facility to provide these kinds of programs in the rural areas of this state.

9. Repair Elvey Annex Roof. (UA/Fairbanks)

The existing roof is leaking water around the periphery of the building, resulting in a deterioration of the structure. Spaces below, like the electronics shops, are out of use due to seepage, especially during the winter months. This should be stopped, and the space returned to the user. It is estimated that about 20% of this space is unused during the major portion of the year.

10. University Center - Phase I. (UA/Juneau)

Included in this phase of the project would be a cultural center, student recreational center, administrative center, plus mechanical and other types of spaces necessary for the building's functions. It will house a number of interrelated programs, making an interaction between them much simpler and easier, resulting in a much more efficient operation. It is thought that one single complex approach has numerous advantages; there are economies related to a large building construction rather than numerous small ones. It is thought that the economies of maintenance are better in a single structure rather than numerous buildings located all over the area. It is expected that the program development and attraction of students would increase having a facility that is of a centralized type.

11. Land Acquisition. (UA/Juneau)

It is necessary to purchase property because of the potential need for the location of water supply tank, since this is the highest point on campus. The water would flow by gravity rather than be assisted by mechanical means.

12. Central Receiving. (UA/Fairbanks)

Currently, the Physical Plant is using about one-third of its space for unrelated storage and warehousing. This is an inefficient use of space, therefore it is proposed that a new central warehouse be constructed. A control warehouse would be much more efficient and will lower current operating costs by a significant amount.

13. Prince William Sound Community College.

Projects that are requested are only those listed before you. All listed projects are new. There are no facilities, at the moment, that the college owns. They are currently in a "borrowed space". The justification simply reads: "We have no buildings. We are an established community college; therefore it is appropriate for us to ask for new facilities as soon as possible."

14. Utilities Modification. (UA/Fairbanks)

This request will include water chiller for environmental science labs, a refrigeration system for Irving Building, water chiller for Elvey Building, heating and cooling systems in Elvey Building, steam system upgrading, ventilation and air handling for KUAC, etc.

15. Sewer Connection. (CC-Sitka)

This project is necessary to connect the college buildings to the Sitka community sewer system. Presently the septic tank system must be frequently cleaned. This is costly. It is felt that it would be more advantageous to connect into the city utility system.

16. Engineering Equipment. (UA/Anchorage)

This equipment is necessary to furnish engineering laboratories in the new building. This building is near completion, and the equipment that will be purchased will serve areas such as thermodynamics, electric power, fluid mechanics, electronic communication, etc. This will provide basic furnishing for the educational needs.

17. Applied Science Building. (UA/Anchorage)

This particular request is based on the consolidation of nursing programs. The programs that will be housed in this building are dental and health occupations, chemistry, biology and general type of classrooms. If approved, this will contribute highly to the education of applied science programs and professions within the Anchorage area.

18. On-Line Computer System. (Statewide Administration)

The funds requested for the UACN will be used to: (1) provide increased accessibility and improved service to the Network for all users throughout the University system; (2) provide improved computer hardware and software support for the Division of Community Colleges, Rural Education and Extension; (3) provide needed life support systems in the Anchorage Computer Center and a security system in the Fairbanks Computer Center.

19. Utilities Monitoring and Building Security. (UA/Fairbanks)

It is intended that a computerized system for monitoring of the utility usage and building security be provided for the Fairbanks campus.

20. Physical Plant - Various Programs. (UA/Fairbanks)

This project includes items such as swimming pool chlorinator, re-roofing of some of the buildings, domestic water cooling tower, carpet replacements, elevator safety devices, etc. All items are too numerous to be listed here. There are improvements that have to be made for which no money has been allocated up to this point.

21. Administrative Equipment. (CC-Tanana Valley)

FY81 requests are administrative equipment. This equipment is necessary for college functioning. The technological areas of the programs require more expensive equipment. Although initial investment costs are high, they do decrease over time.

22. Purchase ABE Facility. (CC-Anchorage)

Currently the college is leasing the space for this particular program. The Board of Regents have decided that it would be wiser to purchase the building rather than continue renting.

23. University/Legislature Teleconference Link. (Statewide Administration)

The purpose of this project is to provide a coordinated system of communication between all the campuses and facilitate the contact between the President and Chancellors and all the community colleges within the University system. It is anticipated that the development of the system will be staggered, and that in the long term the entire teleconferencing will be operational throughout the state.

24. Art Department Equipment. (UA/Anchorage)

Due to the lack of space and proper equipment in the art studios, the student body is decreasing - this action is intended to reverse this process. The equipment and the space improvements will be in areas such as ceramic studios, sculpture studios, printmaking studios, painting and drawing, art education, jewelry, photography, etc.

25. Bookstore - UAA/ACC

Currently, a provisional bookstore exists and it does provide a service on a limited basis to both of the units. However, the facility is limited in size and service. It is intended that the new facility will provide full services to both units within the Anchorage area.

26. Yak Estates Plumbing and Heating Conversions. (UA/Fairbanks)

The current state of plumbing in Yak Estates is rather poor. Also, the existing energy source for the heating system should be converted from electric to oil, because operating costs of the electrical heating system is extremely high. Oil conversion would result in significant savings. Capital investments need to be made on this project so that occupancy rates can be increased, so that the university can cover outstanding indebtedness on the project and so that it will not cause financial loss to the university.

27. Statewide Administration Building.

This is the only other statewide capital project anticipated at this time. The reasons for this project is that currently all the statewide administrative units are dispersed all over the Fairbanks campus. There is no identity to a statewide function. This building will afford a possibility to bring all those statewide units into one central location. It is also thought that by centralizing the activity of the statewide functions a better coordination will be attained between the departments responsible for the entire University system.

28. Vocational/Technical Equipment. (Rural Education)

This is a media services need to provide programs to the rural education which presently aren't available.

29. Classroom/Shop Building - Phase IV. (CC-Kenai Peninsula)

This request is made with the hope that since community demand on the college programs is so great and increase in the student enrollment is rapid, this building is proposed so that no delay occurs for the programs to be accessible to the public. Spaces that will be included in this structure are: heavy duty electrical equipment shop, petroleum electronics, cooperative extension facilities, etc.

30. Vocational Building and Equipment. (CC-Chukchi)

Besides the "standard" programs described previously, the new project requested by Kotzebue is Item No. 2, Vocational Building and Equipment. This building is a staging area for the delivery of programs in the bush. There is a great student interest in these programs, and having a facility as proposed would be extremely helpful for the community college to expand its service in this area of the state.

31. Arctic Health Incenerator. (UA/Fairbanks)

This will be an incinerator for the disposal of waste from the health experimental labs and controlled by Physical Plant operations.

32. Pratt/Ely Property Renovation. (UA/Juneau)

This is a recently acquired property which has existing structures located there. The structures are rather run down and require extensive remodeling and repair. The remainder of the money from the project when it was purchased will be used for that purpose; however, the funds are insufficient and the additional money is requested for that purpose. It will provide new vocational programs in power technology, marine and fish technology, etc.

33. Phase II Rasmusson Library Addition. (UA/Fairbanks)

The library is overcrowded, making use of the facility difficult and time consuming. It is anticipated that addition to the existing space will occur at this time to allow the expansion of stack area, book collections, media and computer services, creating a centralized and functional facility.

34. Conference Center. (UA/Fairbanks)

This facility will serve the entire University. The development of this facility would not only provide a conference center for outside agencies, but also expand information about the University and provide facilities for adult education. It is anticipated that it will increase the student enrollment, as well as the income to the University. The facility would consist of classroom space, registration areas, food areas and offices for the conference staff as well as exhibition areas and meeting spaces.

UNIVERSITY OF ALASKA
Statewide System of Higher Education
Fairbanks, Alaska 99701

February 25, 1980

Dear Thelma:

This letter concerns House Bill 690 which I understand you have scheduled for hearings by the House Health, Education and Social Services Committee this coming Friday.

Last week in Juneau I testified before the Senate Health, Education and Social Services Committee with respect to the governor's proposal for general obligation bond funding for the University of Alaska in FY81 totaling $20,550.0. I thought that you might like to have a copy of the attached related material which I am sending to Senator Glenn Hackney to comply with the request the university received from the Senate Health, Education and Social Services Committee.

I am sorry that I shall not be able to be in Juneau this Friday to testify before your committee with respect to House Bill 690. However, if you or your staff wishes information in addition to what is shown on the attachment with respect to the university's needs and priorities for general obligation bond funding, Dennis Demmert will be able to secure it for you. Or, it may be obtained by contacting me or Sherman Carter, the university's Financial Vice President. His telephone number is 479-7711.

Thank you very much for your assistance in these matters.

Very truly yours,

Jay Barton
President

JB:nba

Representative Thelma Buchholdt
House of Representatives
Pouch V
Juneau, Alaska 99811

UNIVERSITY OF ALASKA
Statewide System of Higher Education
Fairbanks, Alaska 99701

February 25, 1980

Dear Senator Hackney:

On 20 February, the Senate Health, Education and Social Services Committee asked the university to submit a revised capital budget request for general obligation bond funding for FY81 which totaled between $30 and $35 million. Attachment number 1A to this paper presents such a request summarized by major administrative unit of the university and also by budget request unit.

As you know --

a. The board of regents authorized the university administration to submit a capital budget request for funding by general obligation bonds in FY81 which totaled $71,129.0.

b. The governor then recommended that the legislature approve general obligation bond projects for the University of Alaska in FY81 totaling $20,550.0 as listed below:

Handicap Barrier Removal - All Units	$525.0
General Building Upgrade - All Units	950.0
Utilities Modification - UAF	800.0
Yak Estates Changes - UAF	600.0
Arts Classroom - UAA	12,000.0
Sitka Sewer Connection	75.0
Kenai Classroom	5,600.0

Attachment number 1B to this letter shows how the listing of capital projects which were requested by the board of regents for funding by general obligation bonds in FY81 has been changed to comply with the report requested by the Sentate Health, Education and Social Services Committee. It appears that I cannot get the formal approval of the revised listing by the board of regents until the next regular meeting of the board now scheduled for 20-21 March. I believe that the board will then approve my recommendation that, if general obligation bond funding for university capital projects in FY81 is to be provided in an amount of from $30 to $35 million, that projects as listed on the attachments be funded. If the board does not approve this recommendation which

I shall make, I shall let you know promptly.

Thank you for your assistance in these matters.

Very truly yours,

Jay Barton
President

JB:lei

cc: Board of Regents
Chancellors Cutler, O'Rourke, Harrison and Paradise
Ms. Dixie Brown

Senator Glenn Hackney
Alaska State Senate
Pouch V
Juneau, AK 99811

UNIVERSITY OF ALASKA
FY81 Capital Budget Request
General Obligation Bond Funding

Board of Regents/Statewide Administration	$ 917.0
University of Alaska/Fairbanks	6,253.0
University of Alaska/Anchorage	6,716.0
University of Alaska/Juneau	7,162.0
Community Colleges, Rural Education & Extension	13,568.0
Total	$34,616.0

Budget Request Units	Amounts	Subtotal By Unit
Board of Regents/Statewide Administration		
Campus Development Plan	395.0	
On Line Computer System	470.0	
University/Legislative Teleconference Link	52.0	917.0
University of Alaska/Fairbanks		
Instructional Equipment	353.0	
Seward Marine Center	2,000.0	
Roads, Streets & Parking	500.0	
Central Receiving Facility	1,300.0	
Utilities Modification	800.0	
Utilities Monitoring System	200.0	
Physical Plant & Improvements	500.0	
Yak Estates Improvements	600.0	6,253.0
University of Alaska/Anchorage		
Instructional Equipment	296.0	
Handicap Barrier Removal	100.0	
General Building Upgrade	100.0	
Roads, Streets & Parking	500.0	
Engineering Equipment	300.0	
Department of Art Equipment	220.0	
Bookstore to Serve UAA/ACC	5,200.0	6,716.0
University of Alaska/Juneau		
Instructional Equipment	162.0	
Handicap Barrier Removal	100.0	
Roads, Streets & Parking	150.0	
University Center, Phase I	6,000.0	
Land Acquisition	150.0	
Pratt/Ely Property Improvements	600.0	7,162.0

Budget Request Units	Amounts	Subtotal By Unit
CCREE		
Anchorage Community College		
Instructional Equipment	492.0	
Handicap Barrier Removal	150.0	
General Building Upgrade	600.0	
Roads, Streets & Parking	250.0	
Purchase ABE Building	220.0	1,712.0
Chukchi Community College		
Instructional Equipment	43.0	
Roads, Streets & Parking	30.0	
Vocational Building, Equipment	750.0	823.0
Kenai Peninsula Community College		
Instructional Equipment	210.0	
Classroom/Shop Building IV	5,600.0	5,810.0
Ketchikan Community College		
Instructional Equipment	105.0	
Handicap Barrier Removal	120.0	
General Building Upgrade	30.0	
Roads, Streets & Parking	175.0	430.0
Kodiak Community College		
Instructional Equipment	54.0	
General Building Upgrade	75.0	
Roads, Streets & Parking	110.0	239.0
Kuskokwim Community College		
Instructional Equipment	17.0	
Handicap Barrier Removal	15.0	
General Building Upgrade	15.0	
Roads, Streets & Parking	100.0	147.0
Matanuska-Susitna Community College		
Instructional Equipment	54.0	
Handicap Barrier Removal	15.0	
General Building Upgrade	50.0	
Roads, Streets & Parking	450.0	569.0
Northwest Community College		
Instructional Equipment	114.0	
Handicap Barrier Removal	25.0	
General Building Upgrade	70.0	
Roads, Streets & Parking	100.0	309.0
Prince William Sound Community College		
Classroom/Office/Library	1,500.0	1,500.0

Budget Request Units	Amounts	Subtotal By Unit
Sitka Community College		
Instructional Equipment	119.0	
General Building Upgrade	10.0	
Roads, Streets & Parking	200.0	
Sewer Connection	75.0	404.0
Tanana Valley Community College		
Instructional Equipment	774.0	774.0
Rural Education Extension		
Galena Learning Center	750.0	
VoTech Equipment	50.0	800.0
Cooperative Extension Service		
Instructional Equipment	51.0	51.0
Subtotal CCREE		13,568.0
Total U of A		34,616.0

UNIVERSITY OF ALASKA
FY81 Capital Budget Request
General Obligation Bond Funding

Board of Regents/Statewide Administration	$ 917.0
University of Alaska/Fairbanks	5,753.0
University of Alaska/Anchorage	6,716.0
University of Alaska/Juneau	6,562.0
Community Colleges, Rural Education & Extension	13,568.0
Total	$33,516.0

Budget Request Units	Amounts	Subtotal By Unit
Board of Regents/Statewide Administration		
Campus Development Plan	395.0	
On Line Computer System	470.0	
University/Legislative Teleconference Link	52.0	917.0
University of Alaska/Fairbanks		
Instructional Equipment	353.0	
Seward Marine Center	2,000.0	
Roads, Streets & Parking	500.0	
Central Receiving Facility	1,300.0	
Utilities Modification	800.0	
Utilities Monitoring System	200.0	
Yak Estates Improvements	600.0	5,753.0
University of Alaska/Anchorage		
Instructional Equipment	296.0	
Handicap Barrier Removal	100.0	
General Building Upgrade	100.0	
Roads, Streets & Parking	500.0	
Engineering Equipment	300.0	
Department of Art Equipment	220.0	
Bookstore to Serve UAA/ACC	5,200.0	6,716.0
University of Alaska/Juneau		
Instructional Equipment	162.0	
Handicap Barrier Removal	100.0	
Roads, Streets & Parking	150.0	
University Center, Phase I	6,000.0	
Land Acquisition	150.0	6,562.0

Attachment IE

PRIORITY LIST FOR CAPITAL PROJECTS

FY 81

PRIORITY NUMBER	UNIT	PROJECT TITLE	CR CODE	FUNDING GO (000)	FUNDING CUMULATIVE	FUNDING DA (000)	FUNDING CUMULATIVE
1	All	Instructional Equipment (14 listings)	B-3	2,844	4,044		
2	UA/Fairbanks	Seward Marine Education Center	A-1	2,000	6,044		
3	All	Handicap Barrier Removal (7 Listings)	B-2	←		525	525
4	Statewide Admin.	Campus Development Plan	A-1	←		395	920
5	All	General Building Upgrade (8 listings)	B-1	950	6,994		
6	All	Roads, Streets, Parking (10 listings)	A-5	←		2,565	3,485
~~7~~	~~UA/Anchorage~~	~~Classroom Building~~	~~A-1~~	~~12,000~~	~~18,994~~		
8	Rural Education	Galena Learning Center	A-1	750	19,744		
~~9~~	~~UA/Fairbanks~~	~~Repair-Elvey-Building~~	B-1	120	19,864		
10	UA/Juneau	University Center Phase I	A-1	6,000	29,864		
11	UA/Juneau	Land Acquisition	A-6	150	30,014		
12	UA/Fairbanks	Central Receiving	A-1	1,300	31,314		
13	CC-Prince Wm. Sound	Classroom/Office/Library	A-1	1,500	32,814		
14	UA/Fairbanks	Utilities Modification	A-5	800	33,614		
15	CC-Sitka	Sewer Connection	A-5	75	33,689		
16	UA/Anchorage	Engineering Equipment	A-3	←		300	3,785
~~17~~	~~CC-Anchorage~~	~~Applied Science Building~~	A-1	~~5,000~~	~~38,689~~		
18	Statewide Admin.	On Line Computer System					

PRIORITY LIST FOR CAPITAL PROJECTS

FY 81

PRIORITY NUMBER	UNIT	PROJECT TITLE	CR CODE	FUNDING GO (000)	FUNDING CUMULATIVE	FUNDING DA (000)	FUNDING CUMULATIVE
19	UA/Fairbanks	Utilities Monitoring Buildings	A-1			200	3,985
20	UA/Fairbanks	Physical Plant - Various	B-4			500	4,485
21	CC-Tanana Valley	Admin. Equipment	B-3			38	4,523
22	CC-Anchorage	Purchase ABE Building	A-1	220	39,379		
23	Statewide Admin.	University/Legis. Teleconf. Link	A-3			52	4,575
24	UA/Anchorage	Department of Art Equipment	A-3			220	4,795
25	UA/Anchorage	Bookstore to serve UAA/ACC	A-1	5,200	44,579		
26	UA/Fairbanks	YAK Estate Changes	B-1	600	45,179		
27	Statewide Admin.	Administration Building	A-1	4,500	49,679		
28	Rural Education	Voc-Tech Equipment	A-3			50	4,845
29	CC-Kenai Peninsula	Classroom/Shop Bldg. IV	A-1	5,600	55,279		
30	CC-Chukchi (Kotzebue)	Vocational Bldg./Equipment	A-1	750	56,029		
31	UA/Fairbanks	Arctic Health Incinerator	B-4			150	4,995
32	UA/Juneau	Pratt/Ely Property	A-3	600	56,629		
33	UA/Fairbanks	Phase II Rasmuson Library	A-1	12,000	68,629		
34	UA/Fairbanks	Conference Center	A-1	2,500	71,129		

House Health, Education & Social Services Committee — Meeting/Hearing on 690 — Date: 2/29/80

	Name	Address and Phone	Organization/Self	For/Against or Observing
1/	John Sheridy		Bd. of Regents	
2/				
3/				
4/				
5/				
6/				
7/				
8/				
9/				
10/				
11/				
12/				
13/				

House Health, Education & Social Services Committee Meeting/Hearing on HB 690 Date: 3/27/80

	Name	Address and Phone	Organization/Self	For/Against or Observing
1/	Jay Barton	Uof Alaska Fairbanks 479 7311	U of A / President	testify
2/	Rob Mourant	548 Dowling AK 2521 586	Alaska Student Lobby	just observing
3/				
4/				
5/				
6/				
7/				
8/				
9/				
10/				
11/				
12/				
13/				

HB

701

STATE OF ALASKA

Inter-Department Route Slip

TO:
MAIL STATION NUMBER 3100

DEPARTMENT _____

ATTENTION House Health Ed., & Social Services

☐ Approval	☐ Note & Return
☐ Signature	☐ Initial & Return
☐ Comment	☐ Return As Requested
☐ Contact Me	☐ Return For Approval
☐ Prepare Reply	☐ Necessary Action
☐ For Your File	☐ Your Information

Remarks:

FROM:
MAIL STATION NUMBER 2100

DEPARTMENT C+RA

BY LYNN WEGENER DATE 7/17/80

02-002 (REV.10/73)

THE LEGISLATURE OF THE STATE OF ALASKA
ELEVENTH LEGISLATURE

FISCAL NOTE

I. REQUEST

Bill/Resolution No. HB 701

Title An Act making special appropriations for senior citizens in Nenana

Requested by Representative Moss Date

II. FISCAL DETAIL

Agency Affected Community & Regional Affairs

Program Category Affected Community Development

Budget Request Unit(s) Affected Local Government Assistance - Grants

EXPENDITURES (Thousands of Dollars)

	FY 79	FY 80	FY 81	FY 82	FY 83	FY 84
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL						
400 COMMODITIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC.						
TOTAL	0	0	0	0	0	0

FUNDING (Thousands of Dollars)

GENERAL FUND	0	0	0	0	0	0
FEDERAL FUNDS						
OTHER (Specify)						

POSITIONS

FULL TIME	0	0	0	0	0	0
PART TIME						
TEMPORARY						

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

This bill, by itself, does not have enough fiscal impact on our department to require additional appropriations or positions. There are many such bills pending however, and if a significant number pass the cumulative administrative burden will require additional personnel.

IV. DATE 2-21-80 PREPARED BY McKie Campbell

AGENCY Community & Regional Affairs

PHONE 465-4735

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)

33-001 (Rev. 10/78)

HB

704

Report To The Alaska State Legislature
House Of Representatives
Health, Education, and Social Services Committee
Representative Thelma Buchholdt, Chairman

By: John C. Garvin, Ph.D.
President, Alaska Association of Homes for Children, Inc.
Executive Director, Alaska Children's Services, Inc.
1200 E. 27th Avenue
Anchorage, Alaska 99504
Phone: 276-4515

Date: April 9, 1980

RE: HB704

In behalf of the Alaska Association of Homes for Children, Inc., and Alaska Children's Services, Inc., I want to speak in opposition to HB704 entitled "An Act Relating to the Purchase of Services By The State For Persons Under Its Responsibility; and Providing For An Effective Date."

HB704 was drafted by the Department of Health and Social Services and proposes to repeal and/or amend major sections of Alaska Statute 47:40 so that the intent is totally changed.

The Alaska Association of Homes for Children, Inc. is a statewide association consisting of 14 of the State's 16 private non-profit child care agencies. These agencies provide residential care and treatment for some of Alaska's most troubled, abused, and neglected children and youth. More that 2,000 children are cared for each year with approximately 250 in care on any given day. These are children that do not have families of their own who can care for them and have generally been in and out of numerous foster homes.

For the past ten years, private non-profit child care agencies in Alaska have been providing residential care and treatment for children placed by the Department of Health and Social Services. They have been reimbursed according to Alaska Statute 47:40. This is often referred to as the "Full Cost-of-Care Statute".

Although AS 47:40 has never allowed for the full reimbursement of the care of State placed children, it is superior to the reimbursement method of contracting proposed by HB704 in some of the following ways:

1. AS 47:40 currently enables continuity of care for troubled, disturbed, often abused children who need protection and security. Under the changes proposed by HB704, children could be uprooted and moved from one agency to another at the end of a contract period. Relationships with their primary caregivers would be broken and another, often traumatic move from one home to another could undermine any improvement they have made or security they have found. Even knowing in advance that a move is pending would be detrimental to their sense of wellbeing and security unless it is carefully incorporated into their treatment plan which cannot always be made to coincide with the State's fiscal year.

2. AS 47:40 promotes and maintains the private voluntary nature of child care institutions which historically have provided high quality care

and treatment of orphaned and troubled children. Agencies across the State have invested millions of dollars in facilities and equipment for the care of children. Under HB704, private enterprise would suffer. Agencies would be unable to make long-range plans and the recruitment of professional staff would be seriously jeopardized.

3. AS 47:40 protects the small agencies from hard pressure contracting methods. Under provisions of HB704, the Department would hold the upper hand in negotiating contracts with small, private child care agencies. The Department with its resources would be able to hold out indefinitely for a reimbursement rate which may be substantially less than the agency needs to operate a quality program.

   Presently, the Department has the option of contracting with agencies for new services and of discontinuing its placement of children in any agency which it does not care to use. During the past year, its Division of Corrections chose not to use two agencies.

   The present statute requires the Department to provide a cost-of-living increase. If it had not been for this requirement in the law during the past year, the Department would not have granted a cost-of-living increase. It took an opinion of the Attorney General to bring the Department into compliance with the existing statute. Without certain protection provided by the current statute, private agencies would be at the mercy of the Department.

4. AS 47:40 protects against inflation. Not only does it provide in Section 040(a) for a reimbursement rate to include a proportionate share of anticipated cost-of-living and staff salary increment increases but it enables agencies to keep up with inflation even though the Department's annual increase has historically been less than the inflation rate reported by the U.S. Department of Labor. The method of determining the rate incorporates the actual allowable expenses for the preceding year divided by the number of days of care. Under HB704, no guarantee of consideration for inflation will be provided unless it is a part of the negotiation process. The private agencies have historically found the Department to offer less than the actual rate of inflation. The current year is a good illustration where the proposed inflation rate is considered to be 18%. The Department has been insisting on limiting the rate increase for FY 1981 to 9%. The agencies feel that a very minimum of 12% must be included and this has met with considerable resistance.

   A multi-year contract without an automatic inflation increase would cause undue hardship to most private agencies.

5. AS 47:40 encourages creativity, dedication, and joint public/private financing of child care programs. Historically, the private agencies have had to raise 10 to 20 percent of the cost of care. This has encouraged agencies to find private funds for the improvement of their program in situations when the State has been reluctant to support an innovation that would benefit the program and children in care. Furthermore, most child care salaries paid by private agencies are only one half to three fourths that of the salaries paid to State employees for comparable positions. In fact, the private agency employees personally subsidize the care of State placed children to

the tune of several hundred thousand dollars a year, due to their dedication to the agencies and the children they serve even though they cannot be paid the type of salaries they deserve.

Under HB704, private agencies would have less opportunity to develop programs they know to be in the best interest of children inasmuch as the Department would have a greater capacity to dictate the nature and content of the program.

For these and other reasons, the Alaska Association of Homes for Children, Inc. and Alaska Children's Services, Inc. oppose vigorously HB704. It is true that there are limitations to AS 47:40. Primarily the present statute does not require cost settling and reimbursement for depreciation on property and equipment.

Representative Charles Parr has introduced HB637 which would strengthen AS 47:40 by requiring that the Department cost settle and allow depreciation as a reimbursable expenditure.

In behalf of the private child care agencies of the State of Alaska, I urge you to oppose HB704 and to support HB637.

JAY S. HAMMOND, GOVERNOR

DEPT. OF HEALTH AND SOCIAL SERVICES

OFFICE OF THE COMMISSIONER POUCH H 01 – JUNEAU 99811

April 9, 1980

The Honorable Thelma Buchholdt
Chairman
House HESS Committee
Pouch V
Juneau, Alaska 99811

Document # 65-80

Dear Ms. Buchholdt:

COST OF CARE RATE HEARINGS
REPORT TO THE LEGISLATURE

Alaska St tes, Chapter 47.05.010(14), mandate a public meeting be held by the Department of Health and Social Services "in February to review, study, and propose the necessary levels of care and the rates it (the department) will pay to anyone for the services requ red during the succeeding year; before final adoption by the department, the proposed levels of care and the rates of payment shall be reviewed by the Legislature annually while in session."

The meetings to conform to the statutes were held during February, 1980 as required. Testimony was presented on both the rates of payments and the levels of care during the hearing process. Attachment 1 lists the estimated rates which need to be paid during FY 1981 based upon testimony given by the providers. Attachment 2 provides the cost estimate and rates without the provider requested 3% allowance for fringe benefits. Funding for both institutional and foster care for instate costs appears to be insufficient to meet the estimated expenditures.

All calculations of costs presented in this report are based on provisions of current purchase of service statutes.

The rates reflected on Attachment 1 were developed using a 12% increment for salary, a 12% cost of living allowance for all expenditure categories other than salaries and benefits, and a 3% increment for employee benefits. These increases were requested by providers during the rate hearings.

Costs as Requested by Providers at Hearings

	Division of Social Services	Division of Corrections	Department Total
Institutional Care	(In-State)	(In-State)	
Budgeted Amount	$4,281,300.00	$2,001,675.00	$6,282,975.00
Estimated Cost	6,893,119.00	2,550,313.00	9,443,432.00*

Balance (Deficit)	(2,611,819.00)	(548,638.00)	(3,160,457.00)

*The difference in $9,993,958 on Attachment 1 and $9,443,432 shown represents projected changes in placement patterns.

Foster Care	Division of Social Services	Division of Corrections	Department Total
Budgeted Amount	$2,682,513.00	$ 444,100.00	$3,126,613.00
Estimated Cost	2,943,272.00	448,700.00	3,391,972.00
Balance (Deficit)	$ (260,759.00)	$ (4,600.00)	$ (265,359.00)
Total Deficit	$(2,872,578.00)	$ (553,238.00)	$(3,425,816.00)

Unless the legislature appropriates additional funds required or directs that the rates requested by the providers should be granted, the department does not intend to allow the level of increases as requested. We have developed rates allowing for an across the board increase of 12% (Attachment 2).

In the institutional care and foster care components, no increase beyond the 9% guideline was utilized during budget preparations.

There has not been a separate allowance made in the full cost formula for fringe benefits paid by providers to their employees. The department has historically considered any fringe benefit allowance as part of the salary costs. The providers have requested an increase of 3% over the current salary expenses to enable agencies to improve benefits such as medical/dental insurance, retirement plans, and/or other benefits currently not provided or provided at inadequate levels.

While the providers have requested a separate 3% increase for fringe benefits, the department is not recommending a departure from its established position of including fringe benefits in the salary increase allowance.

Costs as Recommended by Department

	Division of Social Services	Division of Corrections	Department Total
Institutional Care	(In-State)	(In-State)	
Budgeted Amount	$4,281,300.00	$2,001,675.00	$6,282,975.00
Estimated Cost	6,763,305.00	2,506,991.00	9,374,398.00
Balance (Deficit)	(2,482,005.00)	(505,316.00)	(2,987,321.00)

Foster Care

Budgeted Amount	$2,682,513.00	$ 444,100.00	$3,126,613.00
Estimated Cost	2,943,272.00	448,700.00	3,391,972.00
Balance (Deficit)	$ (260,759.00)	$ (4,600.00)	$ (265,359.00)
Total Deficit	$(2,742,764.00)	$ (509,916.00)	$(3,252,680.00)

Foster Care rates were developed according to 7 AAC50.720(C) assuming a 9.874% change in the Consumer Price Index during FY 1980. Attachment 3 displays the rates for FY 1981.

Consistent with the information presented as a recommendation from the providers, the department projects additional funds would be required in the amount of $3,425,816 for both institutions, group homes and foster homes as shown below:

The department has recommended the 12% general increase, not allowing for an additional fringe benefit component. Additional funding required to comply with this recommendation is projected at $2,987,321 in the institutional care component.

The foster care component as recommended would require an additional $265,359.

Based upon data developed as the result of recent 1980 hearings, under 47.05.010 (14), the legislature is advised that sufficient provisions have not been made in the current budget request. Additional funds will be required in order to meet anticipated purchase of services at levels proposed either by the providers or the department as set forth in this report.

If such additional funds are not appropriated, the Department of Health and Social Services will not be in position to purchase services from any facility not licensed in FY 1980 and may have to refrain from purchasing services from some existing facilities.

Sincerely,

Helen D. Beirne

Helen D. Beirne
Commissioner

Attachments

Fiscal 1981

FULL COST OF CARE FACILITIES
CALCULATION OF RATES AND COST TO STATE
FY 81

	Rates Per Child Care Day		FY 80 Annualized From 12/31/79 Report			FY 80 Projected	Salaries	Fringe COLA	Other Exp.	Total
	FY-81 Projected Rate	Current Reimbursement	Salaries Reported x2.5	Other Exp Reported x2.5	Total Expenses	State Census/Tot. Census Part-2	FY80 + 12%	x 3%	FY80 x 12%	Expenses
Alaska Childrens Services										
Aquarius House	83.85	85.72	76,917	51,347	128,264	11,616/11,646	86,147	2,584	57,569	146,240
Collett House	87.95	56.12	78,622	52,193	130,825	11,636/11,665	88,063	2,642	58,456	149,166
Jesse Lee Home	145.29	100.43	1,036,250	537,437	1,573,687	11,394/12,262	1,160,600	34,818	601,929	1,797,347
Mary Jordon House	194.25	122.33	277,720	96,903	374,623	2,202/2,208	311,846	9,351	108,531	429,728
North Star Group Home	86.71	57.69	84,623	47,245	131,868	1,510/1,736	94,778	2,843	52,914	150,535
Emergency Shelters	138.25	99.51	427,100	219,470	646,570	2,342/5,242	478,453	14,354	266,750	759,557
Total ACS			1,981,232	1,004,595	2,985,827	24,256/25,780	2,219,892	66,592	1,145,354	3,431,838
Alaska Baptist Fam Svc Ctr	60.33	61.51	87,190	74,390	161,570	2,562/2,654	97,653	2,930	83,306	183,849
Alaska Youth Home	92.05	69.30	404,010	320,725	724,735	7,382/8,722	452,491	13,575	336,012	802,078
Booth Memorial Home	141.93	109.08	326,392	148,410	474,802	3,824/3,824	365,559	10,967	166,219	542,745
Covenant High School	39.05	19.52	140,157	159,158	299,315	151/8,510	135,976	4,709	173,257	313,942
Hilltop Home	80.33	59.70	227,150	237,995	465,145	5,919/5,919	248,898	7,464	266,442	522,714
Juneau Receiving Home	93.53	71.64	154,590	72,845	227,435	2,638/2,633	173,141	5,194	81,586	259,921
Kenai Penn. Comm. Care Ctr	80.69	64.79	135,380	104,340	240,320	3,392/3,392	151,626	4,549	117,533	273,708
Ketchikan Childrens Home	64.93	52.09	115,177	196,605	311,782	5,438/5,438	128,998	3,870	220,198	353,066
Kodiak Baptist Mission	36.21	24.02	84,815	154,948	239,763	6,630/7,494	94,993	2,850	173,533	271,381
Nome Receiving Home	155.03	83.56	95,022	63,248	158,270	1,158/1,158	106,425	3,193	70,838	180,455
N. Slope Boro. Chld. Receiving Home	175.38	106.05	183,555	92,483	276,038	1,796/1,798	205,562	6,137	103,631	315,330
North Star Childrens Home	63.92	51.07	96,862	74,530	171,392	3,054/3,054	108,485	3,255	83,474	195,214
Presbyterian Hosp. Home	122.33	85.75	527,200	168,875	696,075	5,518/5,518	590,464	17,714	189,140	797,318
Sitka Receiving Home	56.07	45.31	76,677	71,295	47,962	974/974	25,873	896	23,839	54,613
Turning Point Boys Home	123.20	73.03	842,477	462,118	1,305,595	12,028/12,094	944,134	28,324	517,572	1,490,030
Totals			5,420,466	3,456,216	8,765,476	87,913/93,176	6,975,309	182,224	3,737,424	9,894,958

Attachment 1

Calculations on this chart are based upon information submitted by providers reflecting costs and number of placements for period July 1, 1979 through December 31, 1979, providing 12% salary increase, 12% other than salary expenses increase and 3% of salaries provided for improved fringe benefits (Medical insurance, retirement, etc).

Fiscal 1981

FULL COST OF CARE FACILITIES
CALCULATION OF RATES AND COST TO STATE
FY 81

	Rates Per Child Care Day		FY 80 Annualized From 12/31/79 Report			FY 80 Projected	Salaries	Other Exp.	Total
	FY-81 Projected Rate	Current Reimbursement	Salaries Reported x2.5	Other Exp Reported x2.5	Total Expense	State Census/Tot. Census Rpt x2	FY80 + 12%	FY80 x 12%	Expenses
Alaska Childrens Services									
Aquarius House	87.27	85.72	76,917	51,267	128,264	1,645/1,645	86,147	57,509	143,656
Colletti House	86.39	56.12	78,632	52,193	130,825	1,696/1,696	88,068	58,456	146,524
Jesse Lee Home	142.57	100.43	1,036,250	537,417	1,573,667	11,964/12,362	1,160,600	601,929	1,762,529
Mary Johnson House	190.02	122.33	277,720	96,903	374,623	2,208/2,208	311,046	108,531	419,577
North Star Group Home	85.07	57.69	84,623	47,245	131,868	1,530/1,736	94,778	52,914	147,692
Emergency Shelters	135.56	99.51	427,190	219,420	646,610	5,342/5,342	478,453	245,750	724,203
Total ACS			1,981,332	1,004,545	2,985,377	24,406/24,990	2,219,092	1,125,089	3,344,181
Alaska Baptist Fam Svc Ctr	49.52	51.51	87,190	74,380	161,570	2,562/3,654	97,653	83,306	180,959
Alaska Youth Home	90.49	69.30	404,010	300,725	704,735	7,082/8,722	452,491	336,812	789,303
Booth Memorial Home	139.06	109.08	326,392	148,410	474,802	3,824/3,824	365,559	166,219	531,778
Covenant High School	39.39	19.52	140,157	159,158	299,315	151/3,510	156,976	178,257	335,233
Hilltop Home	87.06	59.70	227,150	237,895	465,045	5,918/5,918	248,308	266,442	515,250
Juneau Receiving Home	96.56	71.64	154,590	72,845	227,435	2,638/2,638	173,141	81,586	254,727
Kenai Penn. Comm. Care Ctr	79.35	64.79	135,380	104,940	240,320	3,392/3,392	151,626	117,533	269,159
Ketchikan Childrens Home	64.21	52.09	115,177	196,605	311,782	5,438/5,438	128,998	220,198	349,196
Kodiak Baptist Mission	35.83	24.02	84,815	154,948	239,763	6,680/7,494	94,993	173,538	268,531
Nome Receiving Home	153.07	83.56	95,022	63,248	158,270	1,158/1,158	106,425	70,838	177,263
N. Slope Boro. Chld. Receiving Home	171.94	106.05	183,555	92,483	276,038	1,796/1,798	205,582	103,581	309,163
North Star Childrens Home	62.85	51.07	96,862	74,530	171,392	3,054/3,054	108,485	83,474	191,959
Presbyterian Hosp. Home	119.60	85.75	527,200	168,875	696,075	6,518/6,518	590,464	189,140	779,604
Sitka Receiving Home	55.15	45.31	26,677	21,285	47,962	974/974	29,878	23,839	53,717
Turning Point Boys Home	120.86	73.09	842,977	462,118	1,305,095	12,028/12,094	944,134	517,572	1,461,706
Totals			5,428,486	3,336,990	8,765,476	87,620/100,176	6,074,305	3,737,424	9,811,729

Attachment 2

The foster care rates for FY 81 have been calculated in the following manner.

The Anchorage Consumer Price Index (CPI) as of January 1980 was 218.2. Annualizing the rate for the period of March 1979 through March of 1980, the Anchorage CPI is expected to be 221.6 in March. Placing the March CPI over the 1970 base year CPI results in a ratio of 1.9874:1.0. Multiplying the 1970 base year rates by this increase for each of the three age categories we arrive at the annual foster care rate for fiscal year 1981 for the Southeastern, Southern and the Southcentral Regions.

Age Group				Annual Rate	Month Rate	Daily Rate
4 & under	$\frac{221.6}{111.5}$	x	1935 =	$3,846	$321	$10.54
5 thru 11	$\frac{221.6}{111.5}$	x	2140 =	$4,253	$355	$11.66
12 & over	$\frac{221.6}{111.5}$	x	2557 =	$5,082	$424	$13.93

In order to calculate the rate for the Northern, Northwestern and Western Regions a cost of living differential was calculated based on GGU range 14A salary as negotiated under the 1980 contract.

	Pay Schedule	Percentage
Anchorage	$1,850	
Fairbanks	2,132	1.1524
Bethel	2,465	1.3324
Kotzebue	2,556	1.3816

Fairbanks

Age Group							Monthly	Daily
4 & under	$3,846	x	1.1524	=	$4,432	=	$ 369.00	$12.14
5 thru 11	4,253	x	1.1524	=	4,901	=	408.00	13.42
12 & over	5,082	x	1.1524	=	5,856	=	488.00	16.04

Bethel

4 & under	$3,846	x	1.3324	=	$5,124	=	$ 427.00	$14.03
5 thru 11	4,253	x	1.3324	=	5,665	=	472.00	15.52
12 & over	5,082	x	1.3324	=	6,771	=	564.00	18.55

Kotzebue - Barrow

4 & under	$3,846	x	1.3816	=	$5,313	=	$ 442.00	$14.56
5 thru 11	4,253	x	1.3816	=	5,875	=	489.00	16.10
12 & over	5,082	x	1.3816	=	7,021	=	585.00	19.23

Attachment 3

POSITION PAPER/Department of Health & Social Services

POSITION PAPER
ON
HOUSE BILL NO. 704

"An Act relating to the method of purchase of social services by the state; and providing for an effective date."

House Bill 704 substantially amends 47.40 Purchase of Services to enable the Department to contract for the delivery of institutional, foster home or residential care services. The present statutes (47.40.010) require the Department to "determine the rates of payment for the full cost of services required" and to "pay all expenses related directly to the full cost of services at the levels of care required." In addition, this bill would amend current statute to allow salary costs to be provided to qualified foster parents participating in the specialized foster care program. This additional level of foster care expands the options for placement of children in custody and serves as a cost-effective alternative to placement in institutional care. Specialized foster care will provide for care for a child in his/her own region, and if possible, close to his/her biological parents. We have attached a report marked Attachment A on the foster care program which explains this program in more detail.

On the surface the present statutory language seems to provide for a fair and equitable way to determine rates and to pay for the full cost of services rendered by the provider. However, the problem with Chapter 40, Purchase of Services is not in the enactment section (47.40.010) but in section (47.40.040) which outlines the method of determining the full cost of services. This section indicates that full cost of services shall be determined by the per person, per day cost in the preceding fiscal year plus a proportionate share of anticipated cost of living and staff salary increment increases for the fiscal year for which the full cost of services, determined to be necessary by the Department, is being determined. This formula for determination of rates does not consider the occupancy factor for the various facilities. For example, if a group home opens in a given community and asks for a license for a 10 bed facility the Department must by law license them if they meet the requirements even if the Department cannot fully utilize the 10 beds. However, under the formula if the Department utilizes 5 beds in the first fiscal year the next year's rates must include the costs for all 10 beds. Therefore the per person, per day cost is significantly higher due to the vacancy factor.

If House Bill 704 were enacted, it would enable the Department to negotiate contracts for a specific number of beds for the types of services needed by the Department. This process would not only make an impact on the rates of care but would enable the Department to control the number of beds available at each level of care. Presently, the Department's only alternatives are to pay for the empty beds or to stop utilizing a facility completely. Contracting for services would result in a more reasonable and cost effective method of handling the problem of vacancy rates.

POSITION PAPER/Department of Health & Social Services

The Department would adopt regulations describing the contracting procedures. As part of the process of promulgating regulations, the Department plans to have public hearings in at least Anchorage, Fairbanks, and Juneau to explain the proposed regulations and solicit comments for improvements. Providers in other areas of the state would be able to receive copies of the proposed regulations and comment by mail. The Department would take these comments under advisement in finalizing the regulations.

The Department anticipates going to a request for proposals procedure for the purchase of these services if House Bill 704 is passed. To accomplish this the Department plans to describe the type of services they wish to purchase in a fiscal year and the approximate number of placements anticipated at each level of care. These requirements would be made known to existing child-care agencies and any other individual or group who may want to develop one or more services the Department wishes to purchase. Proposals would come to the Department for review with contracts subsequently being neogitated for the required services. We hope to create a truly competitive atmosphere in which to negotiate for the purchase of services. Contracting should serve to provide adequate incentives to contain expenditures at reasonable levels.

The Department supports the modification of the full cost of care statutes to permit purchase of care through contracting and through a specialized foster care program. The Bill would give the Department maximum flexibility in purchasing adequate services for children under the state's care at the lowest possible cost.

APPROVED BY: Helen D Beirne DATE: 4-8-80

Helen D. Beirne, Commissioner
Department of Health and Social Services

ELEVENTH LEGISLATURE

FISCAL NOTE

I. REQUEST
Bill/Resolution No. House Bill 704
Title Purchase of Social Services by the State
Requested by House HESS Date April 3, 1980

II. FISCAL DETAIL
Agency Affected Department of Health and Social Sevices
Program Category Affected Administration of Justice & Social Services
BRU, Program, or Subprogram(s) Affected Youth Services (Div. of Corr.) & Program Services
(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.) (Division of Social Services)

EXPENDITURES (Thousands of Dollars)

	FY 80	FY 81	FY 82	FY 83	FY 84	FY 85
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL						
400 COMMODITIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC.						
TOTAL		-0-	-0-	-0-	-0-	

FUNDING (Thousands of Dollars)

GENERAL FUND		-0-	-0-	-0-	-0-	
FEDERAL FUNDS						
OTHER (Specify Fund Source)						

POSITIONS

FULL TIME		1	1	1	1	
PART TIME						
TEMPORARY						

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

A. Assumptions:

Program costs will continue to rise due to inflationary pressures. The existing statute covering the purchase of institutional juvenile care is significantly vague as to what is "full cost," and contains no incentive for efficient management practices by the providers of service. Through a statutory change, it is assumed that the individual contracts negotiated will be very specific regarding budget line items for which the Department will pay. Through this mechanism, it is envisioned that, through contracting for institutional juvenile care, the Department will be able to slow the exponential growth of program costs.

A highly qualified contract negotiator position is necessary to take on this activity. The incumbent will be responsible for negotiating all of the necessary contracts with child care provider agencies, develop annual departmental budget projections for private institutional child care services, develop and recommend

Roger C. Lange

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)

Prepared by: Roger C. Lange Date: April 3, 1980
Division/Office: Corrections PH: 465-3376
Department of Health & Social Services

33-001 (Rev. 12/79)
Modify by DHSS (11-28-79)

Approval DHSS Mgt. & Bdgt: _____ Date _____

regulations to implement the statutory changes, act as liasion between the provider agencies and the department, etc. A Senior Negotiator is recommended (range 21) at an estimated annual cost of $47,000:

Personnel Services	$39,600
Travel	3,000
Contractual	3,000
Commodities	400
Equipment	1,000

It is assumed there will be a cost savings achieved through the proposed legislative action. The Department of Health & Social Services would be able to contract for the specific number of private institutional beds considered necessary to meet the Departmental needs for these services. Over the past several years the private child care agencies have, collectively, been operating at 70% to 75% of licensed capacity. The methodology given in AS 47.40.040 for rate computation allows for reimbursement of the vacant beds by dividing actual costs for a fiscal year by the bed utilization during the same period. The contracting option will permit the Department to limit the number of beds to a more satisfactory ratio of full to empty beds resulting in a cost savings. The magnitude of the savings is impossible to estimate at this time although it should exceed the costs related to the contract negotiator position requested ($47,000).

Another advantage for the Department will be the ability to request the type of program(s) needed rather than having to take the program(s) offered by the provider. Through the contract procedures, the Request for Proposal can clearly delineate what services the Department wishes to purchase in the various geographical areas of the state.

Both the Division of Corrections and the Division of Social Services have instituted revised procedures to assure that juveniles are placed in appropriate programs at the lowest level of care necessary to meet the needs of the child. This has resulted in a reduced need for private institutional care for juveniles placed by the Department. This program change, however, makes it extremely hard to forecast the savings potential with the enactment of this legislation.

B. Estimated Savings:

Since the economy of the nation is in a period of spiralling inflation, the major savings resultant from this bill will be to curb the quantum jumps in the departments annual budget request for institutional child care services. There are a number of inter-retating variables (case load size, individuals specific program need, geographical area of placement, etc.). Without experience in contrasting or knowing the value of the variables, the Department cannot estimate an estimated savings. However, by contracting for a number of beds more reasonable to the actual caseload enactment of this legislation would have the effect of slowing dow the exponential growth of the expenditures for institutional child care services.

REPORT
ON
SPECIALIZED FOSTER CARE

The original plan for FY80 was to recruit, train, and use for placement, 20 specialized foster homes, by September 1, 1979. Since a statutory amendment is necessary in order to include salary costs for specialized foster homes, the placement phase of this program has not been implemented.

The initial recruitment phase was completed, and between September 1, 1979 and March 1, 1980, a specific training program was developed for specialized foster care and twenty-two parents have completed the training program. Another training session scheduled for June, 1980 will prepare 20 additional parents for specialized foster care providing enough homes to allow for the "best possible placement' for every child.

Specialized foster parents (one parent in a home will be identified as the specialized parent) will receive a salary of $700/month, which will be in addititon to the foster home maintenance rate. The average FY 1980 average institutional group home cost rate is $60/day. The daily cost of specialized foster care would be $35/day, (including both salary and foster home maintenance).

Requirements of Specialized Foster Parents

1) One parent must not work outside of the home in order to be available to provide appropriate intensive specialized care to the child.

2) The parent who will not work outside of the home must have five years experience in working with children. This experience can include:

   a) experience as a foster parent
   b) experience as a social worker
   c) experience in a child oriented work setting.

(Experience as a biological parent of an adolescent may be counted for one year of experience. A Bachelor's degree with specific course work in counseling, clinical psychology, or child development, or a graduate degree in ial work or a related field may be counted for two years of required erience).

3) Specialized foster parents must also have:

   a) the ability to work with children in a therapeutic way.
   b) the ability to work with the biological parent of a child in a therapeutic way.
   c) the ability to accept and work with a child with emotional and behavioral problems.

d) the ability to work with an older child
e) the ability to accept a child who has been raised in a different philosophical environment.
f) a stable family life.
g) must meet all of requirements for regular foster home licensing
h) may have to provide additional references beyond the number required for regular foster home licensing.

Criteria for Selection of Children:

1) The child should be one, who without this program, would require institutional or group home placement due to emotional or behavioral problems.

2) The child should be within the age range of 8-18 years.

3) The child, with intensive supervision, should be able to function and have his/her needs met in a community setting.

					CONT $	ADDITION	FOR B&M USE
FY 80 Est.							
In-State	162,060	444	1,993,338.00	12.30			
Out-of-State	6,935	19	48,055.55	6.93			
Subtotal	168,995	463	2,041,393.55	12.09			
Specialized Foster Care *for 6 mos.	3,650*	20	120,000.00	32.87			
Total	172,645	483	$2,161,393.55	12.52			
Estimates for FY 81 include a 14% COLA increase and an additional 10 children in specialized foster care from institutional care:							
FY 81							
In-State	162,060	444	$2,272,081.20	14.02			
Out-of-State	6,935	19	54,786.50	7.90			
Subtotal	168,995	463	$2,326,867.70	13.77			
Specialized Foster Care	10,950	30	410,406.00	37.48			
Total	159,945	493	$2,737,273.70	17.11	2,737.3		
The request for FY 81 will, of course, be revised in the Department's report to the legislature following the full-cost-of-care rate hearings.							

AGENCY Department of Health & Social Serives PROGRAM AREA General Population

BRU Program Services

COMPONENT Foster Care

Page 4 of 6

REVISED DATE

FY 81

000477

23 18 CONTINUED

02 1023 (Rev. 7/79)

					CONT $	ADDITION	FOR S&M USE
FY 81							
In-State	53,290	146	4,281,318.60	80.34			
Out-of-State	11,315	31*	673,695.10	59.54			
Subtotal	64,605	177	$4,955,013.70	76.70			
*To Specialized Foster Care	(3,650)	(10)*	(217,321.00)	(59.54)			
Total	60,955	167	$4,737,692.70	$77 72	4,737.7		

The FY 81 request will, of course, be revised in the Department's report to the legislature following the full-cost-of-care rate hearings.

AGENCY Department of Health & Social Services PROGRAM AREA General Population

BRU Program Services

COMPONENT Institutional Care

23 18 CONTINUED

Page 4 of 6

REVISED DATE

FY 81

000495

02-1023 (Rev. 7/79)

HB
720

northern alaska health resources association, inc.

April 11, 1980

The Honorable Thelma Buchholdt, Chairman
House HESS Committee
Pouch V
Juneau, AK 99811

Dear Representative Buchholdt:

On behalf of the Northern Alaska Health Resources Association (NAHRA), I am writing to urge you to oppose HB 720, which would establish a single advisory board for DHSS.

NAHRA, the Division of State Health Planning and Development, and the Statewide Health Coordinating Council exist in accordance with P.L. 93-641, as amended by P.L. 96-79. That law mandates the establishment of the Statewide Health Coordinating Council (SHCC) which serves as an advisory body to the Division of State Health Planning and Development of DHSS. Any state which does not have a SHCC is subject to the revocation of all federal health care dollars, including grants, contracts, Medicare, and Medicaid.

Federal requirements for many other health-related grants also mandate the existence of categorial advisory bodies. Mental health and alcoholism programs are examples.

In light of the tremendous financial sanctions associated with abolition of existing advisory boards and creation of a single board, not to mention the harm to the general welfare of the people which could result from the closure of health services and facilities, I feel it is incumbent upon the elected representatives of the state to prevent enactment of HB 720.

Please let us know your position on HB 720.

Sincerely,

J.B. Carnahan
President

JBC/SEM/rlw

529 5th avenue, suite 8 fairbanks, alaska 99701 telephone (907) 456-2553

Southern Region
EMERGENCY
Medical Services Council, Inc.

February 27, 1980

Thelma Buckholdt
Chairperson
House HESS Committee
Pouch V
Juneau, Alaska
99811

Dear Representative Buckholdt:

The Southern Region Emergency Medical Services Council (SREMSC) is a nonprofit corporation dedicated to improving emergency medical care in Southcentral and Western Alaska. The SREMSC represents almost two-thirds of the State's population and has been very active in obtaining improved services for these people.

During the past years we have had numerous opportunities to work with the Advisory Council on Emergency Medical Services (ACEMS). The ACEMS consists of eleven professional medical providers and consumers of emergency medical care who were selected for their knowledge of medical services or their desire to perfect outstanding emergency care system in Alaska. These volunteers serve without pay and provide a state-wide forum for the discussion of critical EMS problems. An emergency medical system is an extremely complex endeavor which requires understanding of such diverse fields as; communications, transportation, medical facilities, public safety, disaster coordination, etc. The members of the ACEMS have spent years evaluating these various technical fields and are now recognized as experts.

The publics' desire to participate in emergency medical development was obvious when over sixty people were nominated to fill the initial eleven vacancies on the ACEMS. There has been a continuous waiting list of people desiring to participate as ACEMS members. This is the one opportunity that the general citizen has to help make a better emergency care system and assist in the saving of human life.

HB 720 "An Act establishing a single advisory board for the Department of Health and Social Services and abolishing existing advisory boards to the department; and providing for an effective date." envisions a single board to advise the Commissioner of Health and Social Services on all health and social matters. We believe that it is impossible for a solitary board to become competent in all phases of health and social affairs. A single specialty, such as emergency medicine, requires a significant dedication of time and effort to achieve reasonable results. The Bill provides for a subcommittee of three people to advise on all matters relating to the Division of Public Health. Since EMS is only one segment of public health, it is

obvious that this subcommittee would not be able to devote sufficient time or effort to the improvement of emergency medicine. We feel this would rob the public of their desire to influence the EMS program and would seriously detract from the development of the system.

The members of the Southern Region EMS Council believe that HB 720 is not a good piece of legislation and should not be passed by the House HESS Committee. The ACMES is serving a very useful purpose and should continue to act in its present role and be given even more authority, if that is possible.

Mr. Richard Pauley, our Executive Administrator, will be in Juneau on March 3rd and 4th, and I would like very much for you to meet with him concerning this critical problem.

Thank you for your kind consideration.

Sincerely,

Gary E. Hessmer,
President
SREMSC Board of Directors

GH/mkh

Aleutian Sub Area
Nancy Greenman
Royal Nelsen
Scotty Cumberlidge

Anchorage Sub Area
Gerald Travis
William Montgomery
Mary Luttig

Bristol Bay Sub Area
Steve Levinson
Gordon Isaacs
Stuart Bowdoin

Copper River Sub Area
Edna Charley
Billie Peters
Clif Palmer

Kenai Peninsula Sub Area
Donna Limbean
Cathy Stingley
Greg Barclay

Kodiak Borough Sub Area
Jerome Selby

Matanuska-Susitna Sub Area
Myron Stevens
Tom Fielding
Gary Hessmer

Norton Sound Sub Area
Darryl Trigg
Penny Chmielewski
Pam McMillan

Prince William Sound Sub Area
Lydia Robart
Barbara Sherman
Gary Mowry

Yukon-Kuskokwim Sub Area
Sue Martin
Don Porter
Dr. Steve Garrish

Directors-at-large
Roy Davie - Communications
Susan Callan - HSA
Lt. John McConnaughey - Public Safety

MATANUSKA-SUSITNA BOROUGH
EMERGENCY MEDICAL SERVICES BOARD

RESOLUTION SERIAL NO. 80-1

A RESOLUTION OF THE MATANUSKA-SUSITNA BOROUGH EMERGENCY MEDICAL SERVICES BOARD OPPOSING HOUSE BILL 720.

WHEREAS, House Bill 720 proposes to combine the nine different advisory councils within the Department of Health, Education and Social Services into one 25-member advisory council and provide for sub-committees of the central council; and

WHEREAS, passage of House Bill 720 would result in the ADVISORY COUNCIL ON EMERGENCY MEDICAL SERVICES being eliminated and a sub-committee under the heading of "Public Health" would deal with the planning and implementation of a statewide emergency medical service system along with the other aspects of public health; and

WHEREAS, the Matanuska-Susitna Borough Emergency Medical Services Board feels that this would limit regional emergency medical services' in-put into State government and that the importance of the service, the specialized training required and liability issues involved warrant a special council to deal specifically with emergency medical services.

NOW THEREFORE, BE IT RESOLVED, that the Matanuska-Susitna Borough Emergency Medical Services Board urges the State Legislature to consider the specialized field of emergency medical services in reviewing and voting upon House Bill 720.

PASSED AND APPROVED by the Matanuska-Susitna Borough Emergency Medical Services Board this 27th day of February, 1980.

Gary E. Hessmer, Chairman

ATTEST:

Kim Kalmbach, Clerk

HB

751

February 28, 1980

Members of the House HESS Committee
P.O. Pouch V
Juneau, Alaska 99811

Dear Representatives:

This letter is in response to House Bill No. 751.

I am currently a member of the UAA Faculty, have been involved in Nursing education in Alaska since 1974 and have approximately eleven years of experience in teaching in University settings.

I do not believe that policies regulating the "outside activities"of University faculty are excessively restrictive NOR do they constitute a danger to personal freedom. Within any academic community the potential exists for utilizing a faculty status to further individual gain at the expense of the primary mission of the University or that extends the University reputation, responsibility and liability into activity areas over which it has no control. This risk is even more serious when the University is tax supported. It can be difficult for the public or for faculty to define the limits of "ones own time," in relation to a faculty position. Because of this there can be problems relating to:

(1) The public not recognizing an "outside activity" as being separate from a faculty activity.
(2) The public may accept an individual's personal representation as being supported and sanctioned by the University.
(3) Faculty have numerous opportunities to utilize a position to establish contacts and credibility for personal gain in "outside activities."
(4) Faculty could receive double reimbursement for a singular activity.
(5) Faculty could engage in "outside activities" which have the potential of weakening or reducing credibility of academic programs.

On the surface no one would be in favor of having his personal choices or freedoms infringed upon. In reality most people recognize and accept responsible and necessary limits in the expression of personal freedom. Within a University system these limits can best be interpreted by acknowledged academic colleagues who provide program leadership and are responsible for program quality and integrity. This is where responsibility is placed by current Regent policies relating to the establishment of faculty workloads and approval of outside activities.

I would urge that you consider the potential risks to the public and to the University community inherent in the proposed bill.

Sincerely,

Betty L. Hodo

Betty L. Hodo

BH/fw

PART IV

PERSONNEL

Chapter VIII

GENERAL INFORMATION

Outside Activities 04.08.03

A. Scope

1. Teaching, research, application of research findings, preparation and publication of articles and books (whether for royalty or not), preparation and delivery of lectures, serving on advisory bodies, memberships and activities in professional societies, participation in artistic performances or activities, when said activities are related to staff members' professional fields and no compensation or honorarium (other than royalties from publication) is received, are considered to be within the regular work duties of University employees.

   Examples of activities considered to be outside the regular work or duties are: consulting for or providing other services to individuals or firms, serving on boards of directors, or as officers of business organizations, and engaging in commercial operations and practice except as noted above.

2. Outside activities may be of one-time nature, intermittent or occasional, or regularly recurring. They may involve little or considerable amounts of compensation.

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1. Prior to engaging in any outside activity, as defined herein, the employee concerned shall secure approval of his/her immediate supervisor. Department heads, deans, and directors or equivalent level are designated as

representatives of the University to grant such approval for employees under their jurisdiction. If the approval is denied, the individual shall have the right to appeal the decision as set forth below.

(a) In making these determinations the chief consideration shall be whether the employee's current or proposed outside activities, taken individually or cumulatively, would substantially interfere with the performance of his/her regular duties. The fact that the outside activity involved compensation or the amount of such compensation will not be a reason for a refusal.

(b) In some cases the outside activity of an employee may be in the interest of the University or contribute to a significant enhancement of the employee's professional standing or competence, even though engaging in the outside activity would substantially interfere with the employee's performance of his/her regular duties. In such cases the University may, upon consideration, determine that a re-allocation of the employee's duties is justified. Heads of departments and offices should process such cases through regular channels for approval.

2. Review

Heads of offices, departments, deans, and other supervisors may, from time to time, review a case if, in their judgment, reasonable evidence suggests that:

(a) The outside activity or activities, individually or cumulatively constitutes in fact a substantial interference with the satisfactory accomplishment of the employee's regular University duties, or

(b) The employee may otherwise be violating the provisions of this policy.

3. Community, State and Governmental Service

Community, state and governmental service is encouraged by the University as a function of citizenship, provided it does not constitute deterimental interference with the employee's discharge of his/her regular work duties. If community, state or governmental service duties, whether compensated or not, in fact substantially interfere with the employee's discharge of his/her regular work duties, then it becomes an outside activity.

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(a) In conducting outside activities for compensation, the employee will make it clear to his/her employers or associates that he/she is serving in an individual

capacity and that the University accepts no responsibility in connection with the outside activities.

(b) Official stationery of the University will not be used in connection with consultant's reports, bills for services or correspondence relating to the fulfillment of the staff member's performance of the outside activity.

(c) Employees whose names are included in commercial listings or other public documents, the purpose of which is to draw attention to the employee's availability for compensated services, will not list University buildings as an address, or list a University telephone number.

5. Purchase Through the University for Private Purposes

Individuals are not permitted to purchase supplies or equipment for personal use through institutional channels.

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The use of University property, equipment, facilities, or services by employees for purposes not directly related to their University duties is prohibited. Exception will be made for the use of specialized equipment not available to industry or individuals through any private source within the state for which a pre-determined fee or rate has been established. The individual staff member may use such equipment on the same basis as other members of the public. (05-18-79)

Patents 04.08.04

The President shall appoint a Patent Committee of at least five members, a majority of whom shall be from the teaching and/or research faculty of the University. This Committee shall advise the President in the administration of the patent policy. However, at his/her discretion, the President may assign this function to some other established committee having membership requirements specified for the Patent Committee.

The agreement which it is recommended that the University make with Research Corporation should provide that a staff member of the University may agree to assign an invention to Research Corporation, with the understanding that Research Corporation, if it accepts the assignment, is to carry out the patenting and commercialization of the invention without any expense to the inventor; that Research Corporation is to pay the inventor a share

Nurses Open First-Of-Its-Kind Office Here

By GAYLE WALKER
Times Staff Writer

Eight independent generalist nurses, basing their practice on the care theory of internationally known nurse Lucille Kinlein, have opened in Anchorage office of professional nursing.

Founders of the first-of-its-kind practice in Alaska are Mary Bolin, Joanne Gladden, Patricia Miller, Charles Morel, Mona Ravin, Patricia Steige, Patti Stepp and Linda Waggoner.

Each is a registered nurse and each has a master's degree in nursing care. They are all working in other fields of nursing in the community, as well.

Lucille Kinlein, who has given classes in Anchorage during her travels across the world, teaches a theory which incorporates the client's body, mind and soul in dealing with illness, the nurses explain.

Ms. Bolin gave a working definition of their practice as "assisting our clients in the exercise of self care in regard to living."

In stating that her group was in no way competing with physicians, Ms. Ravin offered the differences between medical and nurse practices: "Nursing is the maintenance of health and the prevention of disease. Medicine is the diagnosis and treatment of disease."

"When medical care is needed the client goes on to his or her physician with his own (the client's) better knowledge of anatomy and the physiology of his own body," Ms. Ravin says. "The client is a more sophisticated consumer of medical care."

The nurses do not treat diseases, she explains. They can tell a client what to expect of non-treatment, leaving the responsibility with the client to seek care or not — and to accept the consequences of either action, Ms. Ravin says.

"A lot of our clients come to us because they're not sure if they need to go to a physician," said Ms. Waggoner. She added that if a person shows a need for medical attention the patient would be directed to a physician more knowledgeable about needed treatment.

The nurses share their books with clients and refer them to the health science library.

"A doctor gives his diagnosis and prescribes treatment. He doesn't help with the rest of the patient's life. Sometimes not all of their questions are answered about the disease. We help our clients explore their disease and see how it may relate to their life and family decisions," said Morel.

He went on to say, "Several people come to me saying, 'I'm not really sick, but I don't particularly feel good about me.'

"Health doesn't just mean the absence of illness. A healthy person feels good about himself and is able to express his emotions."

"We deal with the total person — their physical, mental, personal and spiritual aspects. We help them discover the self-care assets within themselves to enable them to take care of themselves," said Ms. Ravin.

"People really don't trust their own judgment," said Ms. Waggoner. "Maybe it's because they don't have as much knowledge as they did 100 years ago. I really wouldn't want to see us back with the old home treatments, but I do want to work at helping people to gain confidence in their own care."

"If you have the knowledge, you're really the one to make your own health care decisions. After all, who knows your body better than you?" added Ms. Ravin.

The nurses all agreed that Americans have fallen into a false security about their yearly physical exams. "Women and men should be examining their breasts at least once a month," said Ms. Ravin. "They need to be familiar with their own contours, with their own normal lumps and bumps. When you know about your body you are reassured of your good health."

The professional nurses do physical exams and lab work from their offices. "We never do a physical because we feel our clients need one. They only reason we have (to do a physical) is if the client requests one," said Ms. Bolin.

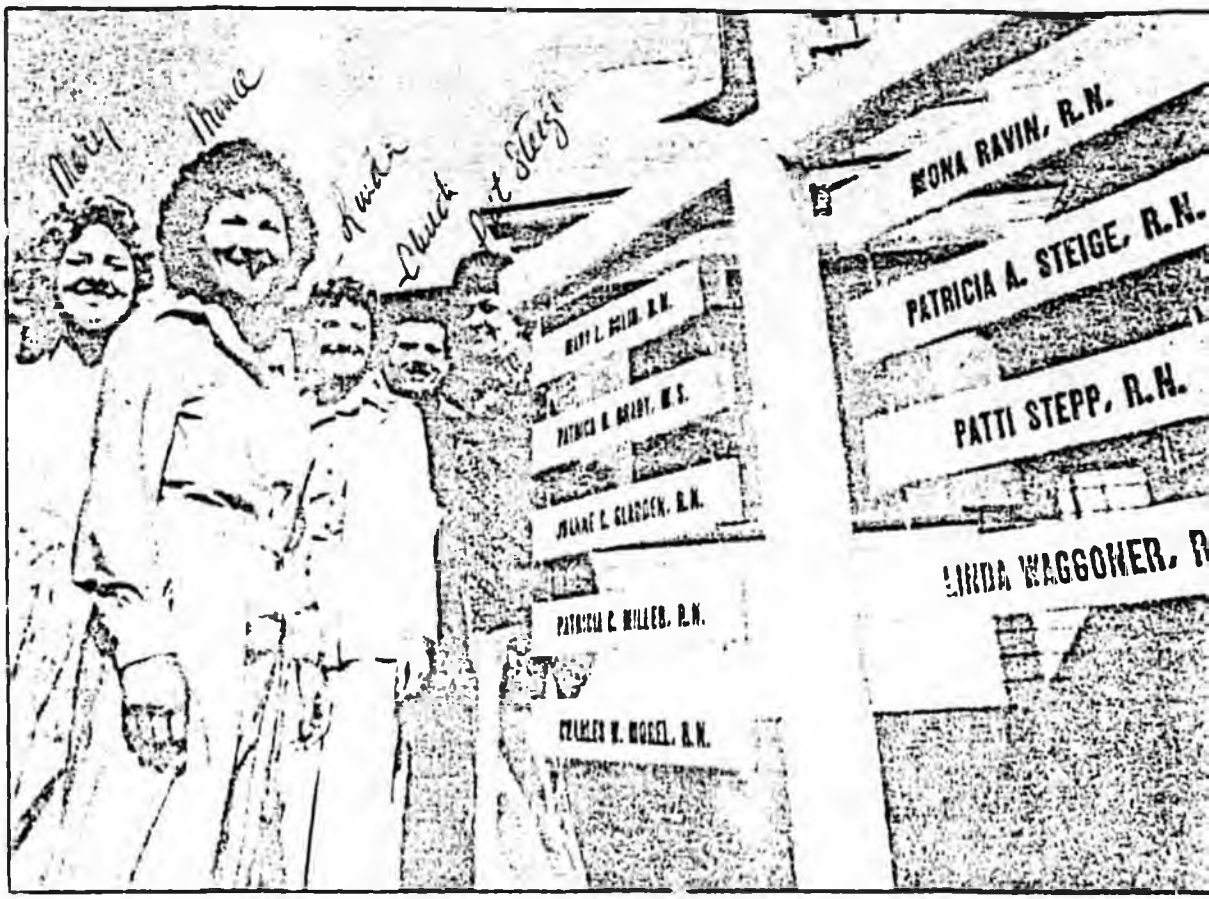
"In all our lab work, we share the results with the patients. It's their property and they have a right to see and understand the results," they concurred.

The practice is based upon client orientation. "This is a very person-enhancing practice," said Ms. "The client is in total contr won't tell them, 'This is wrong with you and this is wh need to do about it.' Instead w several alternatives from whi client is free to pick and which to try."

The nurses help their "take small steps toward get control of their lives," accor Ms. Ravin. "If you work or people come to you with, late may be free to deal with what be their obvious problem, added.

Morel said most commen receive from clients go som like this: "I really feel gooc this. I've never gotten this care from anyone else." He ac guess they see that we are concerned about them.

"All I can say is that it feel to be practicing in a way tha natural and satisfying to m said.



SHINGLES TELL OF NEW ENTERPRISE

Standing in front of their new offices at 327 L St. are some of the independent generalist nurses who follow the health theories of Lucille Kinlein. Eight nurses and geneticist Patrick Bradv share the offices. All with mas er's degrees, the nurses include Mona Ravi foreground, Mary Bolin, Linda Waggone Charles Morel and Pat Steige.
Patti Miller missing from this pictu

Nursing the body, mind and soul

by Annabel Lund

Lucille Kinlein, labeled by the medical profession and the media as a pioneer, revolutionary, and prophet, will be in Homer for two days next week to discuss her radical Kinlein Theory of Nursing with the community. It is a theory so new and so important that her lectures go far beyond an interest confined to the medical care personnel in Homer. Anyone who has ever been to a doctor anywhere will find her ideas exciting stimulation.

Author, teacher, nurse, she is the first registered nurse in history to set up her own independent professional nursing practice, eight years ago.

"When I went into nursing," she said, "I knew I wanted to become a professional, make my own judgments, initiate action, and work with the person I was caring for. Of course, in the traditional setting, it's impossible and it will continue to be impossible as long as medicine controls the field of nursing. I liked nursing. But I went into this field thinking it was a profession in and of itself. If you're in a profession, you've got to be able to stand alone, independent of any other professional connection."

Can nursing, usually thought of as an adjunct to traditional doctor-oriented medicine, stand on its own, independent of medicine as most think of it?

Kinlein has two extremely 1600 clients, has fostered some thirty other professional nursing offices through the U.S. and was recently featured in a Time Magazine article about the changing roles of nurses in the medical field. She has also written two books, lectured in universities across the country and has received the National League of Nursing's highest award for "her outstanding pioneering contributions to nursing" in 1977.

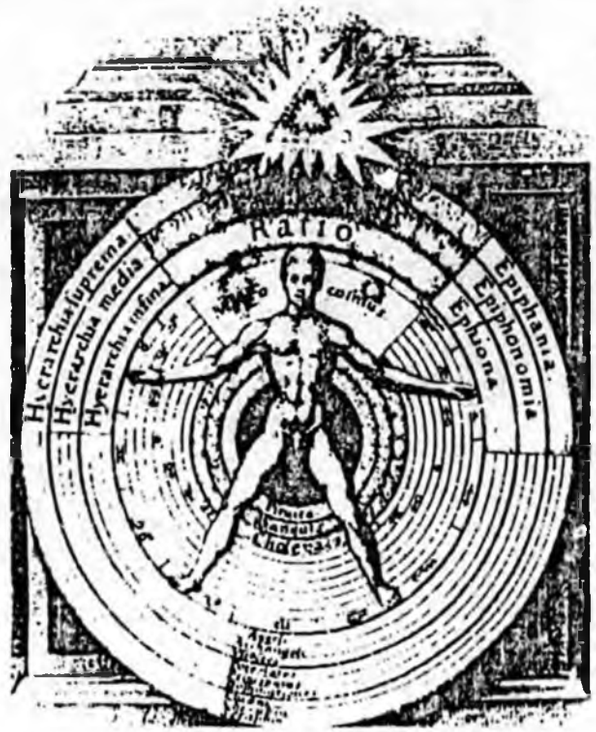
Eight nurses in Anchorage, all RN's with Masters Degrees in Nursing and disciples of Kinlein's theory, have founded a first-of-a-kind Nursing Clinic this year and two local Homer nurses are planning to open their private office here soon.

So what is this radical new theory all about?

Kinlein believes that health is more than an absence of illness. She feels that medicine can be preventative, client-oriented, and that nurses can uniquely help individuals understand, control, and take responsibility for their own health.

"Philosophically speaking," Kinlein says, "the formal object of nursing is the whole person — body, mind and soul."

A Kinlein nurse looks at the client's health from his point of view, helping him to learn about his own self care by helping the client evaluate his own self-care assets. The nurse assists in setting up a program tailored to fit the



Renaissance philosophers such as Robert Fludd visualized the human body as a miniature replica of the universe, a microcosm whose ingredients reproduced and sympathized with the elements of the world at large.

to say, 'I know what's best for you.' The present system fosters dependency and passivity. People want to participate in their own care," Kinlein explains.

"A lot of our clients come to us because they're not sure if they need to go to a physician," said Linda Waggoner, RN in the new Anchorage clinic.

Nurse Mona Ravin, also of the clinic, says "When medical care is needed the client goes on to his or her physician with a better knowledge of the analogue and the cated consumer of medical care.

"A doctor gives his diagnosis and prescribes treatment. He doesn't help with the rest of the patient's life. Sometimes not all of their questions are answered about the disease. WE help our clients explore their disease and see how it may relate to their life and family decisions. In our lab work we share the results with the patient. It's their property and they have the right to see and understand the results," added Charles Morel, a

Kinlein gives physical exams, EKGs, takes blood for lab tests, and offers the unheard-of practice of yesteryear — housecalls.

According to Time Magazine, many doctors admit that up to 80 percent of all office care given by pediatricians and family practitioners could be handled by competent nurses.

Over a hundred nurses nationwide are participating in "learnerships", Kinlein's intensive advanced training courses.

Local nurses and health care authorities participating in Kinlein's workshops in Anchorage and Bethel include Betty Eneboe, Karen Carpenter, Mary Raymond, Lee Daly, Trish Worby, Kathe Gibboney, Mary Kwochka, Janice Todd, Judy Calhoun, Lucia Robinson, and Catherine Stier.

One of the major stumbling blocks for nurses attempting to set up their own practices is money. Nurses average only $13,000 a year in salaries, and the outlay for equipment, office space, and the commitment of time for intensive advanced study is difficult for many health care specialists.

Lucille Kinlein, now in her mid-50s, is a native of Ellicott, Md., where she studied languages to become an interpreter. When World War II broke out, she became a nurse.

She has a bachelors degree in languages from the Col- from the Catholic University of America in Washington D.C.

Her first book, "Independent Nursing Practice with Clients," has become a best seller in the medical profession and her new book, "Kinlein Practice Theory," is slated to hit the market this spring.

In an interview with the Anchorage Times, Ms. Kinlein discusses staying healthy.

"It's important to have a philosophical outlook on life, as a means of keeping body, mind, and soul intact.

"Where you're going in life, your set of values and how you judge your decisions give meaning to your life. Secondly, take care of your body and do not abuse it: eat well, sleep well, have social interactions with people, allow time for solitude, exercise, work and have some diversions and fun.

"All the elements of living come together in a well-integrated person. It's the integrity of the body, mind and soul."

Ms. Kinlein will be speaking in the high school Thursday, Sept. 13, at 7:30 p.m. There is no charge for admittance and the public is urged to attend.

Friday evening there will be "A Chat with Lucille Kinlein" at Mary Raymond's home on Bayview St., at 8 p.m. The public is also invited to attend this informal discussion group.

For more information about Ms. Kinlein's visit,

PART IV

PERSONNEL

Chapter VIII

GENERAL INFORMATION

Outside Activities 04.08.03

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"We deal with the total person — their physical, mental, personal and spiritual aspects. We help them discover the self-care assets within themselves to enable them to take care of themselves," said Ms. Ravin.

"People really don't trust their own judgment," said Ms. Waggoner. "Maybe it's because they don't have as much knowledge as they did 100 years ago. I really wouldn't want to see us back with the old home treatments, but I do want to work at helping people to gain confidence in their own care."

"If you have the knowledge, you're really the one to make your own health care decisions. After all, who knows your body better than you?" added Ms. Ravin.

The nurses all agreed that Americans have fallen into a false security about their yearly physical exams. "Women and men should be examining their breasts at least once a month," said Ms. Ravin. "They need to be familiar with their own contours, with their own normal lumps and bumps. When you know about your body you are reassured of your good health."

The professional nurses do physical exams and lab work from their offices. "We never do a physical because we feel our clients need one. They only reason we have (to do a physical) is if the client requests one," said Ms. Bolin.

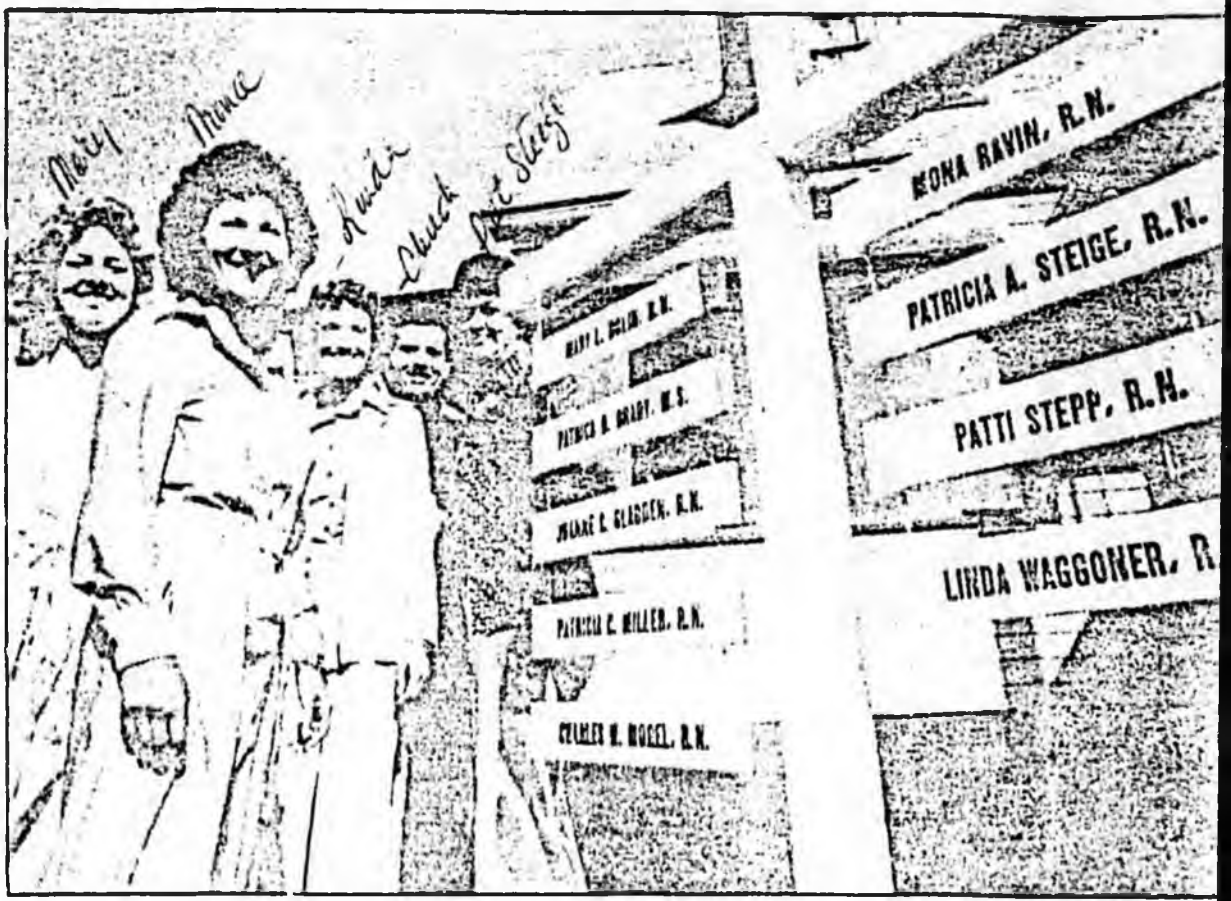
"In all our lab work, we share the results with the patients. It's their property and they have a right to see and understand the results," they concurred.

The practice is based upon client orientation. "This is a very person-enhancing practice," said Ms. "The client is in total contr won't tell them, 'This is wrong with you and this is wh need to do about it.' Instead w several alternatives from whi client is free to pick and which to try."

The nurses help their "take small steps toward get control of their lives," accord Ms. Ravin. "If you work on people come to you with, late may be free to deal with what be their obvious problem, added.

Morel said most comment receive from clients go son like this: "I really feel this. I've never gotten this cure from anyone else." He ac guess they see that we are concerned about them.

"All I can say is that it feel to be practicing in a way tha natural and satisfying to m said.



SHINGLES TELL OF NEW ENTERPRISE

Standing in front of their new offices at 327 L St. are some of the independent generalist nurses who follow the health theories of Lucille Kinlein. Eight nurses and geneticist Patrick Brady share the offices. All with master's degrees, the nurses include Mona Ravi foreground, Mary Bolin, Linda Waggone Charles Morel and Pat Steige.
Patti Miller missing from this pictu

1.16

... does not:

a) interrupt the fulfillment of the teaching or research duties;

b) involve the use of University property, supplies or facilities; or

c) carry the representation of being officially or unofficially endorsed by the University.

Alaska State Legislature

TELECONFERENCE HEARINGS

DATE: 3/4/80
LOCATION: rm. 112 Capitol
SUBJECT: H. HESS

NAME	REPRESENTING	ADDRESS	PHONE	HERE TO OBSERVE	HERE TO TESTIFY
FAIRBANKS (Loretta)					
(1) Dr. Woodward Thrombley	University Academic Co-Pres.				
ANCHORAGE (ROBERTA)					
(2) Fiona Ravin	Self - faculty member - UAFA				
CARL L O'CONNELL	N.E.A.				

THE UNIVERSITY OF ALASKA

MISSION:

A POLICY STATEMENT

Draft

JANUARY 1980

THE UNIVERSITY OF ALASKA

MISSION: A POLICY STATEMENT

January 1980
Published by Statewide Administration
University of Alaska
101 Bunnell Building
Fairbanks, Alaska 99701

The University of Alaska Mission:

A Policy Statement

Unanimously Adopted January
25, 1980, by the Regents
of the University of Alaska

Donald Abel, Jr.

Mildred Banfield

Jeffry Cook

Hugh B. Fate, Jr.

Margaret J. Hall

Sam Kito, Jr.

Herbert Lang

Thomas Miklautsch

Sharilyn Mumaw

Edward B. Rasmuson

John Shively

Jay Barton, President
University of Alaska

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University of Alaska Degree Programs

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FOREWORD

The University of Alaska's mission to the people of the State of Alaska is described in this policy document. Each of the constituent institutions making up the University has its own special mission statement. The University of Alaska mission statement serves as the fundamental planning document for the future development of higher education in the State.

Within the general framework of the mission statements each institution making up the University of Alaska will develop goals and objectives that will further its special academic mission. Each of the institutions has a broad but carefully described responsibility within which it can enthusiastically develop its future and its own special identity.

Like all policy statements, this statement should be regarded as a living document and, as such, be subject to evolutionary change. When it is clear that modification of a University mission or an assignment of institutional responsibilities will render more effective service to citizens of the State, a recommendation for change will be considered by the Board of Regents.

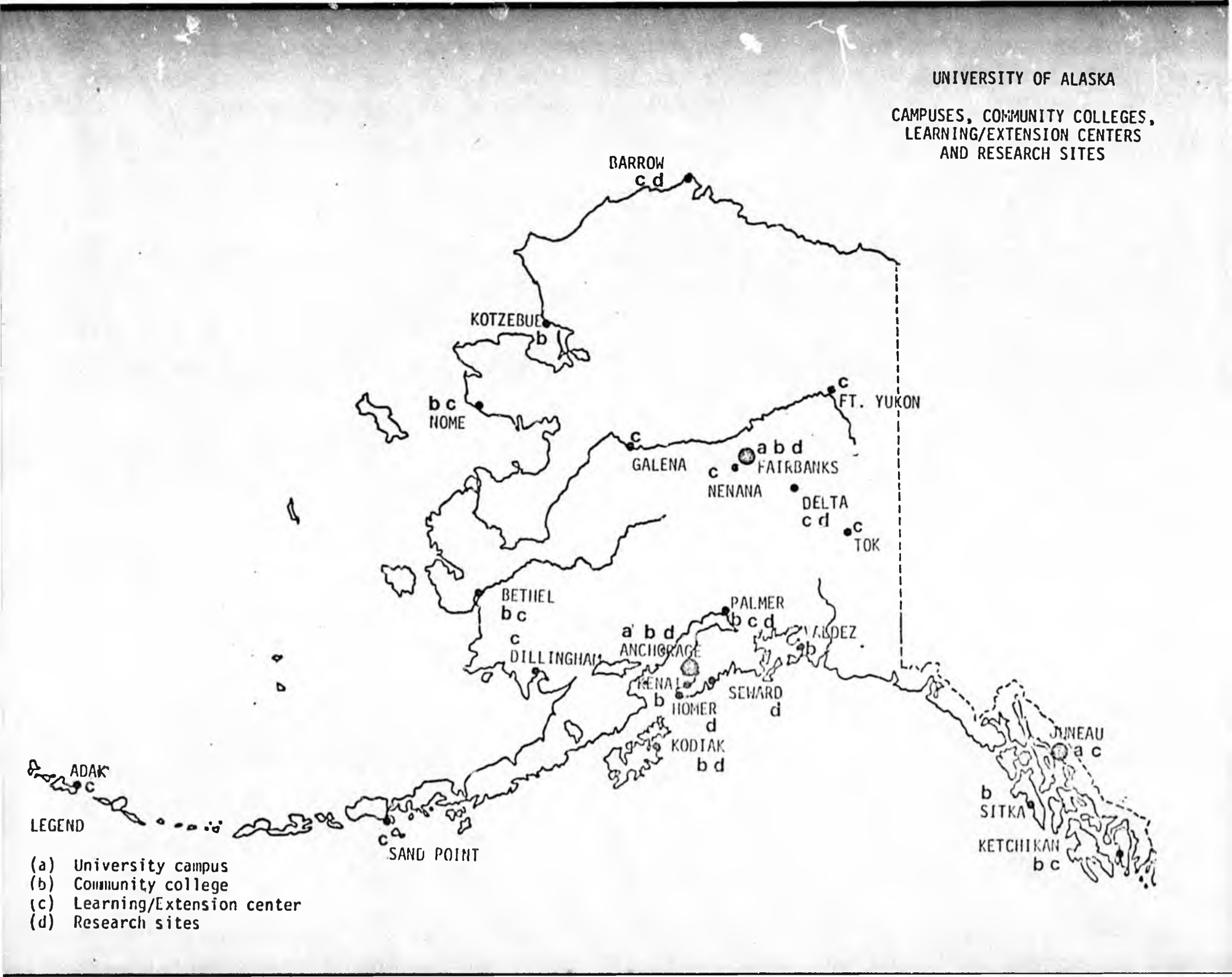
Edward B. Rasmuson, President
University of Alaska Board of Regents
January 25, 1980

THE UNIVERSITY OF ALASKA

The University of Alaska founded in 1917 by an Act of Congress was affirmed in 1959 "as the State University of Alaska" in the Constitution of the new State of Alaska. It is the State's only comprehensive university. Through its many campuses, research institutes, experiment stations, rural education centers, and by means of a wide range of certificate, associate, baccalaureate, professional and graduate degree programs, research and public service activities, the University serves the educational needs of the people of Alaska.

The establishment of the University of Alaska as a land-grant institution to, in the words of the Morrill Act, promote the "agricultural and mechanic arts" places the University of Alaska squarely in the mainstream of public education in the United States. The University of Alaska takes its place among the great universities of America that have learned how to bring together instruction, research, and extension activities for the development of the potential of individual citizens and for the economic development of the resources of the states.

The University of Alaska as a participant in the land-grant tradition accepts as its mission the offering


UNIVERSITY OF ALASKA
CAMPUSES, COMMUNITY COLLEGES, LEARNING/EXTENSION CENTERS AND RESEARCH SITES
BARROW
c d
KOTZEBUE
b
NOME
b c
FT. YUKON
c
GALENA
c
a b d
FAIRBANKS
c
NENANA
DELTA
c d
c
TOK
BETHEL
b c
c
DILLINGHAM
a b d
ANCHORAGE
PALMER
b c d
VALDEZ
b
KENAI
b
HOMER
d
SEWARD
d
KODIAK
b d
ADAK
c
SAND POINT
c
JUNEAU
a c
b
SITKA
KETCHIKAN
b c
LEGEND
(a) University campus
(b) Community college
(c) Learning/Extension center
(d) Research sites

of appropriate instruction of the highest quality to all who have the interest, dedication and ability to learn. A second part of the University of Alaska's mission is to search for truth through basic and applied research. Pushing back the boundaries of the human mind through the generation of new knowledge and the application of this knowledge to the resolution of problems of concern to the peoples of Alaska is a basic and abiding responsibility of the University. Finally, the University accepts as its mission the extension of its resources and the transmission and application of its research beyond the boundaries of the classroom and laboratory to the citizens of the State. The University accepts responsibility to aid in the development of Alaskan agriculture, forestry, fisheries, business and industry, and the professions as well as to enrich the artistic and cultural life of the State.

In accepting its mission, the University has adopted the multiple goals of accessibility, excellence and accountability.

Accessibility. The University is dedicated to the goal of providing postsecondary education to all the citizens of Alaska who possess the ability and the motivation to benefit from higher education. Educational opportunities to be accessible, must be affordable, conveniently located and

non-discriminatory. In Alaska, special efforts must be made to resolve the continuing access problems of rural Alaskans and especially of Alaska's Native peoples. The University recognizes that the barriers to higher education experienced by Native students are not entirely external but may result from previous educational experience and background. It is the responsibility of the University to reduce both the external and the internal barriers to higher education.

Excellence. Excellence can be judged by the qualities of students, faculty, administration, facilities and the educational environment. It can be defined in terms of the excellence of degree programs and research and public service activities. It is reflected in the career and life experiences of graduates, and it is related to the University's success in achieving its goals and purposes. Very importantly, excellence is dependent upon the support the University receives from those who finance its activities and benefit from its services. Public support alone cannot assure excellence, but without it, efforts to build excellence will not succeed. Formal program review and quality control are responsibilities of the University.

Accountability. Accountability reflects the concern of the University to respond to the needs of the State and relates to both the setting of priorities among competing

goals and to accomplishing goals as efficiently as quality and service considerations permit. The University holds a public trust to spend public monies wisely and is responsible for establishing strong management, budget and cost control procedures. The University must also provide the broadest possible range of instructional programs, research talents and outreach services to the citizens of the State without needless and costly duplication. All programs offered by the University cannot be made conveniently available to everyone; neither the State nor the University can afford to be all things to all people. However, an efficient and rational allocation of functions and responsibilities to the various institutions within the University can be made so that they can, collectively, meet the needs for public higher education in the State. Such a system, made up of institutional components, each with optimum missions, will not eliminate all duplication, but should eliminate destructive competition. Some degree of duplication, however, is a necessary consequence of providing for the personal, social and intellectual development of students and of meeting the goals of accessibility and equal opportunity.

INSTITUTIONAL ROLE AND SPECIAL MISSION DESIGNATIONS

The mission of each institution within the University of Alaska has two principal parts. First, each element

of the University of Alaska shares in the overall purposes and obligations of the entire University and, second, each institution has its own special mission conferring identity and special purpose on that component of the University. The two missions, together, ensure that the University can continue to respond effectively to the needs of Alaska and its citizens and, at the same time, encourage each campus to develop its own character and identity. Institutional diversity and programmatic differentiation are important to the development of the University of Alaska.

The role and special mission of each of the major units of the University are not permanent characterizations. Each will be reviewed periodically by the Office of the President and the Board of Regents and changed as new developments and new circumstances may warrant.

The University of Alaska, Anchorage

The special mission of the University of Alaska, Anchorage is influenced by it location in the state's major center of population. UAA serves students from throughout Alaska but is distinguished by the large number of commuter students, including day and evening part-time enrollees, from the greater Anchorage area.

The programmatic emphasis at UAA is on programs appropriate to its urban environment such as business and public administration, criminal justice, social work, education, engineering, and the health sciences. UAA will have the University's only school of nursing, the only baccalaureate degree program in social work, and the only organized research programs in alcohol and drug addiction and criminal justice. UAA will have the major responsibility within the statewide system for research in the health sciences and will emphasize research in the social sciences.

The development and maintenance of truly excellent baccalaureate degree programs in the liberal arts and sciences is at the heart of the mission of the University of Alaska, Anchorage. Development of graduate programs at UAA will be primarily in those professional and applied fields required to serve the urban needs of Anchorage.

UAA will work cooperatively with the private and public institutions of higher education in its geographic area. The University of Alaska, Anchorage, Alaska Pacific University and Anchorage Community College will continue to develop the Consortium Library to serve the entire Anchorage educational community.

The University of Alaska, Fairbanks

The University of Alaska, Fairbanks, the oldest institution within the University system, serves the State as the University's flagship campus. It is the responsibility of UAF to provide a broad range of baccalaureate and graduate degree programs in the arts and sciences and the professions, including selected doctoral programs.

The University of Alaska, Fairbanks has the University's only agricultural and mineral industry schools. Its School of Education will emphasize the preparation of teachers for rural Alaska. UAF is the University's principal biological and physical science research institution. Its primary emphasis in organized research and in its doctoral degree programs is in disciplines and areas relevant to the high latitude and arctic regions.

The University of Alaska, Juneau

The special mission of the University of Alaska, Juneau reflects its location in the State Capitol. UAJ will provide degree and continuing education programs in public administration and in other areas appropriate to the professional development of governmental employees.

Further, in order to meet the educational needs of the southeastern region of Alaska the University of Alaska, Juneau offers associate and baccalaureate programs in the liberal arts and sciences. The University's strengths in scholarship and research provides support for master's degree programs in education, public administration, business administration and fisheries. UAJ will give, in cooperation with State and Federal agencies and other units within the University, special attention to the development of fisheries research.

The Juneau-Douglas Community College Division of UAJ offers associate degree and certificate programs in technical and vocational fields and programs in developmental education.

UAJ, in addition, cooperates with Sheldon Jackson College and the Sitka and Ketchikan Community colleges in programs especially tailored to the needs of Alaska's southeastern population.

The Community College
Rural Education and Extension Division

The University's Community College, Rural Education and Extension Division consists of the Community Colleges, the Office of Rural Education, the Cooperative Extension Service, and several related instructional and research units.

Each of the University's community colleges will offer academic, vocational, developmental and community service programs to its service area in response to identified educational and vocational needs. The ability of the community colleges to train a highly skilled work force is especially important in Alaska, which imports much of its skilled labor force from outside the State. The community colleges will make every effort to utilize the public and private educational and technical resources available in their service areas, including most notably those in the Native corporations, Sheldon Jackson College, Inupiat University, the Cooperative Extension Service, the public school system and private industry.

While the University's community colleges are empowered to offer only associate degree and certificate programs, the Office of Rural Education is authorized to arrange for one of the University's senior institutions to offer upper division and graduate courses in areas of the State not fully served by a University-level campus. Rural Education also offers lower division courses through its eight learning centers in areas not served by a community college.

The Cooperative Extension Service's primary mission is to provide, in cooperation with State and Federal agencies and other units of the University, a program of outreach designed to bring University of Alaska resources to bear upon the needs and problems of the people and institutions of the State.

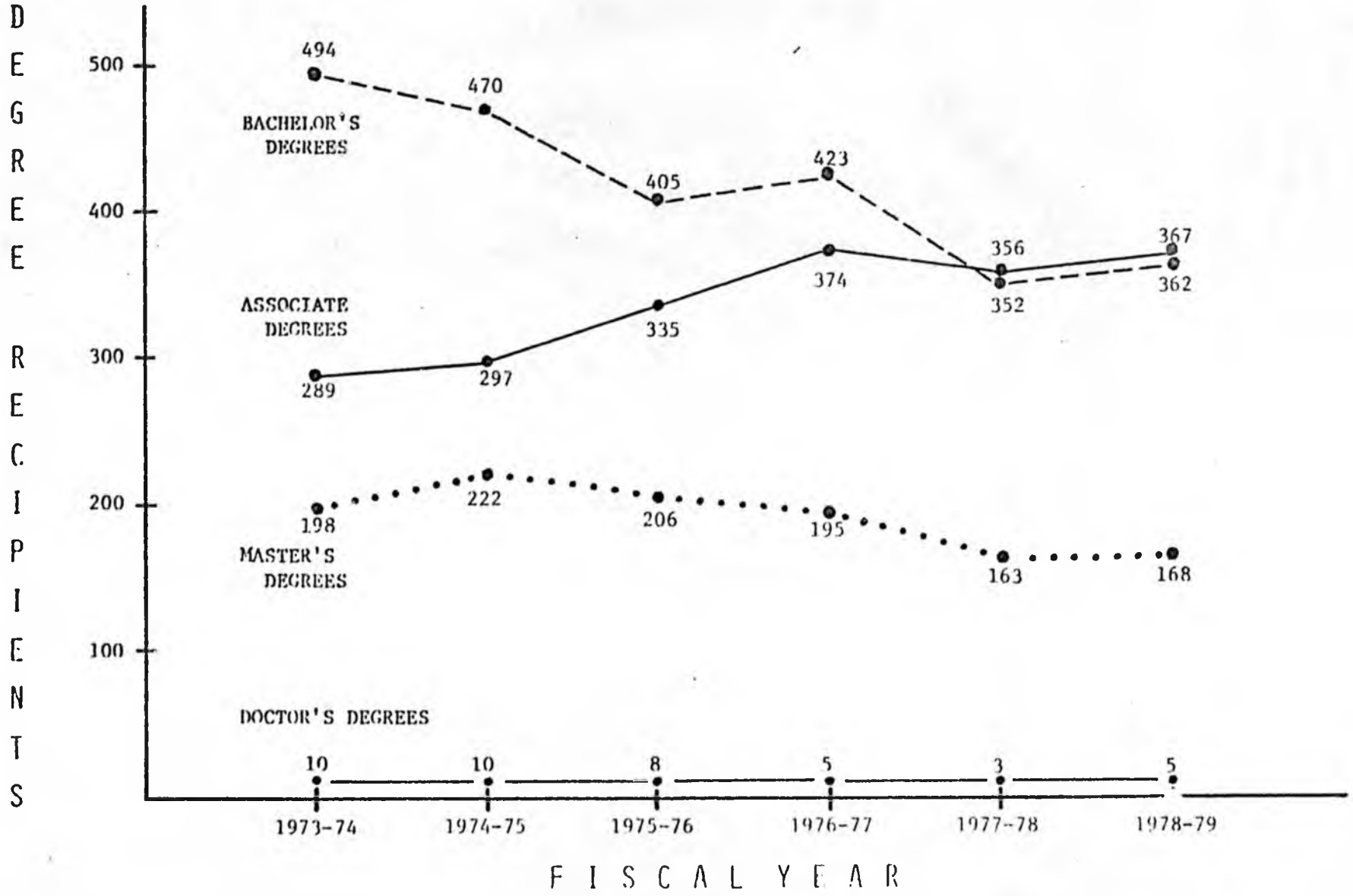
University of Alaska Degree Programs

(January 1980)

Note: Decisions authorizing degree programs are made on the basis of sound academic analysis taking the special mission of each institution into account. Questions of need, quality and appropriateness take precedence over questions of quotas or political trade-offs. Just as importantly, decisions regarding the termination of degree programs are taken only after equally careful academic analysis. The University recognizes that maintaining and improving the quality of its academic programs is essential. It is unlikely that it will ever obtain all the resources necessary to support all possible academic programs. Hence, it is necessary to focus the University's resources on areas of greatest need and with the greatest chances of successful contribution to the State of Alaska and its people.

(List of Degree Programs Forthcoming)

EARNED DEGREES, UNIVERSITY OF ALASKA, 1373-74 TO 1978-79



BACHELOR'S AND HIGHER DEGREES BY INSTITUTION, LEVEL OF AWARD, AND MAJOR DISCIPLINE AREA, UNIVERSITY OF ALASKA, 1974-75 TO 1978-79

Area By Field of Study	BACHELOR'S					MASTER'S					DOCTOR'S					Prof Cert.
	74-75	75-76	76-77	77-78	78-79	74-75	75-76	76-77	77-78	78-79	74-75	75-76	76-77	77-78	78-79	78-79
Agriculture & Natural Resources Total	19	20	22	12	13	4	5	10	7	8	-	2	-	-	-	-
U of A, Fairbanks	19	20	22	12	11	4	5	8	6	6	-	2	-	-	-	-
U of A, Southeastern Senior College	-	-	-	-	2	-	-	2	1	2	-	-	-	-	-	-
Area Studies-Total	1	2	1	1	2	-	-	-	-	-	-	-	-	-	-	-
U of A, Fairbanks	1	2	1	1	2	-	-	-	-	-	-	-	-	-	-	-
Biological Science-Total	61	40	44	33	20	7	5	4	6	5	-	2	1	-	2	-
U of A, Anchorage	12	11	10	10	-	-	-	-	-	-	-	-	-	-	-	-
U of A, Fairbanks	49	29	34	23	20	7	5	4	6	5	-	2	1	-	2	-
Business & Mgmt-Total	59	49	38	33	49	27	27	12	14	11	-	-	-	-	-	5
U of A, Anchorage	32	33	23	21	34	10	7	5	8	1	-	-	-	-	-	5
U of A, Fairbanks	27	16	15	12	15	6	20	7	6	10	-	-	-	-	-	-
U of A, Southeastern Senior College	-	-	-	-	-	11	-	-	-	-	-	-	-	-	-	-
Communications-Total	13	12	14	8	11	-	-	-	-	-	-	-	-	-	-	-
U of A, Anchorage	13	12	14	8	2	-	-	-	-	-	-	-	-	-	-	-
U of A, Fairbanks	-	-	-	-	9	-	-	-	-	-	-	-	-	-	-	-
Computer & Information System-Total	-	1	-	1	-	-	-	-	-	-	-	-	-	-	-	-
U of A, Fairbanks	-	1	-	1	-	-	-	-	-	-	-	-	-	-	-	-
Education-Total	84	75	76	53	57	118	131	117	87	84	-	-	-	1	-	2
U of A, Anchorage	37	46	34	21	24	73	89	83	57	44	-	-	-	-	-	-
U of A, Fairbanks	47	29	35	27	26	21	19	21	20	24	-	-	-	1	-	2
U of A, Southeastern Senior College	-	-	7	5	7	24	23	13	10	16	-	-	-	-	-	-

(CONTINUED)

Area By Field of Study	BACHELOR'S					MASTER'S					DOCTOR'S					Prof Cert.
	74-75	75-76	76-77	77-78	78-79	74-75	75-76	76-77	77-78	78-79	74-75	75-76	76-77	77-78	78-79	78-79
Engineering-Total	30	24	22	36	29	11	13	22	14	14	1	-	-	-	-	-
U of A, Anchorage	1	-	-	5	-	4	3	8	9	2	-	-	-	-	-	-
U of A, Fairbanks	29	24	22	31	29	7	10	12	4	10	1	-	-	-	-	-
U of A, Southeastern Senior College	-	-	-	-	-	-	-	2	1	2	-	-	-	-	-	-
Fine & Applied Arts-Total	29	16	15	14	20	1	-	-	-	-	-	-	-	-	-	-
U of A, Anchorage	18	6	13	5	9	-	-	-	-	-	-	-	-	-	-	-
U of A, Fairbanks	11	10	2	9	11	1	-	-	-	-	-	-	-	-	-	-
Foreign Language-Total	2	4	4	3	1	1	-	-	-	-	-	-	-	-	-	-
U of A, Anchorage	1	-	-	1	1	-	-	-	-	-	-	-	-	-	-	-
U of A, Fairbanks	1	4	4	2	-	1	-	-	-	-	-	-	-	-	-	-
Health Profession-Total	1	1	23	23	22	-	-	-	-	-	-	-	-	-	-	-
U of A, Anchorage	-	-	23	23	22	-	-	-	-	-	-	-	-	-	-	-
U of A, Fairbanks	1	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Home Economics-Total	5	4	7	1	1	-	-	-	-	-	-	-	-	-	-	-
U of A, Anchorage	-	-	2	1	-	-	-	-	-	-	-	-	-	-	-	-
U of A, Fairbanks	5	4	5	-	1	-	-	-	-	-	-	-	-	-	-	-
Letters-Total	12	20	23	12	13	13	7	4	4	1	-	-	-	-	-	-
U of A, Anchorage	8	9	14	6	6	7	5	3	1	-	-	-	-	-	-	-
U of A, Fairbanks	4	11	9	6	7	6	2	1	3	1	-	-	-	-	-	-
Mathematics-Total	9	7	8	7	8	2	-	-	-	1	-	-	-	-	-	-
U of A, Anchorage	4	4	3	4	2	-	-	-	-	-	-	-	-	-	-	-
U of A, Fairbanks	5	3	5	3	6	2	-	-	-	1	-	-	-	-	-	-
Physical Science-Total	16	11	7	9	15	19	6	10	6	12	7	4	2	2	3	-
U of A, Anchorage	1	-	1	-	-	-	-	-	-	-	-	-	-	-	-	-
U of A, Fairbanks	15	11	6	9	15	19	6	10	6	12	7	4	2	2	3	-

(CONTINUED)

Area By Field of Study	BACHELOR'S					MASTER'S					DOCTOR'S					Prof. Cert.
	74-75	75-76	76-77	77-78	78-79	74-75	75-76	76-77	77-78	78-79	74-75	75-76	76-77	77-78	78-79	78-79
Psychology-Total	39	49	32	36	24	7	3	6	2	6	-	-	-	-	-	-
U of A, Anchorage	30	34	28	32	20	7	3	6	2	6	-	-	-	-	-	-
U of A, Fairbanks	9	15	4	4	4	-	-	-	-	-	-	-	-	-	-	-
Public Affairs & Services-Total	-	12	4	-	11	7	8	8	16	18	-	-	-	-	-	-
U of A, Anchorage	-	11	-	-	7	7	5	5	14	15	-	-	-	-	-	-
U of A, Fairbanks	-	1	4	-	4	-	-	1	-	-	-	-	-	-	-	-
U of A, Southeastern Senior College	-	-	-	-	-	-	3	2	2	3	-	-	-	-	-	-
Social Science-Total	87	56	82	65	51	5	-	2	7	4	-	-	-	-	-	-
U of A, Anchorage	42	29	49	40	28	-	-	-	-	-	-	-	-	-	-	-
U of A, Fairbanks	45	27	33	25	23	5	-	2	7	4	-	-	-	-	-	-
Interdisciplinary Studies-Total	3	2	1	5	15	-	1	-	-	4	2	-	2	-	-	-
U of A, Anchorage	-	2	1	4	11	-	1	-	-	4	-	-	-	-	-	-
U of A, Fairbanks	3	-	-	1	4	-	-	-	-	-	2	-	2	-	-	-

THE UNIVERSITY OF ALASKA INTEGRATED STRATEGIC PLANNING SYSTEM

I. The Planning Concept

The concept of an integrated planning system applied to a university setting reflects a significant departure in both philosophy and procedure from planning efforts normally encountered in service institutions, particularly those in higher education. The concept, for example, does not embrace an effort to develop a "Master Plan." There will be no richly-bound volume of plans and aspirations, produced by a single-effort task force composed of a membership having no direct line responsibility. Other universities admittedly do have these "Master Plans" and, while they usually reflect a prodigious expenditure of effort and expense, they are most easily identifiable for the dust they gather.

Integrated planning at the University of Alaska will advance from another premise, namely, that planning is an intrinsic functional responsibility of management; thus, primary responsibility for planning will reside with the managers of the institution. They will be strongly supported in this activity by a developing institution-wide data base and management information system, advisory councils charged with the examination and conceptualization of our future environment, and planning and review procedures which will lead to resource allocation decisions consistent with the established objectives of the university.

The planning system at the University of Alaska will become part of a management process which focuses on the strategic alternatives open to local units and the state system. It is a management activity which notes that high-level achievement is never possible except against specific, limited, and clearly defined and prioritized targets. The planning system assumes that resources will be allocated and reallocated on that basis.

In common with other effective integrated planning systems, the University of Alaska system will embody five fundamental characteristics:

1) Strategic planning, consistent with well established management theory, will be reinforced as a line-management function. This means that primary responsibility for planning will rest with every manager throughout the system including deans, directors, and chancellors. The line managers, however, will be provided strong staff support from the broadly-based campus and university-wide planning councils, and will receive timely data support from the statewide Office of Institutional Research.

2) The integrated strategic planning system will assist the institution and its managers in making the important and frequently complex decisions. The danger frequently realized with Master Plans and with planning in general, is that the planning effort takes on a life of its own and the planning documents become an end in themselves. At the University of Alaska, planning documentation is designed to identify direction, to clarify strategic choice, and to provide the parameters within which resource allocations within the institution will be made. Managers will know that plans are used and that resource allocations and reallocation through the budget period will be based on their goals and the goals of the system, and on priorities which have been established for each budget period.

Planning at the University of Alaska will be a data-based management system which will place a premium on creativity and innovation, but which will require accountability through a scheduled review process - of plans, objectives, priorities, and even of underlying assumptions. This review will take place at both campus (MAU) and system levels, utilizing current hierarchical relationships.

While it requires line management to plan, it is a participatory management planning system on the premise that planning which has the greatest participation of the persons who will have to carry out its results will have a greater probability of success than a system which is not attended to by those who will have to implement it. Since all managers are charged with planning, first tier involvement is assured; however, inasmuch as this is an integrated (finance, facilities, and program), planning system, there must be a process by which persons other than managers can be involved, including faculty, support services, and the student body. Substantive participation in the planning process for these groups will occur through membership on the planning councils. The planning councils will be given the task of providing a forecast of the relevant external conditions which will dominate over the planning period. The councils will identify these areas of impace on the university and will provide an operational description of that environment in terms of "planning assumptions." These assumptions will then become the parameters within which objectives are established and plans are conceived.

3) The integrated planning system becomes the process by which line managers work together in resolving strategic issues of importance for the entire system. The University of Alaska planning system will emerge as an integrated decision system owing not only to the integration of finance, facilities, and program decisions in the planning phase, but perhaps just as importantly, to the team approach in the reivew of unit and campus (MAU) objectives, priorities, and plans.

It is anticipated that the process of coming-together, particularly at the level of chancellor, will enhance any institution-wide activity which requires substantial amounts of coordination in order to be successful. Such is the nature of planning.

4) The strategic planning system is unique to the organizational environment in which it resides. It is generally accepted that the overriding design rule is that there is no general design. There are models, however, both corporate and academic, that can be modified to fit a particular environment.

The unique thrust of the University of Alaska effort is that the planning system will reflect a logical methodology for resource allocation contained within the routine of internal management activity. Management at the University of Alaska will tend to become more forward-looking throughout the system. As planning is made part of a manager's routine, deadlines for thinking about and describing the future become just as important as deadlines for preparing reports about the past.

5) An effective strategic planning system changes continually. One reason, of course, is that the university's internal condition is changing as a result of changes in the external environment. In addition, the design and implementation of this system reflects a significant departure from past practice which suggests that some results will be totally unanticipated and which will argue for modification in the system. Even those planning systems long established in relatively stable organizations require constant modification; thus, the University of Alaska procedures, structure, and documentation of planning will not be carved in granite, rather they will be constantly refined as the planning activity matures. Further, strategic planning systems are considered a major tool for improving the sophistication of managers, a never completed task, but one which requires a developing system to better accommodate improvements in data base, management information systems, and management techniques themselves. Finally, the short time frame for implementation of planning as a prelude to budget construction suggests that some dimension of the planning system which contemplates an 18-21 month long sequence, will not be made operational this cycle.

II. Planning Structure

The formal organization of the planning structure is contained on the chart attached (Appendix A).

There are four organization units created to facilitate the planning process:

A) University Planning Council
B) Campus (MAU) Level Planning Council
C) University Policy and Budget Team
D) Campus (MAU) Policy and Budget Team.

The primary function of the planning councils, as previously described, will be to identify the basic assumptions upon which planning will be based over some precise planning period. These assumptions will normally include such areas as program emphases during planning periods, sources of financial support, and student enrollment projections, as well as broader areas of concern including legislation, economics, and social, cultural, and technological trends. These councils will function at both the MAU and university levels, are composed of a broad cross-section of university staff personnel, are advisory in nature, and will serve to assist line management in its planning function.

The other basic organization form is the Policy and Budget Team, also organized at both MAU and university levels. At the campus level it may already exist in the form of an administrative council; at the university level it is composed of the four chancellors and executive staff of the university. These two units constitute a decision-making dimension of the planning activity and it is these teams which carry out the annual review, first of the deans and directors, and then of the individual MAU plans and budget. This activity occurs once a year as an allocation process and then constantly throughout the year as a reallocation function.

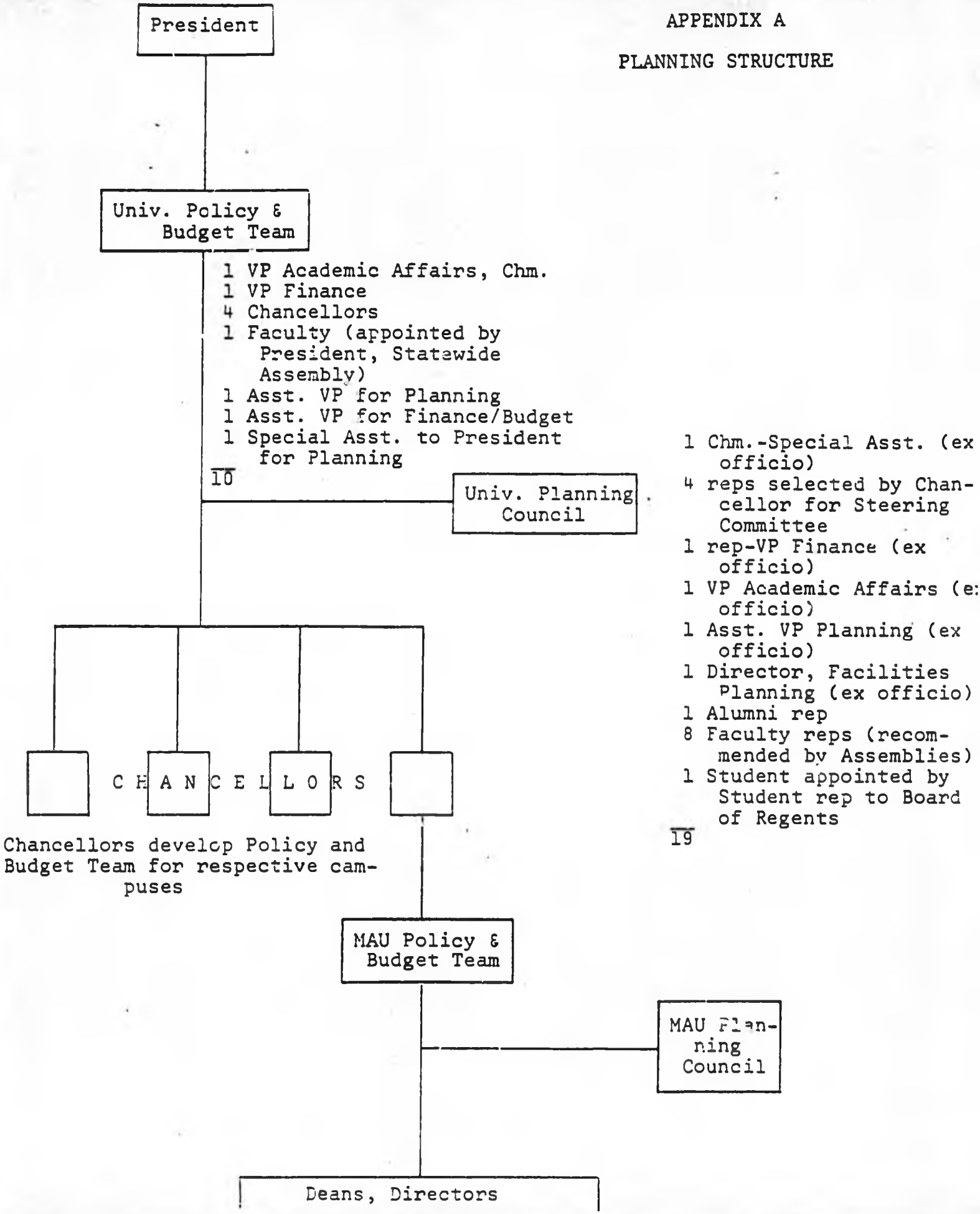
While not mentioned above, it is nonetheless important to stress the planning activity which will occur at the level of each individual dean or director and which may involve department heads and others in the formulation of goals and objectives, priorities and specific budgetary requests - all as part of the planning process. The sum of that effort will constitute the agenda of formal review in conference with the Policy and Budget Teams. Campus plans will be carefully conceived; resource allocations and reallocations which grow out of that planning activity will come to constitute an effective and dynamic strategic management system.

William G. Phillips

January 21, 1980

APPENDIX A

PLANNING STRUCTURE



HB
752

Alaska MUNICIPAL League

TELEPHONES
(907) 586-1325
586-6526

204 N. FRANKLIN ST.
JUNEAU, ALASKA 99801

To: House HESS Committee Members

From: Alaska Municipal League

Re: HB 752 - Cultural Facilities Fund

The Alaska Municipal League supports HB 752. Part I of the 1980 Policy Statement which was adopted by the delegates at the last annual local government conference, reads as follows:

"H. Cultural, Civic and Convention Centers and Museums

While legislation has been enacted into law to enable the state to assist local communities in the construction, maintenance and operation of cultural, civic, convention and community recreation centers, only minimal funding has been available for this purpose. The League, therefore, urges the Legislature to authorize the issuance of bonds for this or any similar legislation in an amount sufficient to meet the construction requirements in Alaska communities."

The AML's Board of Directors also cited this as one of eleven top priority items when they met in Juneau in January.

List of Witnesses - 3/17

Anchorage

CAROL OERTNER (1)

RUTH R. HART

[redacted]

JIM [illegible]

JOE HERMANSON

DAVID CARLSON - MAYOR

EMMA O'BRIEN

DAN O'BRIEN

LEROY OWENS

K. KASE

MICHAEL CAUDILLEO

MATILDA KUSHNICK

EDNA WENDOETE

KEITH STUMP

[redacted]

Bethel

Nome

Kotzebue

For

ROY INOUYE - ARES.
OR WOOD - CITY MAYOR
~~DR. WOOD, CITY MAYOR~~

RUTH BURNETTE, CITY COUNCIL WOMAN

BEN HARDING F.N.S. BOROUGH (PUBLIC INFO.)
MARY BEKKLEY
~~[redacted],~~

BOB VAUGHN - ~~OBSERVE CASE AT THIS TIME~~

Glenn Deckert

Kenai Peninsula (Rhoda)

KATHY SUTTLE
FRANCES MEEKS
~~VINCENT O'REILLY - MAYOR~~

FRANCIS M. JONES

Kodiak (Mary Jo)

ROGER PAGE

BOB ALDRICH

HAZEL JONES

ART JOHNSON

Sitka

MARJORIE LLOYD

* JAN CRADDICK

MELODY [illegible] WILLIAMS

HADI LANGSELOT
COLTHILDE BEHOUEC

~~[redacted]~~

KOOTAK

GEORGE PRUZ

PAT SZABO

NANCY MISSAL

OON [illegible]

CAROLYN [illegible] O

BETTSY MOORE

BOB THOMAS

EVA [illegible]

EMERY WELCH

FOSGINA JOHNSON

MARYAN FOLTZ

DR. BOB JOHNSON

NICK SZABO

VICKY WICKERSHAM

CHRIS ALDRIGE.

List of Witnesses - 3/17

Anchorage

CAROL OERTNER (1)

RH - R. HART (7)

BILL TILLMAN

LOIS HERMANSON (3)

DAVID CARLSON - MAYOR

ERMA O'BRIEN

JAN O'BRIEN

Leroy Owens

K. KAY

MICHEAL CAUDLIEIO

Virginia ~~Kleppen~~ Klepser (16)

MATILDA KUSHNICK

RON WENDETE (11)

KEITH STUMP.

[redacted]

SAXMAN

(4) ?

Bethel

Nome

Kotzebue

Fbx

(5) ROM / NOLYE. - ARCS. OR WOOD - CITY MAYOR

(17) ~~DR. WOOD, CITY MAYOR~~

(9) RUTH BURNETTE, CITY COUNCILWOMAN

BEN HARDING F.N.S. BOROUGH (PUBLIC INFO.)

MARY BENKLEY

~~[redacted]~~

(12) ## BOB VAUGHN - ~~OBSERVE CUCY AT THIS TIME~~

Glenn Deckert (6) KATHY SUTTLE

(10) FRANCIS MEEKS

~~VINCENT O'REILLY - MAYOR~~

Kenai Penin (Rhoda)

(13) FRANCES M. JONES

Gail Blend

KORTAK (MARY JO)

ROGER PAGE

BOB ALCRIGE

HABEL JONES

ART JOHNSON

~~[redacted]~~

Sitka

MARGINE LUND

* JAN CRADDICK

MELODY ~~[redacted]~~ WILLIAMS

(14) HADI LANGSELOT

COLTHILDE BEHOUEC

~~[redacted]~~

Maddey

KOREA

GEORGE PRUZ

PAT SZABO (1)

NANCY MISSAL

DON FIELDS

CAROLYN KLOPO

BETTSY MOORE

BOB THOMAS

EVA BOWERS

EMERY WELCH

FOSCINA JOHNSON

MARYAN FOLTZ

DR. BOB JOHNSON (2)

NICK SZABO

VICKY WICKERSHAM

CHRIS ALDRIGE.

P. O. Box 3964
Kenai, Alaska 99611

March 6, 1980

Ms. Thelma Buchholdt, Chairman
Health, Education and Social Services Committee
Pouch V
State Capitol
Juneau, Alaska 99811

Dear Ms. Buchholdt:

The community and City of Kenai are supporting House Bill No. 752. The need is here for a cultural facility in Kenai.

The arts are active in Kenai, but we are in need of an adequate communal facility. At the present time, the visual art groups are meeting and working in the old firehall; the concerts are being held in the high school gymnasium; and the museum is housed in a portion of the Senior Citizen's Center.

Under adverse conditions, the performing arts in Kenai rank at the top in the state on a per capita basis with audiences ranging from 300-1300 on backbreaking bleachers.

I ask your support of House Bill No. 752.

Sincerely,

Kathy Settle
Kathy Settle

We the undersigned request your support of House Bill No. 752 which is a Bill for an Act entitled:

"An Act making a special appropriation for the cultural facilities development fund; and providing for an effective date."

Jeff Tripp
Irene Richardson
Velma Buell
Marge O'Reilly
Patrick J. Malone
R. Dale Gill
Kevin E. Moore
Michael Sheppard
Craig Phillips
Jack Dickason
Wayne Mallon
Connie Carlson
Jennifer Welch
Jim Shaffer
Brent L. Stevens
Shirley Jackson

Pat L. Ahl
Kathleen Murphy
Wanda Carlson
Edona Stockton
Dorothy Barker
Ruth McMillan
Debbie Hamel
Jean McMahon
Rosemary K. Bird
Lydia Spotted Morning
Walter Larson
Lucian Nye
Cathy Robinson

We the undersigned request your support of House Bill No. 752 which is a Bill for an Act entitled:

"An Act making a special appropriation for the cultural facilities development fund; and providing for an effective date."

Sharon K. Averman
Janice M. Daniels
Patricia Carter
Donna O. Rogers
Anthony J. Warren
Bonnie E. Warren
Geraldine Sparks
Mary Rounds
[illegible]
Andy Clarke
Robin M. Tangye
[illegible]
Frances M. Jones
Hyda Shields
Shirley M. Burns
Janice L. Hutchins

Mary E. Bailey
Pearson G. Bailey
Carol Cambarian
Ruby Windsor
Joseph Hays
[illegible]
Eugene R. Gibbs
Ralph C. Glover
Bertie Schneider
Leslie E. Schneider
[illegible]
Robert K. Schultz
Rhoda Corrigan
Wilma Hurst
Milford Hurst
Hunt C. Turner

Linda Hoegen
Leslie Kinzer
Jacquie Isle
Ledrdrs N Lewis
Mary Jeanne Lewis
Cecil M. Handley

City of Hydaburg
Box 49
Hydaburg, Alaska 99922
(907) 285-3761

March 10, 1980

Representative Thelma Buchholdt
Representative Joyce Munson
Representative Vernon L. Hurlbert
Representative Bill Miles
Representative Ramona Barnes
Representative Mike Beirne
Representative C.V. Chatterton
Pouch V
Juneau, Alaska 99811

Dear Representatives:

My letter to you is in strong support of House Bill No. 752. We, as citizens of Hydaburg, support the act of making a special appropriation for the cultural facilities development; and providing for an effective date.

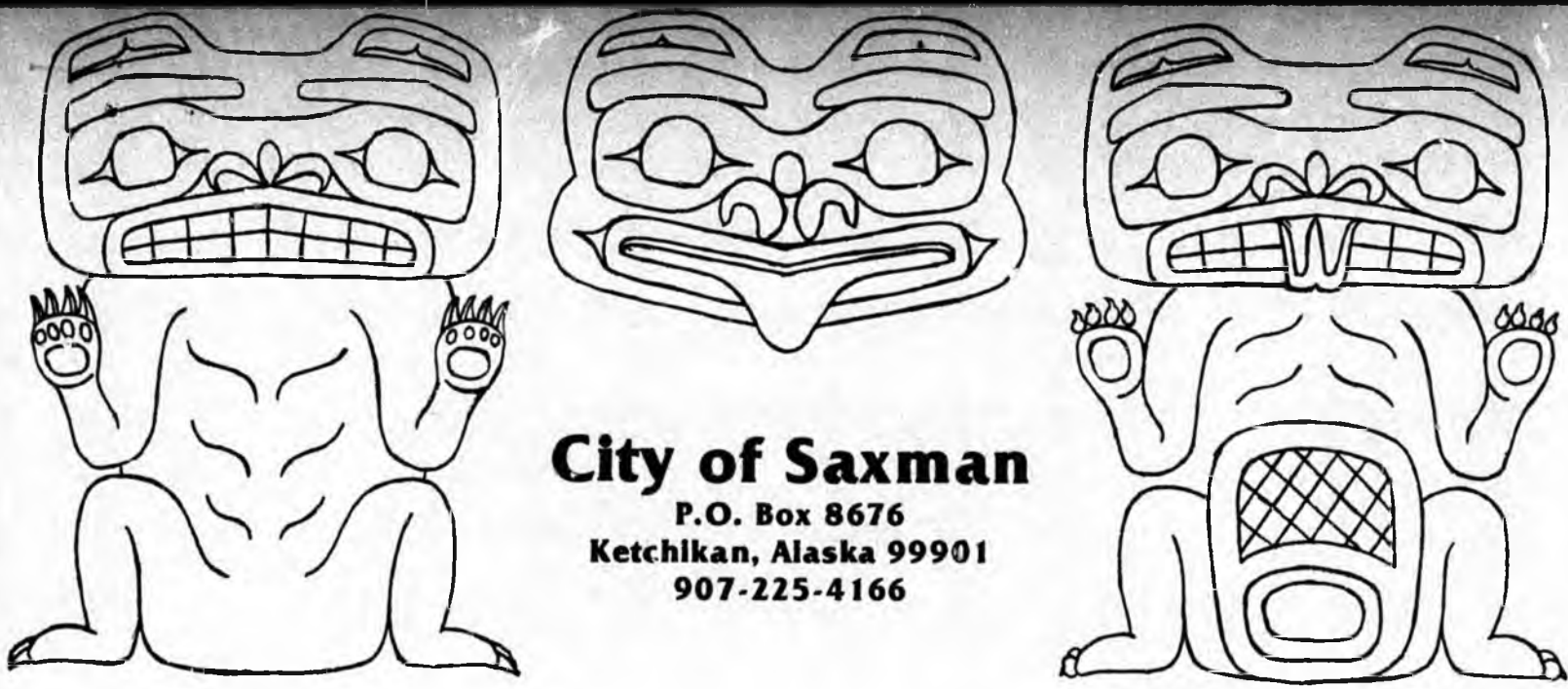
Hydaburg has applied for funds for a Cultural Facilities Grant. Being that we are the only HAIDA Enity here in Alaska your support on our behalf would be much appreciated. A museum will preserve our hertiage and give us some public place to show-off and store our artifacts.

Once again we are in support of HB 752.

Sincerely,

Blanche Kelley

Blanche Kelley
Administrative Assistant
City of Hydaburg



City of Saxman

P.O. Box 8676
Ketchikan, Alaska 99901
907-225-4166

March 7, 1980

The Honorable Thelma Buchholdt
Chairman of HESS
Pouch V
Juneau, Alaska 99811

Dear Representative Buchholdt,

The City of Saxman is a native village. Here, the native culture has become almost a memory. With each death of an elder, the lessons of the past move further out of reach of our youth. With each artifact taken out of the community, another symbol which identifies the people with their past disappears.

Without language, custom and symbols, people have no cultural identity. If the stars and stripes were to suddenly disappear with what would America have to remember the past or envision the future. The very structure of civilization mandates sociopoliticoeconomic diversification to insure continued creativity and appropriate progress. Without this, living would be very stale and non-productive.

By supporting the approval of House Bill No. 752, the legislature is supporting a healthy, productive and integral program development which will not only assist native communities in rediscovering their past, but all communities will be provided a basis for combatting the main antagonists that produce cultural anomie, namely, apathy, alcoholism and drug abuse.

The City of Saxman supports House Bill No. 752 and strongly urges its approval and passage, because it will provide a facility, the principal purposes of which is to serve both the visual and per-

forming arts and as the repository of historical and contemporary heritage of the community and its people.

Sincerely,

W. K. Williams

William K. Williams
Mayor of Saxman

T. F. Martinez

T. F. (Jim) Martinez
I.R.A. President

Michael J. Tavoliero

Michael J. Tavoliero
Saxman City Manager

CC: The Honorable Jim Duncan
The Honorable Nels Anderson
The Honorable Margaret Branson
The Honorable Fred E. Brown
The Honorable Thelma Buchhholdt
The Honorable Richard I. Eliason
The Honorable Oral Freeman
The Honorable E.J. Haugen
The Honorable Hugh Malone
The Honorable Bill Miles
The Honorable Mike Miller
The Honorable Joyce Munson
The Honorable Patrick M. O'Connell
The Honorable Bill Parker
The Honorable Brian Rogers
The Honorable Fred F. Zharoff
The Honorable Terry Gardiner
The Honorable Vernon L. Hurlbert
The Honorable Mike Beirne
The Honorable C. V. Chatterton

Rt. 3, Linwood
Kenai, AK. 99611
March 8, 1980

Dear Thelma,

Hope your Committee will vote for our cultural facilities appropriation.

We've been listening to our concerts on bleacher seats in the high school gym, displaying our art in an old fire hall, and keeping museum artifacts upstairs in the Senior Citizen's Center.

We've needed a civic center here for years. It was voted & approved nine years ago! Now, we're ready with plans, application from the city, land to build it, but not enough money.

Please help us.

Thank you!

Frances M. Jones

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CITY OF KENAI

"Oil Capital of Alaska"

P. O. BOX 580 KENAI, ALASKA 99611
TELEPHONE 283 - 7535

March 6, 1980

Thelma Buchholdt, Chairman
Health, Education & Social Services Committee
Representative, Alaska State Legislature
Pouch V
Juneau, AK 99811

Dear Representative Buchholdt:

In regard to House Bill No. 752:

Appropriation to the Cultural Facilities Development Fund

Please accept this letter as evidence of our strongest support for favorable passage of the above bill.

Working with the State organization and our local group has produced sufficient evidence that the timing is correct, the need is there and the capability exists to bring Alaska to the forefront of facilities in existence. Such facilities will honor our historic heritage and bring current culture experience to our citizens.

Your most earnest attention is respectfully asked.

Sincerely,

Vincent O'Reilly
Mayor

VOR:jw

cc: Kathy Settle

Box 3797.
Kenai AK 99611
March 6. 1980.

Helma Buchholdt, Chairman.
Health, Education and Social Services Committee.
Alaska Legislature, Juneau, Alaska.

Dear Mrs Buchholdt,

As a member of the Central Peninsula Concert Association, I must urgently request that you support House Bill No 752, which is in your committee.

Kenai has met all the requirements of the Cultural Facilities Development Committee, Inc., and are ready to move forward with the facility, when the funds are appropriated.

The Concert Association would find it easier to schedule cultural activities, having the proper facilities, presently the scheduling has it be made around the local schools use of their facilities, which is far from being adequate and has very poor acoustics.

Thank you,
Sincerely
Constance Jackson
Central Peninsula Concert Assoc.
Board member.

CULTURAL FACILITIES PROGRAM

Goals and Objectives – To develop, strengthen and diversify Alaska's economic base through construction of facilities for cultural uses. Utilize the State's natural resources to benefit the human resources. Stabilize the State's population base by offering the cultural amenities that now are achieved by Alaska residents only through extensive travel out of State. Improvements to Alaska's standard of living and an increase in employment opportunities are corollary objectives.

Strategy – Implement Sec. 43.18.500 – An Act authorizing State matching grants for construction of cultural facilities: 1) adopt regulations; 2) prepare application forms; 3) review recommendations from the Advisory Council on Cultural Facilities; and 4) fund those facilities that have submitted a complete application and have met all the requirements of the Act.

Economic Influence – This unique program achieves, to a very significant extent, Governor Hammond's policy theme No. 4, to encourage economic development which offers long-term net benefits to all Alaskans.

Facilities for cultural uses can be considered an integral part of a community, not only in the terms of its "quality of life," but also in terms of contributing to improvements in the local economy.

The facilities will stimulate a visitor clientele, they will serve as additional attractions to enhance the labor intensive tourism industry. The Alaska tourism industry will benefit substantially as past experiences, such as at Ashland, Oregon, have shown that the impact of cultural activity on tourism is more striking in remote than in cosmopolitan settings.

The funding of cultural facilities, rather than representing an expenditure by the State and Alaska communities, are, in fact, seed money which generates more than its original cost in revenues to the cities.

In Anchorage, for example, the combined expenditures in the arts for salaries, fees, goods, services, related advertising and promotion, and other expenditures will total $2.5 million in 1980. The combined revenues are also projected to exceed $2.5 million according to budget data of the Anchorage Arts Council.

Research conducted by the Special Assistant for Cultural Resources in the U.S. Department of Commerce indicate that, for every one dollar of funds spent for cultural centers, that between three and four dollars are generated for the community, directly and indirectly.

Many Alaska cultural centers will include facilities for the creation and production of hand crafts. A high labor intensive activity, this cottage industry furnishes a primary source of income for more than 1,300 Alaskans and a supplemental income for thousands more. The historical and cultural buildings will serve to enhance and facilitate the creative activities of these craftsmen, plus encourage more unemployed or under-employed Alaskans to become craftsmen and increase their incomes.

Benefits – The vast majority of Alaska residents can benefit directly from this program utilizing partial State funds for cultural centers. Others will benefit when travelling to the regional centers and utilizing the facilities constructed by many of the larger municipalities, e.g., Anchorage intends to construct an elaborate cultural complex under the program. Most rural Alaskans residing in the communities of Western Alaska travel to Anchorage for trade and services offered. They will have the opportunity to benefit from use of the facility, not only in the performing and visual arts, but as a repository of Alaska's historical and contemporary heritage.

Advisory Council on Cultural Facilities – Five members appointed by Governor Hammond on September 27, 1979 are:

Carol A. Derfner, Chairperson
402 W. Third Avenue
Anchorage, Alaska

Jane Stewart, Vice Chairperson
925 Calhoun
Juneau, Alaska

Allan P. Gregg
Box 1078
Wrangell, Alaska

Mary E. Binkley
P.O. Box G
College, Alaska 99708

Lois R. Hermansen
PHS, Kanakanak
Dillingham, Alaska 99576

Responsibilities of the Council – The Council has four responsibilities: (1) establish the criteria for making grants for construction of cultural facilities; (2) advise the Commissioner of Commerce and Economic Development of the priority ranking of the approved requests for financial assistance; (3) provide assistance to municipalities in preparation of a need assessment and review proposals for construction or development of cultural facilities upon request; and (4) submit an annual report to the Commissioner and the Legislature, summarizing activities and expenses of the Council.

Program's Major Deadlines: (FY '80)

1. September 27 – Appointment of Cultural Facilities Advisory Council (CFAC)
2. December 1 – Advise each municipality in Alaska of program.
3. January 30 – Formal adoption of regulations.
4. January 31 – Applications deadline, first cut.
5. February 20 – Recommendations to Commissioner of Commerce by CFAC.
6. April 4 – Public hearings and community facility evaluation.
7. March 31 – Final deadline for 1980 applications.
8. April 20 – Final recommendations to Commissioner of Commerce and Economic Development.

ALASKA CULTURAL FACILITIES PROJECT

As of February 13, 1980, eleven communities have completed the application process. They are listed alphabetically below:

Municipality	Type of Facility	Local Cost	State Cost	Total Cost
DILLINGHAM	Com. Cultural Facility	160,806	3,578,864	3,739,670
HOONAH	Museum	369,000	23,300	392,300
HYDABURG	Cultural Center/Museum	20,000	490,000	510,000
JUNEAU	Performing Arts Center	1,990,070	13,804,140	15,794,210
KETCHIKAN	Cultural Center	724,100	7,266,140	7,990,240
KODIAK	Cultural Center	343,200	6,256,800	6,600,000
METLAKATLA	Performing Arts Center	187,200	1,507,426	1,694,626
PETERSBURG	Fine Arts Center	200,000	5,335,000	5,535,000
SAXMAN	Long House	158,756	1,312,775	1,471,531
SITKA	Intercultural Center	1,318,000	10,524,900	11,842,900
VALDEZ	Com. Auditorium Project	1,750,000	1,750,000	3,500,000

Other applications nearly completed which may arrive within the next week include: (5,477,550.00) (St Emb 5,112,745.00)
ANCHORAGE, KENAI, YAKUTAT and HOMER.

Other communities who have expressed interest in the project or who are now in the pre-application process include:

KLAWOCK, CRAIG, NAKNEK, FAIRBANKS, SKAGWAY, TENAKEE SPRINGS, ALAKANUK and CORDOVA.

December 12, 1979

SUMMARY STATEMENT CULTURAL/CIVIC CENTER FOR KENAI

The need for a Cultural/Civic Center in Kenai has been recognized for many years. A bond issue was passed in 1971 addressing this need, but due to diverse circumstances at City and State levels, funds were never available for this purpose, leaving citizens with a library only.

Needs as presently assessed include:

1. An Auditorium
2. A Museum
3. A Visual Arts Area
4. Meeting Rooms

Present facilities in Kenai are either non-existent or physically inadequate and/or technically outmoded.

Performing Arts

Currently, Kenai Central High School Gymnasium is used for most performing arts presentations, with scheduling a major problem since this facility is used for competitive sports events, practice schedules, and community adult recreation. For performing arts groups, acoustics are inadequate, proper lighting is impossible, and seating for the audience is back-breaking. Performances must be scheduled far in advance, and often require last-minute re-shuffling with on-going school activities. The Little Theatre at the high school accomodates only 140 people, which makes it useless for visiting performing groups, since our audience in attendance is usually in excess of 300 people. Last year, eleven performances were scheduled in the high school gym by Central Peninsula Concert Association, with attendance at one performance exceeding 700 people.

The Kenai Performers have been inactive because of lack of performance art facilities. The Peninsula Dancers continue to present an annual performance in spite of lack of a theatre.

It is planned that a medium-sized theatre with fixed seats for 600 people adjoin a flat-floor "forum" area with telescoping mechanized seat banks capable of holding an additional 400 people. This multi-purpose pavillion could be used for banquets, group conferences, trade shows, art fairs, dinner theatre, and square dancing. A caterer's kitchen enables this area to be used for a variety of public functions, even at the same time the theatre is being used in the adjacent area. A moveable wall unit would close off this multi-purpose area from the auditorium visually as well as acoustically.

The Museum

At the present time, there is no museum in Kenai. Heritage items are on display in the Senior Citizen Center, upstairs in the Old Fort Kenay Building. It is inadequate in size (approximately 700 square feet), is not adequately protected with fire humidity controls and safekeeping of irreplaceable articles is in constant jeopardy. Floor space is so inadequate there that donations of museum pieces and artifacts is impossible at this time, there is simply no place to put them. This make-shift

The Museum (Cont'd)

museum is housed jointly with the Senior Citizen Coordinator, who occupies part of the floor space. It is not accessible by ramp by handicapped persons, although there is a lifter for Senior Citizens to be hoisted from the center below. However, when the downstairs room is closed, an exterior stairway is the only way to reach the upstairs area. Kenai is such a historic place, a museum would offer both residents and visitors alike a glimpse into the past as well as providing a safe place for heritage objects.

Visual Arts

The Kenai Fine Arts Center (the old City Firehall) is presently available for use by cultural groups. Fourteen arts and crafts workshops were held there during the past year, involving both children and adults. A gallery is open throughout the year, but since the gallery space is needed for art classes, this presents the problem of shifting standards, re-hanging pictures, and re-structuring for every activity. However, this is not the major problem, the building is uninsulated and is extremely cold during winter months when it is needed most. The pottery room is also extremely cold, is not equipped with a sink and is not properly vented for firing pottery. In spite of these adverse conditions, there is a waiting list of people in the community who want to take pottery classes.

Benefit to Community

Employment and business opportunities would increase by doubling the potential visitor tourism business and extending the season.

Opportunities to attract plays, concerts, art shows and specific talent to the community would expand.

The economic stimulus due to increased revenues from gatherings such as conventions would help defray maintenance and operation costs of the civic center.

Economic long-term gains would be evidenced if new industries felt that our community was a more desirable place to live, work, and play. Thus, the center would be an investment in the future.

Maintenance and Staffing After Construction

The City intends to appoint a board of trustees from non-profit organizations in the community to name or create a non-profit organization to operate the facility. Revenues from activities will accrue to this non-profit organization to be available for maintenance, staffing and programming costs of the facility.

The City of Kenai accepts the ultimate responsibility of maintaining the facility. Should revenues from activities be insufficient to operate the facility, the City will provide funds as necessary to assure continued operation.

Charles A. Brown, Acting City Manager

CITY OF KENAI

"Oil Capital of Alaska"

P. O. BOX 580 KENAI, ALASKA 99611
TELEPHONE 283 - 7535

February 11, 1980

M-E-M-O-R-A-N-D-U-M

Mayor

TO: KENAI CITY COUNCIL AND CITY DEPARTMENT HEADS

FROM: C. A. Brown, Finance Director

SUBJECT: Civic Center Grant Application and Funding

I request that the above subject be added to the items to be discussed at the January 14, 1980 worksessi n.

We have started on the grant application for this project, and before submitting the application, I want to make Council aware of the funding situation. I have enclosed the tentative grant project budget for review. First, the City's local share should be 6.66%. This is derived from the following formula: per capita value of property in Kenai divided by per capita value of property in the State of Alaska times 10%, or $32,066 ÷ by $48,115 x .10.

Our share of the project, estimated at $364,805, is comprised of $178,000 land value and $186,805 cash. The cash is available in the Civic Center bond fund ($335,500 less $120,000 for Health Center portion of City Hall equals $215,500 available). I have been assured that the $178,000 of land value may be taken as match, even though we intend to lease the land and the $178,000 is included in the total project cost for application of the State's share percentage.

The Council must be aware that:

(1) We will be responsible for cost overruns of construction.

(2) The application calls for hiring a manager.

(3) We will be responsible for operation and maintenance costs.

If you have any questions, please let me know at the February 14, 1980 meeting. Thanks.

CAB

STATE OF ALASKA
DEPARTMENT OF COMMERCE AND ECONOMIC DEVELOPMENT

CULTURAL FACILITIES GRANT PROGRAM
GRANT APPLICATION

1. General Information

Name of Municipality	Date
City of Kenai	Feb.

Address: Street or P.O. Box	City	State	Zip Code
P.O. Box 580	Kenai	Alaska	99611

Project Title	Start Date	Est. Completion Date
Kenai Civic Center	May 1, 1981	May 1, 1982

Area Served	Election District
Kenai	Kenai # 13

Cultural Facility Type		Project Characteristics	
☒ Theater	☒ Concert Hall	☒ Totally new facility	☐ Addition to existing facility
☒ Gallery	☒ Museum	☐ Renovation of a facility	☐ Major maintenance or repair
☒ Other visual Arts, meeting Rooms community		☐ One of several phases	☐ Other - explain

2. Site Features

Location or Legal Description	Site Currently Owned
Lots 1, 2, 3, 11, 12, & 13, Block 2, Fidalgo Commercial Center Subd.	☒ Yes ☐ No

If not owned by the municipality - attach a copy of the lease agreement. See attached info from Finance Director

Are All Utilities Available	Is Access Already Available
☒ Yes ☐ No planned	☐ Yes ☒ No Planned

3. Project Costs

Is all of proposed building eligible for funding under the conditions of AS 43.18.500 ☒ Yes ☐ No

If no, what percentage of the building is eligible: N/A

Explain: N/A

Total Project Costs	$5,477,550
Land/Real Property (cost of purchase/lease)	178,000
Cash	186,805
Total Local Match	364,805
Total Funds Requested From The State	$5,112,745

4. Operational Costs

First Operational Year	Annual Operational	Positions (Full time employment)
$170,000	$170,000	One

Funding Source:

☒ General Revenue ☐ Special Tax ☒ Income From The Building
☐ Increase in Property Tax ☒ Private Donations ☐ Other - Explain

5. Approval (Voter)

☒ Authorization of a general obligation bond to provide the contribution of the municipality to the project

☐ Voter approval of the dedication of the proceeds of a general tax of the municipality to the project

☐ If no local cash match is required, an affirmative vote of the majority of the voters at a regular or special election

Municipality	Signature	Date
City of Kenai	Acting City Manager ~~MAYOR~~	

08-043 (11/79)

6. Project Narrative (Refer to instructions on back)

I. Project Need Statement

See attached "Summary Statement Cultural/Civic Center for Kenai."

II. Project Description

P Upper level to be 18,220 sq. feet. Auditorium will have 600 fixed seats, expandable to 1000 seats. This level will also have community meeting rooms, lobby, + Toilets. Stage: 40' proscenium with 20' wings. Stage is 40' deep with fly loft, 60 line grid, and traps. Rehearsal space and scene storage will also be provided.

P Lower level has 5000' gallery/museum with visual arts. This level also includes dressing rooms, green rooms, musicians' dressing rooms, orchestra pit, and mechanical room totaling appr. 4,680'. P Total area of facility to be 27,900'.

III. Identification of Alternative Considered

All existing facilities were examined and found to be inadequate for the uses intended for this new facility. For a broader description, see attached "Summary Statement. Cultural/Civic Center for Kenai."

7. GRANT PROJECT BUDGET

Project Name

Kenai Civic Centre

Location

Lts 1, 2, 3, 11, 12 + 13, Blk 2, Fidalgo Commercial Ctr. Subd.

LAND City owns title = appraised value	175,000	
Appraisals	+	
Acquistion	+	
	TOTAL	175,000
SITE INVESTIGATION		
Soils Information	2,500	
Land Survey	+	
Inspection	+	
Water Survey	+	
	TOTAL	2,500
OTHER SERVICES		
Archeological Study	+	
Design Reviews	+	
Cost Control	+	
Program Consultant	+	
Work of Art	43,050	
Other	+	
	TOTAL	43,050
DESIGN SERVICE		
Architect Fees	374,000	
Engineer Fees	+	
Sub-contractors	+	
Reimburable Expense included in Architect fees	+	
Additional Services	+	
	TOTAL	374,000
ADMINISTRATION		
Municipalities Administrative Charge		
	TOTAL	
CONSTRUCTION		
Construction-Remodel-Repair	+	
Construction, New	4,100,000	
Contingency	205,000	
	TOTAL	4,305,000
EQUIPMENT (& FURNISHINGS)	**TOTAL**	575,000
FINANCING		
Interest on Bonds Issued to Finance Project		
Bond Agents Fee for Bonds Issued		
	TOTAL	+
OTHER		
Indemnity and Surety Bonds		
Premiums on Insurance		
Legal Fees		
Fees and Expenses of Trustees, Depositaries, Financial Advisors		
	TOTAL	+
TOTAL PROJECT COST		5,477,550
LOCAL MATCH 6.65 %		364,805
TOTAL FUNDS REQUESTED 93.34 %		5,112,745

STATE OF ALASKA
DEPARTMENT OF COMMERCE AND ECONOMIC DEVELOPMENT

CULTURAL FACILITIES PROGRAM
COMMUNITY READINESS FACTORS

A. Community planning and support

1. What method was used to facilitate the community planning input?

☐ Survey questionnaire ☐ Public hearing ☒ Public planning session

☐ Other _____

What percentage of user groups have made a contribution to the planning process ..... 100 %

2. Has your local government body prioritized the cultural facilities in its planning ☒ Yes ☐ No

If so, how is a cultural facility ranked?

☐ Top priority project ☒ In the top 5 projects

☐ In the top 10 projects ☐ Lower than tenth priority

B. Length of planning time

1. When did you begin formal planning for this facility?

☒ Prior to 1974 ☐ 1975 ☐ 1976

☐ 1977 ☐ 1978 ☐ 1979

C. Readiness to build

1. When could you start building?

☐ 1980 ☒ 1981 ☐ 1982 ☐ 1983

☐ 1984 ☐ 1985 ☐ 1986

D. Quality and suitability of facility

1. Was a need assessment study completed for this proposed building? ☐ Yes ☒ No

If yes, please attach a copy. No formal written study

2. Is your proposed building designed for the particular site on which it will be built? ☒ Yes ☐ No

3. Do you have a theater planner approval design? ☐ Yes ☒ No

4. What will be the primary use of this building?

Performing arts, museum, arts gallery. Facility to be used by both local and touring groups.

5. What will be the secondary uses of the building?

Community meeting; draw convention and visitor business to community.

6. What hours of the day will the new or renovated facility be available to theater/museum groups?

Appx. 9:00 am to 12:00 midnight

7. What percentage of the total facility use time will be available to theater/museum groups?

This is top priority. Thus, up to 100% of available time.

E. Maintenance and operating capability

1. Detail as closely as possible how the operating and maintenance expenses will be funded:
For example what portion would be funded through:

46 % General revenue

46% User groups, or other income generated by facility

_____ A special tax

8 % Private donations

_____ _____ Increased property tax

2. Would any of the above actions require a special election? ☐ Yes ☒ No
If yes, explain:

3. Do you have a management plan that includes the hiring of professionally qualified management? ☒ Yes ☐ No

4. Has this plan been approved by your municipal government? ☒ Yes ☐ No If not, explain:

F. Availability of land

1. Has the site for your facility been determined? ☒ Yes ☐ No

2. Who owns the land? ☐ Privately owned ☒ City/Borough ☐ State ☐ Federal — See attached Memo from Finance Director

3. If the land is not owned by the city/borough, will the land be purchased? ☐ Yes ☐ No

Please estimate the cost of such land ..... N/A

G. Alternatives to completion of proposed facility

1. Could existing buildings be redeveloped for use as a cultural facility (Give a brief explanation)

No, none are suitable, both in terms of size and design.

2. Have any cost estimates been made on redeveloping existing building? ☐ Yes ☒ No
If so, please explain:

3. Do you have a historical property or building of historical value which is part of a historical district that could be rehabilitated for use as a cultural facility? ☐ Yes ☒ No
If yes, describe briefly the property or building:

4. Have any cost estimates been made for the rehabilitation of historical property or building? ☐ Yes ☒ No

H. Per capita benefit

1. Per capita benefit of proposed cultural facility

Suggested formula:

$$\frac{\text{Cost of the facility}}{\text{Population of area being served}} = \text{Per capita benefit effectiveness}$$

$$\frac{\text{Cost } \$5,477,550}{\text{Population } 4,436} = \$1,235$$

STATE OF ALASKA
DEPARTMENT OF COMMERCE AND ECONOMIC DEVELOPMENT
CULTURAL FACILITIES PROGRAM
EXISTING PERFORMING ARTS FACILITY ADEQUACY DETERMINATION

A. Availability of existing facilities

1. Who owns the facility?
Kenai Peninsula Borough School Dist.

2. List names of user groups
Central Peninsula Concert Association
Peninsula Dancers
Kenai Performers
Redoubt Chamber Orchestra
Community Chorus
Sweet Adelines

3. What hours of the day is the facility (for cultural uses) available to performing groups?
Between school activities and community functions.

4. What proportion of the total facility time is available for cultural uses?
5 percent (approximately once a month)

B. Quality of existing facility

1. Do you have space for cultural uses? ☒ Yes ☐ No

2. Factors to determine adequacy of existing facilities

YES	NO	
☐	☒	Raked auditorium floor
☐	☒	Adequate theater seating
☐	☒	Adequate acoustics
☐	☒	Rehearsal room
☒	☐	A stage
☐	☒	A stage that is at least 40' by 30' in size
☐	☒	A resilient stage floor
☐	☒	Adequate cross-over
☐	☒	Light booth in the rear
☐	☒	Adequacy of fly space
☐	☒	Riggings
☐	☒	Wings
☒	☐	Dressing room(s)
☐	☒	Costume shop
☐	☒	Scenery shop
☐	☒	Storage shop
☐	☒	Dimmer board
☐	☒	Sound System
☐	☒	Loading door on stage level
☒	☐	Adequate voluage (touring groups usually require 200 amps 110 volts A.C.)
☐	☒	Orchestra pit

5. Is the fee schedule a factor in availability? If so, please explain:
No

6. Please describe the quality of existing facility:
The high school gymnasium is unsuitable for performing groups. It must be scheduled months in advance, with conflicts arising with high school sports and other community activities. Bleacher seats are uncomfortable and acoustics totally inadequate.

SEPARATE FORM TO BE COMPLETED FOR EACH FACILITY

STATE OF ALASKA
DEPARTMENT OF COMMERCE AND ECONOMIC DEVELOPMENT

CULTURAL FACILITIES PROGRAM

EXISTING GALLERY, ~~MUSEUM AND HERITAGE~~ & VISUAL ARTS CENTER ADEQUACY DETERMINATION

A. Availability of existing facilities

1. Who owns the facility?
City of Kenai

2. List names of user groups
Kenai Arts & Humanities Council
Kenai Art Guild
Peninsula Dancers (costume storage)
Peninsula Photographers' Guild
Totem Tracers (Geneology group)
Beta Sigma Phi
Cooperative Extension Service

3. What hours is the facility open to the public?
Summer: Mon.-Sat., 10 a.m. to 4 p.m.
Winter: Thurs.-Sat., 10 a.m. to 4 p.m.

4. What proportion of total facility time is available for museum related activities, e.g., visitation, education programs, workshops, etc.
available to all groups by scheduling in advance.

B. Quality of existing facility

1. Do you have space for facilities for ~~cultural/historic~~ visual arts programs? ☒ Yes ☐ No

2. Factors to determine adequacy of existing facilities.

YES	NO	
☐	☒	Adequate collections and supplies storage space
☐	☒	Adequate permanent and gallery exhibits space
☐	☒	Adequate space for educational programs; e.g., school groups, lectures, films, workshops, etc.
		Adequate security protection for collections, staff and public:
☐	☒	a. Intrusion alarm system
☐	☒	b. Fire suppression system (halon preferred)
☐	☒	c. Facility safe public use
☐	☒	d. Proper exhibition security systems, e.g., locable exhibit cases, system to monitor visitor activities, etc.
		Adequate environmental controls:
☐	☒	a. Temperature and humidity control in facility
☐	☒	b. Control of ultraviolet light
☐	☒	c. Pollution control, e.g., dust and dirt
☐	☒	d. Secure from insect and other pest hazards
☐	☒	Safe area in facility for fumigation of objects
☐	☒	Shop: Exhibits fabrication and graphic arts preparation area
☐	☒	Adequate staff office space
☐	☒	Adequate public reception and gift shop space
☐	☒	Adequate exhibits lighting
☐	☒	Adequate collection storage equipment - i.e., cabinets, shelving, etc.

5. Please describe the quality of existing facility:

The building in use as a visual arts center is the old city fire hall and jail, constructed of cinderblock. It is uninsulated, inadequately heated, poorly lighted and too small in size for annual art exhibits. Wiring is totally inadequate. An added-on pottery room is extremely cold, lacks sufficient wiring for an additional kiln, has no hot water, and is not properly vented for firing pottery.

STATE OF ALASKA
DEPARTMENT OF COMMERCE AND ECONOMIC DEVELOPMENT

CULTURAL FACILITIES PROGRAM

EXISTING GALLERY, MUSEUM AND HERITAGE CENTER ADEQUACY DETERMINATION

A. Availability of existing facilities

1. Who owns the facility?
City of Kenai

2. List names of user groups
Kenai Historical Society
Senior Citizens Services

3. What hours is the facility open to the public?
Summer: Open 7 days a week, 9-5
Winter: Open 4 hours per day

4. What proportion of total facility time is available for museum related activities, e.g., visitation, education programs, workshops, etc.
80 percent, depending upon activities scheduled for senior citizens

B. Quality of existing facility

1. Do you have space for facilities for museum and/or cultural/historic programs? ☐ Yes ☒ No

2. Factors to determine adequacy of existing facilities.

YES	NO	
☐	☒	Adequate collections and supplies storage space
☐	☒	Adequate permanent and gallery exhibits space
☐	☒	Adequate space for educational programs; e.g., school groups, lectures, films, workshops, etc.
		Adequate security protection for collections, staff and public:
☐	☒	a. Intrusion alarm system
☐	☒	b. Fire suppression system (halon preferred)
☐	☒	c. Facility safe public use
☐	☐	d. Proper exhibition security systems, e.g., locable exhibit cases, system to monitor visitor activities, etc.
		Adequate environmental controls:
☒	☒	a. Temperature and humidity control in facility
☐	☒	b. Control of ultraviolet light
☐	☒	c. Pollution control, e.g., dust and dirt
☐	☒	d. Secure from insect and other pest hazards
☐	☒	Safe area in facility for fumigation of objects
☐	☒	Shop: Exhibits fabrication and graphic arts preparation area
☐	☒	Adequate staff office space
☐	☒	Adequate public reception and gift shop space
☐	☒	Adequate exhibits lighting
☐	☒	Adequate collection storage equipment - i.e., cabinets, shelving, etc.

5. Please describe the quality of existing facility:

Existing building is two-story log construction with the 20'x30' museum space upstairs shared with the staff office for Senior Citizens Services. Exterior stairway entrance is not accessible in wintertime due to icing conditions on the steps. There is no space available for collections or storage at this time.

KENAI CIVIC CENTER

Primary Users:

Performing Arts

1. Central Peninsula Concert Association.
   9-11 programs per year.
   Attendance: 250-1200 Average 450.
2. Peninsula Dancers
   One major production each spring.
   Total attendance (1979) 1400 - 7 performances.
   Occasional dance presentations.
   This year, 62 performers plus community orchestra will present "Fiddler on the Roof".
3. Kenai Performers
   Planning one production this year. Disbanded for several years due to lack of a place to perform .
4. Redoubt Chamber Orchestra
   Concerts 2-3 times per year.
5. Community Chorus
   3-4 performances per year.
6. Sweet Adelines
   2-4 performances per year.
   Need place to practice each week with piano.

Visual Arts

1. Kenai Arts and Humanities Council
   Council represents fourteen (14) cultural groups meeting six (6) times per ye
2. Kenai Art Guild
   76 members meet once each month.
   Art gallelry open 6 days a week in summer, 3 days in winter.
   Volunteers man gallery. 2000 visitors last summer.
   Workshops: Adult - 16 classes involving 260 people .
   Children - 10 workshops involving 412 people.
   Pottery workshops: 3 classes (1979), 43 participants.
   Annual Juried Art Show: 215 entries (average).
   480 people view 4-day exhibit.

Primary Users (cont'd.):

Visual Arts (Cont'd.)

2. Kenai Art Guild (Cont'd.)

   Annual Arts and Trades Fair: 900 people attend one-day sale of arts and crafts.

3. Beta Sigma Phi

   Annual Art Show: 350 entries (average).
   750 visitors (3 days).

   (This is an open-entry show with all arts and crafts accepted and shown.)

   Need a place to host state conventions every 4 years.

   Five chapters in Kenai-Soldotna area.

4. Peninsula Photographers Guild

   Three photography exhibits held each year.

Historical/Educational Groups

1. Kenai Historical Society

   Meets monthly, keeps museum open.

   (1200 people visited make-shift museum in 1979)

   Group hosts area-wide meetings for the Central Peninsula Historical Association. 150-200 people usually attend these gatherings.

2. Totem Tracers

   Geneology group. 14 members.

   Meets monthly in small room in library.

3. Cooperative Extension Service

   Sponsors annual Mini-university Days.

   In 1979, over 400 persons participated in adult classes during the 3-day sessions. This year it will be held for only 2 days due to lack of facilities available for classes.

KENAI CIVIC CENTER

Secondary Users

Organization (or companies)	Number of meetings per year	Facilities Needed		
		Meeting Room	Banquet	Other
American Assn. of Retired Persons	12	X	X	
Alert (Peninsula Alert Team #648)	10	X		
American Legion Baseball	5	X	X	
Bar Association (Kenai Peninsula)	6	X		
Beta Sigma Phi	12	X	X	Auditorium
Boy Scout Troop # 357	9	X	X	
Brownies	9	X	X	
Business Men's Fellowship Intern'l.	9	X	X	
Cancer Association	6	X	X	
Chamber of Commerce	52	X	X	
Christian Business Men's Committee	9	X		
Conservation Soc.	9	X		
Cub Scouts	9	X	X	
Democrats, House District 13	4	X	X	Auditorium
Desk & Derrick Club	12	X	X	
Dog Racing Assoc.	6	X	X	
Football, Youth	4	X	X	
Garden Club	9	X	X	
Girl Scouts	9	X	X	
Homemakers (2 groups)	10	X	X	
Kennel Club	6	X		
Lions Club	12	X	X	
Mental Health Assn.	12	X		
Petroleum Wives	9	X	X	
Republicans (Dist.13)	4	X	X	Auditorium

KENAI CIVIC CENTER

Secondary Users (cont'd)

Organization (or companies)	Number of meetings per year	Facilities Needed: Meeting Room	Banquet	Other
Tops, Ak. #20	12	X	X	
Twins Club	6	X		
Weight Watchers	12	X	X	
Volleyball Assn.	9	X	X	
Women's Society for Christian Serv.	9	X	X	Auditorium
Civil Air Patrol	12	X	X	
Little League Baseball	5	X	X	
Peninsula Oilers Baseball Club	6	X	X	
Soroptimists	12	X	X	
Swim Team (AAU)	9	X	X	
Local Industries, Secondary Users				
Atlantic Richfield Oil Company	2		X	
American Petroleum Institute	1		X	
Phillips Petroleum	3	X	X	
Tesoro	4		X	
Union Chemical Co.	4		X	

Other secondary users would be small convention gatherings and public forum groups. Garden, boat, and home improvement exhibits could also be scheduled.

Summary Statement

Fiscal Plans for maintaining and operating the Kenai Civic Center

Estimated annual operating and maintenance costs of the Kenai civic Center are as follows:

operating Supplies	$ 7,000
Repair + maintenance Supplies	7,000
Repair + Maintenance	5,000
Insurance	43,100
Electricity	15,000
Gas	7,200
Rental ($ 17,000 x 62%)	10,680
Maintenance (contracted)	35,000
Manager (including benefits)	34,000
Miscellaneous	5,000
	$ 168,980
Rounded	$ 170,000

The City expects that the facility will receive about $ 13,600 per year in private donations. We can only estimate what user charges will generate. It is estimated that they should provide approximately $ 78,000 per year. The balance, or another $ 78,000 will be provided by the General Fund.

Cultural Facilities Grant Program

Grant Application

From: Charles A. Brown, Finance Director

Re: Ownership of Site, Kenai Civic Center

The property where the Civic Center is planned is owned by the City of Kenai, Airport Land System Fund. This land (61 lots) deeded to the City of Kenai by the Federal Aviation Administration. The City (General Fund) should enter into a long-term lease with the Airport Land System Fund.

According to the information I have received, this will allow the City to utilize the $178,000 land value as part of its local match, as well as being a cost of the project to be included in the State's calculated share. Project funding is projected as follows:

	State Funding (93.34%)	Local Funding (6.66%)	Cash Flow
Total Project Cost	$5,477,550	$5,477,550	$5,477,550
Less non-cash expenses (Land)	N/A	N/A	(178,000)
	5477550	5477550	5,299,550
State Funding	$5,112,745		(5,112,745)
Local Funding		$364,805	$186,805

The $186,805 of local cash will be provided from 94 refunded bond monies which are currently available.

KENAI CIVIC CENTER
City of Kenai, Alaska

Kenai Arts and Humanities Council

carmen vincent gintoli architect, kenai

KENAI CIVIC CENTER

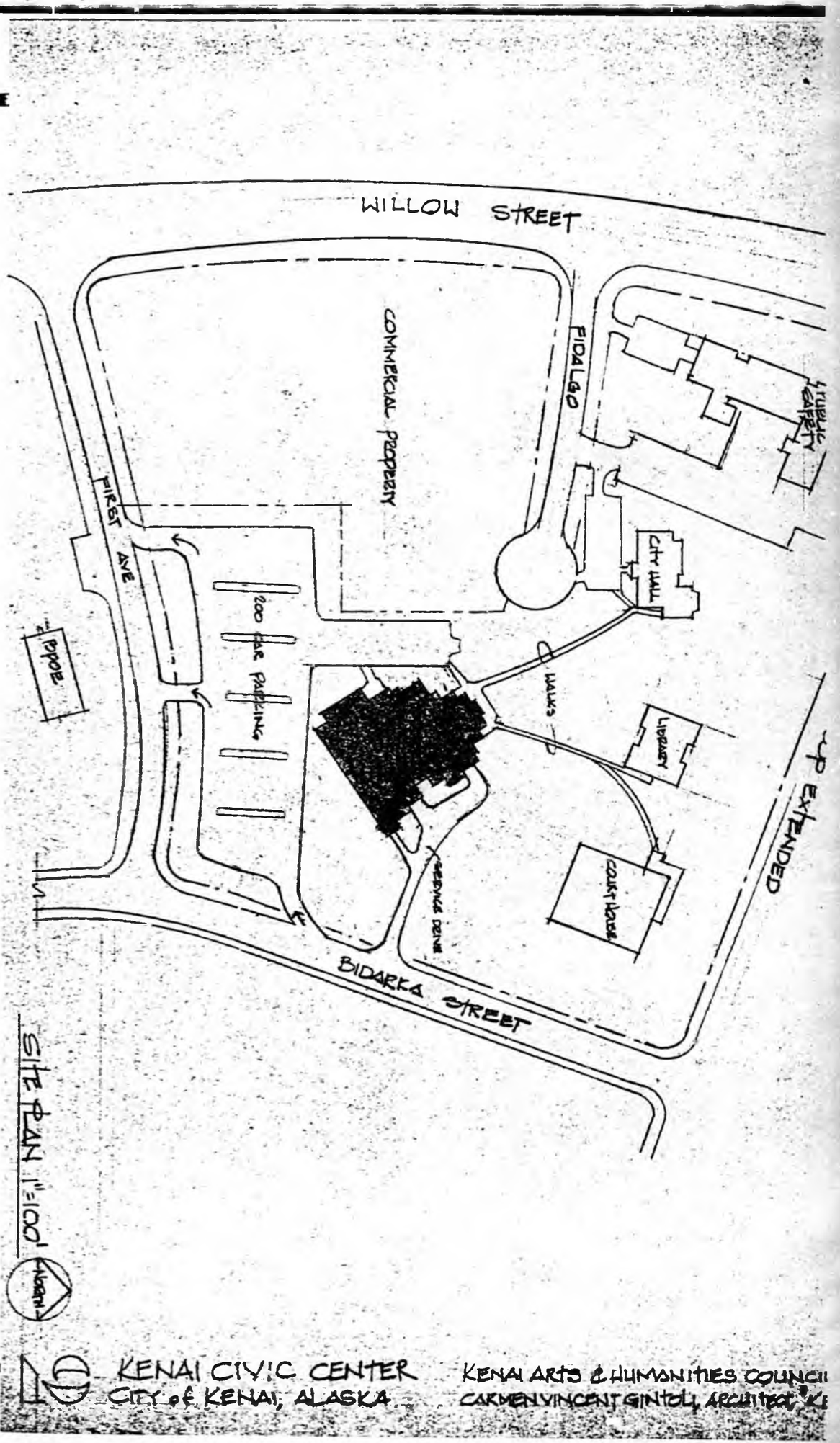
CITY of KENAI, ALASKA

KENAI ARTS & HUMANITIES COUNCIL

CARMEN VINCENT GINTOLI, ARCHITECT

LOCUS (NTS)

NORTH


WILLOW STREET
COMMERCIAL PROPERTY
FIDALGO
PUBLIC SAFETY
CITY HALL
FIRST AVE
200 CAR PARKING
WALKS
LIBRARY
COURT HOUSE
SERVICE DRIVE
BIDARKA STREET
EXTENDED
SITE PLAN 1"=100'
KENAI CIVIC CENTER
CITY of KENAI, ALASKA
KENAI ARTS & HUMANITIES COUNCIL
CARMEN VINCENT GINTOLI, ARCHITECT, K

KENAI ARTS & HUMANITIES COUNCIL
CARMEN VINCENT GINTOLI, ARCHITECT, K

KENAI CIVIC CENTER
CITY of KENAI, ALASKA

MEN
WOMEN
MEN
SCENE S/O
MEETING
KITCHEN
LOBBY
ON
BOX OFF
FOYER
LOBBY
400 RETRACTABLE SEATS
600 FIXED SEATS
STAGE
COATS
MEETING
MEETING
MEN
WOMEN
ACOUST. HALL S/O
BOX OFF
LOBBY
COATS
MEN
WOMEN
REHEARSAL
toilet/ DRESSING
toilet/ DRESSING
ELEV
DOWN to GALLERY

AUDITORIUM PLAN

18,220 sq ft

1/16" SCALE

0 4 8 12 16 20 24

LOWER LEVEL

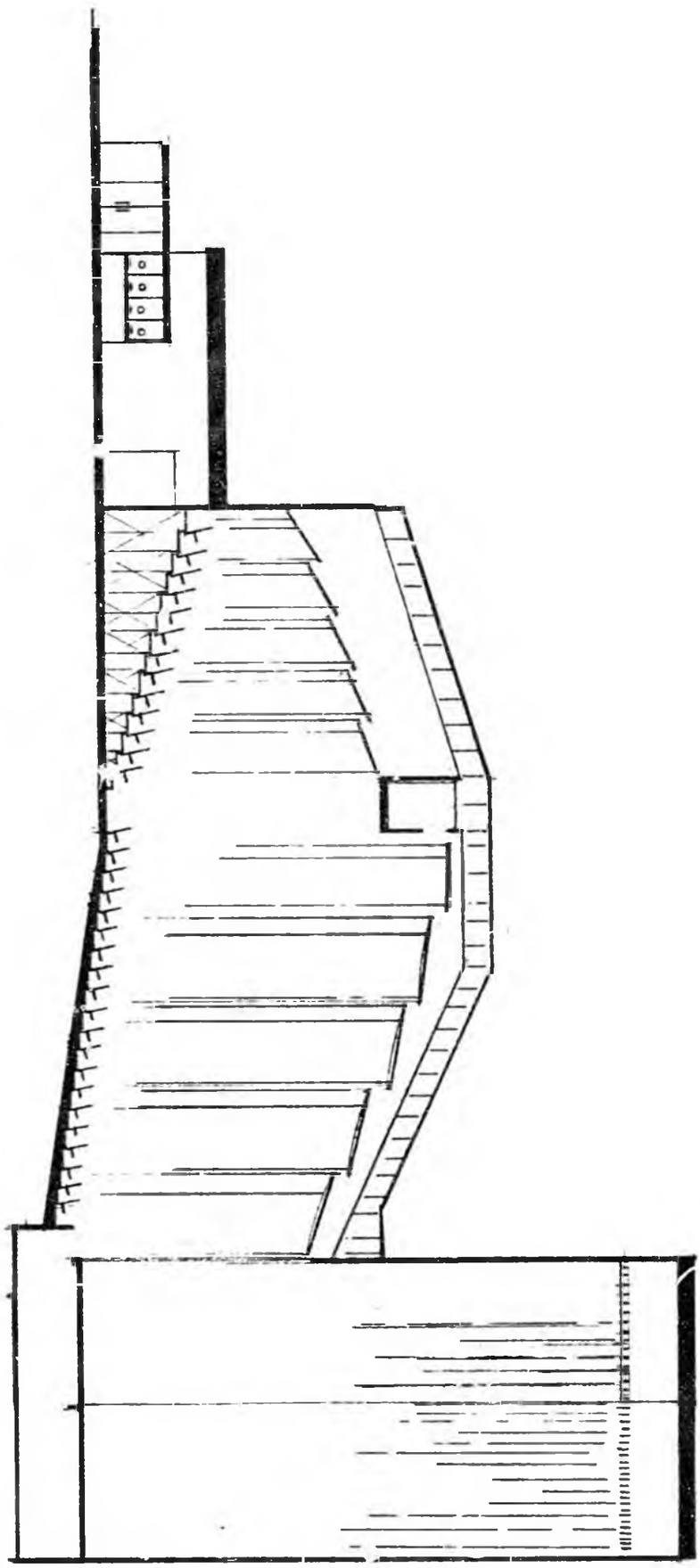
1/16" SCALE

0 4 8 12 16 20 24 28

KENAI ARTS & HUMANITIES COU
CARMEN VINCENT GINTOLI, ARCHIT

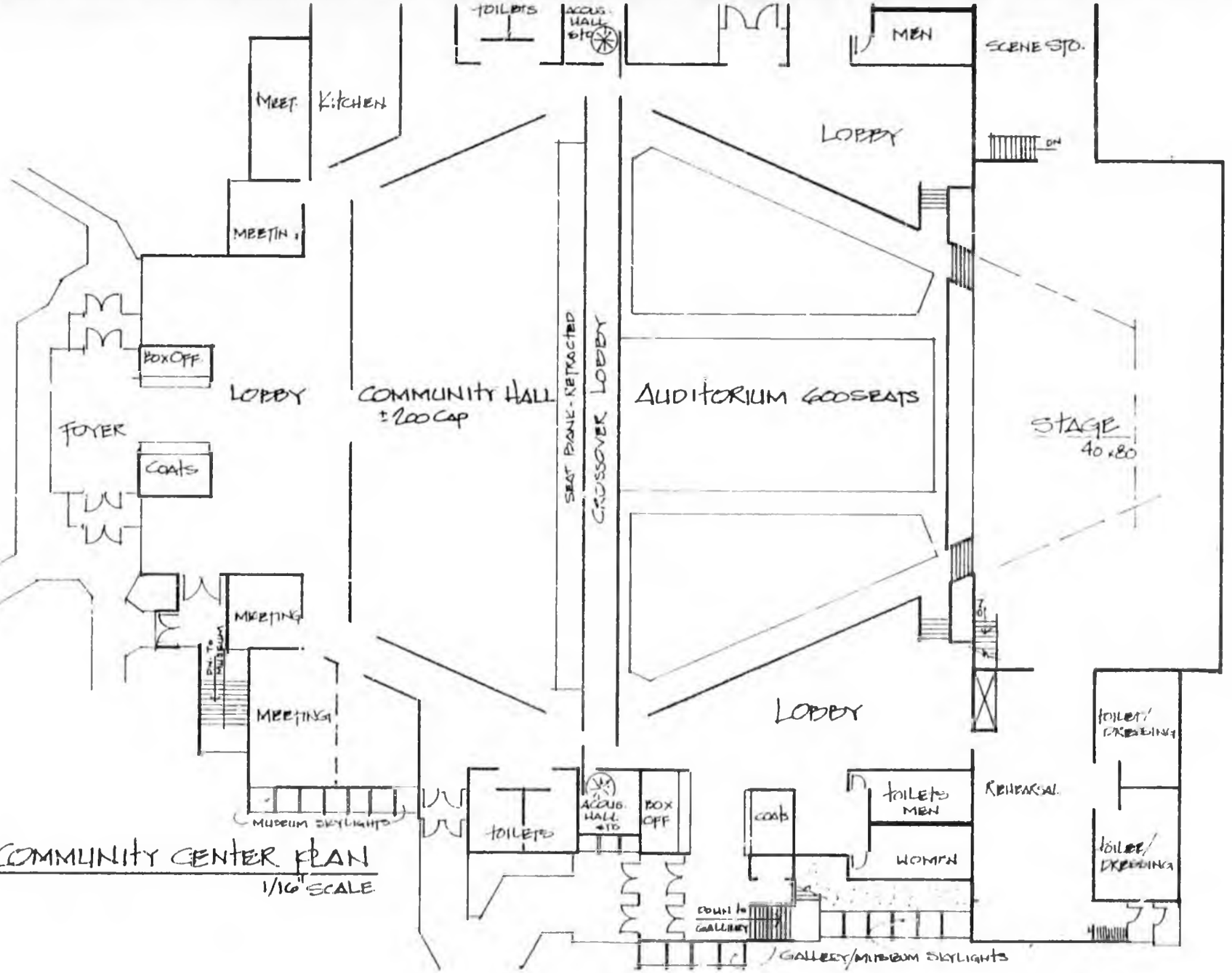
KENAI CIVIC CENTER
CITY of KENAI, ALASKA

SECTION thru AUDITORIUM 1000 seats



KENAI CIVIC CENTER
CITY of KENAI, ALASKA

KENAI ARTS & HUMANITIES COUNC
CARMEN VINCENT GINTOLI, ARCHITECT



AUDITORIUM/COMMUNITY CENTER PLAN

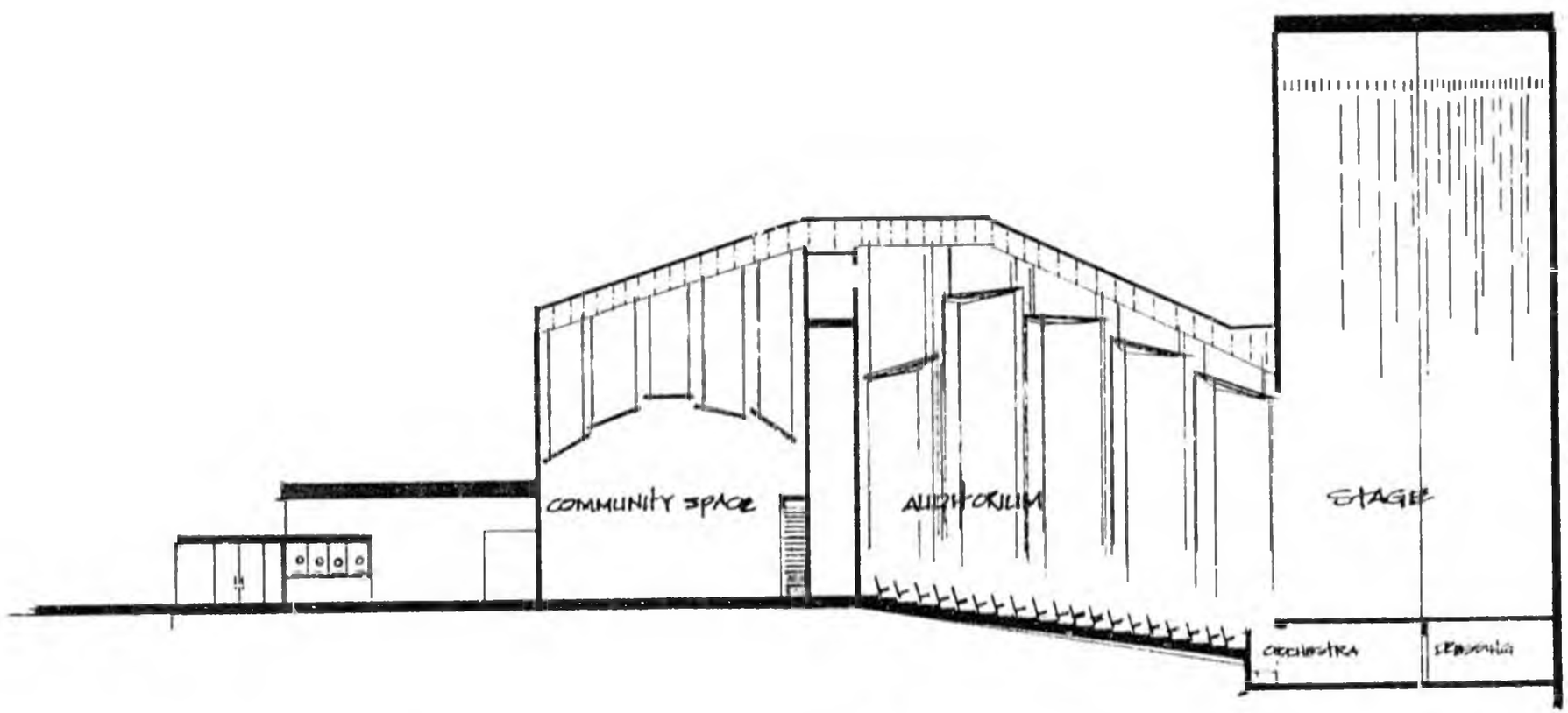
18,220 SF

1/16" SCALE

KENAI ARTS & HUMANITIES COUNC
CARMEN VINCENT GINTOLI, ARCHITECT

KENAI CIVIC CENTER
CITY of KENAI, ALASKA

6



SECTION thru COMMUNITY HALL 200 CAPACITY and AUDITORIUM 600 SEATS

KENAI ARTS & HUMANITIES COUNCI
CARMEN VINCENT GINTOLI, ARCHITECT, KE

KENAI CIVIC CENTER
CITY of KENAI, ALASKA

CHUGIAK-EAGLE RIVER
REPUBLICAN WOMEN'S CLUB
P. O. Box 144
Chugiak, Alaska 99567

February 18, 1980

Honorable Nels Anderson
Alaska State House of Representatives
Pouch V
Juneau, Alaska 99811

Dear Mr. Anderson:

The Chugiak-Eagle River Republican Women's Club supports House Bill No. 672.

Sincerely,

Barbara Franklin

Barbara Franklin
President

rcvd 2/22/80

UNIVERSITY OF ALASKA, RURAL EDUCATION

Dillingham Extension Center
Box 10206
Dillingham, Alaska 99576

February 12, 1980

Representative Nels A. Anderson, Jr.
Pouch V
Juneau, Alaska 99811

Dear Representative Anderson:

Per your suggestion at last evening's Constituent Teleconference, I am forwarding to you my remarks in behalf of the Dillingham Extension Center and its Policy Advisory Council addressed to you and Sen. Hohman in support of HB 672.

"We are here this evening (Trish Dorey, President, PAC, and I) to urge the passage of House Bill 672 allocating funds for Adult Basic Education (ABE) to DOE.

"Various agencies and individuals in the Dillingham Community have over the past five years submitted proposals to bring ABE to the Bristol Bay region. These proposals were never funded and our region is still without an ABE program to serve the needs of more that 5000 people of the 30+ villages in the area.

"I am here as one representative of education in this community to urge passage of HB 672 for the following reasons:

"1. The Bristol Bay region needs an ABE program--as Coordinator of the Dillingham Extension Center I have had the opportunity to travel extensively in the region and ABE is an unmet need which I receive most question about. It is unquestionably, in my opinion, the number one educational priority of the region.

"2. We believe that passage of HB 672, in its present form will finally result in the release of a portion of the total ABE funds ($617,500) for a program in this region.

"3. The Dillingham Extension Center is in a position vis-a-vis the Bristol Bay Regional Resource Center and its Director, Mr. Bob Brown, to train teachers using models developed by the Northern Institute. I have talked with Mr. Dave Alexander of

Rec'd 2/18/80

TNI who has assured us of assistance in the development of a training program for ABE teachers. We will however, need funds to assist our teacher trainees once they are recruited, as well as funds to support them as they work in the villages training adults in basic literacy skills.

"4. Finally, and perhaps most importantly, we believe that a successful ABE program in the Bristol Bay region will go a long way toward insuring the success of other programs in the region. The University of Alaska as it attempts to extend education to all the people of the Bristol Bay area through its Extension Center is acutely aware of the need to impact people at all educational levels if its own programs are to succeed."

Sincerely,

Charles A. Blood, Jr.

Charles A. Blood, Jr.
Coordinator
Dillingham Extension Center

CB/jm
cc-Bob Brown
Trish Dorey

A PROPOSAL FOR EDUCATION LEGISLATION TO SERVE SEVEN REGIONS IN ALASKA

INTRODUCTION

This state offers a free education to every member of its varied society. Even so, there are many adults among us who either could not or would not finish (or, in some cases, even start) their elementary or secondary education. Because these adults are poorly educated, they have, throughout an entire lifetime, held some of the least rewarding jobs in our society. Frequently, they have held no jobs at all. They find themselves on the welfare roles, and each generation begets yet another generation of those who are uneducated, unskilled, and unemployed.

There are men and women in the state who cannot fill out job applications, who cannot read labels on prescriptions or prices at the grocery store, and who cannot help their children with even the simplest homework. They are people who need Adult Basic Education.

On the other hand, there are men and women among us who have recently applied for and received either their first job or a better job. We have adults who no longer must depend upon others to read for them on shopping trips. We have people who take new pride in helping their children learn, who pass that pride in education along to their formerly indifferent families. These are men and women who have received and are now demonstrating the benefits of Adult Basic Education.

DEFINITION

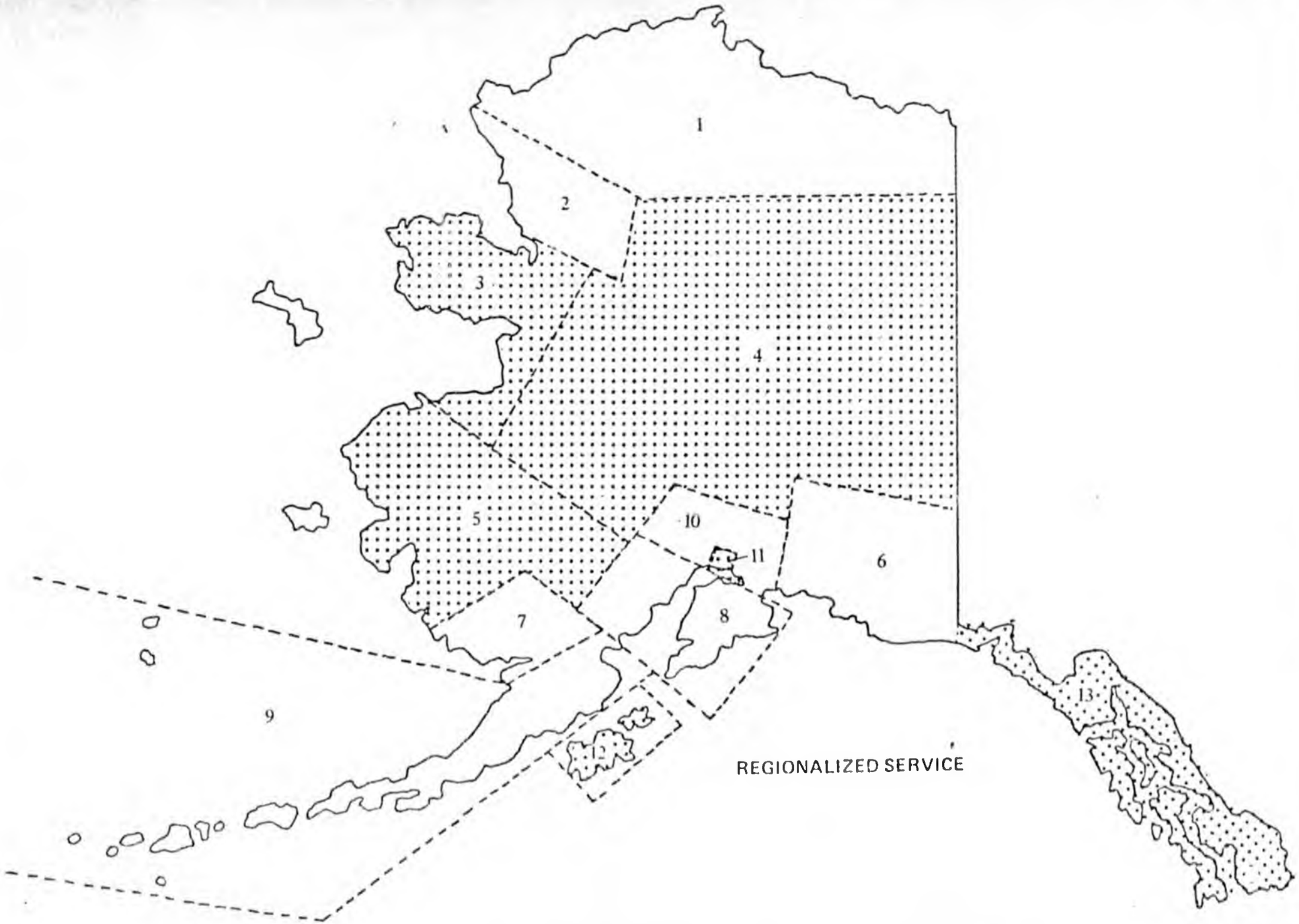
Adult — A person sixteen years of age or older who is not enrolled in a regular public or private school program and who is in need of basic literacy skills, English Language instruction, life skills instruction or other assistance up to secondary school completion.

STATEMENT OF NEED

The goals of Alaska Adult Basic Education are:

> ...to provide the best possible educational opportunities for all undereducated adults in Alaska ... to provide adults opportunities to continue their education to at least the level ... of secondary school ... (to make these) opportunities available for adults who have not completed secondary training as well as adults who have received a certificate of graduation from a school providing a secondary education but are functioning at less than a secondary competency.

There are presently seven geographic regions in the state receiving little or no instructional money for Adult Basic Education. The North Slope, Northwest Arctic, Aleutian/Pribilof Islands and Bristol Bay and Rural Anchorage Regions receive no funding. The Kenai Region receives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REGIONALIZED SERVICE

funding for two part-time classes and Valdez is funded for one teacher. This means that approximately 68,000 Alaskans are being denied access to the advantages of adult education.

At current funding level options are limited. Programs could be drawn out of one region and relocated in another region, but this would cause the loss of experienced staff in whom the state has a considerable investment in training. This would further cause the discontinuation of programs for many students who have had a long term commitment and are in the advanced stages of completion.

A second alternative would be to trim a percentage of money from existing programs and put into the unserved regions. Once again this would cause many people to lose service and take away from programs which already operate at only a minimal level. A case in point is the Kuskokwim Region which serves fourteen out of fifty-three villages now.

The third alternative and that being suggested by this proposal is to leave present funding in place and add minimum funds necessary to complete the network. The state is already in the unfortunate position of denying many of its citizens equal access to educational opportunity. To reduce or remove the programs currently thinly spread over the state would be a denial to our responsibility.

Great social pressure is being exerted upon the Native populations of the state. With Indian Self Determination, the advent of Native Land Claims and localization of the schools people with little education are being required to sit on boards of directors of corporations making decisions with great environmental and financial impact, sitting on school boards making decisions in hiring and firing professional staff as well as judgements on quality of education.

This press for educated adults cannot depend strictly upon the new young graduates to fill the need. Every effort must be made to tap the knowledge and experience of the mature adult in the older geneations. This can be done only through basic education.

The following statistics corroborate the need for basic education in the proposed regions to be served.

REGIONAL NEEDS STATEMENTS

1. Bristol Bay:

"In a special report prepared by Robert Natham and Associates for the Federal Government, a number of statistics were identified relative to the well being of Alaska Natives. For Bristol Bay, the figures are indeed stark:

The Median education in school years completed by
Alaska Native (as a whole) is:.....7.4
For Bristol Bay.....3.5

Further, the studies identified 50.3% of the population 25 years of age or older as having an educational attainment of 0-4 years of formal schooling. In this same population group, only 8.6% have

completed four years of high school or have an equivalent high school diploma. There is an immediate need for Adult Basic Education Courses in virtually all Bristol Bay villages."

No Adult Basic Education courses are currently being taught, therefore, there is no existing program or vehicle for adults within the villages to obtain the basic skills necessary to even apply for and pass the five sub-tests for a General Education Diploma (GED). An Adult Basic Education program would not only provide this service but would help provide for equal educational and growth opportunities for those adults who have been and are still being neglected.

2. Northwest Arctic:

An active, comprehensive program of adult education, based on the conceptual framework of Adult Performance Levels, is a prime requisite for growth of political, social, personal, and economic skills of NANA Region residents. In a recent (December 1978) survey, it was found that 42% of respondents had attended school to eighth grade of less. Another 13% attended between nine and eleven years. 45% were at least high school graduates. Teachers and other relatively transient professionals were included in the random sample and contributed to this last category. The indigenous, stable population is primarily of Inupiaq Eskimo heritage and fewer of this group have completed high school than the survey results suggest. Complicated further by multilingualism, the adult populations thus has a high rate of functional illiteracy. The region's people also suffer a high rate of unemployment. Inuit respondents, 52% had not had a job for the past year. An additional 41% were employed part-time. Only 7% had fulltime jobs. Besides unemployment, alcoholism, high prices, and lack of something to do, were seen by the respondents as the region's major problems.

The above statistics would in themselves suggest a need for an adult basic education/adult education program. But there is further evidence as well. When asked the question, "If a school for adults was available here, would you be likely to go?", 73% replied they would. And 90% said they would attend workshops or classes to teach people self-health care.

In follow-up interviews by school district personnel (April 1979), Ambler adults indicated that an average of 36% of respondents would attend each of sixteen (16) vocationally oriented classes. An average of 61% would enroll in each of two (2) consumer education classes, and in each of four (4) health and safety classes. Three (3) ABE courses would each have an enrollment of 10% of the adult population of this village, and a GED preparation course 32%. If extrapolated to the region's adult residents (approximately 2,500 people in eleven villages), one could anticipate about 150 people interested in a ABE program, 800 in a GED program, 900 in job skills, and 1,525 in other life skills program. Of course, many people indicated interest in several programs, and actual attendance would be well below the level of interest, but the need for an adult education program is apparent.

MEDIAN YEARS OF SCHOOL COMPLETED BY REGIONAL POPULATIONS

The following chart was compiled in an effort to show both the educational services needs and the income levels of the target area populations the A.S.H.E.S. Talent Search Project would be aimed at.

Region	Median Years School Completed		Highest Grade Completed by largest % of population				Eligible youth age 14-24 (17.4% of poverty population	Total below poverty pop.		Total Pop.
	Native	Non-Native	Native	%	Non-N.	%				
ALUET	7.2	12.7	5-6	23.9	12	46.7	73	419	9.6	4359
ARCTIC SLOPE	5.6	18.0	5-6	23.9	12	35.9	154	887	28.8	3079
CALISTA	3.0	13.5	0	33.9	12	33.6	1378	7889	65.5	12040
BERING STRAITS	7.0	13.8	1-4	21.8	12	28.5	387	1938	35.3	5497
BRISTOL BAY	3.9	12.6	1-4	29.9	12	38.3	256	1471	33.1	4446
CHUGACH	8.2	12.5	1-4	17.1	12	41.3	146	839	14.5	5794
COOK INLET	10.2	12.6	12	24.8	12	48.3	1791	10292	7.0	140823
ATMA	5.8	12.4	0	22.9	12	46.2	42	240	18.0	1336
KOMIAG	8.6	12.5	8	2[illegible]8	12	41.9	135	773	9.3	8338
NA	6.2	13.5	1-4	29.2	12	34.2	238	1369	37.2	3634
UTON	6.7	12.6	1-4	21.4	12	42.4	892	5127	10.4	49233
ALASKA	10.3	12.5	9-11	25.3	12	38.1	760	4370	10.4	41957
OTAL	7.5	12.6					6197	35614	12.7	280586

Data compiled from 2(c) Report, Task I. Excerpt from 2(c) Report, Task II, "The lack of basic statistical information prevents educational agencies from evaluating current educational efforts and identifying unmet needs."

3. Aleutian/Pribilof

Due to limited educational opportunities in the past, the people of the Aleutian/Pribilof region have faced many difficulties coping with 20th Century corporate life thrust upon them by the Native Claims Settlement Act. Leadership has been developing with incredible rapidity and effectiveness, but the heavy pressures involved in rapid change have caused frustrations resulting in social disorganization. Village corporations, councils, school committees and school boards have all been forced into leadership decisions for which they often lack basic training and experience. According to the 1970 U.S. Census in the Aleut Corporation area, 15% of the Native people 25 years or older completed grades 1-4; 25% grades 5-6; and 16% grades 7-8. Unless educational needs are met, the following will continue to occur:

A. Village and city governments will fail or falter or will be dominated by non-Natives.
B. School boards will be dominated by non-Natives, and Native parents will have little to say about education of their children.
C. Village corporations will not function at their full potential.
D. Outside investors will reap fortunes in the Aleutian/Pribilof area while the majority of Aleut people will subsist virtually at poverty level.
E. The Aleut cultural heritage will be overrun and lost, leaving behind the vicious circle of poverty, alcoholism, drug abuse, family disintegration and loss of identity.

4. Matanuska-Susitna

Matanuska-Susitna Community College identified 4,600 adults having less than a secondary education in the Matanuska-Susitna service area. Bureau of Labor statistics revealed a July unemployment rate of 15.1 percent and November 23.3 percent combined with Decembers 24.9 percent are symptomatic of the need for basic education and life coping skills training.

5. North Slope

The native residents of the North Slope have a median school completion level of 5.6 years. This lack of education has significant impact upon the ability of natives to compete for and maintain jobs in the now technologically oriented North Slope Region. Additionlly, a bank of educated persons is necessary to train for the roles necessary if the new affluence introduced by massive oil revenues is to remain under control of its rightful owners. The few individuals represented in the leadership need many more trained, educated people to take on the many emerging roles in business, education, industry and arctic leadership.

6. Kenai Region

During the summer of 1979, an assessment of the available educational resources and needs of the adult client population was done under a federally funded program named NETWORK. (Network of Education, Training and work Opportunity Resources Knowledge Bank). The final report will not be in this office unt'l October 30, however, preliminary analysis indicates that the statistics presented last year were in the ball park. Thus, they are repeated here.

The population of the Kenai Peninsula is approximately 25,000 with most of the people living in the Kenai-Soldotna area. In Level I (1-9), it is estimated that 1,500 adults could be served. Additional estimates are that there are approximately 3,000 adults in Level II and 150 needing ESL training.

7. Valdez/Copper River

The Valdez/Copper River Region encompases a population of nearly ten thousand people. Of this ten thousand an estimated 2,400 have less than a high school education. The Native adult population has a median school completion level of 5.8 years. With the pipeline terminal, pumping and maintenance stations throughout the region it is apparent that employment opportunities are fast appearing, but they are at a level which demand solid-scholastic background. Unless the region is given the benefit of ABE services, these opportunities will once again fall to outsiders.

PROPOSED SERVICES

Services shall include instruction in basic literacy, English as a Second Language, life coping skills and vocational counseling in the form of:

an "individualized educational program" a written statement jointly developed by a qualified instructor and by the person, to include:

- present achievement level analysis
- short range and long range goals
- identification of specific services that will be provided toward meeting those goals
- when and where these services will be provided and how long they will last
- a schedule for checking progress achieved under the plan and for rating necessary revisions

These services shall take place in the towns and villages of the respective regions as selected by the educational institution providing the service. Curriculum shall be determined by the student, local educational institution in concert with their local advisory council and the citizens participatory planning process used by the state ABE program.

PROGRAM IMPLEMENTATION

Organization for Delivery of Services

State Organization: In an effort to prevent proliferation of state bureacracy, these funds should be located in the Alaska Department of Education, Adult Basic Education Section.

This section already has in place the mechanisms for granting and administering funds. A statewide network of curriculum assistance, technical assistance and staff development. The addition of this program to the present network could achieve maximum benefit at minimum cost.

LOCAL DELIVERY

Local/Regional delivery is currently conducted throughout the state by a variety of organizations. These organizations include school districts, community colleges, Native Non-profits, private non-profits and public non-profit agencies. The funds are placed on a competitive basis to the organization offering the most service for the available dollars. Programs in most regions reflect cooperation between two or more agencies for delivery of service. The competition between agencies has been very effective in holding down costs without causing instability in the program. In the case of similar bids the program operator with the proven history of performance is always funded.

Program operators not performing will have historically been given one year grace to upgrade and it has been necessary to pull only a program in six years.

FUNDS NECESSARY TO IMPLEMENT NEW REGIONS

North Slope	$80,000
Northwest Arctic	80,000
Bristol Bay	75,000
Aleutian/Pribilof Islands	85,000
Kenai Peninsula	75,000
Rural Anchorage (Mat-Su)	75,000
Valdez/Copper River	75,000
Total Program	$545,000
Staff Development @ 10%	54,500
Support Services - 1 clerk typist III @ 18,000 including fringe, etc.	18,000
Total Cost	$617,500

Justification:

Regional Allotments

North Slope, Northwest Arctic and Aleutian/Pribilof Islands Regions are suggested at a higher level of support due to unusual travel costs. Although travel will be much cheaper in the Kenai and Rural Anchorage regions extra funds are justified due to the population density they must serve.

Staff development is a vital compontent to ABE. Rural teachers are taken from the indigenous population and trained as ABE instructors. This training is a rich source of leaders in the rural areas. Attached find statements of what have happened to many of the ex-instructors once the role of ABE instructor gave them responsibility in the political/social process.

Furthermore, staff development is inherent in quality instruction, particularly when dealing with people who have never taught before or even experienced teachers dealing for the first time with adult students.

Support services are necessary if reasonable service is to be available to the new regions. Although ABE is funded over three times as high as four years ago and is offering many more services to field programs, the present administrative staff need not be expanded but the present 1/2 time secretarial clerical arrangement simply cannot keep up with present volume let alone be expected to handle nearly double the number of contracts currently served.

Matching funds are available from many sources including C.E.T.A., B.I.A., Indian Education, Labor, Social Services, boroughs, etc., once a knowedgable organize services and negotiate contracts. It is anticipated that the first fiscal year funds at least equally the inital grant will be generated by and the third year they would be generating as much as three dolllars per state dollar.

The money being generated tends to be dollars that previsously created overlap programs or furnish ancillary services which, though useful, were not coordinated with ABE, therefore seldom used.

United States Council of State Directors

Adult Education Economic Impact Survey
Alaska - FY79

A. Public Assistance

1. List the number of Adult Education Learners removed from public assistance in FY77 (as reported in Table 5, Item 12 in Annual Report). 24

2. Average annual cost per adult for public assistance in your state. Households average 1 adult and 2 dependents nationally and FY77 statistics from USDE reveal Alaska costs to be 12,948 per household including case work, etc. 12,948

3. Total projected savings per year. (Multiply answer in number one times the answer in number two.) 310,752

B. Employment

1. List the number of Adult Education learners who became employed in FY77 as a result of Adult Education (as reported in Table 5, Item 13 in Annual Report). 112

2. Projected income earned by adults who became employed. Take the number of adults receiving jobs as a direct or indirect result of attending Adult Education class: Multiply this number by the minimum hourly rate (now $2.30) times 40 X 52. If the actual income is known, then use this instead of minimum rate. 1,397,760

Minimum average in Alaska is just over $5.00

EXAMPLE: 112 persons who became employed X $6.00 per hour = $672.00 per hour X 40 hours per week = $26,880 X 52 weeks = $1,397,760 per year new income.

C. Job Promotions

1. List the number of adults who were promoted as a result of Adult Education (as reported in Table 5, Item 14 in Annual Report). 222

2. Using Employers State salary scale minim is 18¢ per hour. Projected additional money earned by adults who were promoted as a result of Adult Education. Multiply the number of adults receiving a promotion by .10 per hour (which is a minimal figure) X 40 hours X 52. 230,880

EXAMPLE: 222 promotions X .50 per hour = $111.00 per hour X 40 hours per week = $4,440 per week X 52 weeks = 230,880 per year.

HB
802

POSITION PAPER/Department of Health & Social Service

POSITION PAPER

HOUSE BILL NO. 802

"An Act relating to nurse midwives."

HB. No. 802 requires that hospitals extend staff privileges to nurse midwives as a condition of licensure. The Bill also defines the coverage of nurse midwives' practice under health and disability insurance policies by requiring coverage by those policies that pay for maternity care. The Bill also requires a medical service corporation, hospital service corporation, and combined medical and hospital service corporation cover nurse midwife services under certain conditions. The Bill also amends the definition of "participant physician" to include a nurse midwife, and adds a new definition defining "nurse midwife" to the Alaska Statutes.

The Department of Health and Social Services will limit its comments to the areas of the practice of the nurse midwife and the requirements of hospitals to extend staff privileges to the midwife as a condition of State licensure. It is our understanding that the Department of Commerce and Economic Development, Division of Insurance, will be commenting separately on the sections dealing with mandatory insurance coverage.

Practice of Nurse Midwives

Nurse midwives have been a part of the American health care system for over fifty years. The practice of nurse midwifery, including the management of labor and delivery, is recognized in the laws of all states except Kansas, Michigan, and Wisconsin. The typical recent graduate of a nurse midwifery educational program has six years of professional nursing experience and a bachelor's degree in addition to nine months to two years of midwifery training Upon successful completion of the course and a national certification examination, the nurse midwife is prepared to care for women's health needs, including normal childbirth and uncomplicated gynecological and family planning services.

The nurse midwife, according to Alaska law, collaborates with a physician. Nationally, nurse midwives are employed by hospitals, public health agencies, private physicians, the military, prepaid health plans, and birthing centers. Their practice, typically, extends beyond pregnancy and birth to include the post-partum care of the well woman and neonatal care of the infant. Health education is a vital component of the role of the nurse midwife.

The use of nurse midwives can offer greater availability of quality prenatal care, delivery, and post-natal care in medically underserved

POSITION PAPER/Department of Health & Social Services

areas. As a member of the health care team, the nurse midwife can provide professional care to the normal obstetrical or postpartum patient, thus freeing her collaborating physician to concentrate on patients with problems requiring his or her medical expertise. An expanded use of nurse midwives also can offer an alternative style of care to families at a special time in their lives. The desire of certain families for such an alternative may partially account for the apparent increase in home deliveries, a practice which involves a greater risk.

Requirement of Extension of Staff Privileges to Nurse Midwives as a Condition of Hospital Licensure

The purpose of licensure, rules, regulations, and standards for hospitals is "...promoting safe and adequate treatment of individuals in the interest of public health, safety and welfare..." (AS 18.20.060).

Historically, the State's responsibility began as licensure and inspection of public facilities to look for fire, environmental health, and other standards for the condition of buildings. It then was extended into the area of professional standards requiring certain levels of competence and experience to have been reached by the staff providing care in the hospital. The strictest requirement for hospitals comes as a result of the need to be certified in order for the hospital to be eligible for Federal Medicare and Medicaid reimbursement. Nowhere in State Statute or regulation are hospitals required, as a condition of licensure, to extend staff privileges to professional groups (such as dentists) or paraprofessional groups (such as therapists). HB 802 would break with past precedence by requiring such an extension as a condition of hospital licensure to nurse midwives.

Department Position

The Department of Health and Social Services recognizes the valuable contribution that nurse midwives can make to the overall physical and emotional health of the family at time of pregnancy and delivery. We would encourage hospitals to provide staff privileges to well-qualified nurse midwives who meet the requirements of the Advanced Nurse Practitioner Guidelines issued by the Alaska Board of Nursing. However, the Department believes that the decision to use the services of nurse midwives or other qualified allied health personnel appropriately should rest with each individual hospital, its governing body and administrative staff, and not with the Department of Health and Social Services licensing authority.

POSITION PAPER/Department of Health & Social Services

Recommended by:

Dean F. Tirador, M.D.
Director, Division
of Public Health

Date: 3/5/80

Joe Betit, Acting Coordinator
Office of State Health
Planning & Development

Date: 3/5/80

Approved by:

Helen D. Beirne
Commissioner

Date: 3/5/80

FISCAL NOTE

I. REQUEST
Bill/Resolution No. House Bill No. 802
Title "An Act relating to nurse midwives."
Requested by Commissioner's Office Date 3/5/80

II. FISCAL DETAIL
Agency Affected Department of Health and Social Services
Program Category Affected Health/Division of Public Health
BRU, Program or Subprogram(s) Affected
(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 80	FY 81	FY 82	FY 83	FY 84	FY 85
100 PERSONAL SERVICES	0	0	0	0	0	0
200 TRAVEL	0	0	0	0	0	0
300 CONTRACTUAL	0	0	0	0	0	0
400 COMMODITIES	0	0	0	0	0	0
500 EQUIPMENT	0	0	0	0	0	0
600 LAND & STRUCTURES	0	0	0	0	0	0
700 GRANTS, CLAIMS, ETC.	0	0	0	0	0	0
TOTAL	0	0	0	0	0	0

FUNDING (Thousands of Dollars)

GENERAL FUND	0	0	0	0	0	0
FEDERAL FUNDS	0	0	0	0	0	0
OTHER (Specify Fund Source)	0	0	0	0	0	0

POSITIONS

FULL TIME	0	0	0	0	0	0
PART TIME	0	0	0	0	0	0
TEMPORARY	0	0	0	0	0	0

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)

Mary Deaver
Prepared by: M. Deaver Date: 3/5/80
Division/Office: P.H. Admin. PH: 3090
Department of Health & Social Services

Approval DHSS Mgt. & Bdgt: [illegible] Date: 3/5/80

33-001 (Rev. 12/79)
Modify by DHSS (11-28-79)

PROVIDENCE HOSPITAL

3200 PROVIDENCE DRIVE - POUCH 6604
ANCHORAGE, ALASKA 99502
PHONE: (907) 276-4521

SISTERS OF PROVIDENCE

SERVING IN THE WEST SINCE 1856

March 5, 1980

The Honorable Thelma Buchholdt
Pouch V
Juneau, Alaska 99811

Position Paper: H.B. 802 - "An Act relating to nurse midwives"

Dear Representative Buchholdt:

Providence Hospital cannot support passage of H.B. 802, "An Act relating to nurse midwives," because of the following reasons:

1. Licensure

To suggest that a hospital's licensure is dependent on permitting para-professionals such as nurse practitioner midwives to practice medicine is irresponsible and probably unconstitutional. The passing of this law would totally disregard the requirements of the medical staff by-laws, the quality assurance and the medical review processes, which are so important in maintaining quality patient care standards.

2. Malpractice Insurance

In the State of Alaska, where malpractice insurance has traditionally been difficult to obtain, requiring them to make available malpractice coverage to nurse practitioners, as primary admitters, would most likely, 1) make malpractice rates skyrocket, and 2) would probably send insurance companies running out of the state.

3. Types of Midwives

It is interesting to note that the bill specifically relates to certified nurse practitioner midwives -- and the traditional, and far more extensively trained certified nurse midwife commonly found in Europe and in a few places in the United States is left out.

The differences in training of these two categories is quite extensive. The nurse practitioner midwife goes to a program of a few months, whereas the Certified Nurse Midwife of the

European model sometimes trains for a couple of years. This further demonstrates the special interest involved. They are certainly not the same, and cannot be grouped together in terms of training, abilities and experience.

4. Currently, under our medical by-laws and those of other hospitals, para-professionals are permitted to practice medicine only under the direction of the sponsoring physicians who monitor the privileges granted and quality of care delivered.

   We also endorse the hiring of these practitioners (para-professionals), by hospitals, to deliver nursing care.

Thank you for the opportunity of expressing our position on this bill.

Sincerely,

Al M. Tamosso
Administrator

AMC/mm

cc: Senator Glenn Hackney
Senator Mike Colletta
Senator Arliss Sturgulewski
Max Kersbergen
William Dann
Charles Rigden
Ron Hammett
Donald Deilers
Jack Brown
Alaskan Hospital Administrators
Advisory Board

TELECOPY INSTRUCTIONS: For Immediate Delivery to Committee

Copy to Rep. Buchholdt
Members House HESS Committee
Above listed Senators

STATE OF ALASKA

JAY S. HAMMOND, GOVERNOR

DEPARTMENT OF COMMERCE & ECONOMIC DEVELOPMENT

DIVISION OF INSURANCE

POUCH D
JUNEAU, ALASKA 99811

March 4, 1980

Honorable Thelma Buchholdt
Chairman
House Education & Social
Services Committee
Alaska House of Representatives
Pouch V
Juneau, Alaska 99811

Dear Ms. Buchholdt:

RE: House Bill 802

You have requested a position paper for House Bill 802. The Division of Insurance has in the past opposed mandated or required coverages for disability insurance policies. We have on two occasions ventured across this line to support mandated coverages. The first was in support of coverage for newly-born children which became law in 1975 (AS 21.42.345). The second was with Senate Bill 227 which would mandate alcoholism benefits. This bill was before your committee last year and is presently in House Rules.

In both cases there was substantial imperative for the types of benefits sought. With newly-born children, the practice of insurers was to provide no coverage until 14 days after birth, which when coupled with the preexisting conditions clause in many policies, gave rise to some substantial financial burdens on new parents with sick, ill or defective newborn children. In the case of a mandated alcoholism benefit, the imperative was, and is, that alcoholism is generally recognized as Alaska's number one health problem. We do not believe that similar imperatives exist to suggest a required maternity or nurse midwife coverage.

We have prepared a section-by-section analysis or commentary which may help in our view of this legislation.

Section 1. This section would most appropriately be commented on by the Department of Health and Social Services. The section is not crucial to the insurance aspects of the bill, which represents the remaining portion of the proposed legislation.

Section 2. Under this section coverages provided on an expense incurred basis shall provide that the health insurance benefits applicable to maternity coverage consider benefits provided by nurse midwife. This language is not objectionable. The title of the section, however, is somewhat misleading and might better be called "COVERAGE FOR COST OF SERVICES PROVIDED BY NURSE MIDWIVES."

Section 3. The language suggests that maternity benefits are required to be provided under an expense incurred policy. Presently, federal law requires maternity benefits on group coverages where the group has more than 15 persons. This proposal would extend to individual policies and to smaller groups. We are opposed to an expansion of this concept because of cost. We believe that removal of this section will not impair the bill since it is really a repeat of Section 2 of the bill. This same comment applies to Section 4 and Section 5.

Section 6. This section in effect mandates maternity benefits for medical service corporations, of which there are two now in the State. The first is Delta Dental Plans which is a dental medical service corporation and the second is Fairbanks Physicians which is currently inoperative. Blue Cross is a hospital service corporation and would appear to be unaffected by this section due to repeated references to AS 21.87.120.

Section 7. This section is not objectionable but does not really affect anyone presently except for the Delta Dental Plan. AS 21.87.330(9) which defines "physician" as distinquished from "participant physicians" should be modified to include nurse midwife.

Section 8. This section is not objectionable.

Finally, the Commerce Committee of the House is presently considering House 882 which permits the Director of Insurance to minimum standards on various lines of insurance which can potentially resolve the problems that this bill appears to address. If all expense incurred policies had to include nurse midwives as physicians or participating physician then I think this bill would become a moot issue.

To summarize, we believe that a number of amendments should be made to this bill to make it a bill that can be supported by the Administration. These references are:

Page 1, line 14, remove the words "REQUIRED PROVISION FOR" and change the word "OF" between "COVERAGE" and "COST" to read "FOR."

Page 1, lines 22 through 29. Eliminate.

Page 2. Eliminate entire page.

Page 3, lines 1 through 3. Eliminate.

Page 3 between lines 3 and 4. Establish new section to read:

AS 21.84.590(6) is amended to read. (6) AS 21.42.290 and AS 21.42.347.

Page 3, line 4. Renumber the section as appropriate and retain the wording that appears on lines 5 through line 8.

Page 3 between lines 8 and 9. Add a new section to read:

AS 21.87.330(9) is amended to read. (9) "physician" [includes also] means a doctor, dentist, osteopath, optometrist, chiropractor, nurse midwife, surgeon, or other licensed health care practitioner.

Page 3, line 14. Add a new section to read:

AS 21.87340(15) is amended to read: (15) 21.42.345 and AS 21.42.347.

The above amendments would result in a bill acceptable to the Division of Insurance. If you have any additional questions, we would be happy to assist in answering them for you.

Very truly yours,

Donald P. Koch
Chief of Market Surveillance

DPK/kkk2/1

Ltr. 112

ALASKA STATE HOSPITAL ASSOCIATION INC.

5401 CORDOVA STREET
PHONE: 277-1633

ANCHORAGE, ALASKA 99503

March 5, 1980

Thelma Bucholdt
Chairman - Health and Social
Services Committee
Alaska State Legislature
Pouch V
Juneau, Alaska 99811

Re: H.B. 802
"An act relating to
nurse midwives"

Dear Representative Bucholdt:

The Alaska State Hospital Association representing seventeen institutional members who provide obstetrical care is extremely concerned over H.B. 802. While the intent, I am sure, was to make availible to patients an alternative which would provide greater access to O.B. services at a possibly reduced cost, a number of considerations should be evaluated before proceeding with this proposal.

1. Sec.18.20.055 Nurse Midwife Staff Privileges:

   Criteria for the licensure of hospitals which is acceptable under present state and federal regulations does not require that paraprofessionals be accorded staff privileges in orde. to retain state licensure. To legislate such a requirement would be legally contestable, as it is contrary to accepted standards of safeguards provided under present licensing and hospital by-laws related to the admission of patients to hospitals. Such legislation would open the door to numerous medical paraprofessionals to mandate similar consideration.

   Such action would circumvent the protection that all patients presently may expect from a licensed hospital, i.e. that a board (trustees), medical staff organization and a competent administration are responsible for assuring that minimal standards of training and licensing have been met by practicing staff. A nurse practitioner does not meet the level or training required for physicians, nor do they meet by-law standards for staff privileges.

2. The continued availability and/or additional cost of hospital malpractice should such legislation be inacted leads one to question the prudency of such a proposal. One of the protections that patients and hospitals presently have is recourse for a financial settlement for ajudicated damages. The removal of that protection by a withdrawal of insurance coverage, or a significant increase in the cost of such coverage, due to the inclusion of paraprofessionals as attending staff is a serious concern for our members.

3. Limited investigation due to the shortness of notification of this proposal has identified that third party carriers are not presently able to assure any reduction in premimum costs due to O.B. services provided by paraprofessionals. Lack of experience with this concept does not yet provide a historical base upon which to draw conclusions.

Although for the above stated reasons our association cannot support the proposed bill, let me hasten to add that under the appropriate medical direction and approved hospital standards of medical treatment, para-professionals can be effectively utilized in the hospital setting to deliver a sophisticated level of health care.

Thank you for this opportunity to express our concerns and recommendations on this proposal.

Sincerely,

Max Kersbergen
Executive Director

MK/lc

Fairbanks Memorial Hospital

1650 Cowles St.
FAIRBANKS, ALASKA 99701

OPERATED BY
LUTHERAN HOSPITALS AND HOMES SOCIETY
FARGO, NORTH DAKOTA 58102

March 12, 1980

Honorable Thelma Buchholdt
Pouch V
Juneau, Alaska 99811

Re: Position Paper - House Bill No. 802
An Act Relating to Nurse Midwives

Dear Representative Buchholdt:

Fairbanks Memorial Hospital recently submitted preliminary comments on House Bill 802, an act relating to nurse midwives. The Hospital has recently gone back and done more research on this bill and would like to submit the following position on House Bill 802.

Fairbanks Memorial Hospital cannot support House Bill 802 because of the following reasons:

1. The bill as it is currently written would let a nurse midwife work in the hospital without a physician's supervision. To my knowledge all hospitals in the state require nurse midwives, physicians assistants and other para-professionals to be directly supervised by a physician preceptor. If this bill passed, this would prevent nurse midwives from being required to have this physician supervision.

2. The bill as it currently stands grants a nurse midwife hospital privileges. At the current time no para-professional in any Alaska hospital to my knowledge is granted full privileges, but is rather granted an extension of their physician preceptor's privileges. This requires the para-professional to be supervised and to do only those procedures and exams the physician preceptor has privileges to perform.

3. Fairbanks Memorial Hospital does not believe that a hospital's license should be dependent upon any one para-professional group. We believe that if this bill was passed, other para-professionals would request similar status.

4. As I am sure you are aware, there is a severe difference between certified nurse practitioner midwives and certified nurse midwives. A certified nurse practitioner midwife attends a specific midwife program only for a few months after she has gained the status of nurse practitioner while a certified nurse midwife has at least several years of training in order to become a certified nurse midwife. This bill directly addresses the least trained of the two categories.

5. Under Section 7.AS21 87.330 we feel that a nurse midwife should not be included under the definition of a participant physician.

6. As the hospital reads section 21.87.125 of the bill we interpret this to mean that all hospitals in the state and other medical service corporations will be required to hire nurse midwives and to have these services available even though some pre-paid plans might not address maternity care.

In closing, the Hospital cannot support this bill as it currently stands. It should be pointed out that Fairbanks Memorial is not objecting to nurse midwives since the hospital has provisions in our bylaws for nurse midwives, physicians assistants and other para-professionals to work in the hospital under the direct supervision of physicians. We are very much against any bill which indicates that a physician would not be supervising this individual.

Thank you for the opportunity to express our position on this bill.

Sincerely,

Tom Mingen
Administrator

TM/mw

Ketchikan General Hospital
3100 TONGASS AVE.
KETCHIKAN, ALASKA 99901
907 – 225-5171

March 6, 1980

Representative Terry Gardiner
House of Representatives
State of Alaska
Pouch "V"
Juneau, Alaska 99811

Dear Terry:

The Medical Staff of Ketchikan General Hospital has asked me to write to you in regard to House Bill 802, introduced by McKinnon, nurse-midwives, particularly in relation to provision of coverage of cost of services provided by nurse-midwives by state licensed insurance companies.

In general, we are in support of the bill and feel it effectively recognizes the role of nurse-midwives in the provision of medical care in the State of Alaska. We have only one problem with the bill and that is Section 18.20.005 which states that a hospital may not be issued a license unless the hospital permits nurse-practitioners to practice in the hospital.

Our objection is essentially a disinterested one as we have a nurse-midwife on the staff at Ketchikan General Hospital who will be accorded full privileges as soon as her certification comes through which we expect within the next two months. We previously had a certified nurse-midwife on the staff and she had full privileges. We are fully in support of the concept of such practitioners functioning in the Ketchikan area. Nonetheless, to restrict a hospital's license simply because it does not choose to employ nurse-midwives seems to be an unnecessary interference in the provision of medical care and an unwarranted intrusion of government regulations into what is essentially a private contractual matter. The intrusion might be warranted if it could be demonstrated that failure to provide nurse-midwifery services would reduce the quality of medical care and jeopardize patients, but I can think of no way of proving such a contention.

It is our feeling that nurse-midwifery is very much a coming thing and it will gradually be accepted throughout the country. We see no need to force the matter and indeed to force the matter only raises resentment.

With alteration of this provision we feel we could support the measure. Thank you for your interest in this matter.

Sincerely,

T.L. Conley, M.D.
Chief of Medical Staff

KGH

March 14, 1980

Representative Thelma Buchholdt
House Hess Committee
Pouch V
Juneau, Alaska 99811

To Legislator:

I would like to lend my support to House Bill 802. As a professional in women's health care, I support the concept of midwifery. Present medicine has evolved to treating pregnancy as an illness rather than as a natural process. A common characteristic of Alaskans is the desire to have control over all aspects of their lives. A Nurse Midwife can provide a cost-effective, personal, scientific, and safe birthing service. Nurses attending modern nurse midwife programs receive much more training in normal pregnancy and delivery than family practice physicians.

This bill can provide the needed impetus for using the nursing talent already residing in this state to a fuller extent.

Thank you for your time,

kay kindt R.N., N.P.
susan emory, r.n.

Fairbanks Health Center
800 Airport Way
Fairbanks, Alaska
99701

KK/mts

cc: Ramona Barnes
Mike Beirne
C.V. Chatterton
Vernon Helburt
Bill Miles
Joyce Munson, Vice Chair

March 11, 1980

Holly Debenham
SR 20114A
Fairbanks, Ak 99701

Dear Sir:

I am writing this letter in support of H.B. 802. I believe that our community could definitely benefit from having nurse practitioners at Fairbanks Memorial Hospital. The doctors would have more of their time to spend with other needful patients if nurse practitioners were allowed to practice (work) in the hospital.

Also the insurance coverage seems to be very important as most doctors, physicians etc have ample insurance coverage, also nurse midwives should be able to get this type of insurance.

I am very happy to see a bill of this sort finally coming through the legislature. It has all of my support.

Holly Debenham

RICHARD J. BABCOCK, M.D.
OBSTETRICS AND GYNECOLOGY
P. O. BOX 513
KETCHIKAN, ALASKA 99901

February 25, 1980

Dear Representative Gardiner:

We would like to add our strong support to House Bill #82, "An Act Relating to Nurse Midwives." The practice of insurance companies in limiting payment arbitrarily to certain health providers while excluding others is grossly unfair to their patrons.

The Nurse Midwife is a well trained, highly skilled practitioner whose services deserve compensation the same as any other recognized member of the healing arts.

Your support of this measure is strongly urged.

Thank you.

Richard J. Babcock, M.D.
Richard J. Babcock

Kat Goodwin, N.M.
Katy Goodwin, N.M.

cc: Representatives: McKinnon
Rogers
Philips

LA21 3997 18.06 03/04/80 JA01 0012 07.45 03/05/80

TO: HOUSE HESS COMMITTEE AND SHANNON GARRETT A.A.

FM: GLENDA STRAUBE, P. O. BOX 81950, FBX AK 99708 PHONE - 479-7692

RE: HB 802

I STRONGLY SUPPORT HB 802, AN ACT RE TO NURSE MIDWIVES. I BELIEVE IT IS
A GOOD STEP IN THE RIGHT DIRECTION. NURSE MIDWIFERY SHOULD BE RECOG-
NIZED AND COVERED BY HEALTH INSURANCE POLICIES AND SHOULD ALSO BE AF-
FORDED THE SAME INDEMNITY AFFORDED TO DOCTORS. THOUGH I DO SUPPORT TH
E
BILL, I DO NOT FEEL THAT IT GOES FAR ENOUGH IN RECOGNIZING THAT BIRTHI
NG
IS A NATURAL EXPERIENCE AND NOT AN ILLNESS. I FEEL NURSE MIDWIVES SHO
ULD
BE PERMITED TO PRACTICED OUTSIDE THE HOSPITALS AND I DO NOT MEAN IN TH
E
PARKING LOTS!.

CAN BE CONTACTED DAYS.

FBX LIO/LJ

TO: HOUSE H.E.S.S. COMMITTEE

FROM: ENID GEIST (CERTIFIED CHILD BIRTH EDUCATOR)
SR BOX 40022, FAIRBANKS, 99701 PH. 452-8740

RE: HB 802

I SUPPORT THIS BILL, I DO NOT THINK THAT IT GOES FAR ENOUGH THAT HOME BIRTH SHOULD BE INCLUDED WITH MEDICAL BACK-UP.

FBX/LIO/MW

SC 1033
Fairbanks Alaska 99701
March 13, 1980

Thelma Buckholdt, Chairman
House HESS Committee
Room 11 - State Capitol
Juneau, Alaska 99811

Dear Ms Buckholdt,

As chairman of the Board of Nursing I have been asked to respond to HB 803 on behalf of the Board. Since our mission is to protect the public, I do not think it appropriate that the Board take a position on a matter of only interest to the nursing profession as an individual, however, I support the bill. We currently have no nurse-midwives authorized to practice under our regulations we have one application that is still being processed. The bill would provide an incentive to attract more of these highly qualified individuals to Alaska.

I do think the matter of mandating third party payers to reimburse nurse-midwives directly needs to be looked at with reference to the availability of medical insurance within the state. Would insurance companies refuse to comply, and hence no insurance coverage would be available to many citizens of our State? I trust Congress has input in this matter, but assume your committee will research it.

Yours truly,
Silvia Hoxtaro

House Health, Education & Social Services Committee Meeting/Hearing on HB802 Date: 3/20/80

	Name	Address and Phone	Organization/Self	For/Against or Observing
1/	Joe McKinnon		Sponsor	
2/	Mrs. Barbara Walker	P.O. Box 282 Anke Bay 789-0977	Alaska Nurses Association	For
3.	DON KOCH	POUCH D JUNEAU 465 2577	DIVISION OF INSURANCE	FOR CONCEPT IF AMENDED
4/				
5/				
6/				
7/				
8/				
9/				
10/				
11/				
12/				
13/				

House Health, Education & Social Services Committee — Meeting/Hearing on HB502 — Date: 2/5/80

	Name	Address and Phone	Organization/Self	For/~~Against~~ or Observing
	Joe McKinnon			
1/	June Debbie Bess introduced			
2/	Vernellia Randall Phillips		DPSS (Dept H+SS)	
3/	Portia ~~Preston~~ Kaufman	~~[illegible]~~	DPSS (") Fam.-health clinic	
4/	Margaret Crawford	(answer questions re: Nurse	nurse midwife practice)	nurse mid-wife
5/	~~[illegible]~~ Don Koch		Div. of Insurance.	
6/	Pam Bradley	Hlns. 455-6152	herself	
7/	Beth Jenson		herself	
8/				
9/				
10/				
11/				
12/				
13/				

STATUTORY PROVISIONS PERTAINING TO LICENSING OF MIDWIVES		ALABAMA (Professions and Businesses 4.34-19-1-.34-19-10)
NURSE-MIDWIFE finition: egistered nurse who as expanded his/her ractice to the care f mothers and babies hrough the maternity ycle.	Requirements	Licensed registered nurse; certificate from school for nurse-midwives.
	Limitations on Practice	Cases of normal childb'rth; physician's supervision necessary.
	Special Statutory Provisions	All deliveries must be planned to take place in hospital.
PROFESSIONAL MIDWIFE finition: n individual who has eceived formal pro- essional training s a midwife.	Requirements	
	Limitations on Practice	
	Special Statutory Provisions	
LAY MIDWIFE finition: individual who actices as a midwife t has not received rmal professional aining.	Requirements	
	Limitations on Practice	Lay midwives holding health department permits may continue to practice until permits are revoked by Board of Health.
	Special Statutory Provisions	

STATUTORY PROVISIONS PERTAINING TO LICENSING OF MIDWIVES		CALIFORNIA (Business and Professional Codes 2.5.2746 - 2.5.2746.8; 12.5.2350-12.5.2359)
NURSE-MIDWIFE efinition: Registered nurse who has expanded his/her practice to the care of mothers and babies through the maternity cycle.	Requirements	
	Limitations on Practice	Practice supervised by physician or surgeon (physician's presence not required); case of normal childbirth. Authorized to provide family-planning care. Shall not use instruments, or artificial, forcible, or mechanical means to assist childbirth, nor perform version; shall refer complicated cases to physician. Shall not perform abortion
	Special Statutory Provisions	Requirements for censure are left up to appropriate boards and committees. In general California's statutes establish the confines of the practice.
PROFESSIONAL MIDWIFE efinition: An individual who has received formal professional training as a midwife.	Requirements	
	Limitations on Practice	
	Special Statutory Provisions	
LAY MIDWIFE efinition: n individual who ractices as a midwife ut has not received ormal professional raining.	Requirements	
	Limitations on Practice	
	Special Statutory Provisions	

STATUTORY PROVISIONS PERTAINING TO LICENSING OF MIDWIVES		CONNECTICUT (377.20-75)
NURSE-MIDWIFE efinition: egistered nurse who as expanded his/her ractice to the care f mothers and babies hrough the maternity ycle.	Requirements	
	Limitations on Practice	
	Special Statutory Provisions	
PROFESSIONAL MIDWIFE efinition: n individual who has eceived formal pro- fessional training as a midwife.	Requirements	Graduate of school of midwifery.
	Limitations on Practice	Cases of normal labor (uncomplicated vertex or head presentation). Shall not use drug instruments, nor perform version or attempt to remove adherent plancenta. Shall not a woman in labor until after seventh month of gestation.
	Special Statutory Provisions	Examination required for licensing.
LAY MIDWIFE efinition: n individual who ractic s as a midwife ut has not received ormal professional raining.	Requirements	
	Limitations on Practice	
	Special Statutory Provisions	

STATUTORY PROVISIONS PERTAINING TO LICENSING OF MIDWIVES		FLORIDA (30.485.011 - 30.485.091)
NURSE-MIDWIFE efinition: egistered nurse who as expanded his/her ractice to the care f mothers and babies hrough the maternity ycle.	Requirements	
	Limitations on Practice	
	Special Statutory Provisions	
PROFESSIONAL MIDWIFE efinition: An individual who has received formal professional training as a midwife.	Requirements	Diploma from school for midwives; sponsorship by two practicing physicians ability t read manual intelligently and write legibly (this may be waived).
	Limitations on Practice	Cases of normal labor; shall not use drugs, instruments, nor assist labor in any artif forcible, or mechanical manner, nor attempt to remove adherent plancenta. Shall not u poisonous drug or herb medicine, nor attempt treatment of disease when attendance of physician cannot be secured.
	Special Statutory Provisions	
LAY MIDWI. efinition: n individual who ractices as a midwife ut has not received ormal professional raining.	Requirements	Attendance, under the supervision of a physician, at not less than fifteen cases of lab and the care of fifteen or more mothers and newborns for periods of at least ten days e sponsorship by two physicians; ability to read manual intelligently and write legibly (this may be waived).
	Limitations on Practice	
	Special Statutory Provisions	

STATUTORY PROVISIONS PERTAINING TO LICENSING OF MIDWIVES		INDIANA (25-22-1-5,22-22-1-6; Admin. Rules (25-22.5-5-5)-1, (25-22.5-5-5)-2
NURSE-MIDWIFE finition: egistered nurse who as expanded his/her ractice to the care f mothers and babies hrough the maternity ycle.	Requirements	
	Limitations on Practice	
	Special Statutory Provisions	
PROFESSIONAL MIDWIFE finition: n individual who has eceived formal pro- essional training s a midwife.	Requirements	Diploma from school of midwifery which has proper equipment to teach anatomy, physiolo hygiene, anticepsis, neurology, toxicology, and the proper management of labor; high school education; ability to read and write the English language* *There are few schools in this country which train midwives who are not nurses. Since many professional midwives were educated at foreign institutions, some states feel is
	Limitations on Practice	necessary to require proficiency in English.
	Special Statutory Provisions	(Statutes pertaining to midwifery in Indiana date to the late 1800's. Midwifery in th state is presently controlled by administrative code. Both the statutes and codes have been included.) Examination required for licensing. Gratuitous services in an emergency not prohibite by act, nor does it restrict licensed physicians.
LAY MIDWIFE finition: individual who ractices as a midwife t has not received rmal professional aining.	Requirements	
	Limitations on Practice	
	Special Statutory Provisions	

STATUTORY PROVISIONS PERTAINING TO LICENSING OF MIDWIVES		MARYLAND (Art.43.82-94)
NURSE-MIDWIFE finition: egistered nurse who as expanded his/her ractice to the care f mothers and babies hrough the maternity ycle.	Requirements	Certified by American College of Nurse-Midwives as a nurse-midwife.
	Limitations on Practice	Normal cases of pregnancy; cannot practice medicine or prescribe drugs. Shall not induc labor or produce abortion.
	Special Statutory Provisions	Person who isnot licensed midwife may practice under the personal and direct supervisio of a physician. Subtitle does not restrict physician or person volunteering service in an emergency.
PROFESSIONAL MIDWIFE finition: n individual who has eceived formal pro- essional training s a midwife.	Requirements	
	Limitations on Practice	
	Special Statutory Provisions	
LAY MIDWIFE finition: individual who actices as a midwife t has not received rmal professional aining.	Requirements	
	Limitations on Practice	
	Special Statutory Provisions	Maryland midwifery laws updated 1970. Previous laws licensed midwives determined qualified by two practicing physicians. (These statutes have been included).

STATUTORY PROVISIONS PERTAINING TO LICENSING OF MIDWIVES		MINNESOTA (148.30 - 148.32)
NURSE-MIDWIFE efinition: Registered nurse who has expanded his/her practice to the care of mothers and babies through the maternity cycle.	Requirements	
	Limitations on Practice	
	Special Statutory Provisions	
PROFESSIONAL MIDWIFE efinition: An individual who has received formal professional training as a midwife.	Requirements	Diploma from a school of midwifery.
	Limitations on Practice	
	Special Statutory Provisions	
LAY MIDWIFE efinition: n individual who ractices as a midwife ut has not received ormal professional raining.	Requirements	Consent of seven members of the State Board of Medical Examiners given after examinati of condidate.
	Limitations on Practice	
	Special Statutory Provisions	

STATUTORY PROVISIONS PERTAINING TO LICENSING OF MIDWIVES		MONTANA (66-1246)
NURSE-MIDWIFE finition: gistered nurse who s expanded his/her actice to the care mothers and babies rough the maternity cle.	Requirements	Certificate in nurse-midwifery from the American College of Nurse-Midwives.
	Limitations on Practice	
	Special Statutory Provisions	
PROFESSIONAL MIDWIFE finition: n individual who has eceived formal pro- essional training s a midwife.	Requirements	
	Limitations on Practice	
	Special Statutory Provisions	
LAY MIDWIFE finition: individual who actices as a midwife t has not received rmal profess onal aining.	Requirements	
	Limitations on Practice	
	Special Statutory Provisions	

STATUTORY PROVISIONS PERTAINING TO LICENSING OF MIDWIVES		NEW JERSEY (45:10)
NURSE-MIDWIFE efinition: egistered nurse who as expanded his/her ractice to the care f mothers and babies hrough the maternity ycle.	Requir ments	
	Limitations on Practice	
	Special Statutory Provisions	
PROFESSIONAL MIDWIFE efinition: An individual who has received formal professional training as a midwife.	Requirements	Certificate from school of midwifery, or maternity hospital granted after 1800 hours instruction in not less than nine months. Certificate from foreign school of midwifery of equal requirements. Endorsement by physician.
	Limitations on Practice	Shall not perform criminal abortion. Normal labor cases. only.
	Special Statutory Provisions	Examination required. Topics covered by examination specifically laid out by statute Chapter does not restrict physician nor gratuitous service in an emergency. New Jersey midwifery laws similar to Washington's.
LAY MIDWIFE efinition: n individual who ractices as a midwife ut has not received ormal professional raining.	Requirements	
	Limitations on Practice	
	Special Statutory Provisions	

STATUTORY PROVISIONS PERTAINING TO LICENSING OF MIDWIVES		OHIO (4731.30-4731.34)
NURSE-MIDWIFE efinition: Registered nurse who has expanded his/her practice to the care of mothers and babies through the maternity cycle.	Requirements	Diploma from college for nurse-midwives
	Limitations on Practice	Practice under direction and supervision of physician. Shall not perform version, treat breech or face presentation, use instruments or treat abnormal condition, except in emergencies.
	Special Statutory Provisions	Examination may be required.
PROFESSIONAL MIDWIFE efinition: An individual who has received formal professional training as a midwife.	Requirements	
	Limitations on Practice	
	Special Statutory Provisions	
LAY MIDWIFE efinition: n individual who practices as a midwife ut has not received ormal professional raining.	Requirements	
	Limitations on Practice	
	Special Statutory Provisions	

STATUTORY PROVISIONS PERTAINING TO LICENSING OF MIDWIVES		UTAH (58-44-1 - 58-44-11)
NURSE-MIDWIFE efinition: Registered nurse who as expanded his/her practice to the care f mothers and babies hrough the maternity ycle.	Requirements	Completed approved certified nurse-midwifery education program.
	Limitations on Practice	Under this act, may also provide normal gynecological services.
	Special Statutory Provisions	Establishes committee to supervise practice or nurse-midwifery. Examination requir Act does not affect rights of parents to deliver their baby, where, when, how and with who they choose regardless of certification.
PROFESSIONAL MIDWIFE efinition: An individual who has received formal professional training as a midwife.	Requirements	
	Limitations on Practice	
	Special Statutory Provisions	
LAY MIDWIFE efinition: n individual who ractices as a midwife ut has not received ormal professional raining.	Requirements	
	Limitations on Practice	
	Special Statutory Provisions	

STATUTORY PROVISIONS PERTAINING TO LICENSING OF MIDWIVES		WASHINGTON (18.50.090 - 18.50.110)
NURSE-MIDWIFE efinition: Registered nurse who has expanded his/her practice to the care of mothers and babies through the maternity cycle.	Requirements	
	Limitations on Practice	
	Special Statutory Provisions	
PROFESSIONAL MIDWIFE efinition: An individual who has received formal professional training as a midwife.	Requirements	Diploma from legally incorporated school on midwifery in good standing, granted after least 2 courses of instruction of at least seven months each in different calendar yea Diploma from foreign institution on midwifery of equal requirements.
	Limitations on Practice	Shall not prescribe any drugs or medicine except some household remedy.
	Special Statutory Provisions	Examination required. Topics covered by examination specifically laid out by statute. Gratuitous service not prohibited by chapter. Washington's midwifery laws similar to New Jersey's.
LAY MIDWIFE efinition: n individual who ractices as a midwife ut has not received ormal professional raining.	Requirements	
	Limitations on Practice	
	Special Statutory Provisions	

STATUTORY PROVISIONS PERTAINING TO LICENSING OF MIDWIVES		WEST VIRGINIA (30-15-1 -30-15-8)
NURSE-MIDWIFE Definition: Registered nurse who has expanded his/her practice to the care of mothers and babies through the maternity cycle.	Requirements	Graduate of school of midwifery; certified by American College of Nurse-Midwives.
	Limitations on Practice	Practice under the supervision of or in association with physician engaged in family practice or specialized field of gynecology or obstetrics.
	Special Statutory Provisions	Persons holding licenses issued before current laws enacted may continue to practice until expiration of licenses without privilege of renewal.
PROFESSIONAL MIDWIFE Definition: An individual who has received formal professional training as a midwife.	Requirements	
	Limitations on Practice	
	Special Statutory Provisions	
LAY MIDWIFE Definition: An individual who practices as a midwife but has not received formal professional training.	Requirements	
	Limitations on Practice	
	Special Statutory Provisions	

STATUTORY PROVISIONS PERTAINING TO LICENSING OF MIDWIVES		ALABAMA (Professions and Businesses 4.34-19-1-.34-19-10)
NURSE-MIDWIFE **Definition:** Registered nurse who has expanded his/her practice to the care of mothers and babies through the maternity cycle.	Requirements	Licensed registered nurse; certificate from school for nurse-midwives.
	Limitations on Practice	Cases of normal childbirth; physician's supervision necessary.
	Special Statutory Provisions	All deliveries must be planned to take place in hospital.
PROFESSIONAL MIDWIFE **Definition:** An individual who has received formal professional training as a midwife.	Requirements	
	Limitations on Practice	
	Special Statutory Provisions	
LAY MIDWIFE **Definition:** An individual who practices as a midwife but has not received formal professional training.	Requirements	
	Limitations on Practice	Lay midwives holding health department permits may continue to practice until permits are revoked by Board of Health.
	Special Statutory Provisions	

STATUTORY PROVISIONS PERTAINING TO LICENSING OF MIDWIVES		CALIFORNIA (Business and Professional Codes 2.5.2746 - 2.5.2746.8; 12.5.2350-12.5.2359)
NURSE-MIDWIFE Definition: Registered nurse who has expanded his/her practice to the care of mothers and babies through the maternity cycle.	Requirements	
	Limitations on Practice	Practice supervised by physician or surgeon (physician's presence not required); cases of normal childbirth. Authorized to provide family-planning care. Shall not use instruments, or artificial, forcible, or mechanical means to assist childbirth, nor perform version; shall refer complicated cases to physician. Shall not perform abortions.
	Special Statutory Provisions	Requirements for censure are left up to appropriate boards and committees. In general, California's statutes establish the confines of the practice.
PROFESSIONAL MIDWIFE Definition: An individual who has received formal professional training as a midwife.	Requirements	
	Limitations on Practice	
	Special Statutory Provisions	
LAY MIDWIFE Definition: An individual who practices as a midwife but has not received formal professional training.	Requirements	
	Limitations on Practice	
	Special Statutory Provisions	

STATUTORY PROVISIONS PERTAINING TO LICENSING OF MIDWIVES		CONNECTICUT (377.20-75)
NURSE-MIDWIFE Definition: Registered nurse who has expanded his/her practice to the care of mothers and babies through the maternity cycle.	Requirements	
	Limitations on Practice	
	Special Statutory Provisions	
PROFESSIONAL MIDWIFE Definition: An individual who has received formal professional training as a midwife.	Requirements	Graduate of school of midwifery.
	Limitations on Practice	Cases of normal labor (uncomplicated vertex or head presentation). Shall not use drugs, instruments, nor perform version or attempt to remove adherent plancenta. Shall not attend woman in labor until after seventh month of gestation.
	Special Statutory Provisions	Examination required for licensing.
LAY MIDWIFE Definition: An individual who practices as a midwife but has not received formal professional training.	Requirements	
	Limitations on Practice	
	Special Statutory Provisions	

STATUTORY PROVISIONS PERTAINING TO LICENSING OF MIDWIVES		FLORIDA (30.485.011 - 30.485.091)
NURSE-MIDWIFE **Definition:** Registered nurse who has expanded his/her practice to the care of mothers and babies through the maternity cycle.	Requirements	
	Limitations on Practice	
	Special Statutory Provisions	
PROFESSIONAL MIDWIFE **Definition:** An individual who has received formal professional training as a midwife.	Requirements	Diploma from school for midwives; sponsorship by two practicing physicians; ability to read manual intelligently and write legibly (this may be waived).
	Limitations on Practice	Cases of normal labor; shall not use drugs, instruments, nor assist labor in any artificial, forcible, or mechanical manner, nor attempt to remove adherent plancenta. Shall not use poisonous drug or herb medicine, nor attempt treatment of disease when attendance of physician cannot be secured.
	Special Statutory Provisions	
LAY MIDWIFE **Definition:** An individual who practices as a midwife but has not received formal professional training.	Requirements	Attendance, under the supervision of a physician, at not less than fifteen cases of labor and the care of fifteen or more mothers and newborns for periods of at least ten days each; sponsorship by two physicians; ability to read manual intelligently and write legibly (this may be waived).
	Limitations on Practice	
	Special Statutory Provisions	

STATUTORY PROVISIONS PERTAINING TO LICENSING OF MIDWIVES		INDIANA (25-22-1-5,22-22-1-6; Admin. Rules (25-22.5-5-5)-1, (25-22.5-5-5)-2
NURSE-MIDWIFE Definition: Registered nurse who has expanded his/her practice to the care of mothers and babies through the maternity cycle.	Requirements	
	Limitations on Practice	
	Special Statutory Provisions	
PROFESSIONAL MIDWIFE Definition: An individual who has received formal professional training as a midwife.	Requirements	Diploma from school of midwifery which has proper equipment to teach anatomy, physiology, hygiene, anticepsis, neurology, toxicology, and the proper management of labor; high school education; ability to read and write the English language* *There are few schools in this country which train midwives who are not nurses. Since many professional midwives were educated at foreign institutions, some states feel is necessary to require proficiency in English.
	Limitations on Practice	
	Special Statutory Provisions	(Statutes pertaining to midwifery in Indiana date to the late 1800's. Midwifery in the state is presently controlled by administrative code. Both the statutes and codes have been included.) Examination required for licensing. Gratuitous services in an emergency not prohibited by act, nor does it restrict licensed physicians.
LAY MIDWIFE Definition: An individual who practices as a midwife but has not received formal professional training.	Requirements	
	Limitations on Practice	
	Special Statutory Provisions	

STATUTORY PROVISIONS PERTAINING TO LICENSING OF MIDWIVES		MARYLAND (Art.43.82-94)
NURSE-MIDWIFE Definition: Registered nurse who has expanded his/her practice to the care of mothers and babies through the maternity cycle.	Requirements	Certified by American College of Nurse-Midwives as a nurse-midwife.
	Limitations on Practice	Normal cases of pregnancy; cannot practice medicine or prescribe drugs. Shall not induce labor or produce abortion.
	Special Statutory Provisions	Person who isnot licensed midwife may practice under the personal and direct supervision of a physician. Subtitle does not restrict physician or person volunteering service in an emergency.
PROFESSIONAL MIDWIFE Definition: An individual who has received formal professional training as a midwife.	Requirements	
	Limitations on Practice	
	Special Statutory Provisions	
LAY MIDWIFE Definition: An individual who practices as a midwife but has not received formal professional training.	Requirements	
	Limitations on Practice	
	Special Statutory Provisions	Maryland midwifery laws updated 1970. Previous laws licensed midwives determined qualified by two practicing physicians. (These statutes have been included).

STATUTORY PROVISIONS PERTAINING TO LICENSING OF MI[illegible]IVES		MINNESOTA (148.30 - 148.32)
NURSE-MIDWIFE Definition: Registered nurse who has expanded his/her practice to the care of mothers and babies through the maternity cycle.	Requirements	
	Limitations on Practice	
	Special Statutory Provisions	
PROFESSIONAL MIDWIFE Definition: An individual who has received formal professional training as a midwife.	Requirements	Diploma from a school of midwifery.
	Limitations on Practice	
	Special Statutory Provisions	
LAY MIDWIFE Definition: An individual who practices as a midwife but has not received formal professional training.	[illegible]quirements	Consent of seven members of the State Board of Medical Examiners given after examination of condidate.
	Limitations on Practice	
	Special Statutory Provisions	

STATUTORY PROVISIONS PERTAINING TO LICENSING OF MIDWIVES		MONTANA (66-1246)
NURSE-MIDWIFE Definition: Registered nurse who has expanded his/her practice to the care of mothers and babies through the maternity cycle.	Requirements	Certificate in nurse-midwifery from the American College of Nurse-Midwives.
	Limitations on Practice	
	Special Statutory Provisions	
PROFESSIONAL MIDWIFE Definition: An individual who has received formal professional training as a midwife.	Requirements	
	Limitations on Practice	
	Special Statutory Provisions	
LAY MIDWIFE Definition: An individual who practices as a midwife but has not received formal professional training.	Requirements	
	Limitations on Practice	
	Special Statutory Provisions	

STATUTORY PROVISIONS PERTAINING TO LICENSING OF MIDWIVES		NEW JERSEY (45:10)
NURSE-MIDWIFE Definition: Registered nurse who has expanded his/her practice to the care of mothers and babies through the maternity cycle.	Requirements	
	Limitations on Practice	
	Special Statutory Provisions	
PROFESSIONAL MIDWIFE Definition: An individual who has received formal professional training as a midwife.	Requirements	Certificate from school of midwifery, or maternity hospital granted after 1800 hours of instruction in not less than nine months. Certificate from foreign school of midwifery of equal requirements. Endorsement by physician.
	Limitations on Practice	Shall not perform criminal abortion. Normal labor cases. only.
	Special Statutory Provisions	Examination required. Topics cov red by examination specifically laid out by statute. Chapter does not restrict physician nor gratuitous service in an emergency. New Jersey midwifery laws similar to Washington's.
LAY MIDWIFE Definition: An individual who practices as a midwife but has not received formal professional training.	Requirements	
	Limitations on Practice	
	Special Statu y Provisions	

STATUTORY PROVISIONS PERTAINING TO LICENSING OF MIDWIVES		OHIO (4731.30-4731.34)
NURSE-MIDWIFE Definition: Registered nurse who has expanded his/her practice to the care of mothers and babies through the maternity cycle.	Requirements	Diploma from college for nurse-midwives
	Limitations on Practice	Practice under direction and supervision of physician. Shall not perform version, treat breech or face presentation, use instruments or treat abnormal condition, except in emergencies.
	Special Statutory Provisions	Examination may be required.
PROFESSIONAL MIDWIFE Definition: An individual who has received formal professional training as a midwife.	Requirements	
	Limitations on Practice	
	Special Statutory Provisions	
LAY MIDWIFE Definition: An individual who practices as a midwife but has not received formal professional training.	Requirements	
	Limitations on Practice	
	Special Statutory Provisions	

STATUTORY PROVISIONS PERTAINING TO LICENSING OF MIDWIVES		UTAH (58-44-1 - 58-44-11)
NURSE-MIDWIFE **Definition:** Registered nurse who has expanded his/her practice to the care of mothers and babies through the maternity cycle.	Requirements	Completed approved certified nurse-midwifery education program.
	Limitations on Practice	Under this act, may also provide normal gynecological services.
	Special Statutory Provisions	Establishes committee to supervise practice or nurse-midwifery. Examination required. Act does not affect rights of parents to deliver their baby, where, when, how and with who they choose regardless of certification.
PROFESSIONAL MIDWIFE **Definition:** An individual who has received formal professional training as a midwife.	Requirements	
	Limitations on Practice	
	Special Statutory Provisions	
LAY MIDWIFE **Definition:** An individual who practices as a midwife but has not received formal professional training.	Requirements	
	Limitations on Practice	
	Special Statutory Provisions	

STATUTORY PROVISIONS PERTAINING TO LICENSING OF MIDWIVES		WASHINGTON (18.50.090 - 18.50.110)
NURSE-MIDWIFE **Definition:** Registered nurse who has expanded his/her practice to the c re of mothers and ba ies through the maternity cycle.	Requirements	
	Limitations on Practice	
	Special Statutory Provisions	
PROFESSIONAL MIDWIFE **Definition:** An individual who has received formal professional training as a midwife.	Requirements	Diploma from legally incorporated school on midwifery in good standing, granted after at least 2 courses of instruction of at least seven months each in different calendar years. Diploma from foreign institution on midwifery of equal requirements.
	Limitations on Practice	Shall not prescribe any drugs or medicine except some household remedy.
	Special Statutory Provisions	Examination required. Topics covered by examination specifically laid out by statute. Gratuitous service not prohibited by chapter. Washington's midwifery laws similar to New Jersey's.
LAY MIDWIFE **Definition:** An individual who practices as a midwife but has not received formal professional training.	Requirements	
	Limitations on Practice	
	Special Statutory Provisions	

STATUTORY PROVISIONS PERTAINING TO LICENSING OF MIDWIVES		WEST VIRGINIA (30-15-1 -30-15-8)
NURSE-MIDWIFE Definition: Registered nurse who has expanded his/her practice to the care of mothers and babies through the maternity cycle.	Requirements	Graduate of school of midwifery; certified by American College of Nurse-Midwives.
	Limitations on Practice	Practice under the supervision of or in association with physician engaged in family practice or specialized field of gynecology or obstetrics.
	Special Statutory Provisions	Persons holding licenses issued before current laws enacted may continue to practice until expiration of licenses without privilege of renewal.
PROFESSIONAL MIDWIFE Definition: An individual who has received formal professional training as a midwife.	Requirements	
	Limitations on Practice	
	Special Statutory Provisions	
LAY MIDWIFE Definition: An individual who practices as a midwife but has not received formal professional training.	Requirements	
	Limitations on Practice	
	Special Statutory Provisions	

House Health, Education & Social Services Committee Meeting/Hearing on HB502 Date: 3/20/80

	Name	Address and Phone	Organization/Self	For/Against or Observing
1/	Joe McKinnon		Sponsor	
2/	Mrs. Barbara Walker	P.O. Box 282 Auke Bay 789-0977	Alaska Nurses Association	For
3/	DON KOCH	POUCH D JUNEAU 465 2577	DIVISION OF INSURANCE	FOR CONCEPT IF AMENDED
4/				
5/				
6/				
7/				
8/				
9/				
10/				
11/				
12/				
13/				

House Health, Education & Social Services Committee Meeting/Hearing on HB502 Date: 2/5/80

	Name	Address and Phone	Organization/Self	For/~~Against~~ or Observing
	Joe McClernon			
1/	Rep Debbie Bebo (introduced)			
2/	Vernellia Randall-Phillips		DA-SS (Dept H+SS)	
3/	Portia ~~Porter~~ Kaufman		D+SS (")	
4/	Margaret Crawford	(answer questions re: Nurse	Fam. Health clinic w/ Nurse practice)	nurse mid-wife
5/	~~Don~~ Don Koch		Dir. of Insurance	
6/	Pam Bradley	Mts. 455-6152	herself	
7/	Beth Jenson		herself	
8/				
9/				
10/				
11/				
12/				
13/				

PROVIDENCE
HOSPITAL

3200 PROVIDENCE DRIVE - POUCH 6604
ANCHORAGE, ALASKA 99502
PHONE: (907) 276-4531

SISTERS OF
PROVIDENCE

SERVING IN THE WEST SINCE 1856

March 5, 1980

The Honorable Thelma Buchholdt
Pouch V
Juneau, Alaska 99811

Position Paper: H.B. 802 - "An Act relating to nurse midwives"

Dear Representative Buchholdt:

Providence Hospital cannot support passage of H.B. 802, "An Act relating to nurse midwives," because of the following reasons:

1. Licensure

To suggest that a hospital's licensure is dependent on permitting para-professionals such as nurse practitioner midwives to practice medicine is irresponsible and probably unconstitutional. The passing of this law would totally disregard the requirements of the medical staff by-laws, the quality assurance and the medical review processes, which are so important in maintaining quality patient care standards.

2. Malpractice Insurance

In the State of Alaska, where malpractice insurance has traditionally been difficult to obtain, requiring them to make available malpractice coverage to nurse practitioners, as primary admitters, would most likely, 1) make malpractice rates skyrocket, and 2) would probably send insurance companies running out of the state.

3. Types of Midwives

It is interesting to note that the bill specifically relates to certified nurse practitioner midwives -- and the traditional, and far more extensively trained certified nurse midwife commonly found in Europe and in a few places in the United States is left out.

The differences in training of these two categories is quite extensive. The nurse practitioner midwife goes to a program of a few months, whereas the Certified Nurse Midwife of the

European model sometimes trains for a couple of years. This further demonstrates the special interest involved. They are certainly not the same, and cannot be grouped together in terms of training, abilities and experience.

4. Currently, under our medical by-laws and those of other hospitals, para-professionals are permitted to practice medicine only under the direction of the sponsoring physicians who monitor the privileges granted and quality of care delivered.

   We also endorse the hiring of these practitioners (para-professionals), by hospitals, to deliver nursing care.

Thank you for the opportunity of expressing our position on this bill.

Sincerely,

Al M. Tamosso
Administrator

AMC/mm

cc: Senator Glenn Hackney
Senator Mike Colletta
Senator Arliss Sturgulewski
Max Kersbergen
William Dann
Charles Rigden
Ron Hammett
Donald DeMers
Jack Brown
Alaskan Hospital Administrators
Advisory Board

TELECOPY INSTRUCTIONS: For Immediate Delivery to Committee

Copy to Rep. Buchholdt
Members House HESS Committee
Above Listed Senators

STATE OF ALASKA

JAY S. HAMMOND, GOVERNOR

DEPARTMENT OF COMMERCE & ECONOMIC DEVELOPMENT

DIVISION OF INSURANCE

POUCH D
JUNEAU, ALASKA 99811

March 4, 1980

Honorable Thelma Buchholdt
Chairman
House Education & Social
Services Committee
Alaska House of Representatives
Pouch V
Juneau, Alaska 99811

Dear Ms. Buchholdt:

RE: House Bill 802

You have requested a position paper for House Bill 802. The Division of Insurance has in the past opposed mandated or required coverages for disability insurance policies. We have on two occasions ventured across this line to support mandated coverages. The first was in support of coverage for newly-born children which became law in 1975 (AS 21.42.345). The second was with Senate Bill 227 which would mandate alcoholism benefits. This bill was before your committee last year and is presently in House Rules.

In both cases there was substantial imperative for the types of benefits sought. With newly-born children, the practice of insurers was to provide no coverage until 14 days after birth, which when coupled with the preexisting conditions clause in many policies, gave rise to some substantial financial burdens on new parents with sick, ill or defective newborn children. In the case of a mandated alcoholism benefit, the imperative was, and is, that alcoholism is generally recognized as Alaska's number one health problem. We do not believe that similar imperatives exist to suggest a required maternity or nurse midwife coverage.

We have prepared a section-by-section analysis or commentary which may help in our view of this legislation.

Section 1. This section would most appropriately be commented on by the Department of Health and Social Services. The section is not crucial to the insurance aspects of the bill, which represents the remaining portion of the proposed legislation.

Section 2. Under this section coverages provided on an expense incurred basis shall provide that the health insurance benefits applicable to maternity coverage consider benefits provided by nurse midwife. This language is not objectionable. The title of the section, however, is somewhat misleading and might better be called "COVERAGE FOR COST OF SERVICES PROVIDED BY NURSE MIDWIVES."

Section 3. The language suggests that maternity benefits are required to be provided under an expense incurred policy. Presently, federal law requires maternity benefits on group coverages where the group has more than 15 persons. This proposal would extend to individual policies and to smaller groups. We are opposed to an expansion of this concept because of cost. We believe that removal of this section will not impair the bill since it is really a repeat of Section 2 of the bill. This same comment applies to Section 4 and Section 5.

Section 6. This section in effect mandates maternity benefits for medical service corporations, of which there are two now in the State. The first is Delta Dental Plans which is a dental medical service corporation and the second is Fairbanks Physicians which is currently inoperative. Blue Cross is a hospital service corporation and would appear to be unaffected by this section due to repeated references to AS 21.87.120.

Section 7. This section is not objectionable but does not really affect anyone presently except for the Delta Dental Plan. AS 21.87.330(9) which defines "physician" as distinquished from "participant physicians" should be modified to include nurse midwife.

Section 8. This section is not objectionable.

Finally, the Commerce Committee of the House is presently considering House 882 which permits the Director of Insurance to minimum standards on various lines of insurance which can potentially resolve the problems that this bill appears to address. If all expense incurred policies had to include nurse midwives as physicians or participating physician then I think this bill would become a moot issue.

To summarize, we believe that a number of amendments should be made to this bill to make it a bill that can be supported by the Administration. These references are:

Page 1, line 14, remove the words "REQUIRED PROVISION FOR" and change the word "OF" between "COVERAGE" and "COST" to read "FOR."

Page 1, lines 22 through 29. Eliminate.

Page 2. Eliminate entire page.

Page 3, lines 1 through 3. Eliminate.

Page 3 between lines 3 and 4. Establish new section to read:

AS 21.84.590(6) is amended to read. (6) AS 21.42.290 and AS 21.42.347.

Page 3, line 4. Renumber the section as appropriate and retain the wording that appears on lines 5 through line 8.

Page 3 between lines 8 and 9. Add a new section to read:

AS 21.87.330(9) is amended to read. (9) "physician" [includes also] means a doctor, dentist, osteopath, optometrist, chiropractor, nurse midwife, surgeon, or other licensed health care practitioner.

Page 3, line 14. Add a new section to read:

AS 21.87340(15) is amended to read: (15) 21.42.345 and AS 21.42.347.

The above amendments would result in a bill acceptable to the Division of Insurance. If you have any additional questions, we would be happy to assist in answering them for you.

Very truly yours,

Donald P. Koch
Chief of Market Surveillance

DPK/kkk2/1

Ketchikan General Hospital
3100 TONGASS AVE.
KETCHIKAN, ALASKA 99901
907 – 225-5171

March 6, 1980

Representative Terry Gardiner
House of Representatives
State of Alaska
Pouch "V"
Juneau, Alaska 99811

Dear Terry:

The Medical Staff of Ketchikan General Hospital has asked me to write to you in regard to House Bill 802, introduced by McKinnon, nurse-midwives, particularly in relation to provision of coverage of cost of services provided by nurse-midwives by state licensed insurance companies.

In general, we are in support of the bill and feel it effectively recognizes the role of nurse-midwives in the provision of medical care in the State of Alaska. We have only one problem with the bill and that is Section 18.20.005 which states that a hospital may not be issued a license unless the hospital permits nurse-practitioners to practice in the hospital.

Our objection is essentially a disinterested one as we have a nurse-midwife on the staff at Ketchikan General Hospital who will be accorded full privileges as soon as her certification comes through which we expect within the next two months. We previously had a certified nurse-midwife on the staff and she had full privileges. We are fully in support of the concept of such practitioners functioning in the Ketchikan area. Nonetheless, to restrict a hospital's license simply because it does not choose to employ nurse-midwives seems to be an unnecessary interference in the provision of medical care and an unwarranted intrusion of government regulations into what is essentially a private contractual matter. The intrusion might be warranted if it could be demonstrated that failure to provide nurse-midwifery services would reduce the quality of medical care and jeopardize patients, but I can think of no way of proving such a contention.

It is our feeling that nurse-midwifery is very much a coming thing and it will gradually be accepted throughout the country. We see no need to force the matter and indeed to force the matter only raises resentment.

With alteration of this provision we feel we could support the measure. Thank you for your interest in this matter.

Sincerely,

T.L. Conley, M.D.
Chief of Medical Staff

KGH

March 14, 1980

Representative Thelma Buchholdt
House Hess Committee
Pouch V
Juneau, Alaska 99811

To Legislator:

I would like to lend my support to House Bill 802. As a professional in women's health care, I support the concept of midwifery. Present medicine has evolved to treating pregnancy as an illness rather than as a natural process. A common characteristic of Alaskans is the desire to have control over all aspects of their lives. A Nurse Midwife can provide a cost-effective, personal, scientific, and safe birthing service. Nurses attending modern nurse midwife programs receive much more training in normal pregnancy and delivery than family practice physicians.

This bill can provide the needed impetus for using the nursing talent already residing in this state to a fuller extent.

Thank you for your time,

kay kindt R.N., N.P.

susan emory, r.n.

KK/mts

cc: Ramona Barnes
Mike Beirne
C.V. Chatterton
Vernon Helburt
Bill Miles
Joyce Munson, Vice Chair

Fairbanks Health Center
800 Airport Way
Fairbanks, Alaska
99701

March 11, 1980

Holly Debenham
SR 20114 A
Fairbanks, Ak 99701

Dear Sir:

I am writing this letter in support of H B 502. I believe that our community could definitely benefit from having nurse practitioners at Fairbanks Memorial Hospital. The doctors would have more of their time to spend with other needful patients if nurse practitioners were allowed to practice (work) in the hospital.

Also the insurance coverage seems to be very important as most doctors, physicians etc have ample insurance coverage, also Nurse Midwives should be able to get this type of insurance.

I am very happy to see a bill of this sort finally coming through the legislature. It has all of my support.

Holly Debenham

HB 802

RICHARD J. BABCOCK, M.D.
OBSTETRICS AND GYNECOLOGY
P. O. BOX 513
KETCHIKAN, ALASKA 99901

February 25, 1980

Dear Representative Gardiner:

We would like to add our strong support to House Bill #82, "An Act Relating to Nurse Midwives." The practice of insurance companies in limiting payment arbitrarily to certain health providers while excluding others is grossly unfair to their patrons.

The Nurse Midwife is a well trained, highly skilled practitioner whose services deserve compensation the same as any other recognized member of the healing arts.

Your support of this measure is strongly urged.

Thank you.

Richard J. Babcock, M.D.
Richard J. Babcock

Katy Goodwin, N.M.
Katy Goodwin, N.M.

cc: Representatives: McKinnon
Rogers
Philips

LA21 3227 18.06 03/04/80 JA01 0612 07.45 03/05/80

TO: HOUSE HESS COMMITTEE AND SHANNON GARRETT A.A.

FM: GLENDA STRAUBE, P. O. BOX 01C50, FBX AK 99708 PHONE - 479-7692

RE: HB 802

I STRONGLY SUPPORT HB 802, AN ACT RE TO NURSE MIDWIVES. I BELIEVE IT IS
A GOOD STEP IN THE RIGHT DIRECTION. NURSE MIDWIFERY SHOULD BE RECOG-
NIZED AND COVERED BY HEALTH INSURANCE POLICIES AND SHOULD ALSO BE AF-
FORDED THE SAME INDEMNITY AFFORDED TO DOCTORS. THOUGH I DO SUPPORT TH E
BILL, I DO NOT FEEL THAT IT GOES FAR ENOUGH IN RECOGNIZING THAT BIRTHI NG
IS A NATURAL EXPERIENCE AND NOT AN ILLNESS. I FEEL NURSE MIDWIVES SHO ULD
BE PERMITED TO PRACTICED OUTSIDE THE HOSPITALS AND I DO NOT MEAN IN TH E
PARKING LOTS!.

CAN BE CONTACTED DAYS.

FBX LIO/LJ

ALASKA STATE HOSPITAL ASSOCIATION INC.

5401 CORDOVA STREET
PHONE: 277-1633

ANCHORAGE, ALASKA 99503

March 5, 1980

Thelma Bucholdt
Chairman - Health and Social
Services Committee
Alaska State Legislature
Pouch V
Juneau, Alaska 99811

Re: H.B. 802
"An act relating to
nurse midwives"

Dear Representative Bucholdt:

The Alaska State Hospital Association representing seventeen institutional members who provide obstetrical care is extremely concerned over H.B. 802. While the intent, I am sure, was to make availible to patients an alternative which would provide greater access to O.B. services at a possibly reduced cost, a number of considerations should be evaluated before proceeding with this proposal.

1. Sec.18.20.055 Nurse Midwife Staff Privileges:

   Criteria for the licensure of hospitals which is acceptable under present state and federal regulations does not require that paraprofessionals be accorded staff privileges in order to retain state licensure. To legislate such a requirement would be legally contestable, as it is contrary to accepted standards of safeguards provided under present licensing and hospital by-laws related to the admission of patients to hospitals. Such legislation would open the door to numerous medical paraprofessionals to mandate similar consideration.

   Such action would circumvent the protection that all patients presently may expect from a licensed hospital, i.e. that a board (trustee), medical staff organization and a competent administration are responsible for assuring that minimal standards of training and licensing have been met by practicing staff. A nurse practitioner does not meet the level or training required for physicians, nor do they meet by-law standards for staff privileges.

2. The continued availability and/or additional cost of hospital malpractice should such legislation be inacted leads one to question the prudency of such a proposal. One of the protections that patients and hospitals presently have is recourse for a financial settlement for ajudicated damages. The removal of that protection by a withdrawal of insurance coverage, or a significant increase in the cost of such coverage, due to the inclusion of paraprofessionals as attending staff is a serious concern for our members.

3. Limited investigation due to the shortness of notification of this proposal has identified that third party carriers are not presently able to assure any reduction in premimum costs due to O.B. services provided by paraprofessionals. Lack of experience with this concept does not yet provide a historical base upon which to draw conclusions.

Although for the above stated reasons our association cannot support the proposed bill, let me hasten to add that under the appropriate medical direction and approved hospital standards of medical treatment, paraprofessionals can be effectively utilized in the hospital setting to deliver a sophisticated level of health care.

Thank you for this opportunity to express our concerns and recommendations on this proposal.

Sincerely,

Max Kersbergen
Executive Director

MK/lc

Fairbanks Memorial Hospital
1650 Cowles St.
FAIRBANKS, ALASKA 99701

OPERATED BY
LUTHERAN HOSPITALS AND HOMES SOCIETY
FARGO, NORTH DAKOTA 58102

March 12, 1980

Honorable Thelma Buchholdt
Pouch V
Juneau, Alaska 99811

Re: Position Paper - House Bill No. 802
An Act Relating to Nurse Midwives

Dear Representative Buchholdt:

Fairbanks Memorial Hospital recently submitted preliminary comments on House Bill 802, an act relating to nurse midwives. The Hospital has recently gone back and done more research on this bill and would like to submit the following position on House Bill 802.

Fairbanks Memorial Hospital cannot support House Bill 802 because of the following reasons:

1. The bill as it is currently written would let a nurse midwife work in the hospital without a physician's supervision. To my knowledge all hospitals in the state require nurse midwives, physicians assistants and other para-professionals to be directly supervised by a physician preceptor. If this bill passed, this would prevent nurse midwives from being required to have this physician supervision.

2. The bill as it currently stands grants a nurse midwife hospital privileges. At the current time no para-professional in any Alaska hospital to my knowledge is granted full privileges, but is rather granted an extension of their physician preceptor's privileges. This requires the para-professional to be supervised and to do only those procedures and exams the physician preceptor has privileges to perform.

3. Fairbanks Memorial Hospital does not believe that a hospital's license should be dependent upon any one para-professional group. We believe that if this bill was passed, other para-professionals would request similar status.

4. As I am sure you are aware, there is a severe difference between certified nurse practitioner midwives and certified nurse midwives. A certified nurse practitioner midwife attends a specific midwife program only for a few months after she has gained the status of nurse practitioner while a certified nurse midwife has at least several years of training in order to become a certified nurse midwife. This bill directly addresses the least trained of the two categories.

5. Under Section 7.AS21.37.330 we feel that a nurse midwife should not be included under the definition of a participant physician.

6. As the hospital reads section 21.87.125 of the bill we interpret this to mean that all hospitals in the state and other medical service corporations will be required to hire nurse midwives and to have these services available even though some pre-paid plans might not address maternity care.

In closing, the Hospital cannot support this bill as it currently stands. It should be pointed out that Fairbanks Memorial is not objecting to nurse midwives since the hospital has provisions in our bylaws for nurse midwives, physicians assistants and other para-professionals to work in the hospital under the direct supervision of physicians. We are very much against any bill which indicates that a physician would not be supervising this individual.

Thank you for the opportunity to express our position on this bill.

Sincerely,

Tom Mingen
Administrator

TM/mw

POSITION PAPER/Department of Health & Social Services

POSITION PAPER

HOUSE BILL NO. 802

"An Act relating to nurse midwives."

HB. No. 802 requires that hospitals extend staff privileges to nurse midwives as a condition of licensure. The Bill also defines the coverage of nurse midwives' practice under health and disability insurance policies by requiring coverage by those policies that pay for maternity care. The Bill also requires a medical service corporation, hospital service corporation, and combined medical and hospital service corporation cover nurse midwife services under certain conditions. The Bill also amends the definition of "participant physician" to include a nurse midwife, and adds a new definition defining "nurse midwife" to the Alaska Statutes.

The Department of Health and Social Services will limit its comments to the areas of the practice of the nurse midwife and the requirements of hospitals to extend staff privileges to the midwife as a condition of State licensure. It is our understanding that the Department of Commerce and Economic Development, Division of Insurance, will be commenting separately on the sections dealing with mandatory insurance coverage.

Practice of Nurse Midwives

Nurse midwives have been a part of the American health care system for over fifty years. The practice of nurse midwifery, including the management of labor and delivery, is recognized in the laws of all states except Kansas, Michigan, and Wisconsin. The typical recent graduate of a nurse midwifery educational program has six years of professional nursing experience and a bachelor's degree in addition to nine months to two years of midwifery training. Upon successful completion of the course and a national certification examination, the nurse midwife is prepared to care for women's health needs, including normal childbirth and uncomplicated gynecological and family planning services.

The nurse midwife, according to Alaska law, collaborates with a physician. Nationally, nurse midwives are employed by hospitals, public health agencies, private physicians, the military, prepaid health plans, and birthing centers. Their practice, typically, extends beyond pregnancy and birth to include the post-partum care of the well woman and neonatal care of the infant. Health education is a vital component of the role of the nurse midwife.

The use of nurse midwives can offer greater availability of quality prenatal care, delivery, and post-natal care in medically underserved

areas. As a member of the health care team, the nurse midwife can provide professional care to the normal obstetrical or postpartum patient, thus freeing her collaborating physician to concentrate on patients with problems requiring his or her medical expertise. An expanded use of nurse midwives also can offer an alternative style of care to families at a special time in their lives. The desire of certain families for such an alternative may partially account for the apparent increase in home deliveries, a practice which involves a greater risk.

Requirement of Extension of Staff Privileges to Nurse Midwives as a Condition of Hospital Licensure

The purpose of licensure, rules, regulations, and standards for hospitals is "...promoting safe and adequate treatment of individuals in the interest of public health, safety and welfare..." (AS 18.20.060).

Historically, the State's responsibility began as licensure and inspection of public facilities to look for fire, environmental health, and other standards for the condition of buildings. It then was extended into the area of professional standards requiring certain levels of competence and experience to have been reached by the staff providing care in the hospital. The strictest requirement for hospitals comes as a result of the need to be certified in order for the hospital to be eligible for Federal Medicare and Medicaid reimbursement. Nowhere in State Statute or regulation are hospitals required, as a condition of licensure, to extend staff privileges to professional groups (such as dentists) or paraprofessional groups (such as therapists). HB 802 would break with past precedence by requiring such an extension as a condition of hospital licensure to nurse midwives.

Department Position

The Department of Health and Social Services recognizes the valuable contribution that nurse midwives can make to the overall physical and emotional health of the family at time of pregnancy and delivery. We would encourage hospitals to provide staff privileges to well-qualified nurse midwives who meet the requirements of the Advanced Nurse Practitioner Guidelines issued by the Alaska Board of Nursing. However, the Department believes that the decision to use the services of nurse midwives or other qualified allied health personnel appropriately should rest with each individual hospital, its governing body and administrative staff, and not with the Department of Health and Social Services licensing authority.

Recommended by:

Dean F. Tirador, M.D.
Director, Division
of Public Health

Date: 3/5/80

Joe Betit, Acting Coordinator
Office of State Health
Planning & Development

Date: 3/5/80

Approved by:

Helen D. Beirne
Commissioner

Date: 3/5/80

THE LEGISLATURE OF THE STATE OF ALASKA
ELEVENTH LEGISLATURE

FISCAL NOTE

I. REQUEST
Bill/Resolution No. House Bill No. 802
Title "An Act relating to nurse midwives."
Requested by Commissioner's Office Date 3/5/80

II. FISCAL DETAIL
Agency Affected Department of Health and Social Services
Program Category Affected Health/Division of Public Health
BRU, Program, or Subprogram(s) Affected
(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 80	FY 81	FY 82	FY 83	FY 84	FY 85
100 PERSONAL SERVICES	0	0	0	0	0	0
200 TRAVEL	0	0	0	0	0	0
300 CONTRACTUAL	0	0	0	0	0	0
400 COMMODITIES	0	0	0	0	0	0
500 EQUIPMENT	0	0	0	0	0	0
600 LAND & STRUCTURES	0	0	0	0	0	0
700 GRANTS, CLAIMS, ETC.	0	0	0	0	0	0
TOTAL	0	0	0	0	0	0

FUNDING (Thousands of Dollars)

GENERAL FUND	0	0	0	0	0	0
FEDERAL FUNDS	0	0	0	0	0	0
OTHER (Specify Fund Source)	0	0	0	0	0	0

POSITIONS

FULL TIME	0	0	0	0	0	0
PART TIME	0	0	0	0	0	0
TEMPORARY	0	0	0	0	0	0

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)

Prepared by: M. Deaver Date: 3/5/80
Division/Office: P.H. Admin. PH: 3090
Department of Health & Social Services

Approval DHSS Mgt. & Bdgt: [signature] Date: 3/5/80

33-001 (Rev. 12/79)
Modify by DHSS (11-28-79)

Alaska State Legislature

House of Representatives

Committee on

Health, Education & Social Services

Official Business

Pouch V
State Capitol
Juneau, Alaska 99811

Dear Interested Persons,

This is to inform you that HB 802, An Act relating to nurse midwives, will be heard in the Health, Education and Social Services Committee at 1:30 p.m. on March 20th. If you care to make any comment on this bill it may be sent to this committee and we will gladly include it in each members file.

Please send any written comments or testimony to the above address.

Shannon Garrett
Administrative Assistant
House HESS Committee

House Health, Education & Social Services Committee — Meeting/Hearing on HB502 — Date: 2/5/80

	Name	Address and Phone	Organization/Self	For/Against or Observing
	Joe McCarron			
1/	Rep Debbie introduces			
2/	Vernellia Randall-Phillips		PH SS	
3/	Portia Kaufman		PH SS Dir-Health clinic	
4/	Margaret Crawford	(answer questions re: nurse-midwifery practice)		
X 5/	Don Koch		Dep. of Insurance	
X 6/	Pam Bradley	444-3654	herself	
X 7/	Beth Jenson		herself	
8/				
9/				
10/				
11/				
12/				
13/				

3/11/80 11.54

TO: CHAIRMAN THELMA BUCHHOLDT
HOUSE H.E.S.S. COMMITTEE

FROM: PAMELA BRADLEY, BOX 10411, FAIRBANKS, 99701 PH. 455-6152

RE: HB 802

I WAS IN JUNEAU AND GAVE ORAL TESTIMONY ON THIS BILL. I'VE VOLUNTEERE
D TO
GATHER WRITTEN TESTIMONY FROM FRIENDS AND SEND IT TO JUNEAU, ALONG WIT
H
MY OWN. I NEED ADVANCE NOTICE OF THE HEARING TO GIVE PEOPLE TIME TO
PREPARE AND SEND THEIR TESTIMONY IN. WOULD YOU POSSIBLY CONSIDER
TELECONFERENCING THIS?

CONTACT: 452-7585 9 - 5:30PM OR 455-6152 EVENINGS OR WEEK-ENDS

FBX/LIO/MW

© Moore Business Forms, Inc.

Ketchikan Medical Clinic, Inc.

3612 TONGASS
KETCHIKAN, ALASKA 99901

H.J. Henricksen, M.D.
D.E. Johnson, M.D.
T.L. Conley, M.D.

Phone 225-5144
Phone 225-5145

March 7, 1980

Honorable Terry Gardiner
% Legislative Affairs
State Capital
Pouch Y
Juneau, Alaska 99811

Dear Representative Gardiner:

I received a call from Sharon Garrett (whom I presume works in Representative Bucholdt's office) a few days ago with reference to drumming up physician support for House Bill 802. I promised to call her after I obtained the bill and set about my normal Sunday activity of trying to recover from the recent bridge tournament.

Today I was able to obtain the bill and here goes. I have been given the circumstances surrounding this bills raison d'etre and certainly am in sympathy with the thinking behind the bill. However, there are problems.

The bill attempts to make the hospital do that which it is not in a position to do. Hospitals do not grant privileges to practitioners. That responsibility is delegated by the corporate body of the hospital to the attending medical staff. Thus, the bill fails, in this first paragraph, by attempting to legislate a requirement on the hospital that the hospital is not able to undertake.

Secondly, there are already sufficient laws, on the books, to offset the problems enumerated in or underlying this bill. The main legislation that works in this is the restraint of trade federal laws of which you are much more familiar than I. In the medical field, wherein a practitioner has felt unfairly denied access to the hospital to practice his/her trade or art or science, he/she has simply initiated a lawsuit and almost universally won when the condition of the denial of privileges was purely a restraint of trade. There are a fair number of cases on record, particularly in California, providing case law on this point, many of them having to do with family practitioners being denied privileges at certain hospitals governed by, or if you will, staffed by, sub-specialty interests. Thus, another reason for this part of the bill's inappropriateness is the fact that a mechanism for righting this wrong already exists and works well.

To reiterate, the bill attempts to make the hospital do that which it is not capable of doing. That is, assume the responsibility or granting of privileges and there is, not only no need for this but there is and has been a very tested way to right such wrongs as periodically crop up. In the case of the nurse mid-wife, he/she may simply obtain the services of a lawyer and institute a law-suit on the denial of privileges on the basis of restraint of trade and very likely win the case. More to the point, such action would serve to publically put the medical staff on record in their restraint of trade exercise, which is probably valuable.

Since there are free legal services in this state, such court action is thusly available to all, including the poorest physicians or other practitioners who have unjustly been denied privileges.

For the practice of good medicine, i.e. for patient protection, it is imperative that the medical staff remain in total control of staff privileges (except for court intervention) because this is the entire basis of peer review (peer review is something we have done here for 13 years plus and is now mandated by federal law) which is the only effective handle we have on the practice of medicine at a hospital.

With regard to the rest of the bill I would simply say I strongly agree discrimination by third party people (insurance companies et al) is nonsense. A service should be paid for on the basis of the service performed, not on how (over) qualified the practitioner is who performs it, so long as the practitioner is indeed qualified.

I have reviewed the bill with Dr. Richard Babcock (OB Gyn) who has a nurse-midwife associate, Dr. Tom Conley, Chief of Staff at Ketchikan General Hospital and Dr. David Johnson, President-elect, Alaska Medical Association and all are in agreement with the position I have outlined.

Thank you for your time.

Sincerely,

Bill Henrickson

Hilbert J. Henrickson, M.D.

HJH/bjr

S.C. 80033
Fairbanks Alaska 99701

March 13, 1980

Thelma Buckalew, Chairman
House H&SS Committee
Room 4 State Capitol
Juneau, Alaska 99811

Dear Mr. Buckalew,

As chairman of the Board of Nursing I have been asked to respond to HB 803 on behalf of the Board. Since our mission is to protect the public I do not think it appropriate that the Board take a position on a matter of policy-interest to the nursing profession.

As an individual, however, I support the bill. We currently have no nurse-midwives authorized to practice under our legislation. We have one application that is still being processed. The bill would provide an incentive to attract more of these highly qualified individuals to Alaska.

I do think the matter of mandating third party payers to reimburse nurse-midwives directly needs to be looked at with reference to the availability of medical insurance within the state. Would insurance companies refuse to comply, and hence no insurance coverage would be available to many citizens of our State? I trust Congress has ignored it in this matter, but someone should check it.

Yours truly,

Ellen Montano

TO: HOUSE H.E.S.S. COMMITTEE

FROM: ENID GEIST (CERTIFIED CHILD BIRTH EDUCATOR)
SR BOX 40022, FAIRBANKS, 99701 PH. 452-8740

RE: HB 802

I SUPPORT THIS BILL, I DO NOT THINK THAT IT GOES FAR ENOUGH THAT HOME BIRTH SHOULD BE INCLUDED WITH MEDICAL BACK-UP.

FBX/LIO/MW

HB
805

Lib & P.O. 5

P.O. Box 380
Cordova, Alaska 99574
February 25, 1980

The Honorable Margaret Branson
Alaska State House of Representatives
Pouch "V" State Capitol Building
Juneau, Alaska 99811

Dear Ms. Branson,

Our daughter Betty Wickett is a patient at Harborview Memorial Hospital in Valdez.

She is presently attending a Harborview School program at the Valdez City School District.

Valdez City School District is planning to build a new school with a wing for the Harborview shhool program.

Since residents of Harborview come from all over the state of Alaska and are residents of a state facility, the Community of Valdez should not be required to pay for the special wing of the new school.

As ooncerned parents we are requesting the State for full funding of the special school wing.

Sincerely,

Mrs. Merle Wickett

cc: Arlene Spaulding, Harborview School

ALASKA DEPARTMENT OF EDUCATION
POSITION STATEMENT
HOUSE BILL 805

The Department is in support of the proposed $600.0 appropriation to the City of Valdez. The appropriation represents less than the amount which would not be reimbursed to the municipality pursuant to AS 43.18.100, for the retirement of bonded indebtedness associated with the construction of a special education facility in Valdez.

The proposed facility would house the educational program required by the institutional residents of the Harborview Developmental Center, a state institution for the severely-profoundly handicapped. Please refer to the attachment provided by the district.

Approved by: William D. Thomson

William D. Thomson
Deputy Commissioner
April 18, 1980

HARBORVIEW PROGRAM & IMPROVEMENTS ENVISIONED BY MOVEMENT TO THE NEW SCHOOL

Currently there are several drawbacks to the educational facility at Harborview that have an impact on teaching and which the Herman Hutchen School design will improve. First, there is considerable isolation of classrooms frome one another. Two meet in the living area, one is on the first floor of the school annex, two are on the secord floor, two in modulars outside the Developmental Center and two in modulars near the elementary school across town. This isolation precludes gradual transition from one classroom to another, sharing equipment and staff, and hinders constructive staff communication. In the proposed school, the classrooms whose programs fit together are next to one another. This will allow students to spend part of their day in each of two classrooms when that is appropriate. The proximity will also allow sharing of equipment, especially large, immobile pieces. The pre-vocational/vocational cluster is an excellent example. The four classrooms will be close enough so that the workshop and kitchen equipment can be shared by all forty students. Secondly, the fact that there are two classrooms now on the second floor means that all physically handicapped students are automatically excluded from those programs. Since the program is sequential this means those students must be ready to jump two steps in order to advance. This is like expecting a second grader to remain in a second grade classroom until he is ready to do fifth grade work. The proposed school will have all classrooms on one floor which eliminates the problem. Third, having all staff in one building will allow better communication and sharing of program ideas. Currently, because classrooms are so spread out, teachers have little opportunity to observe one another or "brainstorm" about mutually beneficial program ideas. The design of the proposed school will correct both.

Another major problem in the present education facility at Harborview is the lack of provisions for physically handicapped students. The second story classrooms have already been mentioned. In addition, the toilet areas do not allow enough stalls large enough for proper transfer from wheelchair to toilet. This is a major safety problem for both students and staff. None of the sinks or home living equipment are presently designed for physically handicapped people which means self-help and home skills programs are difficult for these students. There is also no storage or maneuvering space for wheelchairs and walkers in the one downstairs classroom which is appropriate for physically handicapped students. The proposed facility has storage areas for wheelchairs and walkers and each classroom is large enough to allow students to maneuver in their wheelchairs. In addition to the lack of access to the upstairs classrooms, other areas are awkward or dangerous for wheelchair access, especially in the winter. The proposed school has appropriate access throughout.

Currently the prevocational and vocational classes do not have the space for large pieces of vocational workshop equipment. Since the workshop produces items for sale and is designed as a work setting, provision for as many types of training as possible is desirable. The proposed school has a complete, safely designed woodworking shop. The space and safety limitations also prevent our having a properly set up home living skills area to teach cooking, laundry, and other independent living activities. The new school has a portion designed to meet this section of our curriculum with special provisions for wheelchair bound young people.

In our program toileting, toothbrushing and handwashing are important components. In the present facility there is only one toilet and sink for the twenty one students upstairs. Downstairs, the bathroom facilities are outside the classroom and must be shared with the gym & Occupational Therapy programs.

Finally, the present administrative office serves also as a teachers' lounge and storage area. The lack of administrative privacy makes it difficult to meet individually with staff and infringes on their rights to confidential handling of personal concerns. It also makes it difficult to meet with visitors or parents and focus on the topic at hand. To accomplish any type of written work requiring a large, uninterrupted block of time is almost impossible. In the proposed school administrative, teachers' lounge, and storage areas are separate.

Arlene Spaulding

Arlene Spaulding, Program Coordinator
Harborview School

Governor's Council for the Handicapped and Gifted
600 University Avenue - Fairbanks, Alaska 99701 Phone: 479-6507

April 18, 1980

Representative Thelma Buchholdt
Pouch V
Juneau, Alaska 99811

RE: HB 805

Dear Representative Buchholdt:

The Governor's Council for the Handicapped and Gifted opposes appropriation of state funds for the construction of a special education wing as an attachment to the new elementary school in Valdez.

The Council believes that construction of such a facility will lead to further institutionalization of handicapped individuals at Harborview Developmental Center rather than encourage development of special education programs and community residential services (group homes, foster care homes) in the handicapped children's home communities.

The funds requested would be best utilized for local services so children at Harborview can be returned home. So long as the majority of funds for this population are channeled to institutional care, handicapped children will continue to be required to ~~have~~ leave their families and home communities in order to receive essential services.

We feel this position is consistent with court cases across the country which require deinstitutionalization of handicapped and mentally retarded individuals. It is also consistent with PL94-142, the Education for all Handicapped Children Act, which requires provision of a free, appropriate public education for handicapped children in the least restrictive environment.

Sincerely yours,

Marsha Buck

Marsha Buck
Council Chairperson

MB:mc

POSITION PAPER/Department of Health & Social Services

POSITION PAPER

HOUSE BILL 805

"An Act making a special appropriation to the City of Valdez for the construction of a disability development section at the Valdez School; and providing for an effective date."

(1) The current space available for Special Education Programs in Valdez is inadequate and does not permit non-ambulatory clients to take part in some educational programs.

(2) HB 805 provides $600,000 to the City of Valdez to assist in the construction of a special education portion of a new school that will be separate from the Harborview Developmental Center.

(3) The proposed facility would provide proper space for educational programs for the 96 severely mentally handicapped clients at the Harborview Developmental Center who come from throughout the State as well as for those children who live at home in the Valdez area and who need special education services.

(4) The Department recommends support for the Bill.

Recommended by: Verner Stillnow

Verner Stillnow, M. D., M.P.H.
Director
Division of Mental Health & Developmental Disabilities

Date: 4/22/80

Approved by:

Helen D. Beirne, Commissioner
Department of Health & Social Services

Date: 4/22/80

ELEVENTH LEGISLATURE

FISCAL NOTE

I. REQUEST
Bill/Resolution No. HB 805
Title "An Act making a special appropriation to the City of Valdez."
Requested by _____ Date _____

II. FISCAL DETAIL
Agency Affected Department of Health and Social Sevices
Program Category Affected Health
BRU, Program, or Subprogram(s) Affected _____
(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 80	FY 81	FY 82	FY 83	FY 84	FY 85
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL						
400 COMMODITIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC.						
TOTAL	-0-					

FUNDING (Thousands of Dollars)

GENERAL FUND						
FEDERAL FUNDS						
OTHER (Specify Fund Source)						

POSITIONS

FULL TIME						
PART TIME						
TEMPORARY						

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

No cost impact is foreseen to the Department of Health & Social Services as a result of this legislation.

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)

Prepared by: Verner Stillner Date: 4/22/80
Division/Office: Mental Health & DD PH: 465-3370
Department of Health & Social Services

33-001 (Rev. 12/79)
Modify by DHSS (11-28-79)

Approval DHSS Mgt. & Bdgt: _____ Date: _____

Page ____ of ____

Valdez City Schools

Harborview Special Education
Box [redacted] 487
Valdez, Alaska 99686

Phone: 907 835-4735

February 13, 1980

The Honorable Margaret Branson
Alaska State House of Representatives
Pouch "V" State Capitol Building
Juneau, Alaska 99811

Dear Margaret,

Enclosed is a copy of the letter I sent to parents or guardians of Harborview school students requesting letters of support for full funding for the special wing of Valdez's proposed school. We also sent them names of their district's senators & representatives. The letters went out the 6th of February.

I am also sending you & Jay Kerttula a list of people contacted. I also talked to Dorothy Truran of the Governor's Council for the Handicapped & Gifted but will not know about support from them until next week at the earliest.

Please let me know if there is anything else I need to do at this time.

Sincerely,

Arlene Spaulding

Arlene Spaulding
Harborview School

Enclosures

Valdez City Schools

Harborview Special Education
Box 487
Valdez, Alaska 99686

Phone: 907 835-4735

February 6, 1980

_____
_____
_____

Dear (parents' name)

As you may know, the Valdez City School District is currently planning to build a new school with a wing for the Harborview School program.

The new building is needed for several reasons. First, we do not now have enough classroom space to group all nine classes in one central location. Second, the space we have is not appropriate for the full range of handicaps. And third, it is not adequate for the comprehensive program we should be running.

Since residents of Harborview come from all over the state of Alaska and are residents of a state facility, the community of Valdez should not be required to pay for the special wing of the new school. In order to encourage the state legislature to fully fund the special wing, we are asking concerned parents to write their state senators and representatives requesting that they support full funding for the special school wing.

We would very much appreciate your writing such a letter for us. Will you please send us a copy too, so that we can know what more we must do?

Thank you.

Sincerely,

Arlene Spaulding

Arlene Spaulding, Program Coordinator
Harborview School
P. O. Box 487
Valdez, Alaska 99686

Harborview School - February 6, 1980

Parents Names -- (were asked to write legislators in support of full funding for special school wing)

Mr/Mrs Wayne Bouwens
P. O. Box 1274
Palmer, Alaska 99645

Mr/Mrs Jerry Cogan
1709 Carr Avenue
Fairbanks, Alaska 99701

Dr/Mrs. David Dietz
3352 Wesleyan Drive
Anchorage, Alaska 99502

Mrs. Ed Flershinger
Box 143
Kodiak, Alaska 99615

Mr. Jacob Foley
2906 W. 30th St. Sp. 13
Anchorage, Alaska 99503

Mr/Mrs Daniel Gorman
SR Box 80642 - 1 Mile Hurst Rd.
Fairbanks, Alaska 99701

Mr/Mrs David Hafele
Box 144
College, Alaska 99701

Mr/Mrs Elvest Hawkins
2416 Cottonwood
Anchorage, Alaska 99504

Mr/Mrs Calvin Howard
Box 5514
North Pole, Alaska 99705

Amy Webb
Box 425
Douglas, Alaska 99824

Mr/Mrs Sam Kenton
Box 445
Barrow, Alaska 99723

Mr. Gil Johnson
1007 W. 3rd Avenue - Suite 300
Anchorage, Alaska 99501

Mr/Mrs Charles R. Linsacum
1413 Bannister Drive
Anchorage, Alaska 99504

Mr/Mrs Dennis Marquiss
Box 303
Eagle River, Alaska 99577

Mr/Mrs Leon Marshall
6930 Apollo Drive
Anchorage, Alaska 99504

Virginia Rude
Box 1678 - Blue Spruce
Eagle River, Alaska 99577

Mr/Mrs Eugene Robinson
P. O. Box 828
Homer, Alaska 99603

Mr/Mrs David Robinson
7903 Arlene St.
Anchorage, Alaska 99501

Mr/Mrs R. W. Sanderlin
Star Route A - Box 478 K
Anchorage, Alaska 99507

Mrs. Glen Brandal
Box 217
Port Lions, Alaska 99550

Mr. Cyril Barker
6345 Colgate Drive
Anchorage, Alaska 99504

Grace Slwooko
Box 108
Gambell, Alaska 99742

Mr/Mrs Daniel Smith
Box 2
McGrath, Alaska 99627

Mr. Oren Strader
P. O. Box 4- 2692
Anchorage, Alaska 99509

Mr/Mrs Steve Totemoff
Tatitlik, Alaska 99677

Drs. John & Elizabeth Tower
S. R. A. Box 32 T
Anchorage, Alaska 99507

Mr/Mrs Roy Troseth
Box 252
Wasilla, Alaska 99687

Mr/Mrs Bill Ward
Box 356
Soldotna, Alaska 99669

Arleen McCarver
General Delivery
Valdez, Alaska 99686

Mr/Mrs Merle Wickett
Box 380
Cordova, Alaska 99574

Frederick Pettyjohn (guardian)
Box 1277
Anchorage, Alaska 99510

Dolores Wilks (guardian)
941 4th Avenue
Anchorage, Alaska 99501

Alaska State Legislature

REPRESENTATIVE
MARGARET BRANSON
DISTRICT 5

TEL. (907) 595-1265
BOX 740
COOPER LANDING, ALASKA 99572

WHILE IN JUNEAU
POUCH V
JUNEAU, ALASKA 99811

House of Representatives

March 3, 1980

Mr. Tom Gilson
Asst. City Mgr., City of Valdez
P.O. Box 307
Valdez, Alaska 99686

Dear Tom:

I am sending you copies of HB 805, a special appropriation for the construction of disability development in the Harborview School, and HB 185 and HB 752 concerning cultural facilities.

Both of these issues are of particular significance to Valdez. I will try to keep you informed of their progress.

Cordially,

Margaret Branson
Representative

MAB:mcrs

Enclosures (3)

, from left to right, are Dan Hickok, Doug Cranor, Brent Lisa Wells. In the back row are Brad Jaeger, Mary Ket- Bonte, and Davis Nichols with coach Loyd Nichols.

Notes from Representative Margaret Branson

The issue I will discuss this week concerns the funding of the disability wing in the Valdez school. I have co-sponsored a bill, HB 805, to fund in the amount of $600,000 this special wing on the new Valdez sc[illegible] a project of benefit to all [illegible] of district five and the St[illegible] Alaska.

This wing w[illegible] provide long overdue educational and developmental facilities for the residents of Harborview. This service is currently operating out of the Harborview facilities which are inadequate for several reasons. There is not enough classroom space, it is upstairs, the space available is not appropriate to properly handle the full range of handicaps, and it is not adequate for comprehensive programs that should be provided. The new wing will include many necessary facilities including sensory stimulation areas with a sensory stimulation laboratory, speech therapy facilities and vocational workshops grouped in such a design that students can progress from one to the other without hardship.

The idea of incorporating the facility into the Valdez School rather than an addition to the Harborview facility is important because it will allow much greater versatility in each individual's treatment and education. This combination will allow access to wider range of the school facilities for use by the residents of Harborview and it will also allow for the use of the school by those students who might not be residents of Harborview, but could benefit from some of the special facilities such as the speech therapy area.

Please vote

The program is broken down into classes. These range from a very basic level of sensory stimulation to the level where the student is taught certain vocational skills. With the many advances being made in this field, constant progress is seen in the treatment of the developmental disabilities which affect these young people. The child moves through the program according to ability with the end goal of helping many learn the skills necessary to lead a self-sufficient life.

The State if also taking positive steps in the treatment of developmentally disabled in another area. In the FY 81 budget there has been $48,000 allocated to Prince William Sound Community College to increase instructional programs for the treatment of the developmentally disabled. This has created a very positive situation where the local school district, the state and the University are working together to enhance the care fo the residents of Harborview.

Please vote

Full State funding has been requested for this wing because the residents of Harborview come from all the State of Alaska and do reside in a State facility.

The staff of the Harborview facility and the Valdez school board, administration and staff, and the Dept. of Education deserve a great deal of praise for providing care and training and helping them attain their goals.

Please contact me at Juneau, Pouch V, or 465-4941 if you have need of my help or have comments to make.

[illegible]ts Small as Wrangell-St. Elias head

[illegible] Wyoming as a range conservationist.

Small was born in Chicago and [illegible]ised in the Southwest. He has [illegible]wo degrees from Texas Tech, a [illegible]achelor's in wildlife management and a master's in range [illegible]anagement. He is an infantry [illegible]aptain in the Army Reserve.

The 1.24 million-acre Wrangell-[illegible]. Elias is along the Canadian [illegible]order north of the 10.95-million [illegible]re Wrangell-St. Elias National [illegible]onument.

[illegible]Its natural and cultural [illegible]sources include: The Wrangell [illegible]ountain Foothills, lakes, glacial [illegible]reams and rivers, caribou, [illegible]own bear, Dall sheep, moose [illegible]d wolves.

[illegible]Secretary Andrus's land order [illegible]scribing the area states that [illegible]ith the Wrangell-St. Elias Na[illegible]nal Monument and Kluane Na[illegible]nal Park in Canada, the BLM natural resource area completes the representation and protection of physiographic units and vegetation types from the Pacific Ocean to the Alaskan interior."

The order also prescribes that the area will be administered to provide opportunities for camping, hiking and other forms of outdoor recreation.

The address and telephone number of Mike Small is Manager, Wrangell-St. Elias, Natural Resource Area, Bureau of Land Management, P.O. Box 42, Glennallen, Ak. 99588, (907) 882-3218.

Young gets committee post

WASHINGTON—The House Merchant Marine and Fisheries Committee today designated Congressman Don Young as ranking minority (Republican) member on its Coast Guard and Navigation Subcommittee. The Congressman succeeds Rep. Dave Treen who was inaugurated as Louisiana's Governor recently.

"I'm pleased and proud to be named to this post, and the State of Alaska will benefit," said Young. "Alaskans have a special relationship with the Coast Guard. Their presence is vital to our transporation and our industries. As ranking member of the Subcommittee, I'll make sure this relationship becomes even better."

Young has served on the Merchant Marine Committee since his election to Congress in 1973, and on the Coast Guard Subcommittee since that time.

The ranking member functions as a minority leader on the committees, helping to decide the agenda and appointing the minority staff.

[illegible]ls:
[illegible]20th thru
[illegible]h 26th
[illegible]..... $2[illegible] Off
[illegible]..... $1[illegible] Off
[illegible]s
[illegible]..... $4[illegible] Off
[illegible]..... $2[illegible] Off
[illegible]s Vodka
[illegible]..... $2[illegible] Off
[illegible]..... $1[illegible] Off
[illegible] Schna[illegible]ps
50[illegible] Off

A new line of
Nautical Gifts
for your nautical man.
Nenana Ice Classics Tickets
and shooter's glasses
Now Available
Souvenir[illegible]

Pageant entrants seek 2 crowns

Citing the number of excellent entries already received for the Miss Southcentral Alaska Pageant, the Miss Alaska Pageant has granted them the authority to offer two titles in the final local pageant to be held prior to the 1980 Miss Alaska

House Health, Education & Social Services Committee — Meeting/Hearing on HB 805 — Date: 4/22/80

	Name	Address and Phone	Organization/Self	For/Against or Observing
1/	~~Margaret Braman~~			
2/	Dr. Bob Gregovich		H&SS	
2/	Arlene Spaulding			
3/				
4/				
5/				
6/				
7/				
8/				
9/				
10/				
11/				
12/				
13/				

HB
821

STATE OF ALASKA

Inter-Department Route Slip

TO:
MAIL STATION NUMBER 3100

DEPARTMENT Human Health, Education & Social Services

ATTENTION _____

☐ Approval	☐ Note & Return
☐ Signature	☐ Initial & Return
☐ Comment	☐ Return As Requested
☐ Contact Me	☐ Return For Approval
☐ Prepare Reply	☐ Necessary Action
☐ For Your File	☐ Your Information

Remarks:

FROM:
MAIL STATION NUMBER 2100

DEPARTMENT CDRA

BY Lynn Wegener DATE 3/11/92

02-002 (REV.10/73)

FISCAL NOTE

I. REQUEST
Bill/Resolution No. H B 821
Title An Act making a special appropriation to the Department of Community & Regional Affairs for construction of Health Clinic in King Cove and Sand Point
Requested by _____ Date _____

II. FISCAL DETAIL
Agency Affected Department of Community & Regional Affairs
Program Category Affected Community Planning
BRU, Program, or Subprogram(s) Affected Local Government Assistance
(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 79	FY 80	FY 81	FY 82	FY 83	FY 84
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL						
400 COMMODITIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC.						
TOTAL	0	0	0	0	0	0

FUNDING (Thousands of Dollars)

GENERAL FUND	0	0	0	0	0	0
FEDERAL FUNDS						
OTHER (Specify Fund Source)						

POSITIONS

FULL TIME	0	0	0	0	0	0
PART TIME						
TEMPORARY						

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

This bill, by itself, does not cause enough extra work to justify extra funding or an additional position. Many such bills have been proposed, however, and if a significant number of them pass, additional funding and one or more positions may be necessary.

IV. DATE 3-3-80 PREPARED BY McKie Campbell
AGENCY Community & Regional Affairs
PHONE 465-4735

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)

33-001 (Rev. 12/78)

POSITION PAPER/Department of Health & Social Services

HB 821

POSITION PAPER

HOUSE BILL NO. 821

"An Act making a special appropriation to the Department of Community and Regional Affairs for the construction of health clinics at King Cove and Sand Point; and providing for an effective date."

HB No. 821 appropriates funding for two $120,000 grants, one to King Cove and one to Sand Point, for the construction of community health clinic facilities.

The clinic that is presently in use in King Cove is owned by the cannery and according to our records is well-equipped but not large enough to provide all levels (preventive, primary and emergency) of health care to the population.

The building housing the clinic in Sand Point is owned by the Mission; the clinic is well-equipped. However, as the population increases, the Mission may want the building back for its own use. This would result in displacement of the clinic and may cause a hardship to the community.

The Department of Health & Social Services supports construction of new health clinics to enhance health care in these communities.

Recommended by: _____
Dean F. Tirador, M.D.
Director, Division
of Public Health

Date: 4/8/83

Approved by: _____
Helen D. Beirne
Commissioner

Date: 4/11/83

COMMUNITY KING COVE

Population 420 Native 390 Non-native 30

Date 11-78

Employee D. Ketelsen, PHN

Title Public Health Nurse

COMMUNITY SURVEY FORM

Nearest Major Town Anchorage

Distance 643 Air Miles

School: BIA ( ) State ( ) Other City

No. Enrolled 117

Armed Forces	Yes ( )	No (X)
F.A.A.	Yes ( )	No (X)
National Guard	Yes ( )	No (X)
Hospital	Yes ( )	No (X)
Newspaper	Yes ( )	No (X)
Store	Yes (X)	No ( )
Health Center	Yes (X)	No ( )

AIRSTRIP Yes X No

AVAILABLE TRANSPORTATION: Land plane, Sea plane, Water, Rail, Ferry, Auto, Other (specify charter or scheduled, and company)
Reeve Aleutaan Airways from Anchorage, Via Three Times per week. Charter with Peninsula from Cold Bay

HOUSING-FACILITIES–(specify room, board, etc.)

Hotel None

Hospital None

Home None

Teacherage None

Other Medical personnel can stay at nurses quarters at the Clinic and eat at Cannery Cafeteria

APPROXIMATE DATE OF: "Break-up" None

"Freeze-up" None

CONTACT PEOPLE–(specify name)

Health Aides Patty Hanson, RN

Teacher or Supt. School Ben Kirker, Supt.

Council Chairman, or Mayor Don McCallum

Postmaster

Welfare Worker None

Other

(06-1279)

Electricity	Yes (X)	No ( )
Radio Transmitter	Yes (X)	No ( )
Movie Projector	Yes (X)	No ( )

Volts 120-220 KW When At all times

Call Letters KWA 53 Agency Cannery

mm. 16mm Location School

Describe Water Supply and Waste Disposal System New water system completed. Some families still have own wells, sewer system not hooked up. Garbage to dump- burned.

Type of Housing (Specify Frame, etc.) Wood frame and trailers

Nearest Hospital Facilities – (Type) Anchorage

Predominant Industry Commercial Fishing, Salmon and Crab. Peter Pan Seafood Cannery

Children's Homes – (Specify) None

Churches and Missions – (List) Non-denominational mission, minister: James Ellsmore

Local Organizations – (List) City Council; Women's Club; School Board; Health Board

Additional Information (If no Health Center, location of Clinics, Surveys, Classes; Health Board of Council; Standard of Living; etc.)

Air strip five miles out of town. Taxi service provided by Village. Small Clinic owned by Cannery and salary of R.N. Partly paid, by town. clinic is well equiped with energency supplies. Standard of living is good, employment is available most of the year at the Cannery. process both Salmon and Crab. Have satelite T.V. and most families have vehicles and telephones and nicely furnished homes.

Village R.N. is very capable and providing good comprehensive care. Conducts monthly Well Child Clinics and follow prenatals and provides W/U services & Pap Smears.

COMMUNITY Sand Point

Population 700 Native 550 Non-native 150

Date January 1979

Employee Janis Houseman

Title Public Health Nurse

COMMUNITY SURVEY FORM

Nearest Major Town Anchorage Distance 650 Air Miles

School: BIA ( ) State (X) Other Aleutian Regional School No. Enrolled 137

Armed Forces Yes ( ) No (X)
F.A.A. Yes ( ) No (X)
National Guard Yes ( ) No (X)
Hospital Yes ( ) No (X)
Newspaper school Yes (X) No ( )
Store Yes (X) No ( )
Health Center Yes (X) No ( )

AIRSTRIP Yes X No

AVAILABLE TRANSPORTATION: Land plane, Sea plane, Water, Rail, Ferry, Auto, Other (specify charter or scheduled, and company)

Reeve Aleutian Airways three times a week from Anchorage (Sand Point Service-Charter)

HOUSING-FACILITIES-(specify room, board, etc.)

Hotel Anchorage Inn
Hospital None
Home None
Teacherage None
Other Visiting Medical Personnel can stay at clinic, others at Wakefield Fisheries bunkhouse or at Hotel Meals at Cafe or messhal of Cannery

APPROXIMATE DATE OF: "Break-up" NONE
"Freeze-up" NONE

CONTACT PEOPLE-(specify name)

Health Aides Ingrid Seim CHA, Alice Simmons RN
Teacher or Supt. School Hugh Porter
Council Chairman, or Mayor Jack Foster
Postmaster Shirley Vaughn
Welfare Worker Marina Gunderson
Other State Trooper: Forest Bullington Clinice Phone; 383-3151

(06-1279)

Electricity Yes (X) No ( ) Volts 120-240 KW When At all times
Radio Transmitter Yes (X) No ( ) Call Letters KWC 39, KXN 70 Agency Wakefield Cannery
Movie Projector Yes (X) No ( ) mm. 16mm Location School

Describe Water Supply and Waste Disposal System Water Reservoir and sewerage treatment Garbage taken to dump and burned.

Type of Housing (Specify Frame, etc.) Wood frames and trailers

Nearest Hospital Facilities – (Type) Anchorage
Predominant Industry Commercial Fishing and Processing Plants
Children's Homes – (Specify) None

Churches and Missions – (List) Sand Point Baptist Chapel

Local Organizations – (List) Shumigan Corp. Local Native Corp. XXXXXXXX Peninsula Marketing Assoc. Fishing Union, School Board, Health Board, President "Scottie" Cumberlidge"

Additional Information (If no Health Center, location of Clinics, Surveys, Classes; Health Board of Council; Standard of Living; etc.)

Clinic is very well equiped. Has X-ray machine and laboratory facilities. (not used now) Standard of living is good. Many jobs are availble year round- Canneries, store, school, boatharbor, etc. Most families have telephones, television, vehicles.

THE LEGISLATURE OF THE STATE OF ALASKA
ELEVENTH LEGISLATURE

FISCAL NOTE

I. REQUEST
Bill/Resolution No. House Bill No. 821
Title "...making a special appropriation to CRA for the construction of health clinics.."
Requested by Commissioner's Office Date 2/29

II. FISCAL DETAIL
Agency Affected Department of Health and Social Services
Program Category Affected Health/Division of Public Health
BRU, Program, or Subprogram(s) Affected
(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 80	FY 81	FY 82	FY 83	FY 84	FY 85
100 PERSONAL SERVICES	0	0	0	0	0	0
200 TRAVEL	0	0	0	0	0	0
300 CONTRACTUAL	0	0	0	0	0	0
400 COMMODITIES	0	0	0	0	0	0
500 EQUIPMENT	0	0	0	0	0	0
600 LAND & STRUCTURES	0	0	0	0	0	0
700 GRANTS, CLAIMS, ETC.	0	0	0	0	0	0
TOTAL	0	0	0	0	0	0

FUNDING (Thousands of Dollars)

GENERAL FUND	0	0	0	0	0	0
FEDERAL FUNDS	0	0	0	0	0	0
OTHER (Specify Fund Source)	0	0	0	0	0	0

POSITIONS

FULL TIME	0	0	0	0	0	0
PART TIME	0	0	0	0	0	0
TEMPORARY	0	0	0	0	0	0

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

M. Deaver

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)

Prepared by: M. Deaver Date: 2/29/80
Division/Office: P.H. Admin. PH: 3090
Department of Health & Social Services

Approval DHSS Dir. & Mgt: Date:

33-001 (Rev. 12/79)
DHSS (11-29-79)

HB

826

STATE OF ALASKA

JAY S. HAMMOND, GOVERNOR

DEPARTMENT OF REVENUE

OFFICE OF THE COMMISSIONER

POUCH S – JUNEAU 99811

February 27, 1980

The Honorable Thelma Buchholdt
Chairman
House Health, Education & Social
Services Committee
Room 112 - Capitol Building
Juneau, Alaska 99811

Dear Ms. Buchholdt:

Re: House Bill No. 826

House Bill No. 826, an Act authorizing licensed grocery stores to sell beer and wine, was introduced in the House on February 18, 1980 and was referred to the House Health, Education and Social Services and Judiciary Committees.

For the consideration of the House Health, Education and Social Services Committee, I am enclosing a copy of a Fiscal Note prepared by Patrick Sharrock, Director, Alcoholic Beverage Control Board, Department of Revenue, Anchorage concerning the proposed legislation.

Sincerely,

R. D. Stevenson
Special Assistant

cc: The Honorable Charles Parr
Chairman
House Judiciary Committee

Joseph K. Donohue
Deputy Commissioner
Department of Revenue

Patrick Sharrock, Director
Alcoholic Beverage Control Board
Department of Revenue

04-D2LH

THE LEGISLATURE OF THE STATE OF ALASKA
ELEVENTH LEGISLATURE

FISCAL NOTE

I. REQUEST
Bill/Resolution No. HB 826
Title Grocery liquor license
Requested by Representative Dick Randolph Date February 18, 1980

II. FISCAL DETAIL
Agency Affected Department of Revenue
Program Category Affected Public Protection
BRU, Program, or Subprogram(s) Affected Alcoholic Beverage Control Board
(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 80	FY 81	FY 82	FY 83	FY 84	FY 85
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL						
400 COMMODITIES Note	2.0	2.0	2.0	2.5	2.5	2.5
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC.						
TOTAL						

FUNDING (Thousands of Dollars)

GENERAL FUND	2.0	2.0	2.0	2.5	2.5	2.5
FEDERAL FUNDS						
OTHER (Specify Fund Source)						

POSITIONS

FULL TIME						
PART TIME						
TEMPORARY						

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

NOTE: This legislation establishes a new "grocery store" class retail liquor license. Costs associated with a new class of license include printing of additional license forms, licensee files, telephone communication costs and postage. Estimated number of applicants for this class of license is unknown. Other sections of Title 4 prohibit minors from entering licensed premises. If grocery stores stock beer and wine for sale, minors would be prohibited from entering a licensed grocery store. This could pose additional enforcement endeavors.

Patrick L Sharrock

IV. DATE February 26, 1980 PREPARED BY Patrick L. Sharrock, Director
AGENCY Alcoholic Beverage Control Board
PHONE 277-8638

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)

33-001 (Rev. 12/79)

HB

830

Alaska Department of Health & Social Services
DRAFT/Department of Health & Social Services

HOUSE BILL 830

"An Act relating to alcohol and drug abuse; combining and changing the membership of the advisory boards on alcoholism and drug abuse; changing the responsibilities of the office of alcoholism; amending the alcoholism grant-in-aid program; and repealing a requirement for mandatory discharge of an alcoholic from involuntary commitment."

This bill proposes a number of steps the legislature could take to make alcohol and drug abuse prevention and treatment programming more effective and efficient.

First, it clarifies the ABC boards responsibility to adopt regulations that implement the Intent expressed in HB 832 (a related bill).

Second, it allows one member of the Alcohol Beverage Control Board to also serve on the proposed Advisory Board on Alcoholism and Drug Abuse.

Third, it clarifies the responsibility of the proposed new combined board of Alcoholism and Drug Abuse, to review all Alcohol and Drug related grant applications, submitted to the Department for funding.

Fourth, it enables the Department to waive local community dollar match requirements for State grants, under certain conditions, thereby affording small poverty striken local communities an opportunity to receive State Alcohol and Drug Abuse grant funds for programs.

Fifth, it ratifies an already existing operational reality by formally designating the office as the "Office of Alcoholism and Drug Abuse".

Sixth, it adds appropriate members (especially the Director of the ABC board) to the State "Interdepartmental Coordinating Committee".

Seventh, it creates a combined advisory board for alcoholism and drug abuse. Combination of these two boards is favored by a majority of both existing advisory boards, a majority of local program personnel, the staff of the office of alcoholism and drug abuse, the three regional health systems agencies, a majority of the Native Health Corporations, and the Commissioner.

The benefits of a combined board, as proposed, are; 1) Regional membership which makes the board both more representative and more accessible; 2) Regional membership makes it possible for the board to work more closely with the Health Systems Agencies; 3) Number of full board meetings would be reduced from eight per annum, to four per annum; 4) Makes it possible for all local communities administering both alcoholism and drug abuse programs to negotiate levels of support with one board, in one place, at one time, instead of two; 5) Greatly reduces the time, travel costs, and secretarial support necessary to staff two boards, freeing State Office resources to do more in the areas of planning and program Administration; 6) Affords alcoholism and drug abuse program interests, access to and participation with the State Health Planning process since the combined board would be a subcommittee of the State Health Coordinating Council, and; 7) Makes it more convenient for the legislature to hold the whole alcoholism and drug abuse program effort accountable, through their oversight on one office and one advisory board.

The balance of the bill alters responsibility for custody of intoxicated persons who are involuntarily committed to treatment by the Courts, by removing responsibility for such custody from the State Office and giving that responsibility to the local treatment programs funded by the Office. This provision enhances both the convenience and effectiveness of local courts ability to see to it that their commitment orders are carried out by local programs.

Recommended by:

Robert L. Cole 03/18/80

Robert L. Cole, Coordinator Date
Office of Alcoholism and Drug Abuse

Approved by:

3/25/80

Helen D. Beirne, Commissioner Date
Department of Health and Social Services

DRAFT/Department of Health and Social Services

FISCAL NOTE

I. REQUEST
Bill/Resolution No. HOUSE BILL 830
Title "An Act relating to alcohol and drug abuse"
Requested by _____ Date 03/18/80

II. FISCAL DETAIL
Agency Affected Department of Health and Social Sevices
Program Category Affected Alcoholism and Drug Abuse
BRU, Program, or Subprogram(s) Affected Administration
(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 80	FY 81	FY 82	FY 83	FY 84	FY 85
100 PERSONAL SERVICES						
200 TRAVEL		[11.5]	-0-	-0-	-0-	-0
300 CONTRACTUAL						
400 COMMODITIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC.						
TOTAL		[11.5]				

FUNDING (Thousands of Dollars)

GENERAL FUND		[11.5]				
FEDERAL FUNDS						
OTHER (Specify Fund Source)						

POSITIONS

FULL TIME						
PART TIME						
TEMPORARY						

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)
Presently, the two boards have a total of twenty appointed members. FY 80 costs for eight board meetings will be $42,000 for boards travel and per diem, or an average cost of 5,250 per meeting. The projected cost of four statewide meetings of a combined board of thirteen members in FY 81 would be computed as follows:

FY 80 cost per member per meeting = $ 525
\+ Est. 12% FY 81 travel/per diem inflation = 63
Net cost FY 81 per member per meeting = $ 588

13 members x 4 board meetings @ 588 each per member = 13 x 4 x 588 or, 30,576
Cost savings for board travel and per diem $11,424

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)

Prepared by: Robert L. Cole Date: 3-18-80
Division/Office: SOADA Ph: _____
Department of Health & Social Services

33-001 (Rev. 12/79)
Orig by DHSS (11-28-79)

Approval DHSS Mgt. & Plgt.: _____ Date: _____

STATE OF ALASKA

JAY S. HAMMOND, GOVERNOR

DEPT. OF HEALTH AND SOCIAL SERVICES

OFFICE OF ALCOHOLISM AND DRUG ABUSE

POUCH H 05F
JUNEAU, ALASKA 99811
Tel: (907) 586-6201 (RLC)

April 10, 1980

Document # 72-80

Thelma Bucholdt
Chairperson
Health Education and Social Services
Committee
Capitol Building
Juneau, Alaska

Dear Representative Bucholdt:

Your Health Education and Social Services Committee requested a fiscal note reflecting the impact of a 90% - 10% match requirement for all alcoholism grant-in-aid programs.

Under the existing statute, non-poverty communities have a 25% match requirement while poverty communities have a 10% match.

The attached fiscal note displays these amounts at the level of funding proposed in the Governor's FY 81 budget.

Sincerely,

Robert L. Cole

Robert L. Cole
Coordinator

Encl.

FISCAL NOTE

I. REQUEST
Bill/Resolution No. HOUSE BILL 830
Title "An Act relating to alcohol and drug abuse"
Requested by _____ Date 4-10-80

II. FISCAL DETAIL
Agency Affected Department of Health and Social Sevices
Program Category Affected Alcoholism and Drug Abuse
BRU, Program, or Subprogram(s) Affected Administration
(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 80	FY 81	FY 82	FY 83	FY 84	FY 85
100 PERSONAL SERVICES						
200 TRAVEL		[11.5]	-0-	-0-	-0-	-0-
300 CONTRACTUAL						
400 COMMODITIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC.		634.4				
TOTAL		626.9				

FUNDING (Thousands of Dollars)

GENERAL FUND		626.9				
FEDERAL FUNDS						
OTHER (Specify Fund Source)						

POSITIONS

FULL TIME						
PART TIME						
TEMPORARY						

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)
Presently, the two boards have a total of twenty appointed members. FY '80 costs for eight board meetings will be $42,000 for boards travel and per diem, or an average cost of 5,250 per meeting. The projected cost of four statewide meetings of a combined board of thirteen members in FY 81 would be computed as follows:

	FY 80 cost per member per meeting	=	$ 525
+	Est. 12% FY 81 travel/per diem inflation	=	63
	Net cost FY 81 per member per meeting	=	$ 588

13 members x 4 board meetings @ 588 each per member = 13 x 4 x 588 or, 30,576
Cost savings for board travel and per diem $11,424

Robert L. Cole

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (Bill Legislator Named)

Prepared by: Robert L. Cole Date: 4-10-80
Division/Office: SOADA Ph: _____
Department of Health & Social Services

Approval DHSS Mgt. & Pdgt.: [signature] Date: 4/10/80

33-001 (Rev. 12/79)
Modify by DHSS (11-23-79)

A. Existing Match Requirement	State Funds	+	Local Match	=	Total
* 75% - 25%	$ 3,192,210.		$ 1,064,070.		$ 4,256,280.
90% - 10%	354,690.		39,410.		394,100.
	$ 3,546,900.		$ 1,103,480.		$ 4,650,380.
B. Proposed Match Requirement					
90% - 10%	$ 4,185,342.		$ 465,038.		$ 4,650,380.
additional state funds required	638,442.				

* The prior three year grant-in-aid experience indicates that approximately 90% of the alcoholism grant budget is matched 75%-25% and 10% of the alcoholism grant budget is matched at 90%-10%.

Fairbanks Drug Treatment Center
(907) 456-5715

Fairbanks Drug Education Center
(907) 452-1841

Fairbanks Re-Entry Center

KILA, Inc.

Locally Controlled
Integrated and Coordinated
Human Services
3098 Airport Way
Fairbanks, Alaska 99701
(907) 452-5972

April 8, 1980

Rep. Thelma Buchholdt
House of Representatives
Pouch V
Juneau, Alaska 99811

Dear Thelma,

Thank you for making me aware of the upcoming Committee meeting on HB 830. If I could attend I would be there, but the finances get tight after just returning from a trip to Juneau.

I request that you distribute the enclosed packets to each of your committee members for their consideration. I am angry and frustrated and I guess that shows. We have been going through this type of threat every couple of years as the state office attempts to corner the market on all aspects of drug/alcohol treatment.

If anyone on the Committee has any questions, please allow them the freedom to contact me. I will remain in the office on the 10th of April in case I can be of any additional assistance to the Committee.

Again, thank you for the consideration.

Sincerely,

Frank

Frank J. Gold, EdD
Programs Director

PS: Could you please put the enclosed envelopes in the appropriate mail boxes? That would be appreciated.

STATE OF ALASKA

JAY S. HAMMOND, GOVERNOR

DEPARTMENT OF REVENUE

OFFICE OF THE COMMISSIONER

POUCH S
JUNEAU, ALASKA 99811

March 14, 1980

The Honorable Thelma Buchholdt
Chairman
House Health, Education & Social
Services Committee
Room 112 - Capitol Building
Juneau, AK 99811

Dear Ms. Buchholdt:

HOUSE BILL NO. 830

House Bill No. 830, an Act relating to alcohol and drug abuse; combining and changing the membership of the advisory boards on alcoholism and drug abuse; changing the responsibilities of the office of alcoholism; amending the alcoholism grant-in-aid program; and repealing a requirement for mandatory discharge of an alcoholic from involuntary commitment, was introduced in the House on February 18, 1980 and was referred to the House Health, Education and Social Services and Finance Committees.

For the consideration of the House Health, Education and Social Services Committee, I am enclosing a copy of a Fiscal Note prepared by Patrick Sharrock, Director, Alcoholic Beverage Control Board, Department of Revenue, Anchorage concerning the proposed legislation.

Sincerely,

R. D. Stevenson

R. D. Stevenson
Special Assistant
(907) 465-2397

cc: The Honorable Russ Meekins
Chairman
House Finance Committee

Joseph K. Donohue
Deputy Commissioner
Department of Revenue

Patrick Sharrock, Director
Alcoholic Beverage Control Board
Department of Revenue

04-D21 H

THE LEGISLATURE OF THE STATE OF ALASKA
ELEVENTH LEGISLATURE

FISCAL NOTE

I. REQUEST
Bill/Resolution No. HB830
Title Relating to alcohol and drug abuse
Requested by Representatives Meekins and Beirne Date 2/18/80

II. FISCAL DETAIL
Agency Affected Department of Revenue
Program Category Affected Public Protection
BRU, Program, or Subprogram(s) Affected Alcoholic Beverage Control Board
(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 80	FY 81	FY 82	FY 83	FY 84	FY 85
100 PERSONAL SERVICES						
200 TRAVEL	-0-	2.0	2.0	2.0	2.0	2.0
300 CONTRACTUAL						
400 COMMODITIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC.						
TOTAL	-0-	2.0	2.0	2.0	2.0	2.0

FUNDING (Thousands of Dollars)

GENERAL FUND	-0-	2.0	2.0	2.0	2.0	2.0
FEDERAL FUNDS						
OTHER (Specify Fund Source)						

POSITIONS

FULL TIME						
PART TIME						
TEMPORARY						

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

Costs for the Alcoholic Beverage Control Board with passage of this bill are for travel and per diem for attendance by the executive director and a member of the board at meetings of the Interdepartmental Coordinating Committee and the Advisory Board on Alcoholism and Drug Abuse, respectively.

This legislation enhances communication between agencies involved in alcohol related matters.

IV. DATE March 12, 1980 PREPARED BY Patrick L. Sharrock, Director
AGENCY Alcoholic Beverage Control Board
PHONE 277-8638

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)

33-001 (Rev. 12/79)

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33-001 (Rev. 12/79)

AB 830

Estimated Project Revenues
Alcoholism Grantees
FY 80

	State Grant	Local Cash	Rev Sharing	local In-Kind	Project Income	CETA	NIAAA	Other
Anchorage	907,470	437,840	200,000	302,490	219,980	0	0	0
Fairbanks	370,793	95,000	49,000	0	102,321	107,508	235,000	36,736
Juneau	162,496	38,000	21,000	0	327,894	0	58,200	82,900
Ketchikan	105,000	22,945	12,000	25,597	54,801	0	18,567	0
Sitka	89,956	0	12,000	21,740	16,117	0	0	104,517
Kodiak	135,200	60,356	20,000	17,269	41,900	39,888	0	0
Petersburg	45,197	2,000	0	7,875	5,191	0	0	0
Wrangell	40,478	4,000	0	8,193	1,300	0	0	0
Kenai	53,584	6,817	0	9,000	8,940	21,564	0	0
Bethel	269,760	0	18,322	0	0	110,623	0	0
Seward	58,560	3,000	0	15,050	1,990	0	0	0
Totals	2,238,494	666,958	332,322	407,214	780,434	279,583	311,767	224,353

State $2,238,494
42%

Local Share
$3,002,631
58%

Total $5,241,125
100%

AK830

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House Health, Education & Social Services Committee — Meeting/Hearing on HB 830 alcohol & drug abuse — Date: 4/11/80

	Name	Address and Phone	Organization/Self	For/Against or Observing
4/11/80	1/ George Mundell		Staff Office on Alcohol & Drug abuse	
	2/ Cindy from meetings of will be available but is not testifying			
	3/ ~~—~~			
4/11/80	4/ George Mundell		Office on Alcohol & Drug abuse	
	5/			
	6/			
	7/			
	8/			
	9/			
	10/			
	11/			
	12/			
	13/			

WO 7785
Guthrie

Original sponsors: Meekins and Beirne

IN THE HOUSE

BY THE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

CS FOR HOUSE BILL NO. 830

IN THE LEGISLATURE OF THE STATE OF ALASKA

ELEVENTH LEGISLATURE - SECOND SESSION

A BILL

For an Act entitled: "An Act relating to alcohol and drug abuse; combining and changing the membership of the advisory boards on alcoholism and drug abuse; changing the responsibilities of the office of alcoholism; amending the alcoholism grant-in-aid program; and repealing a requirement for mandatory discharge of an alcoholic from involuntary commitment."

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

* Section 1. AS 04.05.010(a) is amended to read:

(a) There is established an Alcholic Beverage Control Board within the Department of Revenue consisting of five members appointed for overlapping three-year terms. The board is vested with the duties, powers, and responsibilities involved in the control of alcoholic beverages, including the adoption of [PROMULGATION OF RULES AND] regulations and the hearing of appeals from the action of officers and employees charged with enforcing the alcoholic beverage control laws [, RULES,] and regulations. The governor shall appoint the board subject to confirmation by the legislature. With the exception of membership on the Advisory Board on Alcoholism and Drug Abuse, a [NO] member of the board may not hold any other state or federal office, either elective or appointive. Two members of the board shall be actively engaged in the alcoholic beverage industry, except that no member may be an officer, agent, or employee of a wholesal alcoholic beverage enterprise. No three members of the board may be engaged in the same business, occu-

pation or profession. Three members constitute a quorum for the conduct of business. The board shall meet at least once each year in each of the four judicial districts to study, reconsider and modify existing agency [RULES AND] regulations in the light of current local problems.

* Sec. 2. AS 47.30.475(b) is amended to read:

(b) Money available under this section shall be awarded by the department to applicants on the basis of community need, but only if the award is consistent with the annual implementation plan developed under sec. 1513(b)(2) of P.L. 93-641 by the health systems agency for the health system area in which the applicant is located and the state health plan developed by the Statewide Health Coordinating Council under sec. 1524(c)(2)(A) of P.L. 93-641, and only after consideration of comment and advice of the Advisory Board on Alcoholism and Drug Abuse. In awarding grants, the department shall further consider the amount of money that is available for all applications and whether an application would contribute to the wise development of a comprehensive program of alcoholic rehabilitation and prevention.

* Sec. 3. AS 47.30.475(c) is amended to read:

(c) Grants shall be awarded in a ratio of 90 [75] percent state money to 10 [25] percent community money [, EXCEPT THAT IN COMMUNITIES DESIGNATED AS POVERTY AREAS THE RATIO SHALL BE 90 PERCENT STATE MONEY TO 10 PERCENT COMMUNITY MONEY,] for the costs of providing staff and limited improvement, renovation or new construction of facilities for alcoholic detoxification, rehabilitation or "half-way house" care. The department shall count the value of an in-kind contribution made by a community in determining whether the requirement of community money has been met. No grant for improving, renovating or constructing may exceed $50,000 except when there is a lack of applicants for available money and then only with the approval of the Advisory Board on Alcoholism

and Drug Abuse. The department is not required to award all money available under this program, or the full percentages specified in this subsection, when another source of money is available or could reasonably be made available to the applicant.

* Sec. 4. AS 47.37.020 is amended to read:

Sec. 47.37.020. OFFICE OF ALCOHOLISM AND DRUG ABUSE. An office of alcoholism and drug abuse is established in the department. The office shall be headed by a coordinator appointed by the commissioner. The coordinator shall be a qualified professional who has training and experience in the organization and administration of treatment services for persons with medical-social problems. The coordinator is in the classified service.

* Sec. 5. AS 47.37.050(a) is amended to read:

(a) An interdepartmental coordinating committee is created, composed of the coordinator, [AND] the commissioners of health and social services, education, transportation and public facilities [HIGHWAYS], labor and public safety, and the direc or of the Alcoholic Beverage Control Board. The committee shall meet at least twice annually at the call of the commissioner of health and social services who is its chairman. The committee shall provide for the coordination and exchange of information on all programs relating to alcoholism, and act as a permanent liaison among state departments engaged in activities affecting alcoholics and intoxicated persons. The committee shall assist the commissioner of health and social services and the coordinator in formulating a comprehensive plan for prevention of alcoholism and for treatment of alcoholics and intoxicated persons.

* Sec. 6. AS 47.37.060 is amended to read:

Sec. 47.37.060. ADVISORY BOARD ON ALCOHOLISM AND DRUG ABUSE. There is established in the Department of Health and Social Services an

Advisory Board on Alcoholism and Drug Abuse. This board shall function as a standing committee of the Statewide Health Coordinating Council established under AS 18.07.011.

* Sec. 7. AS 47.37.070 is amended to read:

Sec. 47.37.070. COMPOSITION. The [ADVISORY] board [ON ALCOHOLISM] consists of a member of the Alcoholic Beverage Control Board selected by its members and nine members appointed by the governor.

* Sec. 8. AS 47.37.080 is repealed and re-enacted to read:

Sec. 47.37.080. QUALIFICATIONS OF APPOINTED BOARD MEMBERS. (a) Of the nine appointed members of the board

(1) two shall be persons who are licensed to practice medicine in the state, one of whom shall be certified in psychiatry;

(2) one shall be a practicing attorney who has been admitted to the practice of law by the state supreme court;

(3) six shall be persons who have evidenced an interest in the problems of alcoholism or drug abuse and who have knowledge of the social problems associated with alcoholism or drug abuse.

(b) Of the nine members qualified under (a) of this section

(1) three shall be residents of the northern health systems area established under 42 U.S.C. 300;

(2) three shall be residents of the southcentral health systems area established under 42 U.S.C. 300;

(3) three shall be residents of the southeastern health systems area established under 42 U.S.C. 300.

* Sec. 9. AS 47.37.090 is repealed and re-enacted to read:

Sec. 47.37.090. TERM OF OFFICE. (a) The term of a board member is four years, except the chairman of the Alcoholic Beverage Control Broad who serves ex officio.

(b) A vacancy occurring in the appointive membership of the board

shall be filled by appointment of the governor for the unexpired portion of the vacated term.

(c) Appointed board members serve at the pleasure of the governor.

* Sec. 10. AS 47.37.100 is amended to read:

Sec. 47.37.100. COMPENSATION, PER DIEM, OR EXPENSES. Members of the [ADVISORY] board [ON ALCOHOLISM] are not entitled to a salary, but are entitled to per diem, reimbursement for travel and other expenses authorized by law for other boards.

* Sec. 11. AS 47.37.110 is amended to read:

Sec. 47.37.110. DUTIES. The board shall act in an advisory capacity to the commissioner and the Statewide Health Coordinating Council established under AS 18.07.011 in the following matters:

(1) special problems affecting mental health which alcoholism and drug abuse may present;

(2) educational and research activities conducted by the office in respect to the problems presented by alcoholism and drug abuse;

(3) social problems which affect rehabilitation of alcoholics and drug abusers;

(4) legal processes which affect the treatment and rehabilitation of alcoholics and drug abusers;

(5) a program of public relations concerning the problem of alcoholism and drug abuse conducted by a department of the state government or by an organized group; [WHOSE PURPOSE IS THE REHABILITATION OF ALCOHOLICS]

(6) the preparation, review, and approval of local, regional and statewide plans for the prevention, treatment, and control of alcohol and drug abuse.

* Sec. 12. AS 47.37.120 is amended to read:

Sec. 47.37.120. [ALCOHOLISM] PROGRAM COORDINATOR. The [ALCOHOLISM] program coordinator shall carry out the development and implementation of a comprehensive program dealing with the treatment of, research on and education concerning alcoholic problems as they affect the state.

* Sec. 13. AS 47.37.130(c) is amended to read:

(c) The office shall insure that [PROVIDE] adequate and appropriate treatment is provided to [FOR] alcoholics and intoxicated persons admitted under AS 47.37.160 - 47.37.190 within the limits of available state and federal funds.

* Sec. 14. AS 47.37.160(c) is amended to read:

(c) When a patient receiving inpatient care leaves an approved public treatment facility, he shall be encouraged to consent to appropriate outpatient or intermediate treatment. If it appears to the administrator in charge of the treatment facility that the patient is an alcoholic who requires help, the administrator [OFFICE] shall arrange for assistance in obtaining supportive services and residential facilities.

* Sec. 15. AS 47.37.190(a) is amended to read:

(a) After a hearing initiated by petition of his spouse or guardian, a relative, the certifying physician, or the administrator in charge of an approved public treatment facility, a person may be committed to the custody of a private or public facility [THE OFFICE] by the superior court. The petition shall allege that the person is an alcoholic who habitually lacks self-control in using alcoholic beverages and that he (1) has threatened, attempted to inflict, or inflicted physical harm on another and that unless committed is likely to inflict physical harm on another; or (2) is incapacitated by alcohol. A refusal to undergo treatment does not constitute evidence of lack of judgment as to the need for

treatment. The petition shall be accompanied by a certificate of a licensed physician who has examined the person within two days before submission of the petition, unless the person whose commitment is sought has refused to submit to a medical examination, in which case the fact of refusal shall be alleged in the petition. The certificate shall set out the physician's findings in support of the allegations of the petition.

* Sec. 16. AS 47.37.200(a) is amended to read:

(a) At the hearing required under AS 47.37.190(b), the court or the jury, if requested under AS 47.37.190(c), shall hear all relevant testimony, including, if possible, the testimony of at least one licensed physician who has examined the person whose commitment is sought. The person whose commitment is sought shall be present unless the court believes that his presence is likely to be injurious to him, in which case the court shall appoint a guardian ad litem to represent him throughout the proceeding. The court may examine the person in open court, or if advisable, examine him out of court. If the person has refused to be examined by a licensed physician, he shall be given an opportunity to request examination by a court-appointed licensed physician. If he fails to request a medical examination and there is sufficient evidence to believe that the allegations of the petition are true, or if the court believes that more medical evidence is necessary, the court may issue a temporary order committing him to <u>a private or public facility</u> [THE OFFICE] for a period of not more than five days for purposes of a diagnostic examination.

* Sec. 17. AS 47.37.200(b) is amended to read:

(b) If after hearing all relevant evidence, including the results of any diagnostic examination by the <u>private or public facility</u> [OFFICE], the court or the jury finds that grounds for involuntary

commitment have been clearly established, the court shall issue an order of commitment to the private or public facility [OFFICE]. No court may order the commitment of a person unless it determines that a private or public facility [THE OFFICE] is able to provide adequate and appropriate treatment for him.

* Sec. 18. AS 47.37.200(c) is amended to read:

(c) A person committed under AS 47.37.190 - 47.37.200 shall remain in the custody of a private or public facility [THE OFFICE] for treatment for a period of up to 30 days. At the end of the 30-day period, he shall be discharged automatically unless the private or public facility [OFFICE], before the expiration of the period, obtains a court order for his recommitment upon the grounds set out in AS 47.37.190(a) for a further period of up to 90 days. If a person has been committed because he is an alcoholic likely to inflict physical harm on another, the private or public facility [OFFICE] shall apply for recommitment if after examination it is determined that the likelihood still exists.

* Sec. 19. AS 47.37.200(d) is amended to read:

(d) A person recommitted under (c) of this section who has not been discharged by the private or public facility [OFFICE] before the end of the 90-day period shall be discharged at the expiration of that period unless the private or public facility [OFFICE], before expiration of the period, obtains a court order on the grounds set out in AS 47.37.190(a) for recommitment for a further period not to exceed 90 days. If a person has been committed because he is an alcoholic likely to inflict physical harm on another, the private or public facility [OFFICE] shall apply for recommitment if after examination it is determined that the likelihood still exists. No more than two recommitment orders may be permitted under (c) and (d) of this section.

* Sec. 20. AS 47.37.200(f) is amended to read:

(f) A private or public facility [THE OFFICE] shall provide adequate and appropriate treatment for a person in its custody. A public facility [THE OFFICE] may transfer a person in its custody from one approved public treatment facility to another if the transfer is medically advisable.

* Sec. 21. AS 47.37.230(a) is amended to read:

(a) Cities [THE OFFICE AND CITIES] and boroughs may establish emergency service patrols. An emergency service patrol consists of persons trained to give assistance in public places to persons who are intoxicated. Members of an emergency service patrol shall be capable of providing first aid in emergency situations and shall be capable of transporting intoxicated persons to their homes and to and from public treatment facilities.

* Sec. 22. AS 47.37.240(a) is amended to read:

(a) A patient in an approved treatment facility, or the person obligated to provide for the cost of treatment of a person committed under this chapter, is liable to the public or private facility [OFFICE] for the cost of maintenance and treatment of the patient in accordance with rates established by the coordinator.

* Sec. 23. AS 47.37.270(2) is amended to read:

(2) "approved private treatment facility" or "private facility" means a private agency meeting the standards prescribed in AS 47.37.140(a) and approved under AS 47.37.140(c);

* Sec. 24. AS 47.37.270(3) is amended to read:

(3) "approved public treatment facility" or "public facility" means a treatment agency operating under the direction and control of the office or providing treatment under this chapter through a contract with the office under AS 47.37.130(g) or through a grant awarded under AS 47.30.475, and meeting the standards prescribed in AS 47.37.140(a)

and approved under AS 47.37.140(c);

* Sec. 25. AS 47.37.270(11) is amended to read:

(11) "office" means the office of alcoholism and drug abuse within the Department of Health and Social Services;

* Sec. 26. AS 47.37.270 is amended by adding a new paragraph to read:

(13) "board" means the Advisory Board on Alcoholism and Drug Abuse established under AS 47.37.060.

* Sec. 27. AS 44.29.100 - 44.29.140 and AS 47.37.200(g) are repealed.

* Sec. 28. The terms of the present members of the Advisory Board on Alcoholism and the Advisory Board on Drug Abuse terminate on the effective date of this Act. Appointments to the Advisory Board on Alcoholism and Drug Abuse shall be made in accordance with this Act. A person presently serving on either of those boards who meets the qualifications of this Act may be appointed to the Advisory Board on Alcoholism and Drug Abuse.

JA02 0007 10.45 JA01 0019 10.45 03/17/80

TO ALL LEGISLATORS
FROM KTN INFO OFFICE

THE FOLLOWING MESSAGE IS FROM PAT ROWAN, ACTING CHAIRMAN, GATEWAY COUNCIL ON ALCOHOLISM:

THE GATEWAY COUNCIL ON ALCOHOLISM WISHES TO EXPRESS ITS OPINION FAVORING
THE PASSAGE OF HB 830 FOR INCREASED FUNDING OF CONTINUED EDUCATION EFFORTS,
THE PRESENT TREATMENT PROGRAM AND EXPANDED SERVICES INCLUDING DETOXIFICATION
IN SOUTHEAST ALASKA. SIGNED/PAT ROWAN

JA02 0007 10.45 JA01 0019 10.45 03/17/80

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IN SOUTHEAST ALASKA. SIGNED/PAT ROWAN

HB

831

RAPLEY/Department of Health & Social Services

HOUSE BILL 831

"An act relating to admissibility of refusal to take breathalyzer tests".

The Office of Alcoholism and Drug Abuse is supportive of House Bill 831. Drinking drivers presently are the largest contributor to Alaska's high rate of accidental death and injury and increased strategies to curb this serious problem are needed. Data from existing Alaska OMVI diversion programs indicate that in excess of 50% of the people presently being convicted of OMVI in fact have serious drinking problems which require treatment. The passage of House Bill 831 would tend to increase the number of convictions and the subsequent referral of these people to diversion programs for alcohol problem screening and diagnosis.

Recommended by:

Robert L. Cole 2/27/80

Robert L. Cole, Coordinator Date
Office of Alcoholism and Drug Abuse

Approved by:

Helen D. Beirne 3/5/80

Helen D. Beirne, Commissioner Date
Department of Health and Social Services

FISCAL NOTE

I. REQUEST
Bill/Resolution No. House Bill 831
Title "An Act relating to admissibility of refusal to take breathalyzer test"
Requested by Meekins Date 2-18-80

II. FISCAL DETAIL
Agency Affected Department of Health and Social Sevices
Program Category Affected ALCOHOLISM & DRUG ABUSE
BRU, Program, or Subprogram(s) Affected ADMINISTRATION
(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 80	FY 81	FY 82	FY 83	FY 84	FY 85
100 PERSONAL SERVICES		-0-				
200 TRAVEL		-0-				
300 CONTRACTUAL		-0-				
400 COMMODITIES		-0-				
500 EQUIPMENT		-0-				
600 LAND & STRUCTURES		-0-				
700 GRANTS, CLAIMS, ETC.		-0-				
TOTAL		-0-				

FUNDING (Thousands of Dollars)

GENERAL FUND		-0-				
FEDERAL FUNDS		-0-				
OTHER (Specify Fund Source)		-0-				

POSITIONS

FULL TIME		-0-				
PART TIME		-0-				
TEMPORARY		-0-				

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

Robert L. Cole

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)

Prepared by: Robert L. Cole Date: 2-25-80
Division/Office: Alcoholism/Drug Abuse Ph: 586-6201
Department of Health & Social Services

33-001 (Rev. 12/79)
Modify by DHSS (11-28-79)

Approval DHSS Mgt. & Bdgt: Mike Ondrovo Date: 2/29/80

Page ___ of ___

BILL ANALYSIS

ASSIGNMENT DATE_____

UNASSIGNED_____

DEPARTMENT	SPONSOR (PRINCIPAL)	BILL NO.
Public Safety		HB 831

DEPARTMENT POSITION

Support

DIVISION DIRECTOR	DATE	COMMISSIONER	DATE
Robert Rowan	3/5/80	William R. Nix	3/5/80

GOVERNOR'S OFFICE USE

☐ POSITION NOTED ☐ POSITION APPROVED ☐ POSITION DISAPPROVED

BY: DATE:

SUMMARY

(1) RELATED BILLS (SIMILAR OR CONFLICTING)
(2) OTHER AGENCIES AFFECTED BY BILL

(2) a. ORGANIZATIONAL SUPPORT FOR BILL		(2) b. ORGANIZATIONAL OPPOSITION TO BILL

(3) PROGRAM EFFECTS OF BILL

Juries are confused when no testimony regarding a chemical test is admitted in court. Juries do not understand that an individual has a right to refuse to take a breath test. By admitting this information into court, a great deal of confusion will be eliminated and more individuals guilty of drunk driving will be convicted.

(4) FISCAL IMPACT: ☒ NONE ☐ FISCAL ANALYSIS ATTACHED

(5) AMENDMENTS PROPOSED:

(6) COMMENTS:

STATE OF ALASKA

Inter-Depar.ment Route Slip

TO:
MAIL STATION NUMBER _____

DEPARTMENT _____

ATTENTION _____

☐ Approval	☐ Note & Return
☐ Signature	☐ Initial & Return
☐ Comment	☐ Return As Requested
☐ Contact Me	☐ Return For Approval
☐ Prepare Reply	☐ Necessary Action
☐ For Your File	☐ Your Information

Remarks:

~~AK55~~—
~~*~~710 cop.

FROM:
MAIL STATION NUMBER 1200

DEPARTMENT Public Safety

BY _____ DATE 3-10-80

02-002 (REV.10/73)

THE LEGISLATURE OF THE STATE OF ALASKA
ELEVENTH LEGISLATURE

FISCAL NOTE

I. REQUEST

Bill/Resolution No. HB 831

Title An Act relating to admissibility of refusal to take breathalyzer tests.

Requested by _____ Date 3/10/80

II. FISCAL DETAIL

Agency Affected Public Safety

Program Category Affected _____

BRU, Program, or Subprogram(s) Affected _____

(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 80	FY 81	FY 82	FY 83	FY 84	FY 85
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL						
400 COMMODITIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC.						
TOTAL		0	0	0		

FUNDING (Thousands of Dollars)

GENERAL FUND						
FEDERAL FUNDS						
OTHER (Specify Fund Source)						

POSITIONS

FULL TIME						
PART TIME						
TEMPORARY						

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

No fiscal impact.

IV. DATE 3/10/80 PREPARED BY Michael J. Clemens

AGENCY Public Safety

PHONE 465-4356

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)

33-001 (Rev. 12/79)

HB

833

BILL ANALYSIS

ASSIGNMENT DATE_____

UNASSIGNED_____

DEPARTMENT	SPONSOR (PRINCIPAL)	BILL NO.
Public Safety	Meekins	HB 833

DEPARTMENT POSITION

Support

DIVISION DIRECTOR	DATE	COMMISSIONER	DATE
Col. T.R. Anderson	3/6/80	William K. Nix	3/6/80

GOVERNOR'S OFFICE USE

☐ POSITION NOTED ☐ POSITION APPROVED ☐ POSITION DISAPPROVED

BY: DATE:

SUMMARY

(1) RELATED BILLS (SIMILAR OR CONFLICTING)
(2) OTHER AGENCIES AFFECTED BY BILL

(2) a. ORGANIZATIONAL SUPPORT FOR BILL	(2) b. ORGANIZATIONAL OPPOSITION TO BILL

(3) PROGRAM EFFECTS OF BILL

Breath analysis would be added to blood analysis as a method of determining intoxication and to implied consent provisions. The presumption of intoxication at .1% of blood alcohol content would be replaced by a direct definition of intoxication.

(4) FISCAL IMPACT: ☒ NONE ☐ FISCAL ANALYSIS ATTACHED

(5) AMENDMENTS PROPOSED:

(6) COMMENTS:

Existing statutes would be significantly improved by the proposed changes.

POSITION PAPER/Department of Health & Social Services

POSITION PAPER
ON
HOUSE BILL NO. 833

"An Act relating to the crime of driving while intoxicated."

The Office of Alcoholism and Drug Abuse is supportive of House Bill 833. Drinking drivers presently are the largest contributor to Alaska's high rate of accidental death and injury and increased stratgies to curb this serious problem are needed. Data from existing Alaska OMVI diversion programs indicate that in excess of 50% of the people presently being convicted of OMVI in fact have serious drinking problems which require treatment. The passage of House Bill 833 would tend to increase the number of convictions and the subsequent referral of these people to diversion programs for alcohol problem screening and diagnosis.

Recommended by: Robert L. Cole by [illegible] 3/6/80
Robert Cole, Coordinator (DATE)
Office of Alcoholism and Drug Abuse

Approved by: Helen D. Beirne 3/7/80
Helen D. Beirne, Commissioner (DATE)
Department of Health and Social Services

ELEVENTH LEGISLATURE

FISCAL NOTE

I. REQUEST
Bill/Resolution No. House Bill 833
Title "An act relating to the crime of driving while intoxicated".
Requested by Meekins Date 2-25-80

II. FISCAL DETAIL
Agency Affected Department of Health and Social Sevices
Program Category Affected ALCOHOLISM & DRUG ABUSE
BRU, Program, or Subprogram(s) Affected ADMINISTRATION
(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 80	FY 81	FY 82	FY 83	FY 84	FY 85
100 PERSONAL SERVICES		-0-				
200 TRAVEL		-0-				
300 CONTRACTUAL		-0-				
400 COMMODITIES		-0-				
500 EQUIPMENT		-0-				
600 LAND & STRUCTURES		-0-				
700 GRANTS, CLAIMS, ETC.		-0-				
TOTAL		-0-				

FUNDING (Thousands of Dollars)

GENERAL FUND		-0-				
FEDERAL FUNDS		-0-				
OTHER (Specify Fund Source)		-0-				

POSITIONS

FULL TIME		-0-				
PART TIME		-0-				
TEMPORARY		-0-				

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

Robert L. Cole

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (Past Legislator Named)

Prepared by: Robert L. Cole Date: 2-25-80
Division/Office: Alcoholism/Drug Abuse Ph: 586-6201
Department of Health & Social Services

33-001 (Rev. 12/79)
Modify by DHSS (11-28-79)

Approval DHSS Dpt. & Dist: Mike Dalore Date: 2/29/80

Page ____ of ____

THE LEGISLATURE OF THE STATE OF ALASKA
ELEVENTH LEGISLATURE

FISCAL NOTE

I. REQUEST

Bill/Resolution No. HB 833

Title An Act relating to the crime of driving while intoxicated.

Requested by _____ Date 3/10/80

II. FISCAL DETAIL

Agency Affected Public Safety

Program Category Affected _____

BRU, Program, or Subprogram(s) Affected _____

(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 80	FY 81	FY 82	FY 83	FY 84	FY 85
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL						
400 COMMODITIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC.						
TOTAL		0	0	0		

FUNDING (Thousands of Dollars)

GENERAL FUND						
FEDERAL FUNDS						
OTHER (Specify Fund Source)						

POSITIONS

FULL TIME						
PART TIME						
TEMPORARY						

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

No fiscal impact.

IV. DATE 3/10/80 PREPARED BY Michael J. Clemens

AGENCY Public Safety

PHONE 465-4336

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)

33-001 (Rev. 12/79)

HB

838

THE LEGISLATURE OF THE STATE OF ALASKA
ELEVENTH LEGISLATURE

FISCAL NOTE

I. REQUEST

Bill/Resolution No. HB 838

Title An Act relating to debt service for school construction. . . .

Requested by House HESS Date 4/11/80

II. FISCAL DETAIL

Agency Affected Education

Program Category Affected Elementary and Secondary Education

BRU, Program, or Subprogram(s) Affected Financial Support Programs

(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 80	FY 81	FY 82	FY 83	FY 84	FY 85
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL						
400 COMMODITIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC.		61,646.3	-0-	-0-	-0-	-0-
TOTAL						

FUNDING (Thousands of Dollars)

GENERAL FUND		61,646.3	-0-	-0-	-0-	-0-
FEDERAL FUNDS						
OTHER (Specify Fund Source)						

POSITIONS

FULL TIME	n/a					
PART TIME						
TEMPORARY						

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

Section 1 No cost

Section 2 No cost

Section 3 61,646.3 (est.)

It should be noted that payments made under this bill would have to be made upon estimates pending receipt of municipal audits.

IV. DATE April 11, 1980 PREPARED BY William D. Thomson

AGENCY Education

PHONE 465-2800

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)

33-001 (Rev. 12/79)

Alaska MUNICIPAL League

TELEPHONES
(907) 586-1325
586-6526

204 N FRANKLIN ST
JUNEAU, ALASKA 99801

April 10, 1980

To: House HESS

From: Ginny Chitwood

Re: HB 838

The Alaska Municipal League supports legislation such as HB 838 under which the state will provide funding for all approved school capital projects at the time of approval instead of two years later. Depending on administrative requirements, there may be a modification to allow the Department of Education time to review district audits prior to making payments.

Passing a law to eliminate the reimbursement delay, however, will not help municipalities unless the Legislature is willing to fund it. As a first step, we would like to see current law funded at its present level. In FY '79, the appropriation was $5.6 million less than the entitlement; in FY '80, $6.7 million less; and proposed FY '81, $5.2 million less than estimated entitlement. (See reverse side for community by community breakdown in FY '79. The breakout for FY '80 is very similar.)

In summary, we urge the Legislature to assist municipal school districts with their capital construction projects. Please fund the program at its authorized level and, if at all possible, shorten or eliminate the two-year reimbursement delay.

1-29-79

State of Alaska
Department of Education
Chapt. 249, SLA 1970
STATE AID FOR RETIREMENT OF SCHOOL CONSTR. DEBT
FY 1978-79

	100% of Debt Service 1976-77	Credit for Cash Payment Prior to FY72	50% of Cash Payment Prior to FY72	Cash Payment 1976-77	80% of 1976-77 Cash Payment	Debt Service @ 100% Plus Cash Payment	Cigarette Tax 1976-77	Total Entitlement	Actual Payment Prorated @ 79.9238%
Anchorage	11,969,389	19,338	9,669	1,942,254	1,553,803	13,532,861	1,090,725	12,442,136	9,944,227
Bristol Bay	149,585	16,723	8,361	--	--	157,946	13,180	144,766	115,702
Cordova	122,825	--	--	16,020	12,816	135,641	24,469	111,172	88,853
Fairbanks	3,959,632	321,065	160,532	573,180	458,544	4,578,708	295,209	4,283,499	3,423,535
Galena	--	--	--	76,812	61,449	61,449	9,560	51,889	41,471
Haines	95,948	--	--	--	--	95,948	21,902	74,046	59,180
Juneau	985,298	--	--	435,214	348,171	1,333,469	142,967	1,190,502	951,494
Kake	--	--	--	45,072	36,057	36,057	10,751	25,306	20,225
Kenai	2,300,759	483,758	241,879	1,624,771	1,299,817	3,842,455	169,044	3,673,411	2,935,928
Ketchikan	650,498	--	--	--	--	650,498	92,628	557,870	445,870
Kodiak	419,413	17,036	8,518	1,097	877	428,808	73,508	355,300	283,969
Mat-Su	2,085,979	1,842	921	189,120	151,296	2,238,196	108,207	2,129,989	1,702,369
Nenana	21,540	3,022	1,511	11,329	9,063	32,114	10,038	22,076	17,643
North Slope	1,828,748	--	--	--	--	1,828,748	42,576	1,786,172	1,427,575
Petersburg	343,855	44,629	22,314	--	--	366,169	25,602	340,567	272,194
Sitka	410,390	971	485	94,214	75,371	486,246	61,516	424,730	339,460
Skagway	26,784	--	--	--	--	26,784	11,592	15,192	12,142
St. Mary's	--	--	--	128,448	102,758	102,758	6,968	95,790	76,559
Unalaska	--	--	--	12,248	9,798	9,798	8,418	1,380	1,102
Valdez	135,188	4,563	2,281	27,832	22,265	159,734	30,856	128,878	103,004
Wrangell	24,651	--	--	15,000	12,000	36,651	23,140	13,511	10,798
Totals	25,530,482	912,947	456,471	5,192,611	37,254,085	30,141,038	2,272,856	27,868,182	22,273,300

FY 80 @ 30,512,110 → $24,051,000 (78.154% proration)

projected FY 81 @ 33,252,000 → $25,210,000

Testimony - April 11, 1980

In support of H.B. 838

Chairman Buckholdt, and members of the HESS Committee:

My name is Jim Hitchcock, and I'm a Mat-Su Borough Assemblyman, here representing that body. I am a property owner and owner of Caribou Cab Company, a log house building firm. I've lived in Alaska since 1939, and homesteaded in the Mat-Su Valley with my parents in 1943.

I'm before you to speak in favor of H.B. 838, which relates to debt service for school construction. Municipalities desire that the state fund the 80% share of school construction during the same year in which the debt is incurred and bring to date the present two year lag.

The two year delay has increased costs to taxpayers by carrying this debt forward, and causes an erratic mill rate.

There is good reason for the state to relieve taxpayers of this extra burden, therefore I request your support of H.B. 838.

- J. Hitchcock -

James Hitchcock
Borough Assemblyman
Mantanuska-Susitna Borough Assemblyman
Box 867
Palmer, Alaska 99645

April 11, 1980

Chairman Buckholdt, and members of the HESS Committee;

My name is Dorothy Jones from Talkeetna, Alaska. I am a member of the Matanuska-Susitna Borough Assembly. I have been an Alaskan for 47 years and a businesswoman for 25 of those years. As a private citizen and as a Borough Assembly member, I urge your favorable consideration of H.B. 838. This would in effect alleviate a considerable tax burden now placed upon the taxpayer since we now must put up front end money for construction and then wait two years for reimbursement.

Thank you.

Note: The money for the Matanuska-Susitna Borough is expecting for reimbursement for this year and the prior year for expenses incurred amounts to $982,309.00. However, we are having to carry these reimbursible expenses (2 years) ($2,376,314) an extra year because they are not returned on a timely basis. Following our fiscal year end each June 30, the Assembly mandates an independent audit. When the audit has been completed and published we forward it to the State of Alaska and we feel we should be able to have the money sent to the Borough shortly after the State has received the audit and reviewed it.

Dorothy Jones

Dorothy Jones
Matanuska-Susitna Borough Assembly

HB
861

Section-by-section Analysis of HB 861

Section 1. Adds a new chapter to the water, air and environmental conservation title of the Alaska Statutes.

Sec. 46.12.010 establishes a revolving loan fund in the Department of Environmental Conservation. Loans may be made from the fund for the extension of existing municipal water and sewer systems.

Sec. 46.12.020 authorizes the department to administer the loan fund; requires the department to consult with the Department of Community and Regional Affairs during the administration of this loan program.

Sec. 46.12.030 establishes the terms for repayment of loans which are:

(1) 10 percent down payment;

(2) five percent interest; and

(3) repayment over a period of 40 years.

Sec. 46.12.040(a) authorizes the department to sell loans to private investors at face value or at a discount.

(b) authorizes the commissioner of revenue to purchase loans at face value with surplus state revenue.

Section 2. Makes the Act effective on July 1, 1980.

JLB:ljb

THE LEGISLATURE OF THE STATE OF ALASKA
ELEVENTH LEGISLATURE

FISCAL NOTE

I. REQUEST

Bill/Resolution No. House Bill No. 861

Title An act establishing a water and sewer revolving loan fun

Requested by Representative Joyce Munson Date

II. FISCAL DETAIL

Agency Affected Dept. of Environmental Conservation

Program Category Affected Natural Resource Management and Environmental Conservation

BRU, Program, or Subprogram(s) Affected Administration Budget Request Unit

(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

		FY 79	FY 80	FY 81	FY 82	FY 83	FY 84
100	PERSONAL SERVICES			36,424	37,500	49,700	50,900
200	TRAVEL			1,200	1,200	16,200	17,850
300	CONTRACTUAL			1,800	1,950	2,600	2,800
400	COMMODITIES			200	200	300	350
500	EQUIPMENT			500		1,000	100
600	LAND & STRUCTURES						
700	GRANTS, CLAIMS, ETC.						
	TOTAL			40,124	40,850	69,800	72,000

FUNDING (Thousands of Dollars)

GENERAL FUND			40.6	41.6	69.8	72.0
FEDERAL FUNDS						
OTHER (Specify Fund Source)						

POSITIONS

FULL TIME						
PART TIME						
TEMPORARY						

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III) This note is prepared on the assumption that funding for FY 81 would be added to the Department's budget request.

Code 200 - $1200 (Five trips to Railbelt Area and public hearings on regulations)
Code 300 - $1800 (Space rent 100 sq. ft. @ $1.00 x 12 = $1200, telephone $26.00 permonth x 12 =$312 plus $10.00 per month toll charges, plus space rental for public hearings, mailing expense)
Code 400 - $200 (Stationery, pencils, pens, tape dispenser, stapler, punch, phone index, in-out basket, ledgers, journals, etc.)
Code 500 - $500 (Desk, chair)

IV. DATE 2/22/80 PREPARED BY ~~Dale Wallington~~

AGENCY Environmental Conservation

Original: Legislative Finance PHONE 465-2621

Budget and Management

FY 82: The budget for the Loan Administrator should remain about the same in FY 82 except for merit increase in salary and inflation effects on the other categories. Clerical help should still be available in the administrative service section.

FY 83: During FY 82, it is anticipated that discontent with the Loan Program will have surfaced and a Loan Advisory Board will be established. The expenses of the board and part-time clerical help is reflected in the FY 83 budget. Recording equipment and a second typewriter will be needed.

FY 84: This fiscal year's budget should reflect only normal increases.

1	POSITION TITLE: Loan Administrator			RANGE/STEP: 20/A	BARG. UNIT: GGU	LOCATION: Juneau	GOV	APPROV. / DISAPP.
2	TYPE OF POSITION: PFT	STAFF MONTHS: 12	RP No.: -	PCN No.: -	PRIORITY	FORM 12 PAGE/LINE	LEG.	

	TYPE OF EXPENDITURE	1	2	AMOUNT 3
4	PERSONAL SERVICES: SALARY		30,385	
5	BENEFITS		4,515	
6	FICA			
7	HEALTH INS.		1,524	
8	TOTAL PERSONAL SERVICES			36,424
9	TRAVEL			1,200
10	CONTRACTUAL			1,800
11	COMMODITIES			200
12	EQUIPMENT			1,000
13	OTHER			
14	TOTAL COST			40,624

	CODE	FUNDING SOURCE	
15		FED RCPTS.	
16		GF MATCH.	
17		GEN. FUND	40,624
18		I-A RCPTS.	
19		PGM RCPTS	
20		OTHER	
21	CONTINUATION		
22	ADDITION	40,624	

FOR B&M USE ONLY

4A KEY NUMBER _____ COLUMN NO. _____

JUSTIFICATION: The Loan Administrator will monitor the fiscal records of the fund, maintain current and accurate accounts of fund moneys, prepare monthly financial statements for the Commissioner, prepare bills and delinquent statements. The incumbent will confer, coordinate, and advise the appropriate municipal officials.

During the first 6 months of the program, the necessary regulations will be written, public hearings conducted, and regulations adopted. Actual loan processing will follow the adoption of regulations.

AGENCY Environmental Conservation PROGRAM AREA Environmental Conservation

BRU Administration

COMPONENT Administrative Services

FY 81

13 REQUEST FOR NEW POSITION.

REVISED DATE _____

HB 861

MEMO

To: The Honorable Joyce Munson

From: Christine Johnson CJ
Temporary Research Analyst, House Research Agency

Through: Duncan L. Read DLR
Director, House Research Agency

Date: November 20, 1979

Subject: Request for bill regarding revolving loan fund for sewer construction.

Enclosed please find SB 19, introduced in the Ninth Alaska State Legislature, which establishes a revolving loan fund for sewer construction within incorporated municipalities. This bill was introduced in 1975 by former Senator Genie Chance. The bill was referred to Senate Resources, Finance, and Rules, but it was never reported out by the first committee of referral.

Ms. Chance coincidentally was in Juneau when we were locating the bill for you. She recalls that she introduced this legislation to alleviate a problem in Anchorage where the cost of putting in sewer and water systems was significantly increasing the cost of subdivision development. Ms. Chance indicated that the high cost made it difficult for municipalities to require sewer and water systems in some areas under development. SB 19 would have provided long-term low interest loans for municipalities in anticipation that annual property assessments could then be lowered.

Members of the Anchorage Planning and Zoning Commission expressed interest in the bill as did the Anchorage Borough Assembly. The bill also received some support from other municipalities, such as Valdez, who needed additional monies for sewer construction. According to Ms. Chance, there was no opposition to the bill, but because of other revenue issues before the legislature that session, the bill was not acted upon by the first committee of referral. Of course, we kept your inquiry confidential when we obtained this information for you.

We apologize for the quality of the reproduction of the bill. Older bills have been transferred onto microfilm which often will not produce clear copies. Please do not hesitate to contact us if you require further information on this or similar legislation.

re: Girdwood Prob

HB

862

House Health, Education & Social Services Committee — Meeting/Hearing on ~~HB~~ 862 — Date: 3/5/80

	Name	Address and Phone	Organization/Self	For/Against or Observing
1/	Joyce F Munson			
2/	Dr. Verner Stellhorn		D+SS (mental health)	
3/	Gwendolyn Randall-Phillips		D+SS (public health	
4/				
5/				
6/				
7/				
8/				
9/				
10/				
11/				
12/				
13/				

POSITION PAPER/Department of Health & Social Services

POSITION PAPER

HOUSE BILL NO. 862

"An Act making a special appropriation to the Department of Health and Social Services for the purchase and dissemination of materials produced by the Growing Child Program; and providing for an effective date."

Persons may become parents with little or no knowledge or understanding of child development, changes that occur within the family or the variety of emotions evoked in parents and children. Consequently, parents frequently have problems in coping with the normal feelings of depression and anger that accompany the joys of a new baby.

House Bill 862 will provide $68,200 for the purchase and dissemination of educational materials produced by the Growing Child Program. The distribution of these materials will be administered by the Division of Mental Health and the Division of Public Health. The initial introduction of these materials to new parents will be made with a personal visit to the hospital or home. Subsequent copies will be distributed through monthly mailings. The Divisions are presently pursuing options by which parents, according to ability to pay, may contribute to the purchasing cost.

The Department does recommend a change in wording. The Growing Child Program is a copyrighted feature of a specific company. The naming of a particular firm or trade name is contrary to the state's bidding and purchasing policies. The Bill should be amended to provide for the purchase and dissemination of child development and parenting skills materials, rather than specifically naming the Growing Child Program.

The Department therefore recommends the following amendments:

CHANGE TITLE OF BILL TO READ:

"An Act making a special appropriation to the Department of Health and Social Services for the purchase and dissemination of educational materials related to child development and parenting skills."

CHANGE *SECTION 1. TO READ:

"The sum of $68,200 is appropriated from the general fund to the Division of Mental Health, Department of Health

POSITION PAPER/Department of Health & Social Services

and Social Services, for the purchase and dissemination of educational materials related to child development and parenting skills."

The Department supports the need for preventive health education materials.

Recommended by: _____

Dean F. Tirador, M.D.
Director, Division
of Public Health

Date: 3/5/80

_____

Verner Stillner, M.D.
Director, Division
of Mental Health

Date: 3/5/80

Approved by: _____

Helen D. Beirne
Commissioner

Date: 3/5/80

THE LEGISLATURE OF THE STATE OF ALASKA
ELEVENTH LEGISLATURE

FISCAL NOTE

I. REQUEST
Bill/Resolution No. House Bill 862
Title Growing Child Program
Requested by _____ Date _____

II. FISCAL DETAIL
Agency Affected Department of Health and Social Sevices
Program Category Affected Health
BRU, Program, or Subprogram(s) Affected Administration
(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

		FY 80	FY 81	FY 82	FY 83	FY 84	FY 85
100	PERSONAL SERVICES		4941	5336	5763	6224	6722
200	TRAVEL						
300	CONTRACTUAL		56,500	61,020	65,901	71,173	76,867
400	COMMODITIES		6,727	7,265	7,846	8,474	9,152
500	EQUIPMENT						
600	LAND & STRUCTURES						
700	GRANTS, CLAIMS, ETC.						
	TOTAL		68,168	73,621	79,510	85,871	92,741

FUNDING (Thousands of Dollars)

GENERAL FUND		68,168	73,621	79,510	85,871	92,741
FEDERAL FUNDS						
OTHER (Specify Fund Source)						

POSITIONS

FULL TIME						
PART TIME		.25	.25	.25	.25	.25
TEMPORARY						

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

It has been determined that there are approximately 9000 live births per year in Alaska. Each new family would receive a direct mailing with follow-up to provide an annual subscription to a monthly professional production media service. Department material will be included in each monthly mailing to provide educational material on parenting and nurturing skills relative to the age of the child.

Initial contact will be to 9000 persons with an expected participation for 50% of the contacted families. A part time clerk is projected to coordinate and physically prepare mailings of an estimated 58,500 individual mailings per year.

100 - 3 man-months Clerk Typist III
@ 1277 per month + benefits 4941
300 - 4500 annual subscription to prepared
material @ $5.25/year = 23,625

(Continued Page 2)

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)

Prepared by: T. R. Branton Date: 2/29/80
Division/Office: Mental Health & DD PH: 465-3370
Department of Health & Social Services

Approval DHSS Mgt. & Bdgt [signature] Date: 3/5/80

33 001 (Rev. 12/79)
Modify by DHSS (11-28-79)

printing cost for prepared mailing list = 700
postage @ .55 per packet for 58,500 units = 32,175

9000 units X 1 mail per year = 9,000
4500 units X 11 mail per year = 49,500

Total Units 58,500

purchase of 58,500 clasp mailing envelopes
@ .115 each 6727

TOTAL $68,168

All costs for FY 81 forward adjusted
b6 8% per year.

Growing Child®

Babies Like To:

Suck
Listen to repeated soft sounds
Stare at movement and light
Be held and rocked

Give Your Baby:

Your talking and singing
Lamps throwing light patterns
Your arms

Here You Are!

Something new and wonderful has happened to you: you are now parents! You're probably feeling happy, excited, elated, and yes, just a little frightened at the thought of the new life you've created and the responsibility of being Mother and Father. Don't feel alone. We've just described what is probably a universal reaction to parenthood.

During this first month you're going to be concerned with many things – most of them will be new situations for you such as feeding and adjusting to schedules, but after some of the excitement dies down, you're going to have a lot of questions. Most of them will concern the physical health of your child, and we'll discuss this a little later. You're also going to have questions about the proper growth and development of your child.

Today there is a great deal of research being done on how infants develop and how to help them develop. Most research suggests there are lots of things you as parents can do to help your child develop mentally, physically, and emotionally.

This, then, is the purpose of *Growing Child:* to emphasize the importance of mental development and to provide you with information to help you learn about your baby and about yourselves as parents; to help you learn what you can provide for your child so that he might develop, mentally and emotionally, to his fullest potential.

A special note for those of you who have other children: this information is just as important for your second or third child; learning and development is not restricted to a first child so make sure you take advantage of the information available for your new baby.

Brothers & Sisters

At last the big day arrives when you and your baby go home. If you have other small children waiting at home, give some thought to the situation.

When you arrive home, put the baby down and appear to ignore him while you greet the other children and make a big fuss over them. They will then discover Baby and quickly make him their own. Let them touch him, unwrap him, and hold him if they want to. It may take a little control on your part, but they won't hurt him.

In your care for Baby, let the other children help. There are small chores they can do which will include them in your attention and make them feel needed.

Don't be surprised if your youngest regresses to thumb sucking and wet, dirty pants or demands to be fed from a bottle just like Baby. Take a little time to spend with him alone to repair his bruised ego. Mother and Father should make it a point to assure your children you love them as much as before Baby came but that right now he is small and needs extra attention.

A Newborn Baby

Mother-to-be type magazines should publish pictures of newborns more often to prepare new parents a little better for the shock of seeing their baby. One mother told her husband in the delivery room, "Oh, honey, he's beautiful, but we'll really have to love him hard because he's so homely!" She was right. A new life is beautiful, but newborns are not the light pink, round babies smiling from the magazine pages. A newborn's skin is often red and scaling, his little nose is often misshapen or flat after birth, and it's hard to see his eyes as they're often tightly closed.

Baby's head accounts for about one quarter of his size. Although this makes him look a little odd, it's a good thing, and here's why:

The head and the brain have already become very well developed before he was born. From now on the brain will continue to develop, but the rest of the body will have to catch up. The typical pattern of development is from the head downward to the rest of the body and from the center of the body to the extremities (for example, the fingers). As an illustration, in a very short time Baby will learn to watch things. His eyes do see almost from the beginning, but mostly they just see things close to them that are brightly colored. When you lean over

the crib or hold Baby close to you, very likely he does see something. And he can use his eyes to explore the world long before he can use his body to crawl and explore.

Right now Baby may move his arms a little but the fists are usually clenched tightly and the whole arm moves in a jerky way. Later he will have developed better control of his arms and will bat at things. Still later he will be able to use his fingers to try and grasp things. This is an example of development from the center of the body outward (from the whole arm to fingers). In the months ahead, watch for your baby's development.

Birth Marks

Every baby has "birth marks." There are a lot of interesting stories about their being caused by something that happened while the baby was being "carried" or during his delivery. Actually they are either minor variations in normal skin development or inherited or racial characteristics.

The most common birth mark is the nevus flameus. This is a medical name for the pink-red, flame-shaped marks seen on the forehead, upper eyelids, and tail-bone areas of some babies and on the nape of the neck of almost all infants. These are commonly called "stork bites." They become more noticeable when the baby holds his breath or cries. They usually disappear in one or two years although those on the neck may always be there. Nevus flameus is often confused with stains from the silver nitrate that is put into the eyes of babies to prevent serious eye infection at birth. This stain is light brown in color, present only around the eyes and disappears as the face is cleansed.

Sometimes birthmarks are deeper, larger and more blue in color. These are called hemangiomas and although they appear serious, they usually disappear in early childhood. Occasionally some type of surgery or other treatment needs to be carried out on these, but it is usually not done until enough time has gone by to be sure that they are not going to disappear spontaneously.

The familiar brown mole or "freckle" is usually not present at birth. It appears as the skin gets older. Sometimes it also disappears. Most of them, however, will be with your child all of his life and are useful as identification marks.

A port-wine nevus is darker and more blue than nevus flameus and can be located on any body area, particularly the face or scalp. These do NOT disappear and require either cosmetic surgery or cover makeup to make them less noticeable.

Strawberry marks can be found on any part of the baby's body. They are usually not present at birth but appear shortly after. They are small, raised, and irregular in shape and have a raspberry rather than a strawberry color. They usually grow for one to four months and then slowly disappear.

Mongolian spots are smooth, blue-gray, irregularly shaped areas of skin over the tail-bone and buttocks of dark-skinned or oriental infants. They disappear in the first few years of life and have no significance except that they can be mistaken for bruises.

As you can see, most birth marks are not serious and, although they may "mark" your baby at birth, they certainly do not "mark" him for life.

Diet and the New Mother

"Now that that's over, I can go back to eating again!" That is the way most new mothers feel, especially if they have had to watch their diet carefully during pregnancy because they were gaining too much weight or getting too much salt. Unfortunately, the diet watching is only beginning particularly if the mother is still overweight after delivery and/or is breast feeding.

If the problem is just too many pounds and breast feeding is not part of the picture, a balanced, moderately low-calorie diet can be used. It is not wise to use an extremely low-calorie or "fad" diet right after a pregnancy to quickly "get back into shape" again. The body takes time, adequate nutrition and exercise to regain its pre-pregnancy condition. That is why most doctors also advise their new mothers to continue taking their pre-natal vitamins and minerals (including iron, in some cases).

Breast feeding increases the care a new mother must take in selecting her diet for she must be well-nourished to supply adequate good-quality milk for her infant. She must also be alert to the effects of certain foods on the baby's response to the breast feeding. For instance, chocolate, spices, cabbage, certain juices and onions may pass through the breast milk to the child and cause mild stomach upsets such as colic or diarrhea. The amount of trouble these foods cause means a great deal with the individual mother and baby. Most new nursing mothers soon learn to recognize those foods which affect their breast milk and the baby's response to it.

An important, but often overlooked factor concerning the new mother's diet is her emotional response to food and the effect of that response on the baby. The mother who has poor eating habits will pass them on to her baby. Children learn by imitation and when it comes to eating they first imitate their mother. Her reaction to food quickly becomes theirs. If she eats an unbalanced diet herself, she will probably offer the same to her child. And even if she tries the "do as I say and not as I do" routine, the baby will very early sense the contradictory attitude and become the so-called problem eater.

So, along with all of the other responsibilities of being a new mother there is the most important job of eating correctly to maintain your own health and to teach the baby that good nutrition is fun and necessary. It is a lesson that will help him all of his life.

Your Baby and His Intelligence

Experts in child development know that the right kind of experiences in infancy and the early childhood years can increase a child's intelligence, and there are many scientific studies which support this idea.

There are also many studies of identical twins reared in different homes. In general, these studies showed that the twin who had the best kind of early experiences had a higher intelligence than the twin who had poor early experiences. These tests are very important since identical twins come from the same cell, which means their heredity is identical. They have the same genes. This means that heredity is not the only factor which determines intelligence, but experience in early life also plays an important part.

In 1939 there was what experts call a "classic study." The results are rather startling and further support the idea of the importance of early experiences.

The study, by H.M. Skeels and H.B. Dye, tells about 13 infants and young children who were in an orphanage. The youngest was 7 months old and the oldest was 30 months. All 13 children were transferred from the orphanage to a school for mentally retarded children. At the time of transfer, they had an average Intelligence Quotient (IQ) of 64.3 with the lowest being 36 and the highest 89.

When transferred, these children were placed in a ward with some older and brighter girls who started playing with them during most of the time they were awake.

Just by playing with these babies, the older girls provided many more experiences and much more stimulation than was provided for the children left behind in the orphanage.

After the new arrivals had been in the ward for some time, the people making the study gave a second intelligence test. All 13 children showed gains in IQ. The smallest gain was 7 points and the largest 58 points. All but four showed gains of at least 20 points. A check of the 12 children who remained behind in the orphanage showed an amazing difference. One had a decrease of only 8 points but the other 11 children showed decreases from 18 to 45 points.

Twenty-one years later all the children in both groups were located. The differences are startling. Of the 13 transferred to the school for the mentally retarded (the group where the older girls played with the children), all were self-supporting and none was in an institution. Of the group that remained in the orphanage, one died in an institution for the retarded and five were still in state institutions.

The difference in education between the two groups is just as startling. Of the group transferred, the median grade completed was the 12th grade. In fact, one boy received a bachelor's degree from a large state university. For the group of 12 that remained at the orphanage, half did not complete the third grade and none of them went to high school.

Clearly this study shows the importance of early learning experience for development of intelligence and for general independent functioning in the world. A school for retarded children is not the best place for giving these early learning experiences, but even in this setting, the older retarded girls who played with the children seem to have given the kind of stimulation that made tremendous differences in the children's later abilities.

This is what *Growing Child* is all about—to help you give your infant the early experiences that can have an important influence on intelligence and on independent functioning.

Your Baby's Birth Certificate

Be sure to get a birth certificate for your baby. It is legal proof of the date of your child's birth and citizenship. Throughout life he will need this proof of identity. It may be required when a child enters school, requests a driver's license, goes to work. It may be needed to prove his right to vote, to marry, to draw social security benefits, to hold office, inherit property, or obtain a passport to travel in foreign countries.

If the baby is born in a hospital, the staff will see that necessary information is sent to the local health department or registrar of births. If you have not selected a name for the baby before you leave the hospital, be sure to add it to the official record later.

If the baby is born at home, the midwife or doctor (or the parent if no one assists at the birth) is required by law to report the birth to the local authorities.

You will be officially notified when the record of your baby's birth is on file. Some States send a copy of the registration. If any of the information is wrong, be sure to get it corrected immediately. In some States,

the birth certificate is sent only on request and for a fee. There is practically always a charge for a second copy, so keep your baby's certificate in a safe place.

If you do not receive notice of the proper registration in a few weeks, check on it. Call the hospital or local health department. Or write to your State health department, which is usually located in the capital city.

Baby Seating

One of these days you're going to discover you need something for Baby to ride in while in the car. And we'd like to say a few words about what you might use.

It isn't a pleasant fact, but today millions of kids ride unprotected, or close to it, in automobiles. In the last 10 years, over 10,000 children under four have been killed in car crashes. In addition to fatalities, a major concern is permanent brain damage which could have been prevented by a proper infant carrier.

There are several excellent car seats for children. To obtain the most complete, up-to-date information we suggest you take the time to read Consumer Reports' survey. Most libraries have this publication. . .and you can learn a lot about what to look for.

It's so easy to provide protection for Baby and the other youngsters in your household.

Breast Feeding

Both professionals and parents have been known to become emotional on the breast vs. bottle issue. This controversy is unnecessary because the choice is extremely personal – the choice of the mother or mother and father. At this time there is no absolute scientific evidence to indicate that one method is better for infants. If you do choose to bottle feed, it is important to provide Baby with the physical caressing and cuddling he would automatically receive when held for breast feeding. There are some values to breast feeding: it's economic; the milk is always pure; it saves hours of time because there are no bottles to sterilize, formula to mix, refrigeration to worry about, travelling is no problem; it helps mother physically (when the baby nurses there is vigorous contraction of the muscles of the uterus and this helps to restore the uterus to its pre-pregnancy size and shape.

For a variety of reasons breast feeding is not considered by some women. Many of the reasons are "old wives tales", and we'll mention a few. (1) "Nursing mothers lose their figures". There's no need to eat excessively or gain weight in order to make milk. (2) "The effect of breast feeding is large, pendulous breasts". There are women whose breasts have become flatter after breast feeding, but there are women who have nursed several babies and have still maintained fine upright breasts; and finally there are women who have never nursed and whose breasts are flattened. (3) "Working mothers can't nurse". They can, depending upon the working hours and how quickly mother must return to work after Baby's birth. Even if mother is employed for 8 hours a day, she can nurse at night. And even if she can't nurse after resuming work, it is still possible to breast feed for a month or so. (4)"Breast feeding is tiring for the mother". Having and caring for a baby is fatiguing – for all women. However, our bodies adapt quickly to changing energy needs. If a woman feels that breast feeding is "taking a lot out of her", she may be a worrisome person, an overconcerned mother, a woman in poor physical health, or an individual not committed to the idea of breast feeding. For those interested in knowing more about breast feeding, an international organization, La Leche League, provides information. The League has chapters in many cities, small and large, in the U.S.

The Old-Fashioned Rocking Chair

Was there a rocking chair in your childhood? Do you remember one of the old-fashioned kind with comfortable arms and a high back for mother to rest her head against?

Perhaps not, because rocking chairs went out of style when you were young and for a time no one seemed to have one around the house. However, since the time President Kennedy's doctor ordered one for him, rockers are back in style. Rocking chairs are good for anyone, but they seem to have been made especially for mothers and babies. By holding your baby and talking gently to him, you communicate love, warmth and security in ways that even a newborn baby understands. Rocking chairs are wonderfully comfortable and relaxing for both you and Baby. Doctors tell us that as mother rocks gently, she improves the circulation in her legs.

As you rock, the easy to and fro movement stimulates the balance and position sensors deep in Baby's inner ears. As he lies in the curve of his mother's arm he feels the movement. When he is lifted and held upright with his head on your shoulder, he feels movement in a different direction If you lay him across your knees on his tummy, he becomes aware of still a different kind of movement. With each change of position Baby experiences the rock-

ing motion in slightly different ways. But always his nearness to his mother provides warmth and security as a background for his growing awareness of changing positions and of movement in different directions.

From these experiences an infant learns how to interpret and to use the sensations produced in his balance centers by changes of position or direction of movement.

Later this ability to interpret these sensations will help him develop and maintain the balance he will need as he learns to stand and walk. The early stimulation provided by the gentle movements of the rocking chair will make it easier for him to learn to balance on his own two feet. So, we say..."long live the old-fashioned rocking chair, symbol of love and learning"

Get the Right Nipple for His Bottle

Baby's development of good speech and attractive teeth begins as soon as he is born. The tongue and mouth muscles so necessary for good speech must be stimulated and exercised long before the baby is ready to talk. Basic muscle training starts with sucking. At birth, sucking is a reflex which is provoked by hunger or by being stroked around the mouth. For the infant who is bottle fed, the choice and use of proper nipples is very important to sucking. Improper nipples can lead to problems not only of speech but also to serious problems of alignment and structure of the permanent teeth, and here's why:

If the nipple is too long, it reaches far back into the infant's small mouth. The milk then flows directly into his throat and there is no opportunity for any muscle exercise.

If the nipple is the correct size but has too many holes or holes that are too big, Baby gets too much milk and in self defense, he either spits up, lets the surplus spill out of the sides of his mouth, or chokes. Now, to prevent himself from choking, the infant thrusts his tongue forward and squeezes the nipple between the tip of his tongue and the upper gum. Then he swallows. This abnormal combination of tongue thrust and swallowing may become a habit. Later when the child talks, he will lisp and you will be able to see his tongue thrust between his lips when he makes the s, sh, ch, or j sounds. Also the tongue tip sounds of t, d, l, and n will be made incorrectly – the tongue pressed forward against the front teeth rather than against the upper part of the teeth and gums.

As the habit of tongue thrusting is practiced, the child develops a space between the front teeth. As the space grows wider, he thrusts the tongue more frequently. Finally this persistent tongue thrust against the teeth will affect the bite.

If the infant fails to receive enough sucking exercise, he may substitute thumb sucking when the bottle is taken away. As he grows older, he may continue the sucking habit but in a more social way – chewing on pencils or other objects, pushing the lower lip against the upper teeth, licking the lips or thrusting the tongue up under the inside of the upper lip.

Dressing Your Baby

When you get right down to it, the only clothing you really must have for Baby is a good-sized stack of diapers. All other adjustments for warmth could be made with an assortment of blankets. And, in parts of our country, even this item is dispensed with. The Eskimo mother tucks her little one inside her fur parka, absolutely naked.

Starting with absolutely nothing in the way of clothing, you can add items indefinitely. It is largely a matter of personal preference and the size of your budget. Here are some simple ideas you might keep in mind:

(1) In general, simple, easily-washed garments are best—these include drip-dry, machine washable and dryable, no-iron fabrics.

(2) Babies grow so fast it is better to have only a few things of any one size.

(3) Adjust the warmth of the garments to the weather. On very hot days, a shirt and diaper is enough. If you are cool, put a sweater on the baby.

(4) Consider the ease and comfort for the baby. Are the clothes easy to put on, take off; is it easy to change diapers.

What about the individual items? How many of what? Here are some suggestions:

3 to 6 dozen diapers: You'll probably use about 2 dozen a day on the baby and find yourself grabbing a diaper to throw over your shoulder when you "bubble" the baby, as extra sheeting, bib, towel, etc. The extra dozen or so is handy if you can't get diapers washed or dried daily. In some cities it is possible to contract with a company to furnish and launder diapers for the baby. Such service is a great help, if you can afford it, especially at first. The diaper companies often rent certain items of equipment which you might like to have for only a short time. Even if you plan to use a diaper service, you might find it convenient to have a dozen or so diapers of your own. (Diaper service makes an excellent gift.)

Diapers
3-6 dozen
1-2 packages disposable diaper pail

Bedding
Mattress
4-6 crib sheets
4 waterproof pads
2-3 crib blankets
1 comforter

Furnishings
Crib
Chest of drawers
Changing/bath table

Feeding
Breast feeding: 2-4 bottles for juice, water.
Bottle feeding: 8 bottles, 8 oz.
2-4 4 oz. bottles.
Sterilizer and utensils
Bottle and nipple brushes
Extra caps and nipples
Bibs
Baby dish, utensils
Feeder for strained food, cereal

Clothes
4-6 shirts
4-6 gowns, kimonos
4 waterproof panties
3-4 stretch suits
4-6 receiving blankets

Bath/Toilet Articles
Diaper pins
Cotton swabs
Baby oil, lotion, powder
Baby soap or cleanser, baby shampoo, brush & comb
Moist towelettes, ointment
3-4 washcloths
2-3 hand towels
2-3 bath towels

Nice "Extras"
Bassinet
Nursery Lamb
Scale and Pad
Rocking Chair
Diaper Service
Baby Food Grinder

Later
High chair
Stroller
Toilet chair

Diapers are made of gauze, cotton flannel, bird's-eye, and other fabrics. There are squares, rectangles and shapes cut to fit the body and provided with snaps. Everybody has his own idea about which kind is best, and you'll just have to select the kind that appeals to you.

4-6 cotton shirts. Size 2 fits most babies in a few weeks. Sleeveless or short-sleeved shirts can be used in any weather. If it gets cold, you can add a sweater or the light jackets known as "sacks." Be sure to select a style of shirt that will go on the baby easily. Babies hate to have anything over their faces, and a mouthful of shirt sets them wild. Get armholes large enough and neck openings ample for the baby's head.

4-6 nightgowns. Avoid the type with string or cord at the neck. Cotton-knit or jersey doesn't need ironing. One of the advantages of a long nightgown is that the baby's windmill kicking doesn't send the covers off so readily. Some parents like the sleeping garmet which is long and roomy enough to enclose the baby's feet.

A cap for the baby. A warm one to cover the ears for cold weather. Knitted styles are good.

Bootees and socks. Don't expect these to stay on those active feet, though. The baby's feet and hands may feel cold to your touch, but he may be quite warm enough. He still has relatively poor circulation in his extremities. Unless your house is very cold, covering for the feet is not necessary.

Dear Growing Child

"G.C." is almost a necessity in that it provides accurate and pertinent information which is valuable to parents as well as babies and children. I honestly believe that parents who use the informative insights provided by "G.C." have tremendous advantage over others, and the benefits must surely reflect in their children. I use it, depend upon it, enjoy it, and have come to regard it as my essential aid in Mothering!"

Debra B.
Muskogee, OK

Next Month

- How Can I Tell If My Baby is Okay?
- Baby Talk
- The Right Doctor For You and Your Child

Growing Child®

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22 N Second St., Lafayette, IN 47902

Let Me Introduce Myself!

I am Pierre the Pelican, a Disney-like character who gives suggestions to young parents about their first children. I talk with fathers and mothers about their babies, and often tell them in advance what may happen a few weeks or months ahead. That helps them get ready.

How do I know you have a new baby? Mostly, I get names from birth records. In some countries I have a hard time getting names, and sometimes the baby's name comes late, because birth records aren't always kept up to date. But I do the best I can.

I'm interested in your baby's development, but in my messages I won't say much about physical care. You will need to keep in close touch with your doctor or nurse and get advice on all subjects that have to do with physical health. My special interest in your baby is something you'd never guess of a pelican like me. I'm interested in the mental health of that new baby of yours. I want the baby to grow up to be happy and friendly and able to do his part in the world, and to get his full share of love and good care. I know you do, too!

In mental health you have to think a long way ahead, for the way you are beginning to care for the baby now is likely to be the way you will continue for years to come. In physical health you have to think ahead, too. But it is easier to know when things go wrong. If he isn't well, he may fret or have fever. You will know somehow that he is not well. In mental health though, the baby's ways of letting you know whether he is getting along nicely and you are doing a good job are not always as clear as when he is physically ill. For that reason I plan to come for a chat about once a month for the next several months and will tell you what I have learned from people who know about mental health. You can prevent many problems from arising if you know in advance about the causes.

By the way, is yours a boy or a girl? I have forgotten. There are so many these days; and besides, both kinds are as fine as can be. If you don't mind, I'll just call your baby "he" when I'm talking about what to do, because what I say about baby boys goes for baby girls, too.

Here is a suggestion for "Father" and "Mother"

Before I say much about the baby, I'd like to talk to both of you parents about yourselves—the father and mother. Say, it sounds funny for you to be called "father" and "mother," doesn't it? I guess you had been practicing it some before the baby came, just for fun.

You two need to leave the baby with someone else once in a while and have some fun all by yourselves. Yes, I mean that. I know he is wonderful, but just the same you both need some time off together. You will feel so different, now that the baby has come. The mother can take long, natural steps once more, and is also pleased to get back her figure. You remember how it was when everybody noticed and both of you were proud, but a little self-conscious. Remember how careful mother had to be not to fall.

As soon as mother is able to be out—and if the feeding periods are far enough apart—find some reliable person to look after the baby while you are away. A grandmother or an aunt, a friendly neighbor, or some other person who knows how to handle babies can keep him safe for that much time.

When you two are out alone there will be old problems you will want to talk over again, and some new ones also. Many of the old problems may seem rather small now, considering all you have been through. Just the same, it is nice for you to talk things out and understand each other. When you are talking about the baby, you ought to decide together what to do about him. You should decide together the kind of medical service to have, and the use of money, now that there is one more in the family. This will be good for you and the baby. It will get you into the habit of talking with each other about the baby and making decisions that are agreeable to both of you.

Nowadays, I notice young parents often take very young babies two or three months old with them when they go out, and can't get someone to take care of the baby at home. They carry him around in a plastic "infant seat" which can be set up on the table and raised up a little so that the baby can look around a bit. However, young babies catch colds easily, and especially during the season when people are sneezing and coughing it is a good idea to keep them out of crowds as much as possible.

Babies are easiest to take places when they are very young. Then their parents can spend an enjoyable evening with friends, and the baby can sleep in a crib or on a bed. But this period does not last long. Pretty soon the parents will begin to be afraid the baby will roll off a bed while they are in the next room talking or playing at games. And "infant seats," if used at all, may turn over as the child gets older and more active.

The baby's needs come first right now

It doesn't matter what part of the world you live in, or your race, creed, or color, or the kind of government under which you live—your baby's early needs, during the first few years, are going to be the same as every other baby's needs. As children get older the customs of the country and culture in which they live will have much to do with their development.

But the people of the world are becoming more and more alike. They are teaching each other. Scientists from many countries are learning about how human beings develop, and

Fathers and Moth

television broadcasts may soon be made all over the globe at once, teaching us about better ways to care for children. Just as a new medicine is developed successfully in one country—as penicillin in England—soon the whole world uses it. In much the same way, ideas on the better care of children are spreading around the world.

For example, we have learned that every baby should—from the beginning—get used to being handled by several people, and not just his mother. Once in a while you will find a young mother who won't let other people hold her baby, feed him, or change and dress him. This is now a very old fashioned point of view. For it has been found that children develop better if they learn to like and trust many people, and this for a very young child comes from being fed and handled and made comfortable by several different people. As he gets older, it means having fun with more people, and learning from them.

The father needs to share in the care of the young baby. This is not only very satisfying to him, but gives the mother relief—which you can be sure she needs. The baby also should become accustomed to being handled by his father from the beginning.

Learning about baby care

Nature provides the mother cat with instincts to care for her kittens, but more is required of you humans. You learn about babies just as you learn anything else. You are lucky if you have had the chance to see some babies properly cared for by good mothers and fathers. What you have seen has in a way become a model for you. Perhaps you grew up as one of the older members in a family and had a chance to be with younger brothers and sisters. In some schools they teach young people about the care of children, and that is fine, but there is not much of this. There should be a great deal more in the future.

Some people will tell you that you can trust your judgment to do a good job. But judgment depends on experience. It partly depends on **what you have been able to observe,** because I see many educated persons who have difficulty in raising their children and many uneducated persons who do well. Education that is not specifically about children provides little assurance that a child will be easily and properly cared for.

Of course, you know quite a bit already. You have observed babies, and you have talked with mothers, some young, some old. Your doctor is a good source of information. And women who have done a fine job of rearing their children know a lot, too. Then there is published material these days, a great deal of it, such as these letters that are coming to you. And there are articles about child care in the better magazines, and good books which we will be talking about later.

Love for a baby grows

Sometimes your baby may cry a great deal, his food may not agree with him, or he may keep you awake at night and you just can't get enough rest. At such times parents may feel as if they wished they didn't have him. Or they may have moments when they wonder whether they love him. If you ever reach this point, it's time to find other parents whose child is older and who handle him easily, and sit down and talk and talk. I can tell you for sure that as the baby gets adjusted to his routines, he will be less troublesome, and easier to love. If he "gets on your nerves too much," have someone with you, perhaps a sister or a mother or some friend. Don't be ashamed of your feelings, but ask for help. This is a phase many young parents go through. If it happens to you, it does not mean that you are not a good parent or that you will keep on feeling like that.

You will gradually develop a real feeling of affection for your baby, and as you understand his needs better you can take care of him better.

The more you learn about babies the more interesting they become. But don't ever let anybody give you the idea that it is a simple thing to bring up a child. It isn't; but you can do it. You can learn more about the rearing of children. It isn't really quite like learning anything else.

How often does one feed a very young baby?

If five young mothers of very young babies get together to talk about the feeding schedules they have for their young babies, you're likely to hear five different stories. Formerly, there was the notion that babies should be fed exactly by the clock. Few people believe that any more.

On the other hand, most people like some sort of schedule for themselves, and babies do, too. The trick is to gradually work into a rather regular routine, but to keep it flexible enough to change when an unusual situation comes up.

Babies tend to like frequent feeding at first, and then they settle down to a schedule that means longer hours between feedings. Two or three hours at first, and then four hours seems to be most often spoken of as the favorite interval between feedings. But the important practice to keep in mind is to feed him when he's hungry. It must hurt a lot when he's really hungry. Of course, you don't need to feed him **every time** he cries, for he may not be hungry. He may need a change of diapers, or he may be happy with some warm water or a pacifier. But when he cries hard, and none of these things satisfies, you'd better hurry and get the food to him.

As I say, pretty soon you'll find that he settles down to a schedule, and you can help this along by feeding him at regular hours even though he hasn't cried for food. This will surprise and please him and help him to establish a schedule.

Parents these days, however, are pretty clever in working with the little fellow. They will try to get the baby to sleep all night. But at first he can't go that long without food. In fact, you will be lucky if he will sleep through the night by the time he is eight or nine weeks old. Some babies require a night feeding quite a few weeks or even months longer.

If he passes up the night feeding, don't wake him up to feed him. Of course, when he does wake up in the morning he will probably be very hungry and will be crying, so you'd better get right up and feed him, and be thankful you've had most of a good night's sleep.

Breast and bottle feeding

There is much to be said in favor of breast feeding. After all, it is the most natural form. It is a very satisfying experience for both baby and mother. It nurtures a close, secure feeling. Also, breast feeding has in its favor such matters as ease of feeding, a clean milk supply,—and even expense.

Some mothers are not able to feed their infants at the breast, or for other reasons they do not wish to do so. Sometimes mothers find they do not have a sufficient supply of milk. It is very important that such mothers not feel they have failed in their duty if they are unsuccessful at breast feeding.

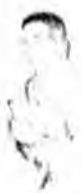
If a baby is fed from the bottle, the mother can hold him in the same way and can give him the same feeling of love and security as if she were feeding him from the breast.

The baby can have just as much enjoyment from a bottle as he can from the breast **if he is held in a lovin, manner and is watched closely to see that he is getting the milk, but that he isn't getting it too fast.**

What about the baby's bottle?

Your doctor or nurse or some other trained person will tell you all about the importance of keeping the baby's bottles clean and mixing the formula, and keeping it cold in the refrigerator. But then comes the question of whether to heat it before the baby is fed.

Most parents and doctors still feel that the milk should be gently heated until it is about body temperature. But the surprising thing is that babies will soon accept cold milk



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just as it comes from the refrigerator. You can gradually warm it less and less and pretty soon he'll drink it cold, just as you yourself like cold milk rather than warm. And it won't give him the colic either. Recent studies with premature infants in one large hospital, using cold milk from the beginning, showed that the babies do just fine. However, your doctor may prefer that your own child have warm milk. In any case, if a baby takes only part of a bottle, throw the rest of it away, or place it in the refrigerator immediately, if you expect to use the same milk again.

The importance of nursing

Nursing is the nicest time of all for the baby, and if his mother is holding him close, and feeding him either by breast or bottle, the baby couldn't be happier.

Here are two cautions: First, no smoking please while feeding the baby! Ashes and even fire have damaged the eyes of some infants while nursing. Also, **NEVER LEAVE THE BABY ALONE WITH THE BOTTLE PROPPED UP BY A PILLOW OR SOMETHING, AT HIS AGE!** I will suggest to you later when you may do so. Much depends upon his age, strength, and development. A young baby left alone with a bottle may choke and strangle badly. And since he is so small, he can't do anything to help himself.

Instead, hold the little fellow, take plenty of time for the feeding, a half hour if necessary. Let other things wait. You will find as the baby gets stronger the feeding time will be shorter.

Good sleep habits for the baby

Speaking of sleeping, it's very nice for the baby to have good sleep habits. You'll appreciate this a lot more as he gets five or six months old. Do not expect him always to go to sleep as soon as you put him in bed for his naps. He may drop right off to sleep while he is very young, but as he gets older he will want to look at things and stay awake for a time. When you put him to sleep you should leave him alone, although you will want to check on him every couple of hours, or until you go to bed yourself.

At his present age he is probably sleeping most of the time. When he is six months old he will sleep about fifteen hours out of twenty-four, and when he is a year old he will sleep about fourteen hours. Two or three months from now I want to talk to you some more about good sleep habits. They make everything a lot easier.

How much does the baby cry?

As I will say to you many times—babies are not all alike. In fact, they are very different. One baby may hardly ever cry, but will take his food and be ready for sleep. (Of course, I'm thinking now of the time when he is very young.) Another baby in the house down the street may be a crying baby. He will cry a great deal. There is usually a reason for this difference. The quiet child is comfortable. The crying child is not; he may be hurting somewhere. It may even be something about his food. If you think your child cries too much you should talk with the doctor about it, and give him all the facts. He may be able to help.

Yes, babies cry when they are uncomfortable, and sometimes it is hard to know what is wrong. Some of them just naturally seem to be irritable for the first two or three months, or have colic. Why some children have colic and others do not is something of a mystery still, but it should be comforting to parents to know that there do not seem to be any unfavorable after effects.

Of course, if a crying baby is wet or soiled, that is easy to discover. Maybe he is too warm or has gas pains in his stomach. Bringing up the bubbles by "burping" will help. In fact, you can prevent much discomfort by being certain to burp him at the end of every feeding. As I said above, if the crying upsets you too much, you must have relief, as some parents cannot endure too much crying. Get somebody to help you part of the time, and get away from the baby for some rest. Mothers of young parents can often be very helpful, if they do not live too far away.

How much attention should you pay the baby?

When the baby is very young he will sleep most of the time, even from one feeding to the next. It is better if you do not pick him up often in between. But after a few weeks you will find him awake more and more. When he is awake, you will want him in the same room with you. Talk to him softly. Hold him some and play with him. You ought to do this especially when he is good. Sometimes it will help if you pick him up when he is fretting or crying, but you ought not to wait always for him to cry before you pick him up. **Pick him up while he is good and in that way you will be rewarding him for being good.**

Some parents are afraid they will spoil their baby if they pick him up and show affection for him. Quite the opposite is true. Loving the baby is good for both him and you. The only way the baby knows you love him is by what you do. While he is very young this means you talk to him, pat him, and show him that you are very interested in him. Of course, you show your love also at other times, as when you are feeding, bathing, and changing him.

To be sure, you can overdo the time you hold the baby and play with him. You certainly don't need to spend all your time with him. Anyway, the baby seems to become tired of too much playing and attention. I am going to talk with you again about this next month.

Does the baby look like an aunt or uncle?

Babies often look like their relatives when they are still very young. However, just because a baby looks like one of the relatives is no reason why he will be like him. You can't count on the baby having a good disposition just because he looks like his aunt who is that way. And it is no guarantee that he will be short tempered, or lazy, or untidy, just because he looks like some other person who is. Anyway, babies look like different people at different times.

And right here I'd like to say that children don't just grow up by themselves. They grow up with help from you. However, bringing up a child isn't like moulding clay. You have probably found out by now that your baby has his wants and his likes. As he gets older he will have ideas of his own—lots of them—and you will want him to have them and to make decisions for himself, but you will know also that you will have to help guide him.

Freedom of movement for the child

From ancient times down to the present in some countries there has been the custom of binding the infant, or swaddling him as it was called, until he could barely move at all. Instead, he should be placed in his bed, sometimes on his back, sometimes on his stomach with his face turned toward the side with complete freedom to move. It is even helpful to place him on his side for a short time.

The baby, like an adult, must get very tired of lying in the same position all the time. Just staring at the ceiling is not much pleasure. One of these days I will talk about making the young baby's life more interesting, because we know now that he can hear and see more than we once thought he could.

The more parents love each other, the better it is for the baby

You've been together quite a while now, and I suppose you have learned the little things you can do to please each other, and what the other person doesn't like. All through these messages I'll be suggesting that you try to understand your baby and not expect more of him than is reasonable. It is the same way between you two. Sometimes fathers and mothers expect too much of each other. They expect more than is fair, and then they are disappointed.

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Address Correction Requested

A First Message to You
From

Also, if you really love each other, and let each other know it, neither of you is likely to become jealous of the baby. I know you don't see how it is possible for a grown-up to be jealous of a baby, but it often happens. Usually grown-ups don't admit it, but I have known lots of cases. You see, sometimes the mother's time is so taken up by the baby, that the father feels left out and without thinking, holds the baby responsible. It can work the other way, too, with the husband paying more attention to the baby than to his wife.

Family planning

Now is also the time for you to be thinking about the number of children you want in your family. I used to talk with mothers and fathers about this in a later message, but they wrote me often and said, "We already have another baby on the way; by the time our first was eleven months old we had another child." So I decided to talk with parents about the number of children they want to have in my very first message. The first baby may have been unexpected, but you can plan when you want to have the second.

In nearly every country of the world there is a large increase in the number of people. In some countries the number will double in the next few years. There are several reasons for this, but probably the most important one is because of improvements in the care now given to children. In earlier times many children died of epidemics, but now the medicines that have been developed by scientists make it possible for many more children to live. I am sure, also, you know that many young mothers who in the past died during childbirth no longer do so because of advances in medical care, and so they live to have more babies.

You want your babies to have the best possible care, but they can't have this if there are too many of them. When a mother has babies too close together she can't give the best attention to the older one because the new one comes while the first one is still an infant. And you are already beginning to know how much of the mother's (and father's) time it takes to care for a baby.

Also, you have to think ahead to the question of whether you will be able to provide house space for a large family, even if you wanted one, and whether there will be enough food. And then there is education — for children will get along much better in the modern world they are going to grow up in, if they have some education.

So the best thing is for the two of you to talk this whole matter over and then go to your doctor this very month. If you want a total of two or three babies, and want them separated by about three years, tell your doctor and ask him for information. If he thinks it better he may send you to a family planning center for instructions. Husbands do not need to go to see the doctor, though many of them will wish to do so.

In some countries a father feels he is not manly unless he has a large family, and mothers may have somewhat the same feeling about their womanliness. But this idea is changing, and people are asking not how many children a family has, but how well they are cared for. Parents hardly ever really want more babies than they feel they can care for and love, and spend time with, and give a good education. There is no nation or religion that disagrees with the idea of spacing children, though there is some difference of opinion on how it should be done.

By the time you read this, people in even the remotest countries will know about "the pill," and the "ring" which is inserted in the uterus of the woman and which for reasons not yet known keeps her from becoming pregnant until the ring is removed. These methods of family planning are easy to use and cost very little, and work very well if instructions are followed carefully. Another is called the "rhythm" method. Some of these ways of spacing children are more effective than others.

The world no longer honors the family which has more children than it can care for; it pities mother, father, and children.

Should you take the baby back for the doctor to see even if he is well?

Yes, indeed! You should take the baby back for the doctor to examine regularly. There is a great deal you need to learn about how to care for him, especially since this is your first child. The doctor knows all kinds of things to do for the baby. He needs to talk over with the mother the kind of food the baby is getting. He needs to ask about how the baby's bowels move and what the movements are like. The doctor knows how to regulate the diet so that there will be very little difficulty about bowel movements. Laxatives to make the baby's bowels move should not be given unless the doctor tells you to give them.

By the way, the mother ought to go back to see the doctor, too. Every mother needs to have proper examinations after the birth of her baby. Her own health will be better and it will be easier for her if she has another baby later.

KEEP MY MESSAGES! They will be coming to you once each month for the first year. By then you will feel better able to care for your baby, so after that I will come less often. Beginning with the third message I will try to leave a little space at the end of my message where you can write down what the baby is doing and what he is like at that time.

Good luck. I'll see you next month!

Growing Parent®

February, 1980, Vol. 8 No. 2

Learning To Manage Life's Stresses

"Stress" — a word we've been hearing a lot lately and a significant factor affecting our lives. But what is it, how can we recognize it, and, more importantly, how can we learn to manage it in a way that is healthy and productive?

Stress Defined

What is stress? I like the definition and explanation given by Blair and Rita Justice.[1] They state that stress is:

> any demand, force, or pressure that requires a person to make an adjustment. It may be physical stress such as rain that drives a person indoors, cold that requires him to bundle up, a noise that interrupts his sleep. It may be emotional stress such as separation from loved ones or death. It may be behavioral stress that comes from what a person does such as overeating and smoking.

Stated another way, "To a scientist, stress is any action or situation that places special physical or psychological demands upon a person — anything that can unbalance his individual equilibrium."[2]

That sounds like scientific talk, doesn't it? In short, it simply means that if we have to consciously or unconsciously change or adjust, we are experiencing stress. We are used to the idea that disasters and other unpleasant events are stress producing, but it is also important to note that stress comes from happy events as well.

Thus, while a divorce is stressful, so is a marriage. Losing one's job is stressful, but so is gaining a promotion. Losing a child is obviously stressful, but so is giving birth and adjusting to the presence of another person in the family. *Anytime* there is a loss or an addition of a family member, the family equilibrium is unbalanced and stress is introduced.

Bodily Reaction to Stress

Our bodies react to stress in the following manner. In extreme stress, our hearts will race and pound, our blood pressure will soar, and a flood of hormones will stimulate some organs and depress the activities of others. Our breathing quickens and our muscles tense. Now remember, this is how our bodies react whether we are exhilarated or scared to death, whether we consider the stress good or bad, welcome or unwelcome.[3]

Occasional reactions of this nature are not likely to be harmful and can certainly be tolerated by the average human body. But, what if we feel like we are constantly under stress? What if our stomach usually seems to be pumping enough acid to keep Rolaids and Tums in business? What if we rarely get through a day without a headache, or our neck feels like someone is practicing knot tieing with it?

One or more of these symptoms is reported as a frequent companion to many people. With as large an audience as is reached by *Growing Parent*, there are likely to be many who read this who can identify with this list of symptoms. This is particularly likely since the period of parenting small children is considered by many to be the most stressful stage of their lives.

If this is true for you, please read on so that you can learn how excessive or chronic stress can be harmful to your body. More importantly, we want to share some steps you may take to reduce your stress level or, at least, to manage the stress you experience rather than being managed by it.

Our Bodies Store Stress

What is harmful about stress, in addition to the extreme physical and emotional discomfort it can

produce in and of itself, is that our bodies tend to store it. Unless we have ways to break the stress cycle, the accumulation of stress produced by noise, constant interruptions, lack of uninterrupted sleep, lack of privacy, lack of exercise, improper diet, worry about finances, broken appliances, broken down cars, the barking dog, the crying baby, the . . . takes a severe toll on our bodies.

The effect of life changes are also cumulative, so that if one experiences a number of changes within the period of a year — a move, a new job, a new baby, marital difficulties, a change of diet, etc., the likelihood of becoming seriously ill increases tremendously.[4]

We React in Different Ways

Illness is only one of the possible tolls of excessive stress, however, for, as noted by the Justices[5]

> The consequences of excessive stress may be physical, emotional, or social. Some people have a heart attack, acquire some form of cancer, get ulcers or colitis, have headaches or arthritis. Others get depressed, suffer chronic anxiety, hostility, guilt, or shame. Still others deal with excessive stress by acting out in such ways as committing incest or physical child abuse, becoming alcoholic and assaultive, or battering wives. A few people express excessive stress in all three areas: the physical, emotional, and social.

Isn't that a sobering list of possible consequences? Surely none of us wants to get either physically or emotionally sick, or lash out at our spouses or children. The thought of sex within the family is repelling to most and, indeed, is a "taboo." But when we experience excessive stress, our internal and external controls may break down. Like the Three Mile Island Nuclear Plant, we are potentially dangerous and unpredictable. And, as in that incident, the question becomes whether we will break down internally, explode outwardly, or possibly both.

Taking Stock

What is your personal stress level at this point in your life (or that of your spouse)? Have you recently experienced, or are you currently experiencing, a great amount of change? Have you noticed weight gains, or losses, that aren't typical for you? Are you more subject to sore throats, colds, or the flu? Do you have head or stomach aches more often? Is your back acting up? If you answered yes to any, or many, of these questions, you may well be under a goodly amount of stress and may not be managing it well.

Managing the Stress

How then can an individual gain more control over his or her own life and manage the stress he or she is experiencing? You have already taken the first step if you have paused to evaluate the amount of life change you have been experiencing, and if you have paid more attention to your recent health history.

By becoming more self-aware you can take more charge of your life if you choose to do so. You have probably seen the poster or plaque that says, "When this mess is over I'm going to have a nervous breakdown. I've worked hard for it and I deserve it." I think we can all identify with the humor in this but, unfortunately, for some of us illness or "breakdown" is the only way we can give ourselves permission to rest, to pamper ourselves or accept pampering. Wouldn't it be better if we could learn to pamper ourselves when we felt great instead of rotten?

Eliminating the Self-Stressers

Stress not only comes from the outside; we can also contribute our share through self-stressing behavior. This internal stress, or "self-stress," is caused by how we view and respond to the events and changes in our lives, situations, and circumstances. It is when we face both external and internal stress that we face excessive stress, so a second significant way to reduce the stress in your life is to learn to eliminate self-stressing behaviors.

Blair and Rita Justice have put their fingers on three specific self-stressing behaviors that too many of us fall into, and which we could certainly do without. These three are:[6]

(1) "awfulizing" — viewing events, situations, or circumstances as catastrophic, horrible, terrible, or unbearable.

(2) "shoulding" — demanding (usually silently in the form of self-talk and thoughts) that others should do or be different, or that the world should be different (fair, just, easy).

(3) "overgeneralizing" — condemning oneself or others on the basis of a single performance or one set of behaviors or traits ("I'm a failure" or "I'm worthless because I got fired" or "I let my family down").

So, in addition to becoming more aware of the amount of external stress in your life and deciding whether to take steps to vary that, you can also significantly reduce the stress you feel by reducing the amount of self-stressing in which you engage.

Be Your Own Person

One good way to reduce self-stressing behavior is to be or become your own person, to learn to

dear Growing Child

Baby Neil wakes up at 6 am for his feeding. Daddy Roger gets up and brings him to our bed for me to breast feed. While Neil chows down, Roger fixes coffee and brings it to our bedroom. After baby is finished, we all spend an enjoyable 30-45 minutes in our bed talking, playing. Neil is always in good humor at this time, and Daddy benefits from the special time together with Neil and Mommy. In the quiet of the early morning when the entire world seems to be asleep, this very special time starts our day off to a terrific, positive beginning, and we would not give anything for it!

Linda S.
Cocoa, Florida

Dear Growing Child:

When we were expecting our second child, we made our daughter feel a part of the pregnancy. She came to the doctor's office with me and toward the end, she was allowed to hear the baby's heartbeat during my examination. We would let her listen to the baby's heartbeat and feel him kicking. We read books about new babies and one about jealous feelings. She also tried to think of names for this new person. When the baby (a boy) was born, our daughter came to see him and me in the hospital, and she came when my husband brought us home. She held her brother as soon as he got in the car. Our daughter turned 3 years old 2 weeks after our son was born.

We allowed our daughter to select clothes, help change and help bathe her brother. When our son was six months and started eating, our daughter fed him when she expressed an interest in doing so.

Consequently, we have avoided major jealous feelings. Our daughter also gets very excited by each new accomplishment of her little brother.

Kay P.
Lake City, Florida

Give the unique baby gift—an eight month gift subscription to **Growing Child.**

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- Your toddler is having a temper tantrum. What should you do?
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Parents' Encyclopedia

Softbound $2.95 **Hardbound $13.95**

Feed Me! I'm Yours

Feed Me! I'm Yours is an informative and entertaining book on nutrition and child feeding. The author has examined the labels on packaged foods and used them to advise parents on quality foods and those which should be avoided. This is not a textbook, nor is the author a purist. It is thoroughly practical advice for contemporary parents.

For example, in evaluating certain products which children prefer, she found too much salt, and salt can cause hypertension in children, according to Mrs. Lansky. Finally she says, "Love is not equal to the amount of food you give your child. Provide quality but not quantity."

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The Baby Exercise Book

In **The Baby Exercise Book,** Dr. Janine Levy shows parents how to aid a child's growth by utilizing his natural movements. These exercises are not "gym" but are based on the movements that young children normally make while playing in cribs or with their parents, rather than on unnatural motions.

These techniques will clearly be beneficial both to the child's physical development and to his emotional stability and relationship with his parents. The photos make the series of very simple exercises easy to follow. The book includes specific advice on such things as carrying the child in the right way and making use of his natural instincts for play.

The Baby Exercise Book can be helpful in developing the child's muscles, giving him sensation and self-image, and helping him to move around in his own immediate environment.

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Quan.	Item		Price	Total
	Z11	Feed Me! I'm Yours	$3.95	
	Z12	The Baby Exercise Book	3.95	
	Z2	Parents' Encyclopedia Softbound	2.95	
	Z3	Parents' Encyclopedia Hb	13.95	
			Sub-Total	
			Ind. Res. add 4% Sales Tax	
			Postage and Handling	$1.00
			Total Enclosed	

22 North Second Street • P.O. Box 620 • Lafayette, IN 47902

Dear Growing Child:

Reading or telling stories is one of the most relaxing and enjoyable times for us because we learn a lot about each other. Daddy tells stories about what he does at work or our three year old tells about nursery school or we read about the values of saying please and thank you, etc. The next day I find things we've talked about the previous evening are incorporated into everyday use.

The next most valuable time is doing household chores together. It is really a thrill to see a child complete a job all by himself when a few months ago it would have been too hard for him to figure out.

Some of the most entertaining times is to give a 2 or 3 year old a pile of kitchen utensils (or anything that he's not sure of the exact use) and let him tell you what he thinks it is or does; an eggbeater is an umbrella, a spoon with holes is a scoop to catch fish which lets the ones that are too small get away . . . it's fun and imaginative.

Our son was only 14 months old when we had the baby—coming home with a new baby when the first is still a baby is hard, but even at 14 months my son adjusted best when he was involved in feeding, changing, picking out clothing, etc., for his new sister. When she would cry, I would not say, "I can't play now, I have to change your sister." I would say, "Let's change Dea—you can help by doing the powder." It worked for a long time. For six months or so I was tired, the housework never got caught up, but the only time the babies conflicted was when they were both sick and wanted to be held all the time or once in a while at a feeding when the older just couldn't wait for her to finish and wanted lunch or a toy for himself.

Nancy W.
Nesconset, New York

SCIENCE & SELF

In olden times the scientist and the philosopher were one. In fact, *science* means *knowing*. The early scientist/philosopher had one primary interest: to understand being or, as the song says, "What's it all about, Alfie?" The old sage wanted the facts, but then he wanted to know what the facts mean for him.

Nowadays we tend to think of philosophy and science as separate. The scientist, like the detective, "just wants the facts, Ma'am."; the philosopher is the dreamer, the guy with his head in the clouds. Scientists and philosophers may deny this, but the fact remains that they follow completely different educational routes to get where they're going. A fellow who keeps his foot in both camps is so unusual that he stands out — a genius. Einstein, for instance.

There's only one large group for whom science and philosophy remain united: children. Until they get turned off, all children are scientist/philosophers.

When a baby meets other living things — dog, insect, bird — an earthquake happens in him. Listen to his exploding laughter. "Eureka!" he is exclaiming. "We are not all!"

All he *says* is, "Wha' dat?" He has so few words. But for goodness' sake *give* him the words! In school he probably won't get science until the fourth or fifth grade. By that time everything has been broken apart into fantasy and fact, and the children labeled as math and science types or as language and history types.

So it's up to you as parents to retain the unity of your child for whom science and philosophy are just two sides of the same coin: being alive.

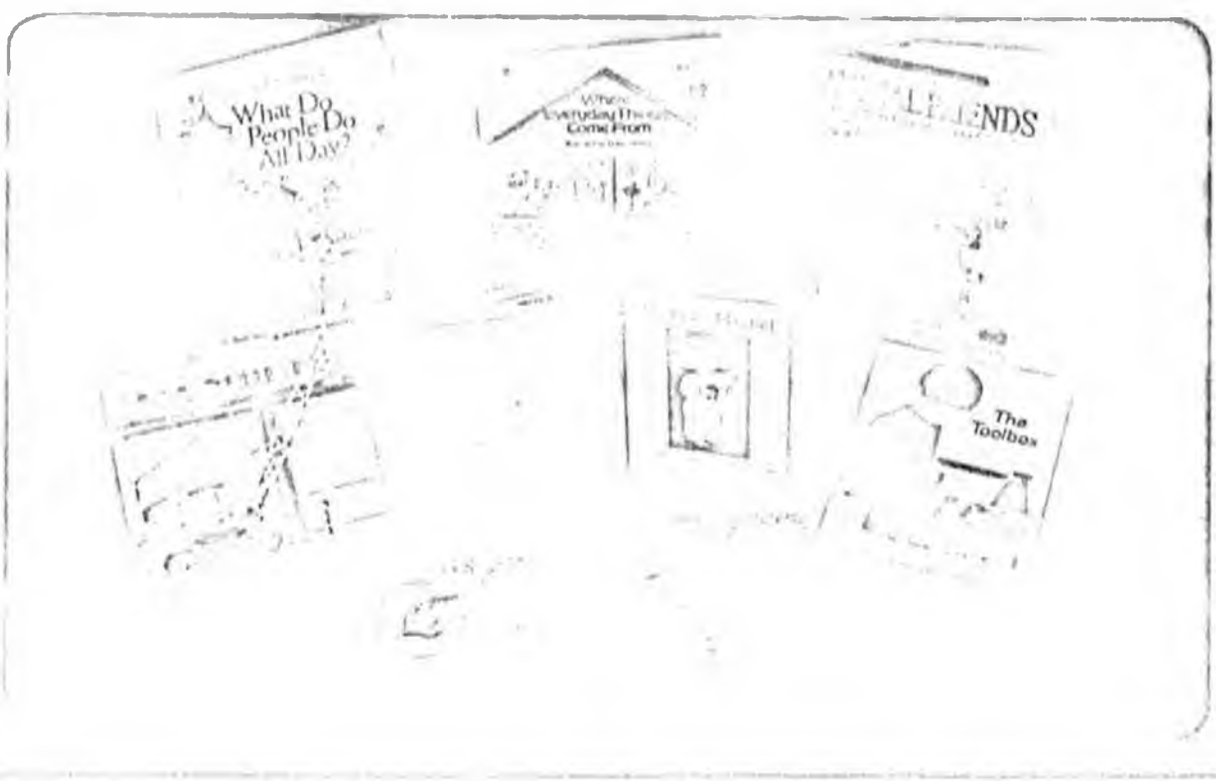
Recognize his questions. Give him the words. Let his whole life be one joyful scientific experiment. When he takes a snowball into the bath, what happens? Did the snowball die? No, it changed — it became water again! If you know how, you can keep a caterpillar alive in a jar. It will make a cocoon. Then, one day, out comes a butterfly! Did the caterpillar die? No, it took another form! Wow!

You don't have to draw his conclusions for him. You must not. But give him the words. Give him the evidence that produces both the questions and the answers.

Above all, this means allowing him to conduct his whole life as scientific research. Whether he's popping the peas on his plate or tasting a mudpie, there is a scientific/philosophical possibility worth pursuing. It also means books. There are so many terrific books to show a child amazing things and to give him the words for his amazing questions.

Not all of the amazing questions are for now. But give him the confidence and the freedom to find out. He will also meet the difficulties in his life with strength and joy and intelligence.

What books to buy? Let his interests guide you. Follow his interests as far as they go. Where the interest stops or where it hasn't begun yet, don't force. The library is a super place to pursue momentary scientific interests — be they astronomical, technological, biological, etc. And here are some books especially well suited to the preschooler.



WHAT DO PEOPLE DO ALL DAY? by Richard Scarry. On the preschool level this is as good as a whole set of encyclopedias. Its delightful animal people busily introduce such topics as government, coal mining, electricity, and the water cycle in terms both accurate and lively. Every preschooler needs a book like this to grow on. Random, hardbound, 4-colors, 96 pp., 2-6 yrs., $5.00.

WHERE EVERYDAY THINGS COME FROM, by Aldren Watson. Besides the questions most parents can answer (like how bread is made and where your cotton shirt comes from), this book includes some less familiar mysteries — where plastic comes from, and chocolate, and paint. Concise, straightforward text with large animal-peopled pictures. Platt and Munk, hardbound, 4 colors, 96 pp., 3 yrs. and up, $5.00.

OUR ANIMAL FRIENDS AT MAPLE HILL FARM, by Alice and Martin Provensen. A totally unique book about the artists' own befoibled animals — dumb, smart, funny, and lovable. Special to this book is its matter-of-fact and tender acceptance of both personal shortcomings and death. Random, 4 colors, 64 pp., 4-6 yrs., hardbound, $4.00.

MACHINES, by Anne and Harlow Rockwell. Another beautifully simple book by the Rockwells — this time about important mechanical devices such as the lever, pulley, and wheel. This with THE TOOLBOX makes a marvelous present for a very young construction-minded child. Collier, hardback, 4 colors, 32 pp., 1 yr. and up. $6.00.

BABY ANIMALS — by Harry McNaught, for the very youngest. This is a friendly way to meet some other small creatures, A board book the young child can't hurt with rounded corners that won't hurt him. Random House, board, 4 color, 12 pp., 1-2 yr., $2.50, 5½" × 8".

MICKEY'S MAGNET, by Franklyn Branley and Eleanor Vaughan. Using the little magnet that comes with the book, let Mickey guide you and your child through a first-rate introduction to the wonders of magnetism. Real magic! Scholastic, paperback, 2 colors, 48 pp., 3-6 yrs, $1.25.

THE TOOLBOX, by Anne and Harlow Rockwell. A simple painting and single sentence about each of fifteen tools. One especially nice thing about this book is the way it seems to portray the tools themselves as works of art. Collier, paperback, 4 colors, 32 pp., 1 yr. and up, $2.00, hb $7.00.

ALL ABOUT EGGS, by Millicent Selsam. The story of how all animals — from fish and frogs to *people* — begin with eggs. This may be *the* most helpful and appropriate book around for answering the preschoolers' questions of *Where did I come from?* Young Scott, hardcover, 1 and 3 colors, 72 pp., 4-6 yrs. $6.00.

BIG RED BOX OF BOOKS — Change your child's lap into Noah's ark by giving him this box of five books any preschool animal lover will love. ANIMAL BABIES by Harry McNaught and Jan Pfloog's KITTENS ARE LIKE THAT and PUPPIES ARE LIKE THAT are beautifully illustrated with full color paintings. THE LITTLE DUCK and THE LITTLE LAMB by Judy and Phoebe Dunn are stories illustrated with the fuzziest, wooliest, cuddliest photos ever. A luxurious exposure to the animal kingdom at a bargain price. Random House, 5 paperback books in a box, 4 colors, 32 pp. ea. 2-4 yrs. $4.75, 8" × 8".

AVAILABLE NOT

Money-back Guarantee. If any of your purchases disappoint you, you may return it for a refund.

For delivery in Canada, multiply packing and shipping charges by x 3. When paying in Canadian currency, remit an additional 20% for exchange rate.

Please fill out address order form and mail to:

Growing Child • 22 N. Second St. P.O. Box 620 • Lafayette, Indiana 47902

	Quan.		Price	Total
28		What Do People Do All Day?	$5.00	
40		Our Animal Friends at Maple Hill Farm	$4.00	
200		Machines	$6.00	
205		Baby Animals	$2.50	
201		Mickey's Magnet	$1.25	
22		The Toolbox (paperback)	$2.00	
220		The Toolbox (hardbound)	$7.00	
202		All About Eggs	$6.00	
204		Big Red Box of Books	$4.75	
			Subtotal	
			Indiana Res. Add 4% Sales Tax	
			Packing and Shipping	$1.50
			Total Enclosed	

Name _____

Address _____

City _____ State _____ Zip _____

be at peace with yourself. Dr. Han Selye, international authority on stress, spoke to this when asked how to cope with stress. He replied:[7]

> The secret is not to avoid stress but to "do your own thing." That is an expression to which I fully subscribe. It implies doing what you like to do and what you were made to do at your own rate.
>
> Medicine can help. There are good drugs for high blood pressure, for instance. But for most people it is a matter of learning how to live, how to behave in various situations, to decide: "Do I really want to take over my father's business or be a musician?" If you really want to be a musician, then be one.

Break the Stress Cycle

Stress is cumulative, *unless* you have ways to break the stress cycle. This is, of course, one of the original intentions behind the Sabbath. Even God felt the need to rest after a week of creation. But some of us seek to pack so much into our weekends that we have to go back to work to relax.

In addition to taking at least one day a week that is for yourself, and in which you truly relax, stress may also be diminished by physical exercise. Such activities as jogging, bicycling, swimming or gardening clean out the system and replenish one's energy reserves.

Meditation is another means to reduce or cope with stress. In meditation, one's thoughts are so specifically focused on a particular image that other concerns, cares, anxieties, are at least temporarily forgotten. After meditation, even if the problems exist, one is more capable of coping with them because your mind has been renewed.

Finally, we can refer to the specific relaxation techniques that have proven effective. Biofeedback therapy, yoga, tensing and relaxing different muscle groups in the body, and hypnosis have all proven their effeciveness. Different individuals respond better to different means of stress reduction, so you need to sample and experiment to find which one(s) work(s) best for you.

We Can Find the Time

No matter how busy we are, no matter how much our lives are subject to interruption, we can find the time to break the stress cycle each and every day if we choose to. What we need is the self-discipline (another self-stress reducer) to redeem those moments we are now wasting to engage in the activity (activities) that are truly refreshing to us.

Best of luck to you as you learn how to manage your life's stresses.

Dr. Bill Peterson

Notes

[1]Blair and Rita Justice. *The Broken Taboo*. New York: Human Sciences Press, 1979; p. 222.

[2]*Stress*. Time-Life Books Human Behavior Series 1976.

[3]*Ibid.*

[4]T.H. Holmes and R.H. Rahe. "The Social Readjustment Rating Scale." *Journal of Psychosomatic Research*, 1967, pp. 213-218.

[5]Blair and Rita Justice, *op. cit.*, p. 223.

[6]*Ibid.*

[7]"The Secret of Coping with Stress," an interview with Dr. Hans Selye. *U.S. News and World Report*, March 21, 1977.

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the back page

Resources for Parents

1) For delayed development or physical handicaps:
National Easter Seal Society for Crippled Children
2023 W. Ogden Avenue
Chicago, IL 60612

2) For learning disabled or delayed development (K-7)
Council for Exceptional Children
Division of Children With Learning Disabilities
1920 Association Drive
Reston, VA 22091

Association for Children With Learning Disabilities
5225 Grace St.
Pittsburgh, PA 15236

3) For mentally retarded:
Council for Exceptional Children
Division of Mental Retardation
1920 Association Drive
Reston, VA 22091

4) For those who live in California, learning disabilities, mental retardation:
California Association for Neurologically Handicapped
Literature Distribution
P O Box 1526
Vista, CA 92083

5) For those who don't have a label as yet; this is an excellent publication put out by the government which answers many questions about slow or delayed development:
Closer Look
P O Box 1492
Washington, DC 20013

Concerned about your house plants? A chart showing the common household plants which may be poisonous is titled "Enjoy your Plants . . . But Protect your Family." Available from Public Information Bulletin, National Poison Center Network, 125 DeSoto Street, Pittsburgh, PA 15213.

A new newsletter for parents titled "Practical Parenting" is now available from the folks who brought you "Feed Me! I'm Yours." It's filled with information and advice from parents about what works for them on a variety of topics. Every issue has an envelope for parents' questions and answers. Replies from everywhere are printed in the next issue.

Six issues cost $5.00.

Practical Parenting
15235 Minnetonka Blvd.
Minnetonka, MN 55343

A PARENT'S QUERY

"My question . . . Baby refuses to go to sleep without the pacifier, and if she does, she wakes up in 10 to 15 minutes. How do I break this habit (I never should have started) and at what ages should I take the pacifier away altogether? Baby is breastfed and does not suck fingers."

Any comments for this mother?

STATUTORY PROVISIONS PERTAINING TO LICENSING OF MIDWIVES		ALABAMA (Professions and Businesses 4.34-19-1-.34-19-10)
NURSE-MIDWIFE Definition: Registered nurse who has expanded his/her practice to the care of mothers and babies through the maternity cycle.	Requirements	Licensed registered nurse; certificate from school for nurse-midwives.
	Limitations on Practice	Cases of normal childbirth; physician's supervision necessary.
	Special Statutory Provisions	All deliveries must be planned to take place in hospital.
PROFESSIONAL MIDWIFE Definition: An individual who has received formal professional training as a midwife.	Requirements	
	Limitations on Practice	
	Special Statutory Provisions	
LAY MIDWIFE Definition: An individual who practices as a midwife but has not received formal professional training.	Requirements	
	Limitations on Practice	Lay midwives holding health department permits may continue to practice until permits are revoked by Board of Health.
	Special Statutory Provisions	

STATUTORY PROVISIONS PERTAINING TO LICENSING OF MIDWIVES		CALIFORNIA (Business and Professional Codes 2.5.2746 - 2.5.2746.8; 12.5.2350-12.5.2359)
NURSE-MIDWIFE Definition: Registered nurse who has expanded his/her practice to the care of mothers and babies through the maternity cycle.	Requirements	
	Limitations on Practice	Practice supervised by physician or surgeon (physician's presence not required); cases of normal childbirth. Authorized to provide family-planning care. Shall not use instruments, or artificial, forcible, or mechanical means to assist childbirth, nor perform version; shall refer complicated cases to physician. Shall not perform abortions.
	Special Statutory Provisions	Requirements for censure are left up to appropriate boards and committees. In general, California's statutes establish the confines of the practice.
PROFESSIONAL MIDWIFE Definition: An individual who has received formal professional training as a midwife.	Requirements	
	Limitations on Practice	
	Special Statutory Provisions	
LAY MIDWIFE Definition: An individual who practices as a midwife but has not received formal professional training.	Requirements	
	Limitations on Practice	
	Special Statutory Provisions	

STATUTORY PROVISIONS PERTAINING TO LICENSING OF MIDWIVES		CONNECTICUT (377.20-75)
NURSE-MIDWIFE Definition: Registered nurse who has expanded his/her practice to the care of mothers and babies through the maternity cycle.	Requirements	
	Limitations on Practice	
	Special Statutory Provisions	
PROFESSIONAL MIDWIFE Definition: An individual who has received formal professional training as a midwife.	Requirements	Graduate of school of midwifery.
	Limitations on Practice	Cases of normal labor (uncomplicated vertex or head presentation). Shall not use drugs, instruments, nor perform version or attempt to remove adherent plancenta. Shall not attend woman in labor until after seventh month of gestation.
	Special Statutory Provisions	Examination required for licensing.
LAY MIDWIFE Definition: An individual who practices as a midwife but has not received formal professional training.	Requirements	
	Limitations on Practice	
	Special Statutory Provisions	

STATUTORY PROVISIONS PERTAINING TO LICENSING OF MIDWIVES		FLORIDA (30.485.011 - 30.485.091)
NURSE-MIDWIFE Definition: Registered nurse who has expanded his/her practice to the care of mothers and babies through the maternity cycle.	Requirements	
	Limitations on Practice	
	Special Statutory Provisions	
PROFESSIONAL MIDWIFE Definition: An individual who has received formal professional training as a midwife.	Requirements	Diploma from school for midwives; sponsorship by two practicing physicians; ability to read manual intelligently and write legibly (this may be waived).
	Limitations on Practice	Cases of normal labor; shall not use drugs, instruments, nor assist labor in any artificial, forcible, or mechanical manner, nor attempt to remove adherent placenta. Shall not use poisonous drug or herb medicine, nor attempt treatment of disease when attendance of physician cannot be secured.
	Special Statutory Provisions	
LAY MIDWIFE Definition: An individual who practices as a midwife but has not received formal professional training.	Requirements	Attendance, under the supervision of a physician, at not less than fifteen cases of labor and the care of fifteen or more mothers and newborns for periods of at least ten days each; sponsorship by two physicians; ability to read manual intelligently and write legibly (this may be waived).
	Limitations on Practice	
	Special Statutory Provisions	

STATUTORY PROVISIONS PERTAINING TO LICENSING OF MIDWIVES		INDIANA (25-22-1-5,22-22-1-6; Admin. Rules (25-22.5-5-5)-1, (25-22.5-5-5)-2
NURSE-MIDWIFE Definition: Registered nurse who has expanded his/her practice to the care of mothers and babies through the maternity cycle.	Requirements	
	Limitations on Practice	
	Special Statutory Provisions	
PROFESSIONAL MIDWIFE Definition: An individual who has received formal professional training as a midwife.	Requirements	Diploma from school of midwifery which has proper equipment to teach anatomy, physiology, hygiene, anticepsis, neurology, toxicology, and the proper management of labor; high school education; ability to read and write the English language* *There are few schools in this country which train midwives who are not nurses. Since many professional midwives were educated at foreign institutions, some states feel is necessary to require proficiency in English.
	Limitations on Practice	
	Special Statutory Provisions	(Statutes pertaining to midwifery in Indiana date to the late 1800's. Midwifery in the state is presently controlled by administrative code. Both the statutes and codes have been included.) Examination required for licensing. Gratuitous services in an emergency not prohibited by act, nor does it restrict licensed physicians.
LAY MIDWIFE Definition: An individual who practices as a midwife but has not received formal professional training.	Requirements	
	Limitations on Practice	
	Special Statutory Provisions	

STATUTORY PROVISIONS PERTAINING TO LICENSING OF MIDWIVES		MARYLAND (Art.43.82-94)
NURSE-MIDWIFE Definition: Registered nurse who has expanded his/her practice to the care of mothers and babies through the maternity cycle.	Requirements	Certified by American College of Nurse-Midwives as a nurse-midwife.
	Limitations on Practice	Normal cases of pregnancy; cannot practice medicine or prescribe drugs. Shall not induce labor or produce abortion.
	Special Statutory Provisions	Person who isnot licensed midwife may practice under the personal and direct supervision of a physician. Subtitle does not restrict physician or person volunteering service in an emergency.
PROFESSIONAL MIDWIFE Definition: An individual who has received formal professional training as a midwife.	Requirements	
	Limitations on Practice	
	Special Statutory Provisions	
LAY MIDWIFE Definition: An individual who practices as a midwife but has not received formal professional training.	Requirements	
	Limitations on Practice	
	Special Statutory Provisions	Maryland midwifery laws updated 1970. Previous laws licensed midwives determined qualified by two practicing physicians. (These statutes have been included).

STATUTORY PROVISIONS PERTAINING TO LICENSING OF MIDWIVES		MINNESOTA (148.30 - 148.32)
NURSE-MIDWIFE **Definition:** Registered nurse who has expanded his/her practice to the care of mothers and babies through the maternity cycle.	Requirements	
	Limitations on Practice	
	Special Statutory Provisions	
PROFESSIONAL MIDWIFE **Definition:** An individual who has received formal professional training as a midwife.	Requirements	Diploma from a school of midwifery.
	Limitations on Practice	
	Special Statutory Provisions	
LAY MIDWIFE **Definition:** An individual who practices as a midwife but has not received formal professional training.	Requirements	Consent of seven members of the State Board of Medical Examiners given after examination of condidate.
	Limitations on Practice	
	Special Statutory Provisions	

STATUTORY PROVISIONS PERTAINING TO LICENSING OF MIDWIVES		MONTANA (66-1246)
NURSE-MIDWIFE Definition: Registered nurse who has expanded his/her practice to the care of mothers and babies through the maternity cycle.	Requirements	Certificate in nurse-midwifery from the American College of Nurse-Midwives.
	Limitations on Practice	
	Special Statutory Provisions	
PROFESSIONAL MIDWIFE Definition: An individual who has received formal professional training as a midwife.	Requirements	
	Limitations on Practice	
	Special Statutory Provisions	
LAY MIDWIFE Definition: An individual who practices as a midwife but has not received formal professional training.	Requirements	
	Limitations on Practice	
	Special Statutory Provisions	

STATUTORY PROVISIONS PERTAINING TO LICENSING OF MIDWIVES		NEW JERSEY (45:10)
NURSE-MIDWIFE Definition: Registered nurse who has expanded his/her practice to the care of mothers and babies through the maternity cycle.	Requirements	
	Limitations on Practice	
	Special Statutory Provisions	
PROFESSIONAL MIDWIFE Definition: An individual who has received formal professional training as a midwife.	Requirements	Certificate from school of midwifery, or maternity hospital granted after 1800 hours of instruction in not less than nine months. Certificate from foreign school of midwifery of equal requirements. Endorsement by physician.
	Limitations on Practice	Shall not perform criminal abortion. Normal labor cases. only.
	Special Statutory Provisions	Examination required. Topics covered by examination specifically laid out by statute. Chapter does not restrict physician nor gratuitous service in an emergency. New Jersey midwifery laws similar to Washington's.
LAY MIDWIFE Definition: An individual who practices as a midwife but has not received formal professional training.	Requirements	
	Limitations on Practice	
	Special Statutory Provisions	

STATUTORY PROVISIONS PERTAINING TO LICENSING OF MIDWIVES		OHIO (4731.30-4731.34)
NURSE-MIDWIFE Definition: Registered nurse who has expanded his/her practice to the care of mothers and babies through the maternity cycle.	Requirements	Diploma from college for nurse-midwives
	Limitations on Practice	Practice under direction and supervision of physician. Shall not perform version, treat breech or face presentation, use instruments or treat abnormal condition, except in emergencies.
	Special Statutory Provisions	Examination may be required.
PROFESSIONAL MIDWIFE Definition: An individual who has received formal professional training as a midwife.	Requirements	
	Limitations on Practice	
	Special Statutory Provisions	
LAY MIDWIFE Definition: An individual who practices as a midwife but has not received formal professional training.	Requirements	
	Limitations on Practice	
	Special Statutory Provisions	

STATUTORY PROVISIONS PERTAINING TO LICENSING OF MIDWIVES		UTAH (58-44-1 - 58-44-11)
NURSE-MIDWIFE **Definition:** Registered nurse who has expanded his/her practice to the care of mothers and babies through the maternity cycle.	Requirements	Completed approved certified nurse-midwifery education program.
	Limitations on Practice	Under this act, may also provide normal gynecological services.
	Special Statutory Provisions	Establishes committee to supervise practice or nurse-midwifery. Examination required. Act does not affect rights of parents to deliver their baby, where, when, how and with who they choose regardless of certification.
PROFESSIONAL MIDWIFE **Definition:** An individual who has received formal professional training as a midwife	Requirements	
	Limitations on Practice	
	Special Statutory Provisions	
LAY MIDWIFE **Definition:** An individual who practices as a midwife but has not received formal professional training.	Requirements	
	Limitations on Practice	
	Special Statutory Provisions	

STATUTORY PROVISIONS PERTAINING TO LICENSING OF MIDWIVES		WASHINGTON (18.50.090 - 18.50.110)
NURSE-MIDWIFE **Definition:** Registered nurse who has expanded his/her practice to the care of mothers and babies through the maternity cycle.	Requirements	
	Limitations on Practice	
	Special Statutory Provisions	
PROFESSIONAL MIDWIFE **Definition:** An individual who has received formal professional training as a midwife.	Requirements	Diploma from legally incorporated school on midwifery in good standing, granted after at least 2 courses of instruction of at least seven months each in different calendar years. Diploma from foreign institution on midwifery of equal requirements.
	Limitations on Practice	Shall not prescribe any drugs or medicine except some household remedy.
	Special Statutory Provisions	Examination required. Topics covered by examination specifically laid out by statute. Gratuitous service not prohibited by chapter. Washington's midwifery laws similar to New Jersey's.
LAY MIDWIFE **Definition:** An individual who practices as a midwife but has not received formal professional training.	Requirements	
	Limitations on Practice	
	Special Statutory Provisions	

STATUTORY PROVISIONS PERTAINING TO LICENSING OF MIDWIVES		WEST VIRGINIA (30-15-1 -30-15-8)
NURSE-MIDWIFE Definition: Registered nurse who has expanded his/her practice to the care of mothers and babies through the maternity cycle.	Requirements	Graduate of school of midwifery; certified by American College of Nurse-Midwives.
	Limitations on Practice	Practice under the supervision of or in association with physician engaged in family practice or specialized field of gynecology or obstetrics.
	Special Statutory Provisions	Persons holding licenses issued before current laws enacted may continue to practice until expiration of licenses without privilege of renewal.
PROFESSIONAL MIDWIFE Definition: An individual who has received formal professional training as a midwife.	Requirements	
	Limitations on Practice	
	Special Statutory Provisions	
LAY MIDWIFE Definition: An individual who practices as a midwife but has not received formal professional training.	Requirements	
	Limitations on Practice	
	Special Statutory Provisions	

Note on changes to Fiscal Note

(1) The new figure ~~in~~ Section 1 is now $125,000

(2) change fiscal note under Contractual and Commodities to a new figure proportionate to the need which includes

(a) bilingual translation of material for rural areas

(2) pre-natal care including alcohol syndrome

THE LEGISLATURE OF THE STATE OF ALASKA
ELEVENTH LEGISLATURE

FISCAL NOTE

I. REQUEST
Bill/Resolution No. House Bill 862
Title Growing Child Program
Requested by _____ Date _____

II. FISCAL DETAIL
Agency Affected Department of Health and Social Sevices
Program Category Affected Health
BRU, Program, or Subprogram(s) Affected Administration
(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

		FY 80	FY 81	FY 82	FY 83	FY 84	FY 85
100	PERSONAL SERVICES		4941	5336	5763	6224	6722
200	TRAVEL						
300	CONTRACTUAL		56,500	61,020	65,901	71,173	76,867
400	COMMODITIES		6,727	7,265	7,846	8,474	9,152
500	EQUIPMENT						
600	LAND & STRUCTURES						
700	GRANTS, CLAIMS, ETC.						
	TOTAL		68,168	73,621	79,510	85,871	92,741

FUNDING (Thousands of Dollars)

GENERAL FUND		68,168	73,621	79,510	85,871	92,741
FEDERAL FUNDS						
OTHER (Specify Fund Source)						

POSITIONS

FULL TIME						
PART TIME		.25	.25	.25	.25	.25
TEMPORARY						

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

It has been determined that there are approximately 9000 live births per year in Alaska. Each new family would receive a direct mailing with follow-up to provide an annual subscription to a monthly professional production media service. Department material will be included in each monthly mailing to provide educational material on parenting and nurturing skills relative to the age of the child.

Initial contact will be to 9000 persons with an expected participation for 50% of the contacted families. A part time clerk is projected to coordinate and physically prepare mailings of an estimated 58,500 individual mailings per year.

100 - 3 man-months Clerk Typist III
@ 1277 per month + benefits 4941
300 - 4500 annual subscription to prepared
material @ $5.25/year = 23,625

(Continued Page 2)

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)

Prepared by: T. R. Branton Date: 2/29/80
Division/Office: Mental Health & MR PH: 465-3370
Department of Health & Social Services

Approval DHSS Mgt. & Bdgt. _____ Date: 3/5/80

33-001 (Rev. 12/79)
Modify by DHSS (11-28-79)

printing cost for prepared mailing list =	700
postage @ .55 per packet for 58,500 units =	32,175
9000 units X 1 mail per year =	9,000
4500 units X 11 mail per year =	49,500
Total Units	58,500
purchase of 58,500 clasp mailing envelopes @ .115 each	6727
TOTAL	$68,168

All costs for FY 81 forward adjusted b6 8% per year.

HB

910

STATE OF ALASKA
Department of Commerce and Economic Development
Division of Occupational Licensing

The Performance Review of the Division of Occupational Licensing (DOL), dated October 30, 1978, was accomplished by the Division of Legislative Audit in response to the sunset law calling for legislative review of boards and commissions with examination and/or licensing authority in professions. A number of recommendations were made regarding procedures and practices of the Division of Occupational Licensing, most of which were concurred with by DOL and most of which have been implemented.

According to the FY'78 Annual Report from the Department of Commerce and Economic Development, the goal of the Division of Occupational Licensing is to "provide preventive consumer protection in occupational areas where the potential harm is so great that the remedies available for recourse to general law will frequently be insufficient to compensate the aggrieved party."

The Division of Occupational Licensing is statutorily charged with administrative and investigative support services for twenty-one boards and commissions and three occupations which are regulated but have no board. Approximately one hundred and twenty-five members serve on the following boards and commissions:

Board of Chiropractic Examiners
Board of Dental Examiners
State Medical Board
Board of Nursing
Board of Dispensing Opticians

Board of Examiners in Optometry
Board of Pharmacy
Board of Veterinary Examiners
Board of Psychologist and Psychological Associate Examiners
Board of Nursing Home Administrators
Physical Therapy Board
Board of Public Accountancy
Board of Barber Examiners
Collection Agency Board
Board of Hairdressing and Beauty Culture Examiners
Board of Electrical Examiners
State Board of Registration for Architects, Engineers and Land Surveyors
Guide Licensing and Control Board
Board of Marine Pilots
Real Estate Commission
Board of Welding Examiners

Professions regulated without a board are Mortuary Science, Construction Contractors, and Concert Promoters.

The Division has a total of twenty-one employees. Two investigators, two Executive Officers, and two administrative support persons comprise the Anchorage Field Office personnel. Juneau personnel consists of eight licensing examiners, one licensing supervisor, one chief investigator, one regulation specialist, one management analyst, three administrative support persons and the Director. The Executive Officer and Executive Secretary located in Anchorage are partially exempt positions and are providing administrative support to the Board of Nursing and the Real Estate Commission.

In FY '79, the Division's staff scheduled and coordinated approximately 71 board meetings and 52 examinations for 3,000 candidates, responded to more than 20,000 inquiries, processed and issued 2,742 new licenses and

8,000 renewal licenses, collected over $717,000 in fees, and maintained more than 28,000 license files.

It should be stressed that DOL is statutorily mandated to provide administrative and budgetary services to boards and commissions; the Division has no authority or decision-making control over any individual board. Legal advice on board activities is provided by the Department of Law, when sought.

Almost without exception the licensing boards have declared their financial independence. That is, they have maintained that they are self-supporting, that revenues from fees charged exceed regulation expenses of their particular profession. Almost without exception this is not the case. Because revenues from all professions are deposited into the general fund, and all expenditures must be allocated from the Division's authorized budget, a penny-by-penny expenditure breakdown is simply not kept for individual boards. The following information was compiled by deducting figures for contractors and mortuary science (who have no board), deducting variables, and assigning administrative expenditures based on number of licensees in each profession in each fiscal year indicated.

FISCAL YEAR 1976

DOL Actual Expenditures:	$478,100.00
- Contractor Expenditures:	1,924.60
- Licensing Examiner:	12,996.00
- Executive Officers:	26,400.27
	18,083.29
- Direct Board Expenditures	124,200.82
TOTAL:	$294,495.02 ÷ 12,601 Licenses = $23.37 per license

BOARD	REVENUES	# OF LICENSES	ALLOCATION PER LICENSES	+	DIRECT EXPENDITURES	=	TOTAL COST PER BOARD
Board of Barber Examiners	$ 4,087.00	275	$ 6,426.75		$ 2,489.19		$ 8,915.94
Board of Chiropractic Examiners	320.00	31	724.47		2,838.78		3,563.25
Collection Agency Board	4,164.00	47	1,098.39		---		1,098.39
Board of Dental Examiners	10,769.40	365	8,530.05		8,654.19		17,184.24
Board of Electrical Examiners	7,857.00	241	5,632.17		2,645.49		8,277.66
Board of Registration for Architects, Engineers and Land Surveyors	101,377.00	2,418	56,508.66		17,876.76		74,385.42
Board of Hairdressing and Beauty Culture Examiners	23,075.00	1,415	33,068.55		5,096.55		38,165.10
Board of Marine Pilots	990.00	46	1,075.02		2,713.52		3,788.54
Medical Board	14,485.00	786	18,368.82		5,553.36		23,922 18
Board of Nursing	54,646.00	3,324	77,681.88		13,931.98		
				(Exec Sec.)	26,400.27		118,014.13
Board of Dispensing Opticians	2,720.00	46	1,075.02		1.728.34		2,803.36
Board of Optometry	530.00	38	888.06		2,578.19		3,466.25
Board of Pharmacy	13,848.00	324	7,571.88		5,854.45		13,426.33
Board of Psychologist and Psychological Associates	1,580.00	32	747.84		3,303.51		4,051.35
Board of Public Accountancy	20,777.00	332	7,758.84		12,325.49		20,084.33
Real Estate Commission	178 *97.50	1,754	40,990.98		19,186.47		
				(Exec. Off.)	18,083.29		78,262.74
Board of Veterinary Examiners	705.00	72	1,682.64		1,706.94		3,389.58
Nursing Home Administrators	1,100.00	15	350.55		1,942.91		2,293.46
Physical Therapy Board	1,880.00	76	1,776.12		804.38		2,580.50
Guide Licensing & Control	38,800.00	911	21,290.07		10,070.31		31,360.38
Board of Welding Examiners	---	53	1,238.61		2,898.01		4,136.62
TOTALS:		12,601	$294,485.37		$168,684.38		$463,169.75

FISCAL YEAR 1977

TOL Actual Expenditures:	$648,000.00
- Contractor Expenditures:	1,739.75
- Licensing Examiner:	13,644.00
- Mortuary Sciences	24.00
- Executive Officers:	32,339.29
	29,331.19
- Direct Board Expenditures:	144,916.01
TOTAL:	$426,005.76 ÷ 14,566 Licenses = $29.24 per license

BOARD	REVENUES	# OF LICENSES	ALLOCATION PER LICENSES	+	DIRECT EXPENDITURES	=	TOTAL COST PER BOARD
Board of Barber Examiners	$ 4,970.54	252	$ 7,368.48		$ 2,913.27		$ 10,281.75
Board of Chiropractic Examiners	1,910.00	30	877.20		2,377.00		3,254.20
Collection Agency Board	8,064.00	50	1,462.00		811.59		2,273.59
Board of Dental Examiners	14,437.00	316	9,239.84		6,400.79		15,640.63
Board of Electrical Examiners	28,359.00	252	7,368.48		7,895.32		15,263.80
Board of Registration for Architects, Engineers and Land Surveyors	31,056.00	2,725	79,679.00		19,323.14		99,002.14
Board of Hairdressing and Beauty Culture Examiners	21,963.00	1,638	47,895.12		5,944.05		53,839.17
Board of Marine Pilots	11,122.10	49	1,432.76		5,515.11		6,947.87
Medical Board	62,023.00	844	24,678.56		5,855.54		30,534.10
Board of Nursing	40,747.00	3,469	101,433.56		12,606.53		
				(Exec. Sec.)	32,339.29		146,379.38
Board of Dispensing Opticians	1,060.00	49	1,432.76		2,091.32		3,524.08
Board of Optometry	2,625.00	55	1,608.20		1,920.03		3,528.23
Board of Pharmacy	8,249.00	388	11,345.12		4,655.23		16,000.35
Board of Psychologist and Psychological Associates	1,550.00	38	1,111.12		2,369.43		3,480.55
Board of Public Accountancy	15,135.00	402	11,754.48		15,138.70		26,893.18
Real Estate Commission	119,533.00	2,833	82,836.92		29,048.93		
				(Exec. Off.)	29,331.19		141,817.04
Board of Veterinary Examiners	4,186.50	82	2,397.68		1,110.19		3,507.87
Nursing Home Administrators	2,000.00	30	877.20		2,489.84		3,367.04
Physical Therapy Board	1,455.00	82	2,397.68		673.68		3,071.36
Guide Licensing & Control	38,695.50	927	27,105.48		10,257.33		37,362.81
Board of Welding Examiners	---	55	1,608.20		4,918.99		6,527.19
TOTALS:		14,566	$425,909.84		$206,586.49		$632,496.33

FISCAL YEAR 1978

DOL Actual Expenditures:	$779,500.00
- Contractor Expenditures:	2,812.54
- Licensing Examiner:	14,832.00
- Mortuary Sciences:	451.49
- Executive Officers:	23,807.99
	30,310.73
- Direct Board Expenditures:	181,228.78
TOTAL:	$526,056.47 ÷ 17,376 Licenses = $30.27 per license

BOARD	REVENUES	# OF LICENSES	ALLOCATION PER LICENSES	+	DIRECT EXPENDITURES	=	TOTAL COST PER BOARD
Board of Barber Examiners	$ 4,400.18	267	$ 8,082.09		$ 2,933.76		$ 11,015.85
Board of Chiropractic Examiners	1,070.00	44	1,331.88		4,218.07		5,549.95
Collection Agency Board	6,950.00	54	1,634.58		4,126.22		5,760.80
Board of Dental Examiners	5,970.24	383	11,593.41		8,775.88		20,369.29
Board of Electrical Examiners	15,437.14	305	9,232.35		6,666.42		15,898.77
Board of Registration for Architects, Engineers and Land Surveyors	110,870.75	2,941	89,024.07		21,250.48		110,274.55
Board of Hairdressing and Beauty Culture Examiners	21,821.00	1,878	56,847.06		4,512.32		61,359.38
Board of Marine Pilots	1,780.00	85	2,572.95		3,819.64		6,392.59
Medical Board	17,551.25	910	27,545.70		6,346.32		33,892.02
Board of Nursing	72,265.87	4,245	128,496.15		20,098.55		
				(Exec. Sec.)	23,807.99		172,402.69
Board of Dispensing Opticians	2,190.00	54	1,634.58		1,910.81		3,545.39
Board of Optometry	795.00	63	1,907.01		5,704.41		7,611.42
Board of Pharmacy	16,482.00	414	12,531.78		4,901.40		17,433.18
Board of Psychologist and Psychologist Associates	2,680.00	44	1,331.88		5,637.68		6,969.56
Board of Public Accountancy	38,675.00	482	14,590.14		17,248.81		31,838.95
Real Estate Commission	285,634.92	3,615	109,426.05		38,177.92		
				(Exec. Off.)	30,310.73		177,914.70
Board of Veterinary Examiners	1,160.00	93	2,815.11		1,640.42		4,455.53
Nursing Home Administrators	1,830.00	37	1,119.99		1,703.66		2,823.65
Physical Therapy Board	3,132.00	102	3,087.54		1,745.59		4,833.13
Guide Licensing & Control	41,617.00	1,295	39,199.65		16,828.17		56,027.82
Board of Welding Examiners	---	65	1,967.55		2,982.25		4,949.80
TOTALS:		17,376	$525,971.52		$235,347.50		$761,319.02

FISCAL YEAR 1979

DOL Actual Expenditures:	$901,072.00
- Contractor Expenditures:	2,839.58
- Licensing Examiner:	15,102.00
- Mortuary Sciences:	319.91
- Executive Officers:	32,196.12
	34,324.92
- Direct Board Expenditures:	219,096.71
TOTAL:	$597,192.76 ÷ 19,477 Licenses = $30.66 per license

BOARD	REVENUES	# OF LICENSES	ALLOCATION PER LICENSES	+	DIRECT EXPENDITURES	=	TOTAL COST PER BOARD
Board of Barber Examiners	$ 4,274.00	276	$ 8,462.16		$ 4,381.59		$ 12,843.75
Board of Chiropractic Examiners	3,047.00	54	1,655.64		4,709.43		6,365.07
Collection Agency Board	3,697.55	61	1,870.26		4,670.76		6,541.02
Board of Dental Examiners	16,937.00	419	12,846.54		15,480.40		28,326.94
Board of Electrical Examiners	36,746.00	378	11,589.48		6,791.03		18,380.51
Board of Registration for Architects, Engineers and Land Surveyors	26,388.43	3,119	95,628.54		23,827.90		119,456.44
Board of Hairdressing and Beauty Culture Examiners	26,970.00	2,037	62,454.42		5,989.43		68,443.85
Board of Marine Pilots	10,722.00	88	2,698.08		8,307.44		1[illegible],005.52
Medical Board	69,919.00	1,001	30,690.66		14,979.85		4[illegible],670.51
Board of Nursing	36,512.50	4,832	148,149.12		21,529.22		
				(Exec. Sec.)	32,196.12		201,874.46
Board of Dispensing Opticians	2,210.00	59	1,808.94		2,287.85		4,096.79
Board of Optometry	3,245.00	72	2,207.52		4,413.32		6,620.84
Board of Pharmacy	6,734.00	429	13,153.14		5,725.01		18,878.15
Board of Psychologist and Psychological Associates	4,435.00	50	1,533.00		7,617.52		9,150.52
Board of Public Accountancy	21,186.00	562	17,230.92		20,174.93		37,405.85
Real Estate Commission	142,659.72	4,202	128,833.32		40,652.49		
				(Exec. Off.)	34,324.92		203,810.73
Board of Veterinary Examiners	5,685.00	107	3,280.62		2,076.94		5,357.56
Nursing Home Administrators	1,435.00	39	1,195		4,226.97		5,422.71
Physical Therapy Board	1,215.00	125	3,832.50		2,293.47		6,125.97
Guide Licensing & Control	40,996.00	1,467	44,978.22		14,249.25		59,227.47
Board of Welding Examiners	1,815.00	100	3,066.00		4,711.91		7,777.91
TOTALS:		19,477	$597,164.82		$285,096.71		$882,782.57

	FY '76		FY '77		FY '78		FY '79	
	Revenues	Expen-ditures	Revenues	Expen-ditures	Revenues	Expen-ditures	Revenues	Expen-ditures
Board of Barber Examiners	$ 4,087.00	$ 2,489.19	$ 4,970.54	$ 2,913.27	$ 4,400.18	$ 2,933.76	$ 4,274.00	$ 4,381.59
Board of Chiropractic Examiners	320.00	2,838.78	1,910.00	2,377.00	1,070.00	4,218.07	3,047.00	4,709.43
Collection Agency Board	4,164.00	--	8,064.00	811.59	6,950.00	4,126.22	3,697.55	4,670.76
Board of Dental Examiners	10.769.40	8,654.19	14,437.00	6,400.79	5,970.24	8,775.88	16,937.00	15,480.40
Board of Electrical Examiners	7,857.00	2,645.49	28,359.00	7,895.32	15,437.14	6,666.42	36,746.00	6,791.03
Board of Registration for Architects, Engineers and Land Surveyors	101,377.00	17,876.76	31,056.00	19,323.14	110,670.75	21,250.48	26,388.43	23,827.90
Board of Hairdressing and Beauty Culture Examiners	23,075.00	5,096.55	21,963.00	5,944.05	21,821.00	4,512.32	26,970.00	5,989.43
Board of Marine Pilots	990.00	2,713.52	11,122.10	5,515.11	1,780.00	3,819.64	10,722.00	8,307.44
Medical Board	14,485.00	5,553.36	62,023.00	5,855.54	17,551.25	6,346.32	69,919.00	14,979.85
Board of Nursing	54,646.00	13,931.98	40,747.00	12,606.53	72,265.87	20,098.55	36,512.50	21,529.22
Board of Dispensing Opticians	2,720.00	1,728.34	1,060.00	2,091.32	2,190.00	1,910.81	2,210.00	2,287.85
Board of Optometry	530.00	2,578.19	2,625.00	1,920.03	795.00	5,704.41	3,245.00	4,413.32
Board of Pharmacy	13,848.00	5,854.45	8,249.00	4,655.23	16,482.00	4,901.40	6,734.00	5,725.01
Board of Psychologist and Psychological Associates	1,580.00	3,303.51	1,550.00	2,369.43	2,680.00	5,637.68	4,435.00	7,617.52
Board of Public Accountancy	20,777.00	12,325.49	15,135.00	15,138.70	38,675.00	17,248.81	21,186.00	20,174.93
Real Estate Commission	178,497.50	19,188 47	119,533.00	29,648.93	285,634.92	38,177.92	142,659.72	40,652.49
Board of Veterinary Examiners	705.00	1,706.94	.50	1,110.19	1,160.00	1,640.42	5,685.00	2,076.94
Nursing Home Administrators	1,100.00	1,942.91	1.00	2,489.84	1,830.00	1,703.66	1,435.00	4,226.97
Physical Therapy Board	1,880.00	804.38	1,495.00	673.68	3,132.00	1,745.59	1,215.00	2,293.47
Guide Licensing and Control	38,800.00	10,070.31	38,695.50	10,257.33	41,617.00	16,828.17	40,996.00	14,249.25
Board of Welding Examiners	--	2,898.01	--	4,918.99	--	2,982.25	1,815.00	4,711.91
Construction Contractors	229,175.00	1,924.60	195,638.50	1,739.75	332,895.40	2,812.54	247,124.05	2,839.58
Mortuary Science	--	--	4,485.00	24.00	802.00	451.49	3,575.00	319.91
TOTALS	$711,382.90	$126,125.42	$619,264.14	$146,679.76	$986,009.75	$184,492.81	$717,523.25	$222,256.20
- direct expenditures	126,125.42		146,679.76		184,492.81		222,256.20	
	$585,257.48		$47[illegible],584.38		$801,516.94		$495,272.05	
DOL Budget (Actual Expenditures)	$478,100.		$648,000.		$779,500.		$901,072.	

With respect to specific recommendations made by the Division of Legislative Audit, appropriate steps for implementation have been taken in most instances.

Recommendation No. 1: The Division of Occupational Licensing's investigation unit should be transferred to the Department of Public Safety.

As of this date, a thorough analysis of such a transfer is continuing. The feasibility of an RSA between the Department of Commerce and Economic Development and the Department of Public Safety is a valid option that may have considerable merit in that the functions could be assumed by the Department of Public Safety in an expedited time frame. If our review indicates a transfer of the unit is merited, the transfer would take place prior to February 15, 1980.

Improvements have been made in this unit within the past year. Complaints are now being screened and prioritized, and reports by investigative staff are being made to the boards. Approximately 1,700 cases were purged from the Division files in the fall of 1978; these are pending board approval for closure due to age, lack of jurisdiction, or no apparent violation. Effective December, 1979, approximately 400 have been closed. The Division is in the process of organizing all investigative files and forwarding appropriate material to the State archives; this is expected to be completed by the end of January, 1980.

The Division's enforcement staff received 298 complaints for investigation in FY '79, ranging in priority from urgent public harm to minor technical violations. In FY '79, 44 cases were closed due to one of the following reasons: no jurisdiction no violation, voluntary compliance or age. Charges were filed against 27 which required process for hearing. Out of the 27 litigation cases, 3 licenses were revoked, 1 license was suspended, 2 licenses were denied, 1 case was dropped due to no violation, 2 closed with the stipulation that they retake the board examination and pass, 1 applicant was allowed to resubmit an application after

1 year, and 1 license was granted with the other 16 litigation cases still pending. As of December 10, the Division had 307 open cases on file.

Recommendation No. 2: Statutory amendments are needed to assure that appropriate action is taken on consumer complaints against licensed persons.

The Office of the Governor has indicated that appropriate amendments to AS 45.50.471, and its application, are being pursued.

Recommendation No. 3: The Office of the Governor should keep the appointments of members of the occupational licensing boards current.

We agree with this recommendation; the Division has solicited and submitted recommendations for board appointments.

Recommendation No.4: Legislation should be enacted limiting the length of service for all board members to two consecutive terms.

We agree with this recommendation and the reasoning supporting it.

Recommendation No. 5: The Department of Commerce and Economic Development should improve the operation, security and internal control of the 3M-Linolex minicomputer system.

To designate a data entry person is a valid recommendation, however, budget restrictions do not allow us to hire one individual solely to enter data. This would be very costly.

The Division is currently locking all copied data diskettes in its fire proof safe. These disks are kept current by creating new copies to replace the old ones after 20 changes have been made to any one master disk. It would be very difficult for a person to come into the office and be able to open a data disk without prior training. The State also maintains security personnel who walk the floors constantly and who question any individual working in the offices after hours. If, by chance, a disk was ruined we would have a current backup disk in the safe.

It is felt that if we prenumbered the blank licenses, it would add to more confusion to the licensee. This would have to be a four digit number, which is the same number of digits in a license number. The cost is also high.

A system utilization log has been established and is maintained daily.

The only operating procedures manual at this time is the one distributed by 3M. For data entry it is very good, for correcting errors on disks caused by power failure and/or fluctuations, it is poor. Time has not allowed us to complete a manual at present.

Recommendation No.6: The Department of Commerce and Economic Development should review the license fee structure of all boards and seek appropriate revisions.

Agreed. The Division has reintroduced legislation (SB 94 in the Senate Finance Committee) which would allow the Department to set fees after consultation with the boards. This request was also made to the 1978 Legislature but no action was taken.

Recommendation No. 7: The Department of Commerce and Economic Development should include the goals, objectives and quantifiable measures of each board in the Division of Occupational Licensing's budget documents and submit performance reports for each board as required by AS 37.07.

In April of 1979, all boards and commissions were contacted by the Division and requested to submit goals and objectives for inclusion in the FY '81 budget documents; 15 boards complied. Boards were also requested to submit performance reports for FY '79; 14 boards complied with this request.

Recommendation No. 8: The Division of Occupational Licensing should collect, record and maintain, for five year periods, files, and statistics of license and testing applicants, and related workload of the licensing examiners.

For the past year, monthly activity reports have been maintained by the Division containing information on board activities and examiner workload. Examiners are also submitting interim reports to the boards which outline licensure activity between meetings. This encourages feedback from the boards regarding staff performance.

Recommendation No. 9: The Department of Commerce and Economic Development, in conjunction with the Office of the Governor, should prepare a board member orientation booklet, including a code of conduct.

A manual for board members was prepared by the Department of Law and was distributed to all members. In addition to this manual, new board members receive information regarding complaint handling and the board's role in investigation and adjudication, an application packet for the regulated profession, appropriate statutes and regulations, a copy of the Administrative Procedure Act, information on the availability of teletype service, a listing of other members' names and address on the particular board, and a listing of Division employees.

Recommendation No. 10: The 11 health-related boards, in conjunction with the Division of Occupational Licensing should review their applications for licensure and delete any questions which could lead to discrimination against applicants.

All 21 boards and commissions are cognizant of the need to ensure against appearances or charges of discrimination, and of their responsibilites in this area. The process of application review is time consuming for most boards due to the infrequency of meetings; however, all boards have, or will, consider this recommendation, with assistance from the Division.

Recommendation No. 11: The Department of Commerce and Economic Development should improve formal board minutes.

The Division has been implementing this recommendation and will continue to do so. A decrease in licensing examiner turnover has resulted in substantial improvements to board minutes preparation.

Recommendation No. 12: The Department of Commerce and Economic Development and all licensing boards should ensure that public notices of examinations are sufficiently and timely advertised.

Public notices for board meetings and examinations are advertised according to legal requirements.

In conclusion, the DOL wishes to ensure the Legislature and the public that every effort is being made within available resources to accomplish the directives outlined in Title 8. The recommendations made as a result of the Sunset process, in addition to any other appropriate suggestions from any source, have been and will continue to be evaluated.

MEDICAL CONSULTING SERVICES
VIRGINIA M. COLLINS, R.N.

3201 "C" STREET, SUITE 240
ANCHORAGE, ALASKA 99503
(907) 276-7943

April 28, 1980

The Honorable Thelma Buchholdt
Chairwoman, Health, Education, and
Social Services Committee
House of Representatives
Pouch B
Juneau, Alaska 99811

RE: House Bill 910

Dear Ms. Buchholdt:

I would like to take this opportunity to thank you for your assistance in obtaining information regarding this bill during my brief stop in Juneau on April 18. I would like to restate my opposition to sections of that bill as follows.

Section 2.01.68.060

Lines 26 to 28 (Page One) currently read: "At least two of the members who are professional nurses must hold a bachelor's degree or higher." Recommendation: I would like to see these lines deleted and substituted with the following - "At least two of the members must be diploma and associate degree registered nurses." Justification for Change: There is no foundation that a professional nurse holding a bachelor's degree is any more qualified as a nurse than one prepared at the three or the two year level. As a matter of fact, a recent study, which I am enclosing for you, published in "RN" magazine in 1980 clearly brings to light the real matter of the problems with baccalaureate programs. This study is sufficient to discredit the idea that the baccalaureate program is inherently better than others in preparing nurses.

Section 6AS 08.68.111

Part B states that "the executive secretary must be a nurse with a bachelor's degree or higher in nursing, must be currently licensed by the state, and must meet other qualifications as established by board regulations." Justification for Change: There is no criteria that indicates that a bachelor's degree registered nurse is any more qualified for the position of executive secretary.

I would appreciate your consideration in changing these two sections so that they refer to registered nurses who have met the state's requirement for licensure. This would cover BSN nurses, nurses who have degrees in health science fields, the ADN, and diploma nurses. In this manner, all segments of the nursing population should be represented.

Thank you again for your help. It has been greatly appreciated.

Very truly yours,

Virginia M. Collins, R.N.
Director

VMC:ah

Enclosure

Is the BSN better?

Superior nursing performance of diploma graduates is confirmed in a survey of nursing directors and in state board test results.

By Anita Zarett, RN, BA

Although the following study applies to only one state out of 50, it makes a point that's true everywhere and anytime: Don't judge labels; judge results. It's individual performance that counts, not just credentials. What we need now is more information: Is the situation in Pennsylvania typical? Or is it a rare exception? RN welcomes data from any state. If you know of any similar studies, please help us share the results.—The Editors.

THE AUTHOR, who conducted this study, teaches [illegible] nursing at Memorial Rosborough School of Nursing and is presently completing the graduate health education program at St. Joseph's University in Philadelphia. Contributions to the study were also made by Patricia Nelson, R.N., ED, EdM; Carol Chenicki, RN, BSN, EdM, and Kathleen Brogan, RN.

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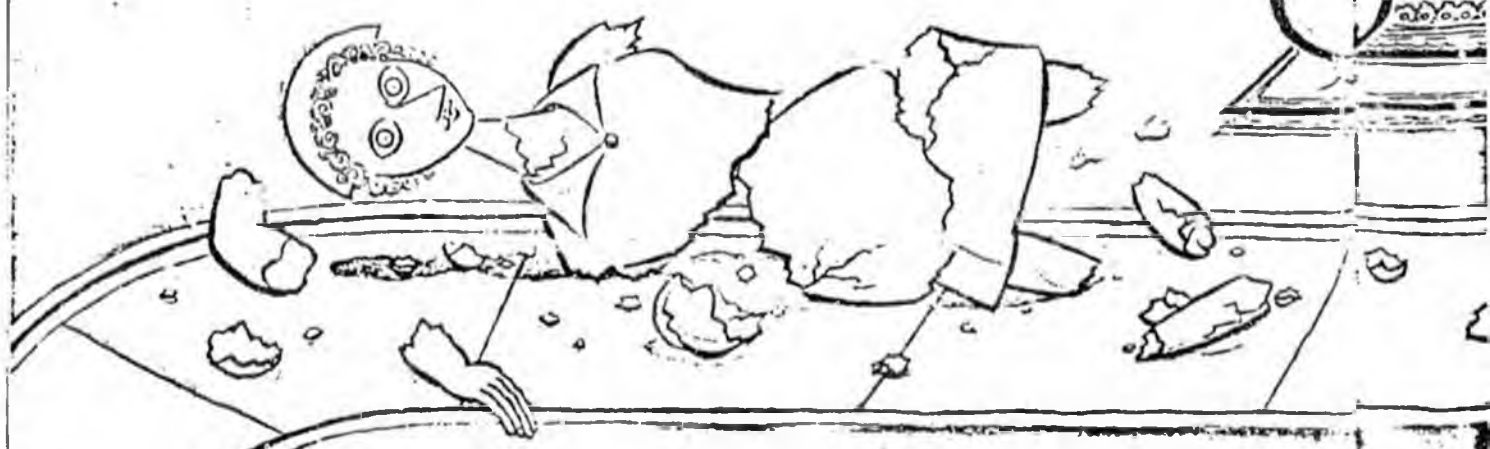
Diploma school graduates rate higher than BSNs in nine of 11 nursing performance categories (and the difference is statistically significant in six of them), according to a survey I conducted of directors of nursing in Pennsylvania. In addition, according to 96% of the respondents, diploma graduates need the least amount of orientation at the time of employment.

I've also discovered that diploma graduates outperformed BSNs in the Pennsylvania State Board Examinations for the past two years. In 1977, the diploma grads scored a mean of 22 points higher, and in 1978, a mean of 28 points higher than BSNs. Further, the percentage of graduates failing state boards in 1978 is lowest for



RN Nov. 1980

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Not necessarily, this study concludes

diploma graduates and highest for BSNs. And although AD grads consistently scored lower than diploma grads, in 1978 they scored higher than the BSNs in four out of five of the nursing areas tested.

A challenge to the '85 proposal

Taken together, these data certainly lead you to wonder about the assumptions of the ANA '85 resolution calling for the BSN as a requirement to enter professional nursing practice. The '85 proposal is, of course, based on the premise that modern nursing practice requires knowledge and skill of a "high order that can only be obtained through a rigorous course of study in

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colleges and universities"; and that hospital schools of nursing are "inadequate" in meeting these demands.

Little evidence has been offered to support these assumptions. Virtually no previous research in Pennsylvania has been reported that directly compares the performance of BSN, AD, and diploma graduates. Some other studies have attempted to assess performance by comparing the entry level of nurses who have reached higher positions, or by examining hospital policy for hiring and promoting various grads. But these results are, at best, confusing (see "Do hospitals prefer diploma grads?", below).

So when I set out to test the soundness of the ANA's assumptions, I decided to focus on nursing competency. My basic question was whether or not the quality of nursing care would, in fact, improve if the BSN requirement became mandatory. I felt the best way to determine this was to scientifically answer the following questions:

1. How high do nursing service directors in acute care settings in Pennsylvania rate the performance of all three levels of beginning nurse practitioners?

2. Of the three levels, which group needs the least amount of clinical orientation upon employment?

3. Of the three levels, which group, in fact, displays the most successful performance on Pennsylvania State Board Licensure Examinations?

The third question was answered by comparing the results of the graduates in their Pennsylvania State Board Examinations for the past two years.

The first two questions were answered through a survey sent to all the directors of nursing in acute care hospitals in Pennsylvania. The survey asked them to rate the performance of graduates of the various programs in 11 categories of nursing practice and to indicate which group upon graduation required the least amount of orientation. A total of 323 surveys were mailed, 68% were returned, and 48% were useable. Here are highlights of the results (see "How the study was conducted," page 33).

The nursing directors rated diploma grads significantly higher that BSNs in the following areas of performance:

- Performing independently—when necessary—in providing health care.
- Assuming responsibility for the patients assigned to their care.
- Establishing and choosing appropriate priorities to achieve nursing goals.
- Performing nursing skills accurately and safely in the promotion, maintenance, and restoration of health.
- Systematically reporting and recording pertinent data to determine nursing care needs.
- Exhibiting a high degree of commitment to quality nursing care.

In three other areas the diploma grads rated higher than the BSNs, but the difference was not statistically significant: utilizing the nursing process competently; interacting effectively with the health care team, patients, family, and society; and respecting the rights and values of patients and significant others.

Other significant results

The directors rated BSN grads significantly higher than diploma nurses in applying selective knowledge of bio-psycho-social influences on health status; and in identifying the need for nurse self-actualization and continuing education.

continued on page 32

Do hospitals prefer diploma grads?

Performance does count with hospital employers because, as some studies show, many hospitals hire and promote according to ability and seniority, rather than educational background. In a survey of 10 acute care community hospitals in California, Scott found that diploma nurses filled 82% of the head nurse positions and 76% of the managerial and administrative slots, though they comprised only 69% of the professional nursing staff as a whole.

A study by Dateman in 1977 showed more than 92% of the directors of nursing in Pennsylvania viewed diploma nurses as best prepared for nursing practice. Hogestell, in another 1977 study, found that over half of the AD graduates were being hired for the same positions as BSN grads, and that over 80% of all graduates were promoted without regard to preparation. Likewise, in a competency study by Smoyak (1970) diploma and baccalaureate graduates were found to be more alike than different.

The verdict is far from unanimous, however. In a study by Nelson (1978) supervisors rated BSN nurses highest in performance.

SOURCES Dateman, J. "Future of Diploma Schools." Unpublished Master's Thesis, Penn State University, 1977. Hogestell, M. O. "Associate Degrees and Baccalaureate Graduates—Do They Function Differently?" *American Journal of Nursing* 77:1598-1600, October 1977. Nelson, L. F. "Competence of Nursing Graduates in Technical, Communicative, and Administrative Skills." *Nursing Research* 27(2):121-125, March-April 1978. Smoyak, S. A. A Panel Study Comparing Self Reports of BSN, Diploma Graduates After the First Week of Experience in Hospitals. Newark, New Jersey. Unpublished Doctoral Paper, Rutgers, 1970. Soules, M. T. "What does a BSN get you?" *RN*, June 1978.

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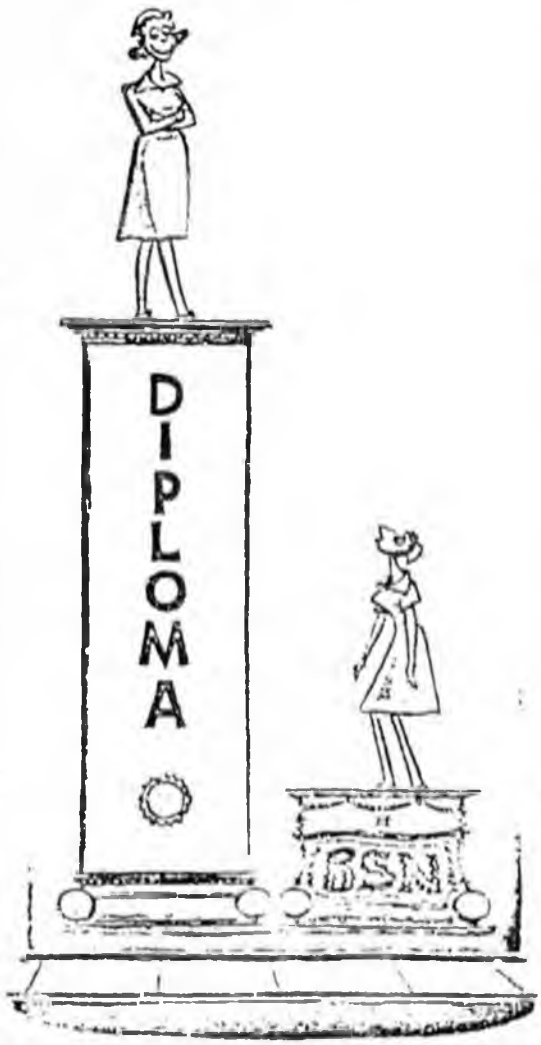
Top honors for diploma grads on nine different counts

When 154 Pennsylvania nursing directors rated diploma, BSN, and AD grads on the skills and attributes listed below, the diploma grads got top scores on nine of 11. Ratings are based on a scale of 5 (highest performance) to 1 (lowest performance). Scores represent the directors' average rating.



Nursing activity	Diploma	BSN	AD
1. Perform nursing skills accurately and safely in the promotion, maintenance, and restoration of health.	4.13*	3.29	2.62
2. Respect the rights and values of patients/clients and significant others.	4.12	4.01	3.58
3. Assume responsibility for the patients/clients assigned to his/her care.	4.09*	3.49	2.29
4. Exhibit high degree of commitment to quality nursing care.	4.03*	3.35	3.31
5. Perform independently when necessary in the provision of health care.	4.01*	3.12	2.53
6. Identify the need for self-actualization and continuing education.	3.93	4.10**	3.41
7. Interact effectively with the health team, patients/clients, family, and society.	3.92	3.82	3.10
8. Systematically report and record pertinent data to determine nursing care needs.	3.92*	3.71	2.98
9. Establish and choose appropriate priorities in order to achieve goals.	3.86*	2.89	2.68
10. Apply selective knowledge concerning biopsycho-social influences on health status.	3.77	4.11**	2.83
11. Utilize the nursing process competently.	3.68	3.47	2.51

*This rating is significantly higher for the diploma graduate than for the BSN graduate.

**This rating is significantly higher for the BSN graduate than for the diploma graduate.

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How diploma, BSN, and AD graduates scored on their state boards

The State Board of Nurse Examiners' minimum competency examination leaves little room for misinterpretation. It's the only standard method of evaluating the graduates of all three programs. Here are the comparative results for two consecutive years. The figures speak for themselves.

Mean score achieved in areas examined

1977

	Diploma	BSN	AD
Medicine	526	490	499
Surgery	542	494	517
Obstetrics	516	504	489
Nursing of Children	522	500	501
Psychiatry	504	517	498

1978

	Diploma	BSN	AD
Medicine	535	490	506
Surgery	535	480	508
Obstetrics	510	484	501
Nursing of Children	511	487	489
Psychiatry	493	505	481

In all cases the diploma nurses rated significantly higher than the AD graduates and in most cases the BSN nurses rated higher than the ADs.

The twelfth entry on the survey gave the directors of nursing an opportunity to point out which program prepared nurses to function appropriately with the least amount of orientation. Respondents were invited to give open-ended comment on their assessment of the graduates. Of the 154 directors of nursing responding, 148 (96%) said the diploma graduate is prepared to begin nursing at the entry level with the least amount of orientation. Twenty-three directors claimed that the only nurse prepared to meet the demands of the hospital milieu is the diploma graduate. Ten commented that it took the BSN and the AD six months to a

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year to "catch up," but five of these said that once the BSN caught up, she exceeded the other two in performance. Although six directors said that the BSN is the best prepared in patient communication, teaching, and similar tasks, three mentioned that after a year of experience, many BSNs accept positions that take them away from the bedside.

The directors of nursing of the larger inner city hospitals associated with a BSN program tended to rate baccalaureate graduates equal to or better than diploma graduates, and those hospitals with their own schools of nursing viewed the diploma graduate as superior. A number of directors (34) expressed concern over nursing shortages that would be created if the '85 proposal became effective. Others stated that instead of closing diploma programs, the ANA and state nurses associations should put pressure on colleges and universities to make the transition from RN to BSN less difficult for those who seek it.

No matter how painstaking the methodology of this research (see "How the study was conducted," below), it remains a survey of the *opinions* of the directors of nursing, rather than a direct measure of nursing performance.

But the second part of my study leaves little room for personal opinion

continued on page 78

How the study was conducted*

Two factors—performance on licensing exams and the opinions of Directors of Nursing—were used to compare the competency of Pennsylvania nurses graduating from BSN, AD, and diploma programs. A null hypothesis was adopted.

Test results of the State Board Registered Nurse Licensing Examinations from the years 1977 and 1978 were used to compare the performances of the examinees. Means were reported individually for the areas tested and failures were expressed in percentages for all three groups.

To study the opinions of directors of nursing, a three-part survey form was developed by the investigators. The first part collected information on hospital size and whether or not nurses from all three programs were employed. The second part listed 11 functions nurses should be able to perform to meet acceptable standards of care and asked the directors to rate the performance of their new graduate nurse employees using a 5 point Likert Scale with a "strongly agree" rating of 5 down to a "strongly disagree" rating of 1 on each of the behaviors. These 11 areas of nursing performance were gleaned from the catalogues of six Pennsylvania baccalaureate, associate degree, and diploma schools. The schools, two of each type, were selected on the basis of their common terminal objectives. The list complies with ANA standards of nursing practice, and the Pennsylvania Nurses Association "1985" position paper's outline of specific nursing qualities.

Content validity for these 11 elements was tested by administering the instrument to four nursing supervisors and two directors of nursing. Unclear areas were revised in accordance with their recommendations if the suggestions agreed with ANA standards.

Reliability of the instrument was assessed by applying the test-retest method three weeks apart. Reliability ($r = .87$) was computed by the Pearson Product Moment Correlation.

The third part of the survey asked the director which level graduate required the least orientation upon employment. Comments were also solicited.

From July through December 1977, a total of 323 survey forms were mailed to hospitals with a census range from less than 50 to over 2,000 beds—modal census was 250. In September of 1977 a second request was mailed to institutions that had not responded to the first. A total of 220 (68%) of the forms were returned completed. Sixty-six were discarded—50 because the hospital did not have either BSN or AD graduates in their employ, the remaining 16 because respondents developed their own rating scale which could not be accurately converted to the survey's scaling system.

After the data was collected and computed, a three-way analysis of variance was employed to test the first 11 hypotheses. An F ratio was obtained at the .05 level of probability. When significance was demonstrated, T tests were applied to indicate exactly between which groups the significance occurred. Both .01 and .05 levels were used. T tests were chosen in preference to the more sophisticated methods because of their simplicity in computation. The results of the 12th variable—the question on orientation—were merely tallied and expressed in the form of a percentage.

*Statistics and measurement tool available on request.

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BSN *continued from page 33*
or prejudice to color the results. It uses the only standardized method of evaluating nurses that we have: the State Board of Nurse Examiners' cognitive-theoretical minimum competency exam. At present, graduates of all three preparatory programs in Pennsylvania take the same test and are scored in the same manner. So it was a simple matter to compare the performance of the graduates from all three programs in both the 1977 and 1978 exams. Here are some highlights of the findings (for details, see page 32).

In both 1977 and 1978, diploma graduates consistently scored higher than AD and BSN graduates in medical, surgical, obstetric, and nursing of children. BSN graduates scored higher than diploma graduates only in psychiatric nursing. Although AD graduates scored lower than their diploma colleagues, in 1978 they scored higher than BSNs in four of the five areas tested.

Overall means place the diploma graduate first, the AD second, and the BSN last. In 1978, the BSNs' mean scores were lower than their 1977 mean scores in all five areas, and the gap between their scores and the diploma graduates' widened.

Conclusion and implications

Although this study applies only to the state of Pennsylvania, it is certainly sufficient to discredit the idea that a BSN program is inherently better than diploma training. Indeed, it demonstrates that, in at least one major state, diploma school preparation is in many ways significantly superior. The implications are clear.

Before any serious consideration can be given to legislative changes in the entry requirements, an objective comparison of all programs' effectiveness must be carried out on a national scale. If the facts I discovered in Pennsylvania hold true throughout the nation, mandating the BSN would clearly be a terrible mistake. In fact, it would actually make more sense to mandate the diploma. □

Diploma vs. BSN: Some caveats

Because the results of this study are controversial, to say the least, *RN* asked for comments on it from a representative group of nurses, including nursing directors and educators. Included in their remarks were a number of specific provisos worth remembering as you weigh the study's results.

- These data are limited to new graduates employed in or having taken state board exams in Pennsylvania. That doesn't mean, however, that these grads all went to nursing school in Pennsylvania. In fact, some may even have been trained abroad. Several respondents claim the same results would not be found in their states.
- The 11 activities surveyed seem, to some observers, to be weighted toward technical, task-oriented clinical performance rather than leadership and management skills. Since diploma programs are noted for their strong technical/clinical orientation and BSN programs for leadership and management, the results of the survey may be skewed in favor of diploma graduates. The same cannot be said of the state board results, however, because of the cognitive/theoretical bases of the exams.
- Directors of nursing in large hospitals, one reviewer notes, are not as well qualified to speak of the performance of new graduates as supervisors and head nurses are. In smaller community and rural hospitals, the directors might have first hand knowledge of new graduate performance, but the study doesn't break down the data according to institutional size.
- Fifty hospitals had to be disqualified because they did not have ADs or BSNs on staff and consequently had no basis for comparing performance. These were probably diploma school hospitals and/or rural hospitals where AD and BSN graduates are scarce. If so, the survey may understate the overall favor diploma graduates enjoy.

Almost everyone saw a need for more studies. One reviewer suggested an evaluation of performance based on the competencies established by the National League for Nursing for the graduates of various programs. Enrica Singleton, RN, DrPH, an *RN* consultant, focused her attention on the finding that BSN grads rated significantly higher than diploma grads in applying selective knowledge of bio-psycho-social influences on health status. "If this is true," she observed, "better care and performance should be the ultimate result." This seems to be confirmed by the comments of some directors who say that, although it takes BSNs six months to a year to "catch up," once they have, they surpass ADs and diploma grads in performance. Ms. Singleton suggested that possibility is worth a follow up study.

But other reviewers express impatience with studies that look back. Contributing Editor Margaret Van Meter, RN, wants nursing to press forward. "What's needed is in-depth analysis of future health-care needs and an educational program that's geared to meet those needs."

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Norman Buchholdt

TO: HOUSE HESS COMMITTEE (Copy to each member)

From: Carol Beardsley, RN, Anch. Fracture & Orthopedic Clinic, Anch. 279-9522
Gail Augdahl, RN, Alaska Hospital - OR, Anchorage - 276-1151
Audrey Ayers, RN, Providence Hospital - OR - Anchorage - 276-4511
[redacted]
Joanne Sidney, RN, Anch. Fracture & Orthopedic Clinic, Latouche
Anchorage, Alaska 99504 - 279-9522
Sue Bear, RN, Manager - Emergency Room - Providence Hospital, Anchorage - 276-4511

Relating to: House Bill 910 - An Act Relating to the practice of nursing.

As diploma and associate degree registered nurses, we continue to oppose HB 910.

We will continue to oppose this bill until we have a guarantee in writing that we will have representation on the board of nursing of a diploma RN graduate and an associate degree RN graduate.

It would require making changes in the language in sections 1 and 2 on page 1 of HB 910.

Regardless of what any other lobbyist, spokesman, legislative writer, or the like, who supports this bill may say to your committee, we are against the bill until the above guarantees are inserted into the bill.

Diploma and associate degree registered nurses comprise the majority of RNs in the State of Alaska. We want equal representation on the board. We do not want to governed by a minority (the Bachelor of Science RNs) -- as it would be unfair, undemocratic and unsupportable.

We did have a meeting with representatives of the Alaska Nursing Association -- whose officers support this bill. Our meeting reconfirmed that we should oppose the bill until diploma and associate degree nurses are represented on the board.

Thank you for your consideration.

Introduced: 2/27/80
Referred: Health, Education & Social Services and Finance

IN THE HOUSE

BY THE RULES COMMITTEE BY REQUEST OF THE GOVERNOR

HOUSE BILL NO. 910

IN THE LEGISLATURE OF THE STATE OF ALASKA

ELEVENTH LEGISLATURE - SECOND SESSION

A BILL

For an Act entitled: "An Act relating to the practice of nursing."

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

* Section 1. AS 08.68.010 is amended to read:

Sec. 08.68.010. CREATION AND MEMBERSHIP OF BOARD OF NURSING. There is created a Board of Nursing, consisting of seven members appointed by the governor. One member must [SHALL] be an actively licensed practical nurse [CURRENTLY INVOLVED IN INSTITUTIONAL NURSING SERVICE], one member an advanced nurse practitioner [IN COMMUNITY OR PUBLIC HEALTH NURSING], one member who is a professional nurse engaged in basic professional nursing education, [AND] two members who are professional nurses with direct or indirect responsibilities for nursing services [IN BASIC OR CONTINUING NURSING EDUCATION, ONE NURSE AT LARGE], and two persons who have no direct financial interest in the health care industry.

* Sec. 2. AS 08.68.060 is amended to read:

Sec. 08.68.060. QUALIFICATIONS OF REGISTERED NURSE AND LICENSED PRACTICAL NURSE BOARD MEMBERS. The five members of the board who are nurses must [SHALL] be licensed [PROFESSIONAL NURSES] in the state, and must [SHALL] have been actively engaged in nursing for not less than four years before appointment, three [TWO] years of which were within the five years immediately preceding appointment. ~~[At least two of the members who are professional nurses must hold a bachelor's degree or higher.]~~ delete adop.

* Sec. 3. AS 08.68.070 is amended to read:

Sec. 08.68.070. ELECTION OF OFFICERS. The board shall annually elect a chairperson [CHAIRMAN] and secretary-treasurer from among its members.

* Sec. 4. AS 08.68.080 is amended to read:

Sec. 08.68.080. MEETINGS. The board [~~shall~~ may] meet at least four times [ONCE] a year.

* Sec. 5. AS 08.68.100 is amended to read:

Sec. 08.68.100. DUTIES AND POWERS OF BOARD. (a) The board shall

(1) adopt [RULES AND] regulations necessary to make this chapter effective, including regulations pertaining to practice as an advanced nurse practitioner [AND WHEN NECESSARY, ADDITIONS TO OR CHANGES IN RULES AND REGULATIONS OF THE BOARD BY A QUORUM VOTE BY MAIL, THESE ADDITIONS TO OR CHANGES IN THE RULES AND REGULATIONS WHICH ARE MADE BY MAIL AND THE VOTE ON THEM TO BE ENTERED IN THE MINUTES OF THE BOARD AT ITS NEXT MEETING];

[(2) MAKE AVAILABLE, UPON REQUEST, COPIES OF THIS CHAPTER AND THE REGULATIONS ADOPTED FOR ADMINISTERING IT;]

(3) approve curricula and adopt standards for

(A) educational programs preparing persons for licensure or authorization to practice under AS 08.68, and

(B) basic and graduate degree educational programs in nursing [LICENSING AND PROVIDE FOR SURVEYS OF THESE PROGRAMS IN THE STATE AT THE TIMES IT CONSIDERS NECESSARY];

(4) accredit [ACCREDITS] educational programs which meet the requirements of this chapter and [THE STANDARDS] of the board, and deny, revoke, or suspend [OR WITHDRAW] accreditation from educational programs for failure to meet board requirements [STANDARDS];

(5) examine, license, and renew the licenses of qualified

applicants [, AND CONDUCT HEARINGS UPON CHARGES AND ADMINISTER OATHS TO PERSONS GIVING TESTIMONY AT HEARINGS];

(6) prescribe requirements to validate competency to continue or re-enter practice; [KEEP A RECORD OF ITS PROCEEDINGS, AND SUBMIT ANNUAL REPORTS TO THE GOVERNOR AND THE LEGISLATURE]

(7) keep a record of its proceedings, and submit annual reports to the governor and legislature;

(8) define by regulation the duties of the executive secretary and delegate such authority of the board to the executive secretary as may be necessary for the conduct of board business.

(b) The board may:

~~(1) issue subpoenas, compel the attendance of witnesses, and administer oaths to persons giving testimony at hearings;~~ delete adop.

(2) conduct hearings upon charges of alleged violations of this chapter or regulations adopted under it;

(3) invoke, or request the department to invoke, disciplinary action against a licensee, in accordance with the Administrative Procedure Act (AS 44.62).

* Sec. 6. AS 08.68.111 is amended to read:

Sec. 08.68.111. EXECUTIVE SECRETARY [OFFICER] OF BOARD. (a) The Department of Commerce and Economic Development, in consultation with the Board of Nursing, shall employ a licensed, professional [REGISTERED] nurse, who is not a member of the board, to serve as executive secretary [OFFICER] of the board.

(b) The executive secretary ~~must~~ May adop. [OFFICER SHALL] be a nurse having a bachelor's degree or higher in nursing, ~~must~~ Shall adop be currently licensed in the state ~~and must meet other qualifications as established by board regulations.~~ delete adop. [WITH NOT LESS THAN FIVE YEARS OF ACTIVE NURSING EXPERIENCE, OF WHICH NOT LESS THAN TWO YEARS WITHIN THE PRE-

CEDING FIVE YEARS HAS BEEN IN AN ADMINISTRATIVE OR A TEACHING CAPACITY IN AN ACCREDITED INSTITUTION ACCEPTABLE TO THE BOARD. IF A LICENSED PROFESSIONAL NURSE HOLDING A BACHELOR'S DEGREE IS NOT AVAILABLE TO FILL THE POSITION OF EXECUTIVE OFFICER, THE BOARD MAY WAIVE THE REQUIREMENT FOR A BACHELOR'S DEGREE AND APPOINT A LICENSED PROFESSIONAL NURSE POSSESSING OTHER QUALIFICATIONS IN EDUCATION AND ADMINISTRATIVE EXPERIENCE WHICH THE BOARD CONSIDERS ACCEPTABLE. HOWEVER, THE APPOINTEE SHALL COMPLETE THE REQUIREMENTS FOR THE AWARD OF A BACHELOR'S DEGREE IN FOUR YEARS AFTER APPOINTMENT TO THE POSITION OF EXECUTIVE OFFICER. ANNUALLY, THE APPOINTEE SHALL OFFER THE BOARD EVIDENCE OF SATISFACTORY PROGRESS TOWARD AWARD OF A BACHELOR'S DEGREE. IF AFTER THE ANNUAL REVIEW THE BOARD BELIEVES THAT THE APPOINTEE HAS NOT MADE SATISFACTORY PROGRESS TOWARD AWARD OF A BACHELOR'S DEGREE, THE DEPARTMENT MAY DISMISS THE APPOINTEE, NOTWITHSTANDING THE PROVISIONS OF AS 39.25.170.]

(c) The executive secretary [OFFICER] shall:

(1) perform the ~~administrative~~ duties ~~as required~~ by law, regulation, or [THE STATUTES AND] the department, including the preparation of minutes of board meetings;

(2) carry out regulations and policy decisions, consistent with law, made by the Board of Nursing, [AND]

(3) review and approve applicants for licensure who meet the qualifications prescribed in this chapter and in the board's regulations, [ASSIST THE BOARD IN THE CONDUCTING OF EXAMINATIONS, EDUCATIONAL PROGRAMS, PREPARATION OF MINUTES AND OTHER BOARD ADMINISTRATIVE WORK]

(4) bring before the board those applications that raise questions requiring full board consideration.

(5) conduct licensure examinations for qualified applicants,

(6) assist the department in informing licensees of the

necessity to renew licenses,

(7) communicate with other state boards and educational institutions regarding licensure of candidates and related concerns,

(8) refer complaints against licensees to the department for investigation,

(9) prepare periodic and special reports and surveys as required, including the annual report to the governor and the legislature,

(10) collect, compile, analyze, and distribute data relating to nursing education and licensure,

(11) respond to communications relating to nursing licensure, the provisions of AS 08.68, nursing education, and other related matters,

(12) direct communications requiring full board action to the board,

delete adp.

(13) provide information concerning the provisions of AS 08.68, board regulations and policies, and trends in nursing and nursing education to members of the public and the nursing profession, and to schools and other interested institutions and organizations,

(14) participate in educational program surveys,

(15) refer educational program reports to the board,

(16) assist the board and the department in the preparation of the annual budget,

(17) prepare and distribute the agenda for board meetings,

(18) collect and make available to the board all pertinent information on issues before the board,

(19) assist the division in the orientation of new board members.

* Sec. 7. AS 08.68.170 is amended to read:

Sec. 08.68.170. QUALIFICATIONS OF PROFESSIONAL OR PRACTICAL NURSE APPLICANTS. An applicant for a license to practice professional or practical nursing shall submit to the board on forms and in the manner prescribed by the board, written evidence, verified by oath, that the applicant has [COMPLETED AN APPROVED FOUR YEAR HIGH SCHOOL COURSE OF STUDY OR THE EQUIVALENT AS DETERMINED BY THE APPROPRIATE EDUCATIONAL AGENCY, AND HAS] successfully completed (1) a professional or practical nursing education program accredited by the board; or (2) a professional or practical nursing education program outside the state which, in the opinion of the board, meets the minimum requirements of the board for an accredited program of study in this state at the time the applicant graduated; or (3) a professional or practical nursing education program accredited by the National League for Nursing at the time the applicant graduated.

* Sec. 8. AS 08.68.190 is amended to read:

Sec. 08.68.190. LICENSE BY EXAMINATION. The applicant shall pass a written examination as prescribed by [IN THE SUBJECTS WHICH] the board [PRESCRIBES]. The board shall issue a license to an applicant who passes the examination to practice professional [NURSING] or practical nursing provided the other qualifications outlined in AS 08.68.170 and 08.68.180 are also met. The board shall conduct examinations annually and as often as it considers necessary.

* Sec. 9. AS 08.68.200 is amended to read:

Sec. 08.68.200. LICENSE BY ENDORSEMENT. The board may issue a license by endorsement to practice professional or practical nursing [OR TO PRACTICE PRACTICAL NURSING], whichever is appropriate, to an applicant who

(1) is licensed as either a professional or practical nurse [OR A PRACTICAL NURSE] under the laws of another state or territory,

if in the opinion of the board the applicant meets the qualifications required for licensing in the state, and meets the requirements of AS 08.68.170 [EITHER SEC. 170 OR SEC. 180 OF THIS CHAPTER, WHICHEVER IS APPLICABLE]; or

(2) meets the requirements of AS 08.68.170 and has successfully completed the Canadian Nurses' Association Testing Service (CNATS) examination if the board determines it is comparable to the examination administered by this state.

* Sec. 10. AS 08.68.210(a)(2) is amended to read:

(2) meets the requirements of AS 08.68.170 [EITHER SEC. 170 OR SEC. 180 OF THIS CHAPTER, WHICHEVER IS APPLICABLE], and

* Sec. 11. AS 08.68.210(b) is amended to read:

(b) The board may issue a nonrenewable permit to an applicant for license by examination if (1) the applicant [HE] meets the qualifications of AS 08.68.170, or (2) the applicant is a graduate of a foreign school of nursing and has successfully completed the examination administered by the Commission on Graduates of Foreign Nursing Schools (CGFNS) [SEC. 180 OF THIS CHAPTER, WHICHEVER IS APPLICABLE, AND PAYS THE REQUIRED FEE]. The permit will be valid for a period not extending beyond the time when the results are published of the first examination the applicant is eligible to take after the permit is issued.

* Sec. 12. AS 08.68.220 is amended to read:

Sec. 08.68.220. FEES. The following fees shall be imposed under this chapter when applicable:

(1) for professional [OR REGISTERED] nursing

(A) application fee..... $40 [$20]

(B) license-by-examination fee..... $20

(C) license-by-endorsement fee..... $20

if in the opinion of the board the applicant meets the qualifications required for licensing in the state, and meets the requirements of AS 08.68. '0 [EITHER SEC. 170 OR SEC. 180 OF THIS CHAPTER, WHICHEVER IS APPLICABLE]; or

(2) meets the requirements of AS 08.68.170 and has successfully completed the Canadian Nurses' Association Testing Service (CNATS) examination if the board determines it is comparable to the examination administered by this state.

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(1) for professional [OR REGISTERED] nursing

(A) application fee..... $40 [$20]

(B) license-by-examination fee..... $20

(C) license-by-endorsement fee..... $20

(D) biennial license renewal fee..... $20 [$15]

(2) for practical or vocational nursing

(A) application fee..... $30 [$15]

(B) license-by-examination fee..... $10 [$15]

(C) license-by-endorsement fee..... $10 [$15]

(D) biennial license renewal fee..... $20 [$15]

* Sec. 13. AS 08.68.251 is amended to read:

Sec. 08.68.251. LAPSED LICENSES. (a) A lapsed license may be reinstated if it has not remained lapsed for more than three [FIVE] years by payment of license fees which have fallen due during the lapsed period.

(b) If a [THE] license has remained lapsed for more than three [FIVE] years and

(1) if the board has reason to believe that the person applying for reinstatement [OF HIS LICENSE] no longer has sufficient knowledge to carry out the duties of a licensed nurse, the board shall [MAY] require the applicant to [TAKE AND PASS THE EXAMINATION GIVEN UNDER SEC. 190 OF THIS CHAPTER OR] complete a course of study [REFRESHER COURSE] approved by the board or pass an examination prescribed by the board, and to pay all applicable fees as if for a new application;

(2) if the board determines that the person applying for reinstatement has been actively employed in nursing in another state and has sufficient knowledge to carry out the duties of a licensed nurse, the lapsed license may be reinstated by payment of a reasonable fee imposed by the board under AS 44.62 (the Administrative Procedure Act), not to exceed the total fees required for a new application.

* Sec. 14. AS 08.68 is amended by adding a new section to read:

Sec. 08.68.260. INACTIVE NURSES UNDER PREVIOUS LAW. A nurse who holds an inactive license issued under previous AS 08.68.261 shall

either (1) activate the license on or before that renewal date, or (2) permit the license to lapse.

* Sec. 15. AS 08.68.270 is amended to read:

Sec. 08.68.270. GROUNDS FOR DENIAL, SUSPENSION, OR REVOCATION. The board, after compliance with the Administrative Procedure Act (AS 44.62), may deny, suspend or revoke the license of a person who

(1) has obtained or attempted to obtain a license to practice nursing by fraud or deceit;

(2) has been convicted of a felony;

(3) has been convicted of any misdemeanor that bears directly on the fitness of the person to practice nursing [A CRIME INVOLVING MORAL TURPITUDE];

(4) [IS] habitually abuses alcoholic beverages, stimulants, or depressants or illegally uses hallucinogenic or stimulant drugs as defined by AS 17.12.150(3) or narcotic drugs as defined by AS 17.10.-230(13) [INTOXICATED OR IS ADDICTED TO THE USE OF NARCOTICS];

(5) has impersonated a professional or practical nurse;

(6) is guilty, in the opinion of the board, of negligence which has resulted in a significant risk to the health or safety of a client or has resulted in [SERIOUS] injury to a client [PATIENT];

(7) practices or attempts to practice nursing while afflicted with physical or mental illness, deterioration, or disability to such an extent that the affliction interferes with the individual's performance of nursing functions [IS MENTALLY ILL OR MENTALLY INCOMPETENT];

(8) is guilty of unprofessional conduct;

(9) has wilfully [OR REPEATEDLY] violated any of the provisions of this chapter;

(10) is considered by the board to be professionally incompetent;

(11) denies care or treatment to a patient or person seeking assistance if the sole reason for the denial is the failure or refusal of the patient or person seeking assistance to execute an agreement to arbitrate a dispute, controversy, or issue arising out of the care or treatment, as provided in AS 09.55.535(a).

* Sec. 16. AS 08.68 is amended by adding a new section to read:

Sec. 08.68.276. CONTINUING COMPETENCE REQUIRED. A license to practice nursing may not be renewed unless the nurse has complied with continuing competence requirements that may be established by the board by regulation.

* Sec. 17. AS 08.68.280 is amended to read:

Sec. 08.68.280. NURSING EDUCATION PROGRAM PROHIBITED UNLESS ACCREDITED. No person, institution or agency may conduct a nursing education program preparing persons for examination, licensure, authorization for specialized practice, or a graduate degree [FOR PROFESSIONAL OR PRACTICAL NURSES] unless the program is accredited by the board. All nursing education programs must be established in an accredited post secondary educational institution within the state.

* Sec. 18. AS 08.68.290 is amended to read:

Sec. 08.68.290. APPLICATION FOR ACCREDITATION BY BOARD. An institution desiring to conduct a nursing education program to prepare p ofessional [OR PRACTICAL] nurses at the associate, baccalaureate or higher degree levels or to prepare a nurse to perform in an expanded role as an advanced nurse practitioner or to prepare practical nurses shall apply to the board and submit evidence that (1) it is prepared to carry out the curriculum which meets requirements prescribed by law and [APPROVED] by the board for professional nursing, [OR] for practice as an advanced nurse practitioner or for practical nursing, [AS THE CASE MAY BE,] and that (2) it is prepared to meet other

requirements prescribed [STANDARDS ESTABLISHED] by law and by the board.

* Sec. 19. AS 08.68.300 is amended to read:

Sec. 08.68.300. SURVEY AND ACCREDITATION BY THE BOARD. The board shall designate a survey team [THE EXECUTIVE OFFICER, A BOARD MEMBER, OR A CONSULTANT TO SURVEY THE INSTITUTION APPLYING FOR ACCREDITATION] to determine if the [STANDARDS AND] requirements prescribed [REQUIRED] by law and the board are met. The board may survey a nursing education program in the state at any time. Written reports of the surveys shall be filed with and retained by the board [AND RETAINED BY IT].

* Sec. 20. AS 08.68 is amended by adding a new section to read:

Sec. 08.68.325. RECOGNITION OF EDUCATIONAL PROGRAMS. No program or course of study will be recognized as satisfying state requirements without board approval.

* Sec. 21. AS 08.68.330 is amended to read:

Sec. 08.68.330. LIST OF ACCREDITED AND APPROVED PROGRAMS. The board shall prepare, maintain, and periodically [FROM TIME TO TIME] publish a list of accredited nursing education programs preparing nurses to practice and programs or courses of study which are approved to validate competency or to prepare a nurse for authorization to practice as an advanced nurse practitioner or to obtain a graduate degree [IN THE STATE].

* Sec. 22. AS 08.68.340 is repealed and re-enacted to read:

Sec. 08.68.340. VIOLATIONS. (a) It is a class A misdemeanor for a person to:

(1) sell or fraudulently obtain or furnish a nursing diploma, license renewal, or record, or knowingly aid in doing so;

(2) practice nursing under cover of a diploma, license, or

record illegally or fraudulently obtained or signed or issued unlawfully, with knowledge of the illegality or unlawfulness of the act;

(3) practice or offer to practice nursing with knowledge that he has not been licensed, except when rendering necessary aid to the ill, injured, or infirm in an emergency, or knowingly to employ as a nurse a person without a license to practice nursing;

(4) knowingly use in connection with his name a designation tending to imply that he is a licensed nurse unless he is licensed;

(5) practice nursing during the time his license is suspended or revoked, knowing of the suspension or revocation;

(6) conduct a nursing education program that represents or implies that it is accredited knowing that the program has not been accredited by the board;

(7) do an act described in AS 08.68.405(10), (11), (14), or (15); or

(8) knowingly do an act described in AS 08.68.405(9).

(b) It is a class B misdemeanor for a person to:

(1) practice nursing under cover of a diploma, license, or record illegally obtained or signed or issued unlawfully;

(2) practice or offer to practice nursing without having been licensed, except when rendering necessary aid to the ill, injured, or infirm in an emergency, or to employ as a nurse a person without a license to practice nursing;

(3) use in connection with his name a designation tending to imply that he is a licensed nurse unless he is licensed;

(4) practice nursing during the time his license is suspended or revoked or with knowledge his license has lapsed;

(5) conduct a nursing education program that represents or implies that is is accredited, unless the program has been accredited

by the board; or

(6) do an act described in AS 08.68.405(4), (6), (7), (8), (12), (17), (18), or (19).

(c) It is a violation for a person to practice nursing during the time his license is lapsed.

* Sec. 23. AS 08.68.400(a) is amended to read:

(a) This chapter does not apply to

(1) a qualified nurse licensed in another state employed by the United States Government or a bureau, or agency, or division of the United States Government while in the discharge of his official duties;

(2) nursing service given temporarily in the event of a public emergency, epidemic, or disaster;

(3) the practice of nursing by a student enrolled in a nursing education program accredited by the board when the practice is in connection with the student's course of study; [OR]

(4) the practice of nursing by an individual [A NURSE] enrolled in an approved program or course of study for purposes of meeting competency re-entry requirements under AS 08.68.251; or [REFRESHER COURSE]

(5) the practice of nursing by a nurse licensed in another state who engages in nursing education or nursing consultation activities when these activities and contact with clients do not exceed 20 working days within a licensing period.

* Sec. 24. AS 08.68 is amended by adding a new section to read:

Sec. 08.68.405. UNPROFESSIONAL CONDUCT. (a) A person who commits one of the following acts is guilty of unprofessional conduct:

(1) failing to use appropriate judgment in the practice of nursing based upon the level of nursing for which the individual is

educationally prepared and licensed;

(2) failing to exercise technical competence in carrying out nursing care,

(3) failing to safeguard a client's dignity and right to privacy;

(4) violating the confidentiality of information or knowledge concerning a client;

(5) verbally abusing a client;

(6) physically abusing a client;

(7) performing new nursing techniques or procedures without proper education and preparation;

(8) using alcohol or other drugs to the extent that the use interferes with nursing functions;

(9) making a disposition of prescription drugs or narcotics other than that ordered or prescribed by a person authorized by law to do so;

(10) falsifying a client's records or intentionally making an incorrect entry in a client's chart;

(11) violating state or federal laws regulating drugs, by forging prescriptions or by making drugs available to himself, friends, or family members;

(12) delegating a nursing care function, task, or responsibility to another who is not licensed under AS 08.68 to perform that function, task, or responsibility, and the delegation involves a substantial risk of harm to a client;

(13) assuming duties and responsibilities, on repeated occasions, without adequate training or when competency has not been maintained;

(14) assisting another person to violate or circumvent any

law or regulation intended to regulate nursing practice;

(15) permitting or allowing another person to use his or her nursing license or permit for any purpose;

(16) failing to exercise adequate supervision over persons who are authorized to practice only under the supervision of the licensed professional;

(17) leaving a nursing assignment without properly notifying appropriate personnel;

(18) committing any act that poses a substantial risk of harm to a client;

(19) failing to perform acts within the nurse's scope of competence which are necessary to prevent substantial risk of harm to a client;

(20) failing to report as required by AS 08.68.406.

(b) The board may by regulation provide that other acts contrary to the standards of the nursing profession constitute unprofessional conduct.

* Sec. 25. AS 08.68 is amended by adding a new section to read:

Sec. 08.68.406. DUTY TO REPORT ILLEGAL CONDUCT OR CONDUCT DANGEROUS TO CLIENTS. A nurse who witnesses a health care provider engaged in the following conduct shall report that conduct to the appropriate licensing board or to the immediate supervisor of that provider:

(1) any act described in AS 08.68.405(6), (8), (9), (10), (11), (12), (14), (15), (18), or (19);

(2) any act described in AS 08.64.380(3)(B) or (F);

(3) any act posing a danger to a client's welfare.

* Sec. 26. AS 08.68.410 is repealed and re-enacted to read:

Sec. 08.68.410. DEFINITIONS. As used in this chapter

(1) "accredited nursing education program" means a program having curricula and standards which meet the requirements established by the board;

(2) "advanced nurse practitioner" means a registered professional nurse authorized to practice in the state who, by virtue of specialized education and experience, has become certified to perform acts of medical diagnosis and the prescription of medical, therapeutic, or corrective measures under regulations adopted by the board;

(3) "board" means the Board of Nursing;

(4) "endorsement" is the licensing of an applicant without examination through the acceptance of a license or registration issued by any state or territory after a comprehensive examination which is substantially equivalent to the examination offered in this state;

(5) "licensed practical nurse" is equivalent to the title "licensed vocational nurse" and to the name suffix abbreviations L.P.N. and L.V.N.;

(6) "licensed professional nurse" is equivalent to the common title "registered nurse" and the name suffix abbreviation R.N.;

(7) "practice of practical nursing" means the performance for compensation or personal profit of selected acts in the prevention of illness, and in the care of the ill, injured, or infirm under the direction of a licensed professional nurse or a licensed physician or a licensed dentist not requiring the substantial specialized skill, judgment, and knowledge required in professional nursing;

(8) "practice of professional nursing" means the performance for compensation or personal profit of acts of professional service requiring substantial specialized knowledge, judgment, and skill based upon the principles of biological, physiological, behavioral, and sociological sciences in assessing and responding to actual or poten-

tial health needs of individuals, families, or communities through such services as:

(A) assessment, problem identification, counseling, and health teaching:

(i) in the maintenance of health or in the prevention of illness of clients; and

(ii) in the care of the ill, injured, or infirm;

(B) administration, supervision, delegation, and evaluation of nursing practice;

(C) teaching of nursing;

(D) execution of a medical regimen as prescribed by a health care provider authorized by the state to perform acts of medical practice;

(E) performance of such additional acts requiring education and training and recognized by the nursing profession as properly performed by registered professional nurses;

(F) performance of acts of medical diagnosis and the prescription of medical therapeutic or corrective measures under regulations adopted by the board;

(9) "professional incompetence" means that a nurse does not possess the skills, knowledge, and awareness of his or her limitations and abilities to continue safely the practice of nursing.

* Sec. 26. Administrative regulations, adopted jointly by the Board of Nursing and the State Medical Board and in effect on the effective date of this Act, remain in effect until amended or repealed by the Board of Nursing under this Act.

* Sec. 27. AS 08.68.180(a), 08.68.260, and 08.68.350 are repealed.

1) get figures on how much the Bd brings in from licensing fees.

2) How much does it cost to run the Bd.

3) cost to administer test

4) proposed budget for next yr.

Introduced: 2/27/80
Referred: Health, Education & Social Services and Finance

IN THE HOUSE

BY THE RULES COMMITTEE BY REQUEST OF THE GOVERNOR

HOUSE BILL NO. 910

IN THE LEGISLATURE OF THE STATE OF ALASKA

ELEVEN[illegible]LATURE - SECOND SESSION

A BILL

For an Act entitled: "An Act relating to the practice of nursing."

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

* Section 1. AS 08.68.010 is amended to read:

Sec. 08.68.010. CREATION AND MEMBERSHIP OF BOARD OF NURSING. There is created a Board of Nursing, consisting of seven members appointed by the governor. One member must [SHALL] be an actively licensed practical nurse [CURRENTLY INVOLVED IN INSTITUTIONAL NURSING SERVICE], one member an advanced nurse practitioner [IN COMMUNITY OR PUBLIC HEALTH NURSING], one member who is a professional nurse engaged in basic professional nursing education, [AND] two members who are professional nurses with direct or indirect responsibilities for nursing services [IN BASIC OR CONTINUING NURSING EDUCATION, ONE NURSE AT LARGE], and two persons who have no direct financial interest in the health care industry.

* Sec 2. AS 08.68.060 is amended to read:

Sec. 08.68.060. QUALIFICATIONS OF REGISTERED NURSE AND LICENSED PRACTICAL NURSE BOARD MEMBERS. The five members of the board who are nurses must [SHALL] be licensed [PROFESSIONAL NURSES] in the state, and must [SHALL] have been actively engaged in nursing for not less than four years before appointment, three [TWO] years of which were within the five years immediately preceding appointment, [At least two of the members who are professional nurses must hold a bachelor's degree or higher.] Delete adopted

* Sec. 3. AS 08.68.070 is amended to read:

Sec. 08.68.070. ELECTION OF OFFICERS. The board shall annually elect a chairperson [CHAIRMAN] and secretary-treasurer from among its members.

* Sec. 4. AS 08.68.080 is amended to read:

Sec. 08.68.080. MEETINGS. The board [shall] may meet at least four times [ONCE] a year.

* Sec. 5. AS 08.68.100 is amended to read:

Sec. 08.68.100. DUTIES AND POWERS OF BOARD. (a) The board shall

(1) adopt [RULES AND] regulations necessary to make this chapter effective, including regulations pertaining to practice as an advanced nurse practitioner [AND WHEN NECESSARY, ADDITIONS TO OR CHANGES IN RULES AND REGULATIONS OF THE BOARD BY A QUORUM VOTE BY MAIL, THESE ADDITIONS TO OR CHANGES IN THE RULES AND REGULATIONS WHICH ARE MADE BY MAIL AND THE VOTE ON THEM TO BE ENTERED IN THE MINUTES OF THE BOARD AT ITS NEXT MEETING];

[(2) MAKE AVAILABLE, UPON REQUEST, COPIES OF THIS CHAPTER AND THE REGULATIONS ADOPTED FOR ADMINISTERING IT;]

(3) approve curricula and adopt standards for

(A) educational programs preparing persons for licensure or authorization to practice under AS 08.68, and

(B) basic and graduate degree educational programs in nursing [LICENSING AND PROVIDE FOR SURVEYS OF THESE PROGRAMS IN THE STATE AT THE TIMES IT CONSIDERS NECESSARY];

(4) accredit [ACCREDITS] educational programs which meet the requirements of this chapter and [THE STANDARDS] of the board, and deny, revoke, or suspend [OR WITHDRAW] accreditation from educational programs for failure to meet board requirements [STANDARDS];

(5, examine, license, and renew the licenses of qualified

applicants [, AND CONDUCT HEARINGS UPON CHARGES AND ADMINISTER OATHS TO PERSONS GIVING TESTIMONY AT HEARINGS];

(6) prescribe requirements to validate competency to continue or re-enter practice; [KEEP A RECORD OF ITS PROCEEDINGS, AND SUBMIT ANNUAL REPORTS TO THE GOVERNOR AND THE LEGISLATURE]

(7) keep a record of its proceedings, and submit annual reports to the governor and legislature;

(8) define by regulation the duties of the executive secretary and delegate such authority of the board to the executive secretary as may be necessary for the conduct of board business.

(b) The board may:

(1) issue subpoenas, compel the attendance of witnesses, and administer oaths to persons giving testimony at hearings; delete adopted

(2) conduct hearings upon charges of alleged violations of this chapter or regulations adopted under it;

(3) invoke, or request the department to invoke, disciplinary action against a licensee, in accordance with the Administrative Procedure Act (AS 44.62).

* Sec. 6. AS 08.68.111 is amended to read:

Sec. 08.68.111. EXECUTIVE SECRETARY [OFFICER] OF BOARD. (a) The Department of Commerce and Economic Development, in consultation with the Board of Nursing, shall employ a licensed, professional [REGISTERED] nurse, who is not a member of the board, to serve as executive secretary [OFFICER] of the board.

(b) The executive secretary [must] [OFFICER SHALL] be a nurse having a bachelor's degree or higher in nursing, [must] be currently licensed in the state. [and must meet other qualifications as established by board regulations.] [WITH NOT LESS THAN FIVE YEARS OF ACTIVE NURSING EXPERIENCE, OF WHICH NOT LESS THAN TWO YEARS WITHIN THE PRE-

May adopted Shall adopted delete adopted

CEDING FIVE YEARS HAS BEEN IN AN ADMINISTRATIVE OR A TEACHING CAPACITY IN AN ACCREDITED INSTITUTION ACCEPTABLE TO THE BOARD. IF A LICENSED PROFESSIONAL NURSE HOLDING A BACHELOR'S DEGREE IS NOT AVAILABLE TO FILL THE POSITION OF EXECUTIVE OFFICER, THE BOARD MAY WAIVE THE REQUIREMENT FOR A BACHELOR'S DEGREE AND APPOINT A LICENSED PROFESSIONAL NURSE POSSESSING OTHER QUALIFICATIONS IN EDUCATION AND ADMINISTRATIVE EXPERIENCE WHICH THE BOARD CONSIDERS ACCEPTABLE. HOWEVER, THE APPOINTEE SHALL COMPLETE THE REQUIREMENTS FOR THE AWARD OF A BACHELOR'S DEGREE IN FOUR YEARS AFTER APPOINTMENT TO THE POSITION OF EXECUTIVE OFFICER. ANNUALLY, THE APPOINTEE SHALL OFFER THE BOARD EVIDENCE OF SATISFACTORY PROGRESS TOWARD AWARD OF A BACHELOR'S DEGREE. IF AFTER THE ANNUAL REVIEW THE BOARD BELIEVES THAT THE APPOINTEE HAS NOT MADE SATISFACTORY PROGRESS TOWARD AWARD OF A BACHELOR'S DEGREE, THE DEPARTMENT MAY DISMISS THE APPOINTEE, NOTWITHSTANDING THE PROVISIONS OF AS 39.25.170.]

(c) The executive secretary [OFFICER] shall

(1) perform the ~~administrative~~ duties ~~required~~ by law, regulation, or [THE STATUTES AND] the department, including the preparation of minutes of board meetings,

(2) carry out regulations and policy decisions, consistent with law, made by the Board of Nursing, [AND]

(3) review and approve applicants for licensure who meet the qualifications prescribed in this chapter and in the board's regulations, [ASSIST THE BOARD IN THE CONDUCTING OF EXAMINATIONS, EDUCATIONAL PROGRAMS, PREPARATION OF MINUTES AND OTHER BOARD ADMINISTRATIVE WORK]

(4) bring before the board those applications that raise questions requiring full board consideration.

(5) conduct licensure examinations for qualified applicants;

(6) assist the department in informing licensees of the

necessity to renew licenses,

(7) communicate with other state boards and educational institutions regarding licensure of candidates and related concerns,

(8) refer complaints against licensees to the department for investigation,

(9) prepare periodic and special reports and surveys as required, including the annual report to the governor and the legislature,

(10) collect, compile, analyze, and distribute data relating to nursing education and licensure,

(11) respond to communications relating to nursing licensure, the provisions of AS 08.68, nursing education, and other related matters,

(12) direct communications requiring full board action to the board,

(13) provide information concerning the provisions of AS 08.68, board regulations and policies, and trends in nursing and nursing education to members of the public and the nursing profession, and to schools and other interested institutions and organizations,

(14) participate in educational program surveys,

(15) refer educational program reports to the board,

(16) assist the board and the department in the preparation of the annual budget,

(17) prepare and distribute the agenda for board meetings,

(18) collect and make available to the board all pertinent information on issues before the board,

(19) assist the division in the orientation of new board members.

* Sec. 7. AS 08.68.170 is amended to read:

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Sec. 08.68.170. QUALIFICATIONS OF PROFESSIONAL OR PRACTICAL NURSE APPLICANTS. An applicant for a license to practice professional or practical nursing shall submit to the board on forms and in the manner prescribed by the board, written evidence, verified by oath, that the applicant has [COMPLETED AN APPROVED FOUR YEAR HIGH SCHOOL COURSE OF STUDY OR THE EQUIVALENT AS DETERMINED BY THE APPROPRIATE EDUCATIONAL AGENCY, AND HAS] successfully completed (1) a professional or practical nursing education program accredited by the board; or (2) a professional or practical nursing education program outside the state which, in the opinion of the board, meets the minimum requirements of the board for an accredited program of study in this state at the time the applicant graduated; or (3) a professional or practical nursing education program accredited by the National League for Nursing at the time the applicant graduated.

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Sec. 08.68.190. LICENSE BY EXAMINATION. The applicant shall pass a written examination as prescribed by [IN THE SUBJECTS WHICH] the board [PRESCRIBES]. The board shall issue a license to an applicant who passes the examination to practice professional [NURSING] or practical nursing provided the other qualifications outlined in AS 08.68.170 and 08.68.180 are also met. The board shall conduct examinations annually and as often as it considers necessary.

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Sec. 08.68.200. LICENSE BY ENDORSEMENT. The board may issue a license by endorsement to practice professional or practical nursing [OR TO PRACTICE PRACTICAL NURSING], whichever is appropriate, to an applicant who

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if in the opinion of the board the applicant meets the qualifications required for licensing in the state, and meets the requirements of AS 08.68.170 [EITHER SEC. 170 OR SEC. 180 OF THIS CHAPTER, WHICHEVER IS APPLICABLE]; or

(2) meets the requirements of AS 08.68.170 and has successfully completed the Canadian Nurses' Association Testing Service (CNATS) examination if the board determines it is comparable to the examination administered by this state.

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(2) meets the requirements of AS 08.68.170 [EITHER SEC. 170 OR SEC. 180 OF THIS CHAPTER, WHICHEVER IS APPLICABLE], and

* Sec. 11. AS 08.68.210(b) is amended to read:

(b) The board may issue a nonrenewable permit to an applicant for license by examination if (1) the applicant [HE] meets the qualifications of AS 08.68.170, or (2) the applicant is a graduate of a foreign school of nursing and has successfully completed the examination administered by the Commission on Graduates of Foreign Nursing Schools (CGFNS) [SEC. 180 OF THIS CHAPTER, WHICHEVER IS APPLICABLE, AND PAYS THE REQUIRED FEE]. The permit will be valid for a period not extending beyond the time when the results are published of the first examination the applicant is eligible to take after the permit is issued.

* Sec. 12. AS 08.68.220 is amended to read:

Sec. 08.68.220. FEES. The following fees shall be imposed under this chapter when applicable:

(1) for professional [OR REGISTERED] nursing

(A) application fee..... ~~$40~~ [$20] adopted

(B) license-by-examination fee..... $20

(C) license-by-endorsement fee..... $20

(D) biennial license renewal fee..... ~~$20~~ [$15]

(2) for practical or vocational nursing

(A) application fee..... ~~$30~~ [$15]

(B) license-by-examination fee..... $10 [$15]

(C) license-by-endorsement fee..... $10 [$15]

(D) biennial license renewal fee..... ~~$20~~ [$15]

* Sec. 13. AS 08.68.251 is amended to read:

Sec. 08.68.251. LAPSED LICENSES. (a) A lapsed license may be reinstated if it has not remained lapsed for more than three [FIVE] years by payment of license fees which have fallen due during the lapsed period.

(b) If a [THE] license has remained lapsed for more than three [FIVE] years and

(1) if the board has reason to believe that the person applying for reinstatement [OF HIS LICENSE] no longer has sufficient knowledge to carry out the duties of a licensed nurse, the board shall [MAY] require the applicant to [TAKE AND PASS THE EXAMINATION GIVEN UNDER SEC. 190 OF THIS CHAPTER OR] complete a course of study [REFRESHER COURSE] approved by the board or pass an examination prescribed by the board, and to pay all applicable fees as if for a new application;

(2) if the board determines that the person applying for reinstatement has been actively employed in nursing in another state and has sufficient knowledge to carry out the duties of a licensed nurse, the lapsed license may be reinstated by payment of a reasonable fee imposed by the board under AS 44.62 (the Administrative Procedure Act), not to exceed the total fees required for a new application.

* Sec. 14. AS 08.68 is amended by adding a new section to read:

Sec. 08.68.260. INACTIVE NURSES UNDER PREVIOUS LAW. A nurse who holds an inactive license issued under previous AS 08.68.250 shall

either (1) activate the license on or before that renewal date, or (2) permit the license to lapse.

* Sec. 15. AS 08.68.270 is amended to read:

Sec. 08.68.270. GROUNDS FOR DENIAL, SUSPENSION, OR REVOCATION. The board, after compliance with the Administrative Procedure Act (AS 44.62), may deny, suspend or revoke the license of a person who

(1) has obtained or attempted to obtain a license to practice nursing by fraud or deceit;

[(2) has been convicted of a felony;] delete

(3) has been convicted of any misdemeanor that bears directly on the fitness of the person to practice nursing [A CRIME INVOLVING MORAL TURPITUDE];

(4) [IS] habitually abuses alcoholic beverages, stimulants, or depressants or illegally uses hallucinogenic or stimulant drugs as defined by AS 17.12.15 (3) or narcotic drugs as defined by AS 17.10.-230(13) [INTOXICATED OR IS ADDICTED TO THE USE OF NARCOTICS];

(5) has impersonated a professional or practical nurse;

(6) is guilty, in the opinion of the board, of negligence which has resulted in a significant risk to the health or safety of a client or has resulted in [SERIOUS] injury to a client [PATIENT];

(7) practices or attempts to practice nursing while afflicted with physical or mental illness, deterioration, or disability to such an extent that the affliction interferes with the individual's performance of nursing functions [IS MENTALLY ILL OR MENTALLY INCOMPETENT];

(8) is guilty of unprofessional conduct;

(9) has wilfully [OR REPEATEDLY] violated any of the provisions of this chapter;

(2) ~~(10)~~ is considered by the board to be professionally incompetent; or demonstrates unprofessional conduct;

~~(as defined by reg.)~~ ?

(3) ~~(B)~~ denies care or treatment to a patient or person seeking assistance if the sole reason for the denial is the failure or refusal of the patient or person seeking assistance to execute an agreement to arbitrate a dispute, controversy, or issue arising out of the care or treatment, as provided in AS 09.55.535(a).

* Sec. 16. AS 08.68 is amended by adding a new section to read:

Sec. 08.68.276. CONTINUING COMPETENCE REQUIRED. A license to practice nursing may not be renewed unless the nurse has complied with continuing competence requirements that may be established by the board by regulation.

* Sec. 17. AS 08.68.280 is amended to read:

Sec. 08.68.280. NURSING EDUCATION PROGRAM PROHIBITED UNLESS ACCREDITED. No person, institution or agency may conduct a nursing education program preparing persons for examination, licensure, authorization for specialized practice, or a graduate degree [FOR PROFESSIONAL OR PRACTICAL NURSES] unless the program is accredited by the board. All nursing education programs must be established in an accredited post secondary educational institution within the state.

* Sec. 18. AS 08.68.290 is amended to read:

Sec. 08.68.290. APPLICATION FOR ACCREDITATION BY BOARD. An institution desiring to conduct a nursing education program to prepare professional [OR PRACTICAL] nurses at the associate, baccalaureate or higher degree levels or to prepare a nurse to perform in an expanded role as an advanced nurse practitioner or to prepare practical nurses shall apply to the board and submit evidence that (1) it is prepared to carry out the curriculum which meets requirements prescribed by law and [APPROVED] by the board for professional nursing, [OR] for practice as an advanced nurse practitioner or for practical nursing, [AS THE CASE MAY BE,] and that (2) it is prepared to meet other

requirements prescribed [STANDARDS ESTABLISHED] by law and by the board.

* Sec. 19. AS 08.68.300 is amended to read:

Sec. 08.68.300. SURVEY AND ACCREDITATION BY THE BOARD. The board shall designate a survey team [THE EXECUTIVE OFFICER, A BOARD MEMBER, OR A CONSULTANT TO SURVEY THE INSTITUTION APPLYING FOR ACCREDITATION] to determine if the [STANDARDS AND] requirements prescribed [REQUIRED] by law and the board are met. The board may survey a nursing education program in the state at any time. Written reports of the surveys shall be filed with and retained by the board [AND RETAINED BY IT].

Delete sec. 19 adopt.

* Sec. 20. AS 08.68 is amended by adding a new section to read:

Sec. 08.68.325. RECOGNITION OF EDUCATIONAL PROGRAMS. No program or course of study will be recognized as satisfying state requirements without board approval.

Delete adopt

* Sec. 21. AS 08.68.330 is amended to read:

A motion to repeal adopted

Sec. 08.68.330 [LIST OF ACCREDITED AND APPROVED PROGRAMS. The board shall prepare, maintain, and periodically [FROM TIME TO TIME] publish a list of accredited nursing education programs preparing nurses to practice and programs or courses of study which are approved to validate competency or to prepare a nurse for authorization to practice as an advanced nurse practitioner or to obtain a graduate degree [IN THE STATE].

* Sec. 22. AS 08.68.340 is repealed and re-enacted to read:

Clarification

Sec. 08.68.340. VIOLATIONS. (a) It is a class A misdemeanor for a person to:

(1) sell or fraudulently obtain or furnish a nursing diploma, license renewal, or record, or knowingly aid in doing so;

(2) practice nursing under cover of a diploma, license, or

A 14
5,000
B 1000 8 days

record illegally or fraudulently obtained or signed or issued unlawfully, with knowledge of the illegality or unlawfulness of the act;

(3) practice or offer to practice nursing with knowledge that he has not been licensed, except when rendering necessary aid to the ill, injured, or infirm in an emergency, or knowingly to employ as a nurse a person without a license to practice nursing;

(4) knowingly use in connection with his name a designation tending to imply that he is a licensed nurse unless he is licensed;

(5) practice nursing during the time his license is suspended or revoked, knowing of the suspension or revocation;

(6) conduct a nursing education program that represents or implies that it is accredited knowing that the program has not been accredited by the board;

(7) do an act described in AS 08.68.405(10), (11), (14), or (15); or

(8) knowingly do an act described in AS 08.68.405(9).

(b) It is a class B misdemeanor for a person to:

(1) practice nursing under cover of a diploma, license, or record illegally obtained or signed or issued unlawfully;

(2) practice or offer to practice nursing without having been licensed, except when rendering necessary aid to the ill, injured, or infirm in an emergency, or to employ as a nurse a person without a license to practice nursing;

(3) use in connection with his name a designation tending to imply that he is a licensed nurse unless he is licensed;

(4) practice nursing during the time his license is suspended or revoked or with knowledge his license has lapsed;

(5) conduct a nursing education program that represents or implies that is is accredited, unless the program has been accredited

by the board; or

(6) do an act described in AS 08.68.405(4), (6), (7), (8), (12), (17), (18), or (19).

(c) It is a violation for a person to practice nursing during the time his license is lapsed.

* Sec. 23. AS 08.68.400(a) is amended to read:

(a) This chapter does not apply to

(1) a qualified nurse licensed in another state employed by the United States Government or a bureau, or agency, or division of the United States Government while in the discharge of his official duties;

(2) nursing service given temporarily in the event of a public emergency, epidemic, or disaster;

(3) the practice of nursing by a student enrolled in a nursing education program accredited by the board when the practice is in connection with the student's course of study; [OR]

(4) the practice of nursing by an individual [A NURSE] enrolled in an approved program or course of study for purposes of meeting competency re-entry requirements under AS 08.68.251; or [REFRESHER COURSE]

(5) the practice of nursing by a nurse licensed in another state who engages in nursing education or nursing consultation activities when these activities and contact with clients do not exceed 20 working days within a licensing period.

* Sec. 24. AS 08.68 is amended by adding a new section to read:

Sec. 08.68.405. UNPROFESSIONAL CONDUCT. (a) A person who commits one of the following acts is guilty of unprofessional conduct:

Clarification

(1) failing to use appropriate judgment in the practice of nursing based upon the level of nursing for which the individual is

educationally prepared and licensed;

(2) failing to exercise technical competence in carrying out nursing care;

(3) failing to safeguard a client's dignity and right to privacy;

(4) violating the confidentiality of information or knowledge concerning a client;

(5) verbally abusing a client;

(6) physically abusing a client;

(7) performing new nursing techniques or procedures without proper education and preparation;

(8) using alcohol or other drugs to the extent that the use interferes with nursing functions;

(9) making a disposition of prescription drugs or narcotics other than that ordered or prescribed by a person authorized by law to do so;

(10) falsifying a client's records or intentionally making an incorrect entry in a client's chart;

(11) violating state or federal laws regulating drugs, by forging prescriptions or by making drugs available to himself, friends, or family members;

(12) delegating a nursing care function, task, or responsibility to another who is not licensed under AS 08.68 to perform that function, task, or responsibility, and the delegation involves a substantial risk of harm to a client;

(13) assuming duties and responsibilities, on repeated occasions, without adequate training or when competency has not been maintained;

(14) assisting another person to violate or circumvent any

law or regulation intended to regulate nursing practice;

(15) permitting or allowing another person to use his or her nursing license or permit for any purpose;

(16) failing to exercise adequate supervision over persons who are authorized to practice only under the supervision of the licensed professional;

(17) leaving a nursing assignment without properly notifying appropriate personnel;

(18) committing any act that poses a substantial risk of harm to a client;

(19) failing to perform acts within the nurse's scope of competence which are necessary to prevent substantial risk of harm to a client;

(20) failing to report as required by AS 08.68.406.

(b) The board may by regulation provide that other acts contrary to the standards of the nursing profession constitute unprofessional conduct.

Sec. 25. AS 08.68 is amended by adding a new section to read:

Sec. 08.68.406. DUTY TO REPORT ILLEGAL CONDUCT OR CONDUCT DANGEROUS TO CLIENTS. A nurse who witnesses a health care provider engaged in the following conduct shall report that conduct to the appropriate licensing board or to the immediate supervisor of that provider:

(1) any act described in AS 08.68.405(6), (8), (9), (10), (11), (12), (14) (15), (18), or (19);

(2) any act described in AS 08.64.380(3)(B) or (F);

(3) any act posing a danger to a client's welfare.

Sec. 26. AS 08.68.410 is repealed and re-enacted to read:

Sec. 08.68.410. DEFINITIONS. As used in this chapter

(1) "accredited nursing education program" means a program having curricula and standards which meet the requirements established by the board;

(2) "advanced nurse practitioner" means a registered professional nurse authorized to practice in the state who, by virtue of specialized education and experience, has become certified to perform acts of medical diagnosis and the prescription of medical, therapeutic, or corrective measures under regulations adopted by the board;

(3) "board" means the Board of Nursing;

(4) "endorsement" is the licensing of an applicant without examination through the acceptance of a license or registration issued by any state or territory after a comprehensive examination which is substantially equivalent to the examination offered in this state;

(5) "licensed practical nurse" is equivalent to the title "licensed vocational nurse" and to the name suffix abbreviations L.P.N. and L.V.N.;

(6) "licensed professional nurse" is equivalent to the common title "registered nurse" and the name suffix abbreviation R.N.;

(7) "practice of practical nursing" means the performance for compensation or personal profit of selected acts in the prevention of illness, and in the care of the ill, injured, or infirm under the direction of a licensed professional nurse or a licensed physician or a licensed dentist not requiring the substantial specialized skill, judgment, and knowledge required in professional nursing;

(8) "practice of professional nursing" means the performance for compensation or personal profit of acts of professional service requiring substantial specialized knowledge, judgment, and skill based upon the principles of biological, physiological, behavioral, and sociological sciences in assessing and responding to actual or poten-

tial health needs of individuals, families, or communities through such services as:

(A) assessment, problem identification, counseling, and health teaching:

(i) in the maintenance of health or in the prevention of illness of clients; and

(ii) in the care of the ill, injured, or infirm;

(B) administration, supervision, delegation, and evaluation of nursing practice;

(C) teaching of nursing;

(D) execution of a medical regimen as prescribed by a health care provider authorized by the state to perform acts of medical practice;

(E) performance of such additional acts requiring education and training and recognized by the nursing profession as properly performed by registered professional nurses;

(F) performance of acts of medical diagnosis and the prescription of medical therapeutic or corrective measures under regulations adopted by the board;

(9) "professional incompetence" means that a nurse does not possess the skills, knowledge, and awareness of his or her limitations and abilities to continue safely the practice of nursing.

* Sec. [26.] Administrative regulations, adopted jointly by the Board of Nursing and the State Medical Board and in effect on the effective date of this Act, remain in effect until amended or repealed by the Board of Nursing under this Act.

* Sec. [27.] AS 08.68.180(a), 08.68.260, and 08.68.350 are repealed.

TO: Rep. Thelma Buchholdt

FROM: Susan Littell, R.N.,M.S.N.
4906 Knights Way, Anch., 99504 338-0393

I'm writing in regard to the bill before your committee regarding Nurses Practice Act. Although on the whole the bill is very good, I do object to the portion making it acceptable for Nurse Practitioners to make "medical diagnosis". The bill has merits, but I feel the part regarding medical diagnosis should be reworked or omitted.

********** ********** **********

ALASKA STATE MEDICAL ASSOCIATION

[illegible] • (907) 277-6891
4107 Laurel St. #1, Anchorage, AK 99504

30 April 1980

Rep. Thelma Buchholdt
House HESS Committee
Pouch V
Juneau, Alaska 99811

RE: House Bill 910

Dear Rep. Buchholdt:

The Alaska State Medical Association respectfully offers the following ammendments in an effort to assure the continued existence of a consultive relationship between a nurse and a physician which utilizes their respective areas of expertise to meet to common goal of providing comprehensive care for the patient.

1. Page 2, lines 11-12, delete: [, including regulations pertaining to practice as an advanced nurse practitioner]

2. Page 16, line 8, delete: [under regulations adopted by the board;]
   add: authorized by regulations promulgated by the State Medical Board and the Board of Nursing and as implemented by the Board of Nursing;

3. Page 17, lines 18-19, delete: [under regulations adopted by the board;]
   add: as authorized under (2) of this section;

4. Page 17, section 27, delete: [lines 23-26]

JAY S. HAMMOND
GOVERNOR

STATE OF ALASKA
OFFICE OF THE GOVERNOR
JUNEAU

March 10, 1980

The Honorable Thelma Buchholdt
Chairman, House Health, Education
& Social Services Committee
Alaska State Legislature
Pouch V
Juneau, Alaska 99811

Re: Attached amendment to
HB 910 (nursing bill)

Thelma

Dear Representative Buchholdt:

An amendment to HB 910 (nursing) is attached. It would clarify the status of incumbent members of the Board of Nursing when the provisions of the new law changing requirements for board members take effect. The bill as written would leave the status of incumbent members in doubt; some amendment is therefore necessary.

The Board of Nursing wishes to allow incumbent board members to serve out the remainders of their terms of office under AS 08.68.020 -- 08.68.030. The amendment so provides; it also provides that any new appointment would then be made on the basis of the amended version of AS 08.68.010.

Sincerely,

Keith

Keith W. Specking
Legislative Assistant
to the Governor

A M E N D M E N T

OFFERED IN THE HOUSE BY_____

TO: HOUSE BILL NO. 910

Page 17, between lines 26 - 27, add the following:

* Sec. 27. An incumbent member of the Board of Nursing may continue to serve until the period of his or her appointment under AS 08.68.020 -- 08.68.030 expires, notwithstanding AS 08.68.010 as amended in sec. 1 of this Act. New appointments to the Board of Nursing shall be made in accordance with the provisions of AS 08.68.010, as amended.

Page 17, line 27:

Delete "* Sec. 27." and insert "* Sec. 28." in its place.

Box 1216
Kodiak, Alaska 99615
April 11, 1980

Ms. Thelma Buchholdt, Representative
Chairman, House HE&SS Committee
Pouch V -
Juneau, Alaska 99811

Dear Representative Buchholdt:

House Bill 919 an act related to the practice of nursing, ie the Nurse Practice Act, was introduced February 27, 1980 and referred to the House HE+SS Committee. As a licensed professional nurse in the state, I am very interested in seeing this legislation passed this session. As introduced, the bill is in a very acceptable form and sections I would like to see stay intact, with no alteration in content, are especially the following:

Sec. 08.68.251. reinstatement of license after lapse
Sec 08.68.270 - grounds for denial, suspension or revocation of license
Sec. 08.68.276 Continued Competence
Sec 08.68.340 Violations
Sec 08.68.405 - Unprofessional conduct
Sec 08.68.410(8) - Definition of nursing.

Your support in initiating movement on this bill would be greatly appreciated.

Sincerely -

Beth Ennis, R.N.

Box 1216
Kodiak, Alaska 99615
April 11, 1980

Fred Zharoff, Representative
Pouch V
Juneau, Alaska 99811

Dear Representative Zharoff:

H.B. 910, an act related to the practice of nursing, ie the Nurse Practice Act, was introduced february 27, 1980 and is presently sitting in the House HESS committee with no reported action to date.

As presented, the bill is in very acceptable form and the following are sections with which I am particularly pleased, and which I would like to see remain intact with no change in intent:

Sec. 08.68.251 - reinstatement of license after a lapse. this addresses competence and controlled, reasonable fees.

Section 08.68.270 - grounds for denial, suspension or revocation of license. makes this very specific

Section 08.68.276. Continued Competence. Does not make continuing education mandatory, and leaves any future regulations in the hands of Nursing thru the Board of Nursing.

Sec. 08.68.340 violations and

Sec 08.68.405 - unprofessional conduct.

these two, together, are excellent, as they

Specify acts in question and the specific class of misdemeanor as a result of infraction. Although I am uneasy as to the potential interpretation of some of the acts listed, ie "verbally abusing client" I have faith, which I hope will be justified, that the Board of Nursing investigator will be reasonable in deciding on any such cases.

Sec. 08.68.410(8) - Definition of nursing. Bring this into the modern world and in line with education and practice.

HB 910 will be referred to HESS and finance committees and your support in getting action moving on this and/or finding out if there are factors not favorable to a move at this time, would be greatly appreciated. I would like to see this passed this session.

Sincerely -

Beth Ennis, R.N.

FACT SHEET FOR NURSE PRACTICE ACT
HB 910

The Nurse Practice Act revisions address the Sunset Review Recommendations.

1. Legislation should be introduced requiring continuing education for nurses as a provision for license renewal. This is addressed by Section 08.68.276 in the continuing competence requirements.

2. A statutory amendment is needed to ensure that all regulated nurses are adequately represented on the Board of Nursing. This is addressed by Section 08.68.010 which adds an LPN and ANP to the membership of the Board of Nursing.

3. The Board of Nursing should discontinue its policy of requiring foreign nurse graduates to have one year of work experience before a temporary permit can be issued. Section 08.68.210(b) speakes to this issue as it allows for substitution of successful completion of the exam administered by the committee on Graduates of Foreign Nursing Schools. This area also more clearly states requirements for licensure of graduates of Canadian programs.

4. The Board of Nursing, in conjunction with the Attorney General, should compose formal regulations which define and list examples of license violations. Section 08.68.340 outlines violations which are classified according to the Alaska criminal code. Section 08.68.405 more clearly defines acts which are contrary to the accepted standards of the nursing profession and constitute unprofessional conduct.

5. The fifth recommendation refers to the Board refining their goals and objectives and submitting a performance report. This recommendation is addressed under Section 08.68.100 a (7) which defines the reporting procedures of the Board of Nursing.

6. The Division of Occupational Licensing should comply with the Board of Nursing resolution requiring the Executive Officer to review and approve all applications for license by endorsement. This is defined as above by Section 08.68.111 c (3). This section delineates the job description for the Executive Secretary. The duties are explained more succintly and are more comprehendable to the public.

Additional highlights of the bill which are of importance to nurses and consumers follow.

7. The powers and duties of the Board of Nursing are further elaborated upon in Section 08.68.100 including a (1) adopt regulations necessary to make this chapter effective, including regulations pertaining to practice as an advanced nurse practitioner; and a (6) prescribe requirements to validate competency to continue or re-enter practice. This section also gives the Board authority to conduct inquiry into revoking licnsure in accordance with the Administrative Procedures Act.

8. The inactive status of nurses was dropped because of the inability to maintain competency of that group.

9. Section 08.68.400 a (5) covers the practice of a nurse licensed in another state engaged in nursing education and consultation in Alaska for a period not to exceed 20 working days.

10. Section 08.68.406 makes it mandatory for nurses to report illegal conduct or conduct dangerous to clients regardless of the providers health care profession.

prepared by the Alaska Nurses Association, Legislative Committee, 3/80

BOARD OF NURSING

HB 910

"AN ACT RELATING TO THE PRACTICE OF NURSING"

SECTION	SUBJECT	RATIONALE
08.68.010 (p. 1-line 9)	Board membership	More effectively represents the profession to be regulated by providing for a LPN & ANP on the board.
08.68.060 (p. 1-line 22)	Qualifications of RN & LPN Board members	Insures that members have recent experience in nursing; and the educational background to evaluate nursing programs.
08.68.080 (p.2-line 5)	Meetings	Assures the Board may meet often enough to accomplish its goals and complete the large volume of work for which it is responsible.
08.68.100 (p.2-line 11)	Board Duties adopt ANP regs	See Sunset Review comments "In September of 1978, after commendable efforts by the Board of Nursing and little cooperation from the State Medical Board, proposed regulations were approved by the Boards for public hearings which will allow registered nurses to perform an expanded role in the delivery of health care." "The Board was impeded in their efforts to compose and approve advanced nurse practitioner regulations by the State Medical Board which was jointly responsible for the promulgation of the regulations." The present ANP regulations jointly promulagted with the medical board, were the original regulations proposed by the Board of Nursing, with very little modification. The joint promulgation is not only a slow process but is also costly for the State.
(p.3-line 6)	Prescribe requirements to validate competency to continue or re-enter practice	Sunset review recommendation was to establish c.e. requirements. The Board feels this is a complex issue and deserves study of other alternatives such as work experience and testing. The impact of any requirement of this nature on the Alaska health care system must be carefully studied. However, in its mission to protect the public, the Board must be granted this power.

SECTION	SUBJECT	RATIONALE
08.68.111	Executive Secretary	The performance of this staff person is so vital to the Board's functioning, the Board feels these duties must be clearly defined.
08.68.210 (b) (p.7-line 15)	Foreign Nurses	Board has found it impossible to evaluate the programs of foreign nurses. CGFNS examination helps to assure the Board that the applicant has the minimal knowledge necessary for safe practice with a temporary permit until passing the SBTPE exam. See also Sunset Recommendation #3.
08.68.220 (p.7-line 1(A)	Fees	The Board has felt it necessary to increase fees to reflect costs. Fees had not been changed for many years.
08.68.251	Lapsed licenses	The board wishes to change the period of time it will allow a license to lapse from five years to three years. Nursing is changing so rapidly that it is necessary to carefully consider an applicants ability to give safe nursing care when they have been inactive for three years.
08.68.261	Inactive Status	Inactive status serves no useful purpose for the applicant, and is costly for the state. In many cases, the Board has found this to be misleading to applicants who believe they may easily activate an inactive license. This is not true - the Board does consider inactive license activation in the same light as a lapsed license.
08.68.270 (p.9-line 4+)	More clearly defines examples of license violations	See Sunset Review recommendation #4 - "The Board of Nursing, in conjuction with the Attorney General, should compose formal regulations which define and list examples of license violations." The Board will find this most helpful in substantiating its decisions on violations.
08.68.276 (p.10-line 7+)	Continuing competency requirements	(see previous remarks concerning 08.68.100 -- p.3-line 6).
	Accreditation of educational programs	The Board already is empowered to accredit programs within our state. This more clearly defines the types of programs to be accredited.

SECTION	SUBJECT	RATIONALE
08.68.340 (p.11-line 25)	Violations	This realigns current violations to comply with the new criminal code.
p. 13-line 17 (4)	Exemptions - nursing educators	Allows nurses to teach/consult within the state for a short period of time without obtaining an Alaska license. These individuals must be licensed in another State. The board wishes to encourage nurses to come to Alaska to share their expertise, without having to go through a formal licensing procedure.
08.68.405 (p. 13-line 26)	Unprofessional conduct	(see previous remarks concerning rationale for 08.68.270 (p.9-line 4+)
08.68.406	Reporting illegal conduct	(see previous remarks concerning rationale for 08.68.270 (p.9-line 4+) The nurse is the patients advocate.
(p.16-line 25)	Definition practice of professional nursing	An updating of what this practice entails.
(p.17-line 23)	Repeal of regualtions	The Board feels this is misleading - it has no present intent to repeal the regulations jointly promulagated with the Board of Medicine.
(p.17-line 26/27)	Board membership	This allows for an orderly reconstitution of the Board membership as specified in A.S. 08.68.010 as amended.

'80 APR 23 PM 7 49

TELEGRAM

ALASCOM, INC.
PHONE: 586-6442
JUNEAU, AK 99802

'2256 NL TDA FAIRBANKS ALASKA 50 04-22 745P AST

PMS REP THELMA BUCHHOLDT

JUNEAU AK

URGE DO PASS ON HB910. NEW CONCEPT IN THE BILL SUCH AS SECTION 08. 68. 410 (8)S. WILL AID IN THE DEVELOPMENT OF A GROWING AND IMPROVING PRACTICE ADJUNCTIVE TO THAT OF PHYSICIANS. REGULATIONS PROMULGATED BY THE BOARD OF NURSING WILL BE TIMELY AND PROTECTIVE OF THE PUBLIC INTEREST.

RUTH BENSON, RN

"endorsement" of out-of-state licenses

LA61 1971 11.24 JA01 0031 11.24 04/16/80

TO: REPRESENTATIVE FRED ZHAROFF

I URGE YOUR SUPPORT OF HB 910 THE NURSE PRACTICE ACT. THIS IS A VITAL BILL T' NURSING.

BETTY HALL, RN
P.O. BOX 614
KODIAK, ALASKA 99615

TELEGRAM

ADDRESS NO.
PHONE 586-6415
JUNEAU, AK 99802

1980 APR 23 AM 11 50

02042 POM ANCHORAGE ALASKA 15 04-23 950A AST

PMS REP THELMA BUCHHOLDT CHAIRMAN

JUNEAU AK

I OPPOSE HB910 NO REPRESENTATION OF 2 AND 3

YEAR NURSES ON BOARD

CAROL BEARDSLEY

1412 ANNAPOLIS DR ANCHORAGE 99504

STATE OF ALASKA

JAY S. HAMMOND, GOVERNOR

DEPARTMENT OF COMMERCE & ECONOMIC DEVELOPMENT

OFFICE OF THE COMMISSIONER

POUCH D
JUNEAU, ALASKA 99811
Phone: 465-2500

April 17, 1980

Honorable Thelma Buchholdt
Chairman, House Health, Education
& Social Services Committee
House of Representatives
Pouch V
Juneau, Alaska 99811

Dear Ms. Buchholdt:

RE: Department of Commerce & Economic Development Synopsis of HB 910

At the request of your committee, the following is a departmental synopsis of HB 910, "An Act relating to the practice of nursing."

Section 1. Changes composition of board of nursing by adding an L.P.N. member and an advanced nurse practitioner. Also, more clearly states minimum necessary qualifications of other board members. These changes are felt necessary to assume board representation for all regulated nurses.

Section 2. More clearly delineates minimum qualifications of the licensed nurses on the board.

Section 3. Housekeeping measure changing "chairman" to "chairperson."

Section 4. Mandates that the board shall meet at least four times a year.

Section 5. More clearly defines the powers and duties of the board. Also, gives the board the authority to define by regulation the duties of its Executive Secretary to make it a more effective position.

Section 6. Changes the title of the executive officer to executive secretary which better establishes this person's relationship to the board. Gives the board the authority to estab-

lish minimum qualifications of the executive secretary by regulation rather than be limited by statute.

Sections 7-10. All housekeeping measures.

Section 11. Better defines temporary permit procedures and the validity of temporary permits.

Section 12. Establishes fees to be collected by the board and a biennial renewal.

Section 13. Changes the criteria for reinstatement of a lapsed license. Makes it more difficult for a nurse who has not been practicing to resume practicing. Must prove competency to reinstate license. This section is felt necessary as a result of section 27 of this bill which repeals the inactive status of nursing licenses.

Section 14. Correction needed: On line 29, the statute referred to should read AS 08.68.260.

Section 15. Housekeeping measure to better define violations and get rid of ambiguous terminology. More in accordance with the new criminal code.

Section 16. Authorizes the board to establish continuing competency for nurses through regulation.

Section 17. Establishes accredited programs for the state. Suggest a wording change on line 17 and 18 to read: "All nursing education programs within the state must be established in an accredited past secondary educational institution [WITHIN THE STATE]."

Section 18. Outlines which programs must apply for board accreditation and establishes the procedures to be followed.

Section 19. Housekeeping measure which would designate a board survey team and allow for better use of board time.

Sections 20-21. Housekeeping measures pertaining to the accredited programs.

Section 22. Outlines violations and provides punishment for violations in accordance with new criminal code.

Section 23. Sets out exemptions from the act; most important being (5) which pertains to nurses licensed in another state.

Section 24. Establishes all possible acts which constitute unprofessional conduct.

Section 25. We question making this a mandatory provision.

Section 26. Definitions. We feel that (2) and (8)(F) should be amended to include language which would provide for regulations to be adopted jointly by the Board of Nursing and the State Medical Board.

Section 27. Should be deleted.

Section 28. Standard houskeeping repeals.

Sincerely,

Charles R. Webber
Commissioner

BY: Ann Griggs, Director
Division of Occupational Licensing

AG/cwA16

S.R. 10033
Fairbanks, Alaska 99701
April 14, 1980

Thelma Buchholdt
Chairman, House Hess Committee
Pouch V
Juneau, Alaska

Dear Ms. Buchholdt,

I understand that objections have been raised by the medical profession relating to the following sections of HB910: Section 5 08.68.100 Duties and Powers of the Board (a) The board shall

(1) adopt regulations necessary to make this chapter effective, including regulations pertaining to practice as an advanced nurse practitioner.

Section 26 AS 08.68.410

(2) "advanced nurse practitioner" means a registered professional nurse authorized to practice in the state who, by virtue of specialized education and experience.....under regulations adopted by the board;

(8) "practice of professional nursing" means .....(F) performance of acts of medical diagnosis and the prescription of medical therapeutic or corrective measures under regulations adopted by the board;

All of these sections listed above refer to advanced nurse practitioner regulations. The former nurse practice act, which HB910 seeks to amend, states that regulations for advanced nurse practitioners must be "promulgated jointly by the State Medical Board and the Board of Nursing".

The rationale of the Board of Nursing in modifying these sections related to the length of time and difficulty in promulgating the regulations jointly. (See "A performance Review of the Board of Nursing" - October 6, 1978 - Division of Legislative Audit -pp. 5-6, 13).

The chairman of the medical board has contacted me about his objections to deletion of the section on joint promulgation. He has objected also to Section 26 "Administrative regulations, adopted jointly by the Board of Nursing and the State Medical Board....remain in effect until amended or repealed by the Board of Nursing under this Act."

The Board of Nursing has no intent to repeal these regulations. We have a good working relationship with the Medical Board and have no desire to jeopordize that relationship.

Therefore, we are in agreement, that the act may be revised to specify "joint promulgation." Therefore, the following sections may be revised to read as follows:

Section 5. AS08.68.100 -

"(1) adopt regulations necessary to make this chapter effective. This includes regulations pertaining to practice as an advanced nurse practitioner which shall be jointly promulgated with the State Medical Board."

Section 26. AS08.68.410 -

(2) "....under regulations jointly promulgated by the Board of Nursing and the State Medical Board."

(8) " practice of professional nursing means .....(F) performance of acts of medical diagnosis and the prescription of medical therapeutic or corrective measures under regulations adopted by the Board of Nursing and the State Medical Board."

Section 26

"Administrative regulations, adopted jointly by the Board of Nursing and the State Medical Board and in effect on the effective date of this Act, remain in effect until amended or repealed by the Board of Nursing under this Act." Delete.

Thank you for your consideration of this matter.

Sincerely,

Eileen Montano, Chairman
Alaska Board of Nursing

EM:mc

MEDICAL CONSULTING SERVICES

VIRGINIA M. COLLINS, R.N.

3201 "C" STREET, SUITE 240
ANCHORAGE, ALASKA 99503
(907) 276-7943

April 28, 1980

The Honorable Thelma Buchholdt
Chairwoman, Health, Education, and
Social Services Committee
House of Representatives
Pouch B
Juneau, Alaska 99811

RE: House Bill 910

Dear Ms. Buchholdt:

I would like to take this opportunity to thank you for your assistance in obtaining information regarding this bill during my brief stop in Juneau on April 18. I would like to restate my opposition to sections of that bill as follows.

Section 2.61.68.060

Lines 26 to 28 (Page One) currently read: "At least two of the members who are professional nurses must hold a bachelor's degree or higher." Recommendation: I would like to see these lines deleted and substituted with the following - "At least two of the members must be diploma and associate degree registered nurses." Justification for Change: There is no foundation that a professional nurse holding a bachelor's degree is any more qualified as a nurse than one prepared at the three or the two year level. As a matter of fact, a recent study, which I am enclosing for you, published in "RN" magazine in 1980 clearly brings to light the real matter of the problems with baccalaureate programs. This study is sufficient to discredit the idea that the baccalaureate program is inherently better than others in preparing nurses.

Section 6AS 08.68.111

Part B states that "the executive secretary must be a nurse with a bachelor's degree or higher in nursing, must be currently licensed by the state, and must meet other qualifications as established by board regulations." Justification for Change: There is no criteria that indicates that a bachelor's degree registered nurse is any more qualified for the position of executive secretary.

I would appreciate your consideration in changing these two sections so that they refer to registered nurses who have met the state's requirement for licensure. This would cover BSN nurses, nurses who have degrees in health science fields, the ADN, and diploma nurses. In this manner, all segments of the nursing population should be represented.

Thank you again for your help. It has been greatly appreciated.

Very truly yours,

Virginia M. Collins, R.N.
Director

VMC:ah

Enclosure

JAY S. HAMMOND
GOVERNOR

STATE OF ALASKA
OFFICE OF THE GOVERNOR
JUNEAU

March 10, 1980

The Honorable Thelma Buchholdt
Chairman, House Health, Education
& Social Services Committee
Alaska State Legislature
Pouch V
Juneau, Alaska 99811

Re: Attached amendment to
HB 910 (nursing bill)

Thelma

Dear Representative Buchholdt:

An amendment to HB 910 (nursing) is attached. It would clarify the status of incumbent members of the Board of Nursing when the provisions of the new law changing requirements for board members take effect. The bill as written would leave the status of incumbent members in doubt; some amendment is therefore necessary.

The Board of Nursing wishes to allow incumbent board members to serve out the remainders of their terms of office under AS 08.68.020 -- 08.68.030. The amendment so provides; it also provides that any new appointment would then be made on the basis of the amended version of AS 08.68.010.

Sincerely,

Keith

Keith W. Specking
Legislative Assistant
to the Governor

A M E N D M E N T

OFFERED IN THE HOUSE BY _____

TO: HOUSE BILL NO. 910

Page 17, between lines 26 - 27, add the following:

* Sec. 27. An incumbent member of the Board of Nursing may continue to serve until the period of his or her appointment under AS 08.68.020 -- 08.68.030 expires, notwithstanding AS 08.68.010 as amended in sec. 1 of this Act. New appointments to the Board of Nursing shall be made in accordance with the provisions of AS 08.68.010, as amended.

Page 17, line 27:

Delete "* Sec. 27." and insert "* Sec. 28." in its place.

March 4, 1980

To: House HESS Committee
House Finance Committee
Senate Health & Social Services Committee

From: Concerned nurses in Anchorage.

A Position Paper relating to H.B. 910 "An Act relating to the practice of nursing."

We, the undersigned, have reviewed H.B. 910. We do not support certain specific changes. The balance of the bill is reasonable, as much of it relates to existing law and is relatively unchanged.

We would appreciate your consideration of the following suggested changes:

Section 2. 08.68.060 - lines 26 - 28 (page 1) currently reads - At least two of the members who are professional nurses must hold a bachelor's degree or higher.

We would like to see these lines deleted:

Reason: By allowing those three lines or that sentence to stand as is, the law would prevent all of the registered nurses who graduated from three year diploma programs from having a representative on the board. The vast majority of registered or professional nurses, the terms used interchangeably, in Alaska -- and other states -- are three and two year registered nurses, not BS degree nurses.

It is also common knowledge around the United States that a small minority of BS registered nurses are trying to dominate the profession. In New Jersey recently, for example, the legislature soundly defeated a proposal which would have required all registered nurses to have Bachelor's degrees -- which was being pushed by a few BS nurses and University nursing programs.

There is absolutely no foundation that a Professional Nurse with a Bachelor's degree or higher can give better patient care or render decisions relating to patient care in a non-supervisory capacity. Quite the contrary, many physicians and hospitals have found that those registered nurses who have come from diploma programs are far better prepared to work with patients than those coming from Bachelor Degree programs. This is because the diploma nurses spend far more time training right on patient floors with patients--whereas the Bachelor's degree RN spends more time in the classroom setting. This is a sore point with many Bachelor's RNs and also why they are trying to change their programs. It is also why many in the health care community put them as head nurses rather than floor nurses -- as their training better prepares them for the administrative role rather than the patient care role. There are exceptions, of course, of Bachelor's RNs who do have good clinical training, but that is not the point.

The vast majority of RNs around the United States are diploma RNs. They are good nurses and deserve to be represented on all state boards of nursing. We seriously object to being left off, as we would be under this section.

We have no objection to your substituting the following: At least two of the members must include diploma and associate's degree registered nurses. The Bachelor's degree nurses are already represented in two other categories.

Section 6 AS 08.68.111 (part b)

(b) states that the executive secretary must be a nurse having a bachelor's degree or higher in nursing, must be currently licensed by the state and must meet other qualifications as established by board regulations.

1. We have no objections to the part about being licensed by the state, providing licensed means and includes all diploma RNs.

2. There is no reason to believe that a Bachelor's Degree RN could handle the job of executive secretary any better than a Diploma RN.

3. It should not be left up to the board to decide other qualifications when the majority of RNs (diploma nurses) are not represented on the board.

As is described in the opening Section (1) Creation and Membership of Board of Nursing -- it is almost impossible for a diploma RN - who are in the majority in every state in the United States including Alaska, to be appointed to the Board. Only two professional nurses can be chosen who are directly or indirectly responsible to nursing services. Then, in the next section as I described before, those two must have Bachelor's degrees. Therefore, we are left out. Nurse practitioners and professional nurses in education both have to have Bachelor's degrees, and the practical nurse is a totally different level of patient care.

Therefore, we would appreciate your consideration in changing these two sections so that they refer to registered nurses who have either diploma, ADN, or bachelor's degrees.

There are hundreds of RNs currently working in Alaska and other states who have diploma degrees. We give good patient care to you and your families. We take offense to a few Bachelor's degree RNs trying to impose their power grabbing tactics on us. There are nursing supervisors, probably some director's of nursing, and head nurses who come from diploma programs. It is a disservice to them and the many staff diploma RNS to not be represented.

Thank you for your consideration. Replies can be sent to: Carol Beardsley, RN
Head Nurse
Anchorage Fracture &
Orthopedic Clinic
3546 Latouche
Anchorage, Alaska 99504

Signed: [illegible], RN ADN
[illegible], RN
[illegible] RN ADN
[illegible] RN ADN
[illegible] RN
[illegible] RN
Pat Kaner, RN
[illegible]
[illegible] RN
[illegible] ADN

Ketchikan Medical Clinic, Inc.

3612 TONGASS
KETCHIKAN, ALASKA 99901

H.J. Henrickson, M.D.
D.E. Johnson, M.D.
T.L. Conley, M.D.

Phone 225-5144
Phone 225-5145

March 14, 1980

Honorable Terry Gardiner
Pouch "V"
Juneau, Alaska 99811

Subject: House Bill No. 910 - Practice of Nursing

Dear Representative Gardiner:

The above bill, in sections 5 and 26, contain provisions that may have significant import with respect to the practice of medicine within the state of Alaska.

For whatever it's worth, it is interesting that in our recent meeting in February, in Juneau, we had a joint meeting for a brief period of time with the nursing board, during which time House Bill 910 was not brought to our attention.

I think it is abundantly clear that the legislature, over the years, has felt that the State Medical Board is the best means of regulating the practice of medicine for the citizens of Alaska. The state board of nursing has had regulatory authority over nursing and now wishes to have regulatory authority over a variety of mid-level practitioners of medicine. As a board member and a practicing physician, I feel very strongly that whenever the practice of medicine arises it should be dealt with by those who have been trained in the traditional practice of medicine. I would like to see sections 5 and 26 deleted or replaced with language that retains the current Board of Medicine, Board of Nursing relationship; that, in fact, retains the concept that the state medical board will indeed be ultimately responsible, under the legislature, for the regulation of the practice of medicine in the state of Alaska.

To permit sections 5 and 26 to stay in House Bill No. 910 will mean that advanced nurse practitioners, mid-wives and whatever other level of practitioners arise in the future to be working independent of any medical guidance except as that which is decreed by the nursing board. What we shall see, under those circumstances, is the development of parallel practices of medicine, some of which will be by physicians, some of which will be by mid-level practitioners. A problem arises in the inability

of the public to select out what levels of training each of these imply. I feel this is a distinct potential hazard to the patient and would opt for mid-level practice of medicine, or any level practice of medicine be under the final responsiblity of the physician. Our current PA and ANP regulations seem to protect the public from this possibility and still permit the mid-level practitioner the opportunity to provide a service for the people of Alaska.

Sincerely,

Hilbert J. Henrickson, M.D.

HJH/bjr

cc: Robert Ziegler, Sr.

Glenn Hackney

Oral Freeman

March 4, 1980

To: House HESS Committee
House Finance Committee
Senate Health & Social Services Committee

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Thank you for your consideration. Replies can be sent to: Carol Beardsley, RN
Head Nurse
Anchorage Fracture &
Orthopedic Clinic
3546 Latouche
Anchorage, Alaska 99504

Signed: Mary Beardsley, RN ADN
Joann T. Schaaf, RN
Judy Dapolo RN, ADN
Connie Hartzheis, RN ASN
[illegible]
James Hastings RN.
[illegible] RN
Pat Kamen, RN.
Sandra Chance RN
Jo Reed RN
[illegible] ADN

S.R. 10033
Fairbanks, Alaska 99701
April 14, 1980

PH 452-8181 Ext 253,254

Home: 479-4418

Thelma Buchholdt
Chairman, House Hess Committee
Pouch V
Juneau, Alaska

Dear Ms. Buchholdt,

I understand that objections have been raised by the medical profession relating to the following sections of HB910: Section 5 08.68.100 Duties and Powers of the Board (a) The board shall

(1) adopt regulations necessary to make this chapter effective, including regulations pertaining to practice as an advanced nurse practitioner.

Section 26 AS 08.68.410

(2) "advanced nurse practitioner" means a registered professional nurse authorized to practice in the state who, by virtue of specialized education and experience.....under regulations adopted by the board;

(8) "practice of professional nursing" means .....(F) performance of acts of medical diagnosis and the prescription of medical therapeutic or corrective measures under regulations adopted by the board;

All of these sections listed above refer to advanced nurse practitioner regulations. The former nurse practice act, which HB910 seeks to amend, states that regulations for advanced nurse practitioners must be "promulgated jointly by the State Medical Board and the Board of Nursing".

The rationale of the Board of Nursing in modifying these sections related to the length of time and difficulty in promulgating the regulations jointly. (See "A performance Review of the Board of Nursing" - October 6, 1978 - Division of Legislative Audit -pp. 5-6, 13).

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The Board of Nursing has no intent to repeal these regulations. We have a good working relationship with the Medical Board and have no desire to jeopardize that relationship.

Therefore, we are in agreement, that the act may be revised to specify "joint promulgation." Therefore, the following sections may be revised to read as follows:

Section 5. AS08.68.100 -

"(1) adopt regulations necessary to make this chapter effective. This includes regulations pertaining to practice as an advanced nurse practitioner which shall be jointly promulgated with the State Medical Board."

Section 26. AS08.68.410 -

(2) "....under regulations jointly promulgated by the Board of Nursing and the State Medical Board."

(8) " practice of professional nursing means .....(F) performance of acts of medical diagnosis and the prescription of medical therapeutic or corrective measures under regulations adopted by the Board of Nursing and the State Medical Board."

Section 26

"Administrative regulations, adopted jointly by the Board of Nursing and the State Medical Board and in effect on the effective date of this Act, remain in effect until amended or repealed by the Board of Nursing under this Act." Delete.

Thank you for your consideration of this matter.

Sincerely,

Eileen Montano, Chairman
Alaska Board of Nursing

EM:mc

FBX/LIO/MW
4/14/80 via E400

JAY S. HAMMOND
GOVERNOR

STATE OF ALASKA
OFFICE OF THE GOVERNOR
JUNEAU

HB 910

February 27, 1980

The Honorable Terry Gardiner
Speaker of the House
Alaska State Legislature
Pouch V
Juneau, Alaska 99811

Dear Mr. Speaker:

Under the authority of art. III, sec. 18, of the Alaska Constitution, I am transmitting a bill relating to qualifications for nursing practice in the state, and to the powers and duties of the Board of Nursing.

The bill revises and clarifies the statutes setting out the powers and duties of the board and its executive secretary. It also revises qualifications required for service on the board.

In addition, the bill clarifies the requirements and procedures to be followed by applicants for licensing to engage in nursing practice, defines "unprofessional conduct," adds a requirement of "continuing competence," and brings criminal penalty provisions into conformity with the new criminal code.

Further, the bill makes two changes of a more substantive nature: (1) it eliminates inactive status for nurses, on the rationale that maintaining competency is more important in the provision of health care than any right to that status; and (2) it creates a duty to report conduct or omissions by another health care provider which can result in serious harm to a patient.

Sincerely,

Jay S. Hammond
Governor

By: Terry Miller
Lieutenant Governor

FISCAL NOTE

I. REQUEST
Bill/Resolution No. HOUSE BILL NO. 910
Title An Act Relating to the Practice of Nursing
Requested by Governor Date 2/21/80

II. FISCAL DETAIL
Agency Affected Department of Commerce & Economic Development
Program Category Affected Public Protection
BRU, Program, or Subprogram(s) Affected Division of Occ. Licensing, Board of Nursing
(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 80	FY 81	FY 82	FY 83	FY 84	FY 85
100 PERSONAL SERVICES	-0-	-0-	-0-	-0-	-0-	-0-
200 TRAVEL		12.9	13.8	14.8	15.8	16.9
300 CONTRACTUAL		5.0	-0-	-0-	-0-	-0-
400 COMMODITIES		-0-	-0-	-0-	-0-	-0-
500 EQUIPMENT		-0-	-0-	-0-	-0-	-0-
600 LAND & STRUCTURES		-0-	-0-	-0-	-0-	-0-
700 GRANTS, CLAIMS, ETC.		-0-	-0-	-0-	-0-	-0-
TOTAL		17.9	13.8	14.8	15.8	16.9

FUNDING (Thousands of Dollars)

GENERAL FUND		17.9	13.8	14.8	15.8	16.9
FEDERAL FUNDS						
OTHER (Specify Fund Source)						

POSITIONS

FULL TIME						
PART TIME						
TEMPORARY						

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

Please see attached.

IV. DATE February 21, 1980 PREPARED BY Ann Griggs, Director
AGENCY Division of Occupational Licensing
PHONE 465-2534

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)

33-001 (Rev. 12/79)

200. Travel costs for FY 81 broken down as follows:

2 meetings in Anchorage 7 board members (trans. + per diem) Executive secretary (no travel costs assoc. w/ Anch. mtg.) Staff (trans. + per diem)	=	$5.2
1 meeting in Fairbanks 7 board members (trans. + per diem) Executive secretary (trans. + per diem) Staff (trans. + per diem)	=	$3.4
1 meeting in Juneau 7 board members (trans. + per diem) Executive secretary (trans. + per diem) Staff (no travel costs assoc. w/ Juneau meeting)	=	$3.3
2 trips to Fairbanks	=	$ .6
1 trip to Juneau Executive secretary (trans. + per diem) to discuss w/ public and nursing community the new act	=	$ .4
TOTAL	=	$12.9

Travel for succeeding years is based on FY 81 costs plus 7% inflation factor.

300. FY 81 contractural cost of 5.0 covers one time printing costs associated with the printing of new statutes for distribution

'80 APR 23 PM 7 49

TELEGRAM

ALASCOM, INC.
PHONE: 586-6442
JUNEAU, AK 99802

Ø2256 NL TDA FAIRBANKS ALASKA 50 04-22 745P AST

PMS REP THELMA BUCHHOLDT

JUNEAU AK

URGE DO PASS ON HB910. NEW CONCEPT IN THE BILL SUCH AS SECTION Ø8. 68. 410 (8)S. WILL AID IN THE DEVELOPMENT OF A GROWING AND IMPROVING PRACTICE ADJUNCTIVE TO THAT OF PHYSICIANS. REGULATIONS PROMULGATED BY THE BOARD OF NURSING WILL BE TIMELY AND PROTECTIVE OF THE PUBLIC INTEREST.

RUTH BENSON, RN

"endorsement of out-of-state licenses"

TELEGRAM

ALASCOM, INC.
PHONE: 586-6442
JUNEAU, AK 99802

1980 APR 28 AM 11 5

02042 POM ANCHORAGE ALASKA 15 04-28 950A AST

PMS REP THELMA BUCHHOLDT CHAIRMAN

JUNEAU AK

I OPPOSE HB910 NO REPRESENTATION OF 2 AND 3

YEAR NURSES ON BOARD

CAROL BEARDSLEY

1412 ANNAPOLIS DR ANCHORAGE 99504

SR Box 30218 - Farmers Loop Rd
Fairbanks, Alaska 99701
19 March 1980

Hon. Thelma Buchholdt, Chair
House HESS Committee
Pouch V
Juneau, Alaska 99811

re: HB 910

Dear Rep. Buchholdt,

I've been reading the proposed amendments to the Nurse Practice Act and am distressed that the bill in this form was introduced - There are substantial changes which I strongly feel are not improvements and some reversions to former terminology for which I can think of no rationale. The proscriptions against "unprofessional" conduct are detailed but the standards by which such conduct is judged are not defined nor credited (American Nurses Association published Standards for Nursing Practice ?) I hope this bill will remain in your committee until nurses in Alaska have had opportunity to study and understand the proposed changes it contains. Thank you.

Ruth Benson R.N.

HB
922

DRAFT

HOUSE BILL NO. 922

IN THE LEGISLATURE OF THE STATE OF ALASKA

ELEVENTH LEGISLATURE - SECOND SESSION

A BILL

For an Act entitled: "An Act relating to state payment for child care costs for foster homes."

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

* Section 1. AS 47.40.040(a) is amended to read:

(a) In this chapter, "full cost" of services shall be determined by the per person, per day cost in the preceding fiscal year plus a propriationate share of anticipated cost of living and staff salary increment increases for the fiscal year for which the full cost of services, determined to be necessary by the department, is being determined. Child care costs for foster homes shall be computed in the same manner as for child care and nursing home institutions except that no salary costs may be considered[.] for nonspecialized foster homes. Salaries may be paid for specialized foster homes as defined by regulations promulgated by the department.

* Sec. 2. AS 47.40.080 is amended by adding a new subsection to read:

(4) "Specialized foster homes" means a foster home for the placement of children who would otherwise be classified for placement in institutional care. The foster parents shall meet particular requirements defined by regulations promulgated by the department for education, therapeutic skills, and experience and

DRAFT

DRAFT

successfully complete training as specified by the department for this purpose.

* Sec. 3. This Act takes effect immediately in accordance with AS 01.10.070(c).

DRAFT

POSITION PAPER/Department of Health & Social Services

POSITION PAPER
HOUSE BILL NO. 922

"An Act relating to state payment for child care cost for foster homes."

This Bill would provide the Department with the authority to pay foster parents a salary for services provided to "special-needs" children in foster homes. Many times, the placement of these youths out of institutions is of benefit to the child and respresents a substantial cost saving to the state. However, it is extremely difficult to recruit foster parents willing and able to take on added burden imposed by "special-needs" youth. This Bill would allow the Department to compensate those foster parents who are willing to assume the burden of care for these youths, through a salary, mandatory training prior to placement and follow-up training and support services throughout the placement. In this way, the Department will have the means of developing alternative specialized foster homes to provide the type of care these youths need in a home environment. Without this authority, these youths will continue to require institutional care resulting in higher costs to the state and removal of these individuals from the mainstreams of normal adolescent development.

The Department is committed to, wherever possible, supporting those intrinsic values found in family structure as this is believed to represent the best means of providing for the care of those youths who are in its custody. In addition, the Department is committed to the deinstitutionalization of youth. Therefore, this Bill is consistent with departmental program objectives and should be enacted.

RECOMMENDED BY: John Pugh DATE: 4/8/80
John Pugh, Acting Director
Division of Social Services

RECOMMENDED BY: for Roger C. Lange DATE: April 8, 1980
Charles F. Campbell, Director
Division of Corrections

APPROVED BY: Helen D. Beirne DATE: 4-8-80
Helen D. Beirne, Commissioner
Department of Health and Social Services

THE LEGISLATURE OF THE STATE OF ALASKA
ELEVENTH LEGISLATURE

FISCAL NOTE

I. REQUEST
Bill/Resolution No. House Bill No. 922
Title "An Act ting to state payment for child care costs for foster homes"
Requested by Finance Committee Date 2/29/80

II. FISCAL DETAIL
Agency Affected Department of Health and Social Sevices
Program Category Affected Administration of Justice
BRU, Program, or Subprogram(s) Affected Youth Services
(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 80	FY 81	FY 82	FY 83	FY 84	FY 85
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL						
400 COMMODITIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC.		(181.4)	(197.7)	(215.5)	(234.9)	(256.1)
TOTAL		(181.4)	(197.7)	(215.5)	(234.9)	(256.1)

FUNDING (Thousands of Dollars)

GENERAL FUND		(181.4)	(197.7)	(215.5)	(234.9)	(256.1)
FEDERAL FUNDS						
OTHER (Specify Fund Source)						

POSITIONS

FULL TIME		-0-	-0-	-0-	-0-	-0-
PART TIME						
TEMPORARY						

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

A. Assumptions

1. Ten (10) juveniles would be placed in specialized foster care, transfered from private juvenile institutions. This represents 11% of the projected institutional caseload for FY'81.

2. The specialized foster care rate would include $700.00 per month for salaries in addition ot the regular foster care rate. The estimated foster care rate for teenagers during FY'81 is $423.70 per month. Therefore, the estimated cost for specialized foster care would be $1123.70 per month.

Roger C. Lange

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)

Prepared by: Roger C. Lange Date: March 24, 1980
Division/Office: Corrections PH: 465-3376
Department of Health & Social Services

Approval DHSS Mgt. & Bdgt: M. Hubbard Date: 4/8/80

33-001 (Rev. 12/79)
Modify by DHSS (11-28-79)

3. The average costs per month for private institutional care in facilities utilized by the Division of Corrections is $86.65 per child care day or $2635.60 per month.

B. Costs Savings with Specialized Foster Care

1. Cost of Specialized Foster Care:

10 juveniles x $1123.70 per month x 12 months = $134,844.00

2. Costs of Private Institutional Care:

10 juveniles x $2635.60 per month x 12 months = $316,272

3. Estimated Savings:

$316,272	Institutional Care
134,844	Specialized Foster Care
$181,428	Net Savings

C. Savings for subsequent fiscal years is based on an inflation rate of 9%.

D. There is a potential for expanding the specialized foster care program, although it will not meet the appropriate program needs of all juveniles. Until such a program is tested, no estimate can be made as to the optimum number of specialized foster care placements which could reasonably be expected.

THE LEGISLATURE OF THE STATE OF ALASKA
ELEVENTH LEGISLATURE

FISCAL NOTE

I. REQUEST
Bill/Resolution No. HOUSE BILL NO. 922
Title "An Act relating to State payment for child care costs for foster homes."
Requested by Finance Committee Date April 8, 1980

II. FISCAL DETAIL
Agency Affected Department of Health and Social Sevices
Program Category Affected Social Services
BRU, Program, or Subprogram(s) Affected Social Services
(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 80	FY 81	FY 82	FY 83	FY 84	FY 85
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL						
400 COMMODITIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC.						
TOTAL	-0-	-0-	-0-	-0-	-0-	-0-

FUNDING (Thousands of Dollars)

GENERAL FUND	-0-	-0-	-0-	-0-	-0-	-0-
FEDERAL FUNDS	-0-	-0-	-0-	-0-	-0-	-0-
OTHER (Specify Fund Source)	-0-	-0-	-0-	-0-	-0-	-0-
	-0-	-0-	-0-	-0-	-0-	-0-
	-0-	-0-	-0-	-0-	-0-	-0-

POSITIONS

FULL TIME	-0-	-0-	-0-	-0-	-0-	-0-
PART TIME	-0-	-0-	-0-	-0-	-0-	-0-
TEMPORARY	-0-	-0-	-0-	-0-	-0-	-0-

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

This Bill has no fiscal impact for the Division of Social Services since cost figures for Institutional Care have been reduced in the FY 81 budget to reflect the anticipated savings which would result from the Specialized Foster Care Program and the costs for the program have been budgeted in the Foster Care component.

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)

Prepared by: [illegible] Date: 4/8/80
Division/Office: Social Services PH: 465-3170
Department of Health & Social Services

Approval DHSS Mgt. & Bd. [illegible] Date: 4/8/80

33-001 (Rev. 12/79)
Modify by DHSS (11-28-79)

Page ____ of ____

REPORT
ON
SPECIALIZED FOSTER CARE

The original plan for FY80 was to recruit, train, and use for placement, 20 specialized foster homes, by September 1, 1979. Since a statutory amendment is necessary in order to include salary costs for specialized foster homes, the placement phase of this program has not been implemented.

The initial recruitment phase was completed, and between September 1, 1979 and March 1, 1980, a specific training program was developed for specialized foster care and twenty-two parents have completed the training program. Another training session scheduled for June, 1980 will prepare 20 additional parents for specialized foster care providing enough homes to allow for the "best possible placement' for every child.

Specialized foster parents (one parent in a home will be identified as the specialized parent) will receive a salary of $700/month, which will be in addititon to the foster home maintenance rate. The average FY 1980 average institutional group home cost rate is $60/day. The daily cost of specialized foster care would be $35/day, (including both salary and foster home maintenance).

Requirements of Specialized Foster Parents

1) One parent must not work outside of the home in order to be available to provide appropriate intensive specialized care to the child.

2) The parent who will not work outside of the home must have five years experience in working with children. This experience can include:

   a) experience as a foster parent
   b) experience as a social worker
   c) experience in a child oriented work setting.

(Experience as a biological parent of an adolescent may be counted for one year of experience. A Bachelor's degree with specific course work in counseling, clinical psychology, or child development, or a graduate degree in social work or a related field may be counted for two years of required experience).

3) Specialized foster parents must also have:

   a) the ability to work with children in a therapeutic way.
   b) the ability to work with the biological parent of a child in a therapeutic way.
   c) the ability to accept and work with a child with emotional and behavioral problems.

d) the ability to work with an older child
e) the ability to accept a child who has been raised in a different philosophical environment.
f) a stable family life.
g) must meet all of requirements for regular foster home licensing
h) may have to provide additional references beyond the number required for regular foster home licensing.

Criteria for Selection of Children:

1) The child should be one, who without this program, would require institutional or group home placement due to emotional or behavioral problems.

2) The child should be within the age range of 8-18 years.

3) The child, with intensive supervision, should be able to function and have his/her needs met in a community setting.

					COST $	ADDITION	FOR BSU USE
FY 80 Est.							
In-State	162,060	444	1,993,338.00	12.30			
Out-of-State	6,935	19	48,055.55	6.93			
Subtotal	168,995	463	2,041,393.55	12.09			
Specialized Foster Care *for 6 mos.	5,650*	20	120,000.00	32.87			
Total	174,645	483	$2,161,393.55	12.52			
Estimates for FY 81 include a 14% COLA increase and an additional 10 children in specialized foster care from institutional care:							
FY 81							
In-State	162,060	444	$2,272,081.20	14.02			
Out-of-State	6,935	19	54,786.50	7.90			
Subtotal	168,995	463	$2,326,867.70	13.77			
Specialized Foster Care	10,950	30	410,406.00	37.48			
Total	159,945	493	$2,737,273.70	17.11	2,737.3		
The request for FY 81 will, of course, be revised in the Department's report to the legislature following the full-cost-of care rate hearings.							

AGENCY Department of Health & Social Serives PROGRAM AREA General Population

BRU Program Services

23 18 CONTINUED

COMPONENT Foster Care

Page 4 of 6

REVISED DATE

FY 81

000477

02 1023 (Rev 7/79)

					CONT $	ADDITION	FOR SGM USE
FY 81							
In-State	53,290	146	4,281,318.60	80.34			
Out-of-State	11,315	31*	673,695.10	59.54			
Subtotal	64,605	177	$4,955,013.70	76.70			
*To Specialized Foster Care	(3,650)	(10)*	(217,321.00)	(59.54)			
Total	60,955	167	$4,737,692.70	$77.72	4,737.7		

The FY 81 request will, of course, be revised in the Department's report to the legislature following the full-cost-of-care rate hearings.

AGENCY Department of Health & Social Service PROGRAM AREA General Population

BRU Program Services

COMPONENT Institutional Care

23 18 CONTINUED

Page 4 of 6

REVISED DATE

FY 81

000493

02-1027 (Rev. 7/79)

STATE OF ALASKA

JAY S. HAMMOND, GOVERNOR

DEPT. OF HEALTH AND SOCIAL SERVICES

DIVISION OF SOCIAL SERVICES

POUCH H-05
JUNEAU, ALASKA 99811

APR 16 1979

Document# 80-80

The Honorable Thelma Buchholdt
House of Representatives
Alaska State Legislature
Pouch V
Juneau, Alaska 99811

Dear Ms. Buchholdt:

This is written in response to your inquiry regarding Alaska foster parent liability insurance coverage. The State of Alaska has broad liability protection which includes liability coverage for foster parents who are providing care for children in state custody . The liability insurance coverage is in excess of a million dollars. The policy is administered by the Division of Risk Management in the Department of Administration. John Haywood at 465-2180, is available to answer any further questions you may have.

I hope this information is helpful. Please let me know if any further information regarding our foster care and licensing program is required.

Sincerely,

John Pugh
Acting Director

JP/PM/ed:gc

cc: John Haywood

06-F13LH

House Health, Education & Social Services Committee Meeting/Hearing on 4822 Date: 4/16/80

	Name	Address and Phone	Organization/Self	For/Against or Observing
1/	~~Dr McGinnis~~		NASS	
2/	~~John Pugh~~	(if needed)		
3/				
4/				
5/				
6/				
7/				
8/				
9/				
10/				
11/				
12/				
13/				

HB

935

FISCAL NOTE

BUDGET FOR PRELIMINARY DATA COLLECTION

&

ASSESSMENT AND RECOMMENDATION

for a

STATE OFFICE of CHILD DEVELOPMENT

	YEAR 1	YEAR 2
PERSONNEL		
COORDINATOR/ADVOCATE	24,500	26,460
SECRETARY II 3/4 time year 1 full time year 2	11,113	15,995
FRINGE @ 19%	6,766	8,066
	42,379	50,521
CONSULTANTS		
Data Processing & Programming Needs Assessment & Resource Information	14,000	14,500
TRAVEL/PER DIEM		
Coordinator		
2 trips/3 days/12 regions	20,400	22,800
850 each, year 1 950 each, year 2		
Advisory Group Planning Meetings		
12 persons, 2 days. 2 meetings, year 1 (750 ea.)	18,000	30,600
Year 2 - same but three meetings (850 ea.)		
	$38,400	$53,400

	YEAR 1	YEAR 2
PRINTING		
Newsletter, 4 at 500, year 1 4 at 600, year 2	2,000	2,400
TELEPHONE		
12 months at 100/month	1,200	1,200
ADMINISTRATION		
Administrative Costs, including Indirect	13,000	17,000
GRAND TOTAL	110,979	139,021

House Health, Education & Social Services Committee Meeting/Hearing on HB935 Date: 3/24

	Name	Address and Phone	Organization/Self	For/Against or Observing
1/	Phil Smith	327 Eagle St. Anchorage	Rural CAP	For
2/	Marie Pignalberi		CPPA	for
3/				
4/				
5/				
/				
7/				
8/				
9/				
10/				
11/				
12/				
13/				

THE LEGISLATURE OF THE STATE OF ALASKA
ELEVENTH LEGISLATURE

FISCAL NOTE

I. REQUEST

Bill/Resolution No. SB 506 HB 935

Title Making $250,000 Special Appropriation to RuralCAP

Requested by House Community & Regional Affairs Committee Date 3-10-80
Senate Finance Committee

II. FISCAL DETAIL

Agency Affected Community & Regional Affairs

Program Category Affected Social Services

BRU, Program, or Subprogram(s) Affected

(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 80	FY 81	FY 82	FY 83	FY 84	FY 85
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL						
400 COMMODITIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC.						
TOTAL	0	0	0	0	0	0

FUNDING (Thousands of Dollars)

GENERAL FUND	0	0	0		0	0
FEDERAL FUNDS						
OTHER (Specify Fund Source)						

POSITIONS

FULL TIME	0	0	0	0	0	0
PART TIME						
TEMPORARY						

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

This bill, by itself, does not have enough fiscal impact on our department to require additional appropriations or positions. There are many such bills pending however, and if a significant number pass the cumulative administrative burden will require additional personnel.

IV. DATE _____ PREPARED BY La Donna Brown

AGENCY Community & Regional Affairs

PHONE 465-4739

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)

33-001 (Rev. 12/79)

THE LEGISLATURE OF THE STATE OF ALASKA
ELEVENTH LEGISLATURE

FISCAL NOTE

I. REQUEST

Bill/Resolution No. SB 506 HB 935

Title Making $250,000 Special Appropriation to RuralCAP

Requested by House Community & Regional Affairs Committee Date 3-10-80
Senate Finance Committee

II. FISCAL DETAIL

Agency Affected Community & Regional Affairs

Program Category Affected Social Services

BRU, Program, or Subprogram(s) Affected

(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 80	FY 81	FY 82	FY 83	FY 84	FY 85
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL						
400 COMMODITIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC.						
TOTAL	0	0	0	0	0	0

FUNDING (Thousands of Dollars)

GENERAL FUND	0	0	0	0	0	0
FEDERAL FUNDS						
OTHER (Specify Fund Source)						

POSITIONS

FULL TIME	0	0	0	0	0	0
PART TIME						
TEMPORARY						

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

This bill, by itself, does not have enough fiscal impact on our department to require additional appropriations or positions. There are many such bills pending however, and if a significant number pass the cumulative administrative burden will require additional personnel.

IV. DATE _____ PREPARED BY La Donna Brown

AGENCY Community & Regional Affairs

PHONE 465-4739

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)

33-001 (Rev. 12/79)

BUDGET FOR PRELIMINARY DATA COLLECTION

&

ASSESSMENT AND RECOMMENDATION

for a

STATE OFFICE OF CHILD DEVELOPMENT

July 1, 1980 - January 20, 1982

PERSONNEL (18.5 mos)	
Coordinator/Advocate	38,830
Secretary II	23,475
Fringe @ 19%	11,838
	74,143
CONSULTANTS	
Data processing & programming—needs assessment and resource information	30,000
TRAVEL/PER DIEM	
Coordinator 4 trips/3 days/12 regions @900	43,200
Advisory Group Planning Meetings 12 reps/2 days/6 mtgs @ 800	57,600
	100,800
PRINTING	
Newsletter 7 @300	5,600
TELEPHONE	
18.5 mos @100/mo.	1,850
ADMINISTRATIVE COSTS	
12%	28,800
GRAND TOTAL	$241,193

House Health, Education & Social Services Committee Meeting/Hearing on _____ Date: 4/10

	Name	Address and Phone	Organization/Self	For/Against or Observing
1/	PAUL GULYAS	465 1855	ACPE	HB 651
2/	Jim Ayers	277-2511	Rural Cap / Self	Supporting 935
3/	Harold Manner	speak on Metabolic Therapy of Cancer		
4/	Alexander Schauss	speak on Orthomolecular Treatment of Criminal Offenders		
5/				
6/				
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12/				
13/				

HB
936

STATE OF ALASKA

Inter-Department Route Slip

TO:
MAIL STATION NUMBER 3100

DEPARTMENT Health Education & Soc Svc Comm.

ATTENTION Rep. Buchholat, Chairman

☐ Approval	☐ Note & Return
☐ Signature	☐ Initial & Return
☐ Comment	☐ Return As Requested
☐ Contact Me	☐ Return For Approval
☐ Prepare Reply	☐ Necessary Action
☐ For Your File	☐ Your Information

Remarks: Prime Sponsor

FROM:
MAIL STATION NUMBER 0500

DEPARTMENT Education

BY Jaren A Boddy DATE 4-4

02-002 (REV.10/73)

THE LEGISLATURE OF THE STATE OF ALASKA
ELEVENTH LEGISLATURE

FISCAL NOTE

I. REQUEST

Bill/Resolution No. House Bill No. 936

Title An Act Relating to Displaced Homemakers, and Providing an Effective Date

Requested by _____ Date March 21, 1980

II. FISCAL DETAIL

Agency Affected Department of Education

Program Category Affected Adult and Continuing Education

BRU, Program, or Subprogram(s) Affected Adult and Continuing Education

(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 80	FY 81	FY 82	FY 83	FY 84	FY 85
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL						
400 COMMODITIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC.						
TOTAL	-0-	-0-	-0-	-0-	-0-	-0-

FUNDING (Thousands of Dollars)

GENERAL FUND						
FEDERAL FUNDS						
OTHER (Specify Fund Source)						

POSITIONS

FULL TIME						
PART TIME						
TEMPORARY						

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

This bill has no fiscal impact on the Department of Education.

IV. DATE March 21, 1980 PREPARED BY [signature]

AGENCY Education

PHONE 465-2800

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)

33-001 (Rev. 12/79)

LA11 2597 16.17 JA01 0091 16.17 03/18/80

TO HOUSE HEALTH AND SOCIAL SERVICES COMMITTEE: REP. BUCHHOLDT, REP. MONSON,
REP. HURLBERT, REP. MILES, REP. BARNES, REP BEIRNE, REP. CHATTERTON

FROM JOYCE RIVERS, PRESIDENT, NATIONAL ORGANIZATION OF WOMEN,
4102 TAFT DRIVE, ANCHORAGE, AK 99503

THE ANCHORAGE CHAPTER OF THE NATIONAL ORGANIZATION FOR WOMEN ENDORSES HB 936. CONCERNS INCLUDE MAKING CERTAIN JOB COUNSELORS DO NOT PLACE DISPLACED HOMEMAKERS ONLY INTO STEREOTYPICAL TRAINING PROGRAMS AND JOBS, THAT BENEFITS GO ONLY TO WOMEN DISADVANTAGED BY HAVING BEEN HOME-MAKERS, AND THAT LOAN PROGRAMS FOR PARTTIME STUDENTS BE IMPLEMENTED.

House Health, Education & Social Services Committee — Meeting/Hearing on HB936 — Date: 3/21/80

HB936 Displaced Homemaker

	Name	Address and Phone	Organization/Self	For/Against or Observing
1/	Liz Muktarean	Dept. of Health Ed Social Services	Fourth H Juneau, Ak DHSS	
2/	Doris Simmons	Dept. of Labor E&D.		
3/	Gerald Hiley	Dept. of Ed.		
4/	Fran Ali	Dept. of CRA		
5/				
6/				
7/				
8/				
9/				
10/				
11/				
12/				
13/				

RE: House Bill 936 3/12/80

I as a Displaced Homemaker partisapating in Fairbanks training and learing skills to enable me to be self supparting of myself and two children. Can not stress enough how help full this program has been! Without having been given the opportunity to return to School and obtain updated skills, I would still be sitting at home. When on Welfare and no education to obtain a job that would pay a substantial income to support the expenses of a job. — transportation - daycare.

The Displaced Homemakers program has been very encouraging that in the near futer I will be employed and self supporting not having to rely on Assistance of the State of Alaska or the tax payers.

I am hoping that many more people in my situation could have the same opportunity to improve themselfs and take ~~o~~ control of their families future.

Beverly E Schulz

Jessie J Harris
witness

3/12/80

There are Women (Displaced Homakers who do have employment Skill and do not necessary have to be trained. But because of Child Care problem can not work and actuely seek employment. This is a major concert that must be met. There is no mention of Child Care Aid in this bill. This is a major problems because women who can work must become AFDC and can not become essential part of the Labor force. And they become Stagnant. Displace Homakers want to become active to Society and to themselves

Catherine E. McCain
3/12/80

Linda Withop, 32yr old mother of four and in a dependency status for 20 yrs. The last fourteen as "common-law". I was directed by Alaska State Employment & CETA division to the "Displaced Homemaker Program" in Fairbanks. I called & was given an appointment. I wished qualified as a "Displaced Homemaker" I had very few self-esteem - very few marketable job skills - a small child to care for - no money - no medical or transportation etc. After an hour with a staff member I was able to identify my most urgent needs & was directed to the existing agencys to help me with the most urgent as I saw it. I also was, with the able guidance of the staff, able to set some short & long range goals & a plan of action to obtain them. Needless to say the staff is excellent. I have observed that they give willingly of their time and have been continually upgrading their program which was declared at the beginning - I was just recently in Juneau to represent my area at the Urban Citizen Participation Conference which was organized to allow the low-socioeconomic citizen an opportunity to view the workings of the government first hand. While there I had the opportunity to confer with thirty-four other members like myself on issues of importance All of which I most are included in HB 926. Over & over again as I listened I realized that there was a lack of information dissemination. I was pleased to hear that two to twelve the Fairbanks Program for "Displaced Homemakers" was well received. I would recommend to the Committee that they review the program as a workable model upon which they could

gain valuable & applicable information to
HB 936

Linda K. Witkop
March 12, 1980

Witness
Dianne Helfferich
March 12, 1980

March 12, 1880

I, Cathy L Overly, am submitting my testimony to the comittee in support of the Displaced Homemaker Program.

I personally have struggled as a divorced parent to support my children financially and still maintain a secure home life for them for six years.

This year, I learned of the Displaced Homemakers Program in Fairbanks, and with the help of the fine counselors, I have recently completed twelve credits of office occupations training at Tanana Valley Community College.

I could not have done this without the moral support and financial assistance that I received from Displaced Homemakers. I have tried for years to get to this point.

Now, I have gained the training, self-confidence and knowledge necessary to become employed at a better job.

I recently received the job that I have been striving for and it will make a difference in my life and my childrens life for the rest of their lives.

I feel that this bill is a very worthwhile cause for the State of Alaska and will improve the economy of Alaska in the long run.

I don't feel that this should be put off until July 1, 1981.

Cathy L Overly

SUBMITTED TO:

HOUSE H.E.S.S. COMMITTEE
CHAIRMAN REP. BUCHHOLDT
MARCH 12th 1980

RE: HOUSE BILL 936

MR. CHAIRMAN:

I would like to speak in behalf of myself and other women who fit into the catagory of "displaced homemakers." I have personally been helped a great deal by the displaced homemakers program currently operating in Fairbanks, not only through the opportunity to attend classes at our community college but also through the moral support and the "you have a friend" attitude of the counsellors.

Through the financial & mental help of this program I have begun a course of study & growth that I can see a future in for myself and my children that will no longer include AFDC or other handouts from the state. I would much rather be a productive member of the community, a stable job holder, & a good example to my own daughter of a well-balanced, self-supporting woman.

This bill and any other bill that will help women to help ~~myself~~ themselves deserve all our attention and support.

Thank You
Debra S. Brown

Chairman: Rep. Buchholdt
House - H.E.S.S.
March 12, 1980

As a client of the Displaced Homemakers Program, I support this bill. Without this programs assistance I would not be able to enter the job market with any skills. I have been at the University of Alaska - TVCC. After two semesters I now I feel that I am better equipped and have more to offer the business community.

Judith J. Rylander

As part of this organization, I have been tremendously helped in my situation. This service is needed in alot of ways. They have enabled me to go to school, acquire skills to enable me to support myself & son. I've had the opportunity to counsel with Deanne Belfich, to learn to cope & solve my problems in a possitive & productive way. There is a need for assistance with day care, also sometimes emergency transportation. There is a real need for emergency funding. I've known several instances ~~were~~ where, because of a lack of day-care-funds women have had to pass up the opportunity to attend school, or because they are single they have difficulty finding employment. I myself am a single parent, during an interview, the man seemed concerned with the fact that I had a child & could I guarantee this wouldn't interfere with the work, would the sitter be reliable & such. This is discriminating & there was really nothing I could do except gracefully say. Thanks when told some-one else had been elected, ~~could~~ ~~that~~. This program can help others as it has me.

Renee Harris

Nancy Hedden
3/12/80

As a Displaced Homemaker I feel there is a great need for more job-getting services. In order to work, child care is essential. Licensed child care is very expensive in this state, and more financial assistance is also greatly needed.

We also need more financial assistance for legal aid, and more prompt legal aid should be made available. We are Persons in crisis and as in any crisis, help is needed immediately.

L. Patricia Hartman

Gene C Kingrea 3/12/80

As a displaced homemaker, I am glad to see legislation for funds for the program. The local program has helped me as a job referral service after I had gone to the state personnel office and job service and chanted the other sources I knew of.

It seems to me that the bill is weak in several areas. We displaced homemakers need help with establishing credit, need help with child care, and need assistance with legal aid. Also, the requirement that a displaced homemaker must have been a homemaker 6 years, seems discriminatory. It is difficult to get into the job market again, having been out of it for even 2 years.

Maureen Wright

Geneseo Dawn 3/12/80

3/12/80

Delores Starkey, age 50, I have a 15 yr. old son to care for. In process of a divorce. I heard of Displaced Homemakers from a friend in the same position as I.
I've had job interviews, I feel my age had alot to do with it. I feel the older woman is discriminated against, because of their age, it's a real problem. I would like the Displaced Homemakers Program to address this question.

Displaced Homemakers is now helping me with schooling. They have been + are a great help to me. Displaced Homemakers is very much needed here in Fairbanks.

Delores Starkey

Cheryl Cameron

March 24, 1980

TO: COMMITTEE MEMBERS

FROM: SHANNON GARRETT

The following are proposed amendments to HB 936 which the committee has received through letters and the teleconferencing on the bill.

PAGE 1 LINE 28- Insert the words "aptitude testing" between the words "counceling" and "training".

PAGE 2 LINE 18- Insert from Pg. 3, line 8, the #(3) section in it's entirety and add a new (A) to read"(A) Supportive transitional counceling." Reletter rest of sec. accordingly.

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PAGE 5 LINE 3- Delete "six years" and insert "two years".

PAGE 5 LINE 4- Insert "in a" between "been"and "dependent" and after "dependent" insert "role".

STATE MANPOWER SERVICES COUNCIL

April 1, and 2, 1980

A G E N D A

5th Floor Conference Room
Juneau State Office Building
Juneau, Alaska

AGENDA ITEM		STAFF RECOMMENDATION
April 1, 1980 - Tuesday		
8:00 a.m.	Call to Order/Roll Call	
8:15 a.m.	"Bush Caucus Issues" - Representive Nels Anderson Guest Speaker	Legislative presentations are for council information. The speakers will be interested in the SMSC's comments on proposed legislation.
	"Rural Economic Development: HB-932" - Representive Jim Duncan, Guest Speaker	
	Council: Question & Answers	
10:00 a.m.	Break	
10:15 a.m.	"Tax Credit: SB-496" - Glenn Lundell, Speaker	
10:45 a.m.	"Displaced Homemakers: HB-936" - Representative Thelma Buchholdt (or Administrative Aide), Guest Speaker	
11:30 a.m.	Break for Lunch	
1:30 p.m.	Old Business:	
	- Articulation Report	Review and approve draft letter to participants of the Articulation workshops.
	- Joint Committee of SMSC/APIC	Status Report - no action necessary.
	- Governor's Grant: A Status Report	Information
	- Job Corps Center - Report of March 13, Meeting	Information
	- Approval of Minutes	Corrections, Additions, Approval
4:00 p.m.	Public Input/Recess	

AGENDA ITEM		STAFF RECOMMENDATION
April 2, 1980 - Wednesday		
	NOTICE: Governor Hammond will appear before the Council for the presentation of the State Manpower Services Council Annual Report to the Governor. At his convenience, the agenda will be adjusted to accommodate this presentation.	
9:00 a.m.	Call to Order	
	"Manpower Planning Process: A Review of Prime Sponsor Participant Information" - Presented by Council and Staff	1) Identify groups that appeared to be underserved in FY79. 2) Identify recommendation for FY81 for Balance of State and Municipality of Anchorage.
	"Discussion - Media Project" - Presented by Staff	Determine purpose of project. Direct staff to develop work plan.
1:15 p.m.	"Unorganized Boroughs: HB-580" - Senator Arliss Sturgulewski and Representative Bill Parker - Guest Speakers	Information speakers will be interested in SMSC's comments on proposed legislation.
1:45 p.m.	"Energy Legislation" - Representative Brian Rogers, Guest Speaker	
	"Urban Citizen's Participation Conference - A Status Report" - Southeast Regional Resource Center Staff, Guest Speaker(s)	Information
	"Status of Federal Legislation and Potential Federal Spending Cuts" - Fred Ali, Speaker	Information
4:15 p.m.	Public Input/Adjournment	

NOTE: Council members are advised that agenda times are flexible for the second day of meetings. This is necessary because of legislators who are guest speakers; we must provide a time which is convenient for them to appear. It may be necessary to adjust the agenda as we proceed.

HB 936
Amendments proposed by Fred Ali, C&RA

Page 1:

Change Section 1 (b)(1) to read as follows (lines 28-29):
(1) provide the necessary counseling, training, employment placement and other services for displaced homemakers [,] through contracts with public or private nonprofit organizations and by utilizing and expanding existing state programs.

Page 2:

Change Section 2, 47.90.010(a) to read as follows (lines 8-12):
(a) The commissioner...may contract with public or private nonprofit organizations for multipurpose service centers for displaced homemakers [.] and expand existing state programs through reimburseable service agreements.

Add to Section 2, 47.90.010 a new subsection (c):
(c) The commissioner shall establish a competive contract procurement process that ensures free and open competition for funds allocated for programs established in this chapter. As part of this procurement process, it is intended that public or private nonprofit organizations and state agencies may propose to provide all or a portion of the services listed under AS 47.90.020.

Page 3:

Add to Section 2, 47.90.020(2), line 7, the words ", and" (and delete [and] from line 5)--- then add a new subsection (E) to this section to read as follows:
(E) expose displaced homemakers to nontraditional occupations.

Page 4:

line 5, p.4 (1.) At the end of Section 2, 47.90.030, add the following sentence:
Under the procurement process established under AS 47.90.010, the commissioner will give preference to applicants proposing to fill staff positions with displaced homemakers.

p.4 delete 18-22 (2.) add Delete Section 2, 47.90.060 and replace it with the following section:
Sec. 47.90.060. STATE EMPLOYMENT ASSISTANCE. Contrators operating programs under this chapter will, to the maximum extent possible, provide displaced homemakers with assistance in being placed on state employment registers. This will be accomplished with the assistance and cooperation of the Division of Personnel and the Department of Community and Regional Affairs.

Page 4:

(3) Delete Section 3, 43.20.037 in its entirety. ~~(If the Committee decides to do this, it must delete the reference to this section on page 4, line 17.)~~

(2) Delete Section 4 and include the following language instead: All provisions of this Act will take effect July 1, 1981. During FY 81, the commissioner will consult with appropriate groups and state agencies concerned with displaced homemakers, adopt resolutions prescribing program standards, adopt a competitive procurement process, provide information and assistance to groups interested in conducting displaced homemaker programs, and fund one or more limited pilot projects.

(4) p. 4, lnie 17-18
delete ~~E~~ AS 47.90.060 and AS 43.20.0[illegible]
and replace with this Act.

(5) new effective date: 1/1/81.
(lnie 15, p. 5)

(6) language for definition of d. hmker:

(A) delete
p. 4, lnies 2-5.
replace w/ "(A) has been a homemaker for at least 6 years dependent on the income of a family member; and"
change [(C)] to (B)

— letter of intent
— facial note

Proposed CS for HB 936 (Work completed by Committee thus far)

For an Act entitled: "An Act relating to displaced homemakers; and providing for an effective date."

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

Section 1. LEGISLATIVE FINDINGS AND INTENT. (a) The legislature finds that there is an increasing number of persons in the state who, after having fulfilled the role of homemaker for a number of years of their life, find themselves "displaced" through the death of a spouse, divorce, separation, desertion, or loss of family income. The legislature finds that displaced homemakers are often without any source of income, face continuing discrimination in employment because they frequently have no recent work experience and may be older than other applicants for employment, are subject to high rates of unemployment and are ineligible for unemployment insurance because they have been engaged in unpaid labor in the home, may be ineligible for categorical welfare assistance, are ineligible for social security if they have been divorced from the family wage earner, may have lost their rights as beneficiaries under employers' pension and health plans through death of a spouse or divorce despite the contribution of years to the well-being of the family, and may be ineligible for Medicaid and unable to purchase private health insurance because of age and lack of income. The legislature further finds that homemakers are an unrecognized part of the work force of the state who have made an invaluable contribution to the welfare of society.

(b) It is the intent of the Act to

(1) provide the necessary counseling, aptitude testing, training, employment placement, opportunities and other services for displaced homemakers[;] through contracts with public or private nonprofit organizations and by utilizing expanding existing state programs.

(2) improve the mental and physical health and welfare of this growing group of members of the community; and

(3) ~~provide~~ assist displaced homemakers ~~with~~ in achieving independence and economic security vital to a productive life.

Sec. 2. AS 47 is amended by adding a new chapter to read:

CHAPTER 90. DISPLACED HOMEMAKERS.

Sec. 47.90.010. PROGRAM ESTABLISHED. (a) The commissioner, in consultation with state and local governmental agencies, community groups, and groups concerned with displaced homemakers, may contract with public or private nonprofit organizations for multipurpose service centers for displaced homemakers[.] and expand existing state programs through reimburseable service agreements.

(b) The commissioner shall adopt regulations prescribing the standards to

be met by each multipurpose service center for displaced homemakers in accordance with the policies established in this chapter.

(c) The commissioner shall establish a competitive contract procurement process that ensures free and open competition for funds allocated for programs established in this chapter. As part of this procurement process, it is intended that public or private nonprofit organizations and state agencies may propose to provide all or a portion of the services listed under AS 47.90.020.

Sec. 41.90.020. MULTIPURPOSE SERVICE CENTERS. A multipurpose service center for displaced homemakers established under AS 47.90.010 may provide the following services:

(1) job counseling services which shall

(A) be specifically designed for displaced homemakers;

(B) counsel displaced homemakers regarding job opportunities; and

(C) consider and build on the skills and experience of a homemaker and emphasize job readiness as well as skill development;

(2) job training and job placement services which shall

(A) emphasize short-term training programs which expand upon homemaking skills and volunteer experience and which lead to gainful employment;

(B) develop through cooperation with state and local government agencies and private employers training and placement programs for jobs in the public and private sector;

(C) assist displaced homemakers in gaining admission to existing public and private job-training programs and opportunities including vocational education, reentry into secondary and postsecondary educational facilities, and apprenticeship training programs; and

(D) assist in identifying community needs and creating new jobs, including nontraditional occupations for displaced homemakers, for displaced homemakers in the public and private sector;

(3) health counseling services including referral to existing health programs with respect to

(A) general principles of preventive health care;

(B) health care consumer education, particularly in the selection of physicians and health care services including health maintenance organizations and health insurance;

(C) mental health care and transitional counseling;

(D) family health care, dental care and nutrition;

(E) alcohol and drug abuse; and

(F) other related health care matters;

(4) financial management services which provide information and assistance relating to insurance, taxes, estate and probate matters,

mortgages, loans, and related financial matters;

(5) educational services including

(A) information, including the availability of monetary assistance programs, relating to courses offering credit through secondary or postsecondary education programs and reentry programs, including bilingual programs if appropriate; and

(B) information about other programs [DETERMINED BY THE COMMISSIONER TO BE] of benefit to displaced homemakers;

(6) legal counseling and referral services; and

(7) information services with respect to federal and state employment, education, health, public assistance, and unemployment assistance programs which the commissioner determines to be of benefit

The Committee stopped its deliberations at this point (end of page 3 in original bill).

HB 936
Amendments proposed by Fred Ali, C&RA

Page 1:

adopted

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Stark here

Page 4:

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C&RA proposed amendments to HB 936.

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During FY '81, the commissioner will consult with appropriate groups and state agencies concerned with displaced homemakers, adopt resolutions prescribing program standards, adopt a competitive procurement process, provide information and assistance to groups interested in conducting displaced homemaker programs, and fund one or more limited pilot projects.

letter of intent

funds w/ be provided to the

Dpt C&RA to . .

STATE of ALASKA

MEMORANDUM

TO: R. D. Stevenson
Special Assistant
Department of Revenue

DATE: March 10, 1980

FILE NO.

TELEPHONE NO.

FROM: Gary L. Jenkins
Director
Audit Division

SUBJECT: House Bill No. 936

Section 3 of this bill would provide for an income tax credit for up to 30 percent of the wages paid to an individual who qualified as a displaced homemaker. There are two issues which should be considered in analyzing this proposed legislation.

First of all, there is considerable pressure at the present time to either suspend or repeal the individual and corporate income taxes. If either of those actions were to take place, it would obviously make this proposal, in effect, null and void.

Secondly, there is a policy question with regard to how programs of this nature should be accounted for by permitting a major portion of the actual cost of the program to be buried as a tax credit, with the result that the total cost of the program is not subject to appropriation. It makes it difficult to easily analyze the benefits of a program as compared to its actual total cost.

In lieu of the tax credit provision, since the Department of Community and Regional Affairs will already be working directly with the various employers involved, it will be a relatively simple operation for them to refund the employer the 30 percent of the wages paid. This would also be very logical from an administration point of view because they are charged with the responsibility of ensuring that each employer meets the conditions set forth in the law and regulations prior to the reimbursement being paid. This concept would also permit the Legislature to clearly understand the total cost of this program when they appropriate the funds for it annually.

THE LEGISLATURE OF THE STATE OF ALASKA
ELEVENTH LEGISLATURE

FISCAL NOTE

I. REQUEST
Bill/Resolution No. HB# 936
Title An Act relating to displaced homemakers
Requested by _____ Date March 11, 1980

II. FISCAL DETAIL
Agency Affected _____
Program Category Affected _____
BRU, Program, or Subprogram(s) Affected _____
(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 80	FY 81	FY 82	FY 83	FY 84	FY 85
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL						
400 COMMODITIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC.						
TOTAL						

FUNDING (Millions of Dollars)

GENERAL FUND	-0-	-0-	--------	approx. (	1.5 to 2.	) annually
FEDERAL FUNDS						
OTHER (Specify Fund Source)						

POSITIONS

FULL TIME						
PART TIME						
TEMPORARY						

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

The bill would establish a displaced homemakers support program. Among other things, it proposes an income tax credit of 30 per cent of the first 12 months of compensation paid by an employer for each certified displaced homemaker.

The above estimate is based on information provided by the Alaska Commission on the Status of Women.

IV. DATE 3/14/80 PREPARED BY Barbara Sorensen
AGENCY REVENUE
PHONE #2174

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)

33-001 (Rev. 12/79)

THE LEGISLATURE OF THE STATE OF ALASKA
ELEVENTH LEGISLATURE

FISCAL NOTE

I. REQUEST

Bill/Resolution No. House Bill No. 936

Title An Act Relating to Displaced Homemakers, and Providing an Effective Date

Requested by _____ Date March 21, 1980

II. FISCAL DETAIL

Agency Affected Department of Education

Program Category Affected Adult and Continuing Education

BRU Program, or Subprogram(s) Affected Adult and Continuing Education

(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 80	FY 81	FY 82	FY 83	FY 84	FY 85
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL						
400 COMMODITIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC.						
TOTAL	-0-	-0-	-0-	-0-	-0-	-0-

FUNDING (Thousands of Dollars)

GENERAL FUND						
FEDERAL FUNDS						
OTHER (Specify Fund Source)						

POSITIONS

FULL TIME						
PART TIME						
TEMPORARY						

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

This bill has no fiscal impact on the Department of Education.

IV. DATE March 21, 1980 PREPARED BY [signature]

AGENCY Education

PHONE 465-2800

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)

33-001 (Rev. 12/79)

March 24, 1980

TO: COMMITTEE MEMBERS

FROM: SHANNON GARRETT

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Regional Adult Learning Center

P. O. BOX 74278 FAIRBANKS, ALASKA 99707

URBAN SERVICES
(907) 456-4810
(907) 456-4819
(907) 456-4829

RURAL SERVICES
(907) 452-8731
(907) 452-6434

CAREER DEVELOPMENT SERVICES
(907) 452-8731
(907) 452-6434

DISPLACED HOMEMAKER'S PROGRAM OF FAIRBANKS

1512 Cushman Street, Suite 203
Fairbanks, Alaska 99701

DISPLACED HOMEMAKERS:
A Needs Assessment

By

Jan Ackerman

DISPLACED HOMEMAKER'S PROGRAM OF FAIRBANKS
GENE KINGREA, DIRECTOR

ADULT LEARNING PROGRAMS OF ALASKA, INC.
A NON-PROFIT TAX EXEMPT 501(C)(3) EDUCATIONAL ORGANIZATION

ACKNOWLEGEMENTS

The Fairbanks Displaced Homemaker's Program would like to acknowlege the following persons for helping to conduct the survey for this report: April Moore, Margie Bauman, Juanita Helms, Beth Kaplan Lauesen and Rosemary Leap. A special thank you and acknowlegement go to Sandra Stringer and Karen Fox for their assistance in all phases of the preparation of this report.

*** ***

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***

INTRODUCTION

The Displaced Homemaker's Program is new to Fairbanks and to the rest of the United States. The problems of the displaced homemaker have just come to light in the last decade. Prior to that time a homemaker who, because of death, divorce or separation, found herself alone was dependent to a great extent on welfare, relatives or a small pension. She had no real hope of transition to a new and productive life.

The skills most homemakers utilize on a daily basis are not recognized as marketable by the great majority of employers. They are also not viewed as marketable by the homemaker herself. Many homemakers have never held salaried positions and those who have often have not worked for a number of years. Frequently their skills are out of date. The majority of these women feel totally unprepared and inadequate to participate in today's competitive job market. Most of these people are intelligent and capable but lack the self confidence, educational and vocational resources to help themselves. They need practical and emotional support to meet their special needs.

The Displaced Homemaker's Program was established to assist women during this transitional period. The Fairbanks program is staffed by professional counselors who, through their training and life experiences, are familiar with and sensitive to the problems of the displaced homemaker.

The primary function of the Displaced Homemaker's Program of Fairbanks is to ease the problems of transition and to act as an advocacy agency for displaced homemakers. The services the program offers are many and varied. They include transitional counseling, peer group support, workshops, educational and vocational training, job referrals and referrals to other agencies with follow-up support.

METHODOLOGY

After a review of the literature, it was determined that no current information was available on the existence or numbers of displaced homemakers in the Fairbanks community. Therefore, in order to obtain the information necessary for this report, a survey of the adult female population of this area was conducted.

Because of the great numbers and diversity of the people who attend the Tanana Valley State Fair in Fairbanks (1979 figures were in excess of 85,000 persons over a period of five days), I chose to conduct the survey at the fairgrounds and circulated my questionnaire for five consecutive days. This survey questionnaire placed emphasis on information relating to marital and/or dependency status and the economic and educational profiles of those women interviewed. Experienced interviewers approached adult females at random and careful consideration was given to days, hours and activities during the fair to insure that we obtained the broadest possible sample. As a further check, note was made of the general geographic location of each respondent's residence. Only Fairbanks area residents were selected for this interview.

Three hundred and two (302) women participated in the survey. Forty-six (46) of these participants were found to be widowed,

divorced or separated. These forty-six (46) women are the basis of this report.

SUMMARY

As this study of divorced, widowed and separated women evolved, the following trends emerged:

1. The divorced, widowed or separated woman is shown to economically disadvantaged. The unemployment rate in this segment of society is nearly four times the average for the Fairbanks area as of August, 1979. (This figure was confirmed by the Fairbanks Community Information Office).

2. While the problems of the divorced and widowed are readily apparent, the needs of the separated are critical by comparison. The separated woman is younger, has more children, has less education and less income per family member than the divorced or widowed displaced homemaker.

3. The displaced homemaker needs help in building employment skills, emotional support, personal effectiveness, money management, skills and finding financial aid for education.

I believe the problems of the Fairbanks displaced homemakers are acute due to several factors. Among these are a skyrocketing

unemployment rate, high costs for basic life necessities and the boom/bust economic cycle. All data gathered to date points to an even more severe decline in the status of displaced homemakers as their numbers increase. Theirs is not a problem which can be resolved with the passage of time. Their need is great and their resources are few.

DISPLACED HOMEMAKER'S SURVEY
302 Respondents

I. MARITAL STATUS

Status	Number of Respondents	Percentage
a. Divorced	26	8.6
b. Widowed	9	2.9
c. Separated	11	3.6
d. Married	211	70.0
e. Single/Never Married	45	14.9

Divorced, widowed and separated equal 15.1% or forty-six respondents. The rest of this report will deal with these forty-six respondents exclusively.

***

II. AVERAGE AGES OF DIVORCED, WIDOWED OR SEPARATED WOMEN

Status	Age
a. Divorced	38 years
b. Widowed	58 years
c. Separated	35 years
	AVERAGE AGE = 43 years

The oldest respondent is seventy-five years of age, the youngest is twenty-three.

***

III. NATIONALITY OR ETHNIC ORIGIN

Nationality	Percentage
a. White	78%
b. Alaska Native	10%
c. Black	9%
d. American Indian	1%

III. NATIONALITY OR ETHNIC ORIGIN (CONT.)

Nationality	Percentage
e. Spanish American	1%
f. Asian	1%

***

IV. DURATION OF MARRIAGE IN YEARS

Status	Average Years
a. Divorced	11
b. Widowed	25
c. Separated	11
AVERAGE YEARS MARRIED =	15

***

V. AVERAGE NUMBER OF CHILDREN BORN TO DIVORCED, SEPARATED AND WIDOWED WOMEN

Status	Number of Children
a. Divorced	1.5
b. Widowed	3.0
c. Separated	2.5
AVERAGE =	2.3

***

VI. AVERAGE NUMBER OF DEPENDENT CHILDREN IN HOUSEHOLD

Status	Number of Children
a. Divorced	1.25

VI. AVERAGE NUMBER OF DEPENDENT CHILDREN IN HOUSEHOLD (CONT.)

Status	Number of Children
b. Widowed	.5
c. Separated	2.5
AVERAGE =	1.72

***

VII. EMPLOYMENT STATUS

Status	Number of Respondents	Percentage
a. Employed	25	54%
b. Unemployed	21	46%

Unemployment in Fairbanks is currently 12.3%.
Source: Fairbanks Community Information Office.

***

VIII. UNEMPLOYMENT

Status	Unemployment Rate
a. Divorced	30%
b. Widowed	51%
c. Separated	57%
AVERAGE UNEMPLOYMENT =	46%

***

IX. OCCUPATIONS OF THE EMPLOYED

Occupation	Percentage
a. Professional	54%
b. Office Occupations	20%
c. Domestic Workers	10%
d. Sales	16%

***

X. SOURCES OF INCOME FOR UNEMPLOYED*

Sources	Percentage
a. Aid for Families with Dependent Children (AFDC)	34%
b. Public Assistance	41%
c. Alimony	2%
d. Child Support	2%
e. Death Benefits	2%
f. Pension	14%
g. Investments	2%
h. Social Security Benefits	21%
i. Other	20%

*Several respondents are receiving income from more than one source.

XI. AVERAGE INCOME OF DIVORCED, WIDOWED AND SEPARATED WOMEN

Employment Status	Average Income
a. Employed	$18,505.00
b. Unemployed	4,970.00
AVERAGE INCOME=	$11,737.00

Average income for a Fairbanks household according Demographic Characteristics of Fairbanks Population, by ISER, 1976, pg. 2 is $29,595.00.

***

XII. EDUCATIONAL PROFILE

Status	School Years Completed
a. Divorced	13
b. Widowed	12
c. Separated	

AVERAGE EDUCATIONAL LEVEL= 12 years

Seven of the respondents did not finish high school and three respondents obtained GED's.

***

XIII. TRANSPORTATION

Percentage of divorced, widowed and separated women who can drive a car:	93%
Percentage of divorced, widowed and separated women who own a car:	68%

***

XIV. HOUSING

Percentage of divorced, widowed and separated women who own their homes:	17%
Percentage of divorced, widowed and separated women who rent:	83%

***

XV. SPECIAL NEEDS

The respondents were asked to indicate which of the following would be most useful to them if help were available:

Displaced Homemaker's Program of Fairbanks

XV. SPECIAL NEEDS (CONT.)

Employment:	Percentage
a. Look for a job	36%
b. Fill out applications	13%
c. Write a resume	20%
d. Be prepared for a job interview	26%
e. Get clear on career goals	30%
f. Identify skills	50%

Building Emotional Support

a. Handle tension/anxiety	39%
b. Deal with confrontations	20%
c. Build parenting skills	22%
d. Manage time	38%
e. Cope with feelings of grief, anger and guilt	39%
f. Identify personal needs & goals	46%

Building Personal Effectiveness

a. Manage money	47%
b. Establish credit	31%
c. Find financial aid for education	46%
d. Find resources for the following:	
1. Legal	31%
2. Medical	26%
3. Child Care	18%
4. Moving	8%
5. Banking	9%

*** *** ***

List of Witnesses

3/12/80

ANCHORAGE

Staff

- ✓ * GORDON JENKINS
- ✓ * LYNN WOODS, AK Com. on Status of ♀
- HELEN FISCHER
- Helen ROBERTS
- REPRESENTATIVE - League of ♀ Voters
- ✓ DR. DONNA GAVAC - Anch. comm. college
- ~~[illegible]~~
- PAT REEVES -

FAIRBANKS

(Marcine)

Staff - Displaced Homemakers

- LESLIE MELLARD
- DEANNE HELFRICH
- CONNIE DAVIS
- NANCY HIDDEN

- ✓ GENE KINGREA, Dir. Senior Counselor for Displaced Homemakers
- LINDA WITKOF
- SUSAN GLEN
- DEBORAH BROWN — Need in Job Service
- BEVERLY SHULZ
- ✓ SISTER ALICE, Catholic Charities
- JUDITH RYLANDER
- DELORES SCHRAER
- KATHY OVERLY
- MAUREEN ~~MORI~~ WRITE
- CATHERINE ~~CRIMP~~ McCAGIN
- ~~[illegible] M. ROBERTS - Mr. ♀'s Resource~~

BETHEL (WALLY)

- ✓ ~~JACKY~~ RHUMALI
- ✓ MARY ABRUSKA
- WARD LOW
- ✓ * DIANE CARPENTER

KENAI PENINSULA (RHODA)

- ✓ JOAN B SCHRADER - SELF
- PATTY KING - ♀'s Resource Center
- JEAN NAPPIER - JUDITH GROUPE

KODIAK

- ✓ KAY ACKERMAN - ♀'s resource center
- ✓ ~~PAM~~ HERMAN

KOTZEBUE

- SKETER ~~[illegible] JEASON~~
- ✓ FLORENCE HAWKJETTON

K. KAN

- REBECKA SMITH
- ALINE ~~[illegible]~~ BARRETT
- GIGI PILCHER
- ✓ ~~[illegible]~~ RADER

---

* Chairman BUCHHOLDT - These 2 individuals would like to testify a.s.a.p. Mr. JENKINS has a 2:00 p.m. appt; Ms WOODS feels her testimony is a good foundation

Fairbanks

DISPLACED HOMEMAKERS PROGRAM

During the period of June 18, 1979 to March 1, 1980, the Displaced Homemakers Program has served 316 persons. Because of certain CETA restrictions, only 241 were served as a matter of record. Of these 241 persons, 62 were granted funds for vocational or educational training.

The following is excerpted from the Displaced Homemakers Program quarterly report on the period of October 1, 1979, through December 31, 1979, and is a descriptive break-down of specific services rendered to clients during that quarter.

138 Clients — 26 Positive Job Placement-18% — 17 Positive Termination-12%

SERVICES OFFERED	NUMBER OF CLIENTS	PERCENTAGE
Personal Counseling	135	97.0%
Educational Funding	37	26.0%
Educational Referral:	83	60.0%
ABE	6	4.0%
TVCC	38	27.0%
GED	28	20.0%
REC'D GED	5	3.0%
FIN. AID (STATE)	13	9.0%
VOC. ED.	9	6.0%
V.A.	2	1.5%
OTHER	18	13.0%
Social Service Referral:	74	53.0%
P.A. (AFDC, Food Stamps, etc.)	35	25.0%
Social Security	1	.75%
Housing	14	10.0%
Borough (Day Care Assistance)	24	17.0%
Legal	19	13.0%
JVR	7	5.0%
OTHER	25	18.0%
Vocational Exploration	98	71.0%
Employment Assessment	97	70.0%
Workshop Participation	29	21.0%
Discussion Group Participation	61	44.0%
Labor Market Orientation:	84	60.0%
CETA	40	28.0%
Job Service	59	42.0%
Other	22	15.0%
Job Search Skills	33	23.0%
Skills Assessment	36	26.0%
Job Application	33	23.0%
Resume	32	23.0%
Interviewing Techniques	33	23.0%

FEMALES - 135

MALES - 3

ETHNIC GROUPS

WHITE	-	107
BLACK	-	14
HISPANIC	-	3
AI/AN	-	13
ASIAN	-	1

AGE

19	-	under	3
20	-	21	9
22	-	44	98
45	-	54	18
55	-	over	10

* * *

ALPA INCORPORATED
Proposed Budget Outline: Displaced Homemakers Program

PERSONNEL

Program Coordinator/Senior Counselor $2300/mo x 12 months x 1	$ 27600.00
Support Counselor $1800.00/mo x 12 months x 3	64800.00
Community Resource Specialist/Training Facilitator $1900.00/mo x 12 months x 1	22800.00
Intake Worker $1500.00/mo x 12 months x 1	18000.00
Secretary $1200.00/mo x 12 months x 1	14400.00

STAFF BENEFITS

1.34% Workmen's Compensation Insurance 5.85% Unemployment Insurance (ESC) 7.39% Health Insurance 14.58% TOTAL	21520.00
TOTAL PERSONNEL	$169120.00

PROGRAM

Rent & Utilities $900.00/mo x 12 months	10800.00
Instructional supplies (books, paper, etc.)	10000.00
Tuition for participants	20000.00
Workshops and Supportive Service	5000.00
Telephone	5300.00
Office and Instructional Equipment Rental	4800.00
Consultant Services	5000.00
TOTAL PROGRAM	$ 60900.00
TOTAL PERSONNEL AND PROGRAM	230020.00
INSTITUTIONAL INDIRECT (10%)	23002.00
** TOTAL REQUEST **	$253022.00

Displaced Homemakers Program, ALPA, Inc.
CURRENT BUDGET SUMMARY

Line Items	Totals
Wages, salaries & fringe benefits	$120,948.00
Intake Center rental	9,936.00
Telephone rental	1,344.00
Staff travel	624.00
Consultant fees	4,800.00
Counselor equipment rental	2,880.00
Supportive services	1,000.00
Instructional materials & supplies	8,800.00
Workshops to enhance employability	1,500.00
Tuition	16,800.00
SUBTOTAL	$168,632.00
Administration at 7 5%	12,647.00
AL	$181,279.00

Bill No. House Bill 936 **Date** March 11, 1980

Title An Act relating to displaced homemakers; and providing for an effective date

Contact: Judy DuBois 465-2700

House Bill No. 936 "An Act relating to displaced homemakers; and providing for an effective date" is proposed to establish multipurpose service centers to provide services for Alaskan displaced homemakers.

Although the conceptual emphasis of the bill is supported, we have four primary concerns in relation to its implementation. First, the bill does not indicate the size or distribution of the population to be served and thus does not indicate sites as where the multipurpose centers will be established. A second concern is the tax credit provision for displaced homemakers. It appears that the displaced homemakers tax credit is a duplication of the proposed Alaska State Jobs Tax Credit program and may be a moot issue in view of the current tax legislation before the Alaska Legislature. A third concern is the current existence of federal funds available for displaced homemaker services. It appears that by consolidating existing displaced homemaker service programs and by utilizing present funding sources, expansion of services to additional geographical areas of the State of Alaska could be accomplished without the inclusion of State funds.

Lastly, the proposed legislation duplicates the current efforts of providing employment, counseling and necessary referral services for eligible displaced homemakers by Job Service and the Alaska Work Incentive program. It would appear that since Job Service and the Work Incentive program are currently operational, they should be utilized as the primary administrative and service provider vehicles for the proposed displaced homemaker legislation. This is especially pertinent when it is recognized that the population to be served by this legislation are or will be eligible for existing agency's services and that the proposed multipurpose centers will function as primarily a referring organization.

Departmental Position: Opposed in current status.

POSITION PAPER/Department of Labor

March 24, 1980

TO: COMMITTEE MEMBERS

FROM: SHANNON GARRETT

The following are proposed amendments to HB 936 which the committee has received through letters and the teleconferencing on the bill.

PAGE 1 LINE 28- Insert the words "aptitude testing" between the words "counceling" and "training".

PAGE 2 LINE 18- Insert from Pg. 3, line 8, the #(3) section in it's entirety and add a new (A) to read"(A) Supportive transitional counceling." Reletter rest of sec. accordingly.

PAGE 3 LINE 4- Some question has been raised as to the age requirements of apprenticeship training (I really don't think the committee can address that problem in this bill but I have included it because it was brought up several times.)

PAGE 3 LINE 5- After "programs;" insert " re-entry refresher courses;".

PAGE 3 LINE 14- Insert the words "dental care" between "care" and "and".

PAGE 3 LINE 21- Insert the words "and assistance" between "information" and "relating."

PAGE 3 LINE 24- Delete "determined by the commissioner to be" It is felt that the commissioner may be inclined to select only that information Which applies to traditional job roles.

PAGE 4 LINE 19- Isert "a reimbursment" between "agency" and "not".

PAGE 5 LINE 3- Delete "six years" and insert "two years".

PAGE 5 LINE 4- Insert "in a" between "been"and "dependent" and after "dependent" insert "role".

March 24, 1980

TO: COMMITTEE MEMBERS

FROM: SHANNON GARRETT

The following are proposed amendments to HB 936 which the committee has received through letters and the teleconferencing on the bill.

Adopted

PAGE 1 LINE 28- Insert the words "aptitude testing" between the words "counceling" and "training".

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Stan's bill

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List of Witnesses

3/12/80

Anchorage

① ✓ STAN ~~Gordon~~ JENKINS

②✓* LYNN WOODS, AK Com. on Status of ♀

HELEN FISCHER

Helen ROBERTS

REPRESENTATIVE - League of ♀ Voters

⑨ DR. DONNA GAVAC - Anch. comm.

STAN ~~JENNINGS~~

PAT REEVES -

Fairbanks

(Maxine) LESLIE MELLARD
DEANNE HELFRICH
CONNIE DAVIS
NANCY HIDDEN
} Staff - Displaced Homemakers

④✓ GENE KINGREA, Dir. Senior Counselor for Displaced Homemakers

LINDA WITKOF

SUSAN GLEN

DEBORAH BROWN

Beverly Shultz

⑪ SISTER ALICE, Catholic Charities

JUDITH ~~RYLANDER~~

DELORES SCHRAER

KATHY OVERLY

~~MAUREEN MORE~~ WHITE

~~CATHERINE CRAFT~~ McCACKEN

~~HELEN M. ROBERTS~~ - AK. ♀'s Resource ✓

Wasilla

⑩ Barbara Sole

Bethel (Wally)

⑫ JACKY RHUMAN

MARY ABRUSKA

WARD LOW

③✓ DIANE CARPENTER

Kenai Peninsula (Rhoda)

⑬ JOAN B. SCHRADER - SELF

⑤✓ PATTY KING - ♀'s Resource Center

JEAN NAPPIER - JUDITH GROUPE

Kodiak

⑥✓ KAY ACKERMAN - ♀'s Resource Center

PAM HERMAN

Kotzebue

~~SKETER~~ ~~JEPSON~~

⑦✓ FLORENCE HAWKJETTON (mental health field)

⑭ Pamela Herman
250 ♀ N. child care
760 region unem. ♀
618 men " "

K. Kan

REBECKA SMITH

~~ALINE~~ BARRETT

GIGI PILCHER

~~LORRINE~~ RADER

---

* Chairman BUCHHOLDT - These 2 individuals would like to testify a.s.a.p. Mr. JENKINS has a 2:00 p.m. appt; Ms WOODS feels her testimony is a good foundation

HB 936
Amendments proposed by Fred Ali, C&RA

Page 1:

Change Section 1 (b)(1) to read as follows (lines 28-29):
(1) provide the necessary counseling, training, employment placement and other services for displaced homemakers [;] through contracts with public or private nonprofit organizations and by utilizing and expanding existing state programs.

Page 2:

Change Section 2, 47.90.010(a) to read as follows (lines 8-12):
(a) The commissioner...may contract with public or private nonprofit organizations for multipurpose service centers for displaced homemakers [.] and expand existing state programs through reimburseable service agreements.

Add to Section 2, 47.90.010 a new subsection (c):
(c) The commissioner shall establish a competive contract procurement process that ensures free and open competition for funds allocated for programs established in this chapter. As part of this procurement process, it is intended that public or private nonprofit organizations and state agencies may propose to provide all or a portion of the services listed under AS 47.90.020.

Page 3:

Add to Section 2, 47.90.020(2), line 7, the word and
(and delete ~~[and]~~ from line 5)--- then add a new subsection (E)
to this section to read as ~~follows~~:
(E) ~~expose~~ introduce displaced homemakers to nontraditional occupations.

Page 4:

At the end of Section 2, 47.90.030, add the following sentence:
Under the procurement process established under AS 47.90.010, the commissioner will give preference to applicants proposing to fill staff positions with displaced homemakers.

Delete Section 2, 47.90.060 and replace it with the following section:
Sec. 47.90.060. STATE EMPLOYMENT ASSISTANCE. Contrators operating programs under this chapter will, to the maximum extent possible, provide displaced homemakers with assistance in being placed on state employment registers. This will be accomplished with the assistance and cooperation of the Division of Personnel and the Department of Community and Regional Affairs.

Page 4:

Delete Section 3, 43.20.037 in its entirety. (If the Committee decides to do this, it must delete the reference to this section on page 4, line 17.)

Delete Section 4 and include the following language instead:
All provisions of this Act will take effect July 1, 1980. During FY '81, the commissioner will consult with appropriate groups and state agencies concerned with displaced homemakers, adopt resolutions prescribing program standards, adopt a competitive procurement process, provide information and assistance to groups interested in conducting displaced homemaker programs, and fund one or more limited pilot projects.

March 24, 1980

TO: COMMITTEE MEMBERS

FROM: SHANNON GARRETT

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Proposed CS for HB 936 (work completed by Committee thus far)

Proposed CS for HB 936 (Work completed by Committee thus far)

For an Act entitled: "An Act relating to displaced homemakers; and providing for an effective date."

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

Section 1. LEGISLATIVE FINDINGS AND INTENT. (a) The legislature finds that there is an increasing number of persons in the state who, after having fulfilled the role of homemaker for a number of years of their life, find themselves "displaced" through the dealth of a spouse, divorce, separation, desertion, or loss of family income. The legislature finds that displaced homemakers are often without any source of income, face continuing discrimination in employment because they frequently have no recent work experience and may be older than other applicants for employment, are subject to high rates of unemployment and are ineligible for unemployment insurance because they have been engaged in unpaid labor in the home, may be ineligible for categorical welfare assistance, are ineligible for social security if they have been divorced from the family wage earner, may have lost their rights as beneficiaries under employers' pension and health plans through death of a spouse or divorce despite the contribution of years to the well-being of the family, and may be ineligible for Medicaid and unable to purchase private health insurance because of age and lack of income. The legislature further finds that homemakers are an unrecognized part of the work force of the state who have made an invaluable contribution to the welfare of society.

(b) It is the intent of the Act to

(1) provide the necessary counseling, aptitude testing, training, employment placement, and other services for displaced homemakers[;] through contracts with public or private nonprofit organizations and by utilizing expanding existing state programs

(2) improve the mental and physical health and welfare of this growing group of members of the community; and

(3) provide displaced homemakers with independence and economic security vital to a productive life.

Sec. ?. AS 47 is amended by adding a new chapter to read:

CHAPTER 90. DISPLACED HOMEMAKERS.

Sec. 47.90.010. PROGRAM ESTABLISHED. (a) The commissioner, in consultation with state and local governmental agencies, community groups, and groups concerned with displaced homemakers, may contract with public or private nonprofit organizations for multipurpose service centers for displaced homemakers[.] and expand existing state programs through reimburseable service agreements.

(b) The commissioner shall adopt regulations prescribing the standards to

Proposed CS for HB 936 (work completed by Committee thus far)

mortgages, loans, and related financial matters;

(5) educational services including

(A) information, including the availability of monetary assistance programs, relating to courses offering credit through secondary or postsecondary education programs and reentry programs, including bilingual programs if appropriate; and

(B) information about other programs [DETERMINED BY THE COMMISSIONER TO BE] of benefit to displaced homemakers;

(6) legal counseling and referral services; and

(7) information services with respect to federal and state employment, education, health, public assistance, and unemployment assistance programs which the commissioner determines to be of benefit

The Committee stopped its deliberations at this point (end of page 3 in original bill).

be met by each multipurpose service center for displaced homemakers in accordance with the policies established in this chapter.

(c) The commissioner shall establish a competitive contract procurement process that ensures free and open competition for funds allocated for programs established in this chapter. As part of this procurement process, it is intended that public or private nonprofit organizations and state agencies may propose to provide all or a portion of the services listed under AS 47.90.020.

Sec. 41 10.020. MULTIPURPOSE SERVICE CENTERS. A multipurpose service center for displaced homemakers established under AS 47.90.010 may provide the following services:

(1) job counseling services which shall

(A) be specifically designed for displaced homemakers;

(B) counsel displaced homemakers regarding job opportunities; and

(C) consider and build on the skills and experience of a homemaker and emphasize job readiness as well as skill development;

(2) job training and job placement services which shall

(A) emphasize short-term training programs which expand upon homemaking skills and volunteer experience and which lead to gainful employment;

(B) develop through cooperation with state and local government agencies and private employers training and placement programs for jobs in the public and private sector;

(C) assist displaced homemakers in gaining admission to existing public and private job-training programs and opportunities including vocational education, reentry into secondary and postsecondary educational facilities, and apprenticeship training programs; and

(D) assist in identifying community needs and creating new jobs, including nontraditional occupations for displaced homemakers, for displaced homemakers in the public and private sector;

(3) health counseling services including referral to existing health programs with respect to

(A) general principles of preventive health care;

(B) health care consumer education, particularly in the selection of physicians and health care services including health maintenance organizations and health insurance;

(C) mental health care and transitional counseling;

(D) family health care, dental care and nutrition;

(E) alcohol and drug abuse; and

(F) other related health care matters;

(4) financial management services which provide information and assistance relating to insurance, taxes, estate and probate matters,

THE FOLLOWING DOCUMENT(S) MAY NOT FILM LEGIBLY BECAUSE OF POOR QUALITY OF THE ORIGINAL.

Testamony to the Health, Education and Social Services Committee on behalf of HB 936 relating to Displaced Homemakers:

As testamony via Teleconference Network was interrupted, I would like to submit these remarks regarding the Displaced Homemakers Bill.

I am an Employment Counselor although I am not representing any governmental agency. I encounter daily women who come looking for jobs who are entering or re-entering the labor force after living as a homemaker. They typically have no experience in the labor market, they lack employable skills, and usually have little or long-distant education. But on top of this, their lives as dependent people have not provided the image of themselves as capable money-makers. As an Employment Counselor, no amount of learning job-search skills will make up for the low-self image most of these women have.

I support most heartily the HB 936 with these recommendations:

1. 6 years is too long a limit; Alaska's population is young and a woman who has spent most of her life as a dependent woman needs assistance with the transition to independence;

2. Page 3, section 3, Line 17 I support the addition recommended by Anchorage women that mental health conseling be added. In order to counter the image of dependency and incompetency, a woman must learn problem resolution, decision-making, coping skills, and assertiveness before she can approach the job-market in a confident manner necessary to compete in the labor market.

Finally, I support the management of Displaced Homemakers Progress by independent service agencies rather than state agencies who are hampered by Federal Regulations. Thank you. Rebecca L. Smith

If these alternatives are not provided to our displaced homemakers, the result will continue to be an ever increasing permanent welfare population. The more practical resolution is a comprehensive plan that will return these women to the job force and allow them to contribute as independent, capable individuals.

Aline Cole Barrett

Aline Cole Barrett
Executive Director

THE PRECEDING DOCUMENT(S) MAY NOT FILM LEGIBLY BECAUSE OF POOR QUALITY OF THE ORIGINAL.

STATE OF ALASKA

JAY S. HAMMOND, GOVERNOR

DEPARTMENT OF REVENUE

OFFICE OF THE COMMISSIONER / POUCH S – JUNEAU 99811

March 12, 1980

The Honorable Thelma Buchholdt
Cahirman
House Health, Education &
Social Services Committee
Room 112 - Capitol Building
Juneau, Alaska 99811

Dear Ms. Buchholdt:

Re: House Bill No. 936, an Act relating to displaced homemakers, was introduced in the House on March 6, 1980 and was referred to the House Health, Education and Social Services Committee.

For the consideration of the House Health, Education and Social Services Committee, I am enclosing copies of Fiscal Notes prepared by Gary Jenkins, Director, Audit Division and Barbara Sorensen, Research Section of the Department of Revenue concerning the proposed legislation.

Sincerely,

R. D. Stevenson
Special Assistant

cc: Joseph K. Donohue
Deputy Commissioner
Department of Revenue

Gary Jenkins, Director
Audit Division
Department of Revenue

Vincent Wright
Research Section
Department of Revenue

04-D2LH

THE LEGISLATURE OF THE STATE OF ALASKA
ELEVENTH LEGISLATURE

FISCAL NOTE

I. REQUEST

Bill/Resolution No. House Bill No. 936

Title An Act relating to displaced homemakers

Requested by House Health, Education & Social Ser. Comm Date 3/10/80

II. FISCAL DETAIL

Agency Affected Revenue

Program Category Affected Fiscal Services

BRU, Program, or Subprogram(s) Affected Audit Division

(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 80	FY 81	FY 82	FY 83	FY 84	FY 85
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL						
400 COMMODITIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC.						
TOTAL	-0-	-0-	-0-	-0-	-0-	-0-

FUNDING (Thousands of Dollars)

GENERAL FUND	-0-	-0-	-0-	-0-	-0-	-0-
FEDERAL FUNDS						
OTHER (Specify Fund Source)						

POSITIONS None

FULL TIME						
PART TIME						
TEMPORARY						

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

See attached memorandum to R. D. Stevenson dated 3/10/80.

IV. DATE March 10, 1980 PREPARED BY Lou Jenkins

AGENCY Department of Revenue, Audit Division

PHONE 465-2320

Original: Legislative Finance

cc: Budget and Management

Prime Sponsor (First Legislator Named)

33-001 (Rev. 12/79)

THE FOLLOWING DOCUMENT(S) MAY NOT FILM LEGIBLY BECAUSE OF POOR QUALITY OF THE ORIGINAL.

March 12, 1980

TESTIMONY ON HOUSE BILL NO. 936

TO THE HEALTH, EDUCATION AND SOCIAL SERVICES

COMMITTEE

THELMA BUCHOLDT, CHAIRMAN

My name is Flora "Skeeter" Jepson, L.PN. at the Kotzebue Senior Citizen Center.

I am representing the Senior Center and myself.

I support the Bill No. 936 "Displacement Homemakers" for the following reasons:

(1). There are no programs or facilities here in Kotzebue for "displaced homemakers". This type of program is greatly needed NOW.

(2). I have had friends stay with us at home because they have had no place else to go. If there was a program like this here in Kotzebue I know that they would make good use of it. Knowing them I know for a fact that they do not want to get on any type of Welfare programs.

(3). Within the NANA Region, I know that there are many other Ladies caught between a "rock and a hard spot" because of no place to go or to turn to.

I would like to see the following changes made:

Page five, line two,

;should be eliminated or expanded to a variety of cases.

Thank you very much.

Flora "Skeeter" Jepson LPN

K.S.C.C.

WISH

Ketchikan, Alaska 99901
(907)225-2730

WOMEN IN SAFE HOMES

A Safe Alternative for Battered Women & Their Children

DISPLACED HOMEMAKERS

Displaced homemakers are those women old and young who have spent years in the home nurturing the family, supplying unpaid labor in the form of housekeeping, child care, budget management, food preparation and providing other contributions that would be considered valuable if anyone other than a housewife performed them.

The traditional role of wife, mother, and homemaker does not provide women with experiences that can readily be translated into recognizable job skills when her services are no longer needed or wanted in the home.

Displaced homemakers are women who are thrust on the job market as a result of divorce, spousal death or separation without appropriate job finding skills, education, or job history. The result is a growing population of unskilled, undereducated women who have a difficult, if not impossible, transition from home to outside occupation.

Of 122 abused women who were provided with shelter and aid last year by Women in Safe Homes, 15 percent became displaced homemakers as an alternative to the violence in their homes. Ketchikan has a high rate of desertion by spouses who leave their families without support because of an inability to find a high paying job in Alaska.

Almost 80 percent of the displaced homemakers serviced last year were transferred outside of the state because of the lack of resources available to them here.

It is so important for the State of Alaska to make a provision for local services for the displaced homemakers in our state.

These services required in Ketchikan include:

1. Individual and supportive group counseling for values clarification, conflict resolution, coping skills, and increased self-esteem.
2. Assertiveness training.
3. On the job training.
4. Education in job hunting techniques, resume preparation, and career alternatives.
5. Adequate and available child care during training, counseling, and work.
6. Employment counseling and aptitude testing.
7. Referral and advocacy services for location of housing, legal advice, medical treatment and health education, parenting skills, nutrition counseling, and alcoholism treatment.

DISPLACED HOMEMAKERS
by Elizabeth Union-Jakubek
Alcoholism Counselor
Ketchikan Alcoholism Program

Many researchers say that women, far more frequently than men, are able to point to a specific incident in their lives which they believe precipitated heavy drinking. The factors most often cited are death of a loved one, divorce, grown children leaving home, and obstetrical and gynecological problems.

These are also some of the factors that force women unprepared into the job market. Women who have been homemakers for years-who have few marketable skills.

The majority of my adult female caseload which at present numbers approximately 20 individuals-have two major hurdles facing them.

1. Attaining and maintaining sobriety as well as
2. finding a way to support themselves and their children

outside of welfare payments and food stamps.

True these women have been handicapped by their alcoholism-but one of the greatest threats to their sobriety are lack of skills, lack of self confidence and a limited job market.

A comprehensive program that could be made available to women such as my clients would greatly increase the chances of these women becoming functional, contributing members of our soci y.

Respectfully submitted,

E. A. Union-Jakubek

Elizabeth A.Union-Jakubek
Counselor for Women and Youth
Ketchikan Comprehensive Alcoholism Prog.

DISPLACED HOMEMAKER

Testimony to H.E. & S.S. committee on HB 936
by Jayne Wagner

Being a Displaced Homemaker I suddenly found myself the sole-supporter of myself and three children, because I would not allow myself to be physically, emotionally, or economically abused in my relationships. Not only was I being abused, but my children were being emotionally abused thru witnessing these incidents.

I found myself with out a home, income, transportation and standing in the welfare lines not being able to support my family above the Public Assistance level because of lack of vocational or educational training and no extended job experience, since I had spent all my time and energys in marriage, running a home, being a wife and mother of young children.

When seeking help in my community in Washington to leave the violent relationship I was referred to a Seattle Shelter for Battered Women where I had time and most of all safety to make arrangements for transportation for myself and children. When arriving in Ketchikan I contacted the WISH office and got some referrals and supportive counseling to continue my search for a job and housing, which I have accomplished with their aid.

More women need to know of the support and resources that can be available to them to have an independance in their life. I feel there is a need for more job services, training, and childcare in Ketchikan for women who want to remain in the Ketchikan area.

Response to HB 930 March 12, 1983 Teleconference

Madam Chairman,

I am Joan Bennett Schrader and [redacted] testifying for myself. As a woman who, except for the most fortunate of circumstances, could be with-in the group you are discussing, [redacted] I am strong and continuing. There is no need for me to list the particulars of what happens to a displaced home-maker. We are all aware of the particular problems. I support this bill; however I feel there are some aspects that need close scrutiny.

Page one, line 9.....the scarcity of aid available to encourage community members to re-set their goals and to learn new skills seems to be [redacted] paucity of pre-advisory testing. This is available in Anchorage but for some-one with little or no money, possibly no vehicle, and a need for baby-sitters, Anchorage may as well be Nome. Insufficient testing and then counseling them into schools or training programs that are not sufficient to meet their needs is devestating to their self-confidence. EX: I am a 49 year old woman who would find herself in a secretarial or office skills program. Nothing wrong with such a course, but for 35 years I have detested office skills. A personal matter but if I am to be successful in learning and applying new skills, I must at least feel comfortable and not drowning in skills or a job that I detest. How comprehensive will this job testing be? The counseling? How integrated will the counselors knowledge be, both in [redacted] places for my area and where is the training available. How imaginative will the counselor be? Will he/she know this state? Will they understand the Alaskan life-style? Will they be bound by what is traditional? Out of 50, will they see training a 49 year old in the computers to sort fish, grade, and learn areas of processing; to implement training for maintence or service [illegible]

Page two, line 20.....Here again, as in counseling, knowledge of the community is essential. In the Kenai-Soldotna area [illegible] oil-related employment. Will the displaced home-maker find the [illegible] only for the lower level office staff? or will the training be [illegible] job with-in these facilities? [illegible] basis of household [illegible] good access to such facilities and well paid employment, with [illegible] defined up-ward movement, not some job with little chance of [illegible] or up-grading.

Page two, line 29..... [illegible] I firmly believe that should I find myself in a [illegible] as a mother and grandmother would [illegible] relative" training [illegible] to children using ideas that [illegible] not prepared me for. Would I be [illegible] of the secretarial school [illegible]

Page two, line 36.....What is short term? A course of three to six months may suffice for those who have had previous grounding in the training being undertaken, but would be insufficient for those newly introduced to the course.

Page two, line 39.....this could be the area where this program would succeed or flounder. If the state agencies and private training see this program as a possible source of well-trained, skilled workers, [illegible]. Would they, on the other hand, view this as a source of [illegible] stenos [illegible]

' feeling of self worth in the displaced homemaker is a great need. Low paying jobs as a goal rest low on the Totem Pole. certainly, many of those retrained will be comfortable in less demanding/lower paying jobs but they should not be channelled into them as a matter of course.

Page three, Line 1.....Omit this for any homemaker over the age of 25 (approx) as trade Union regulations forbid apprenticeships to anyone older. And they would really have to be sold on apprenticeship program that would change this rule when they have apprentices out of work for months at a time.

Line 7.....Good idea, if it avoids the pitfalls I commented on re: alternative training.

Line 10.....Small counties have a desperate need of more health care.

Line 14.....Excellent!

Line 17.....Desperately needed.

Line 21.....Also, provided this service is clearly marked for information of what is available for training throughout the state and nation.

Line 26.....The Omaha State Bar Association could be of aid here as the usual course for the homemaker is to a local attorney first and that is where the homemaker needs to be advised of a vested interest in her spouses pension plan and his/her social security before the divorce. It is not practical for the homemaker to have legal advise only after the divorce.

Line 24.....This could be a problem area. Should the commissioner/staff/feel uncomfortable with the idea of non-traditional jobs, and the homemaker feel he/she has a viable interest and capability in that field, what are the channels of appeal for the homemaker? I see shades of the Peter Principle in this. It may well be the counselor/counselor/staff/commissioner are not able to see homemakers in other than traditional jobs.

Page four, line 10.....It is good to include the Department of Labor. This department, by my understanding is the governing body. We are talking about a section of the work-force, primarily, that is specified as to why they are not meeting the above. Public, legal and other workers are secondary to enabling workers (in this case homemakers) secure profitable, timely and responsible employment. It is in the area of work, the training for work, either in school or on the job, or a combination of these, and the eventual placement of workers on a job site, these would be in turn to contribute to the tax structure. All the health and education efforts are geared to this end and meet the intent of this bill. Why is the Department of Labor not spearheading this effort?

Line 14.....Economically injured men should be made aware of their ability to qualify too.

Line 19.....With the knowledge of unemployment here private business I can foresee problems in this area.

SK: My agency needs 10 workers for lower echelon positions plus 5 highly paid consultants. The budget will not stretch that far. However, if I hire 7 homemakers on the 3% off I can then hire three non-homemaker at the regular rate. My two consultants are now within my reach. My budget is in line, my employer happy and the homemaker staff happy. Everything is fine but the danger here is for the homemakers who need the feeling of being able to compete on a equal basis at the work level, to feel well-trained and capable in the labor force. They could, if this portion of the bill not be closely monitored, become meshed into a "ghetto" situation. Carried to a logical conclusion, the possibility of "de facto" segregation from the valuable "give & take" with non homemakers could result. Part of any employment training is from our fellow workers and that is a very valuable part. It would be destructive to their concept of themselves as valuable and capable workers. That of the non-homemakers view. Does this carry reverse discrimination? The State of Alaska carried the concept of part-time employees far beyond reason, and in my opinion, to the detriment of those workers.

If the training programs are well thought out, imaginative, bold. The staff not out of touch with the realities of our communities; if the programs be well co-ordinated then you will produce good workers who are able and more than willing to compete with any worker.

Equal Pay - Here I have a feeling [illegible] On occasion I can see a weakening of the value of this program to the homemaker. Possibly, even above. Possibly those women from the mainstream of the employment market with its competition and stress are not what I see the homemaker as wanting. Rather let them learn, compete and grow with female employment.

Thank you for listening to me.

Joan Kennedy Schrader

MAUNELUK MANPOWER

P.O. Box 725
Kotzebue, Alaska 99752

Phone
(907) 442-3860

T E S T I M O N Y

in support of
H.B.936

Submitted by: Pamela Herman, Planner
Mauneluk Manpower

Thank you, Madam Chairman, for an opportunity to testify in support of H.B. 936, which would establish a program for Displaced Homemaker Multi-Service Centers through funding from the Alaska Department of Community and Regional Affairs. We enthusiastically support this legislation.

First, I would like to offer some statistics that indicate the size of the population in this region which could be affected by this program:

* There are about 750 unemployed or underemployed females in the regional labor force (estimated at 2276) and about 600 unemployed or underemployed men. The unemployment rate is an estimated 43%.
* There are 250 women for whom "no adequate child care substitute is available." These are women who could become displaced homemakers if their current source of financial support is lost.
* The median grade completed among women 35 years old or older is 6.0; for men of the same age, 6.5 years.
* There are almost as many employed mothers as fathers in the region. By the same token, there are a number of families dependent upon subsistence food-gathering efforts of the father for their livelihood.
* Only 30% of the regional workforce (those who manage to find a job) is employed full-time, year-round.
* According to our Regional Strategy Survey, conducted by the Dept. of Community and Regional Affairs under contract to Mauneluk Association, subsistence resources are significant alternatives to employment income for three times as many families as are state or federal income payments or food stamps.
* According to the records for the Second Judicial District of the Superior Court for the State of Alaska, 36 divorces were filed in 1975; 43 in 1976; 56 in 1977; 63 in 1978. This includes both Nome and Kotzebue.
* In March, 1979, 129 families in this region received AFDC; this is 3.2% of the statewide AFDC caseload, although the region has only 1% of the state's population. The regional AFDC caseload with adults not included is 104, and each of those cases can represent up to 6 children. This is 9.1% of the statewide caseload. Informal placements of children outside their homes is 18 times more common in this region than statewide.
* 25% of live births at the Kotzebue P.H.S. Hospital are to women 19 years old or younger.

This evidence would indicate a potentially large displaced homemaker population in the region, spanning a wide range of age and including members of both sexes. The large unemployment figure should also give an indication of how much of a problem displaced homemakers have finding work when they are thrown onto the job market.

We have spent the last five months planning a displaced homemaker program which we are now seeking to fund. One of the goals of the project is to find out more about the characteristics of our target population, but we already know that displaced homemakers in this region face the following barriers to employment:

* very few jobs are available to anyone
* clients lack education
* clients can't find markets for skills they have
* employers can't find workers with skills they require
* clients often have a poor command of written English
* demands of large families make job retention difficult for single parents
* dietary requirements and cultural patterns require seasonal absences from work to pursue subsistence activities
* individuals of social standing in the community require jobs commensurate in prestige
* the qualities that fit one for traditional subsistence life sometimes make the adjustment to less physically active occupations very difficult
* patterns of alcohol abuse are such that frequently creative or talented individuals suffer through periods of instability on the job.

The program we intend to operate will be a supplement to the services we already provide for displaced homemakers through our CETA program. We want to offer the following services specifically designed to overcome the common problems faced by displaced homemakers: information and outreach, work experience, job training, tuition and allowances while in training, technical assistance in establishing cottage industries, marketing services for cottage industries, expanded day care services, employer education, supportive services including housing assistance, clothing and gear for work, medical and dental services, travel from home village to Kotzebue in order to find work, alcoholism and family crisis counseling and referral, and most important, individual and group counseling to overcome psychological barriers to retaining work and building a satisfactory life. We believe that all of these services are necessary to serve the target population and we would like to help coordinate the efforts of all the agencies in Kotzebue who seek to deliver services to this group.

Displaced homemaker programs already are in operation in Fairbanks and Anchorage, funded by CETA funds administered by the Department of Community and Regional Affairs. In order to allow maximum coordination with the few programs operational now as well as the other CETA-funded employment and training programs which serve displaced homemakers as well as other unemployed and economically disadvantaged people, we would like to recommend that a few small changes be made in the bill to allow a unified approach

to the problem. I say small, because the bill as it stands is remarkably similar in its approach to providing displaced homemaker services. In its recognition that displaced homemakers come to the job market with many skills to offer, it is more enlightened than the federal legislation.

Page 3, line 8, (3) should read "housing services including
(A) loan for rental deposit,
(B) temporary shelter allowance, and
(C) assistance in locating permanent housing."
The following sections would be renumbered to reflect this addition.

Page 5, line 3, should be changed to read "for a substantial number of years. (This will allow the cut-off period to be determined according to agency information about the length of time in which one's marketability as an employee dwindles to the point where it presents problems in finding and holding a job.) Occasional periods of temporary, part-time, or incidental employment shall not be a disqualifying factor."

Page 5, line 5, should be changed to read, "and has lost that income, or who is presently or has just ceased to receive public assistance, or who would qualify to receive public assistance; and" (This makes welfare recipients eligible.)

Page 5, line 6, should be amended to read,"is unemployed or underemployed and has experienced difficulty in finding employment." (This requires the person to be substantially unemployed in order to qualify for assistance.)

Page 5, line 15, should be amended to allow for an early implementation of this program.

I am attaching a copy of the federal displaced homemaker regulations which might suggest other language which the Committee would like to adopt. I am not urging you to replicate the federal scheme, but I would like to suggest that unnecessary differences in language which do not reflect a true difference in approach to the problem might be eliminated at the outset to allow extensive coordination of programs for the target group.

For the same reasons, it is appropriate for the Department of Community and Regional Affairs rather than the Department of Labor to administer this program, since that agency already has expertise in the delivery of services to displaced homemakers.

Thank you for the opportunity to support this most worthwhile legislation.

THE PRECEDING DOCUMENT(S) MAY NOT FILM LEGIBLY BECAUSE OF POOR QUALITY OF THE ORIGINAL.

THE LEGISLATURE OF THE STATE OF ALASKA
ELEVENTH LEGISLATURE

FISCAL NOTE

I. REQUEST

Bill/Resolution No. House Bill No. 936

Title An Act Relating to Displaced Homemakers, and Providing an Effective Date

Requested by: _____ Date: March 21, 1980

II. FISCAL DETAIL

Agency Affected: Department of Education

Program Category Affected: Adult and Continuing Education

BRU, Program, or Subprogram(s) Affected: Adult and Continuing Education

(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 80	FY 81	FY 82	FY 83	FY 84	FY 85
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL						
400 COMMODITIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC.						
TOTAL	-0-	-0-	-0-	-0-	-0-	-0-

FUNDING (Thousands of Dollars)

GENERAL FUND						
FEDERAL FUNDS						
OTHER (Specify Fund Source)						

POSITIONS

FULL TIME						
PART TIME						
TEMPORARY						

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

This bill has no fiscal impact on the Department of Education.

IV. DATE March 21, 1980 PREPARED BY William McKean

AGENCY Education

PHONE 465-2800

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)

33-001 (Rev. 12/79)

THE LEGISLATURE OF THE STATE OF ALASKA
ELEVENTH LEGISLATURE

FISCAL NOTE

I. REQUEST
Bill/Resolution No. HB-936
Title An Act Relating to Displaced Homemakers.....
Requested by _____ Date _____

II. FISCAL DETAIL
Agency Affected Community and Regional Affairs
Program Category Affected Social Services
BRU, Program, or Subprogram(s) Affected CETA
(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 80	FY 81	FY 82	FY 83	FY 84	FY 85
100 PERSONAL SERVICES		94.3				
200 TRAVEL		16.0				
300 CONTRACTUAL		1,117.3				
400 COMMODITIES		1.5				
500 EQUIPMENT		3.8				
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC.						
TOTAL		1,232.9				

FUNDING (Thousands of Dollars)

GENERAL FUND		1,232.9				
FEDERAL FUNDS						
OTHER (Specify Fund Source)						

POSITIONS

FULL TIME		2				
PART TIME		2				
TEMPORARY						

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

The availability of funds for the displaced homemakers program will be advertised statewide and contracts negotiated through a competitive procurement process.

Projected program costs are based on a displaced homemaker program currently funded by the Department in Fairbanks. The program offers the following services, directly or by referral: assessment; counseling; job development; basic education; vocational training; and life skills workshops. The program is staffed by three counselors and two intake workers. The annual cost of the program is $135,884. Approximately 325 individuals are scheduled to be served.

IV. DATE March 12, 1980 PREPARED BY Fred J. Ali, Deputy Director
AGENCY Community & Regional Affairs, CETA Division
PHONE 465-4890

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)

33-001 (Rev. 12/79)

Re: Health Education & Social Services

H.B. 936 3-12-80

"An Act relating to displaced homemakers; and providing for an effective date."

A displaced homemaker should be interpreted as a person, male or female, who has been in a dependent situation and finds themselves for various reasons (death, separation, divorce, abandonment,) ~~find~~ displaced from the position of homemaker.

A displaced homemaker, more often than not, becomes a public charge, due to inability to find employment.

The inability to find employment may be caused by many factors. Skills are non-existent, skills are out-dated, skills are inappropriate for community of residence, child-care is too costly to be paid from wage received, child-care facilities may not be available within reasonable distance of residence or place of employment. Also, transportation or

the form of personal car or public transit may not be available.

Also, due to the trauma of the displacement many homemakers are not ready for employment until they have received good transitional counseling. After transitional counseling there often exists a need for continuing supportive counseling.

Skills must be acquired through class-room training or on-job-training programs. Existing, but out-dated, skills must be renewed through brush-up courses for re-licensing or re-certification. Inappropriate skills must be evaluated to determine what portion, if any, can be transferred into employment which is available in the community of residence.

The displaced homemaker more frequently than not finds themselves without housing which is affordable. Alternative affordable housing is difficult to locate. Low-income housing units are always in too short or supply. In the

case of the single adult with no dependent children there is no low-income housing available. A single or displaced mother of ~~a~~ head of ~~two~~ children could receive a monthly stipend of $400 through A.F.D.C. With rent for a ~~two~~-bedroom apt. at $350 to $400 mo. plus utilities there is often no alternative except to enter another dependent situation for which they are not prepared.

If the displaced person cannot get a job which pays enough to replace A.F.D.C. ~~and~~, Food Stamps and Medicaid they continue as a public charge, thus creating a Catch 22 situation.

Legal problems are also a prime concern. Many displaced persons do not pursue a divorce due to the cost of legal fees. Free legal services through Alaska Legal Services often do not materialize as that agency is overworked and understaffed. So the displaced person may lose child support, property, etc. for which they may be entitled.

Establishing credit is still a problem for the female displaced homemakers. Even if she gets a job and can afford to pay her bills. She finds herself being asked "husband's name", "credit references", "do you own or rent", "how long have you lived in your present residence". Many displaced homemakers find they can't get credit because the ex-husband or ex-wife had a bad credit rating during the marriage.

Persons who are displaced and are seeking employment are not necessarily "hard-core-unemployed" persons. They are persons who are willing to do almost any kind of work for a living wage. It is not felt that the employment of a displaced homemaker is a liability. In fact, it should be considered a definite asset as displaced persons have no alternative sources of income except welfare which they feel is degrading & undesirable.

It is not felt that employers should receive a "tax break" at the further expense of taxpayers for hiring a displaced homemaker.

Section 3, AS 43.20 should be deleted entirely from HB. 939.

Respectfully submitted,

Leslie M. Mallard
Counselor
Displaced Homemaker Program
Fairbanks, Alaska

TELECONFERENCE HEARING
March 12, 1980

ALASKA WOMEN'S RESOURCE CENTER
HELEN ROBERTS, OUTREACH
DISPLACED HOMEMAKERS PROGRAM

RE: HOUSE BILL NO. 936

The Displaced Homemaker Program at Alaska Women's Resource Center has counseled, seen and served approximately 64 women within the past six (6) months who are divorced. separated or widowed. These women represent the population addressed by the intent of House Bill 936. There are many more in the Anchorage area, as well as throughout our state who can be identified and assisted through this legislative bill providing for the services as discussed.

The Displaced Homemaker must be reached in order to be trained. They must also be in touch with the real work world in order to gain realistic work skills. The need for a comprehensive program approach to attack the isolation which contributes to the Displaced Homemaker syndrome is m _ in the Multi-Purpose Center Concept. Not knowing where to turn, not having confidence to seek assistance, finding stop-gap help that is too little, premature and not pertinent is a prime problem. The need for job counseling, training and placement is a major priority. Permanent employment within the clerical, sales, health and food services is one area of need and demand among women who come to the Center. The other side of the coin is that if there were adequate training programs, such as the proposed Anchorage Skill Center, that would offer training in other work areas, there would be guaranteed enrollees for such programs. We support the Fairview Community Council Skill Center Committee, chaired by Mr. Joseph M. Jackson, in their efforts for a site selection for a proposed and funded Anchorage Skill Center.

ALASKA WOMEN'S RESOURCE CENTER _ TESTIMONY _- HOUSE BILL 936

We would like to request that House Bill 936 Provide for mechanisms for identifying Displaced Homemakers throughout the state.

The Women our Center deals with are intimidated by a society that has welshed on its' promises, such as health services, economic security, and to be fully educated in order to be responsible for their own lives.

Displaced Homemakers Program, Alaska Women's Resource Center

approximate number of displaced homemakers served in one year: 128. This is a conservative estimate based on the number of women served since October 1979, when the program became funded as a Displaced Homemakers Program.

salary ranges for jobs displaced homemakers looking for work: $900/mo. This is the lowest salary a displaced homemaker could make and still support a family. Any salary above $900/mo. would be even better.

the types of jobs displaced homemakers are looking for are: clerical, bookkeeping, sales (not retail sales), child care, restaurant and food services, and some very limited requests for non-traditional types of employment. A great many displaced homemakers say they are looking for a job and will take anything.

Any incentive given to a businessperson to employ displaced homemakers will only help. These women are usually very low on marketable skills but are willing and able to learn new skills. They will make very stable employees if given a chance.

ALASKA WOMEN'S RESOURCE CENTER

QUARTERLY PROGRAM REPORTS

DISPLACED HOMEMAKERS PROGRAM Oct - Dec 79

A. Number of client contacts: 73.

B. Client characteristics:

1. Age: 18-25--13 41-45-- 0
26-30-- 7 46-50-- 1
31-35-- 4 unkown-45
36-45-- 3

2. Sex: Female--72 Male--1

3. Ethnic background:
White--56 (76.7%) Hispanic--4 (5.5%)
Black-- 7 (9.6%) Oriental--1 (1.4%)
Native- 5 (6.8%)

4. Marital Status:
Married--12 Separated--6
Single --17 Widow --1
Divorced- 4 unknown ---33

5. Hanicapped: 2

C. Reasons for contacts:

1.	permanent employment	39
2.	workshop	18
3.	miscellaneous	8
4.	SUCESS	7
5.	financial aid for school	6
6.	Self confidence clinic	4
	training programs	4
	list a job with the center	4
7.	support groups	3
8.	general information	2
	professional counseling	2
	volunteer opportunities	2
9.	Social Security information	1
	career counseling	1
	resumes	1

D. Services provided:
These services consisted of counseling clients on the labor market in Alaska and Anchorage; providing information on apprenticeship program openings; moral support for clients; where to find information concerning financial aid for school and what programs are available; discussing what jobs are open and where to apply for jobs which may come open.

E. Referrals received: one from Job Services for positions in the counseling field.

F. Referrals made:

1. Job Services 39
check on available listings
2. Miscellaneous 11
Soroptomist Foundation educational grant; various jobs listed with AWRC.
3. Federal Civil Service 3
take exams for various registers
4. Educational Opportunity Center 6
Strong-Campbell Interest Inventory and financial aid information
5. CETA 3
check eligibility

	State Civil Service apply for register openings	3
	Municipality apply for position openings	3
6.	DVR check eligibility and services	2
7.	Therapy program (AWRC) therapy	1
	Apprenticeship Outreach Program check on union apprenticeship programs	1
	School district apply for position opening	1

G. Summary of activities
Employability Skills Workshop: Held 25-30 Nov 79; 12-15 people in attendence at the 10 hour course. Topics covered were: skill identification; resume preparation; assertiveness training; interviewing techniques; and planning a job campaign.

Advisory Board meetings were held in November and January.

Outreach; contacted 35 agencies and members of the media to discuss the Displaced Homemakers Program; participated in 8 committees and attended various meetings as a representative of the Displaced Homemakers Program ; attended a conference in Seattle of the Region X Displaced Homemakers Program.

H. Plans for next quarter
Self confidence clinic; scheduled to begin 8 Jan 80. This clinic is designed to enable women to start improving their self-esteem and self-image. It is planned once a week for 90 minutes for 4 weeks and is facilitated by a staff member of the AWRC therapy program.

Bilingual-Multicultural Conference: the DPH program is assisting UAF in locating registration workders for the 3 day conference to be held 13-15 Feb 80 in Anchorage.

Employability Skills Workshop: future workshops will be held monthly covering basically the same material as discussed earlier.

I. Progress on Program Objectives:
The DPH program is solidifying present activities into ongoing, self-perpetuating activities. Plans for new activities to assist women in obtaining employment are constantly discussed and evaluated for feasibility.

J. Administrative change:
Sherry White, the VISTA volunteer who initially began the DPH program, took a position with the Division of Vocational Rehabilitation.

K. Training provided
Because of the current limitations of the program, no training was provided during the quarter. However, a funding source was discovered which, if received, would provide funds for establishing training provisions for our clients.

TANANA VALLEY COMMUNITY COLLEGE
Fairbanks, Alaska 99701

Date: March 12, 1980

TO: The House Health Education Social Services Committee

FROM: Nancy Hidden
Counselor

RE: House Bill No. 936

I am in support of House Bill No. 936. During the teleconference on March 12, Cene Kingrea made a suggestion of changes needed in the bill. I would like to support these changes.

One area, which Gene Kingrea covered but I would like to reemphasize, is the importance of Transitional Adjustment Counseling. This should be number one, on page two, line eighteen. Adjustment Counseling is like making sure a building is on a firm foundation before one spends time and energy in remodeling the building. Without this firm foundation the rest of the support services will not bring the desired results.

STATE OF ALASKA

JAY S. HAMMOND, GOVERNOR

DEPT. OF COMMUNITY & REGIONAL AFFAIRS

POUCH BC
JUNEAU, ALASKA 99811
PHONE: (907) 465-4890

COMMUNITY EMPLOYMENT & TRAINING ASSISTANCE DIVISION

March 12, 1980

The Honorable Thelma Buchholdt
House HESS Committee
Alaska State Legislature
Pouch V
Juneau, Alaska 99811

Dear Representative Buchholdt:

The Department of Community and Regional Affairs supports H.B. 936 relating to displaced homemakers. We concur with the Commission on the Status of Women that attention should be focused on displaced homemakers. The creation of Multipurpose Service Centers as outlined in Sec. 47.90.020 of this bill is an excellent method to provide much-needed services.

We would also like to take this opportunity to note that the Multipurpose Service Center concept should be extended to include all groups of the population experiencing difficulties in finding employment. Such centers could be staffed by outstationed employees of various state and local agencies working in the field of social services. The primary purpose of the centers would be to provide comprehensive assessment, counseling, and referral services.

Last summer the CETA Division, through the Southeast Regional Resource Center, conducted three workshops involving 35 women, age 22 through 57, with an average age of 34, from Southeast Alaska in a displaced homemaker program. These workshops provided information and counseling for participants to be referred into training.

In Fairbanks a displaced homemaker program provided coordinated services. Last year the program operated with vocational educational funds from the CETA Governor's Grant, administered by the State CETA Division in the Department of Community and Regional Affairs and the Department of Education. Serving both men and women, it provided job counseling and vocational training to single parents and adults entering the labor market for the first time or after an extended absence. The displaced homemaker program is a sub-agency of the Adult Learning Programs of Alaska and works closely with an associated agency called the Regional Adult Learning Center which provides services such as employment counseling, General Educational Development (GED), English-as-a-second-language and one-to-one tutoring in any subject. Networking with other agencies and services has also helped the program tremendously.

Aside from the Department's involvement on a limited basis as mentioned through these two programs, our other concerns with the proposed legislation include the following:

(1) Page 4, line 6, Sec. 47.90.040: We feel mandatory coordination with other state agencies and the centers is necessary to avoid duplication and should be so outlined in the bill.

(2) Page 4, line 18, Sec. 47.90.060: It should be noted that CETA Public Services Employment funds are available on a competitive basis to state agencies to hire disadvantaged individuals. In addition, we have concerns as to how this section will work mechanically and what regulations would be adopted to carry out this section. Would the displaced homemakers have to be placed on a state register? We also feel this section could impact collective bargaining agreements. It is our opinion that this section should be considered within the broader context of State personnel policy.

(3) Page 5, line 8, Sec. 43.20.037: We feel this section should be considered in the broader context of tax relief and relate to legislation currently being considered in that regard. In addition, this matter is also addressed in the Governor's bill, Senate Bill 496, "An Act providing for Alaska Job Tax Credits; and providing for an effective date."

(4) Page 5, line 15, Sec. 4: Should be amended to provide funding to the Department in state fiscal year 1981 for program development.

Thank you for giving us the opportunity to comment on this bill.

Sincerely yours,

Marie Pignalberi

Marie Pignalberi
Deputy Commissioner

cc: Mr. Keith Specking
Ms. Lynne Woods
Mrs. Lois Lind

THE LEGISLATURE OF THE STATE OF ALASKA
ELEVENTH LEGISLATURE

FISCAL NOTE

I. REQUEST
Bill/Resolution No. HB-936
Title An Act Relating to Displaced Homemakers.....
Requested by _____ Date _____

II. FISCAL DETAIL
Agency Affected Community and Regional Affairs
Program Category Affected Social Services
BRU, Program, or Subprogram(s) Affected CETA
(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 80	FY 81	FY 82	FY 83	FY 84	FY 85
100 PERSONAL SERVICES		94.3				
200 TRAVEL		16.0				
300 CONTRACTUAL		1,117.3				
400 COMMODITIES		1.5				
500 EQUIPMENT		3.8				
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC.						
TOTAL		1,232.9				

FUNDING (Thousands of Dollars)

GENERAL FUND		1,232.9				
FEDERAL FUNDS						
OTHER (Specify Fund Source)						

POSITIONS

FULL TIME		2				
PART TIME		2				
TEMPORARY						

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

The availability of funds for the displaced homemakers program will be advertised statewide and contracts negotiated through a competitive procurement process.

Projected program costs are based on a displaced homemaker program currently funded by the Department in Fairbanks. The program offers the following services, directly or by referral: assessment; counseling; job development; basic education; vocational training; and life skills workshops. The program is staffed by three counselors and two intake workers. The annual cost of the program is $135,884. Approximately 325 individuals are scheduled to be served.

IV. DATE March 12, 1980 PREPARED BY Fred J. Ali, Deputy Director
AGENCY Community & Regional Affairs, CETA Division
PHONE 465-4890

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)

33-001 (Rev. 12/79)

Assuming the Department will fund five similar contracts on an annual basis, projected costs are as follows:

181,000 x 5 = $905,000
Adjusted for inflation, 10%/year x 2 years
Total program costs = $1,095,000

Administrative costs required by the Department are as follows:

Personnel Services			$94,300
Grants Administrator R 17		29,460	
Field Representative R 15		25,620	
PT Clerk Typist III		8,915	
PT Accounting Clerk III		10,010	
	Sub total	74,005	
	Benefits	20,311	
Travel			$16,000
Contract negotiation, monitoring and technical assistance			
Contractual			$22,300
Phones		5,000	
Rents		5,600	
Printing and Advertising		10,000	
Copier services		1,000	
Postage		600	
Repairs and Maintenance		10,000	
		22,300	
Commodities			$ 1,500
Equipment			$ 3,800
1 typing desk		459.80	
1 typing chair		136.02	
2 executive desks		1,311.00	
3 executive swivel chairs		619.00	
1 correcting selectric typewriter		902.48	
1 5-drawer file cabinet		231.48	
1 bookcase		112.49	
		3,772.29	

Department staff, a Grants Administrator and a Project Field Representative, will be responsible for negotiating and executing contracts; monitoring and providing technical assistance; and providing statewide coordination.

(End Fiscal Note Analysis)

STATE OF ALASKA

JAY S. HAMMOND, GOVERNOR

DEPARTMENT OF REVENUE

OFFICE OF THE COMMISSIONER / POUCH S – JUNEAU 99811

March 12, 1980

The Honorable Thelma Buchholdt
Cahirman
House Health, Education &
Social Services Committee
Room 112 - Capitol Building
Juneau, Alaska 99811

Dear Ms. Buchholdt:

Re: House Bill No. 936, an Act relating to displaced homemakers, was introduced in the House on March 6, 1980 and was referred to the House Health, Education and Social Services Committee.

For the consideration of the House Health, Education and Social Services Committee, I am enclosing copies of Fiscal Notes prepared by Gary Jenkins, Director, Audit Division and Barbara Sorensen, Research Section of the Department of Revenue concerning the proposed legislation.

Sincerely,

R. D. Stevenson
Special Assistant

cc: Joseph K. Donohue
Deputy Commissioner
Department of Revenue

Gary Jenkins, Director
Audit Division
Department of Revenue

Vincent Wright
Research Section
Department of Revenue

04-D2LH

FISCAL NOTE

I. REQUEST

Bill/Resolution No. House Bill No. 936

Title An Act relating to displaced homemakers

Requested by House Health, Education & Social Ser. Comm Date 3/10/80

II. FISCAL DETAIL

Agency Affected Revenue

Program Category Affected Fiscal Services

BRU, Program, or Subprogram(s) Affected Audit Division

(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 80	FY 81	FY 82	FY 83	FY 84	FY 85
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL						
400 COMMODITIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC.						
TOTAL	-0-	-0-	-0-	-0-	-0-	-0-

FUNDING (Thousands of Dollars)

GENERAL FUND	-0-	-0-	-0-	-0-	-0-	-0-
FEDERAL FUNDS						
OTHER (Specify Fund Source)						

POSITIONS None

FULL TIME						
PART TIME						
TEMPORARY						

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

See attached memo ndum to R. D. Stevenson dated 3/10/80.

IV. DATE March 10, 1980 PREPARED BY Lars Henkins

AGENCY Department of Revenue, Audit Division

PHONE 465-2320

Original: Legislative Finance

cc: Budget and Management

Prime Sponsor (First Legislator Named)

33-001 (Rev. 12/79)

of ALASKA

MEMORANDUM

TO: R. D. Stevenson
Special Assistant
Department of Revenue

DATE: March 10, 1980

FILE NO:

TELEPHONE NO:

FROM: Gary L. Jenkins
Director
Audit Division

SUBJECT: House Bill No. 936

Section 3 of this bill would provide for an income tax credit for up to 30 percent of the wages paid to an individual who qualified as a displaced homemaker. There are two issues which should be considered in analyzing this proposed legislation.

First of all, there is considerable pressure at the present time to either suspend or repeal the individual and corporate income taxes. If either of those actions were to take place, it would obviously make this proposal, in effect, null and void.

Secondly, there is a policy question with regard to how programs of this nature should be accounted for by permitting a major portion of the actual cost of the program to be buried as a tax credit, with the result that the total cost of the program is not subject to appropriation. It makes it difficult to easily analyze the benefits of a program as compared to its actual total cost.

In lieu of the tax credit provision, since the Department of Community and Regional Affairs will already be working directly with the various employers involved, it will be a relatively simple operation for them to refund the employer the 30 percent of the wages paid. This would also be very logical from an administration point of view because they are charged with the responsibility of ensuring that each employer meets the conditions set forth in the law and regulations prior to the reimbursement being paid. This concept would also permit the Legislature to clearly understand the total cost of this program when they appropriate the funds for it annually.

THE LEGISLATURE OF THE STATE OF ALASKA
ELEVENTH LEGISLATURE

FISCAL NOTE

I. REQUEST
Bill/Resolution No. HB# 936
Title An Act relating to displaced homemakers
Requested by _____ Date March 11, 1980

II. FISCAL DETAIL
Agency Affected _____
Program Category Affected _____
BRU, Program, or Subprogram(s) Affected _____
(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 80	FY 81	FY 82	FY 83	FY 84	FY 85
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL						
400 COMMODITIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC.						
TOTAL						

FUNDING (Millions of Dollars)

GENERAL FUND	-0-	-0-	--------	approx. (	2.5 to 2.0)	annually
FEDERAL FUNDS						
OTHER (Specify Fund Source)						

POSITIONS

FULL TIME						
PART TIME						
TEMPORARY						

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

The bill would establish a displaced homemakers support program. Among other things, it proposes an income tax credit of 30 per cent of the first 12 months of compensation paid by an employer for each certified displaced homemaker.

The above estimate is based on information provided by the Alaska Commission on the Status of Women.

IV. DATE 3/6/80 PREPARED BY Barbara Jorgensen
AGENCY REVENUE
PHONE #2174

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)

33-001 (Rev. 12/79)

THE LEGISLATURE OF THE STATE OF ALASKA
ELEVENTH LEGISLATURE

FISCAL NOTE

I. REQUEST
Bill/Resolution No. House Bill No. 936
Title An Act relating to displaced homemakers
Requested by House Health, Education & Social Ser. Comm Date 3/10/80

II. FISCAL DETAIL
Agency Affected Revenue
Program Category Affected Fiscal Services
BRU, Program, or Subprogram(s) Affected Audit Division
(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

		FY 80	FY 81	FY 82	FY 83	FY 84	FY 85
100	PERSONAL SERVICES						
200	TRAVEL						
300	CONTRACTUAL						
400	COMMODITIES						
500	EQUIPMENT						
600	LAND & STRUCTURES						
700	GRANTS, CLAIMS, ETC.						
	TOTAL	-0-	-0-	-0-	-0-	-0-	-0-

FUNDING (Thousands of Dollars)

GENERAL FUND	-0-	-0-	-0-	-0-	-0-	-0-
FEDERAL FUNDS						
OTHER (Specify Fund Source)						

POSITIONS None

FULL TIME						
PART TIME						
TEMPORARY						

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

See attached memorandum to R. D. Stevenson dated 3/10/80.

IV. DATE March 10, 1980 PREPARED BY [signature]
AGENCY Department of Revenue, Audit Division
PHONE 465-2320

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)

33-001 (Rev. 12/79)

STATE
of ALASKA

MEMORANDUM

TO: R. D. Stevenson
Special Assistant
Department of Revenue

DATE: March 10, 1980

FILE NO:

TELEPHONE NO:

FROM: Gary L. Jenkins
Director
Audit Division

SUBJECT: House Bill No. 936

Section 3 of this bill would provide for an income tax credit for up to 30 percent of the wages paid to an individual who qualified as a displaced homemaker. There are two issues which should be considered in analyzing this proposed legislation.

First of all, there is considerable pressure at the present time to either suspend or repeal the individual and corporate income taxes. If either of those actions were to take place, it would obviously make this proposal, in effect, null and void.

Secondly, there is a policy question with regard to how programs of this nature should be accounted for by permitting a major portion of the actual cost of the program to be buried as a tax credit, with the result that the total cost of the program is not subject to appropriation. It makes it difficult to easily analyze the benefits of a program as compared to its actual total cost.

In lieu of the tax credit provision, since the Department of Community and Regional Affairs will already be working directly with the various employers involved, it will be a relatively simple operation for them to refund the employer the 30 percent of the wages paid. This would also be very logical from an administration point of view because they are charged with the responsibility of ensuring that each employer meets the conditions set forth in the law and regulations prior to the reimbursement being paid. This concept would also permit the Legislature to clearly understand the total cost of this program when they appropriate the funds for it annually.

THE LEGISLATURE OF THE STATE OF ALASKA
ELEVENTH LEGISLATURE

FISCAL NOTE

I. REQUEST
Bill/Resolution No. HB# 936
Title An Act relating to displaced homemakers
Requested by _____ Date March 11, 1980

II. FISCAL DETAIL
Agency Affected _____
Program Category Affected _____
BRU, Program, or Subprogram(s) Affected _____
(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 80	FY 81	FY 82	FY 83	FY 84	FY 85
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL						
400 COMMODITIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC.						
TOTAL						

FUNDING (Millions of Dollars)

GENERAL FUND	-0-	-0-	--------	approx. (	1.5 to 2.0)	annually
FEDERAL FUNDS						
OTHER (Specify Fund Source)						

POSITIONS

FULL TIME						
PART TIME						
TEMPORARY						

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

The bill would establish a displaced homemakers support progra... Among other things, it proposes an income tax credit of 30 per cent of the first 12 months of compensation paid by an employer for each certified displaced homemaker.

The above estimate is based on information provided by the Alaska Commission on the Status of Women.

IV. DATE 3/14/80 PREPARED BY Barbara Jones
AGENCY Revenue
PHONE # 2174

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)

33-001 (Rev. 12/79)

STATE OF ALASKA

JAY S. HAMMOND, GOVERNOR

DEPARTMENT OF LABOR

BOX 1149
JUNEAU, ALASKA 99811

March 12, 1980

Ms. Shannon Garrett
Legislative Aide
House HESS Committee
Pouch V
Juneau, Alaska AK 99811

Dear Shannon:

Attached is the position paper you requested on House Bill 936. Art Zillig, Director of Employment Security, will attend Thursday's hearing and would like to testify on the bill.

If you have any questions, please advise.

Sincerely,

Judy G. DuBois
Legislative Liaison

Enclosure

07-G6LH

Bill No. House Bill 936

Date March 11, 1980

Title An Act relating to displaced homemakers; and providing for an effective date

Contact: Judy DuBois
465-2700

House Bill No. 936 "An Act relating to displaced homemakers; and providing for an effective date" is proposed to establish multipurpose service centers to provide services for Alaskan displaced homemakers.

Although the conceptual emphasis of the bill is supported, we have four primary concerns in relation to its implementation. First, the bill does not indicate the size or distribution of the population to be served and thus does not indicate sites as where the multipurpose centers will be established. A second concern is the tax credit provision for displaced homemakers. It appears that the displaced homemakers tax credit is a duplication of the proposed Alaska State Jobs Tax Credit program and may be a moot issue in view of the current tax legislation before the Alaska Legislature. A third concern is the current existence of federal funds available for displaced homemaker services. It appears that by consolidating existing displaced homemaker service programs and by utilizing present funding sources, expansion of services to additional geographical areas of the State of Alaska could be accomplished without the inclusion of State funds.

Lastly, the proposed legislation duplicates the current efforts of providing employment, counseling and necessary referral services for eligible displaced homemakers by Job Service and the Alaska Work Incentive program. It would appear that since Job Service and the Work Incentive program are currently operational, they should be utilized as the primary administrative and service provider vehicles for the proposed displaced homemaker legislation. This is especially pertinent when it is recognized that the population to be served by this legislation are or will be eligible for existing agency's services and that the proposed multipurpose centers will function as primarily a referring organization.

Departmental Position: Opposed in current status.

POSITION PAPER/Department of Labor

Bill No. House Bill 936

Date March 11, 1980

Title An Act relating to displaced homemakers; and providing for an effective date

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465-2700

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Bill No. House Bill 936

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POSITION PAPER/Department of Labor

Bill No. House Bill 936

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Departmental Position: Opposed in current status.

POSITION PAPER/Department of Labor

STATE OF ALASKA

JAY S. HAMMOND, GOVERNOR

DEPARTMENT OF REVENUE

OFFICE OF THE COMMISSIONER / POUCH S – JUNEAU 99811

March 12, 1980

The Honorable Thelma Buchholdt
Cahirman
House Health, Education &
Social Services Committee
Room 112 - Capitol Building
Juneau, Alaska 99811

Dear Ms. Buchholdt:

Re: House Bill No. 936, an Act relating to displaced homemakers, was introduced in the House on March 6, 1980 and was referred to the House Health, Education and Social Services Committee.

For the consideration of the House Health, Education and Social Services Committee, I am enclosing copies of Fiscal Notes prepared by Gary Jenkins, Director, Audit Division and Barbara Sorensen, Research Section of the Department of Revenue concerning the proposed legislation.

Sincerely,

R. D. Stevenson
Special Assistant

cc: Joseph K. Donohue
Deputy Commissioner
Department of Revenue

Gary Jenkins, Director
Audit Division
Department of Revenue

Vincent Wright
Research Section
Department of Revenue

04-D2LH

FISCAL NOTE

I. REQUEST

Bill/Resolution No. House Bill No. 936

Title An Act relating to displaced homemakers

Requested by House Health, Education & Social Ser. Comm Date 3/10/80

II. FISCAL DETAIL

Agency Affected Revenue

Program Category Affected Fiscal Services

BRU, Program, or Subprogram(s) Affected Audit Division

(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

		FY 80	FY 81	FY 82	FY 83	FY 84	FY 85
100	PERSONAL SERVICES						
200	TRAVEL						
300	CONTRACTUAL						
400	COMMODITIES						
500	EQUIPMENT						
600	LAND & STRUCTURES						
700	GRANTS, CLAIMS, ETC.						
	TOTAL	-0-	-0-	-0-	-0-	-0-	-0-

FUNDING (Thousands of Dollars)

GENERAL FUND	-0-	-0-	-0-	-0-	-0-	-0-
FEDERAL FUNDS						
OTHER (Specify Fund Source)						

POSITIONS None

FULL TIME						
PART TIME						
TEMPORARY						

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

See attached memorandum to R. D. Stevenson dated 3/10/80.

IV. DATE March 10, 1980 PREPARED BY Lars Jenkins

AGENCY Department of Revenue, Audit Division

PHONE 465-2320

Original: Legislative Finance

cc: Budget and Management

Prime Sponsor (First Legislator Named)

33-001 (Rev. 12/79)

HB 936
Amendments proposed by Fred Ali, C&RA

Page 1:

Change Section 1 (b)(1) to read as follows (lines 28-29):
(1) provide the necessary counseling, training, employment placement and other services for displaced homemakers [;] through contracts with public or private nonprofit organizations and by utilizing and expanding existing state programs.

Page 2:

Change Section 2, 47.90.010(a) to read as follows (lines 8-12):
(a) The commissioner...may contract with public or private nonprofit organizations for multipurpose service centers for displaced homemakers [.] and expand existing state programs through reimburseable service agreements.

Add to Section 2, 47.90.010 a new subsection (c):
(c) The commissioner shall establish a competive contract procurement process that ensures free and open competition for funds allocated for programs established in this chapter. As part of this procurement process, it is intended that public or private nonprofit organizations and state agencies may propose to provide all or a portion of the services listed under AS 47.90.020.

Page 3:

Add to Section 2, 47.90.020(2), line 7 the word and
(and delete [and] from line 5)--- then add a new subsection (E) to this section to read as follows:
(E) expose displaced homemakers to nontraditional occupations.

Page 4:

At the end of Section 2, 47.90.030, add the following sentence:
Under the procurement process established under AS 47.90.010, the commissioner will give preference to applicants proposing to fill staff positions with displaced homemakers.

Delete Section 2, 47.90.060 and replace it with the following section:
Sec. 47.90.060. STATE EMPLOYMENT ASSISTANCE. Contrators operating programs under this chapter will, to the maximum extent possible, provide displaced homemakers with assistance in being placed on state meployment registers. This will be accomplished with the assistance and cooperation of the Division of Personnel and the Department of Community and Regional Affairs.

Page 4:

Delete Section 3, 43.20.037 in its entirety. (If the Committee decides to do this, it must delete the reference to this section on page 4, line 17.)

Delete Section 4 and include the following language instead:
All provisions of this Act will take effect July 1, 1981. During FY '81, the commissioner will consult with appropriate groups and state agencies concerned with displaced homemakers, adopt resolutions prescribing program standards, adopt a competitive procurement process, provide information and assistance to groups interested in conducting displaced homemaker programs, and fund one or more limited pilot projects.

Lu Anne -

Here are the comments on HB 936 -

I'll be back in town on Thursday and will be happy to meet with you and the committee to further discuss the bill -

Fred Mc.

465-4580

Call on Thursday.

SECTION 1

(b)(1) should read

provide the necessary counseling, training . . . for displaced homemakers[;] through contracts with public or private non-profit organizations and by utilizing and expanding existing State programs

→ to make DS mandate more specific

SECTION 2

47.90.010 (a) should read

may contract with public . . . for displaced homemakers[.] and expand existing State programs through reimburseable service agreements

→ to show that ones now in existence will get $ w/out being "multipurpose"

add (c)

The commissioner shall establish a competive contract procurement process that ensures free and open competition for funds allocated for programs established in this chapter. As part of the procurement process, it is intended that public or private non-profit organizations

and state agencies may propose to provide all or a portion of the services listed under AS 47.90.020.

SECTION 2

47 90 020 (2) add (E)

and

(E) expose displaced homemakers to non-traditional occupations

→ omit traditional refer to women

SECTION 2

47.90.030 add the following

Under the procurement process established under AS 47.90.010, the Commissioner will give preference to applicants proposing to fill staff positions with displaced homemakers

SECTION 2

47.90.060 delete entire section

Add a Section, entitled State Employment Assistance, that reads as follows:

Contractor operations programs under this chapter will, to the maximum extent possible

provide displaced homemakers with assistance in being placed on State employment registers. This will be accomplished with the assistance and cooperation of the Division of Personnel and the Department of Community and Regional Affairs.

SECTION 3

43.20.037 delete entire section

support SB 436 instead.

SECTION 4 should read

All provisions of this Act will take effect July 1 1981. During State fiscal year 1981, the Commissioner will consult with appropriate groups and State agencies concerned with displaced homemakers, adopt regulations prescribing program standards, adopt a competitive procurement process, provide information and assistance to groups interested in conducting displaced homemaker programs, and fund one or more limited pilot projects.

2 yr in def:

definitely opening up to a larger category.

Proposed CS for HB 936 (Work completed by Committee thus far)

For an Act entitled: "An Act relating to displaced homemakers; and providing for an effective date."

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

Section 1. LEGISLATIVE FINDING AND INTENT. (a) The legislature finds that there is an increasing number of persons in the state who, after having fulfilled the role of homemaker for a number of years of their life, find themselves "displaced" through the death of a spouse, divorce, separation, desertion, or loss of family income. The legislature finds that displaced homemakers are often without any source of income, face continuing discrimination in employment because they frequently have no recent work experience and may be older than other applicants for employment, are subject to high rates of unemployment and are ineligible for unemployment insurance because they have been engaged in unpaid labor in the home, may be ineligible for categorical welfare assistance, are ineligible for social security if they have been divorced from the family wage earner, may have lost their rights as beneficiaries under employers' pension and health plans through death of a spouse or divorce despite the contribution of years to the well-being of the family, and may be ineligible for Medicaid and unable to purchase private health insurance because of age and lack of income. The legislature further finds that homemakers are an unrecognized part of the work force of the state who have made an invaluable contribution to the welfare of society.

(b) It is the intent of the Act to

(1) provide the necessary counseling, aptitude testing, training, employment placement, and other services for displaced homemakers[;] through contracts with public or private nonprofit organizations and by utilizing expanding existing state programs

(2) improve the mental and physical health and welfare of this growing group of members of the community; and

(3) provide displaced homemakers with independence and economic security vital to a productive life.

Sec. 2. AS 47 is amended by adding a new chapter to read:

CHAPTER 90. DISPLACED HOMEMAKERS.

Sec. 47.90.010. PROGRAM ESTABLISHED. (a) The commissioner, in consultation with state and local governmental agencies, community groups, and groups concerned with displaced homemakers, may contract with public or private nonprofit organizations for multipurpose service centers for displaced homemakers[.] and expand existing state programs through reimburseable service agreements.

(b) The commissioner shall adopt regulations prescribing the standards to

be met by each multipurpose service center for displaced homemakers in accordance with the policies established in this chapter.

(c) The commissioner shall establish a competitive contract procurement process that ensures free and open competition for funds allocated for programs established in this chapter. As part of this procurement process, it is intended that public or private nonprofit organizations and state agencies may propose to provide all or a portion of the services listed under AS 47.90.020.

Sec. 41.90.020. MULTIPURPOSE SERVICE CENTERS. A multipurpose service center for displaced homemakers established under AS 47.90.010 may provide the following services:

(1) job counseling services which shall

(A) be specifically designed for displaced homemakers;

(B) counsel displaced homemakers regarding job opportunities; and

(C) consider and build on the skills and experience of a homemaker and emphasize job readiness as well as skill development;

(2) job training and job placement services which shall

(A) emphasize short-term training programs which expand upon homemaking skills and volunteer experience and which lead to gainful employment;

(B) develop through cooperation with state and local government agencies and private employers training and placement programs for jobs in the public and private sector;

(C) assist displaced homemakers in gaining admission to existing public and private job-training programs and opportunities including vocational education, reentry into secondary and postsecondary educational facilities, and apprenticeship training programs; and

(D) assist in identifying community needs and creating new jobs, including nontraditional occupations for displaced homemakers, for displaced homemakers in the public and private sector;

(3) health counseling services including referral to existing health programs with respect to

(A) general principles of preventive health care;

(B) health care consumer education, particularly in the selection of physicians and health care services including health maintenance organizations and health insurance;

(C) mental health care and transitional counseling;

(D) family health care, dental care and nutrition;

(E) alcohol and drug abuse; and

(F) other related health care matters;

(4) financial management services which provide information and assistance relating to insurance, taxes, estate and probate matters,

mortgages, loans, and related financial matters;

(5) educational services including

(A) information, including the availability of monetary assistance programs, relating to courses offering credit through secondary or postsecondary education programs and reentry programs, including bilingual programs if appropriate; and

(B information about other programs [DETERMINED BY THE COMMISSIONER TO BE] of benefit to displaced homemakers;

(6) legal counseling and referral services; and

(7) information services with respect to federal and state employment, education, health, public assistance, and unemployment assistance programs which the commissioner determines to be of benefit

The Committee stopped its deliberations at this point (end of page 3 in original bill).

Bill No. House Bill 936

Date March 11, 1980

Title An Act relating to displaced homemakers; and providing for an effective date

Contact: Judy DuBois
465-2700

House Bill No. 936 "An Act relating to displaced homemakers; and providing for an effective date" is proposed to establish multipurpose service centers to provide services for Alaskan displaced homemakers.

Although the conceptual emphasis of the bill is supported, we have four primary concerns in relation to its implementation. First, the bill does not indicate the size or distribution of the population to be served and thus does not indicate sites as where the multipurpose centers will be established. A second concern is the tax credit provision for displaced homemakers. It appears that the displaced homemakers tax credit is a duplication of the proposed Alaska State Jobs Tax Credit program and may be a moot issue in view of the current tax legislation before the Alaska Legislature. A third concern is the current existence of federal funds available for displaced homemaker services. It appears that by consolidating existing displaced homemaker service programs and by utilizing present funding sources, expansion of services to additional geographical areas of the State of Alaska could be accomplished without the inclusion of State funds.

Lastly, the proposed legislation duplicates the current efforts of providing employment, counseling and necessary referral services for eligible displaced homemakers by Job Service and the Alaska Work Incentive program. It would appear that since Job Service and the Work Incentive program are currently operational, they should be utilized as the primary administrative and service provider vehicles for the proposed displaced homemaker legislation. This is especially pertinent when it is recognized that the population to be served by this legislation are or will be eligible for existing agency's services and that the proposed multipurpose centers will function as primarily a referring organization.

Departmental Position: Opposed in current status.

POSITION PAPER/Department of Labor

STATE OF ALASKA
THE LEGISLATURE

POUCH Y - STATE CAPITOL
JUNEAU, ALASKA 99811
907-465-3800

LEGISLATIVE AFFAIRS AGENCY

M E M O R A N D U M March 5, 1980

SUBJECT: Displaced homemakers.
(Work Order Number 7956)

TO: Representative Thelma Buchholdt, Chairman
House Health, Education and Social Services
Committee

FROM: Richard A. Bradley
Legislative Counsel

The bill requested by the committee is attached.

To a large extent it speaks for itself and best indicates what it includes.

However, certain observations may be useful.

Because the draft given to me embodied more of a concept than a vehicle for legislative drafting, I sought to find a law in another state that would be useful. I think it is clear that the derivation of the concept is law from the State of Washington. See, RCW 28B.04.010 - 28B.04.130.

I used the Washington law as the basis for this bill.

The appropriation suggested in the draft is not included. If the committee wishes, I will prepare a separate bill embodying whatever amount it wishes.

The concept of taxing marriage licenses probably would not generate adequate revenues to accomplish very much. In any case, it would result in a dedicated fund and as such would be unconstitutional. The concept is not included in the bill.

If I may assist further, please advise.

RAB:ljb

Enclosure

Introduced: 3/6/80
Referred: Health, Education & Social Services

IN THE HOUSE

BY THE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

HOUSE BILL NO. 936

IN THE LEGISLATURE OF THE STATE OF ALASKA

ELEVENTH LEGISLATURE - SECOND SESSION

A BILL

For an Act entitled: "An Act relating to displaced homemakers; and providing for an effective date."

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

* Section 1. LEGISLATIVE FINDINGS AND INTENT. (a) The legislature finds that there is an increasing number of persons in the state who, after having fulfilled the role of homemaker for a number of years of their life, find themselves "displaced" through the death of a spouse, divorce, separation, desertion, or loss of family income. The legislature finds that displaced homemakers are often without any source of income, face continuing discrimination in employment because they frequently have no recent work experience and may be older than other applicants for employment, are subject to high rates of unemployment and are ineligible for unemployment insurance because they have been engaged in unpaid labor in the home, may be ineligible for categorical welfare assistance, are ineligible for social security if they have been divorced from the family wage earner, may have lost their rights as beneficiaries under employers' pension and health plans through death of a spouse or divorce despite the contribution of years to the well-being of the family, and may be ineligible for Medicaid and unable to purchase private health insurance because of age and lack of income. The legislature further finds that homemakers are an unrecognized part of the work force of the state who have made an invaluable contribution to the welfare of society.

(b) It is the intent of this Act to

(1) provide the necessary counseling, training, employment placement, and other services for displaced homemakers;

adopted Mental & Physical

(2) improve the health and welfare of this growing group of members of the community; and

(3) provide displaced homemakers with independence and economic security vital to a productive life.

* Sec. 2. AS 47 is amended by adding a new chapter to read:

CHAPTER 90. DISPLACED HOMEMAKERS.

Sec. 47.90.010. PROGRAM ESTABLISHED. (a) The commissioner, in consultation with state and local governmental agencies, community groups, and groups concerned with displaced homemakers, may contract with public or private nonprofit organizations for multipurpose service centers for dis laced homemakers.

(b) The commissioner shall adopt regulations prescribing the standards to be met by each multipurpose service center for displaced homemakers in accordance with the policies established in this chapter.

Sec. 47.90.020. MULTIPURPOSE SERVICE CENTERS. A multipurpose service center for displaced homemakers established under AS 47.90.010 shall [may] provide the following services:

(1) job counseling services which shall

(A) be specifically designed for displaced homemakers;

(B) counsel displaced homemakers regarding job opportunities; and

new (C) consider and build on the skills and experience of a homemaker and emphasize job readiness as well as skill development;

(2) job training and job placement services which shall

(A) emphasize short-term training programs which expand upon homemaking skills acquired on homemaking and volunteer experience and which lead to gainful employment;

(B) develop through cooperation with state and local government agencies and private employers training and placement

programs for jobs in the public and private sector;

(C) assist displaced homemakers in gaining admission to existing public and private job-training programs and opportunities including vocational education, re-entry into secondary & post secondary and apprenticeship training programs; and re-entry refresher courses;

(D) assist in identifying community needs and creating new jobs for displaced homemakers in the public and private sector;

(E) Reconciling of community needs re jobs

(3) health counseling services including referral to existing health programs with respect to (C) mental health care

(A) general principles of preventive health care;

(B) health care consumer education, particularly in the selection of physicians and health care services including health maintenance organizations and health insurance,

(C) family health care, mental health & dental care and nutrition;

(D) alcohol and drug abuse; and

(E) other related health care matters;

(4) financial management services which provide information and assistance relating to insurance, taxes, estate and probate matters, mortgages, loans, and related financial matters;

(5) educational services including

~~information~~ incl. avail of mont tax assist prg.

(A) information relating to courses offering credit through secondary or postsecondary education programs and reentry programs, including bilingual programs if appropriate; and

(B) information about other programs [determined by the commissioner to be] of benefit to displaced homemakers;

(6) legal counseling and referral services; and

(7) information services with respect to federal and state employment, education, health, public assistance, and unemployment assistance programs which the commissioner determines to be of benefit

to displaced homemakers.

Sec. 47.90.030. EMPLOYMENT OF DISPLACED HOMEMAKERS. The staff positions of multipurpose centers established under AS 47.90.010, including supervisory, technical and administrative positions, shall to the maximum extent possible be filled by displaced homemakers.

Sec. 47.90.040. CONSULTATION AND COORDINATION. The commissioner shall consult and cooperate with the Department of Health and Social Services; the Department of Education, including the division of vocational rehabilitation; the University of Alaska, community colleges and other colleges as appropriate; the Department of Labor, including the division of employment security; and other persons or agencies which the commissioner considers appropriate in the implementation of this chapter.

Sec. 47.90.050. CERTIFICATION OF DISPLACED HOMEMAKERS. The commissioner shall adopt regulations under which the commissioner may certify individuals as displaced homemakers for the purposes of AS 47.90.060 [and AS 43.20.037].

Sec. 47.90.060. ASSISTANCE TO AGENCIES. The commissioner may grant to a state agency a reimbursement not to exceed 30 percent of the first 12 months of the compensation paid to a displaced homemaker whom the agency employs and trains if the agency assists the displaced homemaker in obtaining permanent employment.

Sec. 47.90.070. REGULATIONS. The commissioner may adopt regulations to implement this chapter.

Sec. 47.90.080. DEFINITIONS. In this chapter

(1) "agency" means a department or agency of the state or a municipality of the state;

(2) "commissioner" means the commissioner of community and regional affairs;

d has

(3) "displaced homemaker" means a person who

(A) has worked [without compensation] as a homemaker for at least [six years;] 2 yrs. discriminatory

(B) has been dependent on the income of a family member [and has lost that income;] and

(C) has encountered difficulty in finding employment.

* Sec. 3. AS 43.20 is amended by adding a new section to read:

Sec. 43.20.037. DISPLACED HOMEMAKER CREDITS. For purposes of calculating the income tax payable under this chapter, the taxpayer may apply as a credit against his tax liability 30 percent of the first 12 months of compensation paid each person certified by the commissioner of community and regional affairs to be a displaced homemaker and employed and trained by the taxpayer under regulations of the commissioner of community and regional affairs.

* Sec. 4. This Act takes effect July 1, 1980.

neg. income - employer shows no profit

stipend or payment for hiring people in this category

POSITION PAPER/Department of Health & Social Services

POSITION PAPER

HOUSE BILL NO. 936

"An Act relating to displaced homemakers; and providing for an effective date."

This Bill would establish a program for displaced homemakers to be administered by the Department of Community and Regional Affairs. The Bill also authorizes the development of multipurpose service centers for displaced homemakers to provide job counseling, training and placement; health counseling; financial management; education; legal counseling and referral; and information services.

There has been growing concern for displaced homemakers, persons who must change their roles from that of homemaker to that of wage earner as a result of a change in circumstances such as divorce, separation, or death of a spouse. Among this group of individuals would also be those persons who have been on a fixed income which now due to inflation must be supplemented by a job for which they are not prepared. Otherwise they may be forced on to the welfare roles.

The Department recognizes the need for programs for displaced homemakers to assist them through their role transition. The Department does currently provide services aimed at this population. Those displaced homemakers residing in the Anchorage and Juneau areas who are eligible for Aid to Families with Dependent Children (AFDC) may receive a wide variety of employment oriented social services through the Work Incentive (WIN) program. In addition, in the FY 80 capital budget, the legislature appropriated $100,000 to the Alaska Women's Resource Center in Anchorage for a counseling program and a displaced homemaker program. The contract for this program has been administered by the Department of Health and Social Services. During the first two quarters of FY 80 the program reported 396 client contacts, ranging in age from early 20's to mid 60's.

The directors of the shelters for battered women have noted a great need for job training for women served by their programs. Women who have been forced out of their homes due to violence towards them may face a need for immediate employment in order to support themselves and their children. The majority of these women either have not worked for years or have never worked and are competing in an ever tightening job market.

At the present time there is no central source to coordinate services for displaced homemakers, although Division of Social Services workers do provide information and referral and counseling. There is a definite need to have a centralized information and referral system as well as a need to coordinate services which are already available.

POSITION PAPER/Department of Health & Social Services

On the surface it appears that there may be some possible overlap between the services to be provided by the multipurpose service centers and those currently provided by various existing programs. In the Department's view, however, any seeming potential for duplication and overlap, would be reduced by coordinating existing state operated and funded programs as well as community resources.

Should this enhanced program for displaced homemakers be established by statute the Department of Health and Social Services will coordinate with the Department of Community and Regional Affairs to avoid duplication and will provide any technical assistance requested to ensure the development of a quality program.

RECOMMENDED BY: John Pugh DATE: 3/12/80
John Pugh, Acting Director
Division of Social Services

APPROVED BY: Helen D Beirne DATE: 3/13/80
Helen D. Beirne
Department of Health and Social Services

THE LEGISLATURE OF THE STATE OF ALASKA
ELEVENTH LEGISLATURE

FISCAL NOTE

I. REQUEST

Bill/Resolution No. House Bill No. 936

Title "An act relating to displaced homemakers; and providing for an effective date."

Requested by _____ Date March 12, 1980

II. FISCAL DETAIL

Agency Affected Department of Health and Social Sevices

Program Category Affected Social Services

BRU, Program, or Subprogram(s) Affected Social Services

(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

		FY 80	FY 81	FY 82	FY 83	FY 84	FY 85
100	PERSONAL SERVICES						
200	TRAVEL						
300	CONTRACTUAL						
400	COMMODITIES						
500	EQUIPMENT						
600	LAND & STRUCTURES						
700	GRANTS, CLAIMS, ETC.						
	TOTAL	-0-	-0-	-0-	-0-	-0-	-0-

FUNDING (Thousands of Dollars)

GENERAL FUND	-0-	-0-	-0-	-0-	-0-	-0-
FEDERAL FUNDS	-0-	-0-	-0-	-0-	-0-	-0-
OTHER (Specify Fund Source)	-0-	-0-	-0-	-0-	-0-	-0-
	-0-	-0-	-0-	-0-	-0-	-0-
	-0-	-0-	-0-	-0-	-0-	-0-

POSITIONS

FULL TIME	-0-	-0-	-0-	-0-	-0-	-0-
PART TIME	-0-	-0-	-0-	-0-	-0-	-0-
TEMPORARY	-0-	-0-	-0-	-0-	-0-	-0-

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

This Bill has no fiscal impact on the Department of Health and Social Services

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)

Prepared by: _____ Date: 3/12/80
Division/Office: Social Services PH: 465-3170
Department of Health & Social Services

Approval DHSS Mgt. & Bdgt: _____ Date: 3/12/80

33-001 (Rev. 12/79)
Modify by DHSS (11-28-79)

HB
956

JUNEAU ALASKA/Department of Health and Social Servi

POSITION PAPER

HOUSE BILL 956

"An Act making a special appropriation to the Department of Health and Social Services for a mental health transitional facility in Anchorage; and providing for an effective date."

Federal law defines a transitional facility as:

"A program of transitional half-way house services for mentally ill individuals who are residents of its catchment area and who have been discharged from a mental health facility or would without such services require inpatient care in such a facility." Presently, this sector in the continuum of care for the mentally ill adult and adolescent in Alaska is deficient.

The State Plan and Governor's Mental Health Advisory Council all include such a program as high priority. The Department of Health and Social Services recognizes the need for a transitional facility in Anchorage. The chronic mentally ill require both housing and daily supervision to adjust to their return to the community. The present facilities in Anchorage do not provide either the appropriate environment or adequate daily programming. There is also a need for a transitional facility for emotionally disturbed adolescents.

We have a technical suggestion in terms of form. Since capital expenditures cannot be funded under the auspices of Alaska Statute 47.30.520-620, the Community Mental Health Services Act, any capital portion of the $450,000 should be funded under Alaska Statute 18.25.010 and be appropriated to Department of Health and Social Services, Division of State Health Planning and Development. Any program portion of the $450,000 should be funded under the Alaska Statute 47.30.520-620 and appropriated to Department of Health and Social Services, Division of Mental Health and Developmental Disabilities.

There is a statewide need for transitional facilities for the chronically mentally ill and emotionally disturbed adolescents. The Anchorage area provides an excellent pilot arena for a model program due to the presence of the Alaska Psychiatric Institute and the Anchorage Community Mental Health Clinic..

Recommended by: Verner Stillner M.D.

Verner Stillner, M. D., M.P.H.
Director, Division of Mental Health & Developmental Disabilities

Date: 3/18/80

Approved by: Helen D. Beirne

Helen D. Beirne, Commissioner
Department of Health & Social Services

Date: 3/18/80

Funding Information
General Fund $450,000
Other Funds - 0 -
$450,000

IN THE HOUSE BY THE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

HOUSE BILL NO. S HB 956

IN THE LEGISLATURE OF THE STATE OF ALASKA

ELEVENTH LEGISLATURE - SECOND SESSION

A BILL

For an Act entitled: "An Act making a special appropriation to the Department of Health and Social Services for a mental health transitional facility in Anchorage; and providing for an effective date."

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

* Section 1. The sum of $450,000 is appropriated from the general fund to the Department of Health and Social Services, division of mental health and developmental disabilities, for a mental health transitional facility in Anchorage.

* Sec. 2. The unexpended and unobligated portion of the appropriation made by this Act lapses into the general fund June 30, 1981.

* Sec. 3. This Act takes effect July 1, 1980.

TRANSITIONAL LIVING - A STEP TOWARD INDEPENDENCE

Just as a person's treatment plan must be individualized and based on his/her particular needs, so must a plan for living and housing be individualized. The planning and development of discharge goals should be obtainable, appropriate and started already at the time of admission. Individual needs and wishes provide the basis for planning and development of main discharge goals. One factor that has often been overlooked in treatment planning and for maximizing a client's chances for success in any kind of a rehabilitation program, is an assessment of the quality of the client's residential situation. Two major factors must be considered: (a) The client's current family situation, and (b) The extent to which the residential setting is conducive to rehabilitation. An inadequate and destructive family setting, such as involving excessive dependence on family members, or substandard boarding homes or apartment settings are seen as posing the greatest threat to any successful outcomes. If it is determined that at least for a temporary period a client would make more progress away from a family, or in a separate setting, or as an alternative to hospitalization, a community mental health center should be prepared to offer some alternatives.

Basically, staff should be aware of the possibility that the client may have special needs within the community, including: (1) A residential setting which provides appropriate support and offers the least restrictive environment; (2) A mutually caring relationship with one or more persons; (3) Opportunity for social and recreational activities; (4) Assistance to and education of family and significant others in relation to difficulties they may experience as a result of the client's return to his/her home; (5) Vocational guidance training and assistance in securing and holding a job; (6) Provision for useful daily activities for those who are incapable of holding a regular job; (7) Assistance in taking advantage of services as citizens of their respective communities, e.g., S.S.I. payments, food stamps, housing benefits, etc.; (8) A place to go to or person to call for help in dealing with problems with stress; (9) Medical and psychiatric treatment as necessary, including review and assessment of drug therapy; (10) A coordinator or a therapist to provide linkage between the various service delivery systems and the client to assure the client has access to all the needed services.

This link in services from hospital to community, or as an alternative to hospitalization, is missing in many communities. One of the more recent concepts is the development of a transitional living facility which is designed to fill the gap between the institution and the community, or in providing therapeutic services which do not require hospitalization. This facility is designed as short-term, highly therapeutic, with a basic goal of rehabilitating the client in as little time as possible to resume or begin "normal" community living.

This document is a proposal for the development of a transitional home facility for the Anchorage catchment area. The home will be directed toward people who are experiencing a situational crisis, as well as requiring services which are now offered by the Mental Health Center. The funding required for such a program will involve monies allocated for capital outlay for the purchase, construction or lease of a facility adequate for a maximum of twelve individuals who qualify for this program, as well as money to fund the program, to support operating costs, and staff required to operate a quality program.

All of this would be based on a premise that many of the people who are experiencing the types of situational crises which warrant admission to this program, would be without adequate financial resources to fully pay for these services. As such, we are estimating that the operating cost will require a substantial amount of public money as a means of alleviating admission to a psychiatric hospital, or other residential care facility.

Staff has been asked to provide an overview and to research the needs for transitional housing in Anchorage for citizens who require additional situational support. The professional literature reviewed to date points to the following areas of consideration: (1) There is a serious shortage of facilities nationally to deal with the need for housing coupled with a program to improve coping abilities. (2) Federal and State laws mandate care for this population, but a gap in the system is residential living with supervision present to assist in individuals being discharged from a hospital without adequate situational support, and preventing hospitalization when needs can be addressed in the community with adequate resources. (3) Linking people, programs, and organizations is crucial for effective treatment and is consistent with the continuity of care concept which underlies the NIMH commitment to community support. (4) Need for meaningful evaluation criteria to assure quality community service. (5) Need for a coordinating body with clear lines of communication and minimal administrative detail. (6) Need for exclusion of individuals with active primary problems of substance abuse. (7) Needs assessment conducted by the Municipal Health Commission, by the University of Alaska, and by the Department of Health and Social Services indicate that there is a serious gap in this type of living facility to serve the Anchorage catchment area.

Adequate housing for the emotionally unstable is a national problem dating back for generations. The advent of psychotropic drugs in the 1950's and the process for deinstituionalization and acceleration of the community psychiatry movement in the 1960's appear to be major factors affecting the declining acceptance of state mental hospitals as a means for dealing with consumers' lack of support systems in the community. Many of the needs of the acute and chronic "mental patient" are absorbed by the core of the community--family, friends, schools, clergy, community services, professional boarding homes, foster care, independently operated

hotels, apartments and the hospitals. This core has varying levels of commitment, skill, and understanding to assist the individuals with transitional coping needs. Even on the professional end of the spectrum, there is a limited milieu for observation of structured living and monitored progress outside of the hospital. Consequently, the hospital, primarily A.P.I., is inundated with people needing situational support, not necessarily inpatient psychiatric care.

The following is a perception of factors affecting the potential resident population we are addressing: Dysfunctional precursors such as distorted perception of events; inadequate situational and emotional support; inadequate coping abilities and symptoms of mental illness lead to a stressed, potential resident. This potential resident then exhibits such things as dysfunctional attempts at stabilization, loss of motivation, crisis to crisis lifestyle, substance abuse, legal encounters, marginal existent transient lifestyle, agency bouncing, community bouncing, exhaustion of community resources, stressed family, friends and community, and in general, needs not being met. This inability to cope with and relate to the community leads to request for hospitalization and regression to institutionalization.

Stress is an inherent factor of life. The population that is being spoken of does not exhibit the wherewithall of adequate stress management. The theoretical causes or enhancers of this inability to cope are numerous and will not be explored here. Rather, we will look at the interventions and education which can be utilized to assist people with coping needs. The need for, and at times the number of, support systems that this population utilizes to compensate for this inability to cope, is at times a stress source in and of itself defining an imperative need for coordination. The individual's ability to coordinate and to cope with living at the highest potential is the goal. A transitional residence program would provide a base where staff with adequate theoretical knowledge and experience could assist a resident in assessing what coping skills they are lacking to achieve and maintain maximum functioning in the community.

At present there are few statistics available to document the need for this facility in Anchorage. In consultation with planning agencies, and in a review of the various documents and assessments that have variously been done, the need seems evident. The consensus of professionals in the area is that such a facility is desperately needed.

The residential transitional home that we are addressing here is thought to be a short-term facility. Short-term is defined as a maximum single stay of up to a 90-day period of time. This seems like a reasonable period in which an assessement of the individual needs and linkages in the community could be achieved. In some cases, an additional 90-day stay could be recommended. The acceptance criteria for such a facility would be as follows: (1) Age 19 or over. (2) Primary problem of

emotional instability and not other related issues. (3) Inadequate or no support system. (4) Inability to cope with stressful events. (5) Needing coordination of services. (6) Capable of functioning without constant direct supervision. (7) Accepting of and willing to participate in the contract agreed upon with screening person and staff as well as residents. (8) Not imminently dangerous to self or others. (9) Engaged in a therapeutic relationship or willing and able to engage in such. (10) As an alternative to 24-hour inpatient hospital care.

During the resident's stay, growth will be facilitated by: (1) Community meetings, peer supported feedback, decision-making and problem-solving. Here plans for residence managing will occur, including disciplinary actions, allocation of chores for housekeeping, maintaining, purchasing, group therapy, etc. (2) The therapeutic community environment milieu will focus on interaction between members, not intrapsychic content of individual. (3) Group therapy, emotional interdependence, nature of living situation, and review of individual's plan, action, support and confrontation. (4) Individual or conjoint sessions with significant others as necessary. Program framework would undoubtedly have included a preventative approach to self-care, educational resources, community classes, stress management, recreation and physical fitness, nutrition--whatever else is possible or necessary. Complete details of the program will be addressed in the policy and procedures manual.

This facility would receive residents from numerous community areas. The channels that would be utilized to determine acceptance would be as follows: (1) Potential residents would demonstrate need for situational support and express a desire to explore the options and initiate change. (2) Referee consults with staff as part of pre-discharge planning, identifies status as medically and psychiatrically cleared for discharge without adequate situation support; (3) Potential resident is then interviewed by the staff; (4) Following the interview and screening, if the facility is suitable for the potential resident's needs, expectations and responsibilities of potential resident and the facility will be discussed, and if agreed upon, a treatment plan will be initiated.

Linkages within the community for a resident of this facility is imperative. Therefore, due to the nature of the environment of this facility and the individual housed therein, the communication between the facility, the resident and the following community resources must be open, collaborative and responsive: (1) Community consumers; (2) Division of Vocational Rehabilitation; (3) A.P.I., Community Hospital, Community Services; (4) Adult Basic Education; (5) Work and recreational resources; (6) Social Security, Alaska State Housing Authority, Food Stamps, and other supportive services; (7) Police and legal department systems; (8) Substance abuse programs; (9) Emergency services; (10) Community professionals.

In looking at quality assurance for such a facility, it appears that formal evaluation criteria is one of the major areas lacking in documentation of published literature. Due consideration in this area will need to be given. At present, it seems reasonable to measure the following areas:

(1) The resident

(a) Initial resident's assessment of needs and goals

(b) Monthly formal monitoring evaluation

(c) Termination evaluation with report regarding status of goal attainment. Appropriateness of services, follow-up availability.

(2) Staff

(a) Regular supervision and evaluation program

(b) Six-month review of overall operation of program

(c) Yearly evaluation with input from referral sources; follow-up on prior residents and staff recommendations

(d) Two-year evaluation of needs for program changes, funding, referral criteria and other major overall program changes.

It appears that a transitional facility of this nature would be far less expensive than a hospital stay, and a much more favorable and healthier choice for the individual in terms of residing in the community. Hopefully, in the future some arrangements in terms of assisting residents in moving toward semi-independent or apartment living would be the next feasible step for those on the higher end of dysfunctioning continuum. Utilizing data from the ongoing assessment of the resident while in the facility, appropriate referrals to family, friends, boarding home, etc., within the community could be made with the clear understanding of the individual's needs and growth potential.

The emphasis should be on incorporating the facility into an already existing neighborhood. This facility would involve the necessity of meeting the existing codes required by the Municipality of Anchorage, as well as the State of Alaska, in addition to any Federal NIMH or JCHA standards which are warranted. The facility itself would be adequate in terms of square footage to meet zoning requirements per individual, as well as adequate fire, health and other code and zoning requirements. We visualize this facility as housing a maximum of twelve clients with a hoped for average of about eight. This would involve sleeping and cooking facilities adequate to cover the maximum number of clients in the program, as well as leisure and recreation areas such as a TV and recreational room.

Other budgetary items necessary would be to support the program involving money for equipment and supplies of an ongoing nature. This would include funds for capital improvement and upkeep; funds for acquisition; funds for fixed costs such as electricity, gas, telephone and salaries of staff and purchase of equipment which would be necessary for the proper operation of the program. A vehicle should be provided which can be used by the staff to provide transportation for clients, either on a full or part time basis, or in a shared arrangement with another part of the program.

Staffing pattern would include: (a) One full time resident manager who would be required to be on the premises 24 hours a day, five days a week; (b) A part-time cook who would also serve as dietician in arranging for and supervising preparation of at least two meals per day; (c) A part-time or backup manager who will work on weekends and serve as backup to the resident manager; (d) A professional staff person who would do most of the screening, provide the group therapy; provide the liaison with a variety of community agencies; maintain the records; and provide the follow-up.

In 1955, well over half a million people resided in state and county hospitals. The latest data shows that this population has now been reduced by more than half or about 200,000 people. This decrease has been accompanied by a rise to over a million people who now reside in a community nursing homes which have grown in number and now house a large proportion of these former patients. There are many residents currently in nursing homes, however, who are not in need of this type of expensive care, yet inadequate boarding homes or slum hotels offer no solution either. In reviewing the literature concerning those best equipped to initiate a transitional living program, there seems to be general agreement that this type of living should be an extension of the community mental health service.

Research also seems to point to a special need and special attention must be given to the type of community which is to be home to the residents of this facility. This is particularly true in regard to community mores and sociocultural variables.

residents of this home should not be an instrument of social reform, but rather should be a part of an existing community which is most nearly representative of the clients who will be living in the facility.

A second factor that becomes increasingly apparent is that this facility must not be seen as simply a convenient place to house a patient when the emergency or chronic wards are overcrowded in the institution. We will use special care that this facility not become a dumping ground for all those who have no other place.

The third major pitfall to avoid is in reference once again to the host agency. Several instances have shown that the likelihood of success is considerably less where private agencies try to develop programs by themselves without entire community support. Of vital necessity is the support of other service providers. If agencies operate in an isolated fashion, very likely there will be a narrow concentration of similar clients when a mix of clients is much more desirable.

In conclusion, it must become apparent to all that a major value underlying all programs is that those who are suffering from mental disabilities have the same right as anyone else to live in a type of environment which affords a quality of life conducive to self-realization and growth. Since a transitional facility offers relative anonymity to the residents and presents less cause for community fears, they have many advantages not often realized by other residential modalities such as boarding homes. Chief among such advantages is the avoidance of stigma-prone situations brought about in conspicuous community living arrangements, such as large residential care facilities or large hotels. The whole concept of normalization seems to become increasingly apparent in this endeavor.

TRANSITIONAL LIVING FACILITY

PROPOSED BUDGET

Facility Acquisition	$300,000	
Equipment and furniture	40,000	
Transportation	10,000	
Food and consumable supplies	21,000	
Utilities	2,000	
Insurance	2,000	
		$375,000
Staff:		
Resident manager - Salary and fringes	$ 20,000	
Asst. and backup manager - sal. & fringes	12,000	
Cook and aide	12,000	
Professional staff - screening, therapy, etc.	29,000	
		$ 73,000
		$448,000
Miscellaneous		2,000
Estimated Total		$450,000

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United States Code Annotated Title 42

SUBCHAPTER XVI—SUPPLEMENTAL SECURITY INCOME FOR AGED, BLIND, AND DISABLED

Library References

Social Security and Public Welfare ⇐241.

C.J.S. Social Security and Public Welfare § 73.

§ 1381. Statement of purpose; authorization of appropriations

For the purpose of establishing a national program to provide supplemental security income to individuals who have attained age 65 or are blind or disabled, there are authorized to be appropriated sums sufficient to carry out this subchapter.

Aug. 14, 1935, c. 531, Title XVI, § 1601, as added Oct. 30, 1972, Pub. L. 92-603, Title III, § 301, 86 Stat. 1465.

Historical Note

Codification. A prior section 1381, Act Aug. 14, 1935, c. 531, Title XVI, § 1601, as added July 25, 1962, Pub.L. 87-543, Title I, § 141(a), 76 Stat. 197, authorized appropriations for grants to states for aid to the aged, blind, or disabled, and for medical assistance for the aged. See section 801 of this title.

Effective Date. Section 301 of Pub.L. 92-603 provided in part that this section is to take effect Jan. 1, 1974.

Continuation of Federal Financial Participation in Experimental, Pilot, or Demonstration Projects Approved Before Jan. 1, 1973, for Period On-And-After Dec. 31, 1973, Without Denial or Reduction on Account Of Subchapter XVI Provisions; Waiver of Subchapter XVI Restrictions for Individuals; Federal Payments of Non-Federal Share as Supplementary Payments. Subchapter provisions with respect to effect on Federal Financial Participation in Experimental, Pilot, or Demonstration Projects approved before Oct. 1, 1972, for period On-And-After Dec. 31, 1973, see section 11 of Pub.L. 93-233, Dec. 31, 1973, 87 Stat. 958, set out as a note under section 1315 of this title.

Payments Under Chapter Provisions in Effect Before Jan. 1, 197 for: Activities Carried Out Through Dec. 31, 1973, under State Plans Approved Under Subchapter I, X, XIV, or XVI Provisions; and for Administrative Activities After Jan. 1, 1974, Closing Out Such Activities. Pub. L. 93-233, § 19(b), Dec. 31, 1973, 87 Stat. 974, provided that: "Notwithstanding the provisions of section 301 of the Social Security Amendments of 1972 [enacting this subchapter], the Secretary of Health, Education, and Welfare shall make payments to the 50 States and the District of Columbia after December 31, 1973, in accordance with the provisions of the Social Security Act [this chapter] as in effect prior to January 1, 1974, for (1) activities carried out through the close of December 31, 1973, under State plans approved under title [subchapter] I, X, XIV, or XVI, of such Act [this chapter], and (2) administrative activities carried out after December 31, 1973, which such Secretary determines are necessary to bring to a close activities carried out under such State plans."

Puerto Rico, Guam, and Virgin Islands. Enactment of provisions of Pub. L. 92-603, eff. Jan. 1, 1974, not applicable to Puerto Rico, Guam, and the Virgin Islands, see section 303(b) of Pub.L. 92-603, set out as a note under section 301 of this title.

Legislative History. For legislative history and purpose of Pub.L. 92-603, see 1972 U.S.Code Cong. and Adm.News, p. 4980.

Library References

United States ⇐85.

C.J.S. United States § 123.

Code of Federal Regulations

Determination and evidence,
Age, see 20 CFR 416.801 et seq.
Student regularly attending school, see 20 CFR 416.1060 and 416.1061.
Eligibility requirements for benefits under program, see 20 CFR 416.203 to 416.205.
General policy statements for program, see 20 CFR 416.101 to 416.120.
Reporting requirements under program, see 20 CFR 416.701 et seq.

Notes of Decisions

1. State or local regulation or control

No language in either the federal or state Supplemental Security Income related legislation requires or indeed suggests a total preemption of state and local responsibility by the federal government. Fuller v. Nassau County Dept. of Social Services, N.Y.Sup.1974, 352 N.Y.S.2d 978.

Although provision was made in 1973 state legislation for the Supplemental Security Income takeover of the current needs of aged, blind and disabled New Yorkers previously met by state disbursement, the basic duty of care, as imposed by McKinney's N.Y. Constitution and McKinney's N.Y. Social Services Law, remained in the state and local agencies; in specific terms, there still remained state responsibility for special need grants, social services, and medical assistance to the aged, blind and disabled; that is, the federal responsibility was primary but not exclusive. Id.

§ 1381a. Basic entitlement to benefits

Every aged, blind, or disabled individual who is determined under part A to be eligible on the basis of his income and resources shall, in accordance with and subject to the provisions of this subchapter, be paid benefits by the Secretary of Health, Education, and Welfare.

Aug. 14, 1935, c. 531, Title XVI, § 1602, as added Oct. 30, 1972, Pub. L. 92–603, Title III, § 301, 86 Stat. 1465.

Historical Note

Codification. A prior section 1602 of Act Aug. 14, 1935, c. 531, Title XVI, as added July 25, 1962, Pub.L. 87-543, Title I, § 141(a), 76 Stat. 198, and amended Oct. 13, 1964, Pub.L. 88-650, § 5(b), 78 Stat. 1078; July 30, 1965, Pub.L. 89-97, Title II, § 221(d) (3), Title IV, § 403(e), 79 Stat. 358, 418; Jan. 2, 1968, Pub.L. 90-248, Title II, §§ 210(a) (5), 213(a) (4), 241 (d), 81 Stat. 890, 898, 917, formerly classified to section 1382 of this title, set forth the required contents of state plans for aid to the aged, blind, or disabled, and for medical assistance for the aged. See section 802 of this title.

Effective Date. Section 301 of Pub.L. 92-603 provided in part that this section is to take effect Jan. 1, 1974.

Puerto Rico, Guam, and Virgin Islands. Enactment of provisions of Pub. L. 92-603, eff. Jan. 1, 1974, not applicable to Puerto Rico, Guam, and the Virgin Islands, see section 303(b) of Pub.L. 92-603, set out as a note under section 301 of this title.

Legislative History. For legislative history and purpose of Pub.L. 92-603, see 1972 U.S.Code Cong. and Adm.News, p. 4989.

PART A—

§ 1382. Eligibilit
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lative History. For legislative
and purpose of Pub.L. 92-603, see
S.Code Cong. and Adm.News. p.

PART A—DETERMINATION OF BENEFITS

§ 1382. Eligibility for benefits—Definition of eligible individual

(a)(1) Each aged, blind, or disabled individual who does not have an eligible spouse and—

(A) whose income, other than income excluded pursuant to section 1382a(b) of this title, is at a rate of not more than $1,752 (or, if greater, the amount determined under section 1382f of this title) for the calendar year 1974, or any calendar year thereafter, and

(B) whose resources, other than resources excluded pursuant to section 1382b(a) of the title, are not more than (i) in case such individual has a spouse with whom he is living, $2,250, or (ii) in case such individual has no spouse with whom he is living, $1,500,

shall be an eligible individual for purposes of this subchapter.

(2) Each aged, blind, or disabled individual who has an eligible spouse and—

(A) whose income (together with the income of such spouse), other than income excluded pursuant to section 1382a(b) of this title, is at a rate of not more than $2,628 (or, if greater, the amount determined under section 1382f of this title) for the calendar year 1974, or any calendar year thereafter, and

(B) whose resources (together with the resources of such spouse), other than resources excluded pursuant to section 1382b(a) of this title, are not more than $2,250,

shall be an eligible individual for purposes of this subchapter.

Amount of benefits

(b)(1) The benefit under this subchapter for an individual who does not have an eligible spouse shall be payable at the rate of $1,752 (or, if greater, the amount determined under section 1382f of this title) for the calendar year 1974 and any calendar year thereafter, reduced by the amount of income, not excluded pursuant to section 1382a(b) of this title, of such individual.

(2) The benefit under this subchapter for an individual who has an eligible spouse shall be payable at the rate of $2,628 (or, if greater, the amount determined under section 1382f of this title) for the calendar year 1974 and any calendar year thereafter, reduced by the amount of income, not excluded pursuant to section 1382a(b) of this title, of such individual and spouse.

Period for determination of benefits; redetermination of eligibility and amount of benefits; effective date of application

(c)(1) An individual's eligibility for benefits under this subchapter and the amount of such benefits shall be determined for each quarter of a calendar year except that, if the initial application for benefits is filed in the second or third month of a calendar quarter, such determinations shall be made for each month in such quarter. Eligibility for and the amount of such benefits for any quarter shall be redetermined at such time or times as may be provided by the Secretary

(2) For purposes of this subsection an application shall be considered to be effective as of the first day of the month in which it was actually filed.

Limitation on amount of gross income earned; definition of gross income

(d) The Secretary may prescribe the circumstances under which, consistently with the purposes of this subchapter, the gross income from a trade or business (including farming) will be considered sufficiently large to make an individual ineligible for benefits under this subchapter. For purposes of this subsection, the term "gross income" has the same meaning as when used in chapter 1 of the Internal Revenue Code of 1954.

Limitation on eligibility of certain individuals

(e)(1)(A) Except as provided in subparagraph (B), no person shall be an eligible individual or eligible spouse for purposes of this subchapter with respect to any month if throughout such month he is an inmate of a public institution.

(B) In any case where an eligible individual or his eligible spouse (if any) is, throughout any month, in a hospital, extended care facility, nursing home, or intermediate care facility receiving payments (with respect to such individual or spouse) under a State plan approved under subchapter XIX of this chapter, the benefit under this subchapter for such individual for such month shall be payable—

(i) at a rate not in excess of $300 per year (reduced by the amount of any income not excluded pursuant to section 1382a(b) of this title) in the case of an individual who does not have an eligible spouse;

(ii) at a rate not in excess of the sum of the applicable rate specified in subsection (b)(1) of this section and the rate of $300 per year (reduced by the amount of any income not excluded pursuant to section 1382a(b) of this title) in the case of an individual who has an eligible spouse, if only one of them is in such a hospital, home, or facility throughout such month; and

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of the applicable rate tion and the rate of ny income not exclud- le) in the case of an nly one of them is in ut such month; and

(iii) at a rate not in excess of $600 per year (reduced by the amount of any income not excluded pursuant to section 1382a(b) of this title) in the case of an individual who has an eligible spouse, if both of them are in such a hospital, home, or facility throughout such month.

(2) No person shall be an eligible individual or eligible spouse for purposes of this subchapter if, after notice to such person by the Secretary that it is likely that such person is eligible for any payments of the type enumerated in section 1382a(a)(2)(B) of this title, such person fails within 30 days to take all appropriate steps to apply for and (if eligible) obtain any such payments.

(3)(A) No person who is an aged, blind, or disabled individual solely by reason of disability (as determined under section 1382c(a)(3) of this title) shall be an eligible individual or eligible spouse for purposes of this subchapter with respect to any month if such individual is medically determined to be a drug addict or an alcoholic unless such individual is undergoing any treatment that may be appropriate for his condition as a drug addict or alcoholic (as the case may be) at an institution or facility approved for purposes of this paragraph by the Secretary (so long as such treatment is available) and demonstrates that he is complying with the terms, conditions, and requirements of such treatment and with requirements imposed by the Secretary under subparagraph (B).

(B) The Secretary shall provide for the monitoring and testing of all individuals who are receiving benefits under this subchapter and who as a condition of such benefits are required to be undergoing treatment and complying with the terms, conditions, and requirements thereof as described in subparagraph (A), in order to assure such compliance and to determine the extent to which the imposition of such requirement is contributing to the achievement of the purposes of this subchapter. The Secretary shall annually submit to the Congress a full and complete report on his activities under this paragraph.

Individuals outside United States; determination of status

(f) Notwithstanding any other provision of this subchapter, no individual shall be considered an eligible individual for purposes of this subchapter for any month during all of which such individual is outside the United States (and no person shall be considered the eligible spouse of an individual for purposes of this subchapter with respect to any month during all of which such person is outside the United States). For purposes of the preceding sentence, after an individual has been outside the United States for any period of 30 consecutive days, he shall be treated as remaining outside the United States until he has been in the United States for a period of 30 consecutive days.

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Individuals deemed to meet resources test

(g) In the case of any individual or any individual and his spouse (as the case may be) who—

(1) received aid or assistance for December 1973 under a plan of a State approved under subchapter I, X, XIV, or XVI of this chapter,

(2) has, since December 31, 1973, continuously resided in the State under the plan of which he or they received such aid or assistance for December 1973, and

(3) has, since December 31, 1973, continuously been (except for periods not in excess of six consecutive months) an eligible individual or an eligible spouse with respect to whom supplemental security income benefits are payable,

the resources of such individual or such individual and his spouse (as the case may be) shall be deemed not to exceed the amount specified in subsections (a)(1)(B) and (a)(2)(B) of this section during any period that the resources of such individual or individuals and his spouse (as the case may be) does not exceed the maximum amount of resources specified in the State plan, as in effect for October 1972, under which he or they received such aid or assistance for December 1973.

Individuals deemed to meet income test

(h) In determining eligibility for, and the amount of, benefits payable under this section in the case of any individual or any individual and his spouse (as the case may be) who—

(1) received aid or assistance for December 1973 under a plan of a State approved under subchapter X or XVI of this chapter,

(2) is blind under the definition of that term in the plan, as in effect for October 1972, under which he or they received such aid or assistance for December 1973,

(3) has, since December 31, 1973, continuously resided in the State under the plan of which he or they received such aid or assistance for December 1973, and

(4) has, since December 31, 1973, continuously been (except for periods not in excess of six consecutive months) an eligible individual or an eligible spouse with respect to whom supplemental security income benefits are payable,

there shall be disregarded an amount equal to the greater of (A) the maximum amount of any earned or unearned income which could have been disregarded under the State plan, as in effect for October 1972, under which he or they received such aid or assistance for December 1973, and (B) the amount which would be re-

quired to be disregarded
application of this subsec

Aug. 14, 1935, c. 531, Titl
L. 92-603, Title III, § 301
Pub.L. 93-66, Title II, §
Pub.L. 93-233, §§ 4(b)(1)
1974, Pub.L. 93-368, § 6(

Codification. A prior section
Aug. 14, 1935, c. 531, Title XV
as added July 25, 1962, Pub.
Title I, § 141(a), 76 Stat. 199, a
ed Oct. 13, 1964, Pub.L. 88-650,
Stat. 1078; July 30, 1965, Pu
Title II, § 221(d) (3), Title IV
79 Stat. 358, 418; Jan. 2, 1968,
248, Title II, §§ 210(a) (5),
241(d), 81 Stat. 896, 898, 917
1972, Pub.L. 92-603, Title IV,
406(d), 407(d), 410(d), 413(d)
1488, 1489, 1491, 1492, set for
quired contents of state plans
the aged, blind, or disabled, an
ical assistance for the aged.
802 of this title.

1974 Amendment. Pub.L.
6(a)(1)-(4), inserted "(or, if
amount determined under sect
this title)" immediately after
subsecs. (a)(1)(A) and
"$2,628" in subsecs. (a)(2)(A)

1973 Amendments. Subsec.
Pub.L. 93-233, § 4(b)(1),
"$1,752" for "$1,680".

Pub.L. 93-66, § 210(a), sub
680" for "$1,560".
Subsec. (a)(2)(A). Pub.L
4(b)(2), substituted "$2,628"

Pub.L. 93-66, § 210(b),
"$2,520" for "$2,340".

Subsec. (b)(1). Pub.L. 93
(1), substituted "$1,752" for

Pub.L. 93-66, § 210(a), sub
680" for "$1,560".

Subsec. (b)(2). Pub.L. 9
(2), substituted "$2,628" f

Pub.L. 93-66, § 210(b),
"$2,520" for "$2,340".

Subsec. (g). Pub.L. 93-23
corporated existing provi
designated as cl. (1), adde
(3), and substituted "
"1973" for "1972".

Subsec. (h). Pub.L. 93
incorporated existing test

quired to be disregarded under section 1382a of this title without application of this subsection.

Aug. 14, 1935, c. 531, Title XVI, § 1611, as added Oct. 30, 1972, Pub.L. 92-603, Title III, § 301, 86 Stat. 1466, and amended July 9, 1973, Pub.L. 93-66, Title II, § 210(a), (b), 87 Stat. 154; Dec. 31, 1973, Pub.L. 93-233, § 4(b)(1), (2), 18(d), (e), 87 Stat. 953, 968; Aug. 7, 1974, Pub.L. 93-368, § 6(a), 88 Stat. 421.

Historical Note

Codification. A prior section 1382, Act Aug. 14, 1935, c. 531, Title XVI, § 1602, as added July 25, 1962, Pub.L. 87-543, Title I, § 141(a), 76 Stat. 198, and amended Oct. 13, 1964, Pub.L. 88-650, § 5(b), 78 Stat. 1078; July 30, 1965, Pub.L. 89-97, Title II, § 221(d)(3), Title IV, § 403(e), 79 Stat. 358, 418; Jan. 2, 1968, Pub.L. 90-248, Title II, §§ 210(a)(5), 213(a)(4), 232(4), 81 Stat. 896, 898, 917; Oct. 30, 1972, Pub.L. 92-603, Title IV, §§ 405(d), 406(d), 407(d), 410(d), 413(d), 86 Stat. 1489, 1490, 1491, 1492, set forth the required contents of state plans for aid to the aged, blind, or disabled, and for medical assistance for the aged. See section 1382 of this title.

1974 Amendment. Pub.L. 93-368, § 6(a)(1)-(4), inserted "(or, if greater, the amount determined under section 1382f of this title)" immediately after "$1,752" in subsecs. (a)(1)(A) and (b)(1) and "$2,628" in subsecs. (a)(2)(A) and (b)(2).

1973 Amendments. Subsec. (a)(1)(A). Pub.L. 93-233, § 4(b)(1), substituted "$1,752" for "$1,680".

Pub.L. 93-66, § 210(a), substituted "$1,-[illegible]" for "$1,560".

Subsec. (a)(2)(A). Pub.L. 93-233, § 4(b)(2), substituted "$2,628" for "$2,520".

Pub.L. 93-66, § 210(b), substituted "$2,[illegible]" for "$2,340".

Subsec. (b)(1). Pub.L. 93-233, § 4(b)(1), substituted "$1,752" for "$1,680".

Pub.L. 93-66, § 210(a), substituted "$1,-[illegible]" for "$1,560".

Subsec. (b)(2). Pub.L. 93-233, § 4(b)(2), substituted "[illegible]" for "$2,520".

Pub.L. 93-66, § 210(b), substituted "$2,[illegible]" for "$2,340".

Subsec. (g). Pub.L. 93-233, § 18(d), incorporated existing provisions in text designated as cl. (1), added cls. (2) and (3), and substituted final December "1973" for "1972".

Subsec. (h). Pub.L. 93-233, § 18(e), incorporated existing text in provisions designated as cls. (1) and (2), added cls. (3) and (4), redesignated former cls. (1) and (2) as items (A) and (B), and in item (A) inserted phrase "under which he or they received such aid or assistance for December 1973".

Effective Date of 1974 Amendments. Section 1(c) of Pub.L. 93-335, July 8, 1974, 88 Stat. 291, provided that amendments by section 1(a) and (b) of Pub.L. 93-335 to section 8(a)(1), (2), (b)(1)-(3) and (e) of Pub.L. 93-233, Dec. 31, 1973, 87 Stat. 955, set out as notes under section 1382e of this title and sections 612c, 1431 and 2012 of Title 7, Agriculture, shall be effective July 1, 1974.

Effective Date of 1973 Amendments. Section 4(b) of Pub.L. 93-233 provided that amendment of subsecs. (a)(1)(A) and (b)(1) by section 4(b)(1), of subsecs. (a)(2)(A) and (b)(2) by section 4(b)(2), and of provisions set out as a note hereunder by section 4(b)(3) of Pub.L. 93-233, shall be effective with respect to payments for months after June 1974.

Section 210(c) of Pub.L. 93-66, as amended by Pub.L. 93-233, § 4(a)(1), Dec. 30, 1973, 87 Stat. 953, provided that: "The amendments made by this section [to subsecs. (a)(1)(A), (2)(A), (b)(1), (2) of this section] shall apply with respect to payments for months after December 1973."

Effective Date. Section 301 of Pub.L. 92-603 provided in part that this section is to take effect Jan. 1, 1974.

Federal Program of Supplemental Security Income; Supplemental Security Income Benefits for Essential Persons; Definitions of Qualified Individual and Essential Person. Section 211 of Pub.L. 93-66, as amended by Pub.L. 93-233, § 4(a)(2), (b)(3), Dec. 31, 1973, 87 Stat. 953, provided that:

"(a)(1) In determining (for purposes of title XVI of the Social Security Act [this subchapter], as in effect after December 1973) the eligibility for and the amount of the supplemental security income benefit payable to any qualified

if the Secretary after reasonable notice and opportunity for hearing to the State agency administering or supervising the administration of such plan, finds—

(1) that the plan has been so changed as to impose any residence or citizenship requirement prohibited by section 1352(b) of this title, or that in the administration of the plan any such prohibited requirement is imposed, with the knowledge of such State agency, in a substantial number of cases; or

(2) that in the administration of the plan there is a failure to comply substantially with any provision required by section 1352(a) of this title to be included in the plan;

the Secretary shall notify such State agency that further payments will not be made to the State (or, in his discretion, that payments will be limited to categories under or parts of the State plan not affected by such failure) until he is satisfied that such prohibited requirement is no longer so imposed, and that there is no longer any such failure to comply. Until he is so satisfied he shall make no further payments to such State (or shall limit payments to categories under or parts of the State plan not affected by such failure).

Aug. 14, 1935, c. 531, Title XIV, § 1404, as added Aug. 28, 1950, c. 809, Title III, pt. 5, § 351, 64 Stat. 555, and amended 1953 Reorg.Plan No. 1, §§ 5, 8 eff. Apr. 11, 1953, 18 F.R. 2053, 67 Stat. 631; Jan. 2, 1968, Pub.L. 90-248, Title II, § 215, 81 Stat. 918.

§ 1355. Definitions

Section was repealed effective Jan. 1, 1974, by Pub.L. 92-603, Title III, § 303(a), (b), Oct. 30, 1972, 86 Stat. 1484, except with respect to Puerto Rico, Guam, and the Virgin Islands. Therefore, as to Puerto Rico, Guam, and the Virgin Islands, section 1405 of the Soc l Security Act [this section] continues t apply as follows:

§ 1355. Definitions

For the purposes of this subchapter, the term "aid to the permanently and totally disabled" means money payments to, or (if provided in or after the third month before the month in which the recipient makes application for aid) medical care in behalf of, or any type of remedial care recognized under State law in behalf of, needy individuals eighteen years of age or older who are permanently and totally disabled, but does not include any such payments to or care in behalf of any individual who is an inmate of a public institution (except as a patient in a medical institution) or any individual who is a patient in an institution for tuberculosis or mental diseases. Such term also includes payments which are not included within the meaning of such term under the preceding sentence, but which would be so included except that they are made on behalf of such a needy individual to another individual who (as determined in accordance with standards prescribed by the Secretary) is interested in or concerned with the welfare of such needy individual, but only with respect to a State whose State plan approved under section 1352 of this title includes provision for—

(1) determination by the State agency that such needy individual has, by reason of his physical or mental condition, such inability to manage funds that making payments to him would be contrary to his welfare and, therefore, it is necessary to provide such aid through payments described in this sentence;

(2) making such payments only in cases in which such payments will, under the rules otherwise applicable under the State plan for determining need and the amount of aid to the permanently and totally disabled to be paid (and in conjunction with other income and resources), meet all the need of the individuals with respect to whom such payments are made;

(3) undertaking and continuing special efforts to protect the welfare of such individual and to improve, to the extent possible, his capacity for self-care and to manage funds;

(4) periodic review by such State agency of the determination under paragraph (1) to ascertain whether conditions justifying such determination still exist, with provision for termination of such payments if they do not and for seeking judicial appointment of a guardian or other legal representative, as described in section 1311 of this title, if and when it appears that such action will best serve the interests of such needy individual; and

(5) opportunity for a fair hearing before the State agency on the determination referred to in paragraph (1) for any individual with respect to whom it is made.

At the option of a State (if its plan approved under this subchapter so provides), such term (i) need not include money payments to an individual who has been absent from such State for a period in excess of ninety consecutive days (regardless of whether he has maintained his residence in such State during such period) until he has been present in such State for thirty consecutive days, in the case of such an individual who has maintained his residence in such State during such period or ninety consecutive days in the case of any other such individual, and (ii) may include rent payments made directly to a public housing agency on behalf of a recipient or a group or groups of recipients of aid under such plan.

Aug. 14, 1935, c. 531, Title XIV, § 1405, as added Aug. 28, 1950, c. 809, Title III, pt. 5, § 351, 64 Stat. 555, and amended July 25, 1962, Pub.L. 87-543, Title I, § 156(d), 76 Stat. 207; July 30, 1965, Pub.L. 89-97, Title II, § 221(c), Title IV, § 402(d), 79 Stat. 359, 417; Oct. 30, 1972, Pub.L. 92-603, Title IV, §§ 402(c), 409(c), 86 Stat. 1490, 1491.

SUBCHAPTER XVI—SUPPLEMENTAL SECURITY INCOME FOR AGED, BLIND, AND DISABLED

§ 1381. Statement of purpose; authorization of appropriations

Puerto Rico, Guam, and Virgin Islands. Enactment of section 1601 of the Social Security Act [this section] by Pub.L. 92-603, eff. Jan. 1, 1974, was not applicable to Puerto Rico, Guam, and the Virgin Islands. See section 303(b) of Pub.L. 92-603, set out as a note under section 301 of this title. Therefore, as to Puerto Rico, Guam, and the Virgin Islands, section 1601 of the Social Security Act [this section] as it existed prior to reenactment by Pub.L. 92-603 continues to apply as follows:

§ 1381. Authorization of appropriations

For the purpose (a) of enabling each State, as far as practicable under the conditions in such State, to furnish financial assistance to needy individuals who are 65 years of age or over, are blind, or are 18 years of age or over and permanently and totally disabled, (b) of enabling each State, as far as practicable under the conditions in such State, to furnish medical assistance on behalf of individuals who are 65 years of age or over and who are not recipients of aid to the aged, blind, or disabled but whose income and resources are insufficient to meet the costs of necessary medical services, and (c) of encouraging each State, as far as practicable under the conditions in such State, to furnish rehabilitation and other services to help individuals referred to in clause (a) or (b) to attain or retain capability for self-support or self-care, there is authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this subchapter. The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Secretary of Health, Education, and Welfare, State plans for aid to the aged, blind, or disabled, or for aid to the aged, blind, or disabled and medical assistance for the aged.

Aug. 14, 1935, c. 531, Title XVI, § 1601, as added July 25, 1962, Pub.L. 87-543, Title I, § 141(a), 76 Stat. 197.

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½. Due process

Eligible plaintiffs had right to receive the social security benefits for aged, blind and disabled persons and such entitlements could not be ended without due process and substantial delays in payment thereof constituted deprivation of property. Andujar v. Weinberger, D.C.N.Y.1976, 69 F.R.D. 600.

1. State or local regulation or control

The federal supplemental security income program under this subchapter does not effect the simple transfer of a public assistance program within a single governmental entity, but rather creates a new federal program which differs substantially from the state programs it allegedly replaced. Hannington v. Weinberger, D.C.D.C.1975, 393 F.Supp. 553.

§ 1381a. Basic entitlement to benefits

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1. Income maintenance

This provision, which became effective on January 1, 1974, is an income maintenance program for the aged, blind and disabled and has replaced state-administered programs with a new federal program establishing uniform eligibility criteria. Hannington v. Weinberger, D.C.D.C.1975, 393 F.Supp. 553.

2. Replacing state programs

This provision does not effect the simple transfer of a public assistance program within a single governmental entity, but rather creates a new federal program which differs substantially from the state programs it allegedly replaced. Hannington v. Weinberger, D.C.D.C.1975, 393 F.Supp. 553.

3. Provisional benefits

Benefits accorded by Congress under supplemental security income program for those who began receiving benefits under state-administered programs after June 1, 1973 were merely intended to be provisional and temporary and were only "presumptive" and not intended to give any permanent right to recipients. Ashby v. Weinberger, D.C.N.Y.1975, 402 F. Supp. 1203.

Payment of benefits which are clearly defined by Congress as provisional and temporary do not support a property interest in permanent supplemental security income benefits. Hannington v. Weinberger, D.C.D.C.1975, 393 F.Supp. 553.

4. Rollback applicants

By amending the original provision to exclude rollback cases from automatic eligibility, Congress put rollback cases into the category of initial applicants. Hannington v. Weinberger, D.C.D.C.1975, 393 F.Supp. 553.

Action of the Secretary and the subsequent action of Congress in allowing plaintiffs, who were rollback cases to be treated as presumptively disabled did not change their status from that of initial applicants; rather, it was clear from the regulations, the subsequent congressional enactment, and its legislative history that Congress treated the rollback cases as initial applicants while giving the Secretary discretionary authority to treat them as presumptively disabled. Id.

5. Jurisdiction

In view of language of this section relating to payment of benefits by the Secretary to every eligible aged, blind or disabled individual and the regulations, federal district court had jurisdiction under section 1361 of Title 28 relating to compelling an officer of the United States to perform his duty with respect to action by plaintiffs asserting unlawful conduct of Secretary in permitting lengthy delays in the delivery of social security benefits. Andujar v. Weinberger, D.C.N.Y.1976, 69 F.R.D. 600.

6. Disability

Under this chapter, elements of proof of disability are objective medical facts and clinical findings, opinions and diagnoses of doctors, subjective evidence of pain and disability testified to by claimant, and claimant's education, work history and age. Hurst v. Mathews, D.C. Va.1976, 426 F.Supp. 245.

§ 1382. Eligibility for benefits

[See main volume for text of (a) to (d)]

Limitation on eligibility of certain individuals

(e)(1)(A) Except as provided in subparagraph (B) and (C), no person shall be an eligible individual or eligible spouse for purposes of this subchapter with respect to any month if throughout such month he is an inmate of a public institution.

any interested individual a copy of such standards, along with the procedures available in the State to insure the enforcement of such standards and a list of any waivers of such standards and any violations of such standards which have come to the attention of the authority responsible for their enforcement.

(3) Each State shall certify annually to the Secretary that it is in compliance with the requirements of this subsection.

(4) Payments made under this title with respect to an individual shall be reduced by an amount equal to the amount of any supplementary payment (as described in subsection (a)) or other payment made by a State (or political subdivision thereof) which is made for or on account of any medical or any other type of remedial care provided by an institution of the type described in paragraph (1) to such individual as a resident or an inpatient of such institution if such institution is not approved as meeting the standards described in such paragraph by the appropriate State or local authorities.[1]

Cost-of-Living Adjustments in Benefits

Sec. 1617. Whenever benefit amounts under title II are increased by any percentage effective with any month as a result of determination made under section 215(i), each of the dollar amounts in effect for such month under subsections (a)(1)(A), (a)(2)(A), (b)(1), (b)(2) of section 1611, and subsection (a)(1)(A) of section 211 of Public Law 93-66, as specified in such subsections or as previously increased under this section, shall be increased by the same percentage (and rounded, when not a multiple of $1.20, to the next higher multiple of $1.20), effective with respect to benefits for months after such month; and such dollar amounts as so increased shall be published in the Federal Register together with, and at the same time as, the material required by section 215(i)(2)(D) to be published therein by reason of such determination

Operation of State Supplementation Programs

Sec. 1618. (a) In order for any State which makes supplementary payments of the type described in section 1616(a) (including payments pursuant to an agreement entered into under section 212(a) of Public Law 93-66), on or after June 30 1977, to be eligible for payments pursuant to title XIX with respect to expenditures for any calendar quarter which begins—

(1) after June 30, 1977, or, if later,

(2) after the calendar quarter in which it first makes such supplementary payments,

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[1] Subsection (e) was added effective October 1, 1977 by section 505(d) of P.L. 94-566.

the Reserve Corps of the Public Health Service prior to July 1, 1960, shall not be included in computing entitlement to or the amount of any monthly benefit under this title, on the basis of his wages and self-employment income, for any month after June 1960 and prior to the first month with respect to which the Civil Service Commission certifies to the Secretary that, by reason of a waiver filed as provided in paragraph (2), no further annuity will be paid to him, his wife, and his children, or, if he has died, to his widow and children, under subchapter III of chapter 83 of title 5, United States Code, on the basis of such service.

(2) In the case of a monthly benefit for a month prior to that in which the individual, on whose wages and self-employment income such benefit is based, dies, the waiver must be filed by such individual; and such waiver shall be irrevocable and shall constitute a waiver on behalf of himself, his wife, and his children. If such individual did not file such a waiver before he died, then in the case of a benefit for the month in which he died or any month thereafter, such waiver must be filed by his widow, if any, and by or on behalf of all his children, if any; and such waivers shall be irrevocable. Such a waiver by a child shall be filed by his legal guardian or guardians, or, in the absence thereof, by the person (or persons) who has the child in his care.

Cost-of-Living Increases in Benefits

(i) (1) For purposes of this subsection—

(A) the term "base quarter" means (i) the calendar quarter ending on March 31 in each year after 1974, or (ii) any other calendar quarter in which occurs the effective month of a general benefit increase under this title;

(B) the term "cost-of-living computation quarter" means a base quarter, as defined in subparagraph (A)(i), in which the Consumer Price Index prepared by the Department of Labor exceeds, by not less than 3 per centum, such Index in the later of (i) the last prior cost-of-living computation quarter which was established under this subparagraph, or (ii) the most recent calendar quarter in which occurred the effective month of a general benefit increase under this title; except that there shall be no cost-of-living computation quarter in any calendar year if in the year prior to such year a law has been enacted providing a general benefit increase under this title or if in such prior year such a general benefit increase becomes effective; and

(C) the Consumer Price Index for a base quarter, a cost-of-living computation quarter, or any other calendar quarter shall be the arithmetical mean of such index for the 3 months in such quarter.

(2)(A)(i) The Secretary shall determine each year beginning with 1975 (subject to the limitation in paragraph (1)(B)) whether the base quarter (as defined in paragraph (1)(A)(i)) in such year is a cost-of-living computation quarter.

(ii) If the Secretary determines that the base quarter in any year is a cost-of-living computation quarter, he shall, effective with the month of June of that year as provided in subparagraph (B), increase—

(I) the benefit amount to which individuals are entitled for that month under section 227 or 228,

(II) the primary insurance amount of each other individual on which benefit entitlement is based under this title (including a primary insurance amount determined under subsection (a)(1)(C)(i)(I), but subject to the provisions of such subsection (a)(1)(C)(i) and clauses (iv) and (v) of this subparagraph), and

(III) the amount of total monthly benefits based on any primary insurance amount which is permitted under section 203 (and such total shall be increased, unless otherwise so increased under another provision of this title, at the same time as such primary insurance amount) or, in the case of a primary insurance amount computed under subsection (a) as in effect without regard to the table contained therein) prior to January 1979, the amount to which the beneficiaries may be entitled under section 203 as in effect in December 1978, except as provided by section 203(a)(6) and (7) as in effect after December 1978.

The increase shall be derived by multiplying each of the amounts described in subdivisions (I), (II), and (III) (including each of those amounts as previously increased under this subparagraph) by the same percentage (rounded to the nearest one-tenth of 1 percent) as the percentage by which the Consumer Price Index for that cost-of-living computation quarter exceeds such index for the most recent prior calendar quarter which was a base quarter under paragraph (1)(A)(ii) or, if later, the most recent cost-of-living computation quarter under paragraph (1)(B); and any amount so increased that is not a multiple of $0.10 shall be increased to the next higher multiple of $0.10. Any increase under this subsection in a primary insurance amount determined under subparagraph (C)(i)(II) of subsection (a)(1) shall be applied after the initial determination of such primary insurance amount under that subparagraph (with the amount of such increase, in the case of an individual who becomes eligible for old-age or disability insurance benefits or dies in a calendar year after 1979, being determined from the range of possible primary insurance amounts published by the Secretary under the last sentence of subparagraph (D)).[1]

[1] Clause (II) was amended by sec. 201(g)(1) of P.L. 95-216.

(iii) In the case of an individual who becomes eligible for an old-age or disability insurance benefit, or who dies prior to becoming so eligible, in a year in which there occurs an increase provided under clause (ii), the individual's primary insurance amount (without regard to the time of entitlement to that benefit) shall be increased (unless otherwise so increased under another provision of this title and, with respect to a primary insurance amount determined under subsection (a)(1)(C)(i)(I), subject to the provisions of subsection (a)(1)(C)(i) and clauses (iv) and (v) of this subparagraph) by the amount of that increase and subsequent applicable increases, but only with respect to benefits payable for months after May of that year.[2]

(iv)(I) In the case of an individual who is entitled to an old-age insurance benefit that is based on a primary insurance amount determined under subsection (a)(1)(C)(i)(I), such primary insurance amount shall not be increased under this subsection for any year before the year in which occurs the first month with respect to which there is payable to such individual all or some part of such benefit after application of the provisions of section 203 relating to deductions on account of work, or, if earlier, the year in which he attains age 65.

(II) In the case of an individual who is entitled to an insurance benefit under subsection (e) or (f) of section 202 that is based on a primary insurance amount determined under subsection (a)(1)(C)(i)(I), such primary insurance amount shall not be increased under this subsection for any year (except as provided in subdivision (III)) before the year in which occurs the first month with respect to which there is payable to such individual all or some part of such benefit after application of the provisions of section 203 relating to deductions on account of work, or, if earlier, the year in which he attains age 65.

(III) Any increase under this subsection which would otherwise be applied to a primary insurance amount except for the provisions of subdivision (II) of this clause, shall apply to such primary insurance amount if, during any month of the year in which the increase occurs, any individual is entitled to a benefit under subsection (d), (g), or (h) of section 202 based on such primary insurance amount, and such primary insurance amount is based upon the wages and self-employment income of a deceased individual.

(IV) No primary insurance amount determined under subsection (a)(1)(C)(i)(I) shall be increased under this subsection for any year during which no individual was entitled to any benefit based thereon under section 202 or 223 for any month of such year.

(V) In any case in which an increase under this subsection which occurs during any year applies to a primary insurance amount deter-

[2] Clauses (iii), (iv), and (v) were added by sec. 201(g)(2) of P.L. 95-216.

mined under subsection (a)(1)(C)(i)(I), and such an increase occurring in a later year does not apply to such primary insurance amount on account of the provisions of this clause, any such increase which occurs in a later year which is applicable to such primary insurance amount shall be based upon such primary insurance amount as previously increased under this subsection.[1]

(v) Notwithstanding clause (iv), no primary insurance amount shall be less than that provided under section 215(a)(1) without regard to subparagraph (C)(i)(I) thereof, as subsequently increased by applicable increases under this section.[1]

(B) The increase provided by subparagraph (A) with respect to a particular cost-of-living computation quarter shall apply in the case of monthly benefits under this title for months after May of the calendar year in which occurred such cost-of-living computation quarter, and in the case of lump-sum death payments with respect to deaths occurring after May of such calendar year.

(C)(i) Whenever the level of the Consumer Price Index as published for any month exceeds by 2.5 percent or more the level of such index for the most recent base quarter (as defined in paragraph (1)(A)(ii)) or, if later, the most recent cost-of-living computation quarter, the Secretary shall (within 5 days after such publication) report the amount of such excess to the House Committee on Ways and Means and the Senate Committee on Finance.

(ii) Whenever the Secretary determines that a base quarter in a calendar year is also a cost-of-living computation quarter, he shall notify the House Committee on Ways and Means and the Senate Committee on Finance of such determination within 30 days after the close of such quarter, indicating the amount of the benefit increase to be provided, his estimate of the extent to which the cost of such increase would be met by an increase in the contribution and benefit base under section 230 and the estimated amount of the increase in such base, the actuarial estimates of the effect of such increase, and the actuarial assumptions and methodology used in preparing such estimates.

(D) If the Secretary determines that a base quarter in a calendar year is also a cost-of-living computation quarter, he shall publish in the Federal Register within 45 days after the close of such quarter a determination that a benefit increase is resultantly required and the percentage thereof. He shall also publish in the Federal Register at that time (i) a revision of the range of the primary insurance amounts which are possible after the application of this subsection based on the dollar amount specified in subparagraph (C)(i)(II) of subsection (a)(1) (with such revised primary insurance amounts constituting the

[1] Clauses (iii), (iv), and (v) were added by sec. 201(g)(2) of P.L. 95-216.

increased amounts determined for purposes of such subparagraph (C)(i)(II) under this subsection), or specified in subsection (a)(3) as in effect prior to 1979, and (ii) a revision of the range of maximum family benefits which correspond to such primary insurance amounts (with such maximum benefits being effective notwithstanding section 203(a) except for paragraph (3)(B) thereof (or paragraph (2) thereof as in effect prior to 1979)).[1]

(3) As used in this subsection, the term "general benefit increase under this title" means an increase (other than an increase under this subsection) in all primary insurance amounts on which monthly insurance benefits under this title are based.

(4) This subsection as in effect in December 1978 shall continue to apply to subsections (a) and (d), as then in effect, for purposes of computing the primary insurance amount of an individual to whom subsection (a), as in effect after December 1978, does not apply (including an individual to whom subsection (a) does not apply in any year by reason of paragraph (4)(B) of that subsection (but the application of this subsection in such cases shall be modified by the application of subdivision (I) in the last sentence of paragraph (4) of that subsection)). For purposes of computing primary insurance amounts and maximum family benefits (other than primary insurance amounts and maximum family benefits for individuals to whom such paragraph (4)(B) applies), the Secretary shall publish in the Federal Register revisions of the table of benefits contained in subsection (a), as in effect in December 1978, as required by paragraph (2)(D) of this subsection as then in effect.[2]

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[1] Subparagraph (D) was amended by sec. 201(g)(3) of P.L. 95-216.
[2] Paragraph (4) was added by sec. 201(g)(4) of P.L. 95-216. See Appendix F for law as in effect on December, 1978.

URBAN CITIZEN PARTICIPATION CONFERENCE

MARCH 24-26, 1980

PROPOSED AMENDMENT TO HB 968

Section 1- be repealed and reenacted to read:

1. The basic AFDC Grant be increased by $100.00 (to $450.00 for one (1) parent/guardian - one (1) child). The increase for each additional child be raised to $75.00.

2. C.O.L.A. be based on the National index rate of inflation plus 7% for Alaskan higher cost of living. C.O.L.A. shall become effective July 1 each year with an effective date beginning July 1, 1980.

POSITION PAPER/Department of Health & Social Services

POSITION PAPER
ON
HOUSE BILL No. 968

"An Act adding a cost-of-living adjustment to maximum benefits paid as Aid to Families with Dependent Children; and providing for an effective date."

This proposed legislation would amend AS 47.25.320 to provide that the maximum monthly payment for families receiving cash assistance under the Aid to Families with Dependent Children (AFDC) program would increase each year by the same percentage increase as is granted under the Social Security Act to Social Security and Supplemental Security Income (SSI) recipients.

Under federal law, needy elderly, blind, and disabled persons receiving SSI assistance have their SSI payments increased each July 1 by the percentage that the national cost-of-living index has increased in the preceding year. Under Alaska statutes, maximum supplemental state payments to Alaska's needy elderly, blind, and disabled increase automatically by this same percentage. This guarantees that these persons will not suffer an inflation-caused erosion in their ability to purchase the basic necessities.

AFDC recipients are not now afforded this protection against inflation increases in costs of necessities. Despite past periodic legislative increases in AFDC payments levels, the Department believes that the present payment maximums are not adequate to meet most AFDC families' basic needs. (A copy of the Department's annual report to the Legislature on AFDC payment adequacy is attached.) We believe that HB 968 provides the most economical means of assuring that AFDC payments become and remain sufficient to achieve the purpose of the program and meet recipient families' needs.

We strongly support the passage of HB 968.

Recommended by: Eric S. Hewan
for Rod Betit, Director
Division of Public Assistance

Date: April 10, '80

Approved by: Helen O Beirne
Helen D. Beirne, Commissioner
Department of Health & Social Services

Date: 4-11-80

STATE OF ALASKA

JAY S. HAMMOND, GOVERNOR

DEPT. OF HEALTH AND SOCIAL SERVICES

OFFICE OF THE COMMISSIONER

POUCH H 01 – JUNEAU 99811

APR 10 1979

Document# 69-80

Honorable Terry Gardiner
Speaker
House of Representatives
Pouch V MS 3100
Juneau, Alaska 99811

Dear Representative Gardner:

AS 47.25.320(c) provides that the Department shall provide the Legislature with "financial data on the Aid to Families with Dependent Children program with special reference to amount of funds required to maintain adequate payments in consideration of changes in the cost of living."

The Fiscal Year 1981 budget submission for the Aid to Families with Dependent Children (AFDC) program provides fiscal data on recent expenditures, the number of persons served, and the average payment made to each family unit. However, the budget documents do not address the question of the adequacy of the payments being made. This report is intended to apprise you of the Department's current assessment of that question.

I. The AFDC Maximum Payment

The current maximum payments specified in AS 47.25.320 are intended to meet the basic needs of dependent children who are deprived of the support and care of one or both parents, and, if necessary, the needs of the one relative with whom they live. These needs include such subsistence items as food, fuel, shelter, and clothing. At the present time, a typical AFDC family consisting of a mother and one child can be paid up to $350 per month in AFDC funds to enable them to obtain these basic needs.

Federal regulations require that the state exclude all or part of certain kinds of income that AFDC recipients receive when determining their AFDC payment level. The effect of these regulations is that some AFDC families receive more monthly income than other AFDC families. However, we estimate only 10% of the 7564 families who will receive AFDC assistance monthly in FY 81 will have extra income. Thus the vast majority of Alaska's AFDC families exist on a total monthly income equal to the maximum AFDC payment specified by Alaska statute. These monthly income levels depend on family size and are as follows:

Family Size	With Needy Adult Relative	Without Needy Adult Relative
1	---	$ 150
2	$ 350	$ 300
3	$ 400	$ 350
4	$ 450	$ 450

($50 additional for each additional child)

II. Recent Changes in the Maximum Payment

Though no longer in effect, legislation enacted in 1970 established a complex structure of maximum AFDC payments based upon children's ages that was significantly different than that in use now as described above. A mother and one child under 5 received a maximum AFDC payment of $125 per month, $150 if the child were between 5 and 12, and $175 if the child were between 13 and 18.

Effective July 1, 1974, these maximums were again changed to $250 per month for a mother and one child 12 or under, and $300 for a mother and a 13 to 18 year old. On July 1, 1975, these standards were again modified by removing any consideration of the child's age and establishing a universal two-person maximum of $300 with $50 allowed for each additional child, to a ceiling of $520 regardless of family size.

The last AFDC payment change was made effective July 1, 1978. The $520 ceiling for AFDC payment was deleted. The maximum payment for a needy relative and one child was increased from $300 to $350, with $50 continuing to be allowed for each additional child. Whereas, approximately three/fourths of our AFDC caseload includes a needy adult living with one or more children, the effect of this last change in standards was to increase average payments to 75% of all AFDC families by $50 per family. AFDC children living with a non-needy relative have not received an increase since 7/1/74. The $50 increment for each additional child has not been changed since 1974.

III. Adequacy of the Current Maximums

Title IV of the Social Security Act, as amended, states that the purpose of the AFDC program is to "encourage the care of dependent children in their own homes or in the homes of a relative by enabling each state to furnish financial assistance and rehabilitation and other services, as far as practicable under the conditons in each state, to needy dependent childre. and the parents or relative with whom they are living, to help maintain and strengthen family life and to help such relatives to attain or retain capability for the maximum self-support and personal independence consistent with the maintenance of continuing parental care and protection."

The Social Security Act and federal regulation (Title 45) allow the states the freedom to establish their own separate payment levels. They also allow for regional differences in payment levels within a state, if those differences can be supported by objective data. (Alaska has chosen a statewide standard.) Nowhere in these laws or regulations is guidance offered regarding the minimum subsistence level consistent with the purpose of the program.

In Alaska, as in almost all other states, "adequacy" of payments is defined primarily by legislative action. As we view this process, it is an attempt to reach a reasonable compromise among three often conflicting elements: the program purpose, the basic economic needs of the recipient families, and the taxpayer's willingness and ability to provide the funds necessary to maintain needy families intact in dignity and health. Payment levels that are too low to meet legitimate client needs waste the taxpayer's money, for the program cannot then meet its purpose of providing financial support adequate to enable the family to remain together. Payment levels that are too high are wasteful in two senses: they cause unnecessary expenditures, and they encourage unnecessary welfare dependency.

The Department believes that the taxpayer's definition of adequate AFDC payment levels is accurately expressed through the annual administrative and legislative review of the AFDC budget. It is therefore our belief that this report should represent evidence which will help you to define adequacy from the AFDC recipient's point of view.

From the recipient's point of view, we believe that, despite the history of payment increases, AFDC payment levels are presently inadequate to meet most recipient's basic subsistence needs. The evidence supporting this judgement is detailed below.

IV. Measurements of Inadequacy

A. Recipient Reports of Expenses

In 1978, the Legislative Affairs Agency mailed questionnaires to each AFDC recipient, measuring among other things what the AFDC household's expenses were in August 1978. About one third of the households responded, which is in itself a measure of concern about payment levels. While the survey results cannot be considered statistically accurate, they do give some indication of costs of basic subsistence items for AFDC recipients.

A summary of the survey's results are:

	Urban	Rural
Rent or Mortgage	$ 261	$ 180
Fuel	$ 48	$ 108
Utilities	$ 47	$ 76
Food	$ 182	$ 272
TOTAL	$ 538	$ 636

(Note: Some of the households responding had additional household members who were not receiving AFDC benefits. Therefore the costs reported in the survey may be higher than if the survey had been restricted to households in which all members were AFDC recipients.)

The expenditures listed are now quite old. You do not need to be reminded what effect double-digit inflation and the energy crisis have had on living costs since mid-1978.

These survey results tend to support common knowledge about Alaskan costs of basic necessities, particularly housing costs. The majority of Alaska's AFDC cases reside in urban settings, concentrated in Anchorage, Fairbanks, Juneau and Ketchikan. A cursory survey of available housing in those areas shows that there is inadequate low-income housing available. Minimally-acceptable rental units which can accomodate children, when such units are available, range from $180 to $450 per month. Even when the total expense amounts are reduced by the amount of food assistance available through the Food Stamp program, and energy assistance through the Energy Assistance program, the costs of basic necessities exceed many AFDC families maximum monthly grants.

B. Cost of Living Poverty Guidelines

(1) The U.S. Bureau of Labor Statistics maintains a Cost of Living Index for Alaska which measures relative increases in living costs for Anchorage. On January 1, 1970, the Index was 107.9; on January 1, 1979 the Index was 198.1; and on January 1, 1980, it was 218.2. In these 10 years the cost of living more than doubled, and AFDC benefits for a mother with a young child more than doubled, increasing from $150 to $350 per month.

By this measurement, AFDC increases over the years have apparently kept pace with rising costs of living. However, this comparison would indicate that AFDC payment maximums are adequate now only if they were originally adequate in 1970. Absent any convincing information on this question, we leave this to your judgement.

(2) The U.S. Community Services Administration (CSA) publishes annual poverty guidelines for Alaska. This year's (1980) guidelines have not yet been published, but the 1979 CSA annual gross income poverty levels compared to current annual AFDC maximums as follows:

Family Size	CSA 1979 Farm	CSA 1979 Non-Farm	AFDC With a Needy Adult	AFDC With No Needy Adult
1	4562	5338	------	1800
2	6023	7050	4200	3600
3	7463	8763	4800	4200
4	8913	10475	5400	4800

Clearly, current AFDC maximums fall well below federally established poverty levels for Alaska.

C. Comparison with Other States

The following payment levels for several states offer a useful comparison which may be indicative of payment adequacy. In our judgement, Alaska's higher costs of necessities were considered in this comparison, Alaska's maximum payment would not compare favorably with those of most other western states.

Maximum payments for AFDC recipients (1979-early 1980 Levels for needy adult-included cases):

	Parent and One Child	Parent and Three Children
Alaska	$ 350	$ 450
Oregon	304	456
Washington	339	483
Utah	253	389
Idaho	259	366
California	331	487
Hawaii	390	546

This comparison does not consider extra "special needs" which most states except Alaska grant for various items such as school attendance and supplies, laundry, job interviews, etc. Most listed states except Alaska have lower standards for persons with little or no housing costs.

D. Comparison with Adult Public Assistance

Another possible measurement of adequacy is internal to Alaska's own assistance programs. By state statute, the FY 80 Adult Public Assistance programs (Aid to the Blind, Aid to the Disabled, and Old Age Assistance) provides for a $414 maximum monthly payment to an individual, and $608 to a couple. Each year this maximum increases by the percentage amount of the annual national Social Security percentage increase. For FY 81, the $414 maximum for an individual is expected to increase by 13%, to $467, while the couple maximum will increase from $608 to $687. State statutes thus appear to maintain the striking position that a mother and child can maintain themselves on $350 a month, but two elderly or disabled adults require $608 to $687 a month. Not only are adults likely to be more "established" and therefore have lower expenses for necessities, but particularly the elderly have many more programs available which offer them direct or indirect financial benefits.

E. Comparison with Foster Care Costs

A final point of measurement is also internal to the Department of Health and Social Services. The Department establishes foster care rates each year after holding rate hearings throughout the state. Payments are set on a regional basis, varying by ages of children. Payment rates are set to meet, but not exceed, the direct costs of providing basic necessities and adequate recreational and instructional material to families willing to assume the additional responsibility of a foster child.

For a 30-day month, the Division of Social Services reimburses a foster parent as follows for one child:

Region	Lowest (Age 0-4)	Highest (Age 12 and over)
Northern	$ 334.00	$ 442.00
Northwestern	387.00	514.00
Southcentral	291.00	384.00

By comparison, the AFDC program pays $150 for a single child with no needy adult relative, $150 maximum for the second child, and $50 for each additional child.

V. Conclusion

This is the third annual report we have presented to you which has utilized these five basic comparative measures of adequacy. Each year these comparative measures show that Alaska's AFDC families' capacity to meet the costs of the basic necessities of life is diminishing rapidly. To us, there is no longer any question that our AFDC program is u ble to fulfill the purposes for which it was designed by federal law and implemented by Alaska statute.

To correct this situation, Govenor Hammond has requested legislation be placed before you which would provide for AFDC maximum payment levels to be automatically increased each year by the same percentage our adult programs are increased. This bill, HB 968, would at least guarantee that AFDC recipients will not see their comparative situation worsen each year.

We commend HB 968 to your attention as a workable compromise between the AFDC client's obvious need for adequate aid and the taxpayer's equally obvious desire to support a program which achieves its goals at the lowest possible cost.

Sincerely,

Helen D. Beirne

Helen D. Beirne
Commissioner

AFDC
Coles
Geo

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
REGION X
ARCADE PLAZA BUILDING
1321 SECOND AVENUE
SEATTLE, WASHINGTON 98101

SOCIAL SECURITY ADMINISTRATION
BUREAU OF SUPPLEMENTAL
SECURITY INCOME

March 17, 1980

Mr. Rod Betit, Director
Division of Public Assistance
Dept. of Health & Social Services
Pouch H-07
Juneau, Alaska 99811

Dear Mr. Betit:

We have been advised that the cost of living increase in SSI payments will probably be 13.0 percent. This will raise federal payment standards to $235.30 for an individual and $352.90 for a couple. The final figure will be available April 22, and we will relay it to you as soon as it is received.

As soon as possible, please advise us what your new SSI payment standards will be.

Sincerely,

Robert H. Dunn
Assistant Regional Commissioner
for Programs

THE LEGISLATURE OF THE STATE OF ALASKA
ELEVENTH LEGISLATURE

FISCAL NOTE

I. REQUEST
Bill/Resolution No. House Bill 968
Title Annual Cost of Living Increase, Aid to Families with Dependent Children Program
Requested by House Rules Committee, by request Date March 18, 1980

II. FISCAL DETAIL
Agency Affected Department of Health and Social Sevices
Program Category Affected Social & Economic Assistance for General Population
BRU, Program, or Subprogram(s) Affected Assistance Payments (AFDC)
(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 80	FY 81	FY 82	FY 83	FY 84	FY 85
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL						
400 COMMODITIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC.		4047.3				
TOTAL		4047.3				

FUNDING (Thousands of Dollars)

GENERAL FUND		2023.6				
FEDERAL FUNDS		2023.7				
OTHER (Specify Fund Source)						

POSITIONS

FULL TIME		None				
PART TIME						
TEMPORARY						

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

I. The FY 81 Aid to Families with Dependent Children (AFDC) budget anticipates that a monthly average of 7,564 recipient families will each receive an average monthly grant of $343.00 for a total expected AFDC expenditure of 31,133.1 (7,564 x $343.00 x 12 months).

Title XVI annual percentage increases are determined by the percentage increase in the national cost of living index. At this time, the Social Security Administration estimates this percentage increase for the coming year will be 13.0%. The effect of this proposed legislation would be to increase the average monthly payment to each AFDC family by 13.0%, or $44.59, beginning July 1, 1980. The maximum monthly payment for the average AFDC family would increase from $343.00 to $387.59 ($343 x 1.13 = $387.59).

Continued

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)

Prepared by: Gordon Landes Date: March 18, 1980
Division/Office: Public Assistance PH: 465-3347
Department of Health & Social Services

Approval DHSS Mgt. & Bdgt: [signature] Date: 3-18-80

33-001 (Rev. 12/79)
Modify by DHSS (11-28-79)

III. ANALYSIS---Continued

Thus the impact of this legislation on the anticipated AFDC expenditures would be an increase of 4,047.3 (7,564 x $44.59 x 12 months). 50% of this increase, 2023.7 would be federal matching funds.

II. In the AFDC program the statutory maximum payment levels are also the qualifying standards for entry into the program. This proposal would increase these standards. For example, the maximum countable income an applicant with one child can have and still qualify for AFDC assistance is currently $350. (This would also be the recipients's AFDC payment if he or she had no other countable income.) A 13.0% increase in the standard would establish a new qualifying limit of $388.00 for this size family.

It is reasonable to assume that there are Alaskan families who have countable incomes over the current standards but under the higher proposed standards, and to assume that some of these families would choose to apply and would meet all other eligibility factors.

Therefore it is reasonable to assume that the legislation would add new recipients to the anticipated FY 81 caseload. However, there are no factual grounds upon which this assumption can be based. In fact, there is evidence demonstrating that these newly-eligible families are not likely to affect anticipated expenditures:

(a) Effective July 1, 1978, a statutory amendment increased maximum payment levels and qualifying standards for 75% of AFDC applicants and recipients by $50.00 per family. There was no sudden increase in the total number of recipients, and the rate of growth in the number of recipients in the twelve months after this change was not significantly changed from the rate of increase in the twelve months preceding this change.

(b) An annual Social Security cost of living percentage increase has applied to the Adult Public Assistance programs for several years. Each July, the increase in standards and payments has not produced significant changes in the recipient growth rate in those programs.

The Department has no data proving that this legislation will not increase the total number of AFDC recipients, but the recent history of assistance programs does indicate that an increase is unlikely to happen. We are therefore not projecting any additional growth in caseload in AFDC solely as the result of this legislation, nor are we projecting any related increase in expenditures in the Medicaid and Eligibility Determination BRUs.

Ramona took
here
~~hers~~ already.

STATE OF ALASKA

JAY S. HAMMOND, GOVERNOR

DEPT. OF HEALTH AND SOCIAL SERVICES

DIVISION OF PUBLIC ASSISTANCE

POUCH H-07
JUNEAU, ALASKA 99811

April 23, 1980

Document# 86-80

The Honorable Thelma Buchholdt
Chairperson, House HESS Committee
Alaska State Legislature
Pouch V
Juneau, Alaska 99811

Dear Mrs. Buchholdt:

Re: House Bill 968

You have already received copies of our fiscal note on H.B. 968, which adds an annual cost-of-living benefits increase to the Aid to Families with Dependent Children program. That fiscal note was prepared on March 18, 1980. It reflects costs based on the Social Security Administra-tion's preliminary estimate that their annual cost-of-living benefits increase this year would be 13.0%.

However, on Tuesday, April 22, the Social Security Administration issued its final COLA percentage for 1980. This final figure was 14.3%. Social Security Region X officials notified us by telephone of their new percentage and we have used this figure to revise our fiscal note. The revised fiscal note is attached.

Please discard the March 18, 1980 fiscal note. It is no longer accurate.

Sincerely,

Rod Betit

Rod Betit
Director

cc: Office of the Governor,
Division of Budget and Management

06-F51LH

THE LEGISLATURE OF THE STATE OF ALASKA
ELEVENTH LEGISLATURE

FISCAL NOTE

I. REQUEST
Bill/Resolution No. HB 968
Title Annual Cost of Living Increase, Aid to Families with Dependent Children Program
Requested by House Rules Committee, by request Date April 23, 1980

II. FISCAL DETAIL
Agency Affected Department of Health and Social Sevices
Program Category Affected Social & Economic Assistance for General Population
BRU, Program, or Subprogram(s) Affected Assistance Payments (AFDC)
(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section..)

EXPENDITURES (Thousands of Dollars)

	FY 80	FY 81	FY 82	FY 83	FY 84	FY 85
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL						
400 COMMODITIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC.		4452.2				
TOTAL		4452.2				

FUNDING (Thousands of Dollars)

GENERAL FUND		2226.1				
FEDERAL FUNDS		2226.1				
OTHER (Specify Fund Source)						

POSITIONS

FULL TIME						
PART TIME						
TEMPORARY						

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

1. The FY 81 Aid to Families with Dependent Children (AFDC) budget anticipates that a monthly average of 7,564 recipient families will each receive an average monthly grant of $343.00 for a total expected AFDC expenditures of $31,133.10 (7,564 x $343.00 x 12 months).

   Title XVI annual percentage increases are determined by the percentage increase in the national cost of living index. The Social Security Administration has determined that this percentage increase for the coming year will be 14.3%. The effect of this proposed legislation would be to increase the average monthly payment to each AFDC family by 14.3%, or $49.05, beginning July 1, 1980. The maximum monthly payment for the average AFDC family would increase from $343.00 to $392.05 ($343 x 1.43 = $392.05).

Continued

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)

Prepared by: Gordon Landes Date: April 23, 1980
Division/Office: Public Assistance PH: 465-3347
Department of Health & Social Services

Approval DHSS Mgt. & Bdgt: [illegible] Date: 4-23-80

33-001 (Rev. 12/79)
Modify by DHSS (11-28-79)

III. ANALYSIS---Continued

Thus the impact of this legislation on the anticipated AFDC expenditures would be an increase of 4,452.2 (7,564 x $49.05 x 12 months). 50% of this increase, 2226.1, would be federal matching funds.

II. In the AFDC program the statutory maximum payment levels are also the qualifying standards for entry into the program. This proposal would increase these standards. For example, the maximum countable income an applicant with one child can have and still qualify for AFDC assistance is currently $350. (This would also be the recipients's AFDC payment if he or she had no other countable income.) A 14.3% increase in the standard would establish a new qualifying limit of $400.00 for this size family.

It is reasonable to assume that there are Alaskan families who have countable incomes over the current standards but under the higher proposed standards, and to assume that some of these families would choose to apply and would meet all other eligibility factors.

Therefore it is reasonable to assume that the legislation would add new recipients to the anticipated FY 81 caseload. However, there are no factual grounds upon which this assumption can be based. In fact, there is evidence demonstrating that these newly-eligible families are not likely to affect anticipated expenditures:

(a) Effective July 1, 1978, a statutory amendment increased maximum payment levels and qualifying standards for 75% of AFDC applicants and recipients by $50.00 per family. There was no sudden increase in the total number of recipients, and the rate of growth in the number of recipients in the twelve months after this change was not significantly changed from the rate of increase in the twelve months preceding this change.

(b) An annual Social Security cost of living percentage increase has applied to the Adult Public Assistance programs for several years. Each July, the increase in standards and payments has not produced significant changes in the recipient growth rate in those programs.

The Department has no data proving that this legislation will not increase the total number of AFDC recipients, but the recent history of assistance programs does indicate that an increase is unlikely to happen. We are therefore not projecting any additional growth in caseload in AFDC solely as the result of this legislation, nor are we projecting any related increase in expenditures in the Medicaid and Eligibility Determination BRUs.

S. Luhr
4/23/80

House Health, Education & Social Services Committee

Meeting/Hearing on HB 968

Date: 4/24/80

	Name	Address and Phone	Organization/Self	For/Against or Observing
1/	Rod Betit		HHSS	
2/	Gordon Sanders	program off. AFDC	HHSS	
3/				
4/				
5/				
6/				
7/				
8/				
9/				
10/				
11/				
12/				
13/				

THE LEGISLATURE OF THE STATE OF ALASKA
ELEVENTH LEGISLATURE

FISCAL NOTE

I. REQUEST
Bill/Resolution No. Committee Substitute for House Bill 968
Title Cost of Living Increase, Aid to Families with Dependent Children Program
Requested by House Rules Committee, by request Date April 29, 1980

II. FISCAL DETAIL
Agency Affected Department of Health and Social Sevices
Program Category Affected Social & Economic Assistance for General Population; Health;
BRU, Program, or Subprogram(s) Affected Assistance Payments (AFDC), Medicaid, Eliq. Deter.
(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 80	FY 81	FY 82	FY 83	FY 84	FY 85
100 PERSONAL SERVICES		155.0				
200 TRAVEL		3.0				
300 CONTRACTUAL		6.0				
400 COMMODITIES		.6				
500 EQUIPMENT		3.0				
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC.		15449.1				
TOTAL		15616.7				

FUNDING (Thousands of Dollars)

GENERAL FUND		7825.9				
FEDERAL FUNDS		7790.8				
OTHER (Specify Fund Source)						

POSITIONS

FULL TIME		6				
PART TIME						
TEMPORARY						

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

III. ANALYSIS

The FY 81 Aid to Families with Dependent Children (AFDC) budget anticipates that a monthly average of 7564 families will each receive an average monthly grant of $343.00, for a total anticipated AFDC expenditure of 31,133.1 7564 x $343.00 x 12 months).

(1) Assistance Payments BRU, AFDC Program:

(a) Adult Not Included (ANI) Cases: For FY 81, 24.8%, or 1876 of the anticipated 7564 AFDC cases, will consist of children living in the home of non-needy relatives. CSHB 968 calls for granting these cases an automatic annual percentage increase equal to the annual percentage benefits increase in the Social Security and Supplemental Security Income programs. For FY 81, this increase has been established at 14.3%.

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)

Prepared by: Gordon Landes Date: April 29, 1980
Division/Office: Public Assistance PH: 465-3347
Department of Health & Social Services

Approval DHSS Mgt. & Bdgt: Date: 4/30/80

33-001 (Rev. 12/79)
Modify by DHSS (11-28-79)

This COLA would increase the average payment for Adult Not Included AFDC cases by $33.21 per case per month, raising their anticipated average payment from $232.21 to $265.42 per month.

The cost of the COLA addition to ANI cases would be 747.6. ($33.21 increase per month x 1876 cases x 12 months = 747.6.)

(b) Adult Included (AI) Cases: CSHB 968 calls for AFDC children living with a needy relative to experience three increases: (1) an increase in basic maximum payment of $100 per month (from $350 maximum to $450 maximum for a household with a parent and one child); (2) an increase in the additional amount for additional children from $50 to $75 each; and (3) adding the Social Security annual cost-of-living percentage of 14.3% to all AI cases.

(1) $100 Maximum Payment Increase: For FY 81, 5688 cases per month will receive an average monthly payment of $371.47. CSHB 968 would increase the average payment by $100 per family. The cost of this provision would be 6825.6 ($100 increase per month x 5688 cases x 12 months = 6825.6).

(2) $75 Child Increment: CSHB would increase the additional maximum payment for second, third, and additional children by $25, from $50 to $75 for each child. The "average" AFDC-AI case consists of 2.81 persons--a mother and 1.81 children. The first child is included in the base payment. Thus the cost of this provision would be 1382.2 (.81 children x $25.00 increase x 5688 cases x 12 months).

(3) 14.3% COLA Adjustment: CSHB 968 would add the national cost of living percentage increase of 14.3% after the increased base payment and the child increment increase. The cost of this provision would be 4799.8 ($371.47 FY 81 average payment + $100 base increase + $20.25 child increment increase = $491.72 average payment x 14.3% x 5688 cases per month x 12 months).

(c) New Cases: In the AFDC program the statutory maximum payment levels are also the qualifying standards for entry into the program. CSHB 968 would increase these standards. For example, the maximum countable income a needy applicant with two children can have and still qualify for AFDC assistance is currently $400. (This would also be the recipient's AFDC payment if he or she had no other countable income. The provisions of CSHB 968 would establish the new qualifying limit of $600.00 for this 3-person family.

It is reasonable to assume that there are Alaskan families who have countable incomes over the current standards but under the higher proposed standards, and to assume that some of these families would choose to apply and would meet all other eligibility factors. However, there is no data, either within the past ten years of AFDC program utilization or from any other source that indicates whether new families would enter the program, or if they would, in what numbers.

Nevertheless, the Department believes a growth in families served will occur. Though it is nothing but an unsubstantiated guess, we believe the large increase in standards would attract an additional 800 families in FY 81. These new families are most likely to have an average countable non-AFDC income mid-way between the current and the proposed standards and thus qualify for an average monthly AFDC payment of $92.13 (2.81 persons per household: $350 + (.81 x $50) = $390.50 current, versus $514 +(.81 x $75) = $574.75. 1/2 of $574.75 - $390.50 = $92.13). This would produce an increased AFDC cost of 884.5 ($92.13 average payment x 800 cases per month x 12 months).

(d) AFDC BRU Summary

700 Grants:	ANI COLA Increase	=	747.6	
	AI $100 Base Increase	=	6,825.6	
	AI $25 Child Increase	=	1,382.2	
	AI COLA Increase	=	4,799.8	
	AI New Cases	=	884.5	
	TOTAL		14,639.7	
			7,319.9	Federal
			7,319.8	State GF Match

(2) Medicaid BRU

If 800 new families enter the AFDC program, they will be automatically eligible for Medicaid services. Approximately 60%, or 1349, of these 2248 persons (2.81 persons/family x 800 families) will use Medicaid services. Each of these 1349 persons will average $600 in services in FY 81. Total cost to the Medicaid BRU will be 809.4 (1349 x $600); 404.7 federal funds, 404.7 state general fund match; 700, Grants and Claims.

(3) Eligibility Determination BRU

The addition of 800 new AFDC and Medicaid cases will require additional eligibility staff and services. Additional staff required will be four Eligibility Worker IIs, one Eligibility Worker III supervisor, and one Clerk Typist III. The cost to the Eligibility Determination BRU will be:

100	Personal Services	155.0	
200	Travel	3.0	
300	Contractual	6.0	
400	Commodities	.6	
500	Equipment	3.0	
	TOTAL	167.6	66.2 Federal Match 66.2 General Fund Match 35.2 General Fund

Sandra S. Lee

HB
977

6/9/1986

HB 9771
See ~~files~~ H HESS fil's on
"STATE HEALTH INSURANCE"

Jeanie Henry

HB
998

Governor's Council for the Handicapped and Gifted
600 University Avenue - Fairbanks, Alaska 99701 Phone: 479-6507

April 18, 1980

Representative Thelma Buchholdt
Pouch V
Juneau, Alaska 99811

RE: HB 998

Dear Representative Buchholdt:

The Governor's Council for the Handicapped and Gifted supports the development of community programs for severely physically handicapped children and adults in need of personal attendant care or other medical/nursing support services.

There are 20 handicapped young adults in the Anchorage area who have been identified as needing these services who presently reside in nursing homes in order to receive services. These individuals could function very well in architecturally barrier-free small group residences or apartments with special home health aides and personal attendants to assist them in caring for themselves. Funding is also needed to provide physical therapy and related services to such individuals who are inappropriately placed in nursing homes at extremely high financial and social cost.

If HB 998 is intended to provide for these individuals we recommend that it be revised to clearly reflect this purpose. By making a simple amendment to existing statute AS 47.80 stating that the definition of developmental disability would be "as amended by a statutory umbrella for P.L. 95-603," services for this population would be provided. A.S. 47.8[illegible]

Thank you for your support of these needed programs and services.

Sincerely yours,

Marsha Buck

Marsha Buck
Council Chairperson

MB:mc

ALASKA ASSOCIATION OF ADMINISTRATORS FOR SPECIAL EDUCATION

James L. Rich, President
2220 Nichols Street
Anchorage, Alaska 99504

Bill Hawkins, Vice President
Kotzebue, Alaska 99752

Noreen Thompson, Secretary
Kodiak, Alaska 99615

Sharla Peterson, Executive Board
Petersburg, Alaska 99833

Joe Caldarera, Executive Board
Bethel, Alaska 99559

Marsha Buck, Executive Board
Ketchikan, Alaska 99901

Kris Rogers, Executive Board
Soldotna, Alaska 99669

April 18, 1980

MEMORANDUM:

TO : Representatives Buchholdt, Munson, Chatterton, Hurlbert, Miles, Barnes and Beirne

FROM: James L. Rich, President

RE : Support of ALTERNATE HB 998

The Alaska Association of Administrators for Special Education is very concerned about alternative living facilities for severely handicapped children and young adults. We strongly support the Orthopedically Handicapped Action Group (OHAG) and their proposal for the construction of a barrier-free facility to house both long term and short term severely orthopedically impaired young adults. The State of Alaska is currently sending many of these individuals out of Alaska for their care. We feel that this solution is both expensive and totally inappropriate. We would hope that the State would seriously consider development of an Alaskan alternative for this group of handicapped individuals.

Therefore, AAASE requests that you support the alternate version of House Bill 998 to develop a residential program for mentally alert young adults who are severely orthopedically handicapped. For the purpose of planning this housing project, it is hoped that you would appropriate seed monies to HB 998 or support inclusion of the seed money request in House Bill 60.

Thank you for your consideration of this proposal.

c.c. AAASE Board Members
Audrey Aanes, Chairperson OHAG

Gary L. Aanes
SRA 1625 E
Anchorage, AK 99507

April 18, 1980

The Honorable Thelma Bucholdt
House of Representatives
State of Alaska
Capitol, Room 112
Juneau, AK 99811

Dear Representative Bucholdt:

The purpose of this letter is to emphasize my support of House Bill 998. I am delighted to see that you are going to sponsor this bill. It is something that has long been a need in the community and for the state.

I understand there is a possibility that this bill might have been inadvertently directed toward medical care for children rather than severely disabled young adults. Although I do not for a moment denigrate the needs of handicapped children, I do feel that our current need in the rehabilitation community is for more and better services for severely handicapped young adults, many of whom are institutionalized in less than acceptable facilities.

I also heartily recommend favorable action on House Bill 60 to initate planning and implementation of a residential structure for this above-described population. I feel that the requested funding in House Bill 60 to initiate preliminary planning and eventual implementation of a residential structure for this population is imperative. Most severely physically handicapped young adults in Anchorage are institutionalized in less than adequate facilities. Moving these individuals into an appropriately designed and staffed residential structure will not only enable them to improve their independent living possibilities, but will enable them to seek and obtain gainful employment. This will, in turn, improve their self-concept and image and enable the taxpayers to receive some relief by removing them wholly or partially from public support.

I encourage you to support these two pieces of very needed legislation. I know from personal experience of your dedicated and knowledgeable service to the handicapped community. Thank you very much for considering my recommendations.

Sincerely,

Gary L. Aanes

Gary L. Aanes
Chief of Rehabilitation Services

Residential Services Forum
c/o Connie Rawlings
Employment & Training Center
2330 Nichols Avenue
Anchorage, AK 99504

April 18, 1980

The Honorable Thelma Bucholdt
House of Representatives
State of Alaska
Capitol, Room 112
Juneau, AK 99811

Dear Representative Bucholdt:

The Residential Services Forum which is composed of individuals as per the attached sheet supports the intent of House Bill 998. We do recommend that this legislation be directed to mentally alert young adults rather than children as indicated in the present draft of the legislation.

We also support the request for seed money as spoken to in House Bill 60 to initiate action on a residential structure for this population group.

Your support of these two pieces of legislation is encouraged.

If you have questions, please feel free to contact me.

Sincerely,

Constance E. Rawlings

Chairperson

Kathe F. Parker
SRA Box 1728-L
Anchorage, AK 99507

April 18, 1980

The Honorable Thelma Bucholdt
House of Representatives
State of Alaska
Capitol, Room 112
Juneau, AK 99811

Dear Representative Bucholdt:

I want to express my support of House Bill 998, with some modification of the definition of the population discussed. I feel this legislation should be directed to mentally alert young adults rather than children as outlined in the present draft.

I also endorse the request for seed money as spoken to in House Bill 60 to initiate planning and action on a residential structure for this population. In most circumstances, their housing situations are not conducive to vocational training and placement.

I am hopeful that you will support these two pieces of legislation. If you have any questions or concerns, please contact me at 243-5600.

Sincerely,

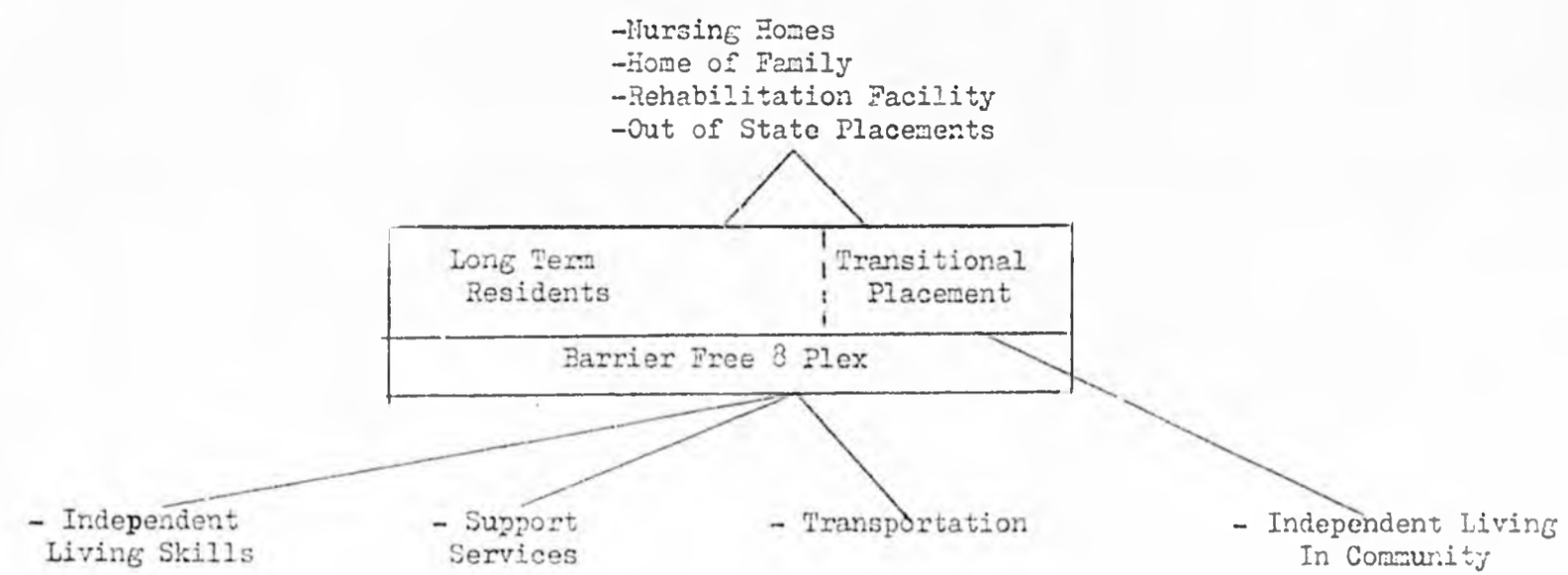
Kathe F. Parker

Kathe F. Parker
Assistant Chief of
Rehabilitation Services

:llm

Residential Care Program For

Mentally Alert Young Adults Who Are Severely Orthopedically Handicapped



THE FOLLOWING DOCUMENT(S) MAY NOT FILM LEGIBLY BECAUSE OF POOR QUALITY OF THE ORIGINAL.

This is a proposed bill by Audrey Hanes

Introduced:
Referred: Health, Education & Social Services

IN THE HOUSE

~~BY THE HEALTH, EDUCATION~~ AND ~~SOCIAL SERVICES COMMITTEE~~

HOUSE BILL NO. 998

IN THE LEGISLATURE OF THE STATE OF ALASKA

ELEVENTH LEGISLATURE - SECOND SESSION

A BILL

For an Act entitled: "An Act establishing a least restrictive residential care program for mentally alert young adults needing continuous medical care."

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

* Section 1. AS 47 is amended by adding a new chapter to read:

CHAPTER 9. RESIDENTIAL CARE PROGRAM FOR YOUNG ADULTS.

Sec. 47.09.010. RESIDENTIAL CARE PROGRAM. There is established in the Department of Health and Social Services a residential care program to provide needed services for mentally alert young adults who require continuous medical care, but who do not need to be kept in a nursing home or hospital. Care for the young adults in this program shall be provided in residential rather than institutional settings.

Sec. 47.09.020. ADMINISTRATION. (a) The department shall administer the residential care program. It shall adopt regulations to provide minimum standards for

(1) residential care facilities, including accessibility requirements;

(2) medical services to be provided;

(3) live-in and day care programs; and

(4) staff requirements.

(b) Within the limits of appropriations made for the purpose, the department may enter into contracts for services with local or state agencies which are able to provide the required residential care for young adults.

Sec. 47.09.030. ELIGIBILITY REQUIREMENTS. (a) To be eligible

for long term services under the residential care program, the young adult must

(1) be at least 18 years of age and under 40 years of age;

(2) be under the care of a physician who diagnoses the young adult's condition as sufficiently serious to warrant consideration for the program;

(3) be in danger of institutionalization or of being placed out of state for purpose of receiving intensive support services;

(4) be diagnosed as having

(A) multiple physical impairment with congenital or acquired defects of the central nervous system or sensory motor systems requiring continued dependency for activities of daily living such as eating, hygiene, grooming, etc., and dependent for chronic or intermittent skilled medical care such as delivery of medications, nursing care, respiratory care, OT, PT, and communication on other rehabilitative measures; as well as impaired use of two or more extremeties, causing the individual to be dependent on a wheelchair or other total body mobility device; or

(B) emotional and social adjustment disorders resulting from a significant motor impairment which impedes the person's ability to function normally in society.

(b) To be eligible for short term, transitional services under the residential care program, the young adult must

(1) be at least 18 years of age and under 40 years of age;

(2) be under the care of a physician who diagnoses the young adult's condition as sufficiently serious to warrant consideration for the program;

(3) be significantly motor impaired as to require training in independent living skills and have the potential for community living in less restrictive environment.

Sec. 47.09.040. PROGRAM PLAN (a) In cooperation with the client, the client's legal guardian and the client's physician, a written program plan shall be developed by the department for each young adult accepted for the residential care program.

(b) The plan shall provide for the coordination of all required services. The services to be available as required by each individual's needs shall include

(1) nursing care;

(2) medical care, including any needed treatment by a specialist on a referral, consultative, or on-going basis;

(3) respiratory therapy or devices;

(4) routine and emergency dental care;

(5) nutritional consultation from a trained professional;

(6) communication disorder therapy;

(7) physical and occupational habilitation and rehabilitation therapy and devices;

(8) education;

(9) leisure time activities and opportunities for recreation and socialization in the community;

(10) group or individual psychological counseling;

(11) transportation; and

(12) employment.

(c) A portion of these required services can be provided from state and local agencies having primary responsibility for such services, but the ultimate responsibility for ensuring and coordinating the delivery of all necessary services shall rest with the department.

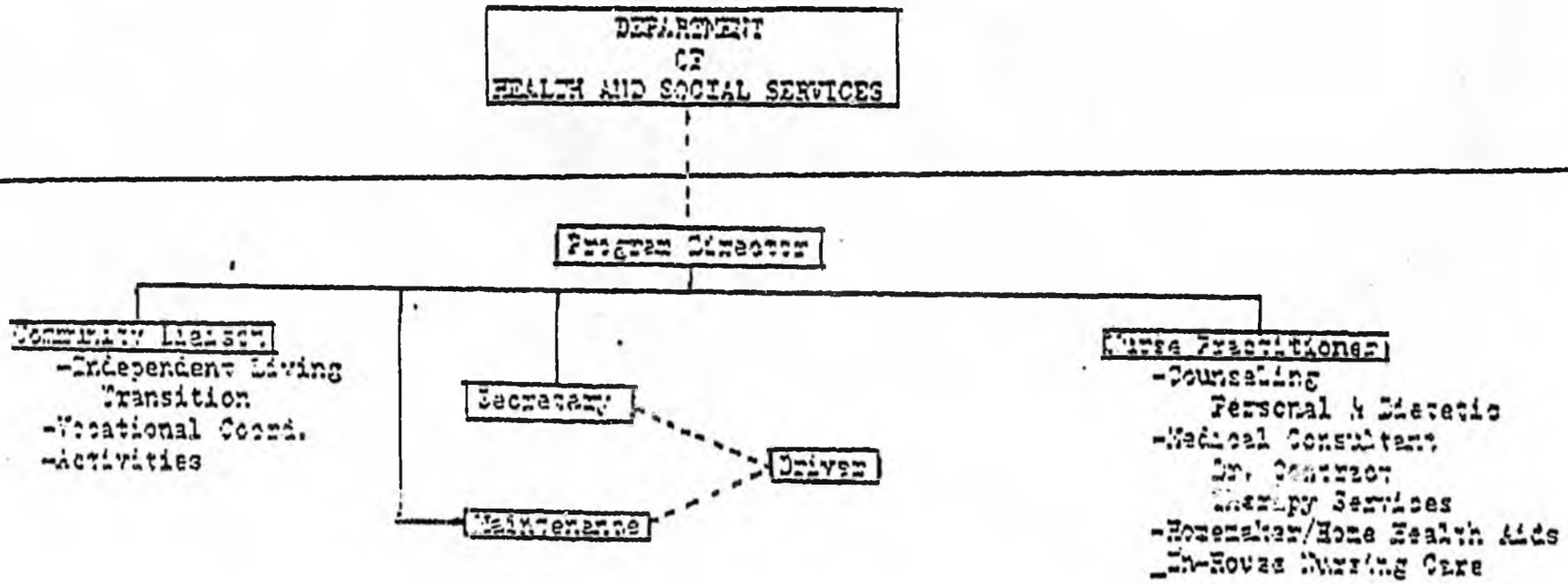
Sec. 47.09.050. COST. Within the limits of appropriations made for the purpose, the residential care program shall be made available to eligible young adults at no cost or at partial cost. However, medical insurance

benefits available to a young adult shall be used as payment for the young adult's medical treatment under the residential care program.

Sec. 47.09.060. DEFINITION. In this chapter "department" means the Department of Health and Social Services.

ORGANIZATIONAL CHART

Residential Care Program
for
Mentally Alert Young Adults Needing Continuous Medical Care



THE PRECEDING DOCUMENT(S) MAY NOT FILM LEGIBLY BECAUSE OF POOR QUALITY OF THE ORIGINAL.

DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT
ANCHORAGE AREA OFFICE
334 WEST FIFTH AVENUE
ANCHORAGE, ALASKA 99501

REGION X

March 19, 1980

IN REPLY REFER TO:
10.1HDH

Audrey Aanes, Chairman
OH Interest Group
Wahley Center
2220 Nichols
Anchorage, AK 99504

Dear Ms. Aanes:

We have been directed to provide response to your letter of February 11, 1980 to Mort Leeds of HUD Central Office.

The most viable and workable program for handicapped housing within the National Housing Appropriation is the Section 202 program, which provides direct loan financing. The interest rates for this program at this time are as follows: Interest during construction is 9.0 percent per annum and 8.5 percent per annum thereafter. Each year a specific amount of loan funds for Section 202 is set aside by HUD for use in developing senior citizens' and handicapped housing. There are many more applications than can be funded in each annual appropriation. Therefore the applications are funded on a competitive basis based on their merits, and unsuccessful proposals must be resubmitted annually.

The Anchorage Area Office has not received an allocation of Section 202 funds in FY 1980. If applications are submitted, we may receive some 202 funding in FY 1981. There are also limited discretionary authorities in the office of the Asst. Sec. for Housing.

Included for your information is a copy of HUD 4571.1 Rev. which describes processing procedures for the program. If you wish to prepare an application this handbook will provide most of the information you need, as well as explain HUD processing procedures.

Obtaining Section 202 funding is a difficult and complicated process. While we in the Anchorage Office are prepared to render what assistance we can, your organization should be prepared to spend considerable time and funds in preparation of an application. The Department expects and requires demonstration of a long term well-orgainzed commitment from 202 sponsors.

Please address your questions regarding an application to Bill Arterburn, Multifamily Housing Representative at 271-4177.

Sincerely,

John G. Duffy
Area Manager

cc: Morten Leeds
Office of Independent Living
Seattle Regional Office
Debbie Peaveler

NAKOYIA HEALTH CARE CENTER

A Division Of HEALTH CARE SERVICES - ALASKA, INC.

4895 CORDOVA • POUCH 6617 • ANCHORAGE, ALASKA 99502

March 18, 1980

Audrey Aanes
Orthopedically Handicapped
Interest Group
Whaley Center
2220 Nichols
Anchorage, Alaska 99504

Dear Audrey:

We certainly commend your energy and interest for handicapped individuals in Alaska.

The "severely handicapped, medically fragile, young adults, with average intelligence" do require "skilled" care. Your source of expertise for meeting their needs is the Department of Social Services, Division of Certification and Licensure. With explicit guidelines from the Federal and State regulations for the provision of skilled care, we feel many of your questions will be answered. Unfortunately, it is a financial fact that it is next to impossible to cost-effectively provide care for less than one-hundred patients. You may want to contact Hope Cottage for cost information that may be similar, as they do have group homes.

From your letter you infer that a less restrictive environment is beneficial to "medically fragile, severely handicapped" persons. The only restriction in institutional settings that we are aware of is the reimbursement system that does not allow meeting more than basic physical and mental needs.

As 90% of our patients are Medicaid-funded, we feel that until we can provide basic care for all, we cannot support specialized care for a few.

The Nakoyia population, per Computerized Patient Assessment, December 31, 1979 statistics showed that 31% of the patients were less than 60 years of age. We wish you the best of luck in developing "small group home type" skilled care facilities as we agree that some of these patients' psycho-social needs could possibly be better met in smaller living situations.

We welcome your visits to Nakoyia and any further need for information in regards to your project.

Sincerely,

NAKOYIA HEALTH CARE CENTER

Heather D. Double, R. N.
Director of Rehabilitation Services -
for Donna M. Stephens, Administrator

HDD:mlc

NAKOYIA HEALTH CARE CENTER

A Division Of HEALTH CARE SERVICES - ALASKA, INC.

4895 CORDOVA • POUCH 6617 • ANCHORAGE, ALASKA 99502

March 18, 1980

Audrey Aanes
Orthopedically Handicapped
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Whaley Center
2220 Nichols
Anchorage, Alaska 99504

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Sincerely,

NAKOYIA HEALTH CARE CENTER

Heather D. Double, R. N.
Director of Rehabilitation Services -
for Donna M. Stephens, Administrator

HDD:mlc

POSITION PAPER/Department of Health & Social Services

POSITION PAPER
ON
HOUSE BILL NO. 998

"An Act establishing a residential medical care program for children needing continuous care."

House Bill 998 provides authority to the Department of Health and Social Services to provide directly, or through contracts, needed medical care in a residential setting the certain chronically-ill children. To be eligible for assistance, the child must:

(1) be under the age of 18 years;

(2) be diagnosed by a physician as having a covered serious medical condition in need of this type of care;

(3) be presently residing in, or in immediate need of residing in a hospital or other medical facility in order to receive intensive support medical services; and,

(4) be suffering from a chronic medical condition listed in Section 47.09.030(4) of the bill.

The Department is responsible for developing a written program plan for each child in cooperation with the child's parents or legal guardian and the child's physician. Subject to the limits of the appropriation, the residential medical care program shall be made available to eligible children at no cost or partial care. The State is required to bill any existing family medical insurance benefits which would cover the costs of care provided under this program.

Overview of this Type of Care in Alaska

Since the bill is primarily focused on the provision of medical services, this level of care would be classed as intermediate or skilled nursing home services, rather than residential care. Residential care is primarily concerned with non-medical support services (such as bathing, dressing) for persons who cannot live independently and are in need of some degree of supervision, but do not require medical or nursing care on a regular basis.

The Department of Health and Services is able to cover such nursing home care for these children through either the Medicaid or General Relief-Medical programs. Currently, the Division of Public Assistance is paying for care for 71 persons aged 18 years of age or younger, at the following facilities:

POSITION PAPER/Department of Health & Social Services

Nursing Home	No. of Children
Harborview Development Center (Valdez)	33
Hope Cottages (Anchorage)	28
Careage North (Fairbanks)	2
Nakoyia (Anchorage)	6
St. Ann's (Juneau)	2
Total	71

Only two (2) nursing home programs, Harborview and Hope Cottage, in the State have specialized care for children, and these programs are primarily for the developmental disabled with mental handicaps.

Nursing home care in Alaska is very costly, averaging about $3,000 a month. Most insurance programs do not cover such care. Medicaid currently pays for the costs of care for a significant number of children residing in nursing homes. The State also limits the parental financial responsibility to $50 a month for children in intermediate care facilities for the mentally retarded.

Currently on a statewide average, nursing homes have an occupancy rate of approximately 70%, leaving 30% of the home's available beds unfilled. The occupancy range of the occupancy rate is from 41% (Careage House in Anchorage) to 100% (Norton Sound Hospital in Nome). (Attachment #1)

Discussion of Issues

1. Clarification of Nursing Home and Residential Care Services - The bill appears to confuse residential care and nursing home care services. Since the bill appears to address the provision of medical services, in lieu of hospitalization, this type of care would be classified as intermediate or skilled nursing care services. It would be helpful for the Committee to consider specification of level of care services to be provided:

   a. intermediate (ICF) and skilled nursing home (SNF) services;

   b. residential care services; or

   c. both intermediate and skilled nursing home services and residential care services.

2. Certificate of Need Requirements - In the implementation of this Act, the health care facilities that would provide this service would be subject to the health care facilities certificate of need statute. Each residential medical care facility as proposed would be reviewed in light of the existing facilities and the degree to which appropriate services are being provided or can be provided, and the degree of utilization of these facilities.

POSITION PAPER/Department of Health & Social Services

3. Modification of Existing Programs Rather Than of Construction of New Facilities - Certainly children have special needs and most generally SNF and ICF facilities in the State do not especially tailor their programs to meet these special needs. The Department favors the use of programs that meet children's needs in the least restrictive environment for the children's care, instead of constructing new facilities.

4. Expansion of Specified Medical Conditions - The bill presently details rather specifically the chronic conditions that the Department is able to cover under this program. This list of conditions excludes coverages of other chronic conditions that affect children that may require continuous medical care. We would recommend more general language to allow for coverage of needed services for persons with significant disabilities. The Department recommends amending AS 47.80.900(7) to include the federal definition of developmental disability as contained in Title V of P.L. 95-602 (Attachment #2). This amendment would open the range of services as specified in AS 47.20 to this additional population.

5. Age Cut-off of 18 years - The Department questions the inclusion of the age of 18 years as a cut-off for services. These children have long-term disabilities and a continuation of services above 18 might be appropriately addressed, as well, in this bill.

Department Position

The Department approves the concept of programs designed to meet the specific needs of the clients, but believes that amendments are necessary to effectively and efficiently implement this concept.

Approved by: _____ 4/21/80
for Helen D. Beirne, Commissioner (DATE)
Department of Health and Social Services

NURSING HOMES — CENSUS: February 29, 1980

	Current Rate		Certified Capacity			Current Occupancy: Medicaid DPA* Placements		Current Occupancy: Non-DPA Placements		Current Census	Vacant Beds	% Occupancy of Total Beds	
	ICF	SNF	ICF	SNF	Total	ICF	SNF	Medicare	Other***			Overall	Medicaid
Careage House (Anchorage)	55.00		101**		101	39	0	0	2	41	60	41%	39%
Careage North (Fairbanks)	84.50	'93.00	101		101	58	17	0	1	76	25	75%	74%
Cordova Hospital L.T.C	135.68		8		8	5	1	0	0	6	2	75%	75%
Ketchikan Hospital L.T.C.	73.31		48		48	38	0	0	0	38	10	79%	79%
Nakoyia (Anchorage)	103.00	125.00	116**	100	216	95	54	0	6	155	61	72%	69%
Norton Sound Hosp. L.T.C. (Nome)	100.00		6**		6	6	0	0	0	6	0	100%	100%
Petersburg Hosp. L.T.C.	51.30	57.00	12		12	7	0	2	2	11	1	92%	58%
South Peninsula Hosp. L.T.C. (Homer)	108.00		4		4	3	0	0	0	3	1	75%	75%
St. Ann's (Juneau)	126.56		45		45	26	3	1	0	30	15	67%	64%
Valley Hospital L.T.C. (Palmer)	104.85		6		6	3	0	0	0	3	3	50%	50%
Wrangell Hospital L.T.C.	75.00	82.50	14		14	13	0	0	1	14	0	100%	93%
Wesleyan (Seward)	52.00		64		64	49	0	0	7	56	8	88%	77%
Kodiak Hospital L.T.C.	100.00		19**		19	11	0	0	0	11	8	58%	58%
TOTAL			544	10	644	353	75	3	19	450	194	70%	6[illegible]%

ICF Certified Capacity means that all beds are certified for both SNF and ICF unless otherwise noted.

* includes GR Medical placements
** beds are certified for ICF only
*** includes V.A., private pay & insurance

Rod Betit 3/19/8
Rod Betit, Director — Date
Division of Public Assistance

#2

Current Statute

Sec. 47.80.900. DEFINITIONS. In this chapter

(1) "council" means the Governor's Council for the Handicapped and Gifted created by sec. 30 of this chapter;

(2) "department" means the Department of Health and Social Services;

(3) "facilities for persons with handicaps" means publicly or privately operated facilities, or specified portions of facilities, designed primarily for the delivery of services to these persons; the term includes but is not limited to residential facilities;

(4) "habilitation" means education or training for the handicapped to enable them to function better in society;

(5) "least restrictive setting" means a residential or other setting for meeting the needs of a handicapped person which requires the least amount of restriction of personal liberty by enabling the person to function in as normal an environment as possible and to live as normally as possible, within the limitations of the handicap;

(6) "person with a handicap" means a person with a developmental disability as defined in (7) of this section or a person who is hard of hearing, deaf, speech impaired, visually handicapped, seriously emotionally disturbed, orthopedically or otherwise health impaired, or who has a specific learning disability; the term includes but is not limited to "exceptional children" as defined in AS 14.30.-350(1) and AS 47.20.050(1);

(7) "person with a developmental disability" means a person having a disability which

(A) is attributable to

(i) mental retardation, cerebral palsy, epilepsy, or autism;

(ii) any other condition found to be closely related to mental retardation because the condition results in impairment of general intellectual functioning or adaptive behavior similar to impairment resulting from mental retardation; or

(iii) dyslexia resulting from a disability described in (i) or (ii) of this subparagraph; and

(B) constitutes a substantial handicap to the person's ability to function normally in society;

(8) "residential facility" means a publicly or privately operated facility which provides 24-hour care for four or more persons with handicaps, excluding family, foster family, or adoptive homes;

(9) "substantial handicap" means a disability which prevents or substantially impedes the person's participating in and benefiting from the social, economic, educational, recreational, or other opportunities generally available to peers in the community who are not similarly handicapped.

Current Federal → Definition of "Developmental Disability" as defined in Title V of Public Law 95-602

The term "developmental disability" means a severe, chronic disability of a person which--

(A) is attributable to a mental or physical impairment or combination of mental and physical impairments;
(B) is manifested before the person attains age twenty-two;
(C) is likely to continue indefinitely;
(D) results in substantial functional limitations in three or more of the following areas of major life activity; (i) self-care, (ii) receptive and expressive language, (iii) learning, (iv) mobility, (v) self-direction, (vi) capacity for independent living, and (vii) economic sufficiency; and
(E) reflects the person's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services which are of lifelong or extended duration and are individually planned and coordinated.

THE LEGISLATURE OF THE STATE OF ALASKA
ELEVENTH LEGISLATURE

FISCAL NOTE

I. REQUEST

Bill/Resolution No. House Bill 998

Title "Residential Medical Care for Children"

Requested by House HESS Date April 21, 1980

II. FISCAL DETAIL

Agency Affected Department of Health and Social Services

Program Category Affected Developmental Disabilities

BRU, Program, or Subprogram(s) Affected Grants and Contracts

(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 80	FY 81	FY 82	FY 83	FY 84	FY 85
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL		579.2	859.6	945.5	1040.1	1144.1
400 COMMODITIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC.						
TOTAL		579.2	859.6	945.5	1040.1	1144.1

FUNDING (Thousands of Dollars)

GENERAL FUND		579.2	859.6	945.5	1040.1	1144.1
FEDERAL FUNDS						
OTHER (Specify Fund Source)						

POSITIONS

FULL TIME		-0-	-0-	-0-	-0-	-0-
PART TIME						
TEMPORARY						

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

1. The bill does not specifically address the construction of new facilities. Since the Department believes that the redirection of programs in existing facilities would be the most cost-effective approach to the problem, we have not included any cost for construction of buildings.

2. The only privately run facility in the state for this age population is Hope Cottage. The daily rate at Hope Cottage presently for this type of care is $130 per day.

3. The population to be served is estimated to be 10 individuals in Anchorage and 5 individuals in Fairbanks.

4. Inflation in future years is 10%.

Deborah Behr

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)

Prepared by: D. Behr Date: 4/21/80
XXXXXXX/Office: Commissioner PH: 3030

33-[illegible] (Rev. 12/79)

5. Implementation of the program would require promulgation of regulations and the issuance of a contract in accordance with the State administrative policies. We estimate this will necessarily delay the implementation of first year of the project, such that only a 9-month appropriation will be needed.

FY 81 Calculations:

Anchorage / 10 children	X	FY 80 Rate + Inflation / $143	X	9 Mos. of Svc. / 270 days	=	Total / $386,100
Fairbanks / 5 children	X	FY 80 Rate + Inflation / $143	X	9 Mos. of Svc. / 270 days	=	Total / $193,050
				Grand Total		$579,150

FY 82 Calculations:

Anchorage / 10 Children	X	FY 81 Rate + Inflation / $157	X	Days / 365	=	Total / $573,050
Fairbanks / 5 children	X	FY 81 Rate + Inflation / $157	X	Days / 365	=	Total / $286,525
				Grand Total		$859,575

HB

1007

POSITION PAPER/Department of Health & Social Services

POSITION PAPER on

HOUSE BILL NO. 1007

For an Act entitled: "An Act relating to comprehensive health planning."

House Bill No. 1007 amends existing statute AS 18.07 to comply with amendments to the National Health Planning and Resources Development Act, as incorporated in PL 96-79, signed into effect October 4, 1979. Such amendments are required of all states wishing to participate in and receive funding under the Public Health Service Act, the Community Mental Health Centers Act, the comprehensive Alcohol Abuse Act and Alcoholism Prevention, Treatment and Rehabilitation Act and the Drug Abuse Office and Treatment Act of 1972. Alaska receives an estimated $5.6 million annually under the four above-named acts.

The purpose of the National Health Planning Act is to encourage consumer and provider involvement at both the local and the state level in planning for and implementing a health care system in Alaska that provides equitable access to quality care at reasonable costs. This process requires the development of local health plans which are incorporated into a State Health Plan; this document is to serve as a guide to the Governor and the Legislature for health policy development and resource allocation.

The incorporation of Article 2 as a new section within AS 18.07 amends the State's existing certificate of need program to bring it into conformance with the new federal requirements outlined in Section 1532 of PL 96-79. The primary additions to this section fall in three categories: major medical equipment, health maintenance organizations and coverage of rehabilitation facilities. Each of these issues is addressed in detail below:

Major Medical Equipment

Section 1527(e) adds a requirement for certificate of need review of major medical equipment costing in excess of $150,000 which will be used for inpatients regardless of its location. Major medical equipment located outside of a health care facility may be exempt from the review if: 1) the sponsor notifies the state agency in writing of intent to purchase such equipment; and 2) the state agency determines that the equipment will not be used for inpatients.

The purpose of this provision is to close a "loophole" which would allow a physician to purchase major medical equipment for a health care facility and thereby avoid the requirement for a certificate of need. Although this provision is required to be in effect in each state, its impact will not be significant in Alaska, since Alaskan physicians generally rely upon hospitals to provide such equipment.

POSITION PAPER/Department of Health & Social Services

Health Maintenance Organizations

Section 1527 has been amended to exempt certain health maintenance organizations (HMOs) which have enrollment of at least 50,000 from certificate of need review. The impact of this provision is not expected to be significant since there are no such HMOs in Alaska.

Rehabilitation Facilities

Section 1527 has been amended to include rehabilitation facilities as facilities subject to certificate of need review. Rehabilitation facility is defined to mean inpatient or outpatient facilities which are operated for the primary purpose of assisting in the rehabilitation of disabled persons through an integrated program of medical and other services which are provided under competent professional supervision. This provision will bring a few facilities under review which previously had not been required to obtain certificate of need.

The amendments to the national planning law, as incorporated in P.L. 96-79 and addressed by reference in House Bill No. 1007 also modify the planning process, strengthen the role of a Governor in approval and use of the State Health Plan and introduce organizational changes within the planning boards and advisory committees. These modifications are highlighted on the attached chart; specific backup material can be found in a more extensive position paper on this matter.

Recommended by: Phoebe A Lindsey
Phoebe Lindsey
Director

Approved by:
Helen D. Beirne
Commissioner

Date: April 29, 1980

Date: May 1, 1980

THE LEGISLATURE OF THE STATE OF ALASKA
ELEVENTH LEGISLATURE

FISCAL NOTE

I. REQUEST
Bill/Resolution No. House Bill 1007
Title Amendment to AS 18.07 "Comprehensive Health Planning"
Requested by Dept of Health and Social Services Date 4-25-80

II. FISCAL DETAIL
Agency Affected Department of Health and Social Sevices
Program Category Affected Health
BRU, Program, or Subprogram(s) Affected
(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 80	FY 81	FY 82	FY 83	FY 84	FY 85
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL						
400 COMMODITIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC.						
TOTAL	Fiscal impact is described in Analysis Section below.					

FUNDING (Thousands of Dollars)

GENERAL FUND						
FEDERAL FUNDS						
OTHER (Specify Fund Source)						

POSITIONS

FULL TIME						
PART TIME						
TEMPORARY						

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

This fiscal note relects the results if legislation is not passed to enable the State Health Planning & Development Agency (SHPDA) to carry out its full responsibilities under the "Health Planning & Resources Development Amendments of 1979" (Public Law 96-79). P.L. 96-79 significantly revises Title XV and XVI of the Public Health Service (PHS) Act, enacted by the "National Health Planning & Resources Development Act of 1974 (Public Law 93-641). Consequently, amendment to AS 18.07, which adopted P.L. 93-641 provisions, is necessary to adopt the revisions in P.O. 96-79. If the SHPDA is not fully empowered by State statute by January 1, 1981 to conduct tne "State Program" mandated by the amended Title XV of the PHS Act, the SHPDA designation agreement with the Federal government will either be terminated, or the SHPDA designation agreements made conditional for one year and the designation then withdrawn. This fiscal note depicts the effects of the withdrawal of "full designation of the State Health Planning & Development Agency (SHPDA) and reversion to "conditional" designation for the period 1-1-81 - 12-31-81, followed by termination of the SHPDA designation agreement. The impact on Federal funding woul be as follows based upon the current level of $5.6 million in Federal grants involved throughout the State as described in the attached listing of grantees and grants.

Original: Legislative Finance
cc. Budget and Management
Prime Sponsor (First Legislator Named)

Prepared by: Linda A Lindsay Date: April 29, 1980
Division/Office: PH:
Department of Health & Social Services

Approval DHSS Mgt. & Bdgt: Date: 2 May 80

33-001 (Rev. 12/79)
Modify by DHSS (11-28-79)

Period	Federal Funds Forfeited	Total Estimated Forfeiture
1-1-81 - 12-31-81	25%	$1.4 million
1-1-82 - 12-31-82	50%	2.8 million
1-1-83 - 12-31-83	75%	4.2 million
1-1-84 -	100%	5.6 million

House Bill 1007 - An Act Relating to Comprehensive Health Planning as outlined in Public Laws 93-641 and 96-79

Issue Area	Current Status AS 18.07	Proposed Change incorporated in HB 1007	Rationale for change	Impact
CERTIFICATE OF NEED				
Coverage of Major Medical Equipment Purchases	Prior review and approval required in institutional setting	Prior approval required for equipment costing more than $150,000 regardless of location	To resolve a gap which previously allowed physicians to purchase major medical equipment for a facility and thereby avoid the requirement for a review	Since Alaska physicians generally rely on hospitals to purchase such equipment, the impact should be insignificant
Health Maintenance Organization coverage	Alaska presently has no HMOs	Exempts certain HMOs which have enrollments of at least 50,000 from CON review	To allow HMOs to develop without constraint from CON	Since Alaska currently has no HMOs, impact would be insignificant
Coverage of Rehabilitation Facilities	Not covered	Will make rehabilitation facilities subject to CON review	To cover all health care services and settings in review process (with exeception of HMO)	Would cover a few Alaska facilities, depending upon the Federal Regulatory Definition
PLANNING CYCLE				
State Health Plan	Done on an annual basis	Done every 3 years with appropriate annual revisions/updates	To provide a longer cycle for plan development and opportunity to implement and evaluate plan	Should allow longer range view of Alaska's health systems and better use of resources to plan for system and status improvements

Issue Area	Current Status AS 18.07	Proposed Change incorporated in HB 1007	Rational for change	Impact
INVOLVEMENT OF OTHER HEALTH RELATED ENTITIES	Done on voluntary, coordinative basis	Includes involvement of authorities from mental and public health and substance abuse	To ensure close working relationships and integration where possible among various planning entities	Fosters continuing working relationships and avoids duplication and overlap
PLAN IMPLEMENTATION	Done on voluntary, coordinative basis	Appropriate agencies and authorities as designated by the Governor will carry out the parts of the State Health Plan which relate to State Government	To use the State Health Plan as a viable document to be used throughout State Government rather than being a document which could/would only be implemented voluntarily	Creates closer working relationships among authorities
GOVERNOR'S ROLE	Governor receives State Health Plans after they are completed. He appoints members of the statewide Health Coordinating Council (SHCC)	Governor can accept or reject State Health Plan on the basis of whether it meets statewide needs assessment. May also appoint chairman of SHCC	To provide a stronger role for the executive branch since the State Health Plan is to be used to guide State health resource allocation and since the SHCC is to advise the State on health policy matters	Affords mutual commitment between State Government and an advisory body
VOLUNTARY DISCONTINUANCE OF UNNEEDED HOSPITAL SERVICES	Hospitals can currently discontinue unneeded services following appropriate input	Formalizes mechanism for discontinuance or conversion of uneeded hospital services; authorizes limited funds for such changes	To encourage the best utilization of facilities and services to meet a target population's need	Alaska's situation is one of access rather than excess. The conversion feature may be useful
HEALTH SYSTEMS AGENCY (HSA) BOARD MEMBERSHIP	Members may currently be suggested/nominated by existing board	Involves the community to a larger extent in the board selection process	To avoid a self perpetuation of these private, nonprofit corporations	May alter composition slightly among Alaska's three HSA boards

Issue Area	Current Status AS 18.07	Proposed Change incorporated in HB 1007	Rational for change	Impact
DATA COLLECTION	Agencies are to use existing data bases wherever possible	Requires Health Systems Agencies to collect information from all hospitals on the rates charged for the most frequently used services and make such available to public	To provide public information/ awareness on health care costs; and foster competition	Will give Alaskans information on hospital costs
NATION HEALTH PRIORITIES	Currently 10 priorities	Adds priorities for cost containment and encourages competition in allocation of health services	To develop additional mechanisms for dealing with rising health care costs	Will not have great impact where access is more important than dealing with an excess

HB
1019

HOUSE RESEARCH AGENCY
Pouch Y - State Capitol
Juneau, Alaska 99811
465-3991

MEMORANDUM

TO: Representative Jim Duncan

FROM: Susan Brody and Jack Fargnoli
Issues Analysts

RE: Day Care Assistance--Alternatives for Legislative Action
Research Request No. 50

This memorandum is in response to your request for an evaluation of possible changes in the present Day Care Assistance Program, for purposes of improving the long term financial stability of day care facilities. Our evaluation is based on interviews with 25 day care center operators throughout the state, and discussions with Lianne Wesley, administrator of the State day care program, and municipal program directors in Anchorage, Fairbanks, Juneau and elsewhere. Our interview findings are summarized in the Appendix to this memorandum and in our two earlier memoranda to you on the day care issue (February 11 and March 5, 1980).

The following alternatives for legislative action are discussed below:

- amendments to the existing day care assistance statute;
- supplemental subsidies to day care centers;
- a State grant program to provide funds to day care centers for equipment acquisition, capital improvements, and staff training; and,
- a State revenue sharing program for day care services.

The grant program could be initiated in conjunction with either of the first two alternatives. We have not had an opportunity to estimate the budget implications of these alternatives but will do so in another memorandum to be completed by mid-April.

AMENDMENTS TO THE DAY CARE ASSISTANCE STATUTE

Our interviews indicate that three of the primary problems in the operation of the current State program are: (1) escalating operating costs of day care centers; (2) the present State method of reimbursing day care centers for services provided; and, (3) the increasing financial burden of day care costs on families who receive little or no subsidy from the State.

Several amendments to the existing day care assistance statute (AS 44.47.250-310) are suggested below as a means of alleviating these problems.

1. Require the Department of Community and Regional Affairs to establish rates of payment which reflect the full cost of services provided by day care facilities, and review and revise those rates annually.

   Our interviews indicate that the current rates paid by the Department of Community & Regional Affairs for day care services do not reflect the actual costs of providing services in many centers. Even in those centers where the rates "appear" adequate to cover costs, this may be the case only because staff salaries are extremely low ($3-$4/hour), or because rents or other basic expenses are subsidized. If rates are to keep pace with likely increases in operating costs some formal mechanism of rate setting and review should be established. It may be especially important to review the current rates paid for infant care, as our interviews indicate that the lack of adequate rates has discouraged many centers from providing services for infants.

   The Department of Health and Social Services currently operates under statutory provisions which establish a fairly concrete method for determining and reimbursing

the full cost of certain services under its jurisdiction. AS 47.40.040 states that the "full cost of services shall be determined by the per person, per day cost in the preceding fiscal year plus a proportionate share of anticipated cost of living and staff salary increment increases for the fiscal year for which the full cost of services... is being determined" (statute attached). Certain expenses are specifically excluded from the determination, such as major capital expenditures, religious training or education, and services which exceed the requirements of the department.

This method of determining costs of care could also be used in the present Day Care Assistance Program. It would eliminate the lag which now occurs between actual increases in the costs of care, and the decision to adjust rates to reflect those increases. It would also allow day care facilites to offer adequate salaries, and, thus, decrease the extremely high rate of staff turnover which now exists.

A requirement for rate setting and review could be added to AS 44.47.250 (attached), which defines the powers and duties of the Department of Community and Regional Affairs in regard to the Day Care Assistance Program.

2. <u>Require the State to reimburse day care providers, for services rendered to eligible families, on the basis of monthly enrollment rather than actual daily attendance</u>.

At present, the State reimburses day care centers only for those days on which the children of subsidized families actually attend. This method of reimbursement is practied by both the Department of Community and Regional Affairs and the Department of Health and Social Services, and results in centers not being able to recapture a significant portion of fixed costs which do not disappear simply because children are not in attendance on a particular day, or for a number of days each month Day care centers are free to bill families <u>not</u> receiving subsidies, however, on an enrollment

basis (a practice many centers have adopted).

The number of subsidized children served as a proportion of total enrollment varies from center to center. For nine of the centers we intereviewed, less than 25 per cent of their enrollment consisted of children receiving subsidies either through the Community and Regional Affairs program or through the Department of Health and Social Services. For an equal number of centers interviewed, however, 50 per cent or more of their enrollment was comprised of children receiving subsidies. An extreme example is the Childrens' Community Center in Juneau, where all but one of the children in their care receive State subsidies.

As the number of subsidized children enrolled in a center increases, the larger becomes the percentage of operating costs reimbursed on an attendance basis only. When this is coupled with a low rate of attendance, day care centers are likely to suffer financially. In fact, our calculations suggest that this may be the most important component of the monthly operating deficits which many centers are currently experiencing.

The difference between enrollment and actual attendance at centers seems clear among the centers we contacted. Of the twenty-five day care centers surveyed, almost all had actual attendance levels that fell below the number of children enrolled in the center. The majority estimated that, on most days, attendance averaged around 80-90 per cent of enrollment, while several centers indicated that their attendance was as low as 65-75 per cent of enrollment. Absences are often the result of sickness, but may also increase dramatically at certain times of the year. Day care centers typically experience significant declines in attendance during the summer months, and during December and January when families take vacations.

To understand the financial implications of reimbursing centers for costs on an attendance basis

only, we calculated the monthly operating costs for two hypothetical centers which have characteristics typical of many of the centers interviewed:

Consider one center with an enrollment of 75 children (all 2 years and over), of which 40 (53%) are receiving subsidies from the State, and where attendance averages about 80 per cent of enrollment. $18,900 represents the total monthly operating costs for the center. (75 full time children X $12/day X 21 days/month = $18,900). This assumes that most of the standard operating costs (salaries, rent, insurance, maintenance, etc.) are fixed costs which must be paid regardless of whether all the children attend. Since 40 children out of 75 are receiving subsidies, 53 per cent of these costs are subject to reimbursement on an attendance basis only (53% X $18,900 = $10,017). If the subsidized children are absent from the center approximately 20 per cent of the time, then $2,003 ($10,017 X 20%) of the center's fixed operating costs will not be reimbursed by the State. In other words, the center might expect to run an operating cost deficit as high as $2,000 per month.

Even for a center with fewer subsidized children and a better attendance record, monthly operating cost losses could be substantial. Consider a second center with 50 children, where 12 of the children (25%) receive subsidies. If these children are absent 10 per cent of the time, the monthly deficit would be $315 per month, as indicated below:

- 50 children X $12/day X 21 days = $12,600 monthly operating costs

- $12,600 X 25% = $3,150 X 10% = $315 per month loss.

A provision requiring the Department of Community and Regional Affairs to reimburse costs (through municipalities) on an enrollment rather than an attendance basis could be added to AS 44.47.300, which establishes how benefits shall be paid. A similar change in the reimbursement policies of the Department of Health and Social Services might be made to insure that centers are not penalized

for offering day care services to children participating in those programs. In the past, the Division of Social Services has followed the lead of the Department of Community and Regional Affairs in the method of reimbursement used and the rate paid.

(3) Require that the income levels which qualify a family for day care assistance be reviewed and adjusted annually to reflect increases in the statewide median income.

Currently, AS 44.47.280 requires the Department of Community and Regional Affairs to determine the eligibility of families for day care assistance based on the net income of the family, the number of children in the family, and whether there is one parent responsible for the care of the family. No mechanism is established, however, for periodically adjusting the qualifying net income levels as incomes rise.

If the desired goal is to identify a population in need of assistance (i.e., "low income" as stated in the statute), it may be helpful to define "need" in terms of how a family's income relates to the median income within the state or a particular region. Then, as the statewide or regional median income rises, the income level qualifying a family for assistance would also rise. Without such an adjustment, fewer and fewer families would qualify for assistance as salaries increase to conform with cost of living increases.

The median family income for Alaska is estimated annually by the U. S. Bureau of the Census (with a 1-2 year time lag), and provides a relatively simple mechanical basis for making this kind of annual adjustment. Other measures exist, such as the mean family income of families and the mean level of personal disposable income; but the median family income would appear to be the soundest basis for distinguishing between "low" and "middle" income families, and thus the most straightforward measure for adjusting family income eligibility levels.

The ratio of family income eligibility levels to the statewide median family income could be established for a base year, and that ratio could then be maintained as the statewide median income rises. For example, the qualifying net income for day care assistance is currently $16,000, or 58 per cent of the statewide median income ($27,572 in 1978). Under the proposed method, if the median family income increased by 8 per cent, the income level qualifying a family for day care assistance would also rise by 8 per cent, to $17,280.

We discussed this possible means of adjusting family income eligibility levels with Jim Sullivan, economist with the Division of Economic Enterprise. He believes it to be a satisfactory method, but also noted that the method would be somewhat more accurate if movement (up or down) in the statewide median income level were also adjusted for movement in the statewide consumer price index, as salary levels often lag behind increases in the cost of living.

A provision requiring this kind of annual adjustment of family income eligibility levels could be added to AS 44.47.280, which establishes the eligibility of families for day care benefits.

The three statutory adjustments described above probably would do much to alleviate the most pressing financial difficulties of day care centers and, to some degree (through annual adjustment of eligibility income levels), ease the burden of rising day care costs on families currently not qualified to receive subsidies. In the following three sections of the memorandum, several additional approaches are discussed which go farther in these respects, and which might be a basis for more comprehensive revision of the State day care statute (and program) in the future.

SUPPLEMENTAL SUBSIDIES TO DAY CARE CENTERS

In discussing any plan for increasing the current State subsidy rates, it seems necessary to consider the effects of such an action on non-subsidized families. The logic for

this is straighforward: if the current per-child subsidy is considered insufficient to cover the actual costs of providing care, then it is also likely that the present fees charged for non-subsidized families (which generally are keyed to State per-child subsidy amounts) are also inadequate. A reasonable expectation, therefore, is that any increase in the State subsidy amount would probably be accompanied by a rise in charges to non-subsidized families. Particularly in the long term, then, as day care costs (and subsidies) continued to rise, the accompanying increases in cost for non-subsidized families could become a significant burden.

One possible approach to mitigating this effect could be an additional subsidy to day care centers, per licensed slot, for both subsidized and non-subsidized children. This would be in addition to the current State subsidy for qualifying children, but would be in lieu of any anticipated increase in that subsidy. In effect, then, the additional subsidy would achieve the same effect as a rate increase, but would mitigate any increased financial burden on non-subsidized families. The chief drawback to this approach, of course, is that the ultimate cost to the State would be somewhat higher than simply raising the per cent per-child subsidy rate. Another consideration is that such an action would constitute a direct subsidy of families which are not "low income", and thus could blur the distinction achieved by eligibility criteria.

A more direct means of accomplishing the same purpose would be to consider increasing (as distinct from annually adjusting) the income levels currently used to determine subsidy eligibility. This would allow more families to qualify for a State subsidy, and thus alleviate for them the burden of a straightforward increase in subsidy rate levels. A further adjustment might be to consider revising the current statutory language of AS 44.47.250, to identify "middle income" as well as "low income" families as qualified for day care assistance. While the implications of an approach such as this have not been investigated in detail, some combination of these two options presumably could be found which would significantly reduce the burden of increasing day care costs on the majority of families.

STATE GRANTS TO DAY CARE CENTERS

While much of the preceding discussion has focused on possibilities for increasing State day care assistance, it is important to note that the emphasis consistently has been on minimal increases (income level and rate adjustments, billing procedures, etc.). Apart from these remedies, however, which attempt only to make day care operations economically feasible on a day-to-day basis, a number of other important needs remain largely unaddressed. The most important of these, as evidenced by most of the day care centers contacted, include (1) the need for major capital improvements, (2) training of staff, and (3) the acquisition of necessary equipment.

The most obvious source of relief is for day care centers to obtain loans which would satisfy some of these needs. Most day care centers, however, are in no shape financially to undertake any kind of debt repayment, and thus it is unlikely that a loan mechanism would afford any realistic possibility for relief. Furthermore, the only existing loan program specifically for day care centers (the Childcare Facility Revolving Loan Fund, administered through the Department of Commerce & Economic Development) limits loans to a maximum of $30,000, has very strict collateral requirements, and provides only for loans necessary to meet licensing or certification requirements.

Creation of a grant mechanism, therefore, would seem the most viable approach for assisting day care centers in obtaining needed capital improvements, training for staff, and equipment necessary for their daily operations. While determining the amount of funding for such a grant program would require more detailed information than has been collected to date, it seems clear that the administrative apparatus required is already at least minimally in place: specifically, the present Day Care Assistance Program within the Department of Community & Regional Affairs, and its established linkages with participating municipalities. Thus, the major concern would appear not to be the mechanical feasibility of such a grant program, but rather a matter of the ultimate costs involved and whether grants for such purposes (capital improvements, staff training, equipment) are considered part of a State responsibility to provide day care services.

Implementing such a grant program, however, would almost certainly require amending the current day care statute (AS 44.33.240-275) to provide for the expansion in authority. The only potential obstacle immediately apparent, as with all the day care adjustments discussed, might be the granting of public monies to those day care centers which are profit-making. (This topic has been discussed in an earlier memorandum; however, a legal opinion may be necessary which focuses on the distinction between providing public monies for day care services as a public purpose, as opposed to day care center improvements as a public purpose.)

REVENUE SHARING FOR DAY CARE SERVICES

A possible alternative to the existing State Day Care Assistance Program would be to incorporate day care services within the present State revenue sharing program. The possibility is a novel one, and has not been investigated in depth, but at face value at least appears to pose no legal or mechanical problems. A major advantage of this approach would be that a predictable amount of funding would be guaranteed for statewide day care services. The pro rata format for distributing shared revenues would also assure that funding for day care services would be distributed equitably among all Alaska communities with qualifying (i.e., licensed) day care centers. Yet an additional advantage would be that, as part of the total annual revenue sharing entitlement, day care funds would pass through municipalities, which at present already are the administrative nexus for State day care funding. Thus, although adjustments might be necessary, in general, no new administrative burden would be created for municipal governments.

One potential problem with this approach, however, is that the shared revenue entitlement each year is fixed, and therefore any inclusion of day care uses might result in a decrease in shared revenues currently allocated for other purposes. The total annual entitlement could be increased to compensate for the inclusion of day care services, by an amount equivalent to the expanded funding needs discussed in this memorandum, but it is unclear at this point what obstacles such an action might encounter. A corollary problem is that at present there is no statutory guarantee or requirement that municipalities must use shared revenues for the purposes identified in computing the allocation. Department of Community

& Regional Affairs regulations currently require only that a minimum of 20% of shared revenues, or the equivalent, be allocated by municipalities for specific purposes. Thus, statutory language similar to that currently provided for hospitals (e.g., "Funds received under this paragraph may be used only for day care centers (sic) and shall be apportioned among qualifying day care centers (sic) as the municipality may determine") probably would be required.

A further consideration is that the trend in shared revenue legislation may be away from specific per capita entitlements, and towards the combining of intended uses within general and miscellaneous shared revenue accounts (although specific exceptions may be possible). Part of the intent, for example, of proposed legislation such as CSHB 192 appears to be to permit municipalities more discretion in allocating shared revenues. This also raises the possibility that monies originally intended for day care services might ultimately be diverted at the municipal level to other purposes. (The converse possiblity, of course, is that such a general account mechanism could also allow municipalities to allocate extra shared revenues for day care services, if they so desired.)

Overall, however, it may be too soon to be considering the inclusion of day care services in the revenue sharing program. Unlike police services, hospitals, roads, etc., the overall contours of the statewide need for day care services are fairly indeterminate at present, and probably will not emerge with any definiteness until the State program has been in operation (as is, or expanded) for a longer period of time than it has been to date. Until specific day care needs and basic operating problems are better identified, therefore, it may not be wise to artificially fix concepts (and, in effect, funding levels) by including day care services within the revenue sharing model. Such action could be premature if undertaken at this time, and possibly might arrest or make difficult the emergence of a developing public service.

A final consideration worth noting, however, is that, in the long term, inclusion of day care services within the State revenue sharing program (if feasible) probably would address

the two most central concerns of day care advocates: guaranteed annual funding, and recognition of day care as an acknowledged public responsibility.

APPENDIX

A. Day Care Problems (Findings From Interviews)

B. Relevant Statutes

APPENDIX A

Day Care Problems: Findings From Interviews

Interview Sample

The issues and problems presented in this discussion are based on telephone interviews conducted recently with 25 day care center administrators throughout the state. Our sample represents 32 per cent of the 70 day care centers currently funded by the State, and a regional representation proportionate to population. The selection criteria for the centers contacted included enrollment capacity, regional representation, and participation in the Day Care Assistance Program. In our initial selection process, we attempted to identify those centers having financial problems, but also included centers operating in good financial health. Our sample is as follows:

City	Number of Centers	Number Interviewed
Anchorage	32	9
Fairbanks	19	2
Juneau	9	4
Ketchikan	2	1
Petersburg	1	0*
Sitka	2	2
Cordova	1	1
Bethel	2	2
Wasilla	3	1
Ft. Greely	1	0
Nome	1	1
Kotzebue	1	1
Kodiak	2	1
Anderson	1	0
Total:	70	25

*Although we did not conduct an interview with Petersburg, we are in receipt of a letter from the Center's Director that will be referenced throughout this report. The letter, submitted to the Juneau Association of Child Care Providers, details child care concerns in Petersburg.

Specific areas identified by administrators during our interviews are as follows:

- escalating operating costs
- attendance vs. enrollment
- capital acquisitions and improvements
- staffing costs
- insufficient salaries
- staff/child ratios
- decrease in CETA funding
- high cost of infant care
- need for additional infant care providers.

These, as well as other problems and issues identified, are discussed in the pages following.

Escalating Operating Costs

Fifty-two per cent of the providers interviewed are experiencing program deficits. The extent of deficit ranges in severity from slight to extreme. However, several of the administrators undergoing slight financial shortfalls have projected a trend of increasing deficits. No administrator interviewed perceived a means for recovery beyond programmatic reduction or rate increases.

A major factor contributing to the current deficits of day care centers is increasing operating costs. The rise in costs is especially apparent in the areas of salaries, supplies and other commidities. For example, center operators reported increases ranging anywhere from 25 per cent to 158 per cent in food costs between FY 77 and FY 79.

Attendance vs. Enrollment

Throughout their fiscal year, day care administrators find themselves frustrated by efforts to meet fixed costs with an undependable and fluctuating income. A chief cause of this frustration, according to administrators, is the fact that the

operating policies established by the Department of Community and Regional Affairs for the Day Care Assistance Program establish a payment structure based on attendance rather than enrollment.

In the course of our interviews, administrators complained that their operating costs cannot be adjusted to the daily fluctuations in attendance, which is the current basis for payment. Several managers mentioned this has weakened the organizational structure of their centers. Paula Fridgen, Supervisor of St. Joseph Child Care in Cordova, added:

> "Because the employment situation has been very poor here all winter, our child care volume has decreased 40 to 50 per cent. Because of this, trying to balance out workers and salaries is a real strain. Some of our workers don't know from day to day or hour to hour when they will be working. It's a real strain for the Director."

Day care center operators in communities experiencing seasonal economic downturns, such as Cordova, expressed special concern about the attendance method of reimbursement. In Fairbanks, one administrator stated her second largest cause for absence, beyond children's illness, to be parents' finances. Economic decline in the community results in parents' inability to pay for child care.

Capital Acquisitions and Improvements

The effects of inflation on operating budgets have caused many providers to neglect capital expansion and maintenance. In some instances, centers developed deficits when operators were forced to make emergency capital repairs and no funds were available for this purpose. In addition, several center operators noted the need for play equipment as an important component of quality care. Patti Meritt, Director of Play n' Learn in Fairbanks, stressed the statewide need for indoor/outdoor large-muscle equipment as essential for preventing developmental learning disabilities such as dyslexia, and added that day care centers do not have the funds necessary for equipment purchases of this magnitude.

Staffing Costs

A major concern of the day care operators surveyed is the large percentage of program budgets committed to staff salaries. Funds obligated toward salaries and benefits range somewhere between 75-85 per cent of a center's operating budget. Since FY 77, however, some centers have been experiencing salary cost increases which have surpassed the rate of inflation. Between FY 77 and FY 79, St. Ann's Nursery had a 51 per cent increase in salaries with only a 17 per cent enrollment increase. In other centers salary increases have not kept pace with inflation. One Anchorage center showed only a 13 per cent salary increase over a two-year period. Another Anchorage provider lowered salaries to prevent an impending deficit.

Insufficient Salaries

Most center administrators indicated that current salaries are not competitive with other similar job classifications in their communities. One indication of the effects of low pay scales is the high turnover rate among staff. The average length of employment in centers can be as low as three to six months, as is the case in Petersburg. Lee N. Robertson, Director of Carousel Child Care Center in Anchorage, stated a need she believes to be shared by all providers - - funding to "pay our staff an attractive and fair wage," thereby providing an incentive "to remain in this dedicated field, when the children we care for is our America of Tomorrow." Some center administrators expressed apprehension about their ability to attract quality staff with substandard pay scales. Vicki Malone, Director of Bethel Social Services, stated that neither of the community's two day care center administrators is drawing a salary commensurate with her skills and training.

Staff/Child Ratios

State regulations for licensed child care establish staff/child ratios, a requirement which all respondents agreed places demands on staffing volumes and costs.

Day care supervisors in Anchorage and Kodiak noted correlations between their programs' financial problems and the 1977 State regulatory amendment requiring more stringent staff/child

ratios. In Kodiak,both the manager and administrator of the U. S. Coast Guard Base Day Care Center stated that they periodically have considered removing the center from State affiliation in order to abandon the current ratio requirements. They have chosen not to exercise this option because they believe the ratios to be necessary, and because they do not want to sacrifice quality of care. They view the problem not to be the ratios, but rather the lack of income necessary to support the costs which required staff/child ratios entail.

Other day care managers viewed the currently required staff/child ratios as minimum guidelines, in contrast to their own centers' quality standards. The centers in Bethel, for example, offer comprehensive programs in child development which require a more strict ratio of 1:6 for children and 1:3.5 for infants. Several providers added that competent staff, rather than ratios, is the truer measure of quality care.

Decrease in CETA Funding

Voluntary or subsidized employment assistance is the most often mentioned means of coping with the high cost of staffing. Fifty-six per cent of the centers contacted are relying on CETA or some form of employment assistance. Administrators expressed concern to us about the transitory nature of these funds, particularly CETA funds. Directors indicated that they would have no means of absorbing losses without CETA positions. Vicki Malone of Bethel projected a combined deficit of $75,000 annually for the community's two centers. Administrators in Petersburg and Nome both stated that their centers "would fold without CETA." Excluding one administrative staff position, Kotzebue's child care center is staffed solely through 5 CETA positions.

Federal funding modifications of CETA during FY 80 have resulted in a decline in the total number of jobs per dollar. The effect of this on day care centers receiving CETA funds from the State will be a 47 per cent decrease in total positions by 9/30/80. This does not include any additional decreases projected by Indian Prime Sponsor funding sources.

High Cost of Infant Care

Currently, 72 per cent of the day care centers contacted provide infant care. Of these, 77 per cent consider the cost of

care for infants to be significantly greater than the care costs for children.* The Day Care Assistance Program's present rate schedule pays providers $15.00 per day for full-time infant care, or an additional 25% above the rate established for children. However, 38 per cent of the providers interviewed believe the cost of infant care to exceed child care costs by as much as two or three times.

The primary reason cited for the disproportionate costs of infant care is a mandatory staff/child ratio (1 care giver for every five infants) which is double that for child care. Most operators regarded the staff/infant ratios to be necessary, however, and in fact many considered them to be substandard. The issue raised, in short, was not the validity of the ratios, but the financial burden which they create.

Another problem cited with regard to infant ratios concerned their inflexibility. Several operators cited problems in increasing their enrollment of infants beyond five, since the addition of a sixth or seventh infant would require a second full-time staff person.

Operators also questioned the accuracy of the age breakdowns in the ratios. A Nome administrator found that infant care required a 1:1 staff ratio, and discontinued the service. An administrator in Bethel noted a similar disparity and extended her thoughts to the rate structure, stating that the adequacy of the infant care rate depends on the number of toddlers enrolled because toddler care is less expensive than younger infant care. In light of these concerns about staff ratios, it is interesting to note that the new federal standards proposed for adoption include the following divisions:

Age of Child	Staff/Child Ratio (Attendance)	Staff/Child Ratio (Enrollment)
0-2 years	1:3	1:3
2-3 years	1:4	1:4
3-5 years	1:8	1:9.

*Four centers were not polled on this question; the percentage could be higher.

Need for Additional Infant Care Providers

The final issue raised in the interviews concerned the need for additional infant care providers. Six of the centers interviewed currently maintain infant waiting lists, while two centers have considered establishing an infant care service, but all are apprehensive about the added expense. Marion Estelle, Director for Petersburg Day Care Center, cited an "extremely urgent need for more licensed care in Petersburg, especially to care for infants and school-aged children." The future of existing infant care programs is being questioned in some other centers. Ricki Govaars, Supervisor of The Nest in Ketchikan, has found infant care to be an overwhelming expense which is draining the financial health of the center. She may need to terminate her infant care program, she said, but is exploring other options because the center is the sole source for this service in Ketchikan.

Other Issues

Several approaches to other issues emerged during the course of our interviews which, while exceeding the boundaries of the current project, are noted below for future consideration:

- An examination of the ramifications of the State's renewed participation in (federal) Title XX (Alaska is the only state not participating at present in the federal program).
- A formalized mechanism for communication and resource coordination between day care centers and public schools.
- A modification of the Department of Health and Social Services Child Protection Day Care Program, to provide less transitory placement of children needing assistance.
- An exploration of the staff training needs of child care providers, for consideration in development of a statewide in-service program.
- Expansion of Day Care Assistance staff to upgrade monitoring capabilities and to add training functions.

APPENDIX B

RELEVANT STATUTES

Section
270. Conditions of receipt of benefits
280. Eligibility of families for benefits
290. Contributions by parent or guardian
300. Child care facilities
310. Definitions

Editor's note. — Section 1, ch. 66, SLA 1975, provides: "Findings of fact; purpose. The legislature finds that a need exists in the state for the provision of adequate day care facilities for families with low income. Adequate child care facilities allow the parent or guardian to work outside the home and in many cases to avoid the need for welfare and other forms of public assistance. The purpose of this Act is to establish in the Department of Community and Regional Affairs a program to aid low income families in urban and rural areas of the state in providing adequate care for their children."

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* Sec. 44.47.250. Powers and duties. (a) The department shall

(1) implement and administer a program to assist in providing day care for the children of low-income families according to the requirements of §§ 250—310 of this chapter;

(2) establish standards of eligibility for day care benefits;

(3) contract for the care of children of eligible families;

(4) establish procedures to periodically review the needs of families receiving day care benefits;

(5) provide notification to the local government body of the request for a contract with a day care facility.

(b) The department may

(1) adopt regulations necessary for the performance of its duties under §§ 250—310 of this chapter;

(2) contract with municipalities to perform its duties under §§ 250—310 of this chapter within that municipality; with the approval of the department, the municipality may subcontract with another organization in the community to perform administrative duties;

(3) [deleted]

(4) contract with day care facilities outside of municipalities; to provide more effective administration of programs in the unorganized borough, the department may contract with another organization in the community or with an organization serving the region in which the community is located to perform administrative duties. (§ 2 ch 66 SLA 1975; am § 1 ch 272 SLA 1976)

Effect of amendment. — The 1976 amendment deleted "with day care facilities" following "contract" in paragraph (3) of subsection (a), and in subsection (b), substituted "municipalities" for "local agencies" in paragraph (2), added the language beginning "within that municipality" to the end of paragraph (2), deleted paragraph (3), which read "solicit recommendations from local governing bodies regarding local agencies which may provide contractual services under this section," and added paragraph (4).

Legislative committee report. — For report on ch. 66, SLA 1975 (HCS CSSB 120), see 1975 Senate Journal, p. 257, 1975 House Journal, p. 876.

Sec. 44.47.260. Local participation. When a contract is made under § 250(b)(2) of this chapter between the department and a municipality, the municipality shall pay the costs of administering the contractual duties within its jurisdiction. (§ 2 ch 66 SLA 1975; am § 2 ch 272 SLA 1976)

Effect of amendment. — The 1976 amendment substituted "municipality" for "local agency within an incorporated borough or city of the state" and for "incorporated borough or city."

Sec. 44.47.270. Conditions of receipt of benefits. Benefits may be paid for the care of children of a low income family only if a parent or guardian, because of the day care, is freed to work or to attend school. In no event shall benefits be paid for the care of children of a family where one parent or guardian is not working or attending school and is physically and mentally capable of caring for the children. (§ 2 ch 66 SLA 1975)

Sec. 44.47.280. Eligibility of families for benefits. The department shall determine the eligibility of families for day care benefits on the basis of the following factors:

(1) net income of the family including salary, alimony, child support, retirement benefits, social security, and any other source of income;

(2) number of children in the family;

(3) whether there is one parent or guardian solely responsible for the care of the family;

(4) whether the family receives aid to families with dependent children and is eligible for day care service under aid to families with dependent children;

(5) other factors found relevant by the department. (§ 2 ch 66 SLA 1975)

Sec. 44.47.290. Contributions by parent or guardian. The department shall develop a sliding fee scale based on the factors listed in § 280 of this chapter for purposes of determining the amount to be contributed by the parent or guardian for child care. The contribution of the parent or guardian shall be paid to the day care facility. (§ 2 ch 66 SLA 1975)

Sec. 44.47.300. Child care facilities. (a) Parents or guardians shall select the day care facility for the care of their children.

(b) Benefits shall be paid by the department directly to the municipality contracting with the day care facility or, outside of a municipality, to the facility upon receipt of a billing from a municipality or facility. (§ 2 ch 66 SLA 1975; am § 3 ch 272 SLA 1976)

Effect of amendment. — The 1976 amendment rewrote this section.

Sec. 44.47.310. Definitions. In §§ 250—310 of this chapter

(1) "day care facility" means a center or home licensed in accordance with the provisions of AS 47.35.010—47.35.080 or recognized by the federal government for the care of children;

(2) "department" means the Department of Community and Regional Affairs;

(3) "child" means a person who has not reached the age of 7;

(4) "day care" means the care, supervision, and guidance of a child or children unaccompanied by a parent or legal guardian on a regular basis for periods of less than 24 hours a day.

(5) "municipality" includes a home rule, general law and unified municipality, as defined in AS 29. (§ 2 ch 66 SLA 1975; am §§ 6—8 ch 253 SLA 1976; am §§ 4, 5 ch 272 SLA 1976)

Revisor's note (1976). — Paragraph (3) of AS 44.47.310 was amended by both § 7, ch. 253, SLA 1976, and § 4, ch. 272, SLA 1976. Since the two amendments appear to be inconsistent, and ch. 253 is superseded by ch. 272, only the later enactment has been given effect here.

Effect of amendments. — The first 1976 amendment rewrote paragraphs (1) and (3) and added paragraph (4).

The second 1976 amendment substituted "who has not reached the age of 7" for "up to the mandatory school age" in paragraph (3) and added paragraph (5).

Part 3. Administrative Officers.

Chapter
50. Notaries Public (§§ 44.50.010 — 44.50.190)
53. Foreign Commissioners for Acknowledgments (§§ 44.53.010 — 44.53.020)

Cross reference. — As to public administrator, see AS 22.15.310 — AS 22.15.350.

Chapter 50. Notaries Public.

Section
10. Appointment and commission
20. Qualifications
30. Term of office
40. Fees
50. Chapter not a limitation on postmasters
60. Duties
70. Presence and identification required
80. Seal
90. Protest of bill or note
100. Return of papers to lieutenant governor
110. Application of Administrative Procedure Act to revocation of notary commission
120. Bond
130. Filing oath and bond
140. Disposition of bond
150. Copy of bond as evidence
160. Misconduct or neglect
170. State employees as notaries
180. Postmasters as notaries
190. Savings clause

(10) "intoxicated person" means a person whose mental or physical functioning is substantially impaired as a result of the use of alcohol;

(11) "office" means the office of alcoholism within the Department of Health and Social Services;

(12) "treatment" means the broad range of emergency, outpatient, intermediate, and inpatient services and care which may be extended to alcoholics and intoxicated persons, including diagnostic evaluation, medical, psychiatric, psychological, and social service care, vocational rehabilitation and career counseling. (§ 1 ch 207 SLA 1972; am § 4 ch 116 SLA 1978)

Effect of amendment. — The 1978 amendment inserted "or through a grant awarded under AS 47.30.475" in paragraph (3).

Quoted in Peter v. State, Sup. Ct. Op. No. 1112 (File No. 2185), 531 P.2d 1263 (1975).

Chapter 40. Purchase of Services.

Section	Section
10. Purchase of services	50. Services
20. Licensing and supervision	60 — 70. [Repealed]
30. Required accounting procedures	80. Definitions
40. Determination of full cost of services	

Sec. 47.40.010. Purchase of services. (a) When the department purchases services for persons for whom the state has assumed responsibility under the laws of the state, the department shall

(1) adopt regulations establishing the levels of care to be provided;

(2) determine the rates of payment for the full cost of services required;

(3) pay all expenses related directly to the full cost of services at the levels of care required;

(4) make the placement of persons in accordance with the levels of care provided for in the regulations.

(b) Services of jails and other penal institutions may not be included in services purchased by the state in this chapter. (§ 1 ch 136 SLA 1970)

Sec. 47.40.020. Licensing and supervision. Anyone providing services which are purchased by the department under this chapter shall, if required by the department, be licensed and supervised in the same manner as boarding homes, foster homes and other institutions as provided for in AS 47.35.010 — 47.35.080. (§ 1 ch 136 SLA 1970)

Sec. 47.40.030. Required accounting procedures. Anyone who solicits or receives funds from the department for the cost of services provided under this chapter shall

(1) meet accepted standards of fiscal accountability for public funds and shall, upon request, submit a complete financial statement by an independent, certified public accountant to the department and to the division of legislative audit;

(2) upon request before the meetings provided for in AS 47.05.010 (14), demonstrate the actual cost of services offered using cost accounting procedures as provided for by the department;

(3) upon request furnish the division of legislative audit all fiscal information, books, records, and accounts pertaining to services paid for under this chapter. (§ 1 ch 136 SLA 1970)

Sec. 47.40.040. Determination of full cost of services. (a) In this chapter, "full cost" of services shall be determined by the per person, per day cost in the preceding fiscal year plus a proportionate share of anticipated cost of living and staff salary increment increases for the fiscal year for which the full cost of services, determined to be necessary by the department, is being determined. Child care costs for foster homes shall be computed in the same manner as for child care and nursing home institutions except that no salary costs may be considered.

(b) Full cost of services does not include the following:

(1) expenses, including salaries and fees, incurred in raising funds;

(2) funds expended for construction, major equipment and other capital expenditures;

(3) depreciation and replacement costs of, and costs of additions to, major property and equipment;

(4) religious training and education; and

(5) services provided which are substandard to, or exceed, the requirements of the department. (§ 1 ch 136 SLA 1970)

Sec. 47.40.050. Services. When determining the levels of service to be required the department shall consider program services as outlined within the Catalogue of Functional or Program Service Categories published by the United Funds and Councils of America, September 1967. (§ 1 ch 136 SLA 1970)

Sec. 47.40.060. Temporary placement.
Repealed by § 1 ch 210 SLA 1970.

Editor's note. — The repealed section derived from § 1, ch. 136, SLA 1970.

Sec. 47.40.070. Permanent placement.
Repealed by § 1 ch 210 SLA 1970.

Editor's note. — The repealed section derived from § 1, ch. 136, SLA 1970.

Sec. 47.40.080. Definitions. In this chapter

(1) "anyone" means any person, city, organized borough and private or voluntary institution or agency;

(2) "services" means family, child welfare and nonprofit nursing home services but does not include health, hospital, profit-making nursing homes or medical services;

(3) "department" means the Department of Health and Social Services. (§ 1 ch 136 SLA 1970; am § 2 ch 210 SLA 1970; am § 55 ch 71 SLA 1972)

Legislative history report. — For report on ch. 71, SLA 1972 (HCSSB 385 am H), see 1972 House Journal, p. 595.

Chapter 45. Alaska Longevity Bonus.

Section
10. Persons who may qualify for longevity bonus
20. Continuous eligibility procedures
30. Absence from the state
40. Disqualification
50. Department hearing
60. Legal remedy
70. Unqualified persons
80. Accrual of bonuses
90. Alaska longevity bonus fund
100. Powers and duties of the administrator
110. Custody of funds
120. Exemption from taxation and process
130. Death or cessation of residency
140. Penalty for false statements
150. Definitions
160. Applicability of Administrative Procedure Act
170. Purpose

Editor's note. — Section 2, ch. 205, SLA 1972, provides: "AS 01.10.030 does not apply to this Act. If any provision of this Act, or the application of a provision of this Act to any person or circumstance is held invalid, this entire Act shall be considered invalid."

Legislative history report. — For report on ch. 205, SLA 1972 (FCCS HCS CSSB 211), see 1972 House Journal, p. 751.

Sec. 47.45.010. Persons who may qualify for longevity bonus. (a) A person who is 65 years of age or over, who was domiciled in the territory on or before January 3, 1959 and who has maintained a continuous domicile in the territory or state for 25 years may apply to the commissioner of administration for qualification to receive a monthly bonus of $150.

(b) When the commissioner of administration determines that an applicant qualifies under this chapter he shall immediately begin payment of the bonus.

(c) A person who otherwise qualifies to receive a bonus provided for in this chapter may continue to do so only as long as he continuously retains a domicile in the state. (§ 1 ch 205 SLA 1972; am § 1 ch 33 SLA 1976; am § 1 ch 89 SLA 1978)

Effect of amendments. — The 1976 amendment increased the monthly bonus in subsection (a) from $100.00 to $125.00.

The 1978 amendment increased the monthly bonus in subsection (a) from $125.00 to $150.00.

Legislative history report. — For report on ch. 33, SLA 1976 (SB 476 am), see 1976 Senate Journal, p. 166.

HOUSE RESEARCH AGENCY
Pouch Y - State Capitol
Juneau, Alaska 99811
465-3901

MEMORANDUM March 5, 1980

TO: Representative Jim Duncan

FROM: Susan Brody and Jack Fargnoli SB

RE: Supplemental Appropriation for the State Day Care Assistance Program (Research Request No. 50)

The following purposes could be the basis for a supplemental appropriation to the FY 80 day care assistance program budget:

(1) to allow additional eligible families to receive day care subsidies between now and the end of the fiscal year;

(2) to provide emergency financial assistance to day care centers which are in danger of closing or severely reducing their program services.

A possible amount for each of these supplemental appropriation purposes is identified below with a brief discussion of the factors used to derive the budget estimates. The total amount would be about $525,000. We have also indicated possible ways to administer the funds.

Subsidies for Families

Lianne Wesley, the State day care program administrator, contacted municipalities participating in the day care assistance program to determine whether they are experiencing any shortfalls in funding which prevent them from offering day care subsidies to all the eligible families within their jurisdiction. Three municipalities--Fairbanks, Anchorage and Juneau--indicated that additional funding for the remainder of the fiscal year would allow them to serve an increased number of eligible families. The total amount which would be required for these municipalities is $227,000, as indicated below:

Fairbanks has a waiting list of 75 families. Dottie Englund, the municipal program administrator, believes that a number of other families qualify for assistance as well, but have not entered their names on the waiting list. She estimates that $142,000 would be adequate to provide

subsidies for the remainder of the fiscal year in Fairbanks. The Municipality of Anchorage has just begun to compile a waiting list for day care subsidies, and the program administrator estimates that they could use approximately $75,000 between now and the end of the fiscal year. The only other community indicating a need for additional funding was Juneau, where they anticipate a need for an additional $10,000. The remaining eleven communities participating in the State day care assistance program appear to have adequate entitlements to last them through the fiscal year.

Emergency Financial Aid for Day Care Centers

To date, we have interviewed the directors of 25 day care centers throughout the state to determine the factors affecting their financial stability. This represents 35 percent of the total number of day care centers participating in the Community and Regional Affairs day care assistance program. Thirteen of the centers we interviewed (52 percent) are sustaining operating deficits which range from $200 to $6,000 a month. These deficits average about $2,200 a month (the median is $2,300). In addition, two of these centers are apparently in danger of closing--one in Ketchikan, and one in Anchorage. A third center, the Children's Community Center in Juneau, was also on the verge of closing until it received an emergency grant from the City and Borough of Juneau. Our data indicate, then, that there may be a need for emergency aid to those centers experiencing financial difficulties until more permanent solutions can be instituted. Our upcoming memorandum on March 7 will identify a number of alternatives for possible legislative action to address these long-term needs.

To estimate the possible amount needed for emergency financial aid, we assumed that the centers we interviewed and their deficit levels were representative of all 70 State-funded day care centers currently operating. If this assumption is correct, it is possible that as many as 40 centers statewide may be sustaining operating deficits of about $2,200 a month, while some 6 centers may be in danger of closing within the near future. If the State were to subsidize this level of monthly operating deficit for 40 centers over the next 3 months, the total cost would range from $250,000 to $300,000, with the actual amount probably closer to the higher figure.

As it is not likely that all day care centers experiencing a deficit would be in danger of closing or seriously reducing their childcare services, an emergency appropriation based on these estimates would probably overcompensate for the likely real degree of emergency need. One way of dealing with this would be make any appropriation subject to

allocation criteria which give first priority to those centers facing imminent closure, and second priority to centers whose operating deficits are likely to require a significant reduction in their child care services (for example, reduction in the number of children served because of inability to meet State required staff-to-child ratios), with unused monies returned to the General Fund.

The emergency financial aid could be administered either through the State Department of Community and Regional Affairs office or through the municipal day care program administrators. In any event, it may be difficult to get an emergency aid program underway in a short period of time. The State and/or municipalities will need to examine the financial records of the applicants and make a determination as the severity of their financial difficulties. If the administration occurs at the State level, time will be needed for the State to finalize allocation criteria. If administered at the local level, the municipality will need to determine the amount required and request these funds from the State.

Some possible criteria for the State or municipalities to use in allocating funds to centers are listed below.

1. The amount of the center's deficit. Documentation should probably be required.

2. The effect of the deficit on the center's operations (e.g., whether it will require the center to close or significantly reduce the number of children it serves).

3. Evidence of a major cutback in CETA-funded staff positions (this potential problem will be discussed in our next memorandum).

4. Inability to meet major loan repayments.

5. The number of State-subsidized children receiving care through the center.

There are probably additional criteria which could be used and we offer these only as suggestions that should be refined futher.

While an emergency appropriation appears to pose no legal problems with regard to non-profit day care centers, there may be a legal question involved in extending the appropriation to include profit-making centers. Specifically, the Alaska Constitution provision that no appropriation of public money shall be made except for public purpose (Article IX, Section 6) probably will have to be satisfied prior to acting on any appropriation which includes profit-making centers.

Satisfying the public purpose requirement probably will not be difficult, but will require some advance preparation prior to legislative action on any appropriation. Essentially, this preparation will include compilation of a fact sheet which both specifies the particulars of the appropriation contemplated, and identifies specifically how the public purpose will be served by the appropriation (public purpose principles are spelled out in statutorary annotations, attached). This fact sheet should then be given to the Legal Services Division of Legislative Affairs if an appropriation bill is drafted, so drafters may ensure that public purpose doctrine requirements are addressed in the proposed legislation.

SB:JF/dp

Pouch - Y, State Capitol
Juneau, Alaska 99811
465-3991

MEMORANDUM February 11, 1981

TO: Representative Jim Duncan

FROM: Susan Brody, Issues Analyst SB

RE: State Day Care Assistance Program
Research Request #50

This memorandum presents our research to date on the State day care assistance program. As per our agreement with Dale Staley, we are providing these preliminary findings now so that you will have time to consider possible legislation by the personal bill deadline. We will be completing a more thorough analysis by the beginning of March to supplement the information contained here.

The information we have obtained is presented in three sections. The first section contains a brief description of the principal features of the existing day care program. The second section discusses some of the major issues and problems, especially regarding the State subsidy rates. The third section suggests alternatives for State legislative action.

Our research has been conducted within a short time frame and we have not been able to collect all of the necessary data yet. However, we were able to contact several day care providers in both Juneau and Anchorage and the administrators of municipal day care assistance programs in Ketchikan, Juneau, Anchorage and Fairbanks, and we therefore believe our preliminary research findings reflect conditions in many parts of the State.

PROGRAM DESCRIPTION

Purpose

The State day care assistance program was established in 1975 to provide day care services to low income parents who are either working or attending school. The program attempts to help defer costs of day care when these may be a factor which prevents parents or guardians from becoming self-supporting. State statute (AS 44.47.270) specifically states that "in no event shall benefits be paid for the care of children of a family where one parent or guardian is not working or attending school and is physically and mentally capable of caring for the children."

Administration

The day care assistance program is administrered by the Local Government Assistance Division of the Department of Community and Regional Affairs. The State contracts with municipalities who administer the program at the local level. In some cases, municipalities subcontract their administrative functions to private nonprofit organizations or to individuals. For example, in Nome, the program is administered by the United Methodist Church.

Subsidy grants are awarded to communities who then allocate the money to day care providers. The grant funds can only be awarded to day care facilities that are licensed by the State Department of Health and Social Services. All local costs of program administration, including office space, equipment and staff time, must be borne by the local communities and are not reimbursable.

The day care assistance program is operated under the statutory provisions of AS 44.47.250-310 and a set of "operating policies." No administrative regulations have been adopted, but the new director of the program, Lianne Wesley, is drafting regulations that will incorporate many of the current operating policies. She hopes to have the regulations ready for public hearings in May.

Licensing

Two kinds of day care facilities are licensed by the Division of Social Services, Department of Health and Social Services--homes and centers. Day care homes are neighborhood family dwellings that serve no more than six children between the ages of 3 and 14, or no more than five children when the age range includes infants. Day care centers serve groups of seven or more children.

In licensing day care facilities, the Division of Social Services requires that a number of specific standards be met, including staff-to-child ratios, insurance coverage, and fire protection (7 AAC 50.120-255). The licensing procedure includes an inspection of the home or center and all licenses must be renewed annually. The following staff-to-child ratios are currently required in day care centers.

- 1 caregiver for every five infants (six weeks to two years)
- 1 caregiver for every ten children between the ages of two to six
- 1 caregiver for every 15 children aged six to ten years
- 1 caregiver for every 20 children aged ten to 14 years

Allocation of Funds

Program funds are allocated to municipalities based on the number of licensed day care spaces within the community as a percentage of the

total number of day care spaces statewide. For example, in FY 80 Anchorage had 2,690 licensed spaces or 54 percent of the 4,956 spaces in the State. The total FY 80 budget for subsidy grants was $1,758,500. Therefore, Anchorage was entitled to 54 percent of this statewide budget or $951,300.

Table A shows the 1980 allocation to communities. Actual community use of the entitlement is monitored during the fiscal year and funds may be reassigned in mid-year if there is more demand for subsidies in one community and less than expected in another. It is important to note that, in the past, no attention was paid in the allocation process to the number of low income families in the community, past use of subsidy grants, or other indicators of need.

Families qualify for subsidy grants based on their net income. For the purposes of the program, net income is determined by first taking the family's gross yearly income and subtracting taxes, retirement and social security payments. A family is then allowed to further deduct $1,200 for each child under the age of 18, not including the first child, to arrive at the "adjusted annual net family income". For example, a family with two working parents and three children might calculate their adjusted net income as follows:

Yearly Salary and Benefits	$19,000
(minus) Taxes, FICA, etc.	4,000
	$15,000
(minus) Family Size Adjustment	2,400
ADJUSTED ANNUAL NET INCOME	$12,600

The amount of State assistance is determined on a sliding fee scale. Table B shows the percentage of total day care costs covered by the State program as a function of net income and area of residence in the State. If our example family lives in Fairbanks, their net income would fall within Income Group III and the State would pay 60-80 percent of their day care costs. The actual percentage that the State will pay within this range is determined by the local program administrator based on any special family circumstances. For example if this family had incurred significant medical expenses over the last year, the State might pay close to the maximum 80 percent allowed for the income group. At the end of each month, a day care center operator bills the program contractor (i.e., the State) for their percentage of the costs and bills the parents for their percentage.

The maximum net income that qualifies a family for a State subsidy ranges from $16,000 in Juneau, Anchorage and Ketchikan to $21,411 in Healy, Tanana and Anderson (see Table B). Once a family has been de-

termined eligible for a subsidy grant, day care payments are made to providers for authorized hours and on an attendance basis only. Thus, the State does not pay the daily rate if the child is absent. Attendance is calculated on the basis of five hour blocks of time. Part time care is defined as care for up to five hours in a 24- hour period: full time care is for 5-10 hours in a 24 hour period; and for any period exceeding 10 hours, payment is calculated per hour. The maximum rates that the State can pay to a day care center are listed below.

Type of care	Part time	Full time	Full Time +
Infant (up to two years)	$9.00	$15.00	$19.00
Child (two years and over)	7.00	12.00	19.00

The last increase in the daily payments occurred in FY 77 when payments were raised to the current $12 and $15 rate. The base net income level that qualifies a family for a subsidy was raised by $1,000 in FY 1979, a 5 percent increase.

Federal Funding

The State day care assistance program is funded soley by the State. Federal funds are available through the Title 20 program, but the State has chosen not to utilize this funding because of the restrictive regulations and "red tape." Some individual day care centers do take advantage of the federal supplemental food program. The amount of food available to a center is calculated based on the type of meal (hot or cold) and the income of each participating child's family.

Loan Programs

One State loan program is available to day care facilities to assist with construction, renovation and equipment costs. Loans of up to $30,000 are offered through the Department of Commerce and Economic Development. Loan interest rates are seven percent with a 5-10 year pay back period, depending on the purpose of the loan. A total of ten loans were awarded between FY 77 and FY 80--seven went to facilities in the Anchorage area, one in the Mat-Su Borough, one in Ketchikan, and one in the Bethel area.

ISSUES AND CONCERNS

This discussion of issues and concerns is based on our conversations with day care administrators and providers in several areas of the State. Our primary sources of information on day care operating costs were Sister Elaine of St. Ann's Day Care and Nursery and Pat Marlin of Wee Cottage, both in Juneau. We also conducted a series of telephone interviews with municipal day care administrators in Ketchikan, Juneau,

Anchorage and Fairbanks to obtain a general overview of the issues and problems faced by day care providers in those four cities.

Operating Costs

Rising operating costs are a major problem for many day care facilities; a number of day care providers have indicated that the State's day care assistance rate is insufficient to cover these operating costs. Rita Jacobs, acting program manager of the Municipality of Anchorage day care program, believes that several centers are running deficits in Anchorage. One of the major day care providers in Anchorage, Lee Robertson, indicated that two of her centers (Infant Inn and Gingerbread House) have monthly deficits of $1,500-3,000. In Juneau, four of the seven centers--Children's Community Center, St. Ann's Day Care, St. Ann's Nursery, and Wee Cottage--are running monthly deficits of between $2,000 and $5,000. The Salvation Army day care center in Ketchikan also has a deficit of about $2,000. In Fairbanks apparently no centers are currently running operating deficits. However, according to the Fairbanks day care administrator, several of the centers do not pay rent or utilities which, of course, decreases their total operating costs.

The operating costs of day care centers consist of salaries, food, rent, utilities, maintenance, insurance, and supplies. We have requested operating cost data from three day care centers in Juneau, and one in Anchorage to determine how much costs have risen from 1977 to 1980. As noted earlier, 1977 was the last year the State increased its daily subsidy rate for the day care assistance program. To date, we have only received data from two of the Juneau centers--St. Ann's Nursery and St. Ann's Day care. At St. Ann's Nursery, total operating costs increased by about 60 percent from 1977 to 1979, while income was up by only 12 percent. Salaries increased by 50 percent, and rent was up 78 percent. At St. Ann's Day care, total operating costs increased by about 24 percent, while income increased by 7 percent. Salaries were up 18 percent, rent was up 13 percent, and food was up 40 percent. If the increases in operating costs experienced by St. Ann's are indicative of increases at other day care centers, then day care providers will need to consider rate increases or other alternatives to alleviate growing deficits. Although we have not obtained data from other centers as yet, our initial interviews suggest that operating costs have also increased substantially for centers in Ketchikan, Fairbanks and Anchorage.

Reimbursement by Attendance vs. Enrollment

One of the major concerns of the day care providers is the method used by the State to reimburse them for services provided to children in the

day care assistance program. The State reimburses centers only for the days that a child actually attends the day care center. Yet, the day care providers argue that their expenditures for rent, utilities, insurance, and so forth are fixed costs that must be paid regardless of whether the children attend. Staffing a day care center is also problematic under these conditions. Several day care providers indicated that it is extremely difficult to send staff home for the day if not all of the children who are enrolled actually attend. In effect, the center must hire and pay staff based on their enrollment and anticipated attendance to ensure that they meet the required staff-child ratios. Under the present system, many staff costs must be wholly absorbed by the day care center operators.

The Anchorage municipal day care program administrator voiced some concern about reimbursing costs strictly on an enrollment basis. She indicated that the available State money can be used to serve more children when centers are payed only for those days that a child attends. For example, if a child is enrolled in a center, but then attends only 10 days during the month, the State, through the municipality, would still be reimbursing the center for the entire monthly cost. The Juneau day care administrator, Pat Audap, suggested that if the State switches to an enrollment system, it might be possible to reimburse day care centers only if the child attends at least 75 percent of the time during the month. In conjunction with this, the day care center would be responsible for contacting parents to determine why children are not attending on a regular basis and then change their enrollment status if necessary.

Income Subsidy Limitation

The current operating policies of the Department of Community and Regional Affairs specify that the rate that a center charges for children receiving State assistance must correspond to the rate charged to those families who do not receive a subsidy.

We asked day administrators and providers whether they felt an increase in the daily rate for subsidized children would affect those families who are not currently receiving day care assistance. There was considerable agreement that increasing the daily rates could place a major burden on the non-subsidized family.

The possible impact of a daily rate increase is demonstrated in the following example. If the daily rates established in 1977 were increased by 15 percent in 1980, this would represent about a 5 percent annual increase, probably a bit less than day care center operating costs have actually increased. Full time rates would increase from $12 per day to $13.80 per day for children over two years old and would increase from $15 to $17.25 per day for infants (children under two years). Consider a family with two children--one infant and one preschool child, aged four. Under the current day care rates, this family would pay about $315 dollars per month in day care costs for the infant

and $350 for the four year old, for a total monthly cost of $545. If rates increase by 15 percent, the family would pay about $360 for the infant and $290 for the pre-school child, for a total of $650.

Many families receiving State assistance would also face increased monthly payments because the State is often only reimbursing a portion of the costs. Consider a family identical to the one described above who is paying 30 percent of its day care costs while the State pays the other 70 percent. Under the current rates, the family is paying about $170 for day care services. With a 15 percent rate increase, the family would pay about $195, or an increase of about $25 dollars per month.

Some of the increased financial burden on the non-subsidized family resulting from rate increases might be alleviated to some extent by increasing the number of families who are eligible for day care assistance. In FY 79, the income limit for a State subsidy was increased by $1,000. Several of the day care administrators and providers that we interviewed indicated that another increase in the eligible family net income level would be desirable to relieve some of the additional burden on non-subsidized families if the daily rate per child were increased. We plan to interview several non-subsidized families in Juneau to determine what problems they face in financing day care costs.

ALTERNATIVES FOR STATE ACTION

Our preliminary research suggests that any legislative action on the day care issue should attempt to relieve the operating deficits of day care centers while, at the same time, minimizing any increases in day care costs for families. The following alternatives are presented with these objectives in mind. None of these alternatives would necessarily require that changes be made in existing State statutes. It is important to note that most of the alternatives presented here would require an increase in the FY 81 program budget. To implement the alternatives without a budget increase would result in fewer families being served by the program.

Increase the Daily Subsidy Rate

Because our data on day care center operating costs is incomplete, it is difficult to recommend an exact percentage increase in the subsidy rate. Our preliminary research suggests that a 15 to 30 percent increase over the 1977 rate may be appropriate to cover the increases in operating costs that many day care centers have experienced. This would be equivalent to a 5 to 10 percent annual increase for the years 1977 to 1981.

The FY 81 budget request for the day care assistance program is $1,850,000. The budget assumes that the day care subsidy will remain at its current rate. A 15 percent increase in the rate would require that an additional $278,000 be added to the FY 81 budget, for a total of about $2,128,000. If day care centers require immediate assistance prior to the beginning of the new fiscal year, then a supplemental appropriation to this year's budget might also be desirable.

To ensure that the State day care assistance rates continue to reflect increases in day care center operating costs, it may be advantageous to include a provision in State statute requiring annual review and adjustment of the rate.

Reimburse Program Costs on the Basis of Enrollment

Several day care providers indicated that they would prefer to avoid any dramatic increases in the rate for day care assistance. They suggested that by basing State payments on enrollment rather than attendance, their financial situation would be significantly improved, thus requiring less of an increase in the daily rate per child.

The current method of reimbursement on the basis of attendance is not a statutory requirement. It is established in the Department of Community and Regional Affairs "operating policies" for the day care assistance program. The Department is currently in the process of drafting regulations that will become part of the Alaska Administrative Code and, according to the day care assistance program director, these regulations will probably continue to require reimbursement on the basis of attendance.

A change to reimbursement based on enrollment could be accomplished in several ways: It could be required by statute; it might be stipulated as a footnote to the budget appropriation; or it might be changed by the Department, if sufficient opposition to the existing method is voiced at the public hearings on the proposed regulations.

Increase the Income Eligibility Level

As discussed earlier, any increase in the rate per child will increase the financial burden on the non-subsidized parent. A possible countermeasure would be to increase the number of families that qualify for day care assistance. Without further research, we hesitate to suggest a new subsidy income level. An increase in the income limit by the same percentage as the increase in the rate per child (i.e., 5-10 percent per year) might be considered. However, the actual increased burden of the new rate on the non-subsidized family depends on the extent to which the family income has kept pace with inflation. The true measure of financial hardship would be the extent to which day care costs have increased as a percentage of total household income, if any. We will continue to do research in this area to determine what changes in the income limit should be considered.

Other Options

In the course of our research, we have identified a number of other options that may be worth exploring. Please let us know which, if any, of the following alternatives you would like us to investigate.

1. State day care payments directly to families rather than to Centers.

2. State reimbursement of certain day care center operating costs, such as rent or insurance.

3. State grants to day care centers for major capital improvements, equipment acquisition, etc.

4. An in depth study of family day care needs, day care center capital and operating costs, and municipal day care administration.

This last item was identified as a priority by Lianne Wesley, the director of the State day care assistance program. She indicated that comprehensive background data would be extremely helpful to them in determining what kinds of changes should be made in the day care program. This might be an appropriate research project for the House Research Agency after adjournment of the current legislative session, subject to the approval of the governing committee.

League of Women Voters

of Juneau, Alaska

May 1, 1980

Honorable Thelma Buchholdt
Pouch Y
State Capitol Building
Juneau, AK 99811

Dear Representative Buchholdt:

The League of Women Voters of Juneau supports HB-1019. The League has a state position on Day Care which says:

> The League of Women Voters of Alaska supports day care for everyone who needs or wants it with priority given to those children whose need is greatest. The members of the League believe users should be primarily responsible for day care financing. Supplemental financial and regulatory responsibilities should be shared by all levels of government to insure that day care is of high quality and available to those who need it.

We urge you to support this bill and pass it out of committee as soon as possible so that it may be acted on this session.

Thank you for your continued support of Day Care.

Sincerely,

Chottie Angst

Chottie Angst
President

POSITION PAPER/Department of Health & Social Services

POSITION PAPER

HOUSE BILL NO. 1019

"An Act relating to day care for children; and providing for an effective date."

This bill would establish criteria for determining the rates paid to a day care facility for reimbursment for the cost of care for eligible children under the Alaska Day Care Assistance Program administered by the Department of Community and Regional Affairs. It would also require that facilities be reimbursed on the basis of enrollment for each child under the program rather than a actual attendance, the current form of state reimbusment.

While the Department of Community and Regional Affairs has major responsibility for purchase of day care services in the state, the Department of Health and Social Services maintains responsibility for purchase of day care in child protective cases and for WIN clients where the Day Care Assistance Program does not meet their needs. The protective services and WIN day care programs are not named in this bill, however, the Department of Health and Social Services has adhered to a policy of administering its day care programs in a manner compatible with the Day Care Assistance Program and plans to continue that policy to the extent feasible. This bill therefore has an impact on Department programs. Comments and suggestions on specific sections follow:

Sec. 44.47.305(a) The Department suggests that the term "cost" be modified to "reasonable or allowable cost" to further establish intent.

Sec. 44.47.305(b) No objections.

Sec. 44.47.300(b) The department is interpreting this change to mean that a child may be enrolled for day care for a specified number of days, including one or more days. The state would make payment based on the child's enrollment, rather than on the child's attendance. The Department has no objection to the amendment if the above interpretation is in keeping with the intent of the amendment.

The Department recognizes that good day care programming from a child development point of view would specify enrollment on a long term basis, generally not less than one month. There are considerations however, for authorizing day care services for periods of time substantially less than a full month. WIN clients need short term day care for their children during job interviews, vocational counseling, testing sessions, or employment related medical sessions. Occasionally only one day of day care is needed. Families may need protective services day care support for only one week of respite from the strusses of parenting during a family crisis. Most day care center enrollment policies and some day care home policies allow enrollment on a drop-in basis and also for periods of less than a full month. The Department assumes that these enrollment options will remain available for WIN and protective services eligible children. It is appropriate to pay for the number of days authorized, recognizing that the day care facility must hold space open for the child.

POSITION PAPER/Department of Health & Social Services

The Department has some question on how this bill will impact families using day care services who are not eligible for a state subsidized program, especially middle income families. The exact nature of the impact could not be determined. Some committee discussion may be warranted.

The Department supports the concepts in this bill and suggests that clarifications be made, based on the Department comments.

RECOMMENDED BY: John R. Pugh DATE: 5/7/80
John R. Pugh, Director
Division of Social Services

APPROVED BY: Helen D. Beirne DATE: 5/7/80
Helen D. Beirne, Commissioner
Department of Health and Social Services

THE LEGISLATURE OF THE STATE OF ALASKA
ELEVENTH LEGISLATURE

FISCAL NOTE

I. REQUEST
Bill/Resolution No. HOUSE BILL NO. 1019
Title "An Act relating to day care for children; and providing for an effective date."
Requested by _____ Date May 7, 1980

II. FISCAL DETAIL
Agency Affected Department of Health and Social Sevices
Program Category Affected Social Services
BRU, Program, or Subprogram(s) Affected Social Services
(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 80	FY 81	FY 82	FY 83	FY 84	FY 85
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL						
400 COMMODITIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC.		58.4	63.6	69.3	75.5	82.3
TOTAL						

FUNDING (Thousands of Dollars)

GENERAL FUND		58.4	63.6	69.3	75.5	82.3
FEDERAL FUNDS						
OTHER (Specify Fund Source)						

POSITIONS

FULL TIME						
PART TIME						
TEMPORARY						

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

It is assumed that the Department will retain the option of authorizing day care services for periods of time less than a full month. The Division plans to issue guidelines to social workers regarding authorization of realistic numbers of days in relation to anticipated child attendance. The fiscal note reflects the anticipated cost difference between days authorized and days of actual attendance. The Division's Fiscal Year 81 budget request of 233.7 was based on actual days of attendance. House Bill No. 1019 would result in an anticipated increase in this budget request of 58.4 for a total Fiscal Year 81 request of 292.1.

A 9% increase was used to indicate inflation in future years.

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)

Prepared by: [signature] Date: 5/7/80
Division/Office: Social Services Ph: 465-3170
Department of Health & Social Services

Approval DHSS Mgt. & Bdgt: _____ Date: _____

33 001 (Rev. 12/79)
Modify by DHSS (11-28-79)

STATE OF ALASKA

JAY S. HAMMOND, Governor

DEPT. OF COMMUNITY & REGIONAL AFFAIRS

OFFICE OF THE COMMISSIONER

POUCH B
JUNEAU, ALASKA 99811

May 6, 1980

The Honorable Thelma Buchholdt
Alaska House of Representatives
Pouch V
Juneau, Alaska 99811

Dear Representative Buchholdt:

RE: HOUSE BILL 1019 - AN ACT RELATING TO DAY CARE FOR CHILDREN

The following comments on HB 1019 were prepared by Lianne Wesley, the Day Care Assistance Coordinator.

Effects

This bill would more fully define the legal basis of the day care assistance program by directing the Department to: 1) annually review and revise, if necessary, the sliding fee scale of parent's contribution to the cost of licensed day care for their children; 2) pay a facility based on enrollment, rather than on an attendance basis; 3) reimburse a facility for the cost of providing the day care service; and 4) annually determine the cost of providing day care in each facility where the service is provided.

Comments

The focus of the Day Care Assistance Program to date has been the needs of families, not day care facility operators. This bill (and HCR 66) significantly alters that focus, and changes the way this Department has traditionally handled this program. Instead of the Department functioning in a contractual relationship with local governing bodies as intermediaries the Department will deal more directly with the service agencies.

A major implication of the bill revolves around the setting of rates for day care services. Raising daily rates or mandating an enrollment rate increases the cost to both the general public and to state-subsidized families. Raising day care rates could price some people out of the market and in the end detrimentally affect the day care operators, this

legislation is designed to help. Facility operators may face declining enrollment and income if the State raises rates beyond what the general public will bear. Unless the appropriation for the Day Care Assistance Program is dramatically increased, raising the payment maximum to the day care facilities will decrease both the number of low income families receiving program subsidy and the level of subsidy available to each family.

Day care services reimbursed on an enrollment basis will require more local administrative staff time to assure the same level of fiscal accountability presently provided. AS 44.47.260 requires the cost of this local administration to be paid by the contracting municipality. Under the present system, local staff only take the facility's attendance figures multiplied by the daily rate and check the calculations to determine the accuracy of the facility's billing. On an enrollment basis, local administrators will presumably check attendance figures to see if the monthly enrollment rate is justified before calculating the accuracy of the billings. If enrollment fees are paid in advance, the current month's attendance must be compared with the previous month's billing before calculations can be checked and payment authorized.

Sincerely,

Lee

Lee McAnerney
Commissioner

FISCAL NOTE

I. REQUEST

Bill/Resolution No. House Bill 1019

Title An Act Relating to Day Care for children

Requested by House H&SS Committee Date 5-6-80

II. FISCAL DETAIL

Agency Affected Department of Community & Regional Affairs

Program Category Affected Social Service

BRU, Program, or Subprogram(s) Affected Child Care

(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 80	FY 81	FY 82	FY 83	FY 84	FY 85
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL		45.0				
400 COMMODITIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC.		2178.8	2253.1	2541.3	2744.6	2964.2
TOTAL		2223.8	2253.1	2541.3	2744.6	2964.2

FUNDING (Thousands of Dollars)

GENERAL FUND		2223.8	2253.1	2541.3	2744.6	2964.2
FEDERAL FUNDS						
OTHER (Specify Fund Source)						

POSITIONS

FULL TIME		0	0	0	0	0
PART TIME						
TEMPORARY						

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

The 45.0 on line 300 (contractual) would provide for a contracted study of the current costs of providing daycare. It is anticipated that the contract would also require the establishment of procedures for annual update. The annual update could then be accomplished by existing office personal.

The 2178.8 on line 700 is a combination of estimates.

978.8	Amount estimated by Community & Regional Affairs to fund existing need at existing price levels
1200.0	Amount estimated by Legislative Affairs to fund 100% of costs of operation of Daycare Centers
2178.8	Total Estimated Cost

IV. DATE 5/6/80 PREPARED BY Lianne Wesley

AGENCY Community & Regional Affairs

PHONE (907) 276-1721

Original: Legislative Finance

cc: Budget and Management

Prime Sponsor (First Legislator Named)

33-001 (Rev. 12/79)

FISCAL NOTE - Continued HB 1019

It should be pointed out that the above figures are only estimates based on very limited data.

The claims costs have been increased 8% per year for inflation.

DATE: 04/28/80

DIVISION OF SOCIAL SERVICES

R03-06S-7100

QUICK INDEX TO SELECTED FACILITIES

CITY: BETHEL TYPE: DAY CARE CENTER

NAME: BETHEL DAY CARE CENTER CONTACT BETHEL SOCIAL SERVICE # 001512
ADDRESS: PO BOX 271 PHONE: 543-2447 CAPACITY: 041
BETHEL AK 99559 LOCALE: 1030 FRONT ST AGE 03Y-10
LICENSE: 12/0178 - 12/01/79 ORGANIZATION: PRIVATE FOR PROFIT

NAME: KAMEROFF INFANT CENTER CONTACT VICKI MALONE # 241002
ADDRESS: BOX 271 PHONE: 543-3457 CAPACITY: 029
BETHEL, AK 99559 LOCALE: AIRPORT RD NEXT PM HOME AGE 06W-03
LICENSE: 07/0179 - 06/30/80 ORGANIZATION: PRIVATE FOR PROFIT

PRINTED FOR: QUARTERLY REPORT

DATE: 04/28/80

DIVISION OF SOCIAL SERVICES

R03-06S-7100

QUICK INDEX TO SELECTED FACILITIES

CITY: ANCHORAGE TYPE: DAY CARE CENTER

NAME: ELMENDORF CHILD CARE CE CONTACT K CHRISTENSEN # 242615
ADDRESS: 21ST ABG/SSN BLDG31-146 PHONE: 753-7169 CAPACITY: 206
ANCHORAGE, AK 99506 LOCALE: ELMENDORF AIR FORCE BAS AGE ???-??
LICENSE: 10/1879 - 03/01/81 ORGANIZATION: PUBLIC (GOVERNMENTAL)

NAME: FT RICHARDSON CHILD CAR CONTACT RITA BARAS # 242616
ADDRESS: PO BOX 5-369 PHONE: 862-4259 CAPACITY: 130
ANCHORAGE, AK 99505 LOCALE: FT RICHARDSON ARMY BASE AGE ???-??
LICENSE: 10/1879 - 03/01/81 ORGANIZATION: PUBLIC (GOVERNMENTAL)

NAME: TEAMSTER REC CTR-DAY CR CONTACT DEBRA FALL # C08305
ADDRESS: 5201 E TUDOR RD PHONE: 337-9550 CAPACITY: 010
ANCHORAGE, AK 99504 LOCALE: SAME AGE 02Y-08
LICENSE: 06/0679 - 06/05/80 ORGANIZATION: PRIVATE FOR PROFIT

PRINTED FOR: QUARTERLY REPORT

DATE: 04/28/80

DIVISION OF SOCIAL SERVICES

R03-06S-7100

QUICK INDEX TO SELECTED FACILITIES

CITY: ANCHORAGE TYPE: DAY CARE CENTER DOWNTOWN

NAME: CAMP FIRE DAY CARE/PRES CONTACT HELENE HOWARD # 008335
ADDRESS: 855 E 20TH PHONE: 279-6735 CAPACITY: 040
ANCHORAGE, AK 99501 LOCALE: SAME AGE 27M-07
LICENSE: 10/2379 - 10/22/80 ORGANIZATION: PRIVATE NON PROFIT

NAME: CAROUSEL'S INFANT INN CONTACT LEE ROBERTSON # 242111
ADDRESS: 6370 DEBARR RD PHONE: 274-6343 CAPACITY: 053
ANCHORAGE AK 99504 LOCALE: 845 K ST AGE 06W-02
RESTRICT:
LICENSE: 02/2980 - 02/28/81 ORGANIZATION: PRIVATE NON PROFIT

NAME: HILLCREST DAY CARE CEN CONTACT RUTH MOUNTS # 001428
ADDRESS: 900 HOLLYWOOD DR PHONE: 272-9924 CAPACITY: 069
ANCHORAGE, AK 99501 LOCALE: SAME AGE 03M-08
RESTRICT: C:-
LICENSE: 04/2379 - 04/22/80 ORGANIZATION: PRIVATE NON PROFIT

NAME: MID TOWN CHILD CARE CEN CONTACT MAXINE FORD # 004200
ADDRESS: 1677 JUNEAU DRIVE PHONE: 274-8424 CAPACITY: 098
ANCHORAGE, AK 99501 LOCALE: SAME AGE 01Y-11
LICENSE: 10/3079 - 10/29/80 ORGANIZATION: PRIVATE FOR PROFIT

NAME: NANNY'S PLACE CONTACT SILVERNAIL, MARY JO # 242269
ADDRESS: 1953 KARLUK APT 1 PHONE: 276-3424 CAPACITY: 013
ANCHORAGE, AK 99501 LOCALE: SAME AGE 12M-07
LICENSE: 10/3179 - 10/30/80 ORGANIZATION: PRIVATE FOR PROFIT

NAME: PARK STRIP DAY CARE CONTACT DEA SUTTON # 242098
ADDRESS: 204 W 10TH AVE PHONE: 274-6122 CAPACITY: 110
ANCHORAGE, AK 99501 LOCALE: SAME AGE 01Y-10
RESTRICT: COMPLIANCE W/REGS
LICENSE: 10/0979 - 05/15/80 ORGANIZATION: PRIVATE FOR PROFIT

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NAME: SAAKAAYA CHILD CARE CEN
CONTACT PAULINE HALKET # 008119
ADDRESS: 1057 W FIREWEED
PHONE: 274-4433 CAPACITY: 100
ANCHORAGE, AK 99503
LOCALE: 3300 WYOMING TURNAGAIN AGE 06W-06
LICENSE: 09/0579 - 04/01/81
ORGANIZATION: PRIVATE NON PROFIT

NAME: WEE CARE TOO CH CENTER
CONTACT NANCY RICHISON # 008367
ADDRESS: 1540 "C" STREET
PHONE: 279-1024 CAPACITY: 043
ANCHORAGE AK 99501
LOCALE: SAME AGE 19M-10
RESTRICT: -
LICENSE: 04/2479 - 04/24/80
ORGANIZATION: PRIVATE FOR PROFIT

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CITY: ANCHORAGE TYPE: DAY CARE CENTER L OTIS/TUDOR

NAME: TANAINA CH DEV CENTER CONTACT DIANE REINERT # 242278
ADDRESS: 3221 PROVIDENCE DRIVE PHONE: 263-1340 CAPACITY: 045
ANCHORAGE, AK 99504 LOCALE: U OF A AGE 12M-06
LICENSE: 05/0179 - 04/30/80 ORGANIZATION: PRIVATE NON PROFIT

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CITY: ANCHORAGE TYPE: DAY CARE CENTER LAKE OTIS

NAME: CAREER CTR CHILD CARE P CONTACT BETTY MCCORMIC # 004838
ADDRESS: 2650 E NO LIGHTS BLVD PHONE: 278-9631 CAPACITY: 020
ANCHORAGE, AK 99504 LOCALE: SAME AGE 03Y-05
RESTRICT: P:FINAL HEP PERMIT P:COMPLIANCE WITH REGULATIONS
LICENSE: 03/3180 - 05/30/80 ORGANIZATION: PUBLIC (GOVERNMENTAL)

NAME: COMM EARLY LEARNING CEN CONTACT SINDI SILLS # 242279
ADDRESS: 2300 OAK DR PHONE: 277-0152 CAPACITY: 025
ANCHORAGE, AK 99504 LOCALE: SAME AGE 01Y-05
RESTRICT: TEXT OF PROVISION NOT ENTERED.
SPECIAL: MULTIPLE HANDICAPPED
LICENSE: 12/1979 - 05/21/80 ORGANIZATION: PRIVATE FOR PROFIT

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CITY: ANCHORAGE TYPE: DAY CARE CENTER LOTIS/N LIGHTS

NAME: ANCH MONTESSORI SCHOOL CONTACT BETSY HOWARD # 008341
ADDRESS: 1200 E 27TH PHONE: 276-2240 CAPACITY: 018
ANCHORAGE, AK 99504 LOCALE: 1200 E 27TH AGE 02Y-06
RESTRICT: -
LICENSE: 05/3079 - 05/29/80 ORGANIZATION: PRIVATE FOR PROFIT

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CITY: ANCHORAGE TYPE: DAY CARE CENTER MT VIEW

NAME: ANGELS CHILD CARE CEN CONTACT ANGELITA DAM # 008291
ADDRESS: 3132 RICHMOND APT 1 PHONE: 272-9956 CAPACITY: 026
ANCHORAGE, AK 99504 LOCALE: SAME AGE 02Y-08
RESTRICT: -
LICENSE: 02/0180 - 01/31/81 ORGANIZATION: PRIVATE FOR PROFIT

NAME: KEE'S KIDDIE KARE CONTACT PAULINE KEE # 004193
ADDRESS: 3920 PETERKIN PHONE: 277-8943 CAPACITY: 097
ANCHORAGE, AK 99504 LOCALE: SAME AGE 11M-12
LICENSE: 11/0179 - 03/30/80 ORGANIZATION: PRIVATE FOR PROFIT

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CITY: ANCHORAGE TYPE: DAY CARE CENTER MULDOON

NAME: ANCH CHRISTIAN NURSERY CONTACT DEL BROCK # 242340
ADDRESS: 6401 E NORTHERN LIGHTS PHONE: 333-5516 CAPACITY: 020
ANCHORAGE, AK 99504 LOCALE: SAME AGE 06W-02
RESTRICT: TEXT OF PROVISION NOT ENTERED.
LICENSE: 03/3180 - 04/20/80 ORGANIZATION: PRIVATE NON PROFIT

NAME: ANCH CHRISTIAN PRESCH. CONTACT CAROLYN TOOLEY # 003829
ADDRESS: 6401 E NORTHERN LIGHTS PHONE: 333-5516 CAPACITY: 110
ANCHORAGE, AK 99504 LOCALE: 6505 DEBARR RD AGE 02Y-14
LICENSE: 03/3180 - 03/30/81 ORGANIZATION: PRIVATE FOR PROFIT

NAME: CAROUSEL CHILD CARE CEN CONTACT LEE ROBERTSON # 002125
ADDRESS: 6370 DEBARR RD PHONE: 333-1231 CAPACITY: 112
ANCHORAGE, AK 99504 LOCALE: SAME AGE 03M-10
LICENSE: 12/2579 - 06/30/80 ORGANIZATION: PRIVATE FOR PROFIT

NAME: WEE WILLIE WINKLE I CONTACT IDA SHENEMAN # 003336
ADDRESS: 3500 ROBIN ST PHONE: 333-0918 CAPACITY: 034
ANCHORAGE, AK 99504 LOCALE: SAME AGE 01Y-12
LICENSE: 09/2479 - 09/23/80 ORGANIZATION: PRIVATE FOR PROFIT

NAME: WEE WILLIE WINKLE II CONTACT IDA SHENEMAN # 008004
ADDRESS: 3500 ROBIN ST PHONE: 333-2187 CAPACITY: 078
ANCHORAGE, AK 99504 LOCALE: 7041 DEBARR RD AGE 01Y-12
LICENSE: 12/2479 - 10/30/80 ORGANIZATION: PRIVATE FOR PROFIT

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CITY: ANCHORAGE TYPE: DAY CARE CENTER SAND LAKE

NAME: BAYSHORE NURSERY DAY C CONTACT BILLIE MULLER # 242258
ADDRESS: 3131 AMBER BAY LOOP PHONE: 349-8422 CAPACITY: 040
ANCHORAGE, AK 99502 LOCALE: SAME AGE 02Y-07
LICENSE: 07/3079 - 07/29/80 ORGANIZATION: PRIVATE FOR PROFIT

NAME: LITTLE RED SCHOOLHOUSE CONTACT KATHY KNOTT # 004052
ADDRESS: 3720 RASPBERRY RD PHONE: 243-3101 CAPACITY: 100
ANCHORAGE, AK 99502 LOCALE: SAME AGE 02Y-09
RESTRICT: C:CAPACITY 69/100 CHILDREN -
LICENSE: 12/2479 - 12/23/80 ORGANIZATION: PRIVATE NON PROFIT

NAME: MT MCKINLEY DAY CARE C CONTACT LEE ROBERTSON # 242207
ADDRESS: 2748 RASPBERRY RD. PHONE: 243-2194 CAPACITY: 018
ANCHORAGE, AK 99502 LOCALE: SAME AGE 03Y-08
RESTRICT: TEXT OF PROVISION NOT ENTERED.
LICENSE: 03/0180 - 04/30/80 ORGANIZATION: PRIVATE FOR PROFIT

NAME: TINY TIGERS DAYCARE CTR CONTACT BARBARA CREED # 008339
ADDRESS: 6938 STELLA LANE PHONE: 243-0719 CAPACITY: 037
ANCHORAGE, AK 99507 LOCALE: 3541 DIMOND BLVD AGE 15M-07
LICENSE: 10/3179 - 10/30/80 ORGANIZATION: PRIVATE FOR PROFIT

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CITY: ANCHORAGE TYPE: DAY CARE CENTER SOUTH ANCHORAG

NAME: THE COUNTRY SCHOOL CONTACT KATHLEEN LUCKSINGER # 008192
ADDRESS: SRA BOX 2094 PHONE: 349-1835 CAPACITY: 020
ANCHORAGE, AK 99507 LOCALE: OLD SEWARD & DARE AGE 03Y-10
RESTRICT: C:CONTINGENT ON WAIVER APPROVA -
LICENSE: 02/2579 - 08/05/80 ORGANIZATION: PRIVATE FOR PROFIT

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CITY: ANCHORAGE TYPE: DAY CARE CENTER SPENARD

NAME: ANCH CHILD CARE & ED C CONTACT TOM BARTH & KAREN BARTH # 242230
ADDRESS: 5611 DENALI STREET PHONE: 272-8859 CAPACITY: 080
ANCHORAGE, AK 99503 LOCALE: SAME AGE 08M-11
RESTRICT: TEXT OF PROVISION NOT ENTERED.
LICENSE: 11/0179 - 07/31/80 ORGANIZATION: PRIVATE FOR PROFIT

NAME: SPENARD KIDDY DROP CONTACT SHIRLEY BRATHE # 001440
ADDRESS: 3307 SPENARD RD PHONE: 279-4713 CAPACITY: 100
ANCHORAGE, AK 99503 LOCALE: SAME AGE 15M-10
LICENSE: 10/3179 - 04/30/80 ORGANIZATION: PRIVATE FOR PROFIT

NAME: WESLEYAN CHURCH CH CARE CONTACT HAPPY CHRONISTER # 004070
ADDRESS: 3201 TURNAGAIN BLVD PHONE: 248-4222 CAPACITY: 05
ANCHORAGE, AK 99507 LOCALE: 3201 TURNAGAIN BLVD AGE 12M-07
RESTRICT: ANNUAL CONTIGENT ON HEP APPROV NO NEW REFERRALS OVER 6 YRS
LICENSE: 05/0179 - 04/30/80 ORGANIZATION: PRIVATE FOR PROFIT

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CITY: ANCHORAGE TYPE: DAY CARE CENTER TUDOR

NAME: CAROUSEL'S GINGERBREAD CONTACT LEE ROBERTSON # 008193
ADDRESS: 6370 DEBARR RD PHONE: 274-2657 CAPACITY: 090
ANCHORAGE, AK 99504 LOCALE: 4520 SHELIOKOF AGE 18M-08
LICENSE: 01/1580 - 01/14/81 ORGANIZATION: PRIVATE NON PROFIT

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CITY: ANCHORAGE TYPE: DAY CARE CENTER TUDOR(NL&LOTIS

NAME: ALASKA DEVELOPMENTAL CE CONTACT SHIRL HORN # 242613
ADDRESS: 2823 TUDOR ROAD PHONE: 272-2519 CAPACITY: 060
ANCHORAGE, AK 99502 LOCALE: SAME AGE 06W-12
RESTRICT: TEXT OF PROVISION NOT ENTERED.
SPECIAL: MULTIPLE HANDICAPPED
LICENSE: 10/0179 - 09/30/80 ORGANIZATION: PRIVATE NON PROFIT

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CITY: ANCHORAGE TYPE: DAY CARE CENTER TURNAGAIN

NAME: BUTTERFLY CH CENTER CONTACT CYNTHIA BARBER # 008174
ADDRESS: 3300 W NO LIGHTS PHONE: 243-2440 CAPACITY: 040
ANCHORAGE, AK 99503 LOCALE: SAME AGE 15M-12
RESTRICT: C: HEP APPROVAL
LICENSE: 11/2579 - 11/24/80 ORGANIZATION: PRIVATE NON PROFIT

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CITY: CHUGIAK TYPE: DAY CARE CENTER

NAME: CHUGIAK CHILDREN SERV CONTACT SHARON LATERY # 002287
ADDRESS: PO BOX 233 PHONE: 688-2660 CAPACITY: 070
CHUGIAK, AK 99567 LOCALE: MILE 19 OLD GLENN HWY AGE 02Y-08
LICENSE: 10/0279 - 10/01/80 ORGANIZATION: PRIVATE NON PROFIT

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CITY: CORDOVA TYPE: DAY CARE CENTER

NAME: ST JOSEPH CHILD CARE CONTACT REVD.MELBOURNE # 242115
ADDRESS: BOX 79 PHONE: 424-3173 CAPACITY: 035
CORDOVA AK 99574 LOCALE: 220 ADAMS AGE 06W-08
LICENSE: 12/0679 - 05/30/80 ORGANIZATION: PRIVATE NON PROFIT

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CITY: DUTCH HARBOR TYPE: DAY CARE CENTER

NAME: UNALASKA DAY CARE CEN CONTACT TODD PETERSEN # 008362
ADDRESS: BOX 144 PHONE: 581-1201 CAPACITY: 015
UNALASKA AK 99685 LOCALE: OLD SCHOOL AGE 02Y-10
LICENSE: 12/0179 - 07/31/80 ORGANIZATION: PRIVATE NON PROFIT

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CITY: EAGLE RIVER TYPE: DAY CARE CENTER

NAME: HASBROUCK'S CELESTIAL CONTACT DIANA HASBROUCK # 242231
ADDRESS: PO BOX 287 PHONE: 694-9342 CAPACITY: 045
EAGLE RIVER, AK 99577 LOCALE: CALESTIAL ST AGE 06W-09
RESTRICT: C:ONLY 5 CH IN BK RO DOOR CLSD
LICENSE: 07/3179 - 07/30/80 ORGANIZATION: PRIVATE FOR PROFIT

NAME: JOY CHILD CARE CENTER CONTACT KAREN JUSTICE # 008337
ADDRESS: PO BOX 736 PHONE: 694-2755 CAPACITY: 040
EAGLE RIVER, AK 99577 LOCALE: EAGLE R RD & EAGLE R LP AGE 34M-08
LICENSE: 12/0679 - 12/05/80 ORGANIZATION: PRIVATE NON PROFIT

NAME: LITTLE RED SCHOOLHSE II CONTACT KATHY KNOTT # 008235
ADDRESS: 3720 RASPBERRY RD PHONE: 694-3214 CAPACITY: 075
ANCHORAGE, AK 99502 LOCALE: GLENN HWY EAGLE RIVER AGE 02Y-09
LICENSE: 12/2579 - 12/24/80 ORGANIZATION: PRIVATE NON PROFIT

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CITY: GIRDWOOD TYPE: DAY CARE CENTER

NAME: LITTLE BEAR'S PLAYHOUSE CONTACT TRISH ADKINS # 242435
ADDRESS: BOX 248 PHONE: 783-2522 CAPACITY: 010
GIRDWOOD, AK 99587 LOCALE: SAME AGE 02Y-12
LICENSE: 07/2379 - 07/22/80

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CITY: KENAI TYPE: DAY CARE CENTER

NAME: BEAVER LOOP CH CARE
ADDRESS: ST RT 3
KENAI, AK 99611
LICENSE: 04/0279 - 04/01/80

CONTACT SANDRA HINRICHS # 242423
PHONE: 283-4320 CAPACITY: 050
LOCALE: SAME AGE 06W-12
ORGANIZATION: PRIVATE FOR PROFIT

NAME: LITTLE PEOPLE PRESCHOOL
ADDRESS: BOX 2485
KENAI, AK 99669
LICENSE: 09/2179 - 09/20/80

CONTACT GLENN KNEPPER # 242222
PHONE: 262-9665 CAPACITY: 030
LOCALE: MI 95.7 STERLING HWY AGE 02Y-10
ORGANIZATION: PRIVATE FOR PROFIT

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CITY: KODIAK TYPE: DAY CARE CENTER

NAME: SMALL WORLD INC CONTACT GAIL OTTO # 008106
ADDRESS: PO BOX 1632 PHONE: 486-5531 CAPACITY: 030
KODIAK, AK 99615 LOCALE: 316 MISSION RD AGE 03Y-10
LICENSE: 08/3079 - 08/29/80 ORGANIZATION: PRIVATE NON PROFIT

NAME: SMALL WORLD INC CONTACT GAIL OTTO # 001883
ADDRESS: PO BOX 1632 PHONE: 486-5531 CAPACITY: 049
KODIAK, AK 99615 LOCALE: 216 MILL BAY AGE 02Y-10
LICENSE: 08/3079 - 08/29/80 ORGANIZATION: PRIVATE NON PROFIT

NAME: US COAST GUARD CHILD CR CONTACT HAROLD SANDERSON # 008202
ADDRESS: US COAST GUARD SUPPORT PHONE: 487-5434 CAPACITY: 120
KODIAK, AK 99619 LOCALE: BOX 24 AGE 06W-11
RESTRICT: C:PURCHASE ADDT'L EQUIPMENT
LICENSE: 08/3079 - 08/29/80 ORGANIZATION: PRIVATE FOR PROFIT

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CITY: PALMER TYPE: DAY CARE CENTER

NAME: PALMER CHILDREN HOUSE CONTACT VERNA EUWER # 001887
ADDRESS: BOX 605 PHONE: 745-3318 CAPACITY: 044
PALMER, AK 99645 LOCALE: EAGLE & COBB ST AGE 02Y-06
LICENSE: 03/3180 - 11/30/80 ORGANIZATION: PRIVATE FOR PROFIT

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CITY: SOLDOTNA TYPE: DAY CARE CENTER

NAME: JELLYBEANS AND JESUS CONTACT SHIRLEY BAILEY # 242068
ADDRESS: P.O. BOX 1584 PHONE: 262-9235 CAPACITY: 031
SOLDOTNA, AK 99669 LOCALE: HILLCREST & RIVER VIEW AGE 01Y-08
LICENSE: 07/31/79 - 07/30/80 ORGANIZATION: PRIVATE NON PROFIT

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CITY: VALDEZ TYPE: DAY CARE CENTER

NAME: PTARMIGAN TOT DROP CONTACT JOAN HANSEN # 004450
ADDRESS: BOX 153 PHONE: 835-4877 CAPACITY: 024
VALDEZ, AK 99686 LOCALE: MASONIC HALL AGE 02Y-10
LICENSE: 10/0179 - 08/31/80 ORGANIZATION: PRIVATE NON PROFIT

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CITY: WASILLA TYPE: DAY CARE CENTER

NAME: HOBBY HORSE HOUSE CONTACT KATHLEEN CARR # 008340
ADDRESS: PO BOX 590 PHONE: 376-2510 CAPACITY: 036
WASILLA, AK 99687 LOCALE: 1.1 MILE BOGARD RD AGE 01Y-10
LICENSE: 08/3079 - 08/29/80 ORGANIZATION: PRIVATE FOR PROFIT

NAME: KIDDIE KOLLEGE CONTACT DON STOKES # 004511
ADDRESS: BOX 41 PHONE: 745-3889 CAPACITY: 049
PALMER, AK 99645 LOCALE: AGE 02Y-10
LICENSE: 12/0179 - 10/30/80 ORGANIZATION: PRIVATE FOR PROFIT

NAME: WASILLA CHILDRENS HOUSE CONTACT VERNA EUWER # 004820
ADDRESS: BOX 605 PHONE: 745-3318 CAPACITY: 044
PALMER, AK 99645 LOCALE: KNIK ST WASILLA AGE 02Y-06
LICENSE: 03/3180 - 11/30/80 ORGANIZATION: PRIVATE FOR PROFIT

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CITY: CLEAR TYPE: DAY CARE CENTER

NAME:	ANDERSON DAY CARE CTR	CONTACT CHRIS BRESCO	# 004866
ADDRESS:	BOX 4011	PHONE: 832-5647 CAPACITY: 024	
	ANDERSON, AK 99704	LOCALE: ANDERSON	AGE 06W-10
LICENSE:	12/0179 - 11/30/80	ORGANIZATION: PRIVATE NON PROFIT	

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CITY: DELTA JUNCTION TYPE: DAY CARE CENTER

NAME: TINY TOTS CHILD CARE CT CONTACT JANE ABREU # 243202
ADDRESS: PO BOX 805 PHONE: 895-4240 CAPACITY: 041
DELTA JUNCTION AK 99737 LOCALE: KIMBAL ST AGE 18M-10
RESTRICT: -
LICENSE: 10/2979 - 10/28/80 ORGANIZATION: PRIVATE FOR PROFIT

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CITY: FAIRBANKS TYPE: DAY CARE CENTER

NAME: BUNNELL HSE CHILD DEV C CONTACT MURCHEWICZ M # 007082
ADDRESS: %TVCC UOFA 104 CONSTIT PHONE: 479-7335 CAPACITY: 025
FAIRBANKS, AK 99701 LOCALE: 703 CHATANIKA AGE 06M-12
RESTRICT: DELETE DELETE
LICENSE: 09/0679 - 09/05/80 ORGANIZATION: PRIVATE NON PROFIT

NAME: COLLEGE DAY NURSERY CONTACT DORIS LUNDGREN # 001424
ADDRESS: BOX 80962 PHONE: 479-2778 CAPACITY: 030
FAIRBANKS, AK 99708 LOCALE: 4 MI COLLEGE ROAD AGE 02Y-05
LICENSE: 05/0179 - 04/30/80 ORGANIZATION: PRIVATE FOR PROFIT

NAME: ENEP'UT CHILDREN'S CTR CONTACT RUTH LISTER # 003514
ADDRESS: BOX 80452 PHONE: 479-6844 CAPACITY: 040
FAIRBANKS, AK 99708 LOCALE: DEBORAH ST COLLEGE AGE 06W-12
RESTRICT: 4 CHILDREN AGES 6 WKS TO 2 YRS INCL THOSE OF STAFF
LICENSE: 11/0179 - 10/31/80 ORGANIZATION: PRIVATE NON PROFIT

NAME: HUTCHISON DAY CARE CEN CONTACT B MACCALLUM # 004878
ADDRESS: 3750 GEIST RD PHONE: 479-2261 CAPACITY: 020
FAIRBANKS, AK 99701 LOCALE: AGE 06M-06
LICENSE: 10/0179 - 09/30/80 ORGANIZATION: PRIVATE NON PROFIT

NAME: LOVE & CARE CHILD CENTE CONTACT KARIN MADISON # 007083
ADDRESS: 802 17TH AVE PHONE: 456-8541 CAPACITY: 034
FAIRBANKS, AK 99701 LOCALE: AGE 02Y-10
LICENSE: 07/0579 - 07/04/80 ORGANIZATION: PRIVATE FOR PROFIT

NAME: PLAY'N LEARN CONTACT PATTI SANDERS # 007008
ADDRESS: 547 7TH AVE PHONE: 452-5997 CAPACITY: 04[illegible]
FAIRBANKS, AK 99701 LOCALE: AGE 02Y-10
LICENSE: 01/0180 - 12/31/80 ORGANIZATION: PRIVATE FOR PROFIT

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NAME: TEAMSTER REC CENTER NUR
CONTACT VICKI BEVENS # 007081
ADDRESS: BOX 609
FAIRBANKS, AK 99701
PHONE: 452-6801 CAPACITY: 050
LOCALE: 750 OLD RICH HWY AGE 02Y-08
LICENSE: 06/0779 - 06/06/80
ORGANIZATION: PRIVATE FOR PROFIT

NAME: WEE CARE NURSERY
CONTACT HILDA VEHMEIER # 007060
ADDRESS: 2830 AIRPORT STREET
FAIRBANKS, AK 99701
PHONE: 456-7560 CAPACITY: 095
LOCALE: SAME AGE 06W-06
RESTRICT: C:20 CHILDREN AGE 6WK-2YR C:75 CHILDREN AGE 2YR-6YR
LICENSE: 11/0179 - 10/31/80
ORGANIZATION: PRIVATE NON PROFIT

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CITY: FORT GREELY TYPE: DAY CARE CENTER

NAME: FT GREELY CHILD CARE CT CONTACT LUCY ELGIN # 243174
ADDRESS: FT GREELY PHONE: 872-4250 CAPACITY: 045
FT GREELEY, AK 99790 LOCALE: BLDG 802 ANNEX B AGE 03M-14
LICENSE: 07/0179 - 11/12/80 ORGANIZATION: PUBLIC (GOVERNMENTAL)

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CITY: NORTH POLE TYPE: DAY CARE CENTER NORTH POLE

NAME: NO POLE CHRISTIAN DAY S CONTACT BETTY KNIGHTON # 007007
ADDRESS: PO BOX 5249 PHONE: 488-2240 CAPACITY: 065
NORTH POLE, AK 99705 LOCALE: 5TH & RICHARDSON HWY AGE 06M-12
LICENSE: 09/0179 - 08/31/80 ORGANIZATION: PRIVATE NON PROFIT

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CITY: KOTZEBUE TYPE: DAY CARE CENTER

NAME: KOTZEBUE DAY CARE CENTE CONTACT KOTZEBUE DAY CARE CENTE # 001716
ADDRESS: BOX 296 PHONE: 442-3157 CAPACITY: 025
KOTZEBUE, AK 99752 LOCALE: COMMUNITY BUILDING AGE 06M-05
LICENSE: 04/3078 - 04/30/80 ORGANIZATION: PRIVATE FOR PROFIT

PRINTED FOR: QUARTERLY REPORT

DATE: 04/28/80

DIVISION OF SOCIAL SERVICES

R03-06S-7100

QUICK INDEX TO SELECTED FACILITIES

CITY: NOME TYPE: DAY CARE CENTER

NAME: NOME CHILD CARE INC
ADDRESS: BOX 907
NOME, AK 99762
LICENSE: 11/0177 - 11/01/80

CONTACT NOME CHILD CARE INC # 007900
PHONE: 443-2130 CAPACITY: 030
LOCALE: 2 & C STREET AGE 03M-06
ORGANIZATION: PRIVATE FOR PROFIT

PRINTED FOR: QUARTERLY REPORT

DATE: 04/28/80

DIVISION OF SOCIAL SERVICES

R03-06S-7100

QUICK INDEX TO SELECTED FACILITIES

CITY: HAINES TYPE: DAY CARE CENTER

NAME: KIDDIE KARE/HEADSTART CONTACT JUDY GOENTT HS # 006051
ADDRESS: PO BOX 122 PHONE: 766-2155 CAPACITY: 020
HAINES, AK 99827 LOCALE: VIEW STREET AGE 03Y-06
LICENSE: 12/0179 - 11/30/80 ORGANIZATION: PRIVATE NON PROFIT

PRINTED FOR: QUARTERLY REPORT

DATE: 04/28/80

DIVISION OF SOCIAL SERVICES

R03-06S-7100

QUICK INDEX TO SELECTED FACILITIES

CITY: JUNEAU TYPE: DAY CARE CENTER

NAME: CHILDRENS COMMUNITY CONTACT MCFARLAND, DIR # 245017
ADDRESS: PO BOX 1452 PHONE: 586-6764 CAPACITY: 035
JUNEAU AK 99801 LOCALE: 211 CORDOVA AGE 03M-10
RESTRICT: C:ONLY 5 CHILDREN UNDER 1 YR
RESTRICT: ONLY 5 CHILDREN UNDER 1 YEAR
LICENSE: 12/0879 - 04/04/80 ORGANIZATION: PRIVATE NON PROFIT

NAME: JACK & JILL DAY CARE CONTACT ALICE STEVENS # 001429
ADDRESS: 342 DISTIN ST PHONE: 586-2980 CAPACITY: 012
JUNEAU, AK 99801 LOCALE: SAME AGE 30M-06
LICENSE: 08/2778 - 08/25/80 ORGANIZATION: PRIVATE FOR PROFIT

NAME: JNOCHRISTIANSCHDAYCARE CONTACT JNOCHRISTIANSCHDAYCARE # 245184
ADDRESS: PO BOX 2000 PHONE: 789-2176 CAPACITY: 020
JUNEAU, AK 99803 LOCALE: 8001 GLACIER HIGHWAY AGE 06Y-14
LICENSE: 10/1579 - 10/14/80 ORGANIZATION: PRIVATE NON PROFIT

NAME: JUNEAU CHRISTIAN PRESCH CONTACT KATHY MARTINDR # 245111
ADDRESS: PO BOX 2000 PHONE: 789-2170 CAPACITY: 050
JUNEAU, AK 99803 LOCALE: 8001 GLACIER HIGHWAY AGE 02Y-06
LICENSE: 04/1680 - 04/15/81 ORGANIZATION: PRIVATE NON PROFIT

NAME: ST ANNS DAY CARE CENTER CONTACT ST ANNS DAY CARE CENTER # 001870
ADDRESS: 500 HARRIS STREET PHONE: 586-6640 CAPACITY: 095
JUNEAU, AK 99801 LOCALE: 500 HARRIS STREET AGE 30M-10
RESTRICT: C:NO MORE THAN 75 CHILDREN IN C: AGE RANGE 2.5 TO 5 YRS
LICENSE: 02/1479 - 02/13/80 ORGANIZATION: PRIVATE NON PROFIT

NAME: ST ANNS NURSERY CONTACT BARBARA HTOLDOR # 006015
ADDRESS: 550 HARRIS ST PHONE: 586-2440 CAPACITY: 035
JUNEAU, AK 99801 LOCALE: 550 HARRIS STREET AGE 05M-03
LICENSE: 11/1879 - 11/17/80 ORGANIZATION: PRIVATE NON PROFIT

PRINTED FOR: QUARTERLY REPORT

DATE:
04/28/80

DIVISION OF SOCIAL SERVICES

R03-06S-7100

QUICK INDEX TO SELECTED FACILITIES

NAME: ST JUDE CENTER
ADDRESS: RR 3 BOX 3050
JUNEAU, AK 99801
LICENSE: 01/0180 - 12/31/80

CONTACT BILLS DIR # 006087
PHONE: 586-2624 CAPACITY: 072
LOCALE: 3272 HOSPITAL DRIVE AGE 06W-14
ORGANIZATION: PRIVATE NON PROFIT

NAME: WEE COTTAGE
ADDRESS: RR6 BOX 3528
JUNEAU, AK 99803
LICENSE: 12/1679 - 10/31/80

CONTACT MARLIN DIR # 006083
PHONE: 789-2611 CAPACITY: 052
LOCALE: MI 9.5 GLACIER HIGHWAY AGE 18M-14
ORGANIZATION: PRIVATE FOR PROFIT

PRINTED FOR: QUARTERLY REPORT

DATE: 04/28/80

DIVISION OF SOCIAL SERVICES

R03-06S-7100

QUICK INDEX TO SELECTED FACILITIES

CITY: MT EDGECUMBE TYPE: DAY CARE CENTER

NAME: MT EDGECUMBE PRESCHOOL CONTACT LINDA SCHMIDT DIRECTOR # 245082
ADDRESS: BOX 130 PHONE: 966-2944 CAPACITY: 022
MT EDGECUMBE, AK 99835 LOCALE: 205 SEWARD AGE 03Y-05
LICENSE: 03/2880 - 03/27/81 ORGANIZATION: PRIVATE NON PROFIT

PRINTED FOR: QUARTERLY REPORT

DATE: 04/28/80

DIVISION OF SOCIAL SERVICES

R03-06S-7100

QUICK INDEX TO SELECTED FACILITIES

CITY: SITKA TYPE: DAY CARE CENTER

NAME: SITKA DAY CARE ANNEX CONTACT DIRKARENMARIE # 245152
ADDRESS: PO BOX 2237 PHONE: 747-3001 CAPACITY: 040
SITKA, AK 99835 LOCALE: 303 KIMSHAM ST AGE 02Y-06
LICENSE: 02/0180 - 01/31/81 ORGANIZATION: PRIVATE NON PROFIT

NAME: SITKA DAY CARE CENTER CONTACT WEST DIRECTOR # 245012
ADDRESS: BOX 2237 PHONE: 747-6042 CAPACITY: 028
SITKA, AK 99835 LOCALE: 611 LINCOLN ST AGE 18M-06
RESTRICT: C:NOMORETHANSCHILDRENUNDERAGE2
LICENSE: 02/0180 - 01/31/81 ORGANIZATION: PRIVATE NON PROFIT

PRINTED FOR: QUARTERLY REPORT

DATE: 04/28/80

DIVISION OF SOCIAL SERVICES

R03-06S-7100

QUICK INDEX TO SELECTED FACILITIES

CITY: KETCHIKAN TYPE: DAY CARE CENTER

NAME: KIDDIE KOLLEGE DCCENTER CONTACT WHITE REV BILL # 006508
ADDRESS: PO BOX 5003 PHONE: 225-2891 CAPACITY: 035
KETCHIKAN AK 99901 LOCALE: 3405 BARANOF AGE 02Y-06
RESTRICT: SECTION OF CENTER C:THE LOWER SECTION OF CENTER
LICENSE: 12/2178 - 12/19/80 ORGANIZATION: PUBLIC (GOVERNMENTAL)

NAME: THE NEST CONTACT J OR R GOVAARS # 246043
ADDRESS: PO BOX 5157 PHONE: 225-4815 CAPACITY: 032
KETCHIKAN, AK 99901 LOCALE: 342 STEDMAN AGE 06W-06
RESTRICT: NO MORE THAN 6 CHILDREN UNDER AGE TWO
LICENSE: 04/2379 - 04/22/80 ORGANIZATION: PRIVATE NON PROFIT

PRINTED FOR: QUARTERLY REPORT

DATE:
04/28/80

DIVISION OF SOCIAL SERVICES

R03-06S-7100

QUICK INDEX TO SELECTED FACILITIES

CITY: PETERSBURG TYPE: DAY CARE CENTER

NAME: PETERSBURG DAY CARE CTR CONTACT M ESTELLE # 004639
ADDRESS: PO BOX 138 PHONE: 772-3419 CAPACITY: 040
PETERSBURG, AK 99833 LOCALE: 2ND & H ST AGE 06W-10
RESTRICT: PENDING COMPLETION OF LIC REQUIREMENTS
LICENSE: 08/3079 - 08/29/80 ORGANIZATION: PRIVATE NON PROFIT

PRINTED FOR: QUARTERLY REPORT

STATE DAY CARE SUBSIDY CHANGE Res. No 35

WHEREAS the State Day Care Subsidy Porgram is a singular success in providing child care support for parents who need it through local community participation; and

WHEREAS it is very important that children who have been abused or neglected continue to be placed outside the home for daytime care by the Health & Social Services Department;

WHEREAS day care services are restricted by prohibitive costs of complying with regulations which allow a center to be paid only on the basis of child attendance rather than enrollment; and

WHEREAS staffing must be maintained whether an enrolled child is present or not;

WHEREAS Day Care Centers are being penalized when they accept children whose parents are subsidised by daycare assistance or by Health & Social Services because parents who are not being subsidized can and in most cases are charged on a monthly rate rather than a daily rate;

WHEREAS Day Care Centers throughout Alaska are facing closure because of financial reasons;

BE IT RESOLVED that the Community & Regional Affairs Department and Health & Social Services Department amend their regulations to permit child care payment by enrollment rather than attendance.

This is a resolution passed without any dissent by the Southeast Regional Alaskan Democratic Party Convention: April 12, 1980.

FISCAL NOTE

I. REQUEST

Bill/Resolution No. HB 1019

Title An Act relating to Daycare for children

Requested by House H&SS Date

II. FISCAL DETAIL

Agency Affected Community & Regional Affairs

Program Category Affected Social Services

BRU, Program, or Subprogram(s) Affected Childcare

(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 80	FY 81	FY 82	FY 83	FY 84	FY 85
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL		45.0				
400 COMMODITIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC.		370.0				
TOTAL		415.0				

FUNDING (Thousands of Dollars)

GENERAL FUND		415.0				
FEDERAL FUNDS						
OTHER (Specify Fund Source)						

POSITIONS

FULL TIME		0	0	0	0	0
PART TIME						
TEMPORARY						

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

The 45.0 on line 300 (contractual) would provide for a contracted study of the current costs of providing daycare. This study will provide needed data to make reasonable estimates by February 1, 1981, of cost for Section 1 and 2 of HB 1019. It is anticipated that the contract would also require the establishment of procedures for annual update. The annual update could then be accomplished by existing office personnel.

Sec. 3 of HB 1019 requires payment based on enrollment instead of the present method of payment based on attendance. The 370.0 on line 700 will pay for this absentee factor based on the current estimated absentee (vacancy) rate of 20%.

IV. DATE 5-9-80 PREPARED BY Lianne Wesley LW

AGENCY Community & Regional Affairs

PHONE (907) 276-1721

Original: Legislative Finance

cc: Budget and Management

Prime Sponsor (First Legislator Named)

33-001 (Rev. 12/79)

FISCAL NOTE

I. REQUEST

Bill/Resolution No. HB 1019

Title An Act relating to Daycare for children

Requested by House H&SS Date

II. FISCAL DETAIL

Agency Affected Community & Regional Affairs

Program Category Affected Social Services

BRU, Program, or Subprogram(s) Affected Childcare

(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 80	FY 81	FY 82	FY 83	FY 84	FY 85
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL		45.0				
400 COMMODITIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC.		370.0				
TOTAL		415.0				

FUNDING (Thousands of Dollars)

GENERAL FUND		415.0				
FEDERAL FUNDS						
OTHER (Specify Fund Source)						

POSITIONS

FULL TIME		0	0	0	0	0
PART TIME						
TEMPORARY						

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

The 45.0 on line 300 (contractual) would provide for a contracted study of the current costs of providing daycare. This study will provide needed data to make reasonable estimates by February 1, 1981, of cost for Section 1 and 2 of HB 1019. It is anticipated that the contract would also require the establishment of procedures for annual update. The annual update could then be accomplished by existing office personnel.

Sec. 3 of HB 1019 requires payment based on enrollment instead of the present method of payment based on attendance. The 370.0 on line 700 will pay for this absentee factor based on the current estimated absentee (vacancy) rate of 20%.

IV. DATE 5-9-80 PREPARED BY Lianne Wesley LW

AGENCY Community & Regional Affairs

PHONE (907) 276-1721

Original: Legislative Finance

cc: Budget and Management

Prime Sponsor (First Legislator Named)

33-001 (Rev. 12/79)

Alaska State Legislature

House of Representatives

Committee on

Health, Education & Social Services

Official Business

Pouch V
State Capitol
Juneau, Alaska 99811

May 5, 1980

Chottie Angst
League of Women Voters of Juneau
Box 221
Juneau, Alaska 99802

Dear Ms. Angst:

I have received your letter in support of HB 1019. We are scheduled to hold hearings on the bill on Thursday and Friday of this week. I hope that we are able to report the bill out of Committee at that time.

I will be sure that the other members of the Committee are made aware of the view of the Juneau league when we are deliberating on the bill.

Sincerely,

Thelma

Thelma Buchholdt
State Representative
District 9 (Spenard);
Chair, House HESS Committee

League of Women Voters

of Juneau, Alaska

May 1, 1980

Honorable Thelma Buchholdt
Pouch Y
State Capitol Building
Juneau, AK 99811

Dear Representative Buchholdt:

The League of Women Voters of Juneau supports HB-1019. The League has a state position on Day Care which says:

> The League of Women Voters of Alaska supports day care for everyone who needs or wants it with priority given to those children whose need is greatest. The members of the League believe users should be primarily responsible for day care financing. Supplemental financial and regulatory responsibilities should be shared by all levels of government to insure that day care is of high quality and available to those who need it.

We urge you to support this bill and pass it out of committee as soon as possible so that it may be acted on this session.

Thank you for your continued support of Day Care.

Sincerely,

Chottie Angst

Chottie Angst
President

STATE OF ALASKA

JAY S. HAMMOND, Governor

DEPT. OF COMMUNITY & REGIONAL AFFAIRS

OFFICE OF THE COMMISSIONER

POUCH B
JUNEAU, ALASKA 99811

May 6, 1980

The Honorable Thelma Buchholdt
Alaska House of Representatives
Pouch V
Juneau, Alaska 99811

Dear Representative Buchholdt:

RE: HOUSE BILL 1019 - AN ACT RELATING TO DAY CARE FOR CHILDREN

The following comments on HB 1019 were prepared by Lianne Wesley, the Day Care Assistance Coordinator.

Effects

This bill would more fully define the legal basis of the day care assistance program by directing the Department to: 1) annually review and revise, if necessary, the sliding fee scale of parent's contribution to the cost of licensed day care for their children; 2) pay a facility based on enrollment, rather than on an attendance basis; 3) reimburse a facility for the cost of providing the day care service; and 4) annually determine the cost of providing day care in each facility where the service is provided.

Comments

The focus of the Day Care Assistance Program to date has been the needs of families, not day care facility operators. This bill (and HCR 66) significantly alters that focus, and changes the way this Department has traditionally handled this program. Instead of the Department functioning in a contractual relationship with local governing bodies as intermediaries the Department will deal more directly with the service agencies.

A major implication of the bill revolves around the setting of rates for day care services. Raising daily rates or mandating an enrollment rate increases the cost to both the general public and to state-subsidized families. Raising day care rates could price some people out of the market and in the end detrimentally affect the day care operators, this

legislation is designed to help. Facility operators may face declining enrollment and income if the State raises rates beyond what the general public will bear. Unless the appropriation for the Day Care Assistance Program is dramatically increased, raising the payment maximum to the day care facilities will decrease both the number of low income families receiving program subsidy and the level of subsidy available to each family.

Day care services reimbursed on an enrollment basis will require more local administrative staff time to assure the same level of fiscal accountability presently provided. AS 44.47.260 requires the cost of this local administration to be paid by the contracting municipality. Under the present system, local staff only take the facility's attendance figures multiplied by the daily rate and check the calculations to determine the accuracy of the facility's billing. On an enrollment basis, local administrators will presumably check attendance figures to see if the monthly enrollment rate is justified before calculating the accuracy of the billings. If enrollment fees are paid in advance, the current month's attendance must be compared with the previous month's billing before calculations can be checked and payment authorized.

Sincerely,

Lee

Lee McAnerney
Commissioner

THE LEGISLATURE OF THE STATE OF ALASKA
ELEVENTH LEGISLATURE

FISCAL NOTE

I. REQUEST

Bill/Resolution No. House Bill 1019

Title An Act Relating to Day Care for children

Requested by House H&SS Committee Date 5-6-80

II. FISCAL DETAIL

Agency Affected Department of Community & Regional Affairs

Program Category Affected Social Service

BRU, Program, or Subprogram(s) Affected Child Care

(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 80	FY 81	FY 82	FY 83	FY 84	FY 85
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL		45.0				
400 COMMODITIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC.		2178.8	2253.1	2541.3	2744.6	2964.2
TOTAL		2223.8	2253.1	2541.3	2744.6	2964.2

FUNDING (Thousands of Dollars)

GENERAL FUND		2223.8	2253.1	2541.3	2744.6	2964.2
FEDERAL FUNDS						
OTHER (Specify Fund Source)						

POSITIONS

FULL TIME		0	0	0	0	0
PART TIME						
TEMPORARY						

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

The 45.0 on line 300 (contractual) would provide for a contracted study of the current costs of providing daycare. It is anticipated that the contract would also require the establishment of procedures for annual update. The annual update could then be accomplished by existing office personal.

The 2178.8 on line 700 is a combination of estimates.

978.8	Amount estimated by Community & Regional Affairs to fund existing need at existing price levels
1200.0	Amount estimated by Legislative Affairs to fund 100% of costs of operation of Daycare Centers
2178.8	Total Estimated Cost

IV. DATE 5/6/80 PREPARED BY Lianne Wesley LW

AGENCY Community & Regional Affairs

PHONE (907) 276-1721

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)

33-001 (Rev. 12/79)

It should be pointed out that the above figures are only estimates based on very limited data.

The claims costs have been increased 8% per year for inflation.

League of Women Voters of Alaska

May 7, 1980

Honorable Thelma Buchholdt
Alaska State Legislature
Pouch V,
Juneau, Alaska 99811

Dear Representative Buchholdt:

The League of Women Voters of Alaska supports HB 1019 which relates to Day Care and Day Care Funding. The League believes that day care for children should provide an environment that maximizes each childs potential. To do this requires sufficient funds to pay the salaries of trained staff and an appropriate facility.

Alaska's day care centers are experiencing a financial crisis and need assistance. HB 1019 which will allow day care centers to receive payment based on enrollment rather than attendance is a key provision to alleviating the financial crisis day care centers in Alaska are experiencing at this time.

The League of Women Voters of Alaska urges you and the other members of your committee to support HB 1019.

Sincerely,

Margaret

Margaret E. Holland
Human Resources Chairperson

RR 6 Box 4020-23
Juneau, Alaska 99803

HB

1030

Alaska Native Health Board

1689 C STREET, SUITE 230, ANCHORAGE, ALASKA 99501 PHONE 276-8989

Reference #A80-0489

RECEIVED
APR 17 1980
DEPUTY COMMISSIONER
DEPT. OF HEALTH & SOCIAL SVS
ANCHORAGE

April 16, 1980

Dr. Fred McGinnis
Deputy Commissioner
Department of Health & Social Services
State of Alaska
MacKay Building
338 Denali Street
Anchorage, Alaska 99501

The purpose of this letter is to proclaim the Alaska Native Health Board's dismay regarding efforts underway to promote the use of State funds to subsidize the financially troubled Alaska Hospital and Medical Center/Professional Office Building in Anchorage.

Speaking as the designated statewide health entity representing the Alaska Native population in health matters -- and as concerned citizens, voters, and taxpayers -- this Board is strongly opposed to the utilization of State funds to subsidize this most costly, underutilized community hospital/office complex. Any such action could not be considered to be in the best interest of all Alaskan citizens.

During its regular meeting on April 10, 1980, this Board did pass a resolution supporting the IHS acquisition of the Alaska Hospital and Medical Center/Professional Office Building. This Board further advised the Alaska congressional delegation that a study should be undertaken to determine how this transfer might best be accomplished while still providing access to quality health care to all Alaskan residents.

Again, we would like to remind you that State funds should be expended for programs and/or improvements that will mutually benefit all Alaska residents and we ask that you lend your support.

A letter containing the above information has been sent to all Alaska State Legislators, the Governor, and Commissioner Beirne. I might add that the Board's decision to support IHS acquisition of the AHMC/POB was by no means a hasty decision and came about as the result of indepth studies conducted regarding both ANMC and AHMC/POB.

ALEUTIAN PRIBILOF ISLAND ASSOC., INC.
BRISTOL BAY AREA HEALTH CORPORATION
CHUGACHMIUT NATIVE ASSOCIATION
COPPER RIVER NATIVE ASSOCIATION
KODIAK AREA NATIVE ASSOCIATION
MAINELINE ASSOCIATION
THE NORTH PACIFIC RIM
NORTH SLOPE BOROUGH HEALTH CORP.
NORTON SOUND HEALTH CORPORATION
SOUTHEAST ALASKA REGIONAL HEALTH CORP.
TANANA CHIEFS CONFERENCE
YUKON-KUSKOKWIM HEALTH CORPORATION

The use of State funds to temporarily alleviate the hospital's indebtedness would not solve the problem but only serve to prolong the real issue -- history has proved that the private sector in Anchorage cannot yet support a second hospital the size of the Alaska Hospital and Medical Center.

If you choose, your response will be incorporated in our records for statewide dissemination.

Thank you again for your support.

Sincerely,

ALASKA NATIVE HEALTH BOARD

David E. Cates, Ph.D.
Executive Director

DEC:blg

of ALASKA

FEB 1980
RECEIVED
Office of the
Commissioner

TO: Helen D. Beirne
Commissioner
Department of Health
and Social Services

DATE: February 28, 1980

FILE NO: J-66-327-80

TELEPHONE NO: 465-3655

FROM: AVRUM M. GROSS
ATTORNEY GENERAL

SUBJECT: Financial Aid For
Alaska Hospital and
Medical Center, Inc.

By:
Thomas H. Robertson
Assistant Attorney General

You have asked whether the Alaska Hospital and Medical Center, Inc., is eligible for financial aid under AS 18.25.040-060. You have informed us that the institition 1/ believes itself to be eligible as a "community operated nonprofit hospital" within the meaning of these statutes.

Having reviewed that institution's Bylaws and Articles of Incorporation, 2/ we believe that the Alaska Hospital and Medical Center, Inc., is not eligible for financial aid under AS 18.25.040-060.

The statutes with which you are concerned were enacted as long ago as 1949 to assist communities whose "taxable values" are limited and who would face "insurmountable hardship" in obtaining local financing for the operation of a hospital or clinic. They provide:

> AS 18.25.040. DEPARTMENT TO RENDER AID. The department may assist in cases of operational deficits of community operated nonprofit hospitals and clinics in the state.
>
> AS 18.25.050. DETERMINATION OF NECESSITY. The department shall initiate appropriate action in accordance with the provisions of §§ 40-60 of this chapter as soon as the department determines which projects are of most immediate necessity.

1/ The phrase "Alaska Hospital and Medical Center, Inc." is apparently used to denote both the hospital and the corporation.

2/ The Articles of Incorporation were "restated and amended" on August 30, 1978.

> AS 18.25.060. INTENT. It is the intent of §§ 40-60 of this chapter to provide financial aid, or funds to match available federal funds to aid localities or municipalities whose taxable values are limited in scope and for whom an attempt at community financing of a community operated nonprofit hospital or clinic would entail insurmountable hardship.

You have informed us that longstanding employees of the Department of Health and Social Services have no recollection of funds ever having been distributed under these statutes. You have also informed us that no funds have been appropriated for distribution during the current fiscal year. See Ak. Const., Art. IX, § 13.

The answer to your question turns on whether the Alaska Hospital and Medical Center, Inc., is a "community operated nonprofit hospital" within the meaning of AS 18.25-.040-060. The statutes do not, of course, refer simply to a hospital operated by a nonprofit corporation. They refer to a "community operated" nonprofit hospital and, as a consequence, your inquiry presents the issue of whether this institution can legitimately be viewed as being operated by the community in which it is situated.

The Alaska Hospital and Medical Center, Inc., is incorporated under AS 20.10 as a nonprofit corporation for the purpose, among others, of operating hospitals, clinics, and related facilities in the State of Alaska and elsewhere. 3/ There are no shareholders and the members of the corporation are limited to its Board of Trustees. 4/ The Board of Trustees is composed of five trustees who must, to be eligible for appointment, be at least twenty-one years of age, at least one year residents of the Third Judicial District, and of good moral character. Trustees are appointed by the Board of Trustees, voting as members of the corporation. The corporation is wholly controlled by the Board of Trustees. 5/ An administrator, who reports to the Board of Trustees, is responsible for its everyday operation. 6/

3/ Articles of Incorporation, Arts. I, III.

4/ Articles of Incorporation, Art. V; Bylaws, Art. III.

5/ Articles of Incorporation, Art. VI; Bylaws, Art. IV.

6/ Bylaws, Art. V.

We believe, in light of these factors alone, that the Alaska Hospital and Medical Center, Inc., is not operated by the community within the contemplation of AS 18.25.040-060. 7/ It does not have access to taxation, as alluded to in AS 18.25.060, and is entirely subject to the will of a five member Board of Trustees. Although undoubtedly dedicated to the pursuit of eleemosynary ends, the Alaska Hospital and Medical Center, Inc., is operated not by the community but rather by a private nonprofit corporation of the same name. It is thus not eligible to receive public funds under the statutes to which you have referred.

7/ In light of this conclusion it is unnecessary to address the other issues you have raised in this regard.

THR:jal

cc: OSHPD
Medsimis
Kaufman
3-3-80

POSITION PAPER/Department of Health & Social Services

POSITION PAPER ON

HOUSE BILL NO. 1030

For an Act Entitled: "An Act relating to assistance to nonprofit hospitals and providing for an effective date."

House Bill 1030 amends AS 18.25.010 to permit the Department of Health and Social Services to assist not only nonprofit hospitals operated by municipalities, communities and associations in the state but also nonprofit hospitals operated by nonprofit corporations in purchasing, constructing, repairing and providing necessary equipment. Section 1 is further amended to permit Departmental support for the retirement of debt in addition to the provisions for purchase, construction and equipping noted above.

The statute was originally enacted to provide the mechanism for disbursement of state funds, along with federal Hill Burton construction funds, for hospitals and long term care facilities. All Alaska hospitals, except Glennallen and Alaska Hospital and Medical Center, have benefited from this program since its enactment in 1949. The original statute did not authorize direct retirement of debts of nonprofit hospitals or grants to hospitals operated by nonprofit corporations unless community operated.

Discussion Items;

1. House Bill 1030 expands the authorizing language whereby resources can be provided to nonprofit hospitals or hospitals operated by nonprofit corporations not only for purchase, construction and equipping purposes, but also for retirement of debt. The Department could assume this expanded responsibility as funds are appropriated under the new authority of this amended act.

2. House Bill 1030, Section 4, also provides for the establishment of standards and critieria (through the development of regulations) for determining the extent and urgency of need by hospitals and the priority of need for funding. Such regulations, developed through the public Administrative Procedures process, are crucial to the responsible and equitable administration of this program.

3. Depending on the size and scope of the amended program, the Department would need to consider limited additional staff capabilities for appropriate administration.

4. To ensure that the rendering of aid includes not only the awarding of grants, but the potential to make loans, consideration might be given to reviewing the language in Section 1, 18.25.010 and in Section 4, 18.25.060 to ensure that rendering of aid encompasses the issuance of loans.

POSITION PAPER/Department of Health & Social Services

5. To ensure that potentially eligible facilities are not required to meet the test of receiving matching federal funds in order to qualify for state aid, it is suggested that the first sentence in Section 18.25.060 be modified to read as follows (suggested changes double underlined):

   Section 18.25.060, INTENT. It is the intent of AS 18.25.040-18.25.060 to provide financial aid, including but not limited to money [OR FUNDS] to match available federal money [FUNDS] to aid localities or municipalities whose taxable values are limited in scope and for whom an attempt at community financing of a community operated nonprofit hospital or clinic would entail insurmountable hardship or to aid other nonprofit hospitals or clinics which face closure because of financial problems.

Recommended by: Phoebe A Lindsey
Phoebe A. Lindsey
Director

Approved by: Helen D. Beirne
Helen D. Beirne
Commissioner

Date: May 7, 1980

Date: 5/7/80

THE LEGISLATURE OF THE STATE OF ALASKA
ELEVENTH LEGISLATURE

FISCAL NOTE

I. REQUEST

Bill/Resolution No. House Bill No. 1030

Title An Act relating to assistance to non profit hospitals

Requested by Dept of Health and Social Services Date 5/6/80

II. FISCAL DETAIL

Agency Affected Department of Health and Social Sevices

Program Category Affected Health

BRU, Program, or Subprogram(s) Affected

(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 80	FY 81	FY 82	FY 83	FY 84	FY 85
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL						
400 COMMODITIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
'00 GRANTS, CLAIMS, ETC.						
TOTAL						

FUNDING (Thousands of Dollars)

GENERAL FUND						
FEDERAL FUNDS						
OTHER (Specify Fund Source)						

POSITIONS

FULL TIME						
PART TIME						
TEMPORARY						

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

In order for the Department to administer this program, it will need to secure staff and/or contract assistance to develop proposed regulations, conduct appropriate public meetings and hearings and implement regulations. It is anticipated that this will require at least a 180-day (6 month) time period to accomplish.

Depending on the size of the program anticipated by the Legislature, it is possible that a professional staff person with skills in fiscal analysis, an understanding of facility mortages and related matters be added to the Department's staff to administer the program.

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)

Prepared by Phoebe A Lindsey Date: May 7, 1980
Division/Office: Department of Health & Social Services PH:

33-001 (Rev. 12/79)
Modify by DHSS (11-28-79)

Approval DHSS Mgt. & Bdgt: _____ Date: _____

Page ____ of ____

Helen D. Beirne
Commissioner
Department of Health
and Social Services

February 28, 1980

J-66-327-80

465-3655

AVRUM M. GROSS
ATTORNEY GENERAL

Financial Aid For
Alaska Hospital and
Medical Center, Inc.

By:
Thomas H. Robertson
Assistant Attorney General

You have asked whether the Alaska Hospital and Medical Center, Inc., is eligible for financial aid under AS 18.25.040-060. You have informed us that the institition 1/ believes itself to be eligible as a "community operated nonprofit hospital" within the meaning of these statutes.

Having reviewed that institution's Bylaws and Articles of Incorporation, 2/ we believe that the Alaska Hospital and Medical Center, Inc., is not eligible for financial aid under AS 18.25.040-060.

The statutes with which you are concerned were enacted as long ago as 1949 to assist communities whose "taxable values" are limited and who would face "insurmountable hardship" in obtaining local financing for the operation of a hospital or clinic. They provide:

> AS 18.25.040. DEPARTMENT TO RENDER AID. The department may assist in cases of operational deficits of community operated nonprofit hospitals and clinics in the state.
>
> AS 18.25.050. DETERMINATION OF NECESSITY. The department shall initiate appropriate action in accordance with the provisions of §§ 40-60 of this chapter as soon as the department determines which projects are of most immediate necessity.

1/ The phrase "Alaska Hospital and Medical Center, Inc." is apparently used to denote both the hospital and the corporation.

2/ The Articles of Incorporation were "restated and amended" on August 30, 1978.

> AS 18.25.060. INTENT. It is the intent of §§ 40-60 of this chapter to provide financial aid, or funds to match available federal funds to aid localities or municipalities whose taxable values are limited in scope and for whom an attempt at community financing of a community operated nonprofit hospital or clinic would entail insurmountable hardship.

You have informed us that longstanding employees of the Department of Health and Social Services have no recollection of funds ever having been distributed under these statutes. You have also informed us that no funds have been appropriated for distribution during the current fiscal year. See Ak. Const., Art. IX, § 13.

The answer to your question turns on whether the Alaska Hospital and Medical Center, Inc., is a "community operated nonprofit hospital" within the meaning of AS 18.25-.040-060. The statutes do not, of course, refer simply to a hospital operated by a nonprofit corporation. They refer to a "community operated" nonprofit hospital and, as a consequence, your inquiry presents the issue of whether this institution can legitimately be viewed as being operated by the community in which it is situated.

The Alaska Hospital and Medical Center, Inc., is incorporated under AS 20.10 as a nonprofit corporation for the purpose, among others, of operating hospitals, clinics, and related facilities in the State of Alaska and elsewhere. 3/ There are no shareholders and the members of the corporation are limited to its Board of Trustees. 4/ The Board of Trustees is composed of five trustees who must, to be eligible for appointment, be at least twenty-one years of age, at least one year residents of the Third Judicial District, and of good moral character. Trustees are appointed by the Board of Trustees, voting as members of the corporation. The corporation is wholly controlled by the Board of Trustees. 5/ An administrator, who reports to the Board of Trustees, is responsible for its everyday operation. 6/

3/ Articles of Incorporation, Arts. I, III.

4/ Articles of Incorporation, Art. V; Bylaws, Art. III.

5/ Articles of Incorporation, Art. VI; Bylaws, Art. IV.

6/ Bylaws, Art. V.

We believe, in light of these factors alone, that the Alaska Hospital and Medical Center, Inc., is not operated by the community within the contemplation of AS 18.25.040-060. 7/ It does not have access to taxation, as alluded to in AS 18.25.060, and is entirely subject to the will of a five member Board of Trustees. Although undoubtedly dedicated to the pursuit of eleemosynary ends, the Alaska Hospital and Medical Center, Inc., is operated not by the community but rather by a private nonprofit corporation of the same name. It is thus not eligible to receive public funds under the statutes to which you have referred.

7/ In light of this conclusion it is unnecessary to address the other issues you have raised in this regard.

THR:jal

ALASKA HOSPITAL

Alaska Hospital and Medical Center, Inc., is a nonprofit private corporation which owns the hospital. The mortgage on the hospital is held by the Alaska Teamster-Employer Pension Trust. The Professional Office Building (which is physically a part of the hospital) is owned by the Teamsters Building Corporation, which leases space exclusively for the practice of medicine.

The original cost of the hospital and clinic for all equipment and building	$33,075,975
Estimated value now (1.42 replacement cost factor)	$46,970,000
Total due to Teamsters Pension Trust as 2/29/80	$40,643,000
Arrears payments to Trust as of 2/29/80	$ 5,714,000
Unfunded depreciation	$ 6,468,000
Professional Office Building (appraisal 12/10/79 by Kenneth M. Zamzow, MAI)	$13,000,000

The hospital has a 5 member board of trustees. The trustees are elected by the board and may succeed themselves. Members are as follows:

Ray L. Snitil, President
Jack Bentley, Vice President
William H. Ivy, M.D., Secretary
Vernon Cates, M.D.
Emmitt Wilson

The hospital administrator is Ronald A. Pavellas, 276-1131. He has been with the hospital approximately 8 months.

Brian J. Brundin, 274-7522, of Hughes, Thorsness, Gantz, Powell, and Brundin , 509 W. 3rd. Avenue represents the hospital.

Alaska Hospital has not made a mortgage payment since April of 1978. The Department of Labor, through ERISA (Employee Retirement Income Security Act), has said that the Teamsters must divest their interest in the hospital. There are two reasons for this. First, only prudent investments are to be made by the pension fund. Second, too much of the portfolio of the pension fund is invested in the hospital--only 5% of the pension fund may be put in any one investment. The mortgage on the hospital constitutes 27% of the pension fund.) The Department of Labor has not made a formal statement yet; however, when they do it will be to require immediate divestiture. They may also file suit against the Teamsters for having too much of their money tied up in the hospital as a violation of ERISA. The Department of Labor is suppose to make a statement regarding their position in the near future, according to Bob Eccles of the Department of Labor's solicitor's office.

The Indian Health Service has expressed interest in obtaining the hospital for a new Native hospital in Anchorage. Originally this was priority #23 in their budget request; it has since become #2. The budget appropriations will be considered in early June by the Senate. At that time, it is expected they will receive approval for the purchase of the hospital, either directly or through a deal with the Cook Inlet Native Association.

The hospital board has requested assistance from the state in order to maintain the hospital as a community one. They estimate they would need a state loan of approximately $55 million to purchase the mortgage on the hospital and the professional office building. The administrator and board feel that their main problem is the mortgage holder. They are seen as a teamster hospital and the medical community refuses to use the facility because of that. The financial status also affects use, since the doctors are afraid that if they support Alaska Hospital and it goes under, they may not have anywhere to put their patients. There is also some stigma attached to the hospital from the Alaska Clinic days that may play a small part in the boycott of the hospital.

South Central Health Planning and Development, Inc., sent out a questionnaire to the local physicians in the Anchorage area regarding Alaska Hospital. 75 (39%) returned the questionnaire. 31 of the 75 said that a change in the mortgage holder would be necessary before they would admit more patients to Alaska Hospital, another 21 stated it would require a change in the structure of the Board.

Providence Hospital has a capacity of 250. Alaska Hospital is certified for 154. Current occupancy at Providences is 78%; Alaska 44%. A hospital is considered full at 85%. In the first three months of 1980 the average daily acute patient census in Anchorage was 281 (85% of Providences' 250 beds is 212). Without Alaska Hospital there would be 69 people a day in need of hospital care and no facilities available. Providence does plan to add another wing to handle an additional 132 patients; however, this project is not expected to be completed before October of 1983.

According to state statute, funding for hospitals can be given under the following:

18.25.010 thru 18.25.060 deals with aid to nonprofit hospitals for operating deficits. In an attorney general's opinion dated 2/28/80 (addressing 18.25.040-060 only) it states that Alaska Hospital would not be eligible for funding under this section because it is not a "community operated" nonprofit hospital; community operated meaning by a municipality or local government. The Department of Health and Social Services has proposed language changes to sections 18.25.010. 040, and 060 that would make private nonprofit hospitals eligible for funding under this section of statute.

18.26.050 deals with the Alaska Medical Facilities Authority and their powers to invest. 18.26.050 (11) allows for the issue of notes and revenue bonds to pay the cost of <u>establishing and equipping</u> medical facilities. This provides for only noncertificated areas of hospitals to be eligible. It also does not allow for the facility to be up and operating at the time of the investment.

37.10.070 lists investment of surplus funds. a(11) allows for investment if the financial institution retains 33-1/3 percent of the mortgage. a(14) allows for purchase of mortgages if mortgage insurance is available; or no insurance under certain loan-to-value ratios. Mortgage insurance only goes up to $13 million and is at the rate of 3 percent per year.

Alaska Hospital does not qualify for funding under any of these statutes. According to Tom Williams. Commission of Revenue, funds could be provided through a direct appropriation to the Department of Revenue for purchase of the mortgage with any stipulations deemed necessary.

Possible alternatives:

Alaska Hospital would like to see a $55 million loan with the understanding that repayment would allow them time to get the hospital financially responsible. This could be done through an appropriation to the Dept. of Revenue to purchase the mortgage.

By changing the statute under 18.25.010-060, the Dept. of Health and Social Services would be able to offer financial assistance to the hospital for the retirement of debts or assistance in operational deficits to insure nonclosure due to financial problems. (HB 1030)

It might also be possible to sell the hospital to a private chain, such as Hyatt House. In this case, however, the hospital would be run like any other private facility to make money and not necessarily for the benefit of the community.

Indian Health Service could be allowed to purchase the hospital. This would result in it becoming a Native hospital exclusively. It would also create a shortage immediately as far as hospital facilities are concerned. Anchorage would be short 69 beds daily and would be in serious trouble should any sort of emergency situation develop.

STATE OF ALASKA

JAY S. HAMMOND, GOVERNOR

DEPARTMENT OF REVENUE

TREASURY DIVISION

ELEVENTH FLOOR
STATE OFFICE BUILDING
POUCH SB
JUNEAU, ALASKA 99811

May 9, 1980

Honorable Thelma Buchholdt, Chairman
Health, Education & Social Services Committee
House of Representatives
Alaska State Legislature
Pouch Y
Juneau, Alaska 99811

Dear Representative Buchholdt:

This is to respond to your questions as to the allowability of investment by the general fund in the mortgage of the Alaska Hospital and Medical Center, Inc.

The following sections of AS 37.10.070 affect this type of investment:

1. (a)(11) - this section requires that another offering financial institution be involved (i.e. a bank) and that it must retain a 1/3 participation; on the basis of equal representation with neither parties interest (i.e. state v. bank) subordinate to the other. Section (b)(3) also requires that such loans be certified by the originating financial institution to be made in compliance with law and that liens supporting the loan have been perfected.

2. (a)(14) - this section allows for purchase of mortgages with mortgage insurance at certain loan-to-value (LTV) ratios. At a 50 percent LTV no such insurance is required. At 50-60 percent LTV, 10 percent insurance is required; at 60-75 percent, 15 percent insurance is required.

In light of the above requirements, the mortgage on the Alaska Hospital and Medical Center could not be purchased under general investment powers available to the department for investment of State general fund surplus. The payments on the existing mortgage are in arrears and the general poor financial health of the hospital make any bank participation unlikely (and not allowed by governing Federal banking laws) and mortgage insurance unavailable or, at best, prohibitively expensive.

If I can be of any further assistance, please contact me.

Sincerely,

Peter A. Bushre

Peter A. Bushre
Deputy Commissioner

kr

4-D12LH

DATE: May 7, 1980

TO: Sam Cotten

FROM: Linda Linda

RE: Bill Miles Questions on Alaska Hospital

1. Who/what owns P.O.B. (Professional Office Building)?

   Teamsters Building Fund. Current appraisal, 12/10/79, is for $13,000,000. The Teamsters Building Fund leases space to various medical concerns.

2. Who/what owns Alaska Hospital?

   Alaska Hospital and Medical Center, Inc., an Alaskan Nonprofit Corporation, owns the hospital.

3. Mortgage balance on P.O.B.?

   If Teamsters have a mortgage on the P.O.B., it is not part of the issue, as they only want to sell it in connection with the Hospital.

4. Mortgage on the Hospital?

   The mortgage is held by the Teamsters Pension Trust Fund. The balance as of 4/30/80 is $34,929,000 on the principal,

5. Arrears on P.O.B.?

   Not in question, same as #3.

6. Arrears on the Hospital?

   As of 4/30/80 the hospital owes $2,710,000 in back payments. (This figure was $5,714,000; however, they applied their revenue sharing money to this.)

7. Other debts on the P.O.B.?

   Same as #3.

8. Other debts of the hospital?

   They are having trouble meeting their operational commitments. And have an outstanding promissory note with the Pension Fund for $950,000 for purchase of the xray and lab equipment from Alaska Clinic. The hospital is making its payments on this debt currently, which is $8,000 per month.

FISCAL NOTE

I. REQUEST

Bill/Resolution No. HB 1030

Title Assistance to Nonprofit Hospitals

Requested by _____ Date _____

II. FISCAL DETAIL

Agency Affected NA

Program Category Affected NA

BRU, Program, or Subprogram(s) Affected NA

(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 80	FY 81	FY 82	FY 83	FY 84	FY 85
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL						
400 COMMODITIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC.						
TOTAL	0	0	0	0	0	0

FUNDING (Thousands of Dollars)

GENERAL FUND						
FEDERAL FUNDS						
OTHER (Specify Fund Source)						

POSITIONS

FULL TIME						
PART TIME						
TEMPORARY						

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

No fiscal impact to the Department.

IV. DATE 5-13-80 PREPARED BY Mary Foster

AGENCY Community & Regional Affairs

PHONE 465-4734

Original: Legislative Finance

cc: Budget and Management

Prime Sponsor (First Legislator Named)

33-001 (Rev. 12/79)

BYLAWS

OF

THE ALASKA HOSPITAL AND MEDICAL CENTER, INC.

(AN ALASKA NONPROFIT CORPORATION)

ARTICLE I. OFFICES

The corporation shall maintain its principal office for the transaction of its business within the Third Judicial District, State of Alaska.

ARTICLE II SEAL

The corporation shall have a seal.

ARTICLE III. MEMBERS

The members of the corporation are its Board of Trustees.

ARTICLE IV. BOARD OF TRUSTEES

Section 1 - General Powers. The business and affairs of the corporation shall be managed by its Board of Trustees.

Section 2 - Number, tenure and qualifications. The Board of Trustees shall be five (5) in number. The number of trustees may be increased by amendment of these bylaws but may not be decreased to less than five (5) without amendment to the Articles of Incorporation. Trustees shall be elected by the Board of Trustees, as members of the corporation, at the annual meeting of the Board for a term of one (1) year or until their successors shall have been duly elected and qualified, and the term of each trustee shall begin immediately after his election. Trustees may succeed themselves.

Any trustee may be removed from office at any time by majority vote of the remaining trustees, without cause stated. Any trustee shall be removed if he fails to attend three (3) consecutive meetings without excuse acceptable to the Board. Any trustee may resign at any time upon giving written notice to the Board. Any vacancy occurring in the office of a trustee shall be filled by majority vote of the remaining trustees, even though such number be less than a quorum.

To be eligible to be a trustee, a person shall be twenty-one (21) years of age or older, shall have been a resident of the Third Judicial District of Alaska for at least one (1) year preceding, and shall be of good moral character. The judgment of the Board as to qualifications of any member shall be final and binding.

Section 3 - Meetings. The annual meeting of the Board and of the corporation shall be held on the FOURTH THURSDAY in the month of JANUARY in each year, or at such other time as conveniently thereafter may be, stated in notice thereof. The Board shall hold such regular meetings from time to time as determined by the President. Special meetings may be called by the President or by any two members of the Board, and at such special meeting no business other than that stated in the notice shall be transacted.

Section 4 - Notice, Place. No notice need be given of annual or regular meetings unless the time or place be other than that stated at the prior meeting. Notice of any special meeting shall be given at least two (2) days previously thereto by means then deemed best to give actual notice. Any trustee may waive notice of any meeting and the attendance of a trustee at a meeting shall constitute a waiver of a notice, except where the trustee attends for the express purpose of objecting to the transaction of any business because the meeting is not lawfully called or convened.

Meetings shall be held at the offices of the corporation or such other place as may from time to time be determined by the Board, the President, or as set forth in the notice.

Section 5 - Quorum. The majority of the number of trustees shall constitute quorum, but if less than a majority is present at a meeting, it may be adjourned from time to time without further notice.

Section 6 - Manner of Acting. The act of a majority of the trustees present at a meeting at which a quorum is present shall be the act of the Board of Trustees.

Section 7 - Action Without a Meeting. Any action that may be taken by the Board of Trustees at a meeting may be taken without a meeting if a consent in writing shall be signed by all of the trustees. The business transacted at any meeting, however called and noticed and wherever held or if no meeting be held, shall be valid if all trustees execute approval of the minutes thereof or written record of the action taken and such writing is made a part of the minutes of the Board.

Section 8 - Compensation. Unless a resolution of the Board shall provide otherwise, no trustee shall be compensated except that he may be paid his expenses, if any. This shall not preclude any trustee from serving the corporation in any other capacity and receiving reasonable compensation therefor.

Section 9 - Committees. The Board may by resolution establish such standing or special committees, composed of such trustees and other persons, as may from time to time be determined. The Board shall ordinarily act as a committee of the whole.

Section 10 - Officers. The Board shall from time to time elect from among its members a president, vice president and secretary, and such other officers as the Board may from time to time determine. Each officer shall serve at the pleasure of the Board. The president shall preside at all meetings and be the chief executive officer of the Board. The vice president shall act in the absence of the president. The secretary shall keep and maintain adequate records of all meetings of the Board and of the corporation.

Section 11 -- Powers. The Board of Trustees shall have and exercise all powers, without limitation, of all of the members or of the Board of Directors or Trustees of a nonprofit corporation not prohibited by law.

ARTICLE V. ADMINISTRATION

ADMINISTRATOR, COMPTROLLER, OTHER REPRESENTATIVES.

Section 1 -- Administrator. The Board of Trustees shall select and appoint as chief administrative officer of the corporation an administrator, who shall be its direct executive representative in the management of the Hospital and other business of the corporation. Subject only to such policies as may be adopted and such orders as may be issued from time to time by the Board of Trustees, the administrator shall act as and be the duly authorized representative of the Board of Trustees in all matters in which the Board of Trustees has not formally designated another person to act. The administrator has authority and responsibility for:

a. Carrying out all policies and orders established and made by the Board of Trustees.

b. Development, submission to the Board for approval and maintenance of organizational and operational plans for the Hospital.

c. In conjunction with the comptroller, preparation and submission for approval of an annual operating budget, and operation of the Hospital in accordance with approved budgets.

d. Selection, employment control and discharge of employees, and development and maintenance of personnel policies and practices of the Hospital.

e. Care, maintenance, repair and management of the physical properties, inventories, supplies and other assets of the corporation.

f. Supervision of business affairs of the corporation.

g. Representative of the Board and corporation and liaison from the Board with all other entities public, private and governmental, and with the medical staff.

h. Preparation of and presentation to the Board of Trustees of regular and special reports as requested by the Board or as needed to keep the Board fully advised.

i. Attendance at all meetings of the Board.

j. Performance of such other duties as may be in the best interests of the Hospital or assigned from time to time by the Board.

Section 2 - Comptroller. The administrator shall, with the advice and consent of the Board, appoint a comptroller, who shall have charge and custody of and be responsible for all funds and securities of the corporation, receive and give receipts for moneys due and payable, deposit all such moneys in the name of the corporation in such banks, trust companies or other depositories as shall be from time to time selected, maintain the financial records of the corporation and prepare financial reports therefrom, prepare the financial portions of annual operating budgets and be responsible for financial management thereunder, and to do and perform all other duties incident to the office of comptroller and such other duties as may be from time to time assigned to him by the administrator or by the Board of Trustees. If required by the Board, the comptroller shall give a bond for the faithful discharge of his duties in such sum and with such surety or sureties as the Board shall determine.

Section 3 - Other Officers. The Board of Trustees or the administrator with the advice and consent of the Board may from time to time create such other offices and describe the duties and functions thereof.

ARTICLE VI. MEDICAL STAFF

The medical staff of the Hospital shall organize, operate and be self-governed under medical staff bylaws, rules and regulations. The Board of Trustees reserves unto itself, however, the final authority and responsibility for all medical and other matters of the Hospital or the corporation, and accordingly:

a. All medical staff, bylaws, rules and regulations shall be advisory to and not binding upon the Board of Trustees, and

b. No medical staff bylaws, rules or regulations, or any amendment thereto, shall be effective unless and until the same shall have been approved by the Board of Trustees, and

c. The Board of Trustees reserves unto itself the absolute right to amend such medical staff bylaws, rules and regulations or to take any action inconsistent therewith which the Board of Trustees, in its sole discretion, deems to be in the best interest of the Hospital or the corporation.

This provision of these Bylaws respecting the medical staff shall be deemed at all times to be a portion of and shall be set forth in all medical staff bylaws, rules and regulations.

ARTICLE VII. FISCAL YEAR

The fiscal year of the corporation shall be the calendar year.

ARTICLE VIII. SPECIAL PROVISIONS

The corporation shall have no authority to and shall take no action which, under the laws of the United States or of Alaska are prohibited by nonprofit corporations or which jeopardize the corporation's tax exempt status.

ARTICLE IX. INDEMNIFICATION

In acting for the corporation, trustees may rely upon financial records and reports prepared by agents of the corporation. Each trustee is entitled by right to defense, indemnifcation and to be held harmless by the corporation for any and all liability of any kind which a trustee may suffer or for actions threatened against a trustee arising from his actions and decisions made for and on behalf of the corporation to the maximum extent permitted by law.

ARTICLE X. AMENDMENTS

These Bylaws may be altered, amended or repealed and new bylaws may be adopted by the Board of Trustees at any regular meeting or at any special meeting.

KNOW ALL MEN BY THESE PRESENTS: That the undersigned secretary of the Board of Trustees of The Alaska Hospital and Medical Center, Inc. does hereby certify that the above and foregoing bylaws were duly adopted by the Board of Trustees as the Bylaws of the corporation on the 30th day of August, 1978.

William H. Lee
Secretary

AMENDED AND RESTATED

ARTICLES OF INCORPORATION

OF

THE ALASKA HOSPITAL AND MEDICAL CENTER, INC.

Pursuant to the provisions of Article 3 of Chapter 20, Title 10, Alaska Statutes, the undersigned corporation adopts the following Amended and Restated Articles of Incorporation:

ARTICLE I

The name of this corporation is THE ALASKA HOSPITAL AND MEDICAL CENTER, INC.

ARTICLE II

The duration and existence of this corporation shall be perpetual.

ARTICLE III

The object and purposes for which this corporation is formed are as follows:

a. To own, build, erect, construct, lease, maintain, manage and operate hospitals and clinics, general and special, or related facilities, or all of them, within the State of Alaska, or elsewhere, for the care of persons suffering from illness or disabilities and for the rendering of inpatient or outpatient medical care to persons; said business to be carried on and the objectives thereof not for profit, but rather exclusively for charitable scientific and educational purposes within the meaning of the Alaska Nonprofit Corporation Act and of Section 501(c)(3) of the Internal Revenue Code of 1954, as now in force or as may hereafter be amended.

b. To carry on educational activities related to the rendering of care to the sick and injured or to promotion of health and to promote and carry on scientific research related to the care of the sick and injured or the promotion of health.

c. To do and engage in all lawful activities that are in furtherance of one or more of the general purposes of this corporation.

d. To have and exercise the general powers specified in AS 10.20.011, as now in force or as may hereafter be amended. The objects and purposes of the corporation shall be construed also as powers, and the matters expressed in each of the foregoing clauses shall, unless otherwise expressly provided, be in no wise limited by reference to or inference from the terms of any other clause, but shall be regarded as independent objects, purposes and powers; and the enumeration of specific objects, purposes and powers shall not be construed to limit or restrict in any manner the meaning of general terms or the general powers of the corporation; nor the expression of one thing be deemed to exclude another not expressed, although it be of like nature.

ARTICLE IV

The following additional provisions are inserted for the regulation of the affairs of the corporation.

a. No substantial part of the activities of the corporation shall consist of attempting to influence legislation by propaganda or otherwise or directly or indirectly participating in or intervening in (including the publishing or distributing of statements), any political campaign on behalf of or in opposition to any candidate for public office.

b. Upon dissolution of the corporation, its remaining assets, if any, shall be distributed to an organization described in Section 501(c)(3), and exempt from taxation under Section 501(a) of the Internal Revenue Code, as now in force or afterwards amended.

c. The corporation shall not engage in any of the prohibited transactions described in Section 501(b) of the Internal Revenue Code or of the Alaska Nonprofit Corporation Act, as now in force or afterwards amended.

d. The corporation shall not unreasonably accumulate income within the meaning of Section 504 of the Internal Revenue Code, as now in force or afterwards amended.

e. The corporation shall not be operated for the primary purpose of carrying on unrelated trade or business as defined in Section 513 of the Internal Revenue Code, as now in force or afterwards amended.

f. No part of the net earnings of the corporation shall inure to the benefit of any private individual or member within the meaning of Section 501(c)(3) of the Internal Revenue Code, as now in force or afterwards amended.

g. No compensation shall be paid to any member, officer, director, trustee, creator or organizer of the corporation or substantial contributor to it, except as to reasonable allowance for services actually rendered to or for the corporation.

h. No loans shall be made by the corporation to any of its directors or officers.

i. The corporation is organized to serve public interests. Accordingly, it shall not be operated for the benefit of private interests, such as contributors to or members of the corporation, or persons controlled directly or indirectly by such private interests.

ARTICLE V

The corporation shall not have shareholders, but it shall have one or more classes of members, and the Bylaws shall set forth the class or classes, the manner of election or appointment and the qualifications and rights of the members of each class and the certificates evidencing membership, if any, that the corporation may issue.

ARTICLE VI

The corporation shall be under the management and control of a Board of Trustees. Such Board shall consist of not less than five (5) members. The qualifications of and manner of election of trustees as well as the number of trustees shall be prescribed in the Bylaws of this corporation.

ARTICLE VII

The Bylaws of the corporation may be adopted or amended by a majority vote of the Board of Trustees.

ARTICLE VIII

These Amended and Restated Articles of Incorporation correctly set forth without change the corresponding provisions of the Articles of Incorporation as amended, and supersede the original Articles of Incorporation and all amendments.

ARTICLE IX

These Amended and Restated Articles of Incorporation shall be considered effective the 30th day of August, 1978.

DATED this 30th day of August, 1978.

President

Secretary

STATE OF ALASKA)
) ss:
THIRD JUDICIAL DISTRICT)

BEFORE ME, the undersigned Notary Public in and for the State of Alaska, duly commissioned and sworn as such, this day personally appeared Ray Snitil and William H. Ivy, M.D, known to me and known to me to be the president and cretary respectively, and they acknowledged they execute the foregoing by virtue of authority granted in the Bylaws or by resolution of the Board of Directors.

WITNESS my hand and Notarial Seal this 30th day of August, 1978.

Notary Public in and for Alaska
My Commission Expires: 1-1-1980

ARTICLES OF AMENDMENT

TO THE

ARTICLES OF INCORPORATION

OF

THE ALASKA HOSPITAL AND MEDICAL CENTER, INC.

Pursuant to the provisions of Article 3 of Chapter 20, Title 10, Alaska Statutes, the undersigned corporation adopts these Articles of Amendment to its Articles of Incorporation:

FIRST: The name of the corporation is THE ALASKA HOSPITAL AND MEDICAL CENTER, INC.

SECOND: The amendment adopted is the attached "Amended and Restated Articles of Incorporation of The Alaska Hospital and Medical Center, Inc."

THIRD: There are no members entitled to vote.

FOURTH: These Articles of Amendment and the attached Amended and Restated Articles of Incorporation of The Alaska Hospital and Medical Center, Inc. were duly and regularly adopted at a meeting of the Board of Trustees on the 30th day of August, 1978, upon receiving the vote of a majority of the trustees in office.

DATED at Anchorage, Alaska this 30th day of August, 1978.

THE ALASKA HOSPITAL AND MEDICAL CENTER, INC.

By _____
President

By _____
Secretary

STATE OF ALASKA)
) ss:
THIRD JUDICIAL DISTRICT)

BEFORE ME, the undersigned Notary Public in and for the State of Alaska, duly commissioned and sworn as such, this day personally appeared Ray Smith and William H. Ivy, M.D., known to me and known to me to be the president and secretary, respectively, of THE ALASKA HOSPITAL AND MEDICAL CENTER, INC. and they acknowledged that they executed the foregoing by virtue of authority granted in the Bylaws or by resolution of the Board of Directors.

WITNESS my hand and Notarial Seal this 30th day of August 1978.

Notary Public in and for Alaska
My Commission Expires: Sept. 14 1980

THE FOLLOWING DOCUMENT(S) MAY NOT FILM LEGIBLY BECAUSE OF POOR QUALITY OF THE ORIGINAL.

Information Update . . .

LAKE OTIS CLINIC, INC. P.O. BOX 4-1539 ANCHORAGE, ALASKA 995
(907) 276-31

THE LAKE OTIS COMMUNITY HOSPITAL

DELIVERED TO HESS COMMITTEE MAY 19, 1980 BY KEITH DOUGLASS

In a manner true to Chicken Little, a few Assemblymen, a hospital administrator, a labor union, and a couple hundred hospital employees, staff and their relatives are running around Anchorage and Juneau crying that the sky is falling in on Anchorage's hospital care. There is a potential community wide crisis, they say, that needs—IMMEDIATE legislative attention to save Anchorage from a catastrophe. They ask the Legislature, AT THE VERY END OF ITS SESSION, to commit 55 MILLION DOLLARS to bail out two pieces of real estate: The Alaska Hospital, and the Teamster's half-vacant office building.

Shouldn't we question the motives behind this eleventh-hour crisis technique? Why has a hospital that has been failing for four years wait until March of this year to present a proposal to the Legislature? Isn't it simply that devoid of the eleventh-hour crisis atmosphere, such a preposterous proposal would receive no serious consideration?

HOW CAN THERE BE A COMMUNITY HOSPITAL BED CRISIS WHEN:

1) The Indian Health Service has stipulated to a transition plan?

2) Providence Hospital can have additional beds on line with

one year?

3) The Lake Otis Hospital could be built as a TRUE COMMUNITY HOSPITAL in eighteen months?

4) THERE ARE 80 AVAILIBLE BEDS in the Old Community Hospital at 525 L Street that COULD BE AVAILIBLE IN 48 HOURS?

Why haven't we heard about this re-convertable emergency hospital at 525 L Street? Behind the facade of offices, there is a hospital in mothballs, with equipment being maintained, and a provision for its re-conversion to a functional hospital in 48 hours. Why hasn't this facility (which the Municipality leases for about ONE TENTH of the annual debt service on the Alaska Hospital Complex) been exposed as a temporary alternate if the Alaska Hospital folds? Because, ladies and gentlemen, such solutions are NOT what crisis are made of.

There is no real crisis in hospital care in Anchorage today, NOR WILL THERE BE IF THE DEPARTMENT OF LABOR FORCLOSES TOMORROW. The ONLY ones that will be caught in a crisis if this Legislature refuses to be swayed by pressure tactics are:

1) Teamsters' Local 959, and its officers

2) The employees, medical staff, and administrator of the Alaska Hospital

3) Local politicians who have made this an election year issue

4) Providence Hospital, who would suddenly have UNKNOWN and UNCONTROLLED competition for profitable medical-surgical beds.

We are told that the Alaska Hospital needs a "loan" of 55 PLUS DOLLARS to save them. Proponents of this move would have you believe that this is a bonafide loan. In reality, it is a direct subsidy to the Hospital and Teamsters IN EXCESS of the 5 million per year that the Hospital already receives. This hospital operation is currently loosing over 4 MILLION DOLLARS PER YEAR IN EXCESS OF UNFUNDED DEPRECIATION. How can anyone seriously expect it to pay back its loan, PLUS the loan on the half vacant office building at ANY time certain?

The real truth is that proponents of H.B. 1030 KNOW that the Legislature would never grant a direct appropriation of this magnitude to any private group, even to the Teamsters. They would have you pass enabling legislation under the guise of a loan program, without insuring any of the normal safeguards, and leave it to the administration to decide its propriety.

It is a credit to the legislative process, and to Mrs. Buchholi that these hearings are being held, and that this committee has resisted special-interest pressures to pass the bill out. I ask only that you continue to look beyond the veneer of the arguments made by proponents of H.B. 1030, and ask "Is the sky REALLY falling?" If you decide that it is, than it is the responsibility of THIS COMMITTEE, not others down the line, to suggest alternate solutions, and to build in safeguards to this expendature of state funds.

Thank you.

THE PRECEDING DOCUMENT(S) MAY NOT FILM LEGIBLY BECAUSE OF POOR QUALITY OF THE ORIGINAL.

HB1030

TELEGRAM

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PHONE: ...
JUNEAU, AK ...

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PMS REP IRELMA BUCHHOLDT

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THE ALASKA NATIVE HEALTH BOARD AGENT OF RECORD FOR REGIONAL HEALTH CORPORATIONS AND NATIVES STRONGLY OPPOSES PASSAGE OF HB1030. IT WOULD LIKE TO BE ADVISED OF HEARINGS AND OFFERED OPPORTUNITIES TO TESTIFY. PLEASE INCLUDE BOARD IN FUTURE PLANNING.

DAVID E. CATES PHD 276-8989

EXECUTIVE DIRECTOR

HB1030

PROVIDENCE
HOSPITAL

3200 PROVIDENCE DRIVE - POUCH 6604
ANCHORAGE, ALASKA 99502
PHONE: (907) 276-4511

SISTERS OF
PROVIDENCE

SERVING IN THE WEST SINCE 1856

May 5, 1980

The Honorable Thelma Buchholdt
State House of Representatives
Pouch V
Juneau, Alaska 99811

Dear Representative Buchholdt:

On April 26 the second annual Providence Medical Staff Planning Congress was held here at Providence Hospital.

The purpose of the Congress was to encourage the free exchange of ideas on several issues relating to achieving and maintaining excellence in patient care. Attendance was high with over 150 participating, including medical staff members, hospital management staff, and a wide variety of citizens and officials involved in health planning programs.

One of the issues discussed was: "Should Anchorage be a one, two, or three hospital town?" Following a thorough discussion of the alternatives by a discussion group, the Congress adopted four resolutions in the afternoon plenary session. Also, due to the serious nature of the resolutions and their timeliness, it was agreed that the resolutions be communicated to appropriate members of the state legislature. They are as follows:

Resolution #1 "We are opposed to the federal government purchasing or leasing Alaska Hospital and Medical Center for the Native services hospital." (Approved unanimously.)

Resolution #2 "Anchorage should be a two-hospital city for planning purposes over the next five years. We strongly endorse maintaining Alaska Hospital and Medical Center as a non-profit community hospital in Anchorage, and recommend that they seek financial assistance from the state legislature to develop interim and long-range financing." (Approved unanimously.)

Resolution #3 "If Alaska Hospital and Medical Center beds are removed from the community through federal purchase for Native beds, there must be a disaster mode plan for both current and long-range needs to accommodate patients." (Approved unanimously.)

Resolution #4 "We currently disapprove of the hospital proposed by Lake Otis Clinic because it lacks community support, medical support, financial support and community planning input, and because it lacks in its current conception the ability to meet the hospital bed needs and the community service needs now available at Alaska Hospital and Medical Center." (Approved at Congress by voice vote with one opposed.)

If you have any questions regarding these resolutions or the Medical Staff Congress, please give us a call.

Sincerely,

Christopher Beardsley
Director of Public Relations
& Governmental Affairs

For Al M. Camosso
Administrator

cc: Senator Ted Stevens
Senator Mike Gravel
Representative Don Young
David Walsh
Ron Pavellas
Ron Hammett
Don DeMers

FISCAL NOTE

I. REQUEST

Bill/Resolution No. HB 1030

Title Assistance to Nonprofit Hospitals

Requested by _____ Date _____

II. FISCAL DETAIL

Agency Affected NA

Program Category Affected NA

BRU, Program, or Subprogram(s) Affected NA

(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 80	FY 81	FY 82	FY 83	FY 84	FY 85
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL						
400 COMMODITIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC.						
TOTAL	0	0	0	0	0	0

FUNDING (Thousands of Dollars)

GENERAL FUND						
FEDERAL FUNDS						
OTHER (Specify Fund Source)						

POSITIONS

FULL TIME						
PART TIME						
TEMPORARY						

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

No fiscal impact to the Department.

IV. DATE 5-13-80 PREPARED BY Mary Foster

AGENCY Community & Regional Affairs

PHONE 465-4734

Original: Legislative Finance

cc: Budget and Management

Prime Sponsor (First Legislator Named)

33-001 (Rev. 12/79)

House Health, Education & Social Services Committee — Meeting/Hearing on HB1030 — Date: 5/9/80

	Name	Address and Phone	Organization/Self	For/Against or Observing
1)	1/ Rep. Sam Cotton			
2)	2/ Comm. Helen Braine		Dept HA+SS	
	3/ Peter A. Bushre		Dept. Rev. for Treasury	
	4/ ANSELM C. STAACK		REVENUE	
	5/			
	6/			
	7/			
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	12/			
	13/			

THE FOLLOWING DOCUMENT(S) MAY NOT FILM LEGIBLY BECAUSE OF POOR QUALITY OF THE ORIGINAL.

State of Alaska

Department of Commerce and Economic Development

Certificate

The undersigned, as Commissioner of Commerce and Economic Development of the State of Alaska, hereby certifies that duplicate originals of Articles of Merger of MEDICAL DENTAL BUILDING CORPORATION, a nonprofit corporation and THE ALASKA HOSPITAL AND MEDICAL CENTER, INC., a nonprofit corporation, duly signed and verified pursuant to the provisions of the Alaska Nonprofit Corporation Act, have been received in this office and are found to conform to law.

ACCORDINGLY the undersigned, as such Commissioner of Commerce and Economic Development, and by virtue of the authority vested in him by law, hereby issues this Certificate of Merger of

MEDICAL DENTAL BUILDING CORPORATION

MERGED INTO

THE ALASKA HOSPITAL AND MEDICAL CENTER, INC.

and attaches hereto a duplicate original of the Articles of Merger.

IN TESTIMONY WHEREOF, I have hereunto set my hand and affixed my official seal at Juneau, the Capital, this

21st day of February A.D. 19 79

H. PHILLIP HUBBARD
COMMISSIONER OF COMMERCE
AND ECONOMIC DEVELOPMENT

FILED FOR RECORD

FEB 21 1978

STATE OF ALASKA

ARTICLES AND PLAN OF MERGER OF MEDICAL DENTAL BUILDING CORPORATION, INC. A NONPROFIT CORPORATION INTO THE ALASKA HOSPITAL AND MEDICAL CENTER, INC. A NONPROFIT CORPORATION

The undersigned corporations, in accordance with Sections 236, 246, 251 and 256 of Article IV, Chapter 20, Title 10, of the Alaska Statutes, hereby adopt the following Articles and Plan of Merger.

FIRST: These Articles and Plan of Merger were duly adopted and approved by the Board of Directors of MEDICAL DENTAL BUILDING CORPORATION, INC. by special meeting of the Board of Directors held May 31, 1977, in the manner and by the vote required by the laws of the State of Alaska. Likewise, these Articles and Plan of Merger were duly adopted and approved by the Board of Trustees of THE ALASKA HOSPITAL AND MEDICAL CENTER, INC. at a special meeting held May 31, 1977, in the manner and by the vote required by the laws of the State of Alaska.

The Plan and Agreement of Merger is as follows:

ARTICLE I

The parties hereto agree to effect this merger.

ARTICLE II

The parties to these Articles and Plan of Merger are MEDICAL DENTAL BUILDING CORPORATION, INC. (hereinafter referred to as MDBC, INC.) and THE ALASKA HOSPITAL AND MEDICAL CENTER, INC. (hereinafter referred to as THE ALASKA HOSPITAL), both incorporated as nonprofit corporations in the State of Alaska.

ARTICLE III

The corporation to survive the merger is THE ALASKA HOSPITAL AND MEDICAL CENTER, INC., an Alaskan nonprofit corporation, which shall continue under the same corporate name.

ARTICLE IV

The principal offices of MDBC, INC. and THE ALASKA HOSPITAL are located at Anchorage, Alaska. MDBC, INC. is the owner of real property, the title of which will become vested in THE ALASKA HOSPITAL as a result of this merger.

ARTICLE V

The Articles of Incorporation of THE ALASKA HOSPITAL, as in effect on the effective date of this merger, shall continue in full force and effect as the Articles of Incorporation of THE ALASKA HOSPITAL and shall not be changed or amended by the merger.

ARTICLE VI

THE ALASKA HOSPITAL reserves the right and power, after the effective date of the merger, to alter, amend, change or repeal any provisions contained in the Articles of Incorporation in the manner now or hereafter provided by statute, and all rights conferred on officers, directors or members are subject to this reservation.

ARTICLE VII

The Bylaws of THE ALASKA HOSPITAL, as such Bylaws exist on the effective date of the merger, shall remain and be the Bylaws of THE ALASKA HOSPITAL, until altered, amended or repealed, or until new Bylaws shall be adopted in accordance with the provisions thereof, the Articles of Incorporation or in the manner permitted by the applicable provisions of law.

ARTICLE VIII

The Board of Trustees of THE ALASKA HOSPITAL, as of the effective date of the merger, shall continue in office until the next annual meeting of the Board of Trustees of THE ALASKA HOSPITAL. The number of the Board of Trustees of THE ALASKA HOSPITAL shall continue to be fourteen (14) in number and shall be the following persons: Michael Barry, Floyd Connors, John Creed, Gary Dixon, William Ivy, M.D., Robert McFarland, William Padgett, Robert Sinnett, Frank Yarnot, Jesse Carr, Vernon Cates, M.D., Barney Gottstein, Gordon Hartlieb and John Forceskie.

The following officers of THE ALASKA HOSPITAL immediately prior to the effective date of merger shall continue in office after the effective date of merger and until the next annual meeting of the Board of Trustees of THE ALASKA HOSPITAL: Jesse Carr, President; Vernon Cates, M.D., Vice President; and William Padgett, Secretary.

ARTICLE IX

MDBC, INC. is a wholly owned subsidiary of THE ALASKA HOSPITAL and, therefore, there is no exchange of shares to be had as a result of this merger. There are no members of either nonprofit corporation entitled to vote in this merger.

ARTICLE X

On the effective date of the merger, the separate existence of MDBC, INC. shall cease (except to the extent continued by statute), and all of its property, rights, privileges and franchises of whatsoever nature and description shall be transferred to, vest in and devolve upon the surviving corporation, without further act or deed. Conformity deeds, assignments or other like instruments, when deemed desirable by THE ALASKA HOSPITAL to evidence such transfer, vesting or devolution of any property, right, privilege or franchise shall at any time, and from time to time, be made and delivered in the name of MDBC, INC. for the last acting officers thereof, or by the corresponding officers of the surviving corporation.

ARTICLE XI

The effective date of the merger shall b May 1, 1977, if these Articles and Plan of Merger are accepted for record by the Department of Commerce and Economic Development of the State of Alaska.

SECOND: There are no members entitled to vote in either corporation a party to this transaction.

THIRD: Pursuant to the Alaska Statute 10.20.236, approval of this merger was had by the Board of Directors of MDBC, INC. and the Board of Trustees of the ALASKA HOSPITAL by a majority vote as indicated below:

NONPROFIT CORPORATION	NO. OF DIRECTORS OR TRUSTEES	THOSE VOTING FOR	THOSE VOTING AGAINST
MDBC, INC.	6	6	0
THE ALASKA HOSPITAL	14	14	0

DATED this 31st day of May, 1977.

MEDICAL DENTAL BUILDING CORPORATION, INC.

By _____
Jesse Carr, President

By _____
William Padgett, Secretary

THE ALASKA HOSPITAL AND MEDICAL CENTER, INC.

By _____
Jesse Carr, President

By _____
William Padgett, Secretary

STATE OF ALASKA)
) ss.
THIRD JUDICIAL DISTRICT)

I, _____, a Notary Public, do hereby certify that on the 24 day of May, 1977, personally appeared JESSE CARR, who being first duly sworn, declared that he signed the foregoing document as President of MEDICAL DENTAL BUILDING CORPORATION, INC. and the statements therein contained are true.

_____
Notary Public in and for Alaska
My Commission Expires: _____

STATE OF ALASKA)
) ss.
THIRD JUDICIAL DISTRICT)

I, _____, a Notary Public, do hereby certify that on the 24 day of May, 1977, personally appeared before me WILLIAM PADGETT, who being first duly sworn, declared that he signed the foregoing document as Secretary of MEDICAL DENTAL BUILDING CORPORATION, INC. and the statements therein contained are true.

_____
Notary Public in and for Alaska
My Commission Expires: _____

STATE OF ALASKA)
) ss.
THIRD JUDICIAL DISTRICT)

I, _____, a Notary Public, do hereby certify that on the 24 day of May, 1977, personally appeared before me JESSE CARR, who being first duly sworn, declared that he signed the foregoing document as President of THE ALASKA HOSPITAL AND MEDICAL CENTER, INC.

and the statements therein contained are true.

Ellen M Sprague
Notary Public in and for Alaska
My Commission Expires: 11-24-78

STATE OF ALASKA)
) ss.
THIRD JUDICIAL DISTRICT)

I, Ellen M Sprague, a Notary Public, do hereby certify that on the 31st day of May, 1977, personally appeared before me WILLIAM PADGETT, who being first duly sworn, declared that he signed the foregoing document as Secretary of THE ALASKA HOSPITAL AND MEDICAL CENTER, INC. and the statements therein contained are true.

Ellen M Sprague
Notary Public in and for Alaska
My Commission Expires: 11-24-78

LAW OFFICES
JOHNSON, CHRISTENSON & GLASS

FILED FOR RECORD

FEB 21 1978 200315

PARTIAL
ASSIGNMENT OF LEASE

The undersigned, TEAMSTERS LOCAL 959 BUILDING CORPORATION, hereinafter referred to as Assignor, for and in consideration of TEN DOLLARS ($10.00), lawful money of the United States of America, and other good and valuable consideration, does hereby assign and transfer to THE ALASKA HOSPITAL AND MEDICAL CENTER, INC., hereinafter referred to as Assignee, all of its right, title and interest in and to that certain real property, including improvements and buildings thereon, described as follows:

A portion of that certain leasehold, ADL #21400, executed on June 26, 1963, the term of which is fifty-five (55) years beginning June 26, 1963, wherein the State of Alaska is the Lessor and Karl A. Bachner was Lessee, which lease was purportedly relinquished by instrument dated August 22, 1972, and recorded March 28, 1974, in Book 224 at Page 536 thereof, said relinquishment having thereafter been declared invalid by judgment of the Superior Court in and for the State of Alaska, Third Judicial District, entered September 22, 1976, in Action No. 75-2887, and thereafter recorded the _____ day of December, 1977, in Book No. _____, at Page _____, of official records in the Anchorage Recording District, Third Judicial District, State of Alaska, said lease through mesne conveyances having been lawfully assigned to the Teamsters' Local 959 Building Corporation, Lessee, as said lease effects that certain real property situated in the Anchorage Recording District, Third Judicial District, State of Alaska, being that portion of the South one-half of the Southeast one-quarter of the Southwest one-quarter (S 1/2 SE 1/4 SW 1/4) of Section 16, Township 13 North, Range 3 West, Seward Meridian, records of the Anchorage Recording District, Third Judicial District, State of Alaska, more particularly described as follows:

From the one-quarter(1/4) corner of Sections 16 and 21, Township 13 North, Range 3 West, Seward Meridian, Alaska; thence West, along the line between said Sections 16 and 21, for a distance of 40.00 feet to a point; thence No. 00°00'00" W., for a distance of 40.00 feet to the intersection of the northerly right-of-way line of DeBarr Avenue with the westerly right-of-way line of Airport Heights Road; thence West, along the northerly right-of-way line of DeBarr Avenue, for a distance of 1052.44 feet to a point; thence N. 39°00'00" E., for a distance of 219.78 feet to a point, the True Point of Beginning of the parcel described herein; thence N. 06°00'00" W., for a distance of 42.43 feet to a point; thence N. 51°00'00" W., for a distance of 31.00 feet to a point; thence N. 39°00'00" E., for a distance of 37.00 feet to a point; thence N. 51°00'00" W., for a distance of 465.25 feet to a point; thence N. 00°06'48" W., for a distance of 65.74 feet to a point; thence S. 89°59'40" E., for a distance of 663.23 feet to a point; thence S. 39°00'00" W., for a distance of 257.38 feet to a point, thence S. 51°00'00" E., for a distance of 123.23 feet to a point; thence S. 39°00'00" W., for a distance of 37.00 feet to a point; thence N. 51°00'00" W., for a distance of

200215

19.00 foot to a point; thence S. 39°00'00" W., for a distance of 241.00 feet to a point; thence N. 51°00'00" W., for a distance of 82.00 feet to the True Point of Beginning.

DATED this 28th day of December, 1977, at Anchorage, Alaska.

TEAMSTERS' LOCAL 959 BUILDING CORPORATION

By _____

STATE OF ALASKA)
) ss
THIRD JUDICIAL DISTRICT)

THIS IS TO CERTIFY that on this 28th day of December, 1977, before me, the undersigned Notary Public in and for the State of Alaska, duly commissioned and sworn as such, personally appeared _____, the _____ of TEAMSTERS' LOCAL 959 BUILDING CORPORATION, a corporation organized and existing by virtue of the laws of the State of Alaska, known to me to be the person who executed the above instrument and who acknowledged that the seal affixed thereto is the corporate seal of said organization, and that the said instrument was signed and sealed on behalf of said corporation by authority of its Board of Directors for the uses and purposes therein mentioned.

IN WITNESS WHEREOF, I have hereunto set my hand and seal the day and year first hereinabove written.

_____
Notary Public in and for Alaska
My Commission expires: _____

CONSENT

The undersigned Assignee by and through its duly authorized agent, does hereby consent to the above and foregoing assignment.

THE ALASKA HOSPITAL AND MEDICAL CENTER, INC.

By _____

STATE OF ALASKA)
) ss
THIRD JUDICIAL DISTRICT)

THIS IS TO CERTIFY that on this 28th day of December, 1977, before me, the undersigned Notary Public in and for the State of Alaska, duly commissioned and sworn as such, personally appeared Ernest E. Webb, the Administrator of THE ALASKA HOSPITAL AND MEDICAL CENTER, INC., a corporation organized and existing by virtue of the laws of the State of Alaska, known to me to be the person who executed the above instrument and who acknowledged that the seal affixed thereto is the corporate seal of said organization, and that the said instrument was signed and sealed on behalf of said corporation

LAW OFFICES
JOHNSON, CHRISTENSON & GLASS
A PROFESSIONAL CORPORATION
1500 ANCHORAGE MUSEUM ROAD SUITE 204
ANCHORAGE, ALASKA 99504
(907) 276-4331

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STARTING FILE 1

POINT	QUAD	BEAR	ANGLE	DISTANCE	NORTHING	EASTING
START					10178.066	9086.170
INV 45	NW	56	57 39.6	51.973	10218.801	9045.802
INV 27	NW	6	0 0.0	42.430	10252.999	9041.367
INV 28	NW	51	0 0.0	31.000	10272.508	9017.275
INV 29	NE	39	0 0.0	37.000	10301.262	9040.5[illegible]
INV 30	NW	51	0 0.0	465.250	10594.053	8670.993
INV 38	NW	0	6 48.0	65.740	10659.793	8678.863
INV 39	SE	89	59 40.0	663.230	10659.729	9342.093
INV 40	SW	39	0 0.0	257.380	10457.707	9180.119
INV 41	SE	51	0 0.0	123.230	10282.156	9275.886
INV 42	SW	39	0 0.0	37.000	10353.432	9252.602
INV 43	NW	51	0 0.0	19.000	10365.359	9237.836
INV 44	SW	39	0 0.0	241.000	10178.066	9086.170
45						

AREA 161678 SF 3.7116 ACRES

Anaya Hospital

HCR
43

POSITION PAPER/Department of Health & Social Services

HOUSE CONCURRENT RESOLUTION NO. 43

"A resolution endorsing the concept and requesting implementation of the Indian Child Welfare Act of 1978."

House Concurrent Resolution No. 43 resolves that the legislature endorse and support the concept and policy of the Indian Child Welfare Act of 1978 (P.L. 95-608) and urgently request the Governor to direct the Department of Health and Social Services to promptly take steps necessary for implementation of the Act in Alaska.

The Department strongly supports the Indian Child Welfare Act of 1978 and certainly supports the legislature's endorsement and support of the Act. The Department, however, questions the necessity for the resolve number two in HCR No. 43. The Department has been actively involved in implementing the Act since its passage in November 8, 1978. During 1979 the Department has taken numerous steps towards full implementation of the Act (report attached).

RECOMMENDED BY: for _____ DATE: 2/5/80
Art Holmberg, Director
Division of Social Services

APPROVED BY: _____ DATE: 2/5/80
Helen D. Beirne, Commissioner
Department of Health and Social Services

REPORT ON IMPLEMENTATION OF THE INDIAN CHILD WELFARE ACT

The Department of Health and Social Services has been quite active since the passage of the Indian Child Welfare Act in working towards full implementation. As early as February 13, 1979 Department representatives met with the Area Director of BIA and representatives from various native non-profit corporations to begin mapping out strategies and procedures necessary for implementation. In early March Department Representatives met with the BIA contractors to further discuss implementation. On March 7, 1979 the Department testified at hearings held in Juneau regarding the first draft of federal regulations (testimony attached). These regulations were finally published as proposed regulations on April 23, 1979 and were not finalized until July of 1979.

During this interim period before finalization of the implementing regulations the Department's Regional Social Services Managers met with representatives of the native non-profit organizations as well as various village and IRA council leaders to discuss the Act and to begin informal working procedures. The Managers also met with court personnel and the attorney general's offices to establish appropriate court procedures. The Social Service's Field Director met with Art Snowden, the Court Administrator, his staff, the BIA Social Services Director, and the BIA Counsel to further work toward state-wide development of court procedures. As a result of this meeting the Court Administrator agreed to include a letter summarizing the Act in the next mailing to the Alaska Bar members.

Since the finalization of regulations the Department has not only attempted to comply with the formal procedures established by the regulations but has developed many cooperative projects for furthering the implementation of the Act. For example, the Division of Social Services has been working with Tanana Chiefs and United Crow Band on locating, studying, and licensing native foster homes. Similar projects have also been operating in Fairbanks (Fairbanks Native Association) and in Southeast Alaska (Tlingit-Haida). The Division also held a two day training session in Anchorage on Oct 8 & 9, 1979 on the Indian Child Welfare Act. The trainer was Bert Hirsh, one of the original drafters of the law. All the native non-profit organizations as well as state and private agencies were invited to attend. Finally, the Division's training director by request of the native non-profit in the Bethel area provided a training session in Bethel.

These are just some of the examples of the cooperative efforts that have been initiated state-wide. It should be noted however that the Department has supported the concepts embodied in the Indian Child Welfare Act before its passage in 1978. In fact the Department supported a change in 47.10.230 (Powers and duties of Department over care of child) which made placement with blood relatives mandatory if they requested custody.

The intent of this statute was to provide for placement of children in surroundings which meet their social and cultural needs.

The Department has attempted to implement this statute to the fullest extent possible. It has been very successful in areas such as Nome and Bethel but less successful in larger cities such as Anchorage, Fairbanks, and Juneau. For example, 10 years ago 92% of all native children placed for adoption were placed in non-native homes. This has been completely reversed. Presently 75% of the native children placed for adoption are placed in native homes. The only exceptions being some severely handicapped children who have special medical needs and some native children who have been in long term foster care with a non-native family. In addition, in the Nome Region in 1969 all but two Eskimo children were in non-native foster homes. Today in Nome the figures are: 32 native children in native homes and 7 in non-native homes. In the Bethel Region there are 42 native children placed in foster homes. All are placed in native foster homes. However, the placements of native children in native foster homes are significantly lower in the larger cities with Anchorage having the lowest percentage (20 out of 127 native children are in native foster homes). The Department has been working diligently to improve the situation. As noted earlier Tlingit-Haida and Fairbanks Native Association have had foster home finding projects in Juneau and Fairbanks respectively. The Department has supported and worked closely with the staff of these projects. However, the success has been limited.

In summary the Department has been supporting the concepts of the Indian Child Welfare Act for a number of years. It had implemented certain policies consistent with the Act prior to its passage. In addition the Department, has worked diligently to develop formal procedures to implement the Act as well as numerous cooperative projects. The Department realizes there is stil much to be accomplished and certainly agrees to continue its present efforts of implementation and to increase its efforts wherever necessary.

PUBLIC HEARING ON THE INDIAN CHILD WELFARE ACT (PL 95-608)

TESTIMONY:

The Department of Health and Social Services appreciates the opportunity to testify at these hearings. We thank the National American Indian Court Judge Association and Tlinget-Haida Central Council for sponsoring and coordinating this public hearing which provides Alaskans a chance to speak out on such important legislation as the Indian Child Welfare Act.

The Department strongly supports the purpose of the bill which is to protect the best interests of native children and to promote the stability and security of native tribes and families by the establishment of minimum federal standards for the removal of native children from their families and the placement of such children in foster or adoptive homes which will reflect the unique values of native culture. We will diligently work to achieve this purpose and to meet these standards. This is in keeping with the revisions of the Alaska Children's Code passed in 1977. We fully recognize that implementation of both these acts will entail maximum cooperation between the Department, the various organizations representing native Americans and the Federal government. Only through cooperation will we be able to accomplish the tasks necessary to implement these legislative mandates.

The Department is particularly concerned about the fact that the draft regulations only address two areas of Title I: notification and payment for appointed counsel. There are many other areas in Title I that need clarification through regulations, particularly notification procedures (Sec. 102(a)), active efforts to provide remedial and rehabilitative programs designed to prevent the break-up of the Indian family (Sec. 102(d)), confidentiality of information regarding both parents and child (Sec. 102(a) and Sec. 105(c) and (f)), definition of qualified expert witnesses (Sec. 102 (e) and (f)), procedures for informed consent (Sec. 103 (a)). The Department would appreciate an opportunity to comment on these proposed regulations once they are drafted.

In conclusion, the Department is concerned with the best interest of all Alaskan children. The programs for children in Alaska have been struggling due to an ever decreasing committment of resources. In this International Year of the Child, all organizations interested in the welfare of children need to cooperate to enable this landmark legislation, the Indian Child Welfare Act, to be implemented.

This letter sent to all members of House & Senate

APR 26 1979

The Honorable Clem Tillion
Alaska State Senate
Alaska State Legislature
Pouch V
Juneau, Alaska 99811

Dear Senator Tillion:

The Indian Child Welfare Act was signed into law in November, 1978. The regulations implementing this law are scheduled for completion sometime in June. Due to the significant impact this law will have on the Department's operations, I wanted to take this opportunity to give each of you a brief summary of the Department's activities regarding its implementation and a review of some of the most significant changes which will result from its passage.

The Department has been quite involved in the developments concerning the implementation of this Act in Alaska. As recently as March 7th, one of my staff and a member of the Attorney General's Office testified at a hearing concerning the proposed federal regulations. In addition, Department representatives have met with the Bureau of Indian Affairs and with various native non-profit organizations to discuss and plan the process of implementation. Further meetings with these organizations are planned and the Department is in the process of developing agreements with some of the organizations.

In relation to specific change, the Indian Child Welfare Act does alter existing procedures for both adoptions and foster child placements of native children. The area of adoptions is addressed in Sec. 103 of the Indian Child Welfare Act. This section requires voluntary relinquishments of the parental rights of parents of native children to be "executed in writing and recorded before a judge's certificate that the terms and

consequences of the consent were fully explained in detail and were fully understood by the parent or Indian custodian." Presently, the Division of Social Services' procedures is that "if there is no active child in need of aid case before the court, the relinquishment may be taken before a social service worker of the Department." In addition, Sec. 103 mandates that "any consent given prior to, or within ten days after birth of the Indian child shall not be valid." Once again this will result in significant change for the Division of Social Services. The Division's policy, as stated in the manual, is that "a relinquishment may not be taken prior to 48 hours following the birth of a child." Finally, Sec. 103 states that "the consent of the parent may be withdrawn for any reason at any time prior to the entry of a final decree of termination of adoption, as the case may be, and the child shall be returned to the parent." Under present Alaskan statutes, the parents have 10 days to withdraw the relinquishment. After the 10 day period, the parents must show good cause for withdrawing consent.

In regard to foster placement, the Indian Child Welfare Act addresses both custody proceedings (Sec. 102) and placement (Sec. 105). In Sec. 102(d) the Act states that "any party seeking to effect a foster care placement, or termination of parental rights to an Indian child under state law, shall satisfy the court that active efforts have been made to provide remedial services and rehabilitative programs designed to prevent the break-up of the Indian family and that these efforts have proved successful." The Act goes on to state in Sec. 102(e) that "no foster care placement may be ordered in such proceedings in the absence of a determination supported by clear and convincing evidence, including testimony of qualified expert witnesses, that the continued custody of the child by the parent or Indian custodian is likely to result in serious emotional or physical damage to the child." The standard of proof that the Indian Child Welfare Act establishes for foster placements is higher than present state law. Under present law a preponderance of the evidence is required and there is no requirement for testimony from expert witnesses.

Sec. 105(b) of the Act establishes an order of preference for placement of native children: (1) a member of the child's extended family; (2) a foster home licensed or approved by the Indian child's tribe; (3) an Indian foster home licensed or approved by an authorized non-Indian licensing authority; or (4) an institution for children approved by an Indian tribe or operated by an Indian organization which has a program suitable to meet the Indian child's needs. The Division's policy now in effect requires workers to give consideration to placement with relatives before exploring other alternatives. This Act, however, states that "a preference shall be given in the absence of good cause to the contrary" to the order of placement delineated above. To accomplish this the Department and the native organizations in the state must develop ongoing cooperative efforts, particularly in the area of the finding and licensing of foster homes.

These are just a few of the changes which will result from the Indian Child Welfare Act. There are many other anticipated changes in the area of court proceedings. Due to the fact that the federal regulations have not been published, the Department cannot determine the total impact of this Act. The Department is working with the Attorney General's Office to develop an implementation plan.

If you have further questions, please feel free to contact my office.

Sincerely,

Helen D Beirne

Helen D. Beirne
Commissioner

CENTRAL COUNCIL
tlingit and haida indians of alaska
One Sealaska Plaza - Suite 200
Juneau, Alaska 99801
(907) 586-1432 or 586-3613

February 7, 1980

Thelma Buchholdt, Chairperson
Health, Education and Social Services
Committee
House of Representatives
Pouch V
Juneau, Alaska 99811

Dear Representative Buchholdt:

The Central Council, Tlingit and Haida Indian Tribes of Alaska supports House Concurrent Resolution No. 43, "A resolution endorsing the concept and requesting implementation of the Indian Child Welfare Act of 1978." We believe that legisaltive recognition and support of this act is essential to full implementation. We also believe that a directive to the Department of Health and Social Services regarding prompt implementation will facilitate the department's establishment of appropriate priorities concerning the act.

As a follow up to the resolution, a review of the existing Children's Code is necessary to identify areas of non-compliance with the Indian Child Welfare Act. Then any statutes found to be in non-compliance should be corrected with appropriate legislation.

Thank you for giving your support and attention to this issue of great concern to Alaska Native families.

Sincerely,

CENTRAL COUNCIL, TLINGIT AND
HAIDA INDIAN TRIBES OF ALASKA

Raymond Paddock, Jr.
President

House Health, Education & Social Services Committee — Meeting/Hearing on HCR 43 — Date: 2/7/80

	Name	Address and Phone	Organization/Self	For/Against or Observing
pos. 2	1/ Emma D. Redmark	P.O. Box 1492 Juneau	Grand Camp 1st Vice President Alaska Native Sisterhood	For
	2/ Joanne Reed	PO Box 591 Douglas	ANB-ANS Johnson O'Malley	For/Observing
(1)	3/ John Pugh	Division of Social Services Pouch H-05	H+SS	For
pos ✓3	4/ Jennifer R Evans	278-4641 1057 W. Fireweed Lane	Cook Inlet Native Assn. Ak Nat. Child Welfare Task Force	For
pos ✓4	5/ Brenda Knapp	One-Sealaska Plaza-Suite 200 Juneau, Ak 99801	Central Council, Tlingit + Haida Indian Tribes of Alaska	For
~~✓~~	6/ David Kafoed	RR#6, Box 6245	Citizen Juneau, AK 99803	For
	7/ Mary A Johns	Juneau	Cheyenne Sioux tribe Self	For
	8/ ester Clark	Sitka	self	For
	9/ Eleanor Dutz		Alaska Native Sisterhood	
	10/ Marie Osterback	Sand Point		
	11/ Herald Osterhaut	BIA		
	12/			
	13/			

HJR

19

STATE OF ALASKA

JAY S. HAMMOND, GOVERNOR

DEPARTMENT OF REVENUE

OFFICE OF THE COMMISSIONER / POUCH S – JUNEAU 99811

March 6, 1979

The Honorable Thelma Buchholdt
Chairman
House Health, Education & Social
Services Committee
Room 112 - Capitol Building
Juneau, Alaska

Re: House Joint Resolution No. 19

Dear Representative Buchholdt:

House Joint Resolution No. 19, proposing an amendement to the Constitution of the State of Alaska relating to tax credits for tuition expenses, was introduced in the House on February 15, 1979 and was referred to the House Health, Education & Social Services and Judiciary Committees.

For the consideration of the House Health, Education & Social Services Committee, I am enclosing a copy of a Fiscal Note prepared by Mr. Gary Jenkins, Director, Audit Division, Department of Revenue concerning the proposed legislation.

Sincerely,

R. D. Stevenson
Special Assistant

cc: The Honorable Charles Parr
Chairman
House Judicary Committee

John Messenger
Commissioner
Department of Revenue

Gary Jenkins, Director
Audit Division
Department of Revenue

04-D2LH

THE LEGISLATURE OF THE STATE OF ALASKA
ELEVENTH LEGISLATURE

FISCAL NOTE

I. REQUEST
Bill/Resolution No. House Joint Resolution No. 19
Title An amendment to the Constitution of the State of Alaska relating
Requested by H.E.S.S. & (to tax credits for tuition expenses 3/2/79
Judiciary Committees

II. FISCAL DETAIL
Agency Affected Revenue
Program Category Affected Fiscal Services
Budget Request Unit(s) Affected Audit Division

EXPENDITURES (Thousands of Dollars) None

	FY 79	FY 80	FY 81	FY 82	FY 83	FY 84
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL						
400 COMMODITIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC.						
TOTAL						

FUNDING (Thousands of Dollars) None

GENERAL FUND						
FEDERAL FUNDS						
OTHER (Specify)						

POSITIONS None

FULL TIME						
PART TIME						
TEMPORARY						

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

See memo dated 3/2/79 to R. D. Stevenson.

IV. DATE March 2, 1979 PREPARED BY Gary Stevenson
AGENCY Department of Revenue, Audit Division
PHONE 465-2320

Originator: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)

53 FN (Rev. 10/78)

STATE
of ALASKA

MEMORANDUM

TO: R. D. Stevenson
Special Assistant
Department of Revenue

DATE: March 2, 1979

FILE NO:

TELEPHONE NO:

FROM: Gary L. Jenkins
Director
Audit Division

SUBJECT: House Joint Resolution No. 19

This resolution would provide for an amendment to the constitution of the State of Alaska whereby the Legislature would be directed to provide a tax credit for tuition paid to all "nonsectarian" educational institutions in the State. In considering this resolution, the Legislature should be aware of two items which appear to be in conflict with the several proposed tax credit bills that have been introduced this year. There are two limiting provisions in the proposed constitutional change. First of all, the credit would be available for payments only to nonsectarian educational institutions, which would eliminate all schools operated by a religious organization. Secondly, it would limit the payments to institutions in the State of Alaska. The current proposed tuition credit bills would allow the credit regardless of where the institution is located.

HJR
29

BACKGROUND MATERIALS

RELATING TO

HJR 29: REQUESTING CONGRESS

TO

PERMIT WORKFARE PROGRAMS

Compiled by:

Deborah E. Behr
Policy Analyst
Legislative Affairs Agency
Research Division

April 12, 1979

MEMO

WORKFARE PROGRAMS FOR AFDC ADULT RECIPIENTS

AND POTENTIAL BENEFITS TO ALASKA IF WORKFARE PROGRAMS

WERE PERMITTED UNDER FEDERAL LAW

The rising costs of welfare have been a source of concern for many Alaskan taxpayers. Welfare costs for cash, food, medical, and social assistance have more than tripled in the most recent eight-year time period. Workfare programs are an outgrowth of a desire by some taxpayers to require that needy able-bodied adult recipients be required to work in exchange for their welfare assistance.

The largest cash assistance program in Alaska is the Aid to Families With Dependent Children (AFDC) Program. AFDC is anticipated to provide over $23 million dollars in aid to over 6,000 needy eligible Alaskan families in Fiscal Year 1980. Each family is anticipated to receive an average of $325 a month to cover the costs of housing, fuel, clothing, utilities, and other life necessities. If one were to divide that total $23 million figure by the state's projected FY '80 population, an annual cost of more than $50 per Alaskan would result. That $50 reflects only the cost of the grants and does not include the cost of administration, eligibility determination, related social services, covered medical assistance, and food stamps. It must be kept in mind, though, that the $50 figure includes the 50 percent funding by the federal government. Alaskans are federal taxpayers too; thus federal dollars spent indirectly affect the individual Alaskan's pocketbook, as well.

Many taxpayers in Alaska and elsewhere have expressed a concern regarding the rising AFDC caseload and expenditures that are occurring in most states due to the high unemployment and high costs of living. Some of the taxpayers are asking that able-bodied AFDC adults be required to work in exchange for their welfare assistance. Many governmental units on state or local basis are seriously examining requiring adult recipients who are not employed or disabled to do public service work as a condition of receiving their welfare checks.

Other States and Workfare

Alaska is not the only state that has expressed an interest in imposing AFDC workfare requirements. In September of 1978, Jay Rowen of the U.S. Department of Labor prepared an informal memorandum on this topic. Mr. Rowen noted that the following 20 states, or communities within these states, have taken the initiative regarding AFDC workfare requirements.

They are:

1. Alaska
2. Colorado
3. Connecticut
4. Florida
5. Idaho
6. Kentucky
7. Maine
8. Massachusetts
9. Michigan
10. Mississippi
11. New Hampshire
12. New Jersey
13. New Mexico
14. New York
15. North Carolina
16. Oregon
17. Pennsylvania
18. Tennessee
19. Utah
20. Wisconsin

(The memorandum detailing each state's actions regarding workfare programs is included in the attached notebook.) These 20 states expressed an interest in mandatory "workfare" requirements be imposed on AFDC clients even though federal law does not presently allow this.

Workfare in Utah

Probably the most publicized workfare experiment is currently being conducted in Utah. Utah's Work Experience and Training (WEAT) Program was originally designed to be a "workfare" program where recipients would work off their grants at one hour for each $1 of aid to a specified maximum. Through time, and in response to federal pressures as well as actual program experience, it was found that the original approach was not effective. The make-work public projects, although keeping clients busy, did not provide them with the necessary job skills and work experience needed for future employability. People simply were not getting off assistance as a result of the WEAT participation. And since the WEAT jobs were seen as make-work, dead-end projects, resentment among the clients was high. Utah thus began to restructure its WEAT program to focus on sheltered work experiences. Thus, all persons who were required to register for WIN but for whom a WIN placement was not available were also required to register for WEAT. WEAT, unlike WIN, is entirely operated by the state welfare department. The eligibility workers develop WEAT project sponsors among public and private non-profit agencies. WEAT registrants are assigned to an available sponsor where they work for no pay three days a week with the remaining two days set aside for job search or job skill improvement activities. Failure to perform acceptably on the work project without a valid excuse could result in the mandatory registrants' ineligibility for assistance.

The welfare rights organization in Utah planned to sue the state over the mandatory features of the program. Participants voiced objections that they did not want to jeopardize the existence of the program and the suit was dropped. The organization now is working for improvements in WEAT. Similarly, the Tribal Council of the San Juan County Navajo Reservation also vigorously objected to federal attempts to have the WEAT program there removed. These clients found that WEAT was more successful for them than WIN, for WEAT could offer a more personal, less demanding environment, than the formal work and training program of WIN. This was especially true for clients with low skills or no job history.

The success of the WEAT program in Utah is due in large part to the uniform attitude found throughout the state. The recipients, the sponsors, the legislature, and the general population share a common work ethic that all able-bodied persons should work. State officials stress the importance of training or finding employment for welfare recipients as soon as possible after application. It is their experience that the greater the wait for WIN or WEAT placement, the less chance for success. Utah has a low unemployment rate (less than six percent) so that, once trained, the chances for employment are good. A major problem still remains in the inadequacy of appropriate long-term training and support services coupled with the fact that many welfare clients may, in fact, never be able to enter competitively into private sector employment. Also, lack of enough licensed day care facilities are also beginning to provide significant barriers to employment for welfare mothers.

Despite WEAT's apparent success in Utah, HEW officials have consistently opposed efforts toward similar programs in other states. Utah's program was implemented at a time when federal policies were unclear, and support within the state was nearly unanimous. These favorable conditions do not exist for other states.

WIN

The federal government currently permits only one job placement and training program for AFDC recipients that program is called WIN.

WIN stands for the Work Incentive Program and was instituted in Alaska in 1968. It is the principal manpower program aimed at assisting AFDC recipients to find and retain jobs. Under provisions of the Federal Social Security Act, any able-bodied member of an AFDC family who is 16 or more years of age, not in school and not otherwise needed to care for a disabled person in the home, must participate in the program as a condition of receiving his or her AFDC grant. AFDC recipients with pre-school children are not required to participate in WIN. WIN provides both manpower (counseling, training, and placement) and support services, subject to its funding limitations. Both administrative and assistance costs are funded 90 percent by the federal government and 10 percent by the state government. Federal participation is subject to a national ceiling with an individual state share based on a intricate formula related to performance and AFDC caseload size. The total national federal authorization for WIN has not been increased since 1968.

Alaska, because of its minimal AFDC program (the state has opted not to operate an unemployed father program), has a small welfare population in comparison to highly-populated urban states with comprehensive AFDC coverage, such as California. Alaska must compete with these states, which automatically receive large appropriations despite the degree to which they effectively penetrate the AFDC caseload. Also, Alaska's share of WIN funds does not take into account the state's higher cost of living. Today, due primarily to funding constraints, WIN offices are open only in Anchorage and Juneau (which serves Southeast Alaska).

WIN and Workfare

Due to WIN, AFDC, and other federal requirements, workfare programs other than WIN, are generally not permitted, except as approved demonstration grants. Federal funding to the state would be jeopardized if the state were to implement a workfare program not approved by the federal government. Louis Weissman, HEW Acting Assistant Regional Commissioner for the Office of Family Assistance, testified before House HESS Committee on March 16, 1978, stating that requiring individuals to work off, or work for, AFDC assistance is inconsistent with AFDC program requirements. Implementation of a workfare system for AFDC recipients would jeopardize federal funding, except as part of an approved federal demonstration project. In a letter to Gregg Erickson, Director of Legislative Research Services, dated September 28, 1978, Bernard E. Kelly, Regional HEW official, confirmed that the federal position remained unchanged. Mr. Kelly's letter notes the "sanctions range from the withholding of specific amounts of money to the disallowance of all federal financial participation for AFDC." Federal funding in other related programs, such as WIN, Title XX, and Medicaid, may be affected, as well by the implementation of a workfare program not approved by the federal government.

HJR 29 and Benefits to Alaska

HJR 29 urges Congress to amend federal law to allow workfare programs for able-bodied AFDC adult recipients. It also requests the legislatures in the other states to pass similar resolutions, so that Congress will be aware that many states, not just Alaska, are interested in this proposed change in federal law.

The benefits of workfare programs commonly cited are:

1) Mechanism for removing able-bodied adult recipients from AFDC rolls who refuse to work for their assistance;

2) Provision of needed services to society that would cost additional state tax dollars; and

3) Promotion of client dignity, self-esteem and responsible work attitudes by allowing clients to work for their assistance as a paycheck, rather than just receiving a welfare "hand-out".

In conclusion, it is important to note that the resolution, if passed, only expresses Alaska's interest in the federal law change. Although

this paper does not address the problems regarding actua implementation of workfare programs or effect on the clients, further action by the legislature would be necessary at a later date to authorize and fund a workfare program. At that time, the costs and merits of the particular workfare programs permitted by Congress could be discussed and reviewed for their appropriateness for Alaska.

HEW TESTIMONY ON WORKFARE

MINUTES OF HOUSE

HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

March 16, 1978

The meeting was called to order at 3:05 P.M. by Chairman Parr. Present was: Mr. Beirne, Mr. Phillips, Mr. Chatterton, Mr. Bennett, Mr. Cotten, Mr. Nakak, Mrs. Buchholdt and Mr. Cse.

Mr. Parr stated House Bill's 410, 415, 891, 493 and SSHB 666, all bills dealing with University of Alaska re-organization, were on the agenda for today. Before discussing the University of Alaska bills, Mr. Dick Wilson introduced Mr. Louis Weissman, Acting Assistant Regional Commissioner, from the Division of Health, Education and Welfare in Seattle, Washington, to speak to the Committee regarding HB 840.

Mr. Weissman spoke from a prepared testimony. Copies were made available to the committee. He stated HB 840 would establish work requirements for recipients of public assistance. Mr. Weissman stated the work requirements under the federal law and regulations. He also told the committee that enactment of HB 840 as it is now written would be inconsistent with the Social Security Act and Federal Regulations. He said enactment of the proposed bill would result in a compliance issue with the State of Alaska's Public Welfare Division and could place the federal financial participation dollars at risk.

Next to be taken up were the University of Alaska re-organization bills. Mr. John Schaeffer, member of the Board of Regents was first to testify. Mr. Schaeffers testified, that given more time he feels that the University of Alaska can correct its own problems. He stated once the financial problems have been corrected, they can begin to address other issues. Mr. Schaeffer also stated that of all proposed legislation, HB 891 would best fit the University of Alaska's needs.

Mrs. Sharilyn Mumaw, student regent University of Alaska, was next to speak. Mrs. Mumaw did not offer testimony but answered questions asked to her by the committee.

Next to testify was Mr. Mason West, President Alaska Community Colleges Federation of Teachers Anchorage. Mr. West stated that ACCFT fully supports HB 410 which advocates total separation of the community colleges from the University of Alaska. He stated they wish to be responsible and responsive to the state legislature, they wish to be accountable for all dollars requested and expended by the community colleges and they wish to provide academic programs that provide students with a quality education by implementing a 5 year plan that is comprehensive, integrated and distributed to all concerned.

No action was taken on these bills today, they will be before the committee again tomorrow.

Meeting adjourned at 4:50 P.M.

REGION X
ARCADE PLAZA BUILDING
1321 SECOND AVENUE
SEATTLE, WASHINGTON 98101

SOCIAL SECURITY ADMINISTRATION
OFFICE OF THE REGIONAL
COMMISSIONER

TESTIMONY REGARDING ALASKA HOUSE BILL NO. 846
MARCH 16, 1973

ALASKA HOUSE BILL NO. 846 WOULD ESTABLISH WORK REQUIREMENTS FOR RECIPIENTS OF PUBLIC ASSISTANCE. INCLUDED AMONG THESE RECIPIENTS WOULD BE CERTAIN PERSONS WHO ARE RECIPIENTS OF BENEFITS UNDER TITLE IV-A OF THE SOCIAL SECURITY ACT, KNOWN COMMONLY AS AID FOR FAMILIES WITH DEPENDENT CHILDREN OR AFDC.

WORK REQUIREMENTS IN RELATION TO THE RECEIPT OF ASSISTANCE UNDER THE FEDERALLY AIDED AFDC PROGRAMS HAVE BECOME A MATTER OF CONSIDERABLE PUBLIC INTEREST.

THE WORK ETHIC IS WELL ESTABLISHED AS A PART OF OUR NATIONAL LIFE. THE NEED AND WISH TO BE ECONOMICALLY PRODUCTIVE MAKES UNEMPLOYMENT A MAJOR PROBLEM IN TODAY'S SOCIETY. IT IS NOT ONLY THOSE WHO ARE POORLY EQUIPPED WHO HAVE DIFFICULTY IN FINDING EMPLOYMENT, MANY WHO ARE WELL EDUCATED AND TRAINED WITH VARIOUS SKILLS ARE ALSO FINDING THEMSELVES IN THE LINES TO CLAIM UNEMPLOYMENT COMPENSATION BENEFITS AND ON THE WELFARE ROLLS FOR VARYING LENGTHS OF TIME. IN ADDITION THERE ARE THE YOUNG PEOPLE WHO ARE SEEKING FOR THE FIRST TIME TO ENTER THE LABOR MARKET WHO ARE UNABLE TO FIND WORK AND THUS SEEK WELFARE AID.

THERE ARE NO DATA TO ESTABLISH THAT PERSONS SEEKING OR RECEIVING WELFARE AID ARE ANY LESS ANXIOUS TO WORK THAN ARE OTHER PERSONS.

WORK REQUIREMENTS UNDER FEDERAL LAW AND REGULATIONS

TITLE IV-A OF THE SOCIAL SECURITY ACT IMPOSES TWO DIFFERENT SETS OF PENALTIES, ONE FOR UNEMPLOYED FATHERS AND ANOTHER FOR ALL OTHER PRESUMED EMPLOYABLES UNDER THE WIN PROGRAM, FOR REFUSING TO REGISTER FOR EMPLOYMENT, REFUSING BONA FIDE OFFERS OF EMPLOYMENT OR TERMINATING WORK WITHOUT GOOD CAUSE.

THE AID FOR FAMILIES OF DEPENDENT CHILDREN UNEMPLOYED FATHERS PROGRAM (AFDC-UF) IS AN OPTIONAL PROGRAM AND ONE IN WHICH THE STATE OF ALASKA HAS DECLINED TO PARTICIPATE.

UNDER SECTION 407(b)(1) OF THE ACT AND 45 CFR 233.100(a)(5) THE ENTIRE FAMILY OF AN UNEMPLOYED FATHER MAY NOT RECEIVE AFDC IF THE FATHER HAS WITHOUT GOOD CAUSE, WITHIN A 30 DAY PERIOD, REFUSED A BONA FIDE OFFER OF EMPLOYMENT OR TRAINING FOR EMPLOYMENT.

I MENTIONED THE SANCTION PROVIDED UNDER THE AFDC-UF PROGRAM TO ILLUSTRATE THAT FEDERAL LAW DOES REQUIRE EMPLOYABLE FATHERS TO ACTIVELY SEEK EMPLOYMENT AS A CONDITION OF RECEIPT OF BENEFITS. ALASKA HOUSE BILL 840 WOULD NOT AFFECT THE TREATMENT OF EMPLOYABLE MALES INSOFAR AS RECEIPT OF FEDERALLY MATCHED WELFARE BENEFITS IS CONCERNED BECAUSE THE STATE HAS NOT ELECTED TO ASSIST THEM UNDER ANY CONDITIONS. HOWEVER, ALASKA HAS BEEN PROVIDING VENDOR PAYMENTS TO THIS GROUP SINCE OCTOBER, 1977 WHEN THE GENERAL RELIEF PROGRAM WAS CHANGED DUE TO COMPLAINTS BY LEGAL AID. I UNDERSTAND THAT THESE PAYMENTS WILL BE TERMINATED SHORTLY.

UNDER SECTION 402(a)(19)(F) THE NEEDS OF ANY INDIVIDUAL WHO FAILS TO PARTICIPATE IN THE WIN PROGRAM OR TO HAVE REFUSED EMPLOYMENT WITHOUT GOOD CAUSE ARE NOT TO BE TAKEN INTO ACCOUNT IN DETERMINING THE NEED OF THE FAMILY AND THE AMOUNT OF THE AFDC ASSISTANCE PAYMENT; ASSISTANCE MUST BE FURNISHED TO THE OTHER ELIGIBLE MEMBERS IN THE FORM OF PROTECTIVE OR VENDOR PAYMENTS TO OTHER THAN THE REFUSING MEMBER. IF AN INDIVIDUAL WHO IS A RELATIVE OTHER THAN THE UNEMPLOYED FATHER RECEIVING AFDC REFUSES WITHOUT GOOD CAUSE TO PARTICIPATE IN THE WORK INCENTIVE PROGRAM OR TO ACCEPT A BONA FIDE OFFER OF EMPLOYMENT IN WHICH HE IS ABLE TO ENGAGE, HIS NEEDS ARE REMOVED FROM THE AMOUNT OF ASSISTANCE OTHERWISE PROVIDED AND AFDC IS PROVIDED TO THE REST OF THE ASSISTANCE UNIT IN THE FORM OF PROTECTIVE OR VENDOR PAYMENTS OR AS FOSTER CARE. (45 CFR 234.60 AND 233.110).

IF SUCH INDIVIDUAL WHO REFUSES IS THE ONLY CHILD IN THE FAMILY, AFDC ASSISTANCE IS DENIED TO THE ENTIRE FAMILY. (45 CFR 224.51(a)(2))

THIS DENIAL OF AID TO THE REFUSING REGISTRANT IS NOT APPLIED DURING THE 60 DAYS IN WHICH THE INDIVIDUAL ELECTS TO RECEIVE COUNSELING OR OTHER SERVICES BUT AFDC ASSISTANCE IS PAID AS A PROTECTIVE OR VENDOR PAYMENT. (45 CFR 224.51(b))

HOWEVER, IF AN UNEMPLOYED FATHER FAILS TO REGISTER FOR WIN AND IS NOT EXEMPT FROM WIN REGISTRATION, THE ENTIRE FAMILY IS INELIGIBLE FOR AFDC (SECTION 407(b)(2)(C) OF THE ACT).

THE LAW SPECIFIES THAT EVERY INDIVIDUAL, AS A CONDITION OF ELIGIBILITY FOR AID UNDER THE AFDC PROGRAM MUST REGISTER FOR MANPOWER SERVICES, TRAINING, AND EMPLOYMENT, AS PROVIDED BY REGULATIONS OF THE SECRETARY OF LABOR UNLESS SUCH INDIVIDUAL IS:

A CHILD WHO IS UNDER AGE 16 OR ATTENDING SCHOOL FULL TIME;

A PERSON WHO IS ILL, INCAPACITATED, OR OF ADVANCED AGE;

A PERSON SO REMOTE FROM A WORK INCENTIVE PROGRAM THAT HIS EFFECTIVE PARTICIPATION IS PRECLUDED;

A PERSON WHOSE PRESENCE IN THE HOME IS REQUIRED BECAUSE OF ILLNESS OR INCAPACITY OF ANOTHER MEMBER OF THE HOUSEHOLD;

A MOTHER OR OTHER RELATIVE OF A CHILD UNDER THE AGE OF 6 WHO IS CARING FOR THE CHILD; OR

A MOTHER OR OTHER FEMALE CARETAKER OF A CHILD IF THE FATHER OR ANOTHER ADULT MALE RELATIVE IS IN THE HOME AND NOT EXCLUDED FROM THE PROGRAM.

INDIVIDUALS WHO HAVE BEEN DETERMINED TO BE EXEMPT FROM REGISTRATION ON THE BASIS OF INCAPACITY ARE REFERRED TO THE APPROPRIATE STATE VOCATIONAL REHABILITATION AGENCY.

A MOTHER OR OTHER RELATIVE OF A CHILD UNDER THE AGE OF 6, WHO IS CARING FOR THE CHILD, IS ADVISED OF HER OPTION TO REGISTER IF SHE SO DESIRES, AND OF THE FACT THAT CHILD CARE WILL BE PROVIDED IF NEEDED. OTHER EXEMPTED INDIVIDUALS MAY REGISTER, SUBJECT TO ACCEPTANCE OF SUCH REGISTRATION BY THE SECRETARY OF LABOR.

WORK RELIEF PRECLUDED UNDER FEDERALLY AIDED ASSISTANCE PROGRAMS

QUESTIONS HAVE ALSO BEEN RAISED BY STATES AS TO WHETHER A CHILD, OTHERWISE ELIGIBLE FOR AFDC, OR THE ENTIRE UNIT COULD, UNDER FEDERAL POLICIES BE DENIED AID IF AN APPLICANT OR RECIPIENT REFUSED TO WORK WITH IN PROJECTS OR WORK RELIEF PROGRAMS, THE ASSISTANCE TO WHICH HE WAS OTHERWISE ENTITLED UNDER TITLE IV-A OF THE ACT.

SUCH A STATE PLAN PROVISION IS CLEARLY PROHIBITED UNDER 45 CFR 233.140 WHICH SPECIFIES THAT:

> "FEDERAL FINANCIAL PARTICIPATION WILL NOT BE AVAILABLE IN EXPENDITURES MADE IN THE FORM OF PAYMENTS FOR WORK PERFORMED IN ANY MONTH AFTER JUNE 1968, EXCEPT UNDER THE WORK INCENTIVE PROGRAM AUTHORIZED BY TITLE IV, PART C OF THE SOCIAL SECURITY ACT, OR UNDER THE WORK EXPERIENCE AND TRAINING PROGRAMS AUTHORIZED BY TITLE V OF THE ECONOMIC OPPORTUNITY ACT."

ABSENT CONGRESSIONAL AUTHORITY TO THE CONTRARY, A NEEDY AND OTHERWISE ELIGIBLE CHILD AND HIS NEEDY CARETAKER RELATIVE MUST RECEIVE ASSISTANCE UNDER TITLE IV-A OF THE ACT TO WHICH HE IS OTHERWISE ENTITLED. THIS VIEW IS CONSISTENT WITH THE UNITED STATES SUPREME COURT DECISION IN THE CASE OF TOMKINS v. SWANK. (404 U.S. 202)

WORK RELIEF REFERS TO ANY SYSTEM IN WHICH AN INDIVIDUAL IS ASSIGNED TO WORK-OFF THE ASSISTANCE GIVEN, OR TO WORK WITHOUT PAY AS A CONDITION OF

RECEIVING SUCH NEEDS-RELATED CASH ASSISTANCE FOR HER OR HIS FAMILY. IT INCLUDES SYSTEMS IN WHICH THE AFDC ASSISTANCE IS SPECIFICALLY CHARACTERIZED AS PAYMENT FOR THE WORK, SYSTEMS IN WHICH HOURS OF WORK REQUIRED ARE DETERMINED BY ASSIGNING AN HOURLY VALUE TO THE WORK PERFORMED AND DETERMINING THE NUMBER OF HOURS THAT NEEDED TO BE WORKED OFF THE PAYMENT, AND SYSTEMS IN WHICH ACCEPTANCE OF THE OTHERWISE UNPAID WORK IS SIMPLY A CONDITION OF ELIGIBILITY FOR ASSISTANCE. IT IS UNCLEAR AS TO WHETHER THE INTENT OF ALASKA HOUSE BILL 840 IS TO LIMIT ELIGIBILITY AT INTAKE OR TO DENY AN ALREADY DETERMINED ELIGIBLE RECIPIENT UPON REFUSAL TO WORK FOR NO COMPENSATION. SUCH A DISTINCTION HOWEVER IS MOOT. SUCH WORK RELIEF CREATES A CLASS OF WORKERS WHO PERFORM WORK WITH NEITHER THE STATUS NOR THE BENEFITS GENERALLY ACCEPTED AS THE RIGHT OF EMPLOYEES. FOR EXAMPLE, AS NON-EMPLOYEES THEY ARE EXCLUDED FROM COLLECTIVE BARGAINING, FROM PENSION SYSTEMS, AND THEY CANNOT QUALIFY FOR PROMOTION. IN ADDITION, GENERALLY THE FAMILY SUFFERS AN OUT-OF-POCKET LOSS SINCE THEY CONTINUE TO RECEIVE ONLY THE AMOUNT OF THEIR REGULAR AFDC ASSISTANCE WITHOUT AN INCREMENT TO ACCOUNT FOR THE EXPENSES INCURRED AS A RESULT OF PARTICIPATION IN THE WORK RELIEF ASSIGNMENT.

FROM THE INITIAL ENACTMENT OF THE PUBLIC ASSISTANCE PROGRAMS IN 1935 HEW HAS TAKEN THE POSITION THAT REQUIRING AN INDIVIDUAL TO ACCEPT ASSIGNMENT TO A WORK RELIEF PROJECT, I.E., TO WORK OFF, OR WORK FOR, ASSISTANCE PROVIDED FOR IN TITLE IV-A OF THE ACT IS INCONSISTENT WITH THE BASIC REQUIREMENT THAT AFDC PAYMENTS BE UNRESTRICTED MONEY PAYMENTS, 42 U.S.C. §606(b). THIS PORTION IS REFLECTED IN THE MINUTES OF THE SOCIAL SECURITY

BOARD, FEBRUARY 25, 1936, BD. DOCUMENT NO. 73, 45 CFR 233.140. THE VIEW WAS BASED ON ITS CONCLUSION THAT A REQUIREMENT THAT AN INDIVIDUAL ACCEPT OTHERWISE UNDENUMERATED WORK AS A CONDITION OF ELIGIBILITY FOR AID IS, IN FACT, A REQUIREMENT THAT THE INDIVIDUAL "EARN" THE FAMILY'S ASSISTANCE BY WORK SO THAT THE WELFARE PAYMENT IS ACTUALLY COMPENSATION FOR SERVICES RENDERED AND NOT AID WITHIN THE MEANING OF U.S.C. § 606(b).

THE CORRECTNESS OF THIS INTERPRETATION OF THE STATUTE WAS CONFIRMED BY THE 1962 ENACTMENT OF 42 U.S.C. §609, THE COMMUNITY WORK AND TRAINING PROGRAM, WHICH PROVIDED SPECIFIC AUTHORIZATION FOR THE ESTABLISHMENT OF WORK RELIEF TYPE PROGRAMS IN AFDC UNTIL ITS REPEAL IN 1968 BECAUSE OF CONGRESSIONAL DISSATISFACTION WITH THE PROGRAM. UPON THIS RPEAL HEW PROMULGATED THE STILL EFFECTIVE 45 CFR 233.140 TO REESTABLISH ITS PRE-1962 RULE. SUBSEQUENT LEGISLATIVE PROPOSALS TO REINSTATE 42 U.S.C. §609 WERE REJECTED.

THIS POSITION WAS REAFFIRMED BY HEW IN 1971, WHEN BOTH CALIFORNIA AND NEW YORK PROPOSED WORK RELIEF PROGRAMS FOR AFDC RECIPIENTS AND WERE ADVISED THAT FEDERAL FUNDING WOULD NOT BE AVAILABLE IF THEIR REGULAR AFDC PLAN REQUIRED RECIPIENTS TO ACCEPT ASSIGNMENT TO WORK RELIEF. THE ONLY EXCEPTION HAS BEEN THE APPROVAL OF PLACEMENTS FOR NOT TO EXCEED 13 WEEKS UNDER THE WIN PROGRAM, ON THE GROUNDS THAT WHERE THE INDIVIDUAL HAD HAD VERY MINIMAL ATTACHMENT TO THE LABOR MARKET, ONE COULD CONSIDER "EXPOSURE TO WORK" TO BE A FORM OF TRAINING. SEE WIN HANDBOOK, CHAPTER SIX, PAGE 5, PARAGRAPH E.

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IN 1974 HEW PUBLISHED A REVOCATION OF §233.140 OF THE REGULATIONS; HOWEVER THIS REVOCATION WAS CHALLENGED IN A SUIT BROUGHT BY RECIPIENTS ORGANIZATIONS (INMRO v. DWIGHT) AND, THE REGULATION WAS REINSTATED.

STATE-ONLY WORK REQUIREMENTS

DURING THE PAST YEAR THERE WERE NUMEROUS INQUIRIES AS TO WHETHER, IN THE ABSENCE OF FEDERAL LAW, STATES COULD IMPOSE THEIR OWN WORK REQUIREMENTS AS A CONDITION OF RECEIVING AID UNDER TITLE IV-A IN ADDITION TO THESE PROVIDED IN THE ACT AS DESCRIBED ABOVE. THE ONLY ADDITIONAL INDIVIDUALS NOT COVERED UNDER CURRENT LAWS AND REGULATIONS WOULD BE RECIPIENTS IN NON-WIN AREAS. (THE POSITION OF HEW TO DATE HAS BEEN THAT IN THE ABSENCE OF LEGISLATIVE AUTHORITY THE DEPARTMENT WOULD NOT ISSUE A POLICY TO SUPPORT STATE-ONLY WORK REQUIREMENTS.)

CONGRESS ENACTED, AS A PART OF P.L. 95-216, THE SOCIAL SECURITY AMENDMENTS OF 1977, SECTION 404 ENTITLED STATE DEMONSTRATION PROJECTS. THIS SECTION AMENDS AND EXPANDS SECTION 1115 OF THE SOCIAL SECURITY ACT WHICH RELATES TO DEMONSTRATION PROJECTS. UNDER THIS AUTHORITY THE SECRETARY OF HEW COULD WAIVE CERTAIN STATUTORY REQUIREMENTS AND PERMIT NOT MORE THAN THREE DEMONSTRATION PROJECTS PER STATE. THESE PROJECTS COULD PROVIDE FOR PUBLIC SERVICE EMPLOYMENT. THERE ARE CERTAIN RESTRICTIONS CONNECTED WITH THIS AUTHORITY:

A. NOT MORE THAN ONE SUCH PROJECT COULD BE CONDUCTED ON A STATEWISE BASIS.

B. WITH RESPECT TO PUBLIC SERVICE EMPLOYMENT -

- APPROPRIATE HEALTH AND SAFETY STANDARDS AND TRAINING CONDITIONS MUST BE MADE
- THE PROJECT MUST NOT RESULT IN DISPLACEMENT OF EMPLOYED WORKERS
- COMPENSATION FOR WORK IS SPECIFIED AT AN HOURLY WAGE EQUAL TO THE LOCAL PREVAILING WORK WAGE
- WORK CONDITIONS MUST BE REASONABLE
- WORKMEN'S COMPENSATION MUST BE PROVIDED

(DEMONSTRATION PROJECTS MUST NOT LAST LONGER THAN TWO YEARS AND ALL MUST BE TERMINATED NOT LATER THAN SEPTEMBER 30, 1978)

THE FACT THAT THE CONGRESS FELT COMPELLED TO BROADEN SECTION 1115 OF THE ACT TO PERMIT WORK PROGRAMS SUCH AS THOSE UNDER DISCUSSION HERE IS CONSISTENT WITH THE CURRENT DEPARTMENTAL POSITION THAT SUCH PROGRAMS ARE INCONSISTENT WITH THE PROVISIONS OF THE SOCIAL SECURITY ACT ABSENT ANY OTHER SPECIFIC LEGISLATIVE AUTHORITY.

THE ONLY PROVISIONS IN FEDERAL LAW OR REGULATIONS WHEREBY A STATE MAY DENY AFDC TO INDIVIDUALS OR TO CHILDREN, ON THE BASIS OF WORK REQUIREMENTS, ARE THOSE CONTAINED IN SECTION 407 (b)(1) OF THE ACT AND 45CFR 233.100 (a)(5) PERTAINING TO THE UNEMPLOYED FATHER AND IN SECTION 402 (a)(19)(F) OF THE ACT AND 45CFR 224.21(b), 224.51(a)(1) AND 233.110 PERTAINING TO THE PROVISION OF FOSTER CARE FOR OTHER INDIVIDUALS UNDER THE WIN PROGRAM.

ENACTMENT OF ALASKA HOUSE BILL NO. 840 AS IT IS NOW WRITTEN WOULD BE INCONSISTENT WITH THE SOCIAL SECURITY ACT AND FEDERAL REGULATIONS. ENACTMENT OF THIS PROPOSED BILL WOULD RESULT IN A COMPLIANCE ISSUE WITH THE STATE OF ALASKA'S PUBLIC WELFARE DIVISION AND COULD PLACE THE FEDERAL FINANCIAL PARTICIPATION DOLLARS AT RISK.

THANK YOU,

LOUIS E. WEISSMAN
ACTING ASSISTANT REGIONAL COMMISSIONER
OFFICE OF FAMILY ASSISTANCE

- HEW LETTER ON
- WORKFARE

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
REGION X
ARCADE PLAZA BUILDING
1321 SECOND AVENUE
SEATTLE, WASHINGTON 98101

September 28, 1978

OFFICE OF THE REGIONAL DIRECTOR

Mr. Gregg K. Erickson
Director of Research
Legislative Affairs Agency
State of Alaska
Pouch Y - State Capitol
Juneau, Alaska 99811

Dear Mr. Erickson:

This is in response to your inquiry regarding potential Federal implications if the State of Alaska withdrew from participation in the AFDC Program. The State may, of course, withdraw from the AFDC Program at any time.

Before addressing the specific questions you raised, a general discussion of the compliance process, as it pertains to each of these programs, may be helpful. The compliance process reflects one way in which the Secretary may withhold part or all of the Federal funding for a particular program. The Social Security Act and regulations give the Department broad discretion in compliance proceedings. Pertinent sections of the Social Security Act which describe the compliance process include Sections 404(a) for AFDC, 443 for WIN, 1904 for Medicaid and 2003(c) and (e) for Title XX. The compliance processes for AFDC, Medicaid and Title XX are similar.

There are three ways stated in the regulation in which a question of compliance may arise. 45 CFR 201.6(a) states that:

> A question of noncompliance of a State plan may arise from an unapprovable change in the approved State plan, the failure of the State to change its approved plan to conform to a new Federal requirement for approval of state plans, or the failure of the State in practice to comply with a Federal requirement, whether or not its State plan has been amended to conform to such requirement.

All or part of the payments made pursuant to a State plan may be withheld after a finding of noncompliance. 45 CFR 201.6(e) provides that:

> If the Administrator makes a finding of noncompliance with respect to a matter under paragraph (a) of this section, the State agency is notified that further payments will not be made to the State (or, in his discretion, that payments will be limited to categories under or parts of the plan not affected by such failure), until the Administrator is satisfied that there will no longer be any such failure to comply. Until he is so satisfied, no further payments will be made to the State (or will be limited to categories under or parts of the plan not affected by such failure).

A State may appeal an adverse decision to the Court of Appeals for the circuit in which the State is located. (45 CFR 201.7.)

WIN's provision differs, but contains notice and hearing requirements (Section 443). Title XX contains an additional requirement that a State must comply with certain funding requirements (Section 2003(c)), but again there is a notice and hearing requirement.

You have inquired as to which part of a program would lose funds, or whether funding for a certain program would be jeopardized under a given set of circumstances. As stated previously, the Social Security Act gives the Secretary broad discretion in compliance proceedings. For example, noncompliance with one AFDC requirement could result in the withholding of part or all of the Title IV-A funds. There is no loss of Federal funds until a State has its hearing.

The State should be aware that Federal funds may be affected by audit exceptions or fiscal disallowances with respect to individual payments that may occur prior to or at the same time the Department decides to initiate compliance proceedings.

Regional office staff have the primary responsibility for identifying questions of compliance and reporting them to the State involved and to the appropriate officials in Washington, D.C. If a question of compliance cannot be resolved through negotiation, a compliance hearing may be scheduled. If a State is dissatisfied with an action taken on a State plan, it can request a reconsideration.

Title IV-D does not contain the compliance and hearing provisions found elsewhere in the Social Security Act. Instead, Congress enacted a 5 percent penalty to be assessed at such time as the annual audit establishes that a State failed to have an effective child support enforcement program, (Section 403(h)). In order to have an effective program, a State must be in compliance with each of the State plan requirements identified in 45 CFR 305.20. Use of the term "compliance" in discussions of the child support enforcement program refers to the audit and penalty provisions, rather than the process of raising a question of compliance and then holding a hearing.

We now proceed to the questions raised in your letter of June 28, 1978, answering them in the order raised.

I. TITLE IV-D OF THE SOCIAL SECURITY ACT

1. If the Department of Revenue were to implement these instructions, would Alaska be found noncompliant with Title IV-D requirements?

There are two situations in which implementation of the instructions of House Concurrent Resolution 134 would result in noncompliance with Title IV-D regulations.

The first is one in which the practical result of the instruction is that the Child Support Enforcement Agency works no paternity cases. Under those circumstances, the State does not meet the criteria outlined in 45 CFR Part 305. If a limited number of cases are worked, there is a serious question about compliance and therefore a serious question about the effectiveness of the child support program.

The second situation arises from OCSE's approach to the audit and penalty regulations. Although regulations covering the initial start up period are more flexible, HEW intends to amend those regulations and apply more stringent standards as the child support program moves out of the developmental stage and becomes more fully operational nationwide.

2. If found noncompliant, what fiscal penalties would be assessed on the Title IV-D program?

If the State does not comply with the audit criteria, Alaska's Title IV-A reimbursement will be reduced by 5 percent for the period audited.

While not a penalty provision, there is another fiscal consequence of implementation of the resolution that should be mentioned. Activities such as notifying individuals of their right to privacy under the State constitution and obtaining a waiver are outside the scope of Title IV-D and therefore are not eligible for Federal financial participation. The Department of Revenue would need to establish a mechanism for identifying those costs and excluding them from the claim for Federal reimbursement.

There are also some additional ramifications for children and taxpayers in Alaska we feel should be mentioned. The failure to establish the paternity of a child can have grave social and legal consequences. A child's right to those benefits which accrue to a child via the parent-child relationship may be lessened or eliminated if paternity has never been established. This could affect such benefits as Social Security, workmen's compensation and medical and life insurance. The failure to establish paternity will, in many cases, result in shifting the burden for child support from the child's father to the taxpayers in Alaska.

If there is no AFDC program in the State, and therefore no AFDC component of the child support program, there is virtually no chance that HEW could approve a State plan for child support. In that event, no Federal funds would be available for the costs of obtaining financial support for children. It seems likely that Alaskans would want to continue providing child support services to women and children not on assistance and that taxpayers would want the State to recover welfare costs from parents with the obligation and financial ability to support their children. Without a IV-D State plan, Alaska would have to pay all costs pf providing these services. In the twelve-month period ending March 31, 1978, costs of these services were $1,043.445. The Federal Government paid $782,584 of this amount.

3. Would noncompliance with Title IV-D result in noncompliance for Title IV-A (AFDC)?

If a question of compliance is raised with regard to whether an aspect of a Title IV-A requirement would not or could not be met, there could be both a compliance and a Federal matching issue involved. Clearly, a compliance issue would exist if the State plan does not contain language requiring applicants and recipients to cooperate in establishing paternity, as well as if, in practice, the State does not assist recipients in establishing paternity. Furthermore, Federal matching questions may arise if recipients are not cooperating in establishing paternity.

Section 402(a)(27) of the Social Security Act requires that as a part of the State's plan for aid and services to needy families, provision is to be made for a child support program which conforms with Part D of Title IV, as well as the State plan requirements of Section 454, "State Plan for Child Support."

4. If the answer to question number 3 is yes, what would be the penalty assessed on Alaska's Title IV-A program?

If a State is found to be out of compliance after a hearing, it could jeopardize all of their Federal AFDC funds, should the State fail to take steps to immediately come into compliance. (45 CFR 201.6).

II. WORK REQUIREMENTS FOR AFDC RECIPIENTS

1. Has this Federal position remained unchanged regarding the impact on AFDC for institution of a work requirement program as outlined by House Bill No. 840?

Yes, the Federal position remains unchanged with regard to the implications of the enactment of House Bill No. 840. Should Alaska wish to explore alternatives allowable under current policy and law, HEW is willing to explore the possibility of demonstration programs authorized under Sections 1115(a) and 1115(b) of the Social Security Act.

2. Would the Alaska AFDC program be deemed wholly or partially noncompliant if Alaska were to enact House Bill No. 840?

3. What would be the fiscal penalty assessed on the AFDC program if a question of compliance were raised?

These two questions can be best addressed with a single response. Simply enacting the legislation without further action on the part of the State would not affect the program. Should Alaska choose to implement the legislation, however, HEW would be faced with two courses of action. First, the necessary State plan would be disapproved and expenditures for the portion of the grant affected would not be subject to Federal financial participation (FFP). Second, HEW would have to determine whether the nature of the program, should the State choose to operate it without FFP, raises a substantial compliance issue. If HEW decides this is the case, and the State, subsequent to a hearing, is found to be substantially out of compliance with any provision required by Section 402 of the Social Security Act, fiscal sanctions would be imposed. These sanctions range from the withholding of specific amounts of money to disallowance of all FFP for AFDC.

4. Would Federal financial participation be withdrawn from the Alaska WIN program? In whole or in part?

Alaska's WIN allocation would not be affected by a compliance issue generated by the passage of House Bill 840. The term "Federal financial participation" has no direct relevance to the WIN program. That term applies to the Federal share of AFDC grants and administrative costs, not to WIN program funds.

The amount of funding Alaska receives for the WIN program is determined by two factors:

a. Fifty percent of the funds for Alaska's WIN program are based on the number of WIN registrants in Alaska in January of the previous fiscal year, as a proportion of the average number registered in all the States. Hence, any reduction in the number of AFDC recipients registered in WIN will directly affect the level of WIN funds provided to Alaska.

b. In addition to this statutory requirement, the balance of Federal funding to the State's WIN program is allocated on a formula in which the State's performance and potential are measured against other States. A high performance level by the State's WIN program in reducing welfare grants and placing individuals in well-paying jobs having a high job retention rate, will have a positive affect on WIN funding. In contrast, any modification of the AFDC program which results in fewer WIN registrants or a reduced level of WIN performance will adversely affect program funding.

5. Would Federal financial participation in the AFDC foster care component also be jeopardized?

   Yes. This would, however, depend upon the nature of the compliance issue. If the State was found substantially out of compliance, a fiscal sanction would be imposed on the entire program, including the foster care component.

6. If the answer to question 5 is yes, what amount of monies would be lost?

   In the event that a fiscal sanction were imposed on the entire program, then all FFP for AFDC foster care would cease.

7. Could the Alaska WIN program itself be expanded without penalty to include a nonpaid public service component such that nonprofit agencies and public agencies could provide at no cost to the WIN program nonpaid work experience and job training for WIN registrants who are not in other WIN components?

   Our response is a "qualified yes." The WIN regulations provide for a work experience component (45 CFR 224.43(b)) which has similarities to a nonpaid public service component.

   A WIN experience assignment is limited to 13 weeks for any individual (45 CFR 224.35(b)). Participants must be provided a $30 per month incentive payment plus training and related expenses. Assignment to WIN work experience, as with any other WIN training or employment component, must be part of an individual's employability development plan. Work experience sites can only be established in public and private nonprofit agencies.

   As all WIN funding has been allocated to the States, the only way work experience could be expanded would be to restructure the existing program to give work experience a higher priority. Such restructuring would necessitate a modification to the State's WIN plan and approval by the Regional Coordination Committee (RCC).

   Increased utilization of the work experience component could, of course, adversely affect Alaska's WIN allocation. If this restructuring resulted in fewer placements, Alaska's allocation in the subsequent year would be reduced as a result of the performance-based feature of WIN's allocation formula.

8. If the answer to question 7 is yes, to what extent can Alaska receive Federal financial participation in such a component (assuming a compliant AFDC program)? Or have WIN funds essentially reached a ceiling such that any additional expenditures would be State-only funds?

   As explained in the answer to question #4, the term "Federal financial participation" is not applicable to the WIN funding process. Should the

State decide to modify its program to provide for more extensive use of work experience, this should be addressed in the form of a request to the RCC for a WIN plan amendment. Such an amendment would have to be viable given existing funding levels and constraints.

III. MEDICAID (TITLE XIX)

1. (a) If Alaska had no approved Title IV-A (AFDC) plan because it chose to withdraw from AFDC, could its Medicaid State plan still be approved even though we would be lacking coverage of a mandatory group?

   (b) Could Alaska's Medicaid State plan be approved if the State covered these same individuals under Medicaid, but they received their cash assistance under a 100 percent State funded grant program rather than AFDC, if the State chose t withdraw from that program?

These two questions can best be answered together.
Title XIX coverage is mandated for the categorically needy, defined in 42 CFR 448.1(a)(1)(i) as individuals who are eligible for or receiving financial assistance under Titles IV-A (AFDC) or XVI (SSI) of the Social Security Act, or under an SSI State supplement. A State also has the option of extending coverage to the medically needy, as defined in 42 CFR 448.1(a)(2) as well as certain other optional coverage groups described in 42 CFR 448.1(c).

There are no specific provisions in Title XIX or the applicable Federal regulations which require a State to implement a Title IV-A and/or a Title IV-D program as a prerequisite for participating in Medicaid. If Alaska withdrew from participation in AFDC, but elected to retain Medicaid, then Medicaid services could continue to be made available, but only to the SSI required coverage group and the optionally-related Title XVI individuals included in the approved Title XIX State plan. If this were to occur, a question might be raised as to where eligibility determination for SSA eligibles for Medicaid services would be made.

Furthermore, it is not possible to operate a medically needy program without a Title IV-A program, since Section 1903 (f)(1)(B)(i) relates medically needy income to 133 1/3 of the highest money payment under an approved Title IV-A State plan. If no Title IV-A State plan exists, there would be no basis for making this determination.

Title IV-A - type families and individuals receiving cash assistance under a State-only funded program would not be eligible for Title XIX services, because eligibility is based in part upon eligibility under an approved Title IV-A program. If the State opted to withdraw from Title IV-A, there would be no basis under law or regulation to determine eligibility for Medicaid services.

2. Does the phrase "approved State plans under Title IV-A" mean total compliance with provisions of Title IV-A or substantial compliance? If the latter is the case, what constitutes substantial compliance? Specifically:

   (a) If Alaska were found not in compliance with the AFDC program due to noncompliance with Title IV-D requirements, would the Title XIX (Medicaid) State plan also be ruled noncompliant as well, due to that action?

   (b) If Alaska instituted mandatory work requirements as outlined in Alaska House Bill No. 840 and the State was found to be noncompliant with Title IV-A (AFDC), would the Title XIX (Medicaid) State plan also be ruled noncompliant due to that action?

   (c) If Alaska was found not in compliance with Title IV-A (AFDC) for reasons listed in both above questions 2(a) and 2(b), would the State's Medicaid State plan also be found noncompliant?

   All the components of this question are best answered together. As stated earlier, compliance is judged on the accurancy of the State plan, as well as the way in which it is actually being administered. If a question of compliance is raised regarding the Medicaid State plan and cannot be resolved through negotiation, a compliance hearing may be scheduled by the Administrator of the Health Care Financing Administration. A finding of substantial compliance or noncompliance would be made after the hearing, and would depend on the nature of the question. If a compliance hearing were held on a Title IV-A and/or Title IV-D issue, the decision rendered would not directly affect Title XIX in the witholding of Federal Medicaid funds. On the other hand, if the result of a Title IV-A hearing was a determination that a given AFDC population was ineligible for AFDC, this group of individuals would not be eligible for Title XIX either. There must be a clear and undisputed eligibility for Title IV-A or Title XVI before there is an entitlement to Federal financial participation (FFP) under Title XIX. Therefore, in response to your specific questions, the Title XIX State plan would not necessarily be judged out of compliance as a direct result of a finding that Alaska's AFDC State plan is out of compliance because of Title IV-D requirements or a mandatory work program.

3. What would be the fiscal penalty in the Medicaid program for a partially noncompliant AFDC program? Would the result be a total, a partial, or zero withholding of Federal funding under Title XIX (Medicaid)?

4. If the Title IV-A State plan were deemed totally noncompliant, would the fiscal effect on the Medicaid program be the same as if the State withdrew from participation in the AFDC program? Would this result in a total loss of Federal financial participation in Medicaid?

These two questions are best answered with a single response. As noted in our response to question #2, we are unaware of any fiscal penalty which would be applied to Title XIX if Alaska were to withdraw from participation in the Title IV-A and/or Title IV-D programs, but there may be FFP implications.

Donna Rogers of Alaska met with HCFA staff on August 21, 1978. During that meeting, she posed several questions regarding the relationships between Titles XIX, IV-A and IV-D. Our response to the questions she raised follows:

1. Could Alaska have a medically needy program and include unemployed fathers not included in the IV-A program?

   No, this would not be possible. 42 CFR 448.1(d) specifies that if a State opts to include medically needy individuals under Title XIX, the State plan must specify that it covers all medically needy groups that correspond to the categorically needy groups covered in the plan. There is no provision in law or regulation to extend medically needy coverage to other groups of individuals.

2. Can retroactive 90 day coverage go before that date if service were delivered, e.g. 4 or 5 months previously?

   No, this would not be possible. 45 CFR 206.10(a)(6)(ii) provides for retroactive medical coverage up to three months prior to the month of application. Again, there is no provision in law or regulation to allow coverage prior to the 3 month retroactive period.

3. Spend-down: Utah requires recipients to make their payments the first of each month before medical coupons are issued. Is this acceptable?

   No, this would not be possible. 42 CFR 448.3(c)(2)(ii) provides that in determining when spend-down requirements are met "income will be applied to costs incurred . . ." (emphasis added). Since the Utah method requires that individuals not only incur costs, but pay them as well, before eligibility is established, it is not acceptable.

IV. SOCIAL SERVICES (TITLE XX)

1. We are concerned that the fifty percent rule (45 CFR 228.56) may cause a partial or total reduction in the amount of Title XX Federal financial participation if the State withdrew from participation in AFDC. Thus, we need to know the fiscal impact of 45 CFR 228.56. Would the effect be to eliminate all Social Services Federal funding if the State no longer had an approved State plan under Title IV-A? Or would the effect be to reduce the amount of Title XX funding due to the fact there would be no AFDC Federal funding included in the calculation contained in the fifty percent regulation?

The fifty-percent rule (45 CFR 228.56) applies to Title XVI (SSI), Title XIX (Medicaid), and Title IV-A (AFDC) recipients or those eligible to participate in these three programs. If there were no AFDC program, the fifty-percent rule would then need to be applied to the remaining two income maintenance groups -- Medicaid and SSI. If Medicaid eligibles would no longer be eligible for Title XIX services because of no approved Title IV-A AFDC plan, the fify-percent rule would then need to be applied to the category of SSI recipients and SSI eligibles only. If this were to happen, some Title XX funding would be lost, but not the total amount.

If the fifty-percent rule is not met, the Federal share is adjusted downward until the rule is, in effect, met. You may wish to refer to 45 CFR 228.56(a) which states, in part, that ". . .Federal funds will be adjusted so the total Federal reimbursement does not exceed twice the amount of the total expenditures in behalf of those individuals. . ." who come under the rule.

The loss of Federal dollars for failure to meet the fifty-percent rule would amount to the difference between what the total Federal share would have been had the rule been met, and twice what was spent on social services and personnel training. Downward adjustment of the eligible population will reduce the Federal share of Title XX funds, but will not eliminate Federal participation altogether.

2. If the State were found noncompliant with AFDC Federal requirements, would the fiscal effect on Title XX Federal funding be the same as if the State withdrew from Title IV-A? If there is a different fiscal impact, please detail those differences.

   If the State were found noncompliant with AFDC Federal requirements, it would be assumed that the State would be operating an AFDC program under a plan which would be approved to a certain degree. There would be no change in Title XX FFP in such a case. If the State withdrew from Title IV-A, however, there would be no approved plan under Title IV-A, and the fifty-percent rule would then need to be applied, minus this former category of income maintenance status eligibles.

3. If the State no longer had an approved State plan under Title IV-A, but instituted a State-only cash assistance program for those individuals who previously were or would have been covered by AFDC, would Federal financial participation for Title XX services to these people be the same as if they were receiving AFDC? If so, to what degree? We are assuming here that such a State-only program would be essentially the same as a Title IV-A program.

Application of the Title XX fifty-percent rule is based on individuals ". . .who are receiving aid under the plan of the State approved (our emphasis) under Part A of Title IV or who are eligible to receive such aid. . ." (45 CFR 228.56(a)(1)). The fifty-percent rule would not allow FFP consideration of State-only cash assistance recipients as though they were eligible for AFDC.

4. If the State were only partially noncompliant with Title IV-A requirements and partial rather than total Federal penalties were assessed on the AFDC program, would there be a partial withholding of Title XX Federal funding? If so, to what degree and for what reasons?

As indicated in our response to question #2, if the State had an approved AFDC plan and was found partially noncompliant, there would be no Title XX funding constraints, assuming there would be no change in the number of eligibles (45 CFR 228.56(a)(1)).

5. Title XX requires AFDC recipients to be informed of the availability of family planning services. If the State had no AFDC program, how would this action affect this Title XX mandatory requirement? Would fiscal penalties result? What if the State were able to inform these types of low income individuals of family planning services and these individuals received their grants through a 100 percent funded State-only program, would Title XX funding still be jeopardized? What fiscal penalties might still result?

6. If the State were found noncompliant with all or part of the AFDC Federal requirements, but still was informing AFDC recipents of family planning service availability, would there be any fiscal penalty imposed on Title XX? That is, is the family planning issue totally separate from other AFDC requirement considerations when compliance with Title XX requirements are addressed?

These two questions can be best addressed with a single response. Failure to provide family planning services under provisions of Section 402(a)(15) of the Social Security Act would result in a disallowance of a reduction by one percentum of the quarterly amount payable to the State for all expenditures under Title IV-A (45 CFR 201.14 (a)(2)). The fiscal penalty involved is not a Title XX funding penalty, but rather a loss of FFP to the State under its AFDC program. If there is no AFDC program with no AFDC FFP, there can be no reduction. If, however, there continues to be a program with noncompliance Title IV-A reductions, there would be no further penalties, providing there was compliance with the provisions of Section 402(a)(15).

V. OTHER PROGRAMS

There would undoubtedly be many other programs affected by a decision to withdraw from the AFDC program. For example, loss of Medicaid funds for AFDC eligibiles would almost certainly have a negative impact on Community

Mental Health Centers (CMHCs). Although there are no references in the CMHC legislation (Title III of P.L. 94-63) requiring that AFDC clients be served, there are a number of areas which could be interpreted as applicable:

--Within the limits of its capacity, a CMHC should provide services to any individuals residing or employed within the catchment area regardless of ability to pay (Section 201 (a)(1)(B)).

--The provision of services shall be coordinated with the provision of services by other health and social services agencies (Section 201 (b)(2)).

--If the area is a designated poverty area, additional grant funds received because of this designation will be used to provide services for people unable to pay (Section 206 (c)(1)(G)).

--CMHCs will develop a financial plan to insure adequate support from other Federal and nonfederal sources, will have a contractual arrangement with the State agency that administers Title XIX and will make every effort to collect reimbursement. (Section 206 (c)(1)(H)(I)(J)).

Because most CMHCs are currently operating on such tight budgets, we expect that potential clients with no means of reimbursement are likely to receive minimal, if any, services. CMHCs claim a significant number of fee reimbursements through Medicaid. Loss of Medicaid funds for AFDC eligibles would limit access to mental health care and could seriously undermine the comunity mental health program in Alaska. Other public health services would probably be similarly affected.

Because of the magnitude of the issues you have raised, we recognize there may well be other Federal implications not addressed in this letter, and that our response may precipitate additional questions. This response constitutes a preliminary reaction to the questions you have raised. Some portions have been sent to Washington, D.C. for review and it is possible there may be some modifications. We shall look forward to a continuing dialogue with the Legislative Affairs Agency on these subjects. Please feel free to contact me again if I can be of additional assistance.

Sincerely,

Bernard E. Kelly

Bernard E. Kelly
Principal Regional Official

- STATES INTER-ESTED
- IN WORKFARE
-

U.S. DEPARTMENT OF LABOR
EMPLOYMENT AND TRAINING ADMINISTRATION
WASHINGTON, D.C. 20213

SEP 29 1978

MEMORANDUM FOR: MERWIN S. HANS ✓
SHELLY BLOOM

FROM: JAY ROWEN JWR

SUBJECT: State Initiatives Toward AFDC Workfair Programs

The attached "TABA" represents the most recent Office of Family Assistance attempt to get information on State initiatives.

From the list and my discussions with Gene Walker I identify the following as of most immediate concern to us:

Kentucky

The State plan amendment request should be in the regional office in the near future.

Michigan

S'arted out with a focus on Kent County (Grand Rapids). This is not pure work relief, but a mixture of employment training and work relief. The word is that Michigan is looking at what happens in Colorado, and may move in that direction. Sue Foster (Under Secretary's Office) is supposed to be calling a meeting. Hans name is on the list.

Wisconsin

Regional office has this request, but for some odd reason has not sent a copy into National OFA. So Walker does not know its contents. Supposedly, the regional office is waiting to see what response is made to Michigan.

Alaska

We have been in on this. There is pending legislation to establish a work program. State is looking a consequences.

Other efforts either appear to be dormant, have not reached an action point, or are not really workfair proposal, ie-- Pennyslvania is taking about a strong work search and acceptance of jobs in non-WIN counties.

For the directors meeting, I suggest we give them the attached document and ask that they give us more complete information where available, also that they obtain any documents such as legislative actions and plan requests on State initiatives. Caution them to use fineese in dealing with Regional OFA staff since they have just been approached by Walker to get this information.

TAB A

The following States have expressed interest in implementing mandatory work programs for AFDC recipients:

REGION I

CONNECTICUT – State law passed which established Employability Benefit and Equity Program which requires all employable persons to participate in a community project program. Law has not been implemented.

MAINE – Discussed with Regional Office staff the possibility of a work program.

MASSACHUSETTS – Submitted Amendment to State plan establishing Work Experience Program, but withdrew plan in favor of Special Initiative under the WIN program.

NEW HAMPSHIRE – Discussed with Regional Office staff the possibility of having a work program.

REGION II

NEW JERSEY – Senate Minority Leader plans to introduce a Bill which would establish public work programs.

NEW YORK – State is not interested in a work program, however several upstate counties have discussed with State staff the desirability of such a program.

REGION III

PENNSYLVANIA – Has submitted an amendment to State plan establishing a work registration requirement.

REGION IV

FLORIDA	-	Currently has an 1115 project in operation.
KENTUCKY	-	State law passed January 1978 establishing a work requirement. Plan material not yet submitted.
MISSISSIPPI	-	Expressed interest to R.O.
NORTH CAROLINA	-	Expressed interest to R.O.
TENNESSEE	-	Expressed interest to R.O.

REGION V

MICHIGAN	-	State plan amendment submitted establishing an employment and training requirement. Pending in Central Office.
WISCONSIN	-	State plan amendment submitted establishing an employment and training requirement. Pending in Regional Office.

REGION VI

NEW MEXICO	-	A Bill establishing a work requirement has been introduced in the State Senate.

REGION VII

No interest in a work requirement, however, Iowa, Kansas, Missouri, and Nebraska has discussed with Regional Office staff a Job Search requirement.

REGION VIII

COLORADO	-	State Law passed which establishes a work requirement. State plan material pending in Central Office.
UTAH	-	Operating an approved Work Experience and Training Program.

REGION IX

No interest.

REGION X

ALASKA – A Bill establishing a Work Requirement has been introduced in the State Legislature.

IDAHO – The State has passed legislation which establishes a WIN-like work in non-WIN counties, however the legislature did not fund the program.

OREGON – Discussion with Regional staff to establish a program under 1115(b).

WASHINGTON – ~~The Governor is in favor of a Work Requirement.~~ Apparently not in favor

- PAST & PRESENT
- WARFARE BILLS

Introduced: 3/8/79
Referred: Health, Education &
Social Services

IN THE HOUSE BY PHILLIPS AND MARTIN

HOUSE JOINT RESOLUTION NO. 29

IN THE LEGISLATURE OF THE STATE OF ALASKA

ELEVENTH LEGISLATURE - FIRST SESSION

Requesting Congress to permit workfare programs and urging all states to make similar requests of Congress.

BE IT RESOLVED BY THE LEGISLATURE OF THE STATE OF ALASKA:

WHEREAS welfare costs have skyrocketed in Alaska, more than tripling in the most recent eight-year time period; and

WHEREAS excess welfare costs drain scarce dollars that are much needed throughout Alaska for many other basic state programs and services such as education, health, and public safety; and

WHEREAS Aid to Families with Dependent Children (AFDC) is the largest federal and state funded cash assistance program providing over $18 million in aid to over 13,000 needy Alaskan children and their families; and

WHEREAS Alaska pays one-half of the total costs of the AFDC program administered in the state, yet is given little flexibility by the federal government to design a program that channels our limited dollars to needy children and only to those needy AFDC adults who are disabled or who are willing to work in exchange for their welfare checks; and

WHEREAS many Alaskans, as well as other taxpayers across the United States, are alarmed by the rising costs of welfare and are demanding a mechanism to require able-bodied AFDC adults to provide society with some tangible work product; and

WHEREAS mandatory workfare programs are seen by many as not only providing the state with a mechanism to remove from the welfare rolls idlers who refuse to work for their welfare grant, but also as (1) promoting client dignity, self-esteem, and responsible work attitudes, (2) assisting clients

in establishing a work history often necessary for obtaining permanent gainful employment, and (3) providing needed services to society that might otherwise require additional state revenues; and

WHEREAS those states which have attempted to implement workfare systems have been threatened with the loss of substantial federal funds because workfare programs are not permitted under federal law;

BE IT RESOLVED that the Alaska State Legislature respectfully requests the United States Congress to amend provisions of federal law to permit workfare programs for AFDC able-bodied adults without jeopardizing federal funding for the state's welfare programs; and be it

FURTHER RESOLVED that the Alaska State Legislature calls on the state legislatures in all of the states to forward similar resolutions to the United States Congress acknowledging their interest in such a change of federal law and urging Congress to pass legislation allowing for workfare programs.

COPIES of this resolution shall be sent to the Honorable Warren G. Magnuson, President Pro Tempore of the United States Senate; the Honorable Thomas P. O'Neill, Jr., Speaker of the United States House of Representatives; to the Honorable Ted Stevens and the Honorable Mike Gravel, U. S. Senators, and the Honorable Don Young, U. S. Representative, members of the Alaska delegation in Congress; and to the presiding officers of each house of the legislatures of all the states and the governing bodies of Puerto Rico, the Virgin Islands, Guam and the District of Columbia.

Introduced: 2/8/79
Referred: Health, Education & Social Services and Finance

IN THE SENATE BY TILLION

SENATE BILL NO. 124

IN THE LEGISLATURE OF THE STATE OF ALASKA

ELEVENTH LEGISLATURE - FIRST SESSION

A BILL

For an Act entitled: "An Act relating to general relief assistance; and providing for an effective date."

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

* Section 1. The legislature

(1) finds that excessive welfare costs are a burden on the taxpayers of the state and a drain on limited state revenues which are much needed in other state programs and services; that, in view of these constraints, state general relief assistance must be provided only to those needy citizens who are unable to work and those with dependent children; and that to discourage idlers and to promote responsible work attitudes and self-esteem, a work requirement must accompany state general relief assistance for able-bodied recipients; and

(2) declares that the purpose of this Act is to limit general relief assistance payments to persons who are at least 55 years old, are disabled, or have dependent children in their homes, and who are unable to provide sufficient support for themselves or their dependents.

* Sec. 2. AS 47.25.120 is repealed and re-enacted to read:

Sec. 47.25.120. ELIGIBILITY FOR ASSISTANCE. (a) Financial assistance may be given under AS 47.25.120 - 47.25.300, so far as practicable under the conditions in this state, to an eligible individual who is

(1) at least 55 years old, or disabled, or who has dependent children in the home;

(2) not receiving other assistance under this chapter;

(3) unable to provide sufficient support for himself or those dependent upon him; and

(4) a resident of the state.

(b) For the purpose of determining whether an individual seeking assistance under this section is a resident of the state, the department shall consider, but is not limited to considering, the following factors:

(1) enrollment in the welfare program of another state and receipt of welfare benefits from another state;

(2) physical presence in the state;

(3) maintenance of a place of residence in the state;

(4) furnishings and household and personal effects sufficient to lead a reasonable person to conclude that the place of residence is more than a public accommodation;

(5) registration to vote;

(6) motor vehicle operator's license and motor vehicle registration;

(7) enrollment of children in local schools;

(8) bank accounts in this state or another state.

(c) An individual who is at least 55 years old is eligible for general relief assistance if the individual

(1) is unemployed for reasons other than misconduct or voluntary separation without cause;

(2) is actively and diligently seeking gainful employment;

(3) has not refused to accept employment when offered;

(4) has registered and is available for work as required by AS 23.20.375; and

(5) has exhausted all of his benefits, if so entitled, under AS 23.20, except that if his benefits under AS 23.20 are less than those

for which he would otherwise be eligible under this section, he is eligible for supplementary general relief assistance.

(d) A disabled individual between the ages of 18 and 65 years is eligible for general relief assistance if the individual is (1) determined to be needy in accordance with standards established by regulations of the department; (2) unable to meet the requirements established by the federal Supplemental Security Income Program or its successor agency; and (3) unable to engage in substantial gainful employment because of a physical or mental impairment determined and certified by a licensed physician. "Substantial gainful employment" as used in this paragraph means at least 30 hours of work per week. An individual determined to be eligible under this subsection may be referred to the appropriate state agency for vocational rehabilitation services and is required to accept such services as an additional condition of eligibility under this section. An individual determined to be eligible under this subsection may be required to seek employment or to participate in public service employment projects under AS 47.25.145 as an additional condition of eligibility under this section.

(e) An individual with children is eligible for general relief assistance if he satisfies the requirements of (c)(1) - (5) of this section.

(f) In addition to the requirements and conditions of (c) and (e) of this section, the department shall require that an individual who is physically fit, able to work, and employable shall, as a condition to receiving general relief assistance, accept an assignment to work under AS 47.25.145.

(g) An applicant for and recipient of general relief assistance must satisfy all applicable provisions of this section. Recipients disqualified for failure to comply with a requirement of this section

shall be excluded from general relief assistance for a period not longer than 12 months.

(h) The department shall adopt regulations under the Administrative Procedure Act (AS 44.62) necessary to enforce this section and to establish criteria and standards for the conditions and requirements of general relief assistance.

* Sec. 3. AS 47.25 is amended by adding a new section to read:

Sec. 47.25.145. PUBLIC SERVICE EMPLOYMENT. (a) The department is responsible for providing public service employment on public works projects to an individual who is receiving (1) general relief assistance under this chapter; or (2) unemployment compensation benefits under AS 23.20 that are within the last two weeks of eligibility and who, upon termination of those benefits, will be eligible for full or partial general relief assistance from the state. A general relief assistance recipient participating in public service employment is considered to be an employee of the employing agency. Except for workmen's compensation coverage under AS 23.30, the laws relating to public employees do not apply to individuals employed under this section. Payment for public service employment may not be made from the funds of the agency employing the general relief assistance recipient, but shall be made from the funds of the department.

(b) The department shall adopt regulations under the Administrative Procedure Act (AS 44.62) to carry out the purpose of this section. The regulations shall include, but are not limited to, provisions requiring that

(1) the employment of a general relief assistance recipient may not displace a state or municipal employee or an individual performing work for the state or a municipality on a contractual basis;

(2) the period of employment may not exceed that number of

hours which, when multiplied by the prevailing rate of compensation for the work, equals the amount of general relief assistance provided;

(3) there shall be no discrimination based upon race, color, creed, sex, age, religion, or national origin; and

(4) an individual refusing without justification to accept suitable work under this section shall be ineligible for general relief assistance.

* Sec. 4. AS 47.25.300 is amended by adding new paragraphs to read:

(5) "children" does not include unborn children and means individuals who are

(A) ineligible for and unable to obtain aid under a federal assistance program;

(B) in need, and without sufficient income or other resources to provide health care and essential support;

(C) under 18 years old, except that a child between 18 and 21 years may be eligible for assistance under AS 47.25.120 - 47.25.300, if the child is

(i) regularly attending high school to complete requirements leading to a high school diploma or its equivalent;

(ii) employed part time and is enrolled at least half time in an organized program of vocational or technical training designed to fit the child for gainful employment; or

(iii) employed part time and is enrolled at least half time in a local college or university; and

(D) living in a home with his father, mother, grandfather, grandmother, brother, sister, stepfather, stepmother, uncle, aunt, first cousin, nephew, niece, or foster parents in a place of residence maintained by the relative as his own home; or

is living in a family home or institution conforming to the standards fixed by the department;

(6) "public work projects" includes any kind of labor under the Department of Transportation and Public Facilities, department of public works of any municipality, or under any other agency of the state or a municipality.

* Sec. 5. An individual receiving general relief assistance on the effective date of this Act who would otherwise be excluded by the provisions of this Act shall continue to receive assistance if he satisfies the requirements of AS 47.25.120(c), 47.25.120(e), and 47.25.120(f).

* Sec. 6. This Act takes effect July 1, 1979.

Introduced: 2/14/78
Referred: Health,Education &
Social Services and Finance

BY PHILLIPS,DANKWORTH,HAYES,
KELLY,LETHIN AND URION

IN THE HOUSE

HOUSE BILL NO. 840

IN THE LEGISLATURE OF THE STATE OF ALASKA

TENTH LEGISLATURE - SECOND SESSION

A BILL

For an Act entitled: "An Act relating to work requirements for recipients of public assistance."

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

* Section 1. AS 47.05.010 is amended by adding a new paragraph to read:

(15) solicit the cooperation of all governmental units and nonprofit agencies in developing unpaid job positions with those units or agencies, with a view toward placing persons receiving assistance under AS 47.25.120 - 47.25.300 and 47.25.310 - 47.25.420 in the positions.

* Sec. 2. AS 47.25 is amended by adding new sections to read:

Sec. 47.25.285. WORK REQUIREMENT. Needy persons receiving assistance under secs. 120 - 300 of this chapter are required to work for no compensation up to 24 hours a week in positions developed under AS 47.05.010(15), if available. Refusal to accept, or to perform with due diligence, work required under this section shall result in discontinuance of the assistance provided under secs. 120 - 300 of this chapter.

Sec. 47.25.407. WORK REQUIREMENT. Parents or relatives receiving assistance under secs. 310 - 420 of this chapter, not participating in the work incentive program for welfare recipients authorized under AS 23.15.650 and not exempt under 42 U.S.C. 602(19)(A)(i), (ii), (iv) - (vi) are required to work for no compensation up to 24 hours a week in positions developed under AS 47.05.010(15), if available. Refusal to accept, or to perform with due diligence, work required under this section shall result in discontinuance of that portion of the monthly assistance

provided under secs. 310 - 420 of this chapter attributable to the needs of the parent or relative.

* Sec. 3. AS 23.10.055(6) is amended to read:

(6) an individual engaged in the activities of a nonprofit religious, charitable, cemetery or educational organization where the employer-employee relationship does not, in fact, exist, and where services rendered to the organization are on a voluntary basis, or an individual placed in a position developed under AS 47.05.010(15);

SB

15

FISCAL NOTE

I. REQUEST
Bill/Resolution No. SB 15
Title An Act increasing the Alaska Longevity Bonus and providing an effective date
Requested by Senators Kerttula and Ferguson Date 1-26-79

II. FISCAL DETAIL
Agency Affected Department of Administration
Program Category Affected Division of Pioneers' Benefits
Budget Request Unit(s) Affected Alaska Longevity Bonus

EXPENDITURES (Thousands of Dollars)

	FY 79	FY 80	FY 81	FY 82	FY 83	FY 84
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL						
400 COMMODITIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC.	Ø	4,482.6	4,736.4	4,990.2	5,244.0	5,497.8
TOTAL	Ø	4,482.6	4,736.4	4,990.2	5,244.0	5,497.8

FUNDING (Thousands of Dollars)

GENERAL FUND	Ø	4,482.6	4,736.4	4,990.2	5,244.0	5,497.8
FEDERAL FUNDS						
OTHER (Specify)						

POSITIONS

FULL TIME						
PART TIME						
TEMPORARY						

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

This bill would raise to $200 the amount of the Alaska Longevity Bonus and provide an effective date of July 1, 1979

YEAR	RECIPIENTS		$		MO.		TOTAL
FY 1980	7471	x	50	x	12	-	4,482.6
FY 1981	7894	x	50	x	12	-	4,736.4
FY 1982	8317	x	50	x	12	-	4,990.2
FY 1983	8740	x	50	x	12	-	5,244.0
FY 1984	9163	x	50	x	12	-	5,497.8

IV. DATE February 26, 1979 PREPARED BY Marie E. Swanson
AGENCY Longevity Bonus Program
PHONE 465-4416

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)

33-001 (Rev. 10/78)

THE LEGISLATURE OF THE STATE OF ALASKA
ELEVENTH LEGISLATURE

FISCAL NOTE

I. REQUEST
Bill/Resolution No. S.B. 15
Title An Act increasing the Alaska Longevity Bonus & providing for an effective date.
Requested by Senators Kerttula & Ferguson Date 01/26/79

II. FISCAL DETAIL
Agency Affected Department of Administration
Program Category Affected Social & Economic Assistance to the Aged.
Budget Request Unit(s) Affected Alaska Longevity Bonus

EXPENDITURES (Thousands of Dollars)

	FY 80	FY 81	FY 82	FY 83	FY 84	FY 85
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL						
400 COMMODITIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC.	Ø	4,932.6	5,299.8	5,667.0	6,034.2	6,401.4
TOTAL	Ø	4,932.6	5,299.8	5,667.0	6,034.2	6,401.4

FUNDING (Thousands of Dollars)

GENERAL FUND	Ø	4,932.6	5,299.8	5,667.0	6,034.2	6,401.4
FEDERAL FUNDS						
OTHER (Specify)						

POSITIONS

FULL TIME						
PART TIME						
TEMPORARY						

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

Since submission of the Fiscal Note dated February 26, 1979, it has become apparent that the number of Alaskans who are eligible for the Longevity Bonus is increasing at a more rapid rate than anticipated. This revised Fiscal Note is based on a projection which includes actual experience from the beginning of FY 77 to the present time.

This bill would raise the amount of the Alaska Longevity Bonus from $150 to $200 per month, and provide an effective date of July 1, 1980.

Year	Recipients		Increase		Months		Total Increase
FY 1981	8,221	x	$50	x	12	=	$4,932.6
FY 1982	8,833	x	50	x	12	=	5,299.8
FY 1983	9,445	x	50	x	12	=	5,667.0
FY 1984	10,057	x	50	x	12	=	6,034.2
FY 1985	10,669	x	50	x	12	=	6,401.4

IV. DATE 12/19/79 PREPARED BY George T. Michael
AGENCY Department of Administration
PHONE 465-4401

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)

33-001 (Rev. 10/78)

SB

32

POSITION PAPER/Department of Health and Social Servi

POSITION PAPER

SENATE BILL NO. 32

"An Act adopting the Interstate Corrections Compact; and providing for an effective date."

The Department of Health and Social Services and the Division of Corrections are in support of Senate Bill No. 32.

Alaska is presently a party to the Western Interstate Corrections Compact along with 11 other states. There are presently 16 member states to the Interstate Corrections Compact; 5 of those states are also parties to the Western Corrections Compact. In effect, joining the Interstate Corrections Compact would increase Alaska's out-of-state placement resources for prisoners by 50 percent; 11 additional states.

The Interstate Corrections Compact was initiated in order to allow an exchange of prisoners for the purpose of treatment and long-range release planning. Also, the Compact provides a means of placing prisoners out of state for protective purposes.

Alaska has prisoners with special needs. Membership in the Interstate Corrections Compact would expand the Division of Corrections ability to meet these special needs, and provide the most effective rehabilitation programs on an individual basis without increasing the cost of care.

Alaska would maintain jurisdiction over prisoners confined out of state. Alaska would also have the authority to inspect out-of-state facilities and to communicate with Alaska inmates.

Recommended by: _____ 1/26/79
Charles E. Sothan, Acting Director — Date
Division of Corrections

Approved by: Helen D. Beirne 2/1/79
Helen D. Beirne, Commissioner — Date
Department of Health & Social Services

FISCAL NOTE

I. REQUEST

Bill/Resolution No. Proposed Legislation

Title An Act Adopting Interstate Corrections Compact

Requested by Department of Health & Social Services Date 1/9/79

II. FISCAL DETAIL

Agency Affected Department of Health and Social Services

Program Category Affected Administration of Justice

Budget Request Unit(s) Affected Adult Confinement

EXPENDITURES (Thousands of Dollars)

	FY 79	FY 80	FY 81	FY 82	FY 83	FY 84
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL						
400 COMMODITIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC.						
TOTAL	0	0	0	0	0	0

FUNDING (Thousands of Dollars)

GENERAL FUND						
FEDERAL FUNDS						
OTHER (Specify)						

POSITIONS

FULL TIME						
PART TIME						
TEMPORARY						

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

IV. DATE January 9, 1979 PREPARED BY Leland Dalby

AGENCY Division of Corrections

PHONE 465-2376

Original: Legislative Finance

cc: Budget and Management

Prime Sponsor (First Legislator Named)

33-001 (Rev. 10/78)

SB

88

Proposed C:

Amend AS 47.10.010 (a) (2) by adding a new subsection (F) to read:

(F) the child being habitually truant from school, except as provided in AS 14.30.010 (b); however, when a child is found to be in need of aid under this subsection, the court may issue no orders under AS 47.10.080 (c) (1) and (3).

Memo

To: Thelma
From: Don Clocksin
Date: April 16, 1979
Subject: SB 88 - Truant Children

Proposed CS:

Amend AS 47.10.010 (a) (2) by adding a new subsection (F) to read:

(F) the child being habitually truant from school, except as provided in AS 14.30.010 (b); however, when a child is found to be in need of aid under this subsection, the court may issue no orders under AS 47.10.080 (c)(1) and (3).

Explanation: As I understand it, the concern is that courts would have the power to terminate parental rights, allow an adoption, or institutionalize a child because ~~[redacted]~~ he or ~~[redacted]~~ she doesn't go to school, regardless of whether the parent is at fault. My proposed CS would allow a child to be (determined) in need of aid if he or she is habitually truant (except where there is an exception to the mandatory attendance statute) but would NOT allow a court to order the child institutionalized under AS 47.10.080 (c)(1) or terminate parental rights under AS 47.10.080 (c)(3). Therefore, the court would be allowed in truancy situations only to 1) release the child to "his parents, guardian, or some other suitable person," 2) order that person to

"provide medical or other care or treatment," or 3) have the department "supervise the care and treatment given to the minor..."

These powers, which appear in AS 47.10.080 (c)(2), would be strong enough to be the deterrence the school administrators want yet would not impose the severe punishments of institutionalization or termination of parental rights, which the committee seems to fear.

I hope this helps.

SB

162

SB162

9 April 1979

Representative Thelma Buchholdt
Capitol 110
Juneau, Alaska 99801

Dear Representative Buchholdt:

The undersigned respectfully solicit your support for passage in the House of Senator Don Bennett's Senate Bill 162 which recently passed in the Senate by a margin of 12 to 7. The bill amends the definition of "peace officer" to include probation officers who supervise adults, parole officers, and correctional officers.

Without elaboration I wish to refer you to the attached:

(1) Copy of SB 162

(2) Recent editorial in behalf of SB 162

(3) Letter of support from the State President of the Alaska Peace Officers Association directed to Governor Hammond.

(4) Letter of support from the President of the Fairbanks Chapter of the Peace Officers Association.

(5) Letter of support from the President of the Juneau Chapter of the Peace Officers Association.

What better endorsement for passage of this bill to include Adult probation officers, parole officers and correctional officers than from the Peace Officers Association themselves. Other letters of support could have been attached but it is felt the ones selected here convey with logical reasoning the justification for passage of this bill.

Respectfully yours,

Curtis Masingill

CURTIS MASINGILL
Adult Parole/Probation Supervisor

Ronald A. Murray

RONALD A. MURRAY, Parole/Probation Officer

DONALD H. ALLEN, Parole/Probation Officer

Joe L Anderson

JOE L. ANDERSON, Parole/Probation Officer

Stephen D. Korenek

STEPHEN D. KORENEK, Parole/Probation Officer

Lawrence Calderone

LAWRENCE CALDERONE, Superintendent of
Fairbanks Correctional
Center.

P.S. Administration attempts to subvert SB 162 by amendment were rejected by the Senate. We support only the bill as presented in its original form.

SENATE BILL NO.

IN THE LEGISLATURE OF THE STATE OF ALASKA

ELEVENTH LEGISLATURE - FIRST SESSION

A BILL 162

For an Act entitled: "An Act relating to peace officers."

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

* Section 1. AS 01.10.060(6) is amended to read:

(6) "peace officer" means any officer of the state troopers, members of the police force of any incorporated city or borough, United States marshals and their deputies, probation officers who supervise adults, parole officers, correctional officers, and other officers whose duty it is to enforce and preserve the public peace;

A Need for Firearms For Safety's Sake

Unfortunately state probation and parole officers have been forced between a rock and a hard place. They have been caught in the cross-fire of clashing political philosophies and petty jealousies in a matter that greatly affects their work and service to the state. At the crux is the need of probation and parole officers who supervise adult felons to carry concealed weapons.

In the past the probation and parole officers have carried concealed weapons either on the off-the-cuff interpretation of judges that they were peace officers and allowed to do so or on the basis of special permits issued by the Commissioner of Public Safety. But recently the new Commissioner of Public Safety William R. Nix moved to revoke the special permits issued just last fall by former Commissioner Richard Burton and the probation and parole officers have been forced to go to court to get the revocations blocked by restraining order or injunction. In the meantime, Senator Don Bennett has sponsored a bill, Senate Bill 162, which would make it perfectly clear that probation and parole officers are "peace officers" and are allowed to carry concealed weapons. The bill has passed the senate and is now being considered in the House.

But certain high officials in the state administration who reportedly believe "it's bad enough to have state troopers carrying concealed weapons, let alone probation and parole officers." These officials are attempting to lobby against Senate Bill 162 although they have been unsuccessful thus far in presenting a logical rationale of why probation and parole officers should not be able to carry concealed weapons. At first, opponents brought up the lack of firearms training as a reason. Then it was shown that the probation and parole officers have the same firearms training as troopers. One bubble popped. Next it was alleged that the probation and parole officers did not have occasion to use concealed weapons. Then it was shown that often these officers get into precarious situations where they were needed. In one case they foiled a bank robbery scheme. In another, they arrested a parolee who had a cache of high-powered weapons, even a bullet-proof vest. Another bubble popped. And so on down the line.

Still the Commissioner of Public Safety, the Commissioner of Health and Social Services, and the State Attorney General appear to be vehement in their opposition to the parole-probation officers being able to carry concealed weapons, despite the fact that the Peace Officers Associatons are fully behind the latter, despite the fact that most judges are behind the latter, despite the fact that most rank and file police officers are behind the latter. Even the former Director of Corrections was behind them on this issue.

The probation and parole officers say this matter is very vital to them because it affects their quality of work. How can they adequately supervise probationers and parolees if they are afraid to make unannounced home or work visits? Are probation and parole officers indirectly being forced to slack off their supervision and be content to receive once-a-month written reports from those under their charge? Is this a move to force good probation and parole officers--those with integrity--to leave state employment? If this is the design of some state cabinet members, they may very well succeed but the real brunt will be felt in the long run by the people of Alaska. We urge State House members to pass SB 162 without delay.

"Good, the more communicated, the more abundant grows."
John Milton

State APOA Office
P.O. Box 3520 DT
Anchorage, AK 99510
Phone 337-7712

February 9, 1979

Governor Jay S. Hammond
Pouch "A"
Juneau, Alaska 99811

Dear Governor Hammond:

It has come to my attention that the Acting Commissioner of Public Safety has recently attempted to rescind the Special Commissions that had been extended to the Adult Probation/Parole Officers of the State. I observe that Commissioner Nix's opinion is inconsistent with the decision that had been previously made by Commissioner Burton. Commissioner Burton and previous representatives of the Department of Public Safety were so convinced of the Probation/Parole Officers' need to protect themselves, that to resolve the dispute between the Attorney General and the Probation/Parole Officers, Commissioner Burton, as others have done in the past, issued Special Officer status pursuant to AS 18.65.010. Probation/Parole Officers have not changed their role or function. Their job, if anything, has become tougher in recent years.

The zealous attempt of the Attorney General to strip the Adult Probation/Parole Officer of the concealed firearm is beyond comprehension. I understand the Attorney General has focused on the definition of peace officer and has argued that the legislature's failure to specifically include the Probation/Parole Officer meant that the legislature must have meant to exclude the class from the coverage of the definition. It is observed that in the Criminal Code, which recently passed the legislature and which will go into effect January 1, 1980, the legislature specifically defined a peace officer as: "a public servant vested by law with a duty to maintain order or to make arrests, whether the duty extends to all offenses or is limited to a specific class of offenses or offenders." This new definition of "peace officer" includes Probation/Parole Officers. I have also been apprised that the Attorney General has taken issue with a court order issued by Superior Court Judge Gerald J. VanHoomissen. The court order specifically orders that the Adult Probation/Parole Officer of the Fourth Judicial District is authorized to carry a concealed firearm.

Court action to resolve the Special Commission issue is pending in the Third Judicial District. Action to resolve the Attorney General's question concerning Superior Court Judge Gerald J. VanHoomissen's court order is pending a Supreme Court Hearing in Fairbanks. A great deal of effort is being expended by the Attorney General in opposing judicial and executive efforts in trying to disarm the State's Adult Probation/Parole Officers.

It is difficult to understand why the Attorney General has taken such a fanatic position in attempting to disarm the Adult Probation/Parole Officer of this critically needed tool. It would appear that the Attorney General's motivations for taking issue with such a trivial matter is motivated by something other than a fact of law.

It has been my personal observation that on numerous occasions, the Adult Probation/Parole Officer, while acting within his authority, has initiated and assisted in investigations and the arrests of dangerous and armed felons. I, as a supervisor of a narcotics unit over the past four years, have had occasion to work closely with the Adult Probation/Parole Officers in Fairbanks and have found their actions to be of the highest quality and professionalism. I have participated in investigations where the presence of an armed Probation/Parole Officer was of a great advantage to the safety of all concerned.

Why such tunnel-visioned focus on this issue is not yet understood.

I understand that one area frequently argued by the Attorney General is that a State Trooper or other police officer could be called upon to accompany an Adult Probation/Parole Officer when violence is expected. It would be a serious waste of manpower to require an additional police officer to assist when the Adult Probation/Parole Officer is more than capable of handling the situation at hand. It should be noted that the most dangerous situations are not always the most obvious situations.

When the State sends out an Adult Probation/Parole Officer to effect an arrest of a felon (all arrests made by the Adult Probation/Parole Officers are felonies), it will be done peaceably if possible or forcibly if necessary. It is beyond my comprehension how the Attorney General and the Acting Commissioner of Public Safety can rationalize their attempts to disarm these officers. We should be careful not to make their jobs so dangerous to perform that they might shrink from their duties and hesitate from the action which the proper protection of society demands.

I submit that the continued arming of our Adult Probation/Parole Officers is in the best interest of the citizens of this state. I am writing you in an effort to keep you informed of law enforcement's position in this important issue. I simply seek to make our position known and sincerely hope it will not create any animosities.

Your attention to this important issue would be greatly appreciated.

Sincerely,

Craig A. Forster

Craig A. Forster, President
Alaska Peace Officers Association
656 7th Avenue
Fairbanks, Alaska 99701

ALASKA PEACE OFFICERS ASSOCIATION
FARTHEST NORTH CHAPTER

AFZT-PM-W

9 February 1979

Mr. Wayne Anthony Ross
Attorney at Law

Dear Sir,

Information concerning the recent objection for Removal of Commissions for Adult Parole and Probation Officers to carry concealed weapons in the performance of their duties has been brought to our attention. This alarming objection comes as a grave disappointment and extreme concern for our fellow Law Enforcement Officers. The reasoning for this action considering their role in the Criminal Justice System is baffling to say the least. These Officers confront on a daily basis known felons who without question have little or no respect for law and order and even less for representatives of Law Enforcement.

These Officers have all met the Police Standards Council and are fully qualified. Additionally a vast majority have previous Law Enforcement background which include the attendance of Police Academies and various Law Enforcement Seminars. Many Law Enforcement Officers were personally contacted and expressed their concern over this action.

The Farthest North chapter of APOA gave their vote of confidence in addressing Former Commissioner Burton's Task Force report in 1976 for commissioning these officers. Our position is unchanged and speaking for the largest chapter of APOA we fully support and indorse the Parole and Probation Officers of Fairbanks Office. They are without question true professionals and exhibit the highest standards of any parole and probation office I have worked with.

Having been associated with Law Enforcement work over the last nineteen (19) years there is little question in my mind that these Officers of the Adult Parole and Probation Office are fully qualified and warrant the commission to carry weapons, by virtue of their extreme high potential of encountering a felon who has little regard for Law Enforcement representatives. The decision of this action impacts greatly upon their mission. It is our sincere wish that in the final analysis that these Officers be permitted to retain their Commissions.

Sincerely,

JAY R. RHYMES
President

cc: Adult Parole/Probation
Executive Board APOA

ALASKA PEACE OFFICERS ASSOCIATION

Capital City Chapter
P. O. Box 751
Juneau, Alaska 99802

27 February 1979

Mr. Wayne Anthony Ross
Attorney at Law

Dear Mr. Ross:

The Capital City chapter of the Alaska Peace Officers Association has recently been advised of an effort to prevent select probation officers handling adult caseloads from carrying a concealed weapon (hand gun) in the performance of their official duties.

This has been an on-again, off-again situation for a considerable number of years, to the point that many members of our association have been concerned about the extent State government is willing to go in providing avenues of legal and administrative relief for criminal offenders and, at the same time, fail to recognize the need of those Justice System personnel who are hired and sworn to uphold the law.

In our opinion, government is supposed to represent the best interests of the people and, in doing so, ensure that the probation officers in this case, who are public servants, have the necessary equipment to properly discharge their duties in the safest manner possible.

This most recent action directed against probation officers who exercise, by law, their authority to arrest with or without a warrant, the very same criminal element as police, many of which the police would not even think of apprehending, if unarmed and expected to do so, only tends to reinforce our concern about the criminal element's welfare and rights being placed above the safety and welfare of those government employees charge with enforcing the law.

No one can argue philosophy with any degree of success in the face of cold facts and reality concerning this matter. When a probation officers happens upon a probation or parole violator, there are two thing he will know for sure if he is prohibited from carrying a firearm in the performance of his duties.

A. He will know for sure that he is not armed.

B. He will have no way of knowing whether the violator is armed or not.

In view of such facts, it would appear an easy decision to make: allowing probation officers to carry firearms in the performance of their duties.

Thank you.

Very truly yours,

William H. Huston
President
Capital City Chapter
Alaska Peace Officers Association

P. O. Box 751
Juneau, Alaska 99802

From the Desk of

SENATOR DON BENNETT

3 May 1979

Dear Thelma,

Thought you might find this interesting, as it directly supports my SB 162 which seems to be bogged down.

Don

RECEIVED APR 23 1979

IN THE SUPERIOR COURT FOR THE STATE OF ALASKA

THIRD JUDICIAL DISTRICT AT ANCHORAGE

ALASKA PUBLIC EMPLOYEES ASSOCIATION, et al.,

Plaintiffs,

vs.

STATE OF ALASKA,

Defendant.

No. 3AN79-846 Civil

MEMORANDUM DECISION AND ORDER

The State of Alaska (State) and the Alaska Public Employees Association (APEA), together with the individual probation and parole officers, have filed cross motions for summary judgment. These motions came on for hearing on March 8, 1979.

The court finds that there are no genuine issues of material fact and that summary judgment is appropriate on the following issues raised in the summary judgment motions:

I. Whether probation and parole officers are peace officers within the immunity to prosecution for carrying concealed weapons offenses. See AS 11.55.010 and AS 11.55.020.

II. Whether the Commissioner of Public Safety was within his discretion to revoke the special officer appointments of the probation and parole officers.

III. Whether the subject of carrying weapons while on duty is a subject for grievance arbitration under the contract between APEA and the State.

I.

AS 11.55.010 makes it unlawful for a person to carry a concealed weapon. AS 11.55.020 makes this section inapplicable to "a peace officer whose duty it is to serve process or make arrest." Plaintiff probation and parole officers claim that they are peace officers with the duty to

make arrests within the contemplation of AS 11.55.020 so that they are immune to prosecution for carrying a concealed weapon. The duty of probation and parole officers to make arrests is clear. See AS 33.05.070 and AS 33.15.210.

The primary point of contention on this issue is whether parole and probation officers are "peace officers" within the contemplation of AS 11.55.020. Plaintiffs have offered several definitions for "peace officer" derived from the Alaska Statutes. The State correctly asserts that the applicable definition is the general definition found at AS 01.10.060(6):

> "peace officer" means any officer of the state troopers, members of the police force of any incorporated city or borough, United States marshals and their deputies, and other officers whose duty it is to enforce and preserve the public peace.

(Emphasis added.) Plaintiffs argue that they fall within the emphasized language in that their duties as parole and probation officers require them to help enforce and preserve the public peace. The State relies on Alaska Attorney General's Opinion of September 18, 1977, Definition of "Peace Officer" under AS 01.10.060(6) and "Police Officer" under AS 18.65.290(2), which defines "peace officer" in a restrictive fashion:

> . . . he or she must be empowered with a full range of police duties and authority and must be currently functioning on essentially a full time basis in that role.

Opinions of the Attorney General are usually accorded some persuasive weight by the courts. In this case, however, the court finds the opinion relied upon by the State to be most unpersuasive. The Attorney General's analysis depends on assumptions for which this court finds no basis, either in the opinion or the language of the statute construed.

This court finds that the duties of probation and parole officers in enforcing the parole and probation laws

clearly help preserve the public peace and are an integral part of Alaska's system of enforcement of its laws. Therefore, the court holds that probation and parole officers are "peace officers" within AS 01.10.060(6) and that they may not be prosecuted under AS 11.55.010 in accordance with AS 11.55.020.

Plaintiffs are not persuasive, however, in asserting that their status as peace officers mandates them to carry weapons while on duty. The power of peace officers to carry and use weapons while on duty is subject to limitation. See Figaro v. Ward, 383 N.Y.S.2d 529 (1976).

The Commissioner of Health and Social Services is charged with general supervision and control of probation and parole officers. See AS 33.05.010; 33.05.020; and 33.15.150. It is up to the commissioner to determine the methods and equipment to be used by probation and parole officers in carrying out their functions. Section 2210, Firearms Policy of the Department of Health and Social Services Manual, is an apparently well considered and admirable set of guidelines for implementing the policies of the commissioner as regards firearms use by probation and parole officers. This policy made the officer's ability to carry firearms contingent on training and obtaining a special officer commission from the Commissioner of Public Safety. Apparently, Dr. Beirne had decided to revise this firearms policy to deny the use of firearms to parole and probation officers. In the light of the court's holding, supra, that the legislature has determined that such officers may carry concealed weapons without being prosecuted, it is incumbent on the commissioner to articulate her reasoning and the underlying policies that led her to effectively reverse this legislative judgment.

The court will not substitute its judgment for that of the commissioner in formulating a firearms policy, in the absence of the commissioner's arbitrary abuse of her discretion. But the court feels that the firearms policy here in issue is of such fundamental concern to the plaintiff officers' safety, and the public welfare, that some explanation of the reasoning behind the new policy must be forthcoming before the court can rule on whether Dr. Beirne has abused her discretion. Accordingly, the temporary restraining order will remain in effect until Dr. Beirne fully articulates the basis for her policy decision with regards to firearms and her reasons for abrogating the policy of Section 2210. If such a policy determination is not forthcoming within 60 days from the date of this order, this court will enter its order permitting parole and probation officers to carry concealed weapons in performing their duties under appropriate guidelines formulated by this court after appropriate hearings.

II.

Even if this court could find an abuse of discretion by Dr. Beirne in revoking the earlier policy of the Department of Health and Social Services as embodied in Section 2210, Firearms Policy, it would not help the plaintiffs with regard to special officer permits. They have consistently maintained that they are properly subject to Section 2210. Section 2210 makes the ability of the parole and probation officers to carry concealed weapons subject, among other conditions, to the officer being appointed special officer by the Commissioner of Public Safety under AS 18.65.010. The Commissioner of Public Safety has revoked the special officer commissions of the plaintiffs, so that they no longer qualify under Section 2210.

Plaintiffs contend that the revocation of their permits was an abuse of the Commissioner of Public Safety's discretion. This court cannot agree. By its terms, AS 18.65.010 vests the power to make special officer commissions ". . . as he [the commissioner] considers necessary . . ." The statute is also quite clear that special officers serve at the pleasure of the commissioner. The court interprets this grant of discretion to be broad enough to permit the Commissioner of Public Safety to revoke special officer commissions when he no longer perceives the speci officer to be necessary to aid and assist the state troopers. This court also finds persuasive the argument advanced by the State that AS 18.65.010 was enacted for the purpose of strengthening state trooper personnel in remote areas of Alaska rather than to those in the position of the plaintiffs. See Report of the Committee on State Affairs accompanying CSHB 48, Alaska State House of Representatives, House Journal, Alaska State Legislature, Second Legislature, First Session, p. 105 (1961) (quoted in Alaska Attorney General's Opinion of December 22, 1977, Special Police Commissions).

Accordingly, the court holds that the Commissioner of Public Safety was within his authority in exercising his discretion to revoke the special officer commissions of the plaintiff parole and probation officers. However, parole and probation officers' rights to carry concealed weapons are not dependent upon the special officer commission from the Commissioner of the Department of Public Safety. This procedure used by the two commissioners in authorizing weapons to the petitioning officers is commendable and consistent with insuring they were properly trained in use of the weapons before being permitted to carry them, but is not dispositive of their rights to carry concealed weapons.

III.

Plaintiffs also assert that the subject of carrying weapons is a subject for grievance arbitration under the contract between APEA and the State and that their special officer commissions cannot be revoked until the matter has been grieved. As discussed above, plaintiffs' rights to carry weapons are subject to the discretion of the Commissioner of Health and Social Services and their right to special officer permits is subject to the discretion of the Commissioner of Public Safety. This discretion is one of policy rather than "wages, hours and other terms and conditions of employment." See AS 23.40.070 and AS 28.40.250(1). This court cannot assume that the legislature has implicitly divested these executive departments of their power to determine policy matters. Kenai Peninsula Borough School District v. Kenai Education Association, 572 P.2d 416 (Alaska 1977). Additionally, firearms policy is generally regarded as a management decision outside the proper scope of collective bargaining. See San Jose Police Officer's Association v. City of San Jose, 144 Cal. Rptr. 638 (Cal. App. 1978).

Therefore, this court holds that the firearms policy of the Commissioner of Health and Social Services and the revocation of special officer commissions by the Commissioner of Public Safety are not subject to collective bargaining or the grievance and arbitration procedures of the contract between the APEA and the State.

DONE at Anchorage, Alaska, this 23rd day of April, 1979.

Ralph E. Moody, Presiding
Superior Court Judge

SB
163

ALASKA SCHOOL ACTIVITIES ASSOCIATION
650 INTERNATIONAL AIRPORT ROAD ANCHORAGE, ALASKA 99502
LESLIE D. WELLS
EXECUTIVE SECRETARY
907-272-9045

January 18, 1980

The Honorable Vernon L. Hurlburt
House HESS Committee
House of Representatives
Pouch V
Juneau, Alaska 99811

Dear Mr. Hurlburt:

This letter concerns Senate Bill 163am which has been setting in the House HESS Committee since last spring. As you may know, we had asked that this bill be held without action as it was necessary for the Activities Association to work with the State Board of Education and the Alaska Association of School Boards to strengthen the concept of local school board control in this bill. This has been accomplished and both of these bodies have given their approval to the changes as outlined in the attached amendment. They support the bill as revised and we now seek favorable action by your committee.

I have been in contact with your Chairman, Mrs. Buchholdt, and have discussed the next steps with her. She agreed that it would be timely for this communication to bring you up to date on the status of this bill. Please note my letter to Mrs. Buchholdt and the complete backup materials.

We ask for your support and assistance in moving this bill favorably through the committee. If you have any questions, please call me at 272-9045.

Sincerely yours,

ASAA Board of Control
By: Leslie D. Wells
Executive Secretary

LDW:jle

Enclosures

cc: Board of Control
Mrs. Thelma Langdon
Mr. Robert Greene
Mr. Cliff Hartman

Introduced: 2/13/79
Referred: Health, Education
& Social Services

IN THE SENATE BY HACKNEY

SENATE BILL NO. 163 am

IN THE LEGISLATURE OF THE STATE OF ALASKA

ELEVENTH LEGISLATURE - FIRST SESSION

A BILL

For an Act entitled: "An Act relating to interschool activities; and providing for an effective date."

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

* Section 1. PURPOSE. The legislature finds that the establishment, promotion and governance of interscholastic athletic activities and other interschool contests and programs can best be accomplished by the schools in the state through self-organization and control and with a minimum of state supervision and involvement and that accomplishment of these goals is a valid public purpose. The legislature further finds that, because of the relatively small number of schools in the state and the high costs associated with coordinating, on a statewide basis, various interschool activities, the establishment, promotion and governance of interscholastic activities cannot be carried out in an efficient and adequate manner without the provision of some financial assistance from the state.

* Sec. 2. AS 14.12 is amended by adding new sections to read:

ARTICLE 4. INTERSCHOOL ACTIVITIES.

see proposed amendment

Sec. 14.12.200. VOLUNTARY INTERSCHOOL ACTIVITIES ASSOCIATION. (a) School districts, on behalf of one or more of their schools, and private schools in the state may join together to establish a voluntary association to provide for the efficient governing, promotion and control of interscholastic athletic activities and other interschool contests or programs recognized by the association.

(b) The association established under (a) of this section is not a state agency, nor is it a school district or other political subdivision

over

see proposed amendment

of the state. However, employees of the association may participate in the public employees' retirement system (AS 39.35) or, if the employee possesses or is eligible to possess a teacher certificate under AS 14.20.020, the teacher's retirement system (AS 14.25).

Sec. 14.12.210. INTERSCHOOL ACTIVITIES GRANTS. The commissioner of education may make grants to an association established under AS 14.12.200 from funds appropriated for that purpose if the association

(1) has adopted a constitution and bylaws for the governance, operation, regulation and supervision of interschool activities which treat the regions of the state and students in member schools on an equitable basis and in the best interests of the entire state;

(2) has a governing body whose membership is elected and is representative of the member schools in the various regions of the state;

(3) has adopted a reasonable operating budget for the period covered by the grant; and

(4) provides for an audit of the association's use of its grant funds within four months of the close of the grant period.

* Sec. 3. AS 14.07.053 and 14.07.054 are repealed.

* Sec. 4. This Act takes effect July 1, 1979.

SB 163am - PROPOSED AMENDMENT

As Approved By:
ASAA Board of Control
State Board of Educatio
Robert Greene-AASB

- December 10, 1979

Sec. 14.12.200 Voluntary Interschool Activities Association

(A) School Districts, by formal resolution of the board of education, on behalf of one or more of their schools, and private schools in the State may join together to establish a voluntary Association to provide for the efficient governing, promotion and control of interscholastic activities, contests or programs recognized by the Association.

(B) Governance for the Association established under (A) of this section is provided when a majority of member school boards, by resolution, have:

(1) Adopted a Constitution & By-Laws for the operation, regulation and supervision of interschool activities which treat the regions of the State and students in member school districts on an equitable basis and in the best interests of the entire State.

(2) Has a governing body whose membership is elected and is representative of the member school districts in the various regions of the State.

(C) The Association established under (A) of this section is not a State agency, nor is it a school district or a political subdivision of the State. However, employees of the association may participate in the public employees' retirement system (AS 39.35) or, if the employee possesses or is eligible to possess a teacher certificate under AS 14.20.020, the teacher's retirement system (AS 14.25).

(D) The State Board of Education shall approve the Association's Constitution and By-Laws and any revisions thereof to insure that all regions of the State are treated on an equitable basis and in the best interests of the State.

Sec. 14.12.210 Interschool Activities Grants

The commissioner of education may make grants to an association established under AS 14.12.200 from funds appropriated for that purpose if the association:

(1) Has complied with the provisions of A.S. 14.12.200 (B) (1 and 2);

(2) Has adopted a reasonable operating budget for the period covered by the grant; and

(3) Provides for an audit of the association's use of its grant funds within four months of the close of the grant period.

ALASKA SCHOOL ACTIVITIES ASSOCIATION
650 INTERNATIONAL AIRPORT ROAD ANCHORAGE, ALASKA 99502
LESLIE D. WELLS
EXECUTIVE SECRETARY
907-272-9015

January 1980
Les Wells

RATIONALE FOR LEGISLATIVE AMENDMENT - SB 163am

The membership and the Board of Control of the Alaska School Activities Association believes that school interscholastic activities programs, including athletics, music, and speech and drama, can best be accomplished by member schools through self organization and control, with a minimum of state supervision and involvement. It is recognized that the Association requires a legal basis and assistance in funding its efforts because of the relatively small number of schools and high costs associated with the coordination and operation of activities in such a large state.

The Association has done an outstanding job of sponsoring activities for Alaskan youth over the past twenty-two years and now believes that the current legislation passed in 1976 should be amended in order that the Association may better function to serve the needs of its membership. Current problems are:

1. There is duplication of effort and unnecessary administrative structure. It is agreed by the Commissioner of Education and the Association that it is unnecessary to operate the Association within the Department of Education. The authority for school participation and the operation of the Association also comes from member schools, their school boards, superintendents and principals.

2. The current statute is restrictive and does not allow each regional association to freely elect their Board of Control member.

3. The operation of the budget and the accounting system should be accomplished at the Association level to facilitate the needs of the organization, i.e., collection of officials' fees, purchase and sale of rule books, funding of officials' workshops, and the operation of state meets, tournaments and events.

The control of the Association lies with school districts and Boards of Education in the approval of organizational structure. The Association is operated by the superintendents of schools as approved by school boards, either directly or through appointed representatives. The revised legislation would foster this local control and would give the Association greater ability to react to the needs of its members.

Adequate funding from the state is essential in order to support the basic operation of the Association Office. While other states have adequate income from state tournament receipts to support their total operation and to pay for participant's travel expenses, the small number of Alaskan schools and long distances between communities severely limits tournament gate receipts for such needs. A basic state grant program is thus necessary.

LAWS OF ALASKA

1976

Source

SCS SSHB 399(Finance)

Chapter No.

120

AN ACT

Creating the School Activities Association within the Department of Eduoation; and providing for an effective date.

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

* Section 1. AS 14.07 is amended by adding new sections to read:

Sec. 14.07.053. ALASKA SCHOOL ACTIVITIES ASSOCIATION. (a) There is created within the Department of Education the Alaska School Activities Association.

(b) The purposes of the association are to provide for the efficient governing of interscholastic activities through the promotion of those activities and other inter-school contests or programs sanctioned by the association and to assist in the promotion of those other activities and interests as it may from time to time elect.

(c) A public or private school or school district in the state may become a member of the association if it applies for membership. The Department of Education shall make applications available to all public or private schools or school districts in the state.

(d) The governing body of the association shall be the board of control with at least one member from each judicial district on the board of control. A member of the board shall be elected from each regional activities association by the members of that region. The term of office for each member is two years, except that one-half of the members elected to the first elected board shall be elected for one-year terms under regulations prescribed by the commissioner of education.

(e) The board in consultation with the Department of Education shall appoint an executive secretary, prescribe his duties and fix his compensation. He shall serve at the pleasure of the board.

(f) The board of control of the existing Alaska High School Activities Association in office on the effective date of this Act shall serve as the initial board of control for no longer than six months.

(g) The Department of Education shall approve the association's constitution and bylaws to ensure that all regions of the state are treated on an equitable basis and in the best interests of the state.

Sec. 14.07.054. ALASKA SCHOOL ACTIVITIES FUND. (a) The Alaska school activities fund is established within the Department of Education.

(b) The commissioner of education shall review the budget request of the Alaska School Activities Association and request a sum he approves that is equitable to all regions of the state.

(c) School districts and member schools of the Alaska School Activities Association may appropriate money to the fund.

* Sec. 2. This Act takes effect July 1, 1976.

Committed to become law without signature

ALASKA SCHOOL ACTIVITIES ASSOCIATION
650 INTERNATIONAL AIRPORT ROAD ANCHORAGE, ALASKA 99502
LESLIE D. WELLS, ED.D.
EXECUTIVE SECRETARY
907-272-9045

April 17, 1979

Representative Thelma Buchholdt
Pouch V
Juneau, Alaska 99811

Dear Mrs. Buchholdt:

As you know, I have been in contact with Shannon Garrett, your Administrative Assistant, concerning Senate Bill 163 am. We appreciate your cooperation in not calendaring this bill as it has given us the opportunity to work with the educational agencies who have an interest in this legislation.

We are interested in keeping this bill in Committee until we can meet this next month with the State School Boards Association and members of the State Board of Education. It is hoped that we can work out language that is mutually satisfactory and come back to your Committee with a unified position.

If you have any questions concerning this request, please do not hesitate to call me.

Sincerely yours,

Leslie D. Wells
Executive Secretary

LDW:jle

cc: Glenn Hackney

STATE OF ALASKA

JAY S. HAMMOND, GOVERNOR

DEPARTMENT OF EDUCATION

STATE BOARD OF EDUCATION

March 29, 1979

Honorable Thelma Buchholdt
State House of Representatives
Pouch V
Juneau, Alaska 99811

Dear Representative Buchholdt:

During its March 22 Special Meeting on Legislation, the State Board of Education took formal action on several bills presently before the Legislature.

The Board is on record supporting the passage of CSSB 199 (Finance), which deals with the Public School Foundation Program.

The Board does not support either SB 163 am, which deals with the Interschool Activities Association, or HB 411, which deals with sex discrimination in education.

I respectfully request that you take into account the State Board's position on these bills as you determine your own degree of support for them.

Sincerely,

Thelma Langdon

Thelma Langdon, President
State Board of Education

KETCHIKAN HIGH SCHOOL
2610 Fourth Avenue
KETCHIKAN, ALASKA
99901

R.W. STEKL, SUPERINTENDENT
M. BRUCE SLAMA, PRINCIPAL
ROBERT D. VINCENT, VICE-PRINCIPAL

17 March 1979

Representative Thelma Bucholdt
Health, Education and Social Services
Alaska State Legislature
Pouch V
Juneau, Alaska 99811

Dear Thelma:

As a former Anchorage resident and current principal of Ketchikan High School, I am writing to you to voice my opposition to the passage of Senate Bill 163 relating to the creation of an independent Alaska School Activities Association. This constructive action on my part is related to the continually changing policies of the Board of Control which hampers effective control of student acitivies at the Building level because the Board of Control neither has the foresight or planning ability to stick with a decision over a long period of time. They are continually rewriting and changing policies. Let me give you the latest example. Almost over a year ago they voted to limit the number of students traveling to State tournaments. Two weeks ago they caved in and expanded, once again, the number of participants.

On some occasions the Board of Control will make decisions at almost the last minute without regard for the problems it creates for the member schools. Example, changing the seasons of the Girl's Basketball program in June for the coming school year. Result: Ketchikan High School had to host a State Tournament and play in a Boy's Southeast Tournament the same weekend. After requesting the Board of Control to help us out and getting nowhere, our local school board protested the action to the State Board of Education and finally succeeded in winning the appeal.

I hope your committee will not pass this Bill out to the House floor. Let the Alaska School Activities Association clean up its act first and earn its independence.

Sincerely,

M. Bruce Slama
Principal

Les Wells -
272-9045

ALASKA SCHOOL ACTIVITIES ASSOCIATION

650 INTERNATIONAL AIRPORT ROAD ANCHORAGE, ALASKA 99502

LESLIE D. WELLS, ED.D.
EXECUTIVE SECRETARY

907-272-9045

February 27, 1979

Hon. Thelma Buchholdt, Chairman
HESS Committee
House of Representatives
Pouch V
Juneau, Alaska 99811

Dear Mrs. Buchholdt:

The Board of Control and members of the Alaska School Activities Association request your support for the attached legislation, Senate Bill 163. Basically, it is a clean up bill and contains no request for funds. It will serve to improve the Association's operation and remove some limiting aspects. The full rationale is attached with the proposed bill, the current statute and other background information.

The proposal was drafted by Mr. Ron Lorensen of the Attorney General's office and has the support of the Commissioner of Education. Resolutions of support have been passed by the membership of the State School Boards Association, the Superintendent's Association and the Secondary School Principals Association and are enclosed.

The Association earnestly requests your leadership and assistance in this effort and assures you that it is in the best interest of girl's and boy's school activities and the total educational community. This office stands ready to give full attention to this effort and supply you with any information that may be requested.

I will contact you next week (March 5th) concerning this legislation. I am available to meet with you and/or your committee with 24 hours advance notice.

Sincerely,

Les Wells

Leslie D. Wells
Executive Secretary

LDW:jle
Attachments:
cc: HESS Committee:
Joyce Munson, Vice Chairman
Ramona L. Barnes
M. F. "Mike" Beirne
C. V. "Chat" Chatterton
Vernon L. Hurlbert
Bill Miles

Board of Control:

Region I	Dale Lunsford, Naknek
Region II	Wayne Taylor, Nenana
Region III	Ed Frandser Wasilla
Region IV	Ed Nash, Eagle River
Region V	Ed James, Juneau-Douglas
Region VI	Bill Brannian, Fairbanks
State Dept.	Vern Williams, Juneau
Student Mem.	Sheryl Hall, AASG

ALASKA SCHOOL ACTIVITIES ASSOCIATION
650 INTERNATIONAL AIRPORT ROAD ANCHORAGE, ALASKA 99502
LESLIE D. WELLS, ED.D.
EXECUTIVE SECRETARY
907-272-9045

February 1979

RATIONALE FOR ALASKA SCHOOL ACTIVITIES ASSOCIATION

LEGISLATIVE AMENDMENT

The membership and the Board of Control of the Alaska School Activities Association believe that school interscholastic activities programs, including athletics, music, and speech and drama, can best be accomplished by member schools through self organization and control, with a minimum of state supervision and involvement. It is recognized that the Association requires a legal basis and assistance in funding its efforts because of the relatively small number of schools and high costs associated with the coordination and operation of activities in such a large state.

The Association has done an outstanding job of sponsoring activities for Alaskan youth over the past twenty-two years and now believes that the current legislation passed in 1976 should be amended in order that the Association may better function to serve the needs of its membership. Current problems are:

1. There is duplication of effort and unnecessary administrative structure. It is agreed by the Commissioner of Education and the Association that it is unnecessary to operate the Association within the Department of Education. The authority for school participation and the operation of the Association also comes from member schools, their school boards, superintendents and principals.

2. The current statute is restrictive and does not allow each regional association to freely elect their Board of Control member.

3. The operation of the budget and the accounting system should be accomplished at the Association level to facilitate the needs of the organization, i.e., collection of officials' fees, purchase and sale of rule books, funding of officials' workshops, and the operation of state meets, tournaments and events.

The control of the Association lies with school districts and Boards of Education in the approval of organizational structure. The Association is operated by the superintendents of schools, either directly or through their appointed representatives. The revised legislation would foster this local control and would give the Association greater ability to react to the needs of its members.

Adequate funding from the state is essential in order to support the basic operation of the Association office. While other states have adequate income from state tournament receipts to support their total operation and to pay for participants' travel expenses, the small number of Alaskan schools and

(Over)

long distances between communities severely limits tournament gate receipts for such needs.

The Association has applied for funding of $65,000 for Fiscal Year 1980 through the Department of Education. At this time the amount included in their budget as submitted to the legislature is $57,700 for the Alaska School Activities Association. Current year funding is $57,200. This provides funding only for the Association office operation and salaries and represents about 50% of the total financial plan. The other 50% is raised by membership dues and income from officials' fees, rule books and tournaments' income.

Further information concerning the Association is given in the attached "11 Questions About Your Alaska School Activities Association."

LDW:jle

"11 Questions About Your Alaska School Activities Association"

Other Information That May Be Requested:

ASAA Constitution and Bylaws
ASAA Member School Director
ASAA 1978/79 Annual Report & Audit

RESOLUTIONS FAVORING SENATE BILL 163

Alaska School Boards Association
Resolution Passed November 12, 1978 #24

ALASKA SCHOOL ACTIVITIES ASSOCIATION

LEGISLATION

WHEREAS, schools in Alaska have ever-increasing activities for students; and

WHEREAS, there is a statewide Alaska School Activities Association; and

WHEREAS, the Alaska School Activities Association is controlled by appointed representatives of the member schools, their administration and their school boards; and

WHEREAS, the Alaska School Activities Association is now tied to the Alaska Department of Education by law; and

WHEREAS, this position leaves the functions of Alaska School Activities Association hindered by further administrative and appeals channels; and

THEREFORE BE IT RESOLVED, that the Association of Alaska School Boards support separation of the Alaska School Activities Association from the Department of Education.

Alaska Association School Administrators
October 1978 - Passed - Resolution #14

Title: Legislation - Alaska School Activities Association

WHEREAS, schools in Alaska have ever increasing activities for students, and

WHEREAS, there is a Statewide Alaska School Activities Association, and

WHEREAS, the Alaska School Activities Association is controlled by appointed representatives of the member schools, their administration and their School Boards

WHEREAS, this position leaves the functions of Alaska School Activities Association hindered by further administrative and appeals channels, and

WHEREAS, the Alaska Commissioner of Education is in favor of a separate State of Alaska funded agency

NOW THEREFORE BE IT RESOLVED, that the Alaska Association of School Administrators support separation of the Alaska School Activities Association from the Department of Education and be established as a separate agency under the draft law attached.

(Over)

Alaska Association Secondary School Principals
Resolution 10-78 #10 Passed

ALASKA SCHOOL ACTIVITIES ASSOCIATION

LEGISLATION

WHEREAS, schools in Alaska have ever increasing activities for students, and

WHEREAS, there is a statewide Alaska School Activities Association, and

WHEREAS, the Alaska School Activities Association is controlled by appointed representatives of the member schools, their administration and their school boards,

WHEREAS, the Alaska School Activities Association is now tied to the Alaska Department of Education by law, and

WHEREAS, this position leaves the functions of Alaska School Activities Association hindered by further administrative and appeals channels, and

WHEREAS, the Alaska Commissioner of Education is in favor of a separate State of Alaska funded agency,

NOW THEREFORE BE IT RESOLVED, that the AASSP supports separation of the Alaska School Activities Association from the Department of Education and established as a separate agency.

ALASKA SCHOOL ACTIVITIES ASSOCIATION
650 INTERNATIONAL AIRPORT ROAD ANCHORAGE, ALASKA 99502
LESLIE D. WELLS, ED.D. 907-272-9045
EXECUTIVE SECRETARY

11 QUESTIONS

ABOUT YOUR

ALASKA SCHOOL ACTIVITIES ASSOCIATION

1. WHAT IS ASAA?

The Alaska School Activities Association is a voluntary, non-profit state legislature-approved organization of member schools operating under the auspices of the State Department of Education. Organized by and for the schools, the purpose of the Association is to promote, improve and regulate interschool competition and activities in music, speech and drama, athletics and other areas of activities as the membership may so desire.

2. WHY ARE REGULATIONS NEEDED?

In early high school days, problems in interschool competition began to appear. Among the problems were that coaches played on school teams, playing rules and conditions could not be agreed upon, trained officials were lacking, etc. Fair, equal and safe competition was by chance. Chaos often prevailed. Today girls and boys are assured of the opportunity to participate in sound and healthy educational activities.

3. HOW WAS ASAA STARTED?

In the early 1950's school administrators showed a deep concern about the abuses in interscholastic athletics. They saw the need for rules on age, amateurism, and attendance and formed the organization known as the Alaska High School Activities Association in 1956. Meetings were held in conjunction with the annual Fur Rendezvous. A five-man Board of Control administered the affairs of the Association. This was a time for groping, yet much of the basic philosophy for our Activities Association was established during these early years. Basketball in twenty-four high schools was the only area of concern in early years.

Today some twenty-three years later, ninety-five schools are involved in one or more of nine non-athletic areas and eleven athletic areas of interschool activities. On July 1, 1976, legislation became law which placed the Activities Association under the general direction and support of the State Department of Education. It is operated by member schools who vote for and instruct their regional representative to the State Board of Control, approve changes in the constitution and bylaws and participate in activities that fit the needs of their school and community.

Member schools are represented by their elected member on the State Board of Control. This body sets policies, schedules, state event site, budget and employs an Executive Secretary and other staff to administer the Association's business.

(over)

4. WHO MAKES THE RULES?

Being aware that rules and regulations are necessary for any well-run activity organization, the member schools, through ASAA, have set forth necessary rules to assure equal opportunity and competition.

The constitution outlines the scope and purpose of the Association, while the bylaws deal with age, health, transfer, residence, scholarship, officials awards, insurance, amateurism, etc., of pupils; the qualification of coaches; the sponsorship, supervision and number of games; practice and playing seasons; and special rules for various sports.

By adoption of the constitution and bylaws through application for and payment of membership dues, member schools by their own initiative have acted to control their own interscholastic activities accordingly. It is therefore the schools themselves through their school board and superintendent that provides the authority under which the Association functions as approved at this time through State Board of Education.

5. HOW DOES ASAA WORK?

New rules and modifications of existing regulations are made by the member schools through the six regional associations. For purposes of administration and representation, the State of Alaska is divided into six representative regions. Membership in a region is based upon considerations including geography, school size and transportation considerations.

At present there are six regions:

Region I in western Alaska with 33 schools and 2,400 students.
Region II in central and south central Alaska with 20 schools and 1,500 students.
Region III a region of schools from all parts of Alaska (except southeast) with 11 schools and 3,400 students.
Region IV in the Anchorage bowl with 6 schools and 12,000 students.
Region V in southeast Alaska with 16 schools and 3,600 students.
Region VI in the Fairbanks area with 5 schools and 3,400 students.

The Board of Control is the executive and administrative body that carries out the work of the Association through their Executive Secretary. This body enforces the rules voted by member schools. The members of the Board are elected for terms of two years and represent the six regional associations. The Board, which meets four to six times per year, is in charge of the funds of the Association, rules on the eligibility of contestants in all activities, hears and decides protests, recommends changes in regional school placement, and sets dates, sites and qualifications and number of participants for the various state activities and tournaments.

6. WHAT DOES ASAA AND THE REGIONAL ASSOCIATIONS DO?

Develops, approves and directs interscholastic activities such as:

Basketball
Cross-Country Running
Cross-Country Skiing
Future Homemakers of America
Future Farmers of America
Football
Forensics & Drama
Distributive Ed. Club
Gymnastics
Honor Band and Choir

(over)

Hockey	Tennis
Music Festivals	Track & Field
Office Education Assoc.	Volleyball
AASG(Student Gov't. Assoc.)	Wrestling
Swimming	Vocations & Ind. Club

- Sets dates, sites and qualifications for state events;
- Publishes a monthly newsletter, the official handbook and numerous guidelines;
- Works constantly for the safety of participants;
- Strives to promote good sportsmanship and cooperative spirit among schools;
- Encourages a high quality of scholarship;
- Requires physical examinations and insurance standards for participants;
- Seeks to keep awards for achievement on a sound, sensible basis;
- Requires a coach to be a certified teacher and regularly employed by the school they represent, or controlled exceptions;
- Aids officials, coaches and players in acquiring a thorough knowledge of the playing rules;
- Distributes rule books and films to schools and officials;
- Promotes ethical codes among officials, coaches, players and fans;
- Conducts clinics and rule interpretations meetings;
- Tests and registers officials;
- Provides numerous free publications and materials to schools;
- Sactions interstate events and meets;
- Organizes, controls and directs state championships.

7. HOW IS ASAA FINANCED?

ASAA, with a budget of $110,000 in 1978/79, derives its income from the State Legislature through the Department of Education (50%), membership dues (25%), officials dues, sale of publications, and tournaments (largely basketball)(25%).

No transportation expenses for participants are paid by the State Association due to lack of income.

All monies over and above operating expenses from tournaments and meets are used to make up losses in other activity areas.

8. WHAT IS ASAA'S ROLE IN EDUCATION?

School people have long recognized the values of a reasonable and sound school activities program. The purpose of the Alaska School Activities Association is to approve, develop and direct interscholastic programs so that these values are enhanced. ASAA exercises control to reduce over-emphasis and to assure that activities will remain in proper perspective as an integral part of the total educational program. It stresses the cultural values involved in all activities so that the students who participate will grow educationally. The goal is a well-rounded, educational experience for all students.

(over)

9. WHAT IS ASAA'S RELATIONSHIP TO OTHER ORGANIZATIONS AND OTHER STATES?

ASAA cooperates and workswith all agencies that are concerned with the health and educational welfare of high school and junior high school students. Alaska, through ASAA, belongs to the National Federation of State High School Associations, an organization of all fifty states and some Canadian provinces. They assist in formulating uniform policies, standards and game rules so that all schools and students are playing the same games under the safest conditions.

10. WHO MAY BELONG?

Membership in the Association is open to all public and non-public secondary schools desiring participation in interscholastic activities. Over ninety-five are members.

11. WHERE IS THE ASAA OFFICE?

The Association office is located at 650 International Airport Road, Anchorage, Alaska 99502.

FOR ADDITIONAL INFORMATION CONTACT:

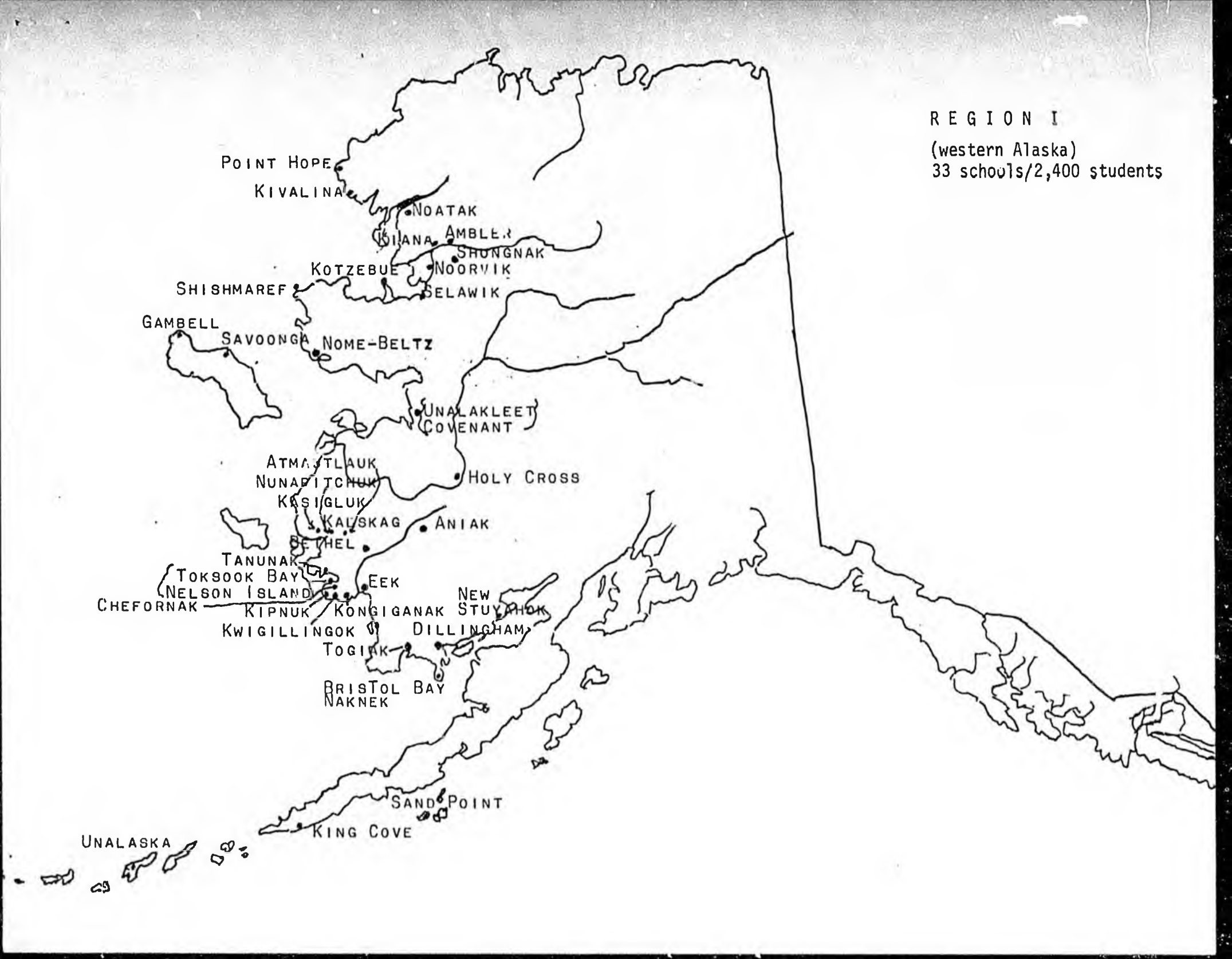
Dr. Les Wells
Executive Secretary
Alaska School Activities Association
650 International Airport Road
Anchorage, Alaska 99502

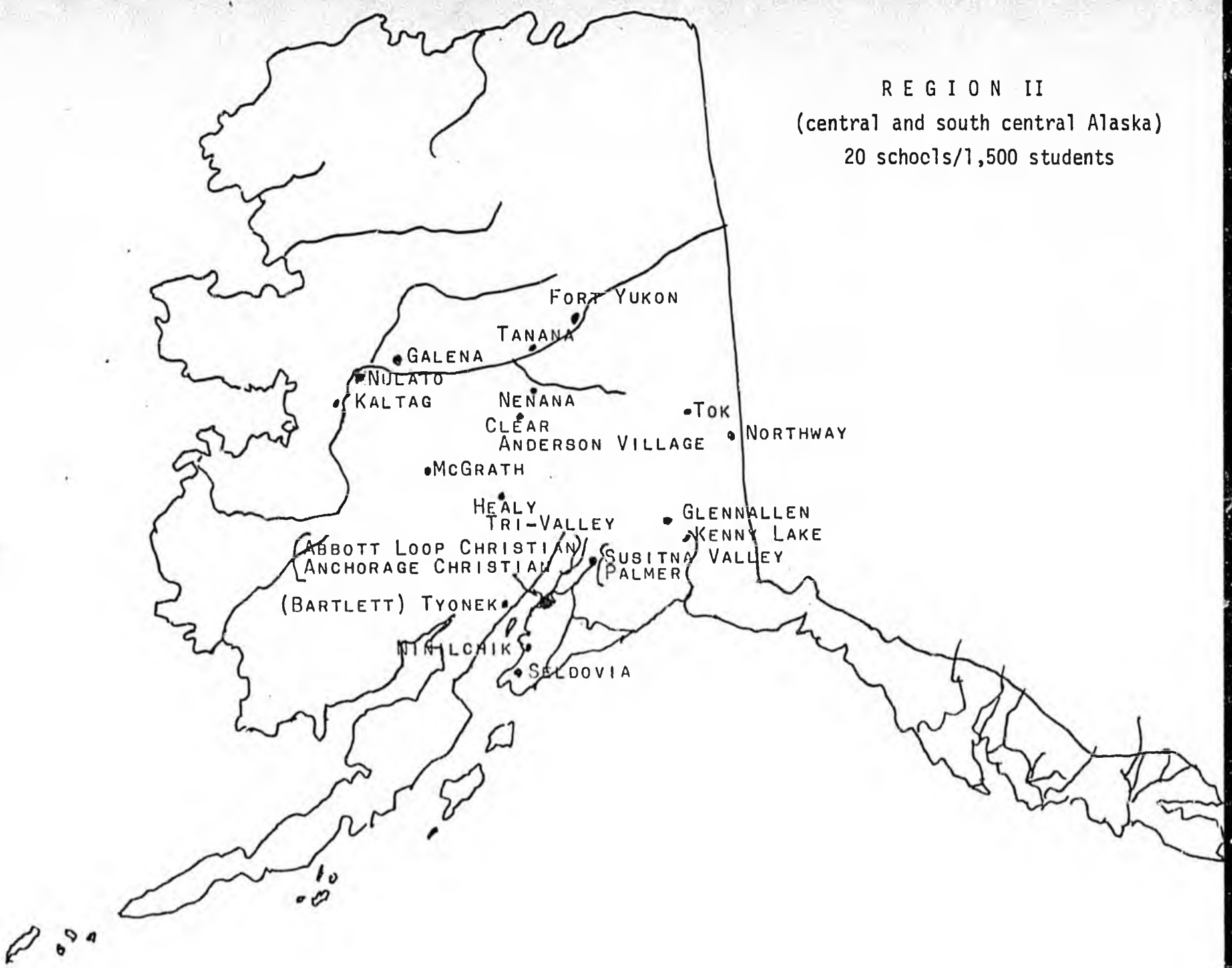
Telephone 272-9045

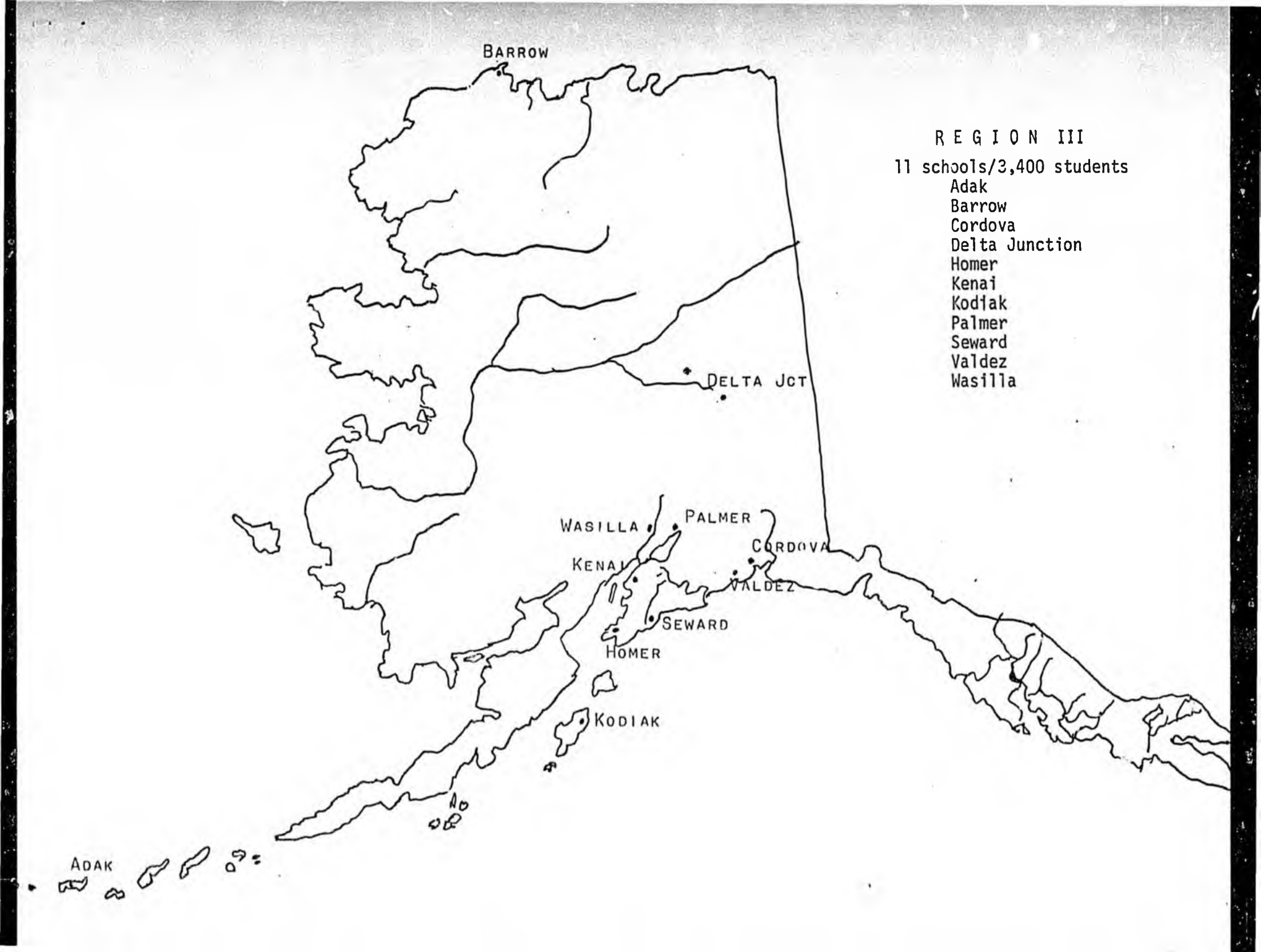
Revised February, 1979.

BOARD OF CONTROL MEMBERS:

Region I:	Dale Lunsford, Superintendent, Bristol Bay School District
Region II:	Wayne Taylor, Principal, Nenana High School
Region III:	Ed Frandsen, Principal, Wasilla High School (President)
Region IV:	Ed Nash, Principal, Chugiak High School (Vice President)
Region V:	Ed James, Activities Director, Juneau-Douglas High School
Revion VI:	Bill Brannian, Principal, Lathrop High School, Fairbanks
	Sheryl Hall, Student Member, AASG, Dimond High School
	Vern Williams, Consultant, Department of Education, Juneau


REGION I
(western Alaska)
33 schools/2,400 students
POINT HOPE
KIVALINA
NOATAK
KOTZEBUE
NOORVIK
SHUNGNAK
SHISHMAREF
SELAWIK
GAMBELL
SAVOONGA
NOME-BELTZ
UNALAKLEET
COVENANT
ATMAUTLAUK
NUNAPITCHUK
HOLY CROSS
KASIGLUK
KALSKAG
ANIAK
BETHEL
TANUNAK
TOKSOOK BAY
EEK
NELSON ISLAND
NEW STUYAHOK
CHEFORNAK
KIPNUK
KONGIGANAK
KWIGILLINGOK
DILLINGHAM
TOGIAK
BRISTOL BAY
NAKNEK
SAND POINT
KING COVE
UNALASKA

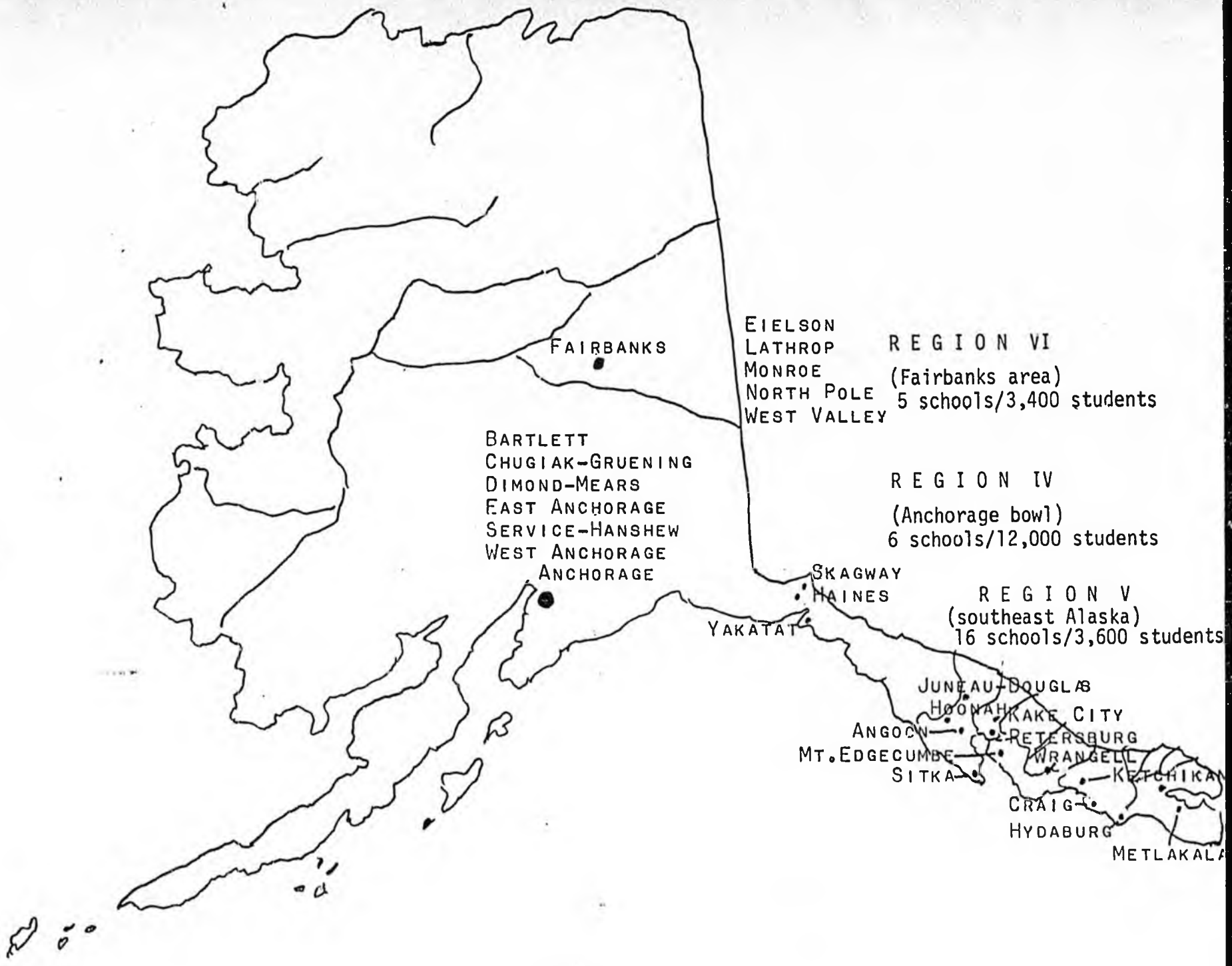

REGION II
(central and south central Alaska)
20 schools/1,500 students
FORT YUKON
TANANA
GALENA
NULATO
KALTAG
NENANA
TOK
CLEAR
ANDERSON VILLAGE
NORTHWAY
McGRATH
HEALY
TRI-VALLEY
GLENNALLEN
KENNY LAKE
(ABBOTT LOOP CHRISTIAN)
(ANCHORAGE CHRISTIAN)
SUSITNA VALLEY
(PALMER)
(BARTLETT) TYONEK
NIKOLCHIK
SELDOVIA



REGION III

11 schools/3,400 students

Adak
Barrow
Cordova
Delta Junction
Homer
Kenai
Kodiak
Palmer
Seward
Valdez
Wasilla


FAIRBANKS
EIELSON
LATHROP
MONROE
NORTH POLE
WEST VALLEY
REGION VI
(Fairbanks area)
5 schools/3,400 students
BARTLETT
CHUGIAK-GRUENING
DIMOND-MEARS
EAST ANCHORAGE
SERVICE-HANSHEW
WEST ANCHORAGE
ANCHORAGE
REGION IV
(Anchorage bowl)
6 schools/12,000 students
SKAGWAY
HAINES
YAKATAT
REGION V
(southeast Alaska)
16 schools/3,600 students
JUNEAU-DOUGLAS
HOONAH
KAKE
CITY
ANGOON
PETERSBURG
MT. EDGECUMBE
WRANGELL
SITKA
KETCHIKAN
CRAIG
HYDABURG
METLAKALA

ALASKA SCHOOL ACTIVITIES ASSOCIATION

ANNUAL REPORT FOR 1977-78

This report reflects the paper shortage and the desire to set forth in outline form the accomplishments, conditions and needs of the Association as we continue to strive to serve the needs of the membership and their students. First, let us recognize that this is an Association of schools who elect to become members and are partners in setting the bylaws for all activities and eligibility rules. It is organized to promote and control good, sound interscholastic activities for all high school youths.

MEMBERSHIP AND PARTICIPATION

Let's look at the growth of membership. Ten schools joined in 1977-78. Eighteen new schools joined this year for a total of 94. Most of these are small schools in Region I ranging in size from 8 to 40. In the fall of 1976 there were 66 members.

Participation has increased in girls interscholastic sport activities by 76% over the past two years for a total of 3,290 in sports. Another 2,500 are in vocal and instrumental music, forensics-drama, student government and career club activities. Boys sports activities have increased by 15% during the same period for a total of 5,600 in sports and 2,200 in the other activities.

Thus, as David Hartman of NBC states on television for the National Federation of High School Associations during NCAA events "Support High School Activities - the Other Half of Education". Over half of Alaska's high school students gain educational and career value and leadership training from these important activities.

The state tournaments and meets report (Exhibit A) shows that approximately 1,900 students participated in state level championship activities. The current picture (1978-79) is not as bright due to financial restraints that were projected to your Board of Control by several school districts. Only 600 to 700 students will have the opportunity to participate in state level competition this year. Your Board of Control and this office are working to find means of improving this picture for the future. Many feel that a good program at state level should include 1200-1400 participants.

FINANCIAL REPORT

This report (Exhibit B) gives the financial status of the Association at the end of FY 1978. We are happy to report that the loss of FY 1977 has been turned around with reserves increasing by over $5,000 in FY 1978. The budget for the current FY 1979 is shown with the proposed budget FY 1980 (Exhibit C). The one big need that is not included is funds to offset costs of team travel to state tournaments and meets.

The total interscholastic activities growth picture is only slowed because of the lack of finances, lack of coaches and sponsors and the limitation of facilities. In the years ahead these limitations should be eliminated to give more students the best possible option to the drug and drop out society. Certainly this program must continue to be built upon a strong school academic program and a co-committment for intramurals and other local school activities to serve the needs and desires of all young people.

PRIORITIES AND NEEDS

First, the Association is seeking legislation to clean up and revise the legal foundation by which it operates. The plan calls for an uncomplicated law that allows flow-through state funding through the State Department of Education and authorizes

the Association to operate its own affairs under the auspices of member schools, their school boards and administrators. Removal from the State Department of Education would both save money and shorten administrative lines. It is noteworthy to report that the Alaska School Board Association, the Superintendents' Association and the Secondary Principals Association all have passed resolutions supporting the proposed revision to the Association legislation.

The second priority is funds to support interscholastic activity travel by Alaska high school groups. This is needed both to establish a support foundation for state tournaments and meets travel and for the many schools that have to travel by airline or air taxi service to achieve interscholastic competition during the regular activity season.

If these first two needs are met, it will follow that the need for stability in programming and participation at the state level will follow. This would then assure Alaska students the same opportunity that is found in other states where travel costs are not so expensive.

SUMMARY

1977-78 was a year of growth and improvement for the Association. Thanks to the hundreds of coaches, sponsors and administrators, Alaska students had many fine opportunities for growth, competition and just good participation.

We would like to recognize the leadership of President Ed Frandsen, Region III representative and Principal of Wasilla High School, and Vice-President Ed Nash of Region IV and Principal of Chugiak High School. These gentlemen have been reappointed by their regions for another two-year term and were re-elected to their respective office for 1979.

We would also like to express the Association's appreciation to past board member Ivan Gillespie, Region VI, who moved from Eielson High School to the central administration in the North Star School District as Director of Vocational Education. Let us also recognize the other board members who have given freely of their time to work for Alaska's youth. Dale Lunsford, Region I, Superintendent Bristol Bay School District; Wayne Taylor, Region II, Principal Nenana High School; Ed James, Region V, Assistant Principal Juneau-Douglas High School; Bill Brannian, Region VI, Principal Lathrop High School; and Vern William, Director, Department of Education, Juneau.

It is also noted that the Board of Control voted in March, 1977, to accept the recommendation of Alaska Association of Student Government to name a student to the Board of Control. Miss Sheryl Hall, senior at Dimond High, was selected to serve in this role as a non-voting member from A.S.G.A. for the 1978-79 school term.

Leslie D. Wells
Executive Secretary
November 1978

ALASKA SCHOOL ACTIVITIES ASSOCIATION

1977/78 State Event Champions and Statement of Income & Expenses

Event & Site		1st & 2nd Place Winners	No. of Participants	Director	Income	Expenses		Net Income or Expenses
						On-Site Expenses	Medals & Trophies	
X-Country Running Eielson	Girls	Service	120	Ivan Gillespie	$ -0-	$ 225	$ 239	-$ 464
	Boys	Dimond / Dimond / Service						
Honor Band, Choir, Orch. Kenai Central			235	Renee' Henderson	2,703	2,693	515	- 505
Volleyball Sitka	Girls	Dimond / East	120	Mack McGown	316	1,190	160	- 1,034
Gymnastics East/Anchorage	Girls	East/Anchorage / Bartlett/Dimond-tie	120	Diana Peterson	807	1,119	355	- 667
Swimming & Diving Ketchikan	Girls	Ketchikan / Dimond	240	Gene Horne	588	491	645	- 548
	Boys	Bartlett / West/Anchorage						
Basketball Wasilla	Girls	Bartlett / East	96	Ed Frandsen	3,325	2,094	214	+ 1,017
X-Country Skiing Chugiak	Girls	Service / East	125	Kathy Christy	-0-	300	166	- 466
	Boys	West Valley / East						
Basketball West Valley/Fairbanks	Boys	East / Dimond	96	Don Klepper	12,368	4,820	213	+ 7,335
Wrestling Service/Anchorage	Boys	West Valley / Chugiak	192	William Mell	5,773	3,890	239	+ 1,644
Forensics-Drama Dimond/Anchorage		East / Bartlett	250	Mel McKelvey	-0-	184	431	- 615
Track & Field Bartlett/Anchorage	Girls	Dimond / East	300	Eldon King / Don Kassube	-0-	1,138	758	- 1,896
	Boys	Kodiak / Bartlett						
				TOTALS	$25,830	$18,144	$ 3,935	+ 3,801

Note: No transportation, food or lodging can be paid to participating teams due to lack of income.

EXHIBIT "A"

ALASKA SCHOOL ACTIVITIES ASSOCIATION

BALANCE SHEET - JUNE 30, 1978

ASSETS

Cash and Savings		$38,829
Office Supplies		149
Iventory		644
Total Current Assets		$39,622
Property-Office Equipment	$1,093	
Accumulated Depreciation	266	827
		$40,449

LIABILITIES

Unearned Dues for 1978-1979	$ 8,750
Prepaid Rule Books, Officials Fees	1,038
Total Current Liabilities	$ 9,788
Fund Balance	30,661
	$40,449

STATEMENT OF CHANGES IN FUND BALANCE FOR THE YEAR ENDED JUNE 30, 1978

Fund Balance, July 1, 1977	$22,692
ADD: Revnues and Other Income	35,788
	$58,480
DEDUCT: Expenditures and Other Expenses	27,819
Fund Balance, June 30, 1978	$30,661

STATEMENT OF REVENUE EXPENDITURES FOR THE YEAR ENDED JUNE 30, 1978

	REVENUE	EXPENDITURES
Dues	$15,910	
Rule Books, Officials Fees	4,381	
State Events	13,803	
Interest	1,294	
Income From Fines	400	
Executive Secretary Travel and Expenses		$ 3,339
Board of Control Expense		6,267
Bookkeeping Expense		1,020
Dues, Subscriptions and Miscellaneous		504
Equipment Rental, Maintenance		603
Postage, Printing, Office Supplies		2,663
Telephone		1,695
Depreciation		208
Audit Expense		500
Rule Books, Officials Workshop		3,585
Tournaments and Awards		7,435
	$35,788	$27,819

NOTE: Does not include state funds of $54,000 that paid for salaries, benefits, office rent and telephone.

ALASKA SCHOOL ACTIVITIES ASSOCIATION

Approved Budget 1978-79
Tentative Budget 1979-80

	1978-79 Budget FY 79	Proposed 1979-80 Budget FY 80
Income:		
1) Dues - Membership	24.0	24.5
2) Tournaments and Events	26.0	26.5
3) Officials' Fees	.8	1.0
4) Sale of Rule Books	2.0	2.0
SUBTOTAL	52.8	54.0
5) State Funding Request	57.2*	65.0*
TOTAL PROJECTED INCOME	110.0	119.0
Expenses:		
1) Executive Secretary Salary	32.5*	34.0*
1-a) Retirement & Benefits	8.0*	8.5*
2) Executive Secretary Travel & Expenses	3.5	4.0
3) Clerical Salary & Benefits (10 month)	15.7*	16.8*
4) Extra Office Help	2.0	2.0
5) National Meeting - Executive Secretary	1.0	1.5
6) Board of Control Meetings & Travel	6.5	7.2
7) Rent & Utilities	3.5*	4.0*
8) Postage	1.5	1.7
9) Printing & Printing Machine Rental	4.0	4.0*
10) Phone	2.5	2.5
11) Supplies	1.4	1.6
12) Rule Books	3.0	3.5
13) Fidelity Bond	.5	.5
14) Audit	.6	.6
15) Liability & Property Insurance	.4	.4
16) Subscriptions, Dues & Miscellaneous	.7	.7
17) Equipment and Maintenance	1.1	2.0
18) Contract Services, Off. & Coaches Workshops	1.6	2.5
19) Tournaments & Awards	20.0	21.0
TOTAL EXPENSES	110.0	119.0
Estimated Deficit (Budget Request to State)	57.2* (Budgeted)	65.0*

*State Funds Request

DIRECTORY---1978-79

ALASKA SCHOOL ACTIVITIES ASSOCIATION

650 INTERNATIONAL AIRPORT ROAD

ANCHORAGE, ALASKA 99502

TELEPHONE 272-9045

BOARD OF CONTROL

REGION I
Mr. Dale Lunsford
Superintendent
Bristol Bay School District
Box 69
Naknek, Alaska 99633
Telephone 268-4225

REGION II
Mr. Wayne Taylor
Principal
Nenana High School
Box 127
Nenana, Alaska 99760
Telephone 832-5484

REGION III
Mr. Ed Frandsen
Principal
Wasilla High School
Box 1580
Wasilla, Alaska 99687
Telephone 376-5341

REGION IV
Mr. Ed Nash
Principal
Chugiak High School
Box 218
Eagle River, Alaska 99577
Telephone 688-2141

REGION V
Mr. Ed James
Director
Juneau-Douglas High School
Box 808
Douglas, Alaska 99824
Telephone 586-3911

REGION VI
Mr. William Brannian
Principal
Lathrop High School
901 Airport Way
Fairbanks, Alaska 99701
Telephone 456-7794

Mr. Vern Williams
Administrator K-12 Program
Department of Education
Pouch F
Juneau, Alaska 99811

Ms. Sheryl Hall
Student Member
ASGA
7001 Town & Country Drive
Anchorage, Alaska 99502

STATE EXECUTIVE SECRETARY
Dr. Leslie D. Wells
650 International Airport Road
Anchorage, Alaska 99502

ALASKA SCHOOL ACTIVITIES ASSOCIATION
DIRECTORY - 1978-79

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ALASKA SCHOOL ACTIVITIES ASSOCIATION
DIRECTORY - 1978-79

VOCATIONAL CLUB SPONSORS

DECA	Bill Schrier Box 1509 Kenai, Alaska 99611	Conference Date - March 9 - 10 Anchorage
OEA	Korlyn Williams Box 1580 Wasilla, Alaska	Conference Date - March 16 - 17 ACC - Anchorage
VICA	Howard Lowry Wasilla, Alaska	Conference Date - April 13 - 14 Skill Center, Seward
FHA-HERO	Marge Schmeige Juneau-Douglas High School Juneau, Alaska	Conference Date - March 30 - 31 Anchorage
FFA	Steve Talovich P. O. Box 654 Delta Junction, Alaska 99737	Conference Date - April 12 - 14

ALASKA STUDENT GOVERNMENT ASSOCIATION OFFICERS

Tim Pearson, President - Nome
Laura Willey, Vice President - Wasilla
John Handeland, Secretary-Treasurer - Nome
Sara Hannan, President - Anchorage West High
Beth Overtelt, Vice President - Palmer
Carolyn Barry - Representative to State Board of Education

Executive Secretary
Mr. Lance Bowie
Assistant Principal
West Anchorage High School
Anchorage, Alaska 99503
Telephone: 274-2502

ALASKA SCHOOL ACTIVITIES ASSOCIATION
DIRECTORY - 1978-79

ACTIVITY CODES

SC	Student Council
B	Band
O	Orchestra
CL	Cheerleaders
VM	Music/Vocal Activities
SP	Forensics/Speech
DR	Drama
OEA	Office Education Association
FHA	Future Homemakers of America
FFA	Future Farmers of America
VICA	Vocational/Industrial Club of America
DECA	Distributive Education Club of America
FB	Football
CC	X-Country Running
GVB	Girls Volleyball
GYM	Gymnastics
S	Swimming & Diving
GBB	Girls Basketball
BBB	Boys Basketball
W	Wrestling
H	Hockey
SKI	X-Country Skiing
GTF	Girls Track & Field
BTF	Boys Track & Field
T	Tennis
DT	Drill Team

REGION I

SUPERINTENDENT PRINCIPAL ACTIVITY ADMINISTRATOR SCHOOL DISTRICT	ADDRESS TELEPHONE NUMBERS	ENROLLMENT GRADES COLORS MASCOT & SONG	DIRECTORS, COACHES, SPONSORS
AMBLER S - George White P - Floyd G. Ellis Northwest Arctic	Box 51 KOTZEBUE 99752 442-3472 AMBLER 99786 445-2154	20 9-12 Brown/Gold Grizzly	SC Peggy Mae Manus CL CC Orlando Lawhorn GBB Orlando Lawhorn BBB Orlando Lawhorn
ANIAK HIGH S - Robert McHenry P - Bill Reynolds Kuspuk	Box 108 ANIAK 99557 675-4380 675-4363	31 9-12 Black/Gold Half-Breed	SC B CL Ginny Stone CC LaMort E. Albertson GVB Bobette Bush GBB Glenn Vaughn BBB Dorman Wilson SKI LaMont E. Albertson
ATMAUTLUAK S - B. A. Weinberg P - Sue C. Hare Lower Kuskokwim	Box 305 BETHEL 99559 543-2677 ATMAUTLAUK 99559	25 9-12 Green/Gold Falcon	SC Ray Mitchell CL Judy Cottschalk GBB Bruce Wegner BBB Frank Neal W SKI Janet Carpenter
BETHEL REGIONAL HIGH S - B. A. Weinberg P - Lon Winters Activities-K. Coughlin Lower Kuskokwim	Box 305 BETHEL 99559 543-2677 543-2247	425 9-12 Blue/Gold Eskimo Warrior	SC B Dick Barker CL Karan Gier VM Dick Barker SP DR FFA VICA DECA CC David Williams GVB Diann Haynes GBB Mark Joshu BBB Bob Lenz W Darrold Sisler SKI David Williams
BRISTOL BAY S - Dale Lunsford P - Jim Henriksen Bristol Bay Borough	Box 169 NAKNEK 99633 268-4225 268-4265	85 9-12 Purple/Gold Angels	SC B J. Littau CL Mrs. Whicker Miss Kahl DR Bill Hatch GBB Pete Hahn BBB Bob Whicker W Bob Hardgrave
CHEFORNAK S - B. A. Weinberg P - Howard Appel Lower Kuskokwim	Box 305 BETHEL 99559 543-2677 CHEFORNAK 99561 787-8001	24	SC George Sam CL George Sam VM Walter Tirchiak GBB Walter Tirchiak BBB Walter Tirchiak W Walter Tirchiak
COVENANT HIGH P - Alfred White Private	Box 184 UNALAKLEET 99684 624-3282	80 Blue/Gold Wolverine	CC Jim Hjelm GBB Sue Eckels BBB Paul Johnson

DILLINGHAM HIGH S - Herb Oba P - Roy Warner Activities-D.LeClair Dillingham	Box 202 DILLINGHAM 99576 842-5223 842-5221	186 9-12 Blue/Gold Wolverine	SC B CL SP CC GVB	Roy Warner Judy Mowery Rod Mehrtens Ward Jones	GYM GBB BBB W SKI	Don LeClair Vic Belleque Ward Jones J. Satterfield
EEK HIGH S - B. A. Weinberg P - Daryl Mannausau Lower Kuskokwim	Box 305 BETHEL 99559 543-2677 EEK 99578 543-2004	13 9-12	SC CL GVB W			
GAMBELL HIGH S - Ron Hohman P - Helen Hickox Bering Strait	Box 1088 NOME 99762 443-5237 Box 189 GAMBELL 99742 746-8001	41 9-12 Blue/White Polar Bear Gambell Fight Song	SC CL FHA GBB	Gary Jennings Christine Oozevaseuk Helen Hickox Gary Jennings	BBB	Rich Binek
KASIGLUK HIGH S - B. A. Weinberg P - Cauline Ferguson Lower Kuskokwim	Box 305 BETHEL 99559 543-2677 KASIGLUK 99609 543-2032	37 9-12 Black/Orange/White Tundra Fox	SC CL VM BBB	Stephen Marble Zack Brink Stephen Marble Zack Brink		
KIANA HIGH S - George White P - Richard Curtis Northwest Arctic	Box 51 KOTZEBUE 99752 442-3472 KIANA 99749 475-2195	70 9-12 Red/Gold Lynx	SC CL FHA CC S	Richard Curtis Alice Reed Ken Kristenson Dick Blair Ken Kristenson	BBB W GTF BTF	Jerry Covey Dick Blair Dick Blair Dick Blair
KING COVE S - Ben Kirker P - Ken Jones King Cove	Box 6 KING COVE 99612 497-2354 497-2354	22 9-12 Black/Gold Brown Bear	B CL VM GBB BBB	Irene Meyer Irene Meyer Irene Meyer Joe Linduska Ken Jones	GBB BBB	Joe Linduska Ken Jones
KIPNUK S - B. A. Weinberg P - Fred Johnson Lower Kuskokwim	Box 305 BETHEL 99559 543-2677 KIPNUK 99614 598-8001	43	CL W 	Kathy Nelson Loretta Kumya Gilbert Amik Rick Nelson		
KIVALINA-McQUEEN HIGH S - George White P - Calvin Baker Northwest Arctic	Box 51 KOTZEBUE 99752 442-3472 KIVALINA 99750 442-3742	85 9-12 Black/Yellow Quaviks	SC CL FFA CC	Dave Watkins Nancy Baker A. Hart Allex A. Hart Allex	GBB BBB W	Mary Ellen Bliss George Harbeson Charlie Sage
KONGIGANAK HIGH S - B.A. Weinberg P - J. P. Hogan Lower Kuskokwim	Box 305 BETHEL 99559 543-2677 KONGIGANAK 99559 696-8001	43	SC CL VM GBB BBB	Jim Hogan Lois Carey Michelle Renner Bill Wilkenson Rick Carey		

KOTZEBUE HIGH S - George White P - Jerry Covey Northwest Arctic	Box 51 KOTZEBUE 99752 442-3472 KOTZEBUE 99752 442-3341	204 9-12 Blue/Gold Husky	SC B Jesse Baker CL Wyn Huss VM CC Doris Brock	GBB Nancy Westlund BBB Ken Kester W Craig Eldred
KWIGILLINGOK HIGH S - B. A. Weinberg P - W. P. Shepard Lower Koskokwim	Box 305 BETHEL 99559 543-2677 KWIGILLINGOK 99622	24 9-12 Blue/White Eagles	SC W. P. Shepard CL Suzanne Fleming GVB Suzanne Fleming GBB Suzanne Fleming	BBB W. P. Shepard W W. P. Shepard GTF Suzanne Fleming BTF W. P. Shepard
MANOKOTAK S - Dr. Robert Van Slyke P - Brian Lewis Southwest Region	Box 196 DILLINGHAM 99576 MANOKOTAK 99628	23 9-12 Purple/Gold Lynx	CC Steven Campbell GVB W Greg Paxton	
NELSON ISLAND S - B. A. Weinberg P - Jim Swartz Lower Kuskokwim	Box 305 BETHEL 99559 543-2677 TOKSOOK BAY 99637	79 9-12 Red/White/Blue	CL B. McCarthy GBB Ruth Jimmie/Katie Curtis BBB Douglas Birch W Lawrence Tung	
NEW STUYAHOK S - Dr. Robert Van Slyke P - Nels Nichols Southwest Region	Box 196 DILLINGHAM 99576 842-5288 NEW STUYAHOK 99636 693-8001	16	SC Nels Nichols CC Pat Costello GVB Molli Sipe W Pat Costello	SKI Pat Costello
NOATAK S - George White P - Valez Ransom Northwest Arctic	Box 51 KOTZEBUE 99752 442-3472 NOATAK 99761 342-3344	20 9-12 Green/White Lynx		
NOME-BELTZ HIGH S - Darroll Hargraves P - Robert Bellmore Activities-H. Green Nome	Box 131 NOME 99762 443-2231 443-5201	200 9-12 Blue/White Nanook	SC Robert Bellmore B Clifford Roundtree CL Bonnie Hahn DR Dick Tardiff OEA Linda Green FHA Andy Mruzik FFA Cindy Schmidge DECA John Currie	FB Jim Skelton CC Jim Skelton VB Bonnie Hahn GBB BBB Paul Carlson W Tom Brannon SKI Jim Skelton
NOORVIK HIGH S - George White P - Nathan Kyle Northwest Arctic	Box 51 KOTZEBUE 99752 442-3472 NOORVIK 99763 468-8001	60 9-12		

NUNAPITCHUK HIGH S - B. A. Weinberg P - Michael Murray Lower Kuskokwim	Box 305 BETHEL 99559 543-2677 NUNAPITCHUK 99641 543-2064	25 9-12	
POINT HOPE S - Don Renfroe P - Flore Lekanof North Slope	Box 307 BARROW 99723 852-6900 Box 22 POINT HOPE 99766 362-8001	49 9-12 Black/White	SC Charles Travis VM Debbie Mello GBB Helen Diggs BBB Charles Travis
SAND POINT HIGH S - Dr. Dick Bower P - Dr. Hugh Porter Aleutian Region	640 West. 36th Ave. Anchorage 99503 276-0006 Box 101 SAND POINT 99661 383-2393	51 9-12 Blue/White Eagle	SC Dr. Hugh Porter/Alan Saunders B Mrs. Norgen Steinbrecher CL Mrs. Jerri Nyberg GBB Roger Steinbrecher BBB Dan Krier
SELAWIK HIGH S - George White P - Ed Werneke Northwest Arctic	Box 51 KOTZEBUE 99752 442-3472 Box 29 SELAWIK 99770 484-2142	79	SC Gordon Heitzeberg CL Donna Werneke FHA Donna Werneke FFA Charley McNally DECA Trish Knight and Chuck Johnson GBB Jerry Olive BBB Eddie Knight
SHISHMAREF HIGH S - Ronald W. Hohman P - John Novak Bering Strait	Box 1088 NOME 99762 443-5237 SHISHMAREF 99772 649-3601	65 9-12 Green/White Northern Lights	SC Joan Novak CL Jill Beach GBB Randy Altermatt BBB Mike Beach
SHUNGNAK HIGH S - George White P - W. H. Armistead Northwest Arctic	Box 51 KOTZEBUE 99752 442-3274 437-2151 SHUNGNAK 99773	28 9-12 Maroon/Gold Eagles	SC Bryan Colson CL Bonnie Bless FHA Jill Carpenter FFA Bryan Colson CC Jeff Smith GBB Bonnie Bless BBB Douglas Walker
TOGIAK S - Dr. Robert Van Slyke P - Ben Cherry Southwest Region	Box 196 DILLINGHAM 99576 842-5288 TOGIAK 99678	44	SC Jim Moras CL Debbie Moras CC Kim Hubert GVB Dennis Dean GBB Carol Burmeister BBB Kim Hubert W Dan Zuspann SKI Dennis Dean
TULUKSAK S - B. A. Weinberg P - Brian Luebke Lower Kuskokwim	Box 305 BETHEL 99559 543-2677 TULUKSAK 99679 543-2089	22 9-12	
TUNUNAK S - B. A. Weinberg P - Paul Chilgren	Box 305 BETHEL 99559 543-2677 TUNUNAK 99681 599-8001	26 9-12	

UNALAKLEET HIGH S - Ronald Hohman P - Jerry Roach Activities-R.Johnson Bering Strait	Box 1088 NOME 99762 443-5237 624-5444 Box 130 UNALAKLEET 99684	81 9-12 Black/Gold Panthers	SC CL GVB GBB	Dennis Johnson Leana Grishkawski Sue Roach Jim Werden	BBB W SKI	J. Roach Jim Werden Don Peterson
UNALASKA HIGH S - William R. Gregory Unalaska City School	UNALASKA 99685 581-1222	44 9-12 Purple/Gold	SC B CL GVB	Richard Lee Robert Pritchett Susan Whiton Richard Lee	GBB BBB	Richard Lee Delmar Olson

REGION II

SUPERINTENDENT PRINCIPAL ACTIVITY ADMINSTRATOR SCHOOL DISTRICT	ADDRESS TELEPHONE NUMBERS	ENROLLMENT GRADES COLORS MASCOT & SONG	DIRECTORS, COACHES, SPONSORS
ABBOTT LOOP CHRISTIAN P - Don Shields Private	2626 Abbott Road ANCHORAGE 99507 349-1723	82 9-12 Blue/White Eagle No Weapon Formed Against Thee	B Bill Colver BBB Randy Meier CL Jan Shields GTF Randy Meier SP Robin Wangaard BTF Randy Meier GBB
ANCHORAGE CHRISTIAN P - Dr. Del A. Brock Private	6401 E. Northern Lights ANCHORAGE 99504 337-9575	125 9-12	B James L. Kring BBB Carlin Dempsey CL Gail Billings W Joe Burton FB Carlin Dempsey BTF Joe Burton
ANDERSON VILLAGE S - Larry Nyland P - Robert Murray Central Railbelt	Box 4029 CLEAR 99704 832-5664 832-5462	45 9-12 Purple/Gold Grizzly	SC CC Bob Harty B Mr. Haeck GBB Bernie Clark CL Christine Knights BBB Bryan Etley DR Mrs. Crowder GTF Bob Harty BTF Bob Harty
COOK INLET ACADEMY P - Charles Crapuchettes Private	Drawer A SOLDOTNA 99669 262-5101	29 9-12 Blue/Gold Eagle The Fight Is On	SC Chuck Crapuchettes GBB Don Stump B Bert Schultz BBB Bill Goold CL MaryLou Elliott W Bill Goold VM Chuck Crapuchettes GTF Bill Goold CC Bill Goold BTF Bill Goold
FORT YUKON HIGH S - James P. Whitt P - Wilfred Files, Jr. Activities-M. Doppler Yukon Flats	Box 359 FT YUKON 99740 662-2515 Box 129 FT YUKON 99740 662-2352	55 9-12 Columbia Blue Eagle Eagle's Song	SC Mike Doppler GBB Bill Black B BBB Mike Doppler CL John Alexander W VM SKI Mike Mastel DR
GALENA CITY S - Peter E. Flisock P - Nancy Schave Galena	Box 266 GALENA 99741 656-1205 656-1205	80 9-12 Blue/Gold Hawk	SC Nancy Schave GBB Bob Shirley CL Shirley Langford BBB Buck Garritson CC Buck Garritson SKI
GLENNALLEN S - Dr. Al Krinkie P - Phil Barra Copper River	Box 108 GLENNALLEN 99588 822-3234 Box 66 GLENNALLEN 822-3232	135 9-12 Gold/Black Panther	SC Phil Barra GVB Gari Normand B Gary Buchman GBB Marilyn Pinned CL Gary Buchman BBB Gari Normand VM Gary Buchman W Chuck Elliott DR Geneva Durkee
KALTAG S - Joe B. Cooper P - Alex P. Tatum Yukon Koyukuk	Box 307 NENANA 99760 KALTAG 99748 832-5594	50 9-12 Purple/Gold Wildcat	SC GBB BBB SKI
KENNY LAKE S - Dr. Alfred Krinke P - Dave Spear Copper River	Box 108 GLENNALLEN 822-3235 COPPER CENTER 99573 822-3870	33 9-12 Blue/Gold Hawk Dear Kenny Lake	CL W Ben Doerksen VM Pete Lyse H Pete Lyse GVB GTF GBB BTF Stan Wallace

McGRATH COMMUNITY S - Jim Zuelow P - Harry Depp Iditarod	Box 105 McGRATH 99627 584-3599 584-3388	45 9-12 Royal Blue/White Arctic Knights Knights Will Shine	SC Tom Sheets CL Kathie Yoder OEA Patricia Henslee VICA Marion Symington	GBB B SKI	
NENANA HIGH S - Richard Leath P - Wayne Taylor Nenana	Box 127 NENANA 99760 832-5625 832-5484	60 9-12 Black/Gold Lynx	SC Scott Iverson B Jerry Coulter CL Sharon Leonard FHA Janice Slaughter CC Scott Iverson	GVB Elwin Leach GBB Rob Chambers BBB Scott Iverson W Scott Iverson	
NINILCHIK S - Dr. Paul C. Gallaher P - Stanley Friese Kenai Peninsula	Box 1200 SOLDOTNA 99669 262-5846 Box 145 NINILCHIK 99639 567-8151	65 9-12 Blue/Gold Wolverine	SC Elaine Thomas B Thane Curry CL Elaine Thomas VM Thane Curry FHA Karen Maze CC GYM Elaine Thomas	GBB BBB Thane Curry W John Lindeman SKI Dave Brann GTF BTF	
NORTHWAY (Walter) S - Carl Peterson P - Ralph Rudzik, Sr. Alaska Gateway	Box 226 TOK 99780 883-4541 NORTHWAY 99674 778-6301	13 9-12 Red and Black Warrior	CL Jeanne Spitler VM Steve Anderson Judy Anderson CC Bill Bryson GBB Bill Bryson	BBB Don Spitler W Bill Bryson Steve Anderson H Bill Bryson SKI Barbara Bryson	
NULATO S - Joe Cooper P - Bob Denny Yukon-Koyukuk	Box 367 NENANA 99760 832-5594 NULATO 99765 898-8001	46	SC Rich Berne CL Dee Stickman GBB Rich Berne BBB Bob Simpson SKI Brian Zinck		
SELDOVIA (Susan B. English) S - Dr. Paul Gallaher P - Thomas E. Overman Kenai Peninsula	Box 1200 SOLDOTNA 99669 262-5846 Box 171 SELDOVIA 99663 234-7616	45 9-12 Scarlet & White Sea Otter	B Rod Hilts CL Kelley Smith VM Rod Hilts DR Susan Mumma CC Hal Neace GVB	S GBB Hal Neace BBB Len Lusk W GTF BTF	
SUSITNA VALLEY S - Dr. Norman Rousey P - Jerne C. Olson Matanuska-Susitna	Box AB PALMER 99645 745-4822 Box 599 WILLOW 99688 733-2241	60 9-16 Blue/Gold Ram	SC Norm Solberg B Paul Trygstad CL Jackie Donoho VM Paul Trygstad DR Sondra Porter OEA Jackie Donoho VICA Joel Heck GVB Jane Griffith	GYM GBB Richard Derrickson BBB W SKI Jane Griffith GTF Tom Sisul BTF James Mead	

TANANA HIGH S - Dr. Robert Jackman Yukon-Koyukuk	Box 367 NENANA 99760 832-5594 Box 127 TANANA 99777 355-7207	49 9-12 Red/White Wolf	SC CL CC GVB	Dr. Robert Jackman Ede Reisland Jack Reisland Loretta Granatelli	GBB BBB W	Dorothy Jordan Bob Bartlett Randy Nelson Diana Hubbs
TOK S - Carl Peterson P - Gary A. Hebert Alaska Gateway	Box 236 TOK 99780 883-4551 Box 247 TOK 99780 883-4351	65 9-12 Red/White/Blue Wolverine Hey Look Us Over	SC B CL CC GVB	Mrs. Mattila Mrs. Dussell Mrs. Dussell Mr. Stiefel Mr. Noonkesser	GBB BBB W H SKI	Mr. Noonkesser Mr. Noonkesser Mr. Dussell Mr. Millanowsk Mr. Stiefel
TRI-VALLEY S - Larry Nyland P - Rich Culver Alaska Central Railbelt	Box 4009 CLEAR 99704 832-5664 Box 60 HEALY 99743 683-2267	57 9-12 Royal Blue/Gold Viking Warrior	SC B CL SP DR	Carroll McCaleb Stuart Nutter Jurine Riley Terry Winet Terry Winet	GVB GBB BBB GTF BTF	 Terry Winet Carroll McCaleb Carroll McCaleb
TYONEK (Bartlett High) S - Dr. Paul Gallaher P - Clifford Myers	Box 1200 SOLDOTNA 99669 262-5846 TYONEK 99682 583-2291	29 9-12 Blue & White Chiefs	CL GBB BBB	Paul Zobeck Paul Zobeck Paul Zobeck		

SUPERINTENDENT PRINCIPAL ACTIVITY ADMINISTRATOR SCHOOL DISTRICT	ADDRESS TELEPHONE NUMBERS	ENROLLMENT GRADES COLORS MASCOT & SONG	DIRECTORS, COACHES, SPONSORS
ADAK (Bob Reeve) S - Dr. Monte McBride P - Vernell C. Pinsom Adak	ANS Box 34 NAVSTA FPO Seattle, WA 98791 (Intra Alaska) 579-2244	106 9-12 Red/White/Blue Eagle	SC Harold Gilstad; B Steve Shore; CL Betsy Morgan; VM Sharon Acree; DR Patricia Watkins; OEA Carole Williams; FHA Veronica Dunn; GBB Willie Theis; BBB Chuck Boerger; W Bruce Stanton; DR Carole Williams
BARROW S - Don Renfroe P - Bill W. Barron North Slope	Box 169 BARROW 99723 852-6900 Box 450 BARROW 99723 852-4711	180 9-12 Blue/Gold Whalers	SC Dick Wilson; B Roger Harms; CL Sandy Mello; VM Roger Harms; CC Steve Mello; GVB Charlene Polak; GYM Charlene Polak; GBB Don Fisher; BBB Sam Bushon; W Steve Mello
CORDOVA JR.SR. HIGH S - William W. Fairall P - Charles D. Taylor Cordova	Box 140 CORDOVA 99574 424-3265 424-3266	133 9-12 Blue/White Wolverine	SC Nat Good; B Eldon Wolfe; CL Nancy Courtwright; VICA J. Goodridge; S David Lederman; GBB Lenny Williams; BBB Bill Bacon; W John Durbin
DELTA JUNCTION HIGH S - Glen Chowning P - Ron Beck Delta/Greely	Box 527 DELTA JUNCTION 99737 895-4658 Box 883 DELTA JUNCTION 99737 895-4696	245 9-12 Green/White Huskie	SC Jack Detzel; B Dale Tumey; O Dale Tumey; CL Cynthia Wener; VM Dale Tumey; DR Cynthia Wener; FHA Judy Dewar; FFA Steve Talovich; GBB Nancy Cook; BBB Jim Harris; W Mike Sarver; OEA Jean Risdal
HOMER JR.SR. HIGH S - Paul C. Gallaher P - Vic Varick Activities-Bill Johnson Kenai Peninsula	Box 1200 SOLDOTNA 99669 262-5846 Box 274 HOMER 99603 235-8186	270 9-12 Blue/Gold Mariner Mariner's Fight	SC Don Ronda; B Susan Oliver; CL Suzanne Rozak; VM Susan Oliver; SP Barb Browning; DR; OEA Randy Hunt; FHA Rose Ekerstrom; FFA Chuck Poindexter; CC Al Poindexter; GYM Bill Johnson; S Robt. Haagensen; GBB Don Harrison; BBB Frank Libal; W Al Poindexter; SKI Bob Macauley; GTF Don Harrison; BTF Dave Schroer
KENAI CENTRAL HIGH S - Paul C. Gallaher P - Gary Deutschlander Activities-B.Boudreaux Kenai Peninsula	Box 1200 SOLDOTNA 99669 262-5846 Box 1509 KENAI 99611 283-7524	1137 9-12 Red/White Cardinal Washington & Lee Swing	SC Tom Ackerly; B Bob Richardson; CL Barbara Brown; VM Renee Henderson; SP Tom Murphy; DR Tom Murphy; OEA Georgia Alexander; FHA June Kohler; VICA Bud Crawford; DECA Jack Castimore; FB Bob Boudreaux; CC Mike Christian; GVB Cyndi Romberg; GYM Carolyn Horne; S Don Oberg; GBB Cyndi Romberg; BBB Bill Bacon; W Mark Brown; H Bob Bird; GTF Mike Christian; BTF Hal Smalley

KODIAK HIGH S - Dr. John Anttonen P - Thomas G. Wischer Activities-J.Witteveen Kodiak Island	Box 886 KODIAK 99615 486-3131 Box 1516 KODIAK 99615 486-3131	575 9-12 Blue/Gold Bears	SC B CL VM VICA CC	Gail Parsons Emory Welch Suzanne Gaffney Emory Welch Bill Barker Mike Platt	S GBB BBB W GTF BTF	Charmaine Purucker Mike Platt Harry Mickelson Jim Heikes Charmaine Purucker Gary Lambert
PALMER HIGH S - Dr. Norman Rousey P - William Butler Activities-G. Horrell Matanuska-Susistna	Box AB PALMER 99645 745-4822 745-3241	600 9-12 Blue/White Moose Night Flight	SC B CL VM SP DR OEA FHA FFA	P. O'Hara J. McAlister E.Richmond and E. Hermon J. McAlister D. Long D. Long G. Sarvela E. Richmond E. Henderson	VICA FB CC GVB GBB BBB W GTF GTF	D. Richards D. Strouse R. Rogney and M. Janecek E. Bentti R. Rogney D. Carney L. Smith R. Rogney R. Rogney
SEWARD HIGH S - Dr. Paul Gallaher P - Dale A. Sandahl Activities-Gary Horrell Kenai Peninsula	Box 1200 SOLDOTNA 99669 262-5846 Box 427 SEWARD 99664 224-3010	180 9-12 Green/Gold Seahawk Seahawks of Victory	SC B CL VM DR OEA FHA CC	Sam Daniel Elaine Larson Janet VanDriessche Elaine Larson Doug Capra Barbara Blowers June Daniel Gary Horrell	GYMC S GBB BBB W GTF BTF	Sara Horrell Janet VanDriessche Dale Sandahl Gary Horrell Mark Larson Gary Horrell Gary Horrell
VALDEZ HIGH Acting S - Larry LaBolle P - Tom Thomas Activities-Jean Kalish Valdez	Box 398 VALDEZ 99686 835-4357 Box 397 VALDEZ 99686 835-4767	200 9-12 Black & White Buccaneer	SC B CL VM SP DR	Bette Cato Rich Danielson Susan Eide Rich Danielson Bette Cato Alice Bosshardt	GVB S GBB BBB W SKI	Dianne Russell Nancy Lazenby Dan Eide Joe Young Rick Cavens
WASILLA HIGH S - Dr. Norman Rousey P - E. M. Frandsen Activities-Brad Snodgrass Matanuska-Susitna	Box AB PALMER 99645 745-4822 Box 1580 WASILLA 99687 376-5341	496 9-12 Red and White Warrior Wasilla Fight Song	SC B CL VM SP DR OEA VICA FB	Vern Cherneski Richard Kraus Mary Jo Parks Richard Kraus Robert Check Robert Check Korlyn Williams Howard Lowery Steve Olson	CC GVB GBB BBB W H SKI GTF BTF	Roxanne Olson Dee Jilek Don Teegarten Dale Schweible Jeff Trotter Brush Christianson Steve Samler Charles Heath Dennis MacKinnon

REGION IV

SUPERINTENDENT PRINCIPAL ACTIVITY ADMINISTRATOR SCHOOL DISTRICT	ADDRESS TELEPHONE NUMBERS	ENROLLMENT GRADES COLORS MASCOT & SONG	DIRECTORS, COACHES, SPONSORS
BARTLETT HIGH S - Dr. John Peper P - Dee Durst Activities-E. King Anchorage	Pouch 6614 ANCHORAGE 99502 333-9561 25-500 N. Muldoon Rd. ANCHORAGE 99504 337-1585	1930 9-12 Royal and Gold Golden Bear Notre Dome Fight Song	SC T. Parnell; B R. von Kennen; O; CL L. Lee/K. Estes; VM B. McDonald; SP; DR; OEA M. Askeland; FB R. Swatosch; CC J. Helen; GVB D. Peterson GYM J. Earl; S G. Chambers; GBB E. Lathan; BBB S. Eberly; W G. Palmer; H D. Anderson; SKI R. Fitchett; GTF L. Whitmore; BTF L. Whitmore; T
CHUGIAK-GRUENING HIGH S - Dr. John Peper P - Ed Nash Activities-Bill Kuhlman Anchorage	Pouch 6614 ANCHORAGE 99502 333-9561 Box 218 EAGLE RIVER 99577 688-2141	1397 9-12 Columbia Blue & Black Mustang Minnesota Rouser	SC Ed Nash; B Darrel Daley; O Mr. Thomas; CL Sally Callaway/Ethyl Owens; VM Mrs. Jaynes; SP Warren Hagman; DR Gina Ornquist; FB Tom Huffer; CC Andy Kirk/Renee Henry; GVB Priscilla Robbins; GYM Sue Roskopf; S Dick Green GBB; BBB; W Darrel White; H Don Bernard; SKI David Christy; GTF Renee Henry; BTF Andy Kirk; T Ethyl Owen
DIMOND/MEARS HIGH S - Dr. John Peper P - Richard Mize Activities - T.Johnson Anchorage	Pouch 6614 ANCHORAGE 99502 333-9561 2909 W. 88th Avenue ANCHORAGE 99502 243-1141	2000 9-12 Maroon/Gold Lynx	SC Teresa Johnson; B; O Bea Boring; CL Becky Voris; VM Betty Fedge; SP Lee Wilson; DR; OEA Rolle Lee; DECA Janey Nye; FB Mark Whitehurst; CC Lynn Rowmagoux GVB Donna Dooley; GYM Sylvia Swatosch; S Jerry Lusk; GBB Earl Walker; BBB Larry Jelle; W Charles Vandergaw; H Bernie Simon; SKI; GTF Lynn Rowmagoux; BTF John Bundy; T Dave Reeves

EAST ANCHORAGE S - Dr. John Peper P - Robert Hahn Activities-Arlene Dey Anchorage	Pouch 6614 ANCHORAGE 99502 333-9561 4025 E. 24th Ave. ANCHORAGE 99504 277-3575	2159 9-12 Blue/Red Thunderbird	SC B O CL VM SP DR DECA FB CC GVB	R. Arduser K. Muse K. Muse D. Peterson H. Hedberg N. Simmons J. Lynn J. Manison B. Durado B. Hart E. Doggett	GYM S GBB BBB W H SKI GTF BTF T	B. Cassel S. Purcella C.White L. Weatherwax D. Bell C. Haines J. Peterson
SERVICE-HANSHEW HIGH S - Dr. John Peper P - Richard Arndt Activities-Carl Miller Anchorage	Pouch 6614 ANCHORAGE 99502 333-9561 5577 Abbott Road ANCHORAGE 99507 344-2561	1778 9-12 Green/Gold Cougar Go Northwestern	SC B O CL VM SP DR OEA DECA FB CC	Marietta Blakney James Terrill Becky Zankie Marietta Blakney Robert Ried Vicki Russell Vicki Russell Sharon Feeley Nancy DeRewe Robert Senden Tom Corbin	GVB GYM S GBB BBB W H SKI GTF BTF T	Alice Gommoll Kathy Meyer Ron Todd Gary Beller Jackie Lewis Byron Wilson Richard Thompson Chancey Crawford Ray Reekie Ray Reekie Ron Todd
WEST ANCHORAGE S - Dr. John Peper P - Larry Graham Activities-M.McKelvey Anchorage	Pouch 6614 ANCHORAGE 99502 333-9561 1700 Hillcrest Drive ANCHORAGE 99503 274-2502	2180 9-12 Black/Orange Eagle On the Anchor	SC B O CL VM SP DR OEA DECA FB CC	Russ Seppi Ed Harbke Beth Leffingwell Pat Furnace Cam Bohman Lucky Watkins Lucky Watkins LaForrest Clark Hap Jones Don Larson Dean Southam	GVB GYM S GBB BBB W H SKI GTF BTF T	Ellie Dudley Brinkerhoff Roberta Chandler Dean Southam Lee Sneddon Doug Jackson Gerald Helvey Charles Hostetler Bill Wiltrout Lee Sneddon Bill Stone

SUPERINTENDENT PRINCIPAL ACTIVITY ADMINISTRATOR SCHOOL DISTRICT	ADDRESS TELEPHONE NUMBERS	ENROLLMENT GRADES COLORS MASCOT & SONG	DIRECTORS, COACHES, SPONSORS
ANGOON HIGH S - Joseph M. Kahklen P - Roland Brice Chatham	Box 109 ANGOON 99820 788-3302 788-3262	55 9-12 Navy Blue/White Eagle	SC Chuck Tennessen; B Wayne Sanger; CL; CC Terry Barlow; GVB Ron Gleason; GBB Ron Gleason; BBB Rick Anderson; W Ron Gleason
CRAIG (Prince of Wales) S - Michael Sexton P - Kathleen Formella Activities-T. Peterson Craig	Box 71 CRAIG 99921 826-3251 826-3322	100 9-12 Green/Gold Panther	CL Nora Ann Peterson GVB Todd Peterson BBB Todd Peterson
HAINES HIGH S - Stephen T. McPhetres Activities-R.Vlasak Haines Borough	Box 636 HAINES 99827 766-2411	135 9-12 Kelly Green Glacier Bear	SC Stephen McPhetres; B Gary Matthews; CL Marian Engel; VM Gary Matthews; OEA Betty Bryse; FHA Carol Knight; CC Jack James; GVB Marian Engel; BBB Terry Friske; W Duane Synoground; GTF Frank Holmes; BTF Carlyle Stuart
HOONAH HIGH S - Dr. Thomas R. Brown P - Thomas W. Budd Hoonah	Box 157 HOONAH 99829 945-3611 945-3611	85 9-12 Maroon & White Brave	SC Marta Mertinsen; B Bob Hutton; CL Dorothy McKenzie; FHA Nicki Sheldon; VICA Don Wark; GVB Don Hather; GBB; BBB; W Don Hather; GTF; BTF
HYDABURG HIGH S - Dr. Elbie Gann P - Sasha Soboleff Hydaburg	Box 109 HYDABURG 99922 285-3491	38 9-12 Gold/Purple Warriors	SC Mr. Soboleff; B Dr. Gann; CL Mrs. LeAnn Reed; SP Mr. Walker; GVB Mrs. Reed; BBB Mr. Richmond; BTF Mr. Richmond
JUNEAU-DOUGLAS HIGH S - John Coffee P - Hans Mercer Activities-Ed James Juneau	Box 808 DOUGLAS 99824 364-2182 586-3911	950 9-12 Red/Black Crimsom Bear Notre Dame Victory	SC Beth Belflower; B Stan Sells; O Stan Sells; CL Betsy McHugh; VM Bernie Hendricks; DR Ken Koelsch; FHA Marge Schmiefe; DECA Mike Herold; CC Ron Metzgar; GVB Mike Daniels; GYM Cyndy Daniels; S Bob Solow; GBB Russ McDowell; BBB Jim Hamey; W Mike Herold; GTF Mary Herold; BTF Bob Peel; DT

KAKE CITY HIGH S - David Dillman P - Dr. David Dudinsky Activities-L.Anderson Kake City Schools	Box 450 KAKE 99830 785-3731	48 9-12 Red & White Thunderbird	SC B CL CC	Larry Frazer Connie Erskine Sue Ohmer Dave Ohmer	GBB BBB GTF BTF	 Dave Ohmer Dave Ohmer Dave Ohmer
KETCHIKAN S - Ron Stekl P - Bruce Slama Activities-B.Vincent Gateway Borough	Pouch Z KETCHIKAN 99901 225-2118 2610 Fourth Ave. KETCHIKAN 99901 225-2115	738 9-12 Maroon and White King Salmon School Pledge	SC B CL VM SP DR CC GVB	David Crockett Roy McPherson Trudy Elliott Clarice Stefon Robert Landis Judy Jenkinsen Don Dillenberg Dick Ortiz	S GBB BBB W GTF GTF DT	Mike Smithers Dick Ortiz John Brown Sal Beraldi Fred Reeder Fred Reeder Barbara Knapp
METLAKATLA HIGH S - James Jennings P - Harvey T. King Annette Island	Box 7 METLAKATLA 99926 886-6332 886-6000	100 9-12 Blue & Gold the "Chief"	SC B CL VM	Don Christensen Pat Kolp Theresa Pempek Pat Kolp	GVB GBB BBB DT	Clinton J. Daly Clinton J. Daly Dave Boxley Theresa Pempek
MT. EDGECUMBE HIGH S - LeRoy Demmert P - Lawrence Welch Activities-Gil Truit BIA	Bureau of Indian Affairs MT. EDGECUMBE 99835 966-2201 966-2203	415 9-12 Cardinal & Gold Brave "Fight Song"	SC B CL VM FHA CC GVB	Lincoln Saito Juan Coursey Ron Hawk Marcia Strand Dwayne Davies Dan Dagle	S GBB BBB W GTF BTF	Steve Lay Rod Nutting Verdell Briggs Joe Slatts Sam Meyers Sam Meyers
PETERSBURG HIGH S - Don Schultz P - Syd Wright Petersburg	Box 289 PETERSBURG 99833 772-4271 772-4434	175 9-12 Blue/White Viking Viking Fight Song	B CL VM DR GVB	Les Snyder Kathy Benson Marilyn Baumgartner Syd Wright Bill Beck	S GBB BBB W	Rich Myers Lee Ribich John Bisson Pat Curtiss
SITKA HIGH S - Neland J. Haavig P - James A. Broschat Activities-Mick Megown Sitka	Box 179 SITKA 99835 747-8622 747-3263	500 9-12 Blue/White/Red Wolf	SC B CL VM FHA VICA CC	Marvin Krause James Hope Sarah Bell James Hope Marilyn Wilson Stephen Vieira/ Leo P. Galli Bruce Ellingson	GVB S GBB BBB W GTF BTF DT	Aleeta Bauder Don Seesz Theresa Gatarz Don Lehmen Michael Turner Michael Hirai Michael Hirai Karen Grussendorf
SKAGWAY HIGH S - P - Jim Reynolds Skagway	Box 514 SKAGWAY 99840 983-2320	69 9-12 Blue/Gold Panther	SC B CL VM CC GVB	Waneta Coring Don Johnson Barbara Iams Don Johnson Dean Ray Bonnie Sherar	GBB BBB W GTF BTF DT	Bonnie Sherar Dean Ray Tim McDonald Dean Ray Dean Ray Don Johnson

THORNE BAY S - Bruce Hill P - Franklin Adreon Southeast Island	640 Park Avenue KETCHIKAN 99950 225-9658 Box 5 THORNE BAY 99950 828-3921	49 9-12 Blue/Gold Wolverine	CL DR CC GVB BBB	Waide G. Bryant Wilburn Wilburn Wilburn		
WRANGELL HIGH S - Robert W. McConnell P - Richard B. Hansen Wrangell	Box 651 WRANGELL 99929 874-3395 874-3395	142 9-12 Red/White Wolf	SC B CL VM OEA FHA DECA	Ron Castle Haig Demerjian Therese Pempek Richard Port Joan Eagle Therese Pempek Jerry Brown	CC GVB GBB W GTF BTF	Ken Cash Myron Myers Wallace Schmidt Phil Wayne Tim Buckley Tim Buckley
YAKUTAT (Mt. St. Elias) S - Fred Kent P - Mary Boario Yakutat	Box 227 YAKUTAT 99689 784-3318 784-3318	50 9-12 Black/Orange Eagle On Wisconsin	B CL CC GVB S	Greg Sawyer Cherie Thompson Mark Cross Tim Kenworthy Mark Cross	GBB BBB GTF BTF	Bill Cass Tim Kenworthy Mark Cross Mark Cross

SUPERINTENDENT PRINCIPAL ACTIVITY ADMINISTRATOR SCHOOL DISTRICT	ADDRESS TELEPHONE NUMBERS	ENROLLMENT GRADES COLORS MASCOT & SONG	DIRECTORS, COACHES, SPONSORS
EIELSON HIGH S - Dr. Bryce Stallard P - Charles A. Lowry Activities-Jim Holt North Star	Box 1250 FAIRBANKS 99707 456-7924 EIELSON AFB 99702 377-1140	441 9-12 Red/White/Black Raven All Hail You Mighty Ravens	SC Chas. Mattioli; B; CL Evelyn McGee; VM; DR T. P[illegible]erson; FHA J. E[illegible]ickson; FB Buck Nystrom; CC Floyd Reishus; GVB Dee Black; S Marie Morgan; GBB; BBB Tom Devor; W Vern Delaney; SKI Floyd Reishus; GTF Tom Devor; BTF Tom Devor
LATHROP HIGH S - Dr. Bryce Stallard P - William N. Brannian Activities-Robert Boko North Star	Box 1250 FAIRBANKS 99707 456-7924 901 Airport Way FAIRBANKS 99701 456-7794	1150 9-12 Purple/Gold Malemute Malemute Fight Song	SC John Selle; B Robert Boko; O Anne Lackey; CL Sharon Boko; VM Robert Boko; DR Joel Mattson; FB Roscoe Livingston; CC John Nagy; GVB Steve Lackey; GYM Gene Cole; S Gene Cole; GBB Leneve Johnson; BBB Dick Lee; W Bob Hawkins; GTF John Rima; BTF John Rima
MONROE HIGH P - Bill Cooper Private	615 Monroe Street FAIRBANKS 99701 452-2044	80 9-12 Blue/Gold Ram	SC Bill Cooper; CL B. Sullivan; GVB R. Colston; GBB K. Norris; BBB R. Colston
NORTH POLE S - Dr. Bryce Stallard P - Larry Noble Activities-J.Henderson North Star	Box 1250 FAIRBANKS 99707 456-7934 488-2271	586 9-12 Red/White/Blue Patriot	SC L. Noble; B M. Gerschefski; O M. Gerschefski; CL S. Gers; VM M. Gifford; SP L. Allison; DR C. Rudolf; FB J. Tobin; CC K. Jinsk; GVB L. Marquette; GYM B. Julig; S L. Konetski; GBB R. Morris; BBB T. Shea; W J. Tobin; H B. Teitz; SKI W. Wenstrom; GTF R. Morris; BTF R. Morris
WEST VALLEY HIGH S - Dr. Bryce Stallard P - Don Klepper North Star	Box 1250 FAIRBANKS 99707 456-7924 3800 Geist Road FAIRBANKS 99701 479-4221	1100 9-12 Red/Gold Wolfpack Go West High	SC Edith Green; B George Wiese; O Donna Matschke; CL Marcia Snyder; VM Marvilla Davis; SP Marcis Burnside; DR Gene DeWild; FB Joe Caciari; CC Bob Sprague; GVB Matt Steffes; GYM Diadre Dalrymple; S Judy Soolook; GBB Don Klepper; BBB Ted DeLeon; W Charles Scott; H Richard Tarkiainen; SKI Marianne Carlson; GTF Bob Sprague; BTF Bob Sprague

ALASKA SCHOOL ACTIVITIES ASSOCIATION

CONSTITUTION AND BY-LAWS

Revisions APPROVED by Board of Control December 15, 1976, and by a vote of the membership on January 20, 1977. Approved by the State Board of Education on January 29, 1977.

Approved Revisions September 1, 1977
Pages 11, 14

Reprinted October 1977

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pages 6, 9,11 and 11a

OFFICES

650 INTERNATIONAL AIRPORT RD.

ANCHORAGE, ALASKA 99502

ALASKA SCHOOL ACTIVITIES ASSOCIATION

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The Constitution and By-Laws of the Alaska School Activities Association as set out in pages 1-19 were approved by the State Board of Education, January 29, 1977, and adopted as state regulations effective March 24, 1977.

ALASKA SCHOOL ACTIVITIES ASSOCIATION

STATE BOARD OF CONTROL

REGION I (Alternate)
Mr. Dale Lunsford, Supt.
Bristol Bay School Dist.
Box 69; Naknek, Ak. 99633

REGION II
Mr. Wayne Taylor, Prin.
Nenana High School
Nenana, Alaska 99760

REGION III
Mr. Ed Frandsen, Prin.
Wasilla High School
Wasilla, Alaska 99687

REGION IV
Mr. Ed Nash, Prin.
Chugiak High School
Chugiak, Alaska 99567

REGION V
Mr. Ed James, Director
Juneau-Douglas High Sch.
Box 808; Douglas, Ak. 99824

REGION VI
Mr. William Brannian, Prin.
Lathrop High School
Fairbanks, AK. 99701

STATE DEPARTMENT CONSULTANT
Mr. Vern Williams
Alaska State Dept. of Ed.
Juneau, Alaska 99811

AASG Student Member
Sheryl Hall-Dimond High

STATE EXECUTIVE SECRETARY

Dr. Leslie D. Wells
650 International Airport Road
Anchorage, Alaska 99502
907-272-9045

The Alaska [High] School Activities Association, an organization created by the Superintendents' Advisory Commission in 1956 and recreated under state law, Chapter 128-SLA 1976, has been placed within the Department of Education. The Activities Association is authorized to prescribe the regulations and rules for conducting interscholastic activities involving teams, groups, or contestants when a second high school or organization is participating in athletics, music, dramatics, speech and debates, and any other interscholastic activity that may be desired. The Constitution and By-laws of the Association must be approved by the State Board of Education.

ASSOCIATION FORMS

Available upon request from:

1. Membership Forms
2. Contest Contracts
3. Master Eligibility List
4. Constitution and By-Laws
5. Physical/Parent Consent Forms
6. Rule Violation and Protest Forms
7. Rule Books
8. Activitity Guides

Executive Secretary
Alaska School Activities Assn.
650 International Airport Road
Anchorage, Alaska 99502

PHONE: 272-9045

STATEMENT OF PHILOSOPHY

The purpose of the Alaska School Activities Association is to coordinate the efforts of its member schools toward the ultimate objectives of interscholastic activities. The Association shall provide a means for schools to cooperate in order to enhance and protect their interscholastic programs. In order to accomplish this, the A.S.A.A. is guided by a philosophy consistent with the purposes of secondary education in Alaska.

Member school's programs must be administered in accordance with the following basic beliefs:

Interscholastic activities shall be an integral part of the total secondary school educational program, with emphasis on teaching "through" activities, in addition to teaching the "skills" of activities. They shall have as their purpose:

a. to provide educational experiences not otherwise provided in the curriculum;

b. to develop better citizens; and

c. to encourage high standards of citizenship.

Interscholastic activities shall be tailored to the physical, mental and emotional maturity levels of the youths participating in them and shall be primarily for the benefit of those youths.

Any district, regional or state contest or event held to determine what is a champion shall provide fair opportunities for schools to demonstrate and to evaluate what is best taught in their programs with the best taught from other schools and from other areas of the state.

Participation in interscholastic activities is to be granted to those students who meet the minimum standards of eligibility adopted cooperatively by this association and those additional standards established by each school or region for its own students.

The A.S.A.A. is concerned with the development of those regulations, standards, and policies essential to assist school districts, their boards of education, and administration of member schools in the implementation of their philosophy of interscholastic activities. Interschool activities shall be kept in proper perspective and must complement the academic program of the schools.

Nonschool activities sponsored primarily for the benefit of the participants in accordance with the philosophy compatible with the school district and school philosophy of interscholastics may have values for youth. When they do not interfere with the academic and interscholastic programs, and do not result in exploitation of youth, they shall be considered as a worthwhile supplement to interschool activities.

BRIEF HISTORY

In the early 1950's, interested school men in western Alaska, led by Mr. William Zahradnicek of Palmer, Mr. W. W. Lahnum, Acting Superintendent of Anchorage, and Mr. Gordon Guffey, Anchorage High School, saw the need for separating high school basketball tournaments from local business promotion as part of the Fur Rendezvous. Thus, the Western Alaska High School Activities Association was organized to assure the needed educational leadership. During these same years, Mr. Sterling Sears of Juneau, Mr. Les Wingard, and Mr. J. E. Danielson of Ketchikan, were moving ahead to fill the same need in Southeastern Alaska.

In 1956 the desire to have a state organization led to the establishment of the Alaska High School Activities Association by the State Department of Education Superintendents' Advisory Commission. The Constitution and By-Laws were approved in the fall of 1957. The officers of the two divisions elected Mr. J. E. Danielson, Superintendent of Ketchikan, as Secretary-Treasurer; Mr. William Zahradnicek of Palmer was elected Chairman; and Mr. George McMillan of Juneau, Mr. Joe Montgomery of Anchorage, and Mr. Sterling Sears of Juneau, were members of this first State Board of Control.

In April of 1973 regions were established for basketball tournament purposes by a vote of the schools involved in those regions. Consideration was given to both school population and/or geographical location. From these basketball regions evolved the regional concept for all activities using the same criteria: size and location.

Early years saw 20-25 schools (4,000 to 8,000 students) as members of the Association. Today, over 70 schools hold membership serving the needs of over 32,000 students.

The state operates under one Constitution and set of By-laws regarding membership, student eligibility, contest organization, sport seasons, and other areas of general concern.

A.S.A.A. EXECUTIVE SECRETARIES

1957-1960	J. E. Danielson, Ketchikan
1960-1965	Joe Montgomery, Anchorage
1965-1971	Les Wells, Anchorage
1971-1975	Rick Arndt, Anchorage
1976-1976	Ed Frandsen, Wasilla
1977-	Les Wells, full time

ALASKA SCHOOL ACTIVITIES ASSOCIATION

CONSTITUTION

ARTICLE I NAME

This organization shall be known as the Alaska School Activities Association.

ARTICLE II OBJECT

The object of this Association is to promote and control interscholastic activities and other interschool contests or programs sanctioned by the Association and to assist in the promotion of those other activities and interests as it may from time to time elect.

ARTICLE III MEMBERSHIP

INTRODUCTION:

Secondary schools of Alaska are defined as schools, public or private, with grades 7 through 12 or any combination of those grades.

SECTION 1. Eligible Schools

A. Any state public school district, or if not a part of a state public school district, any accredited or state approved secondary school may become a member of the Association by paying the applicable annual dues. Being a member constitutes recognition by the member of the Association's authority over the membership and agreement to comply fully with the Association's by-laws and policies.

B. A high school is defined as a school which offers grades 9 through 12 or any combination thereof.

C. A junior high school is defined as a school which offers grades 7 through 9 or any combination thereof.

D. On or before May 1 of each year participating schools of member school districts and other member schools must declare whether they will participate with grades 9, 10, 11, and 12 or 10, 11, and 12 and whether they will participate with grades 7 and 8 or 7, 8, and 9, if at all.

E. The Board of Control will hear any request for an organizational structure other than those mentioned above should a school district organize its secondary school or schools on a different basis.

SECTION 2. Membership Definition

A school district's membership status applies to all school units for which the district has made application and paid the applicable annual dues. Each of these school units is considered a "member school" for the purposes of this Constitution.

ARTICLE IV DUES

The annual dues and dates of payments shall be as set forth in the By-laws.

ARTICLE V OFFICERS AND DUTIES

SECTION 1. Board of Control

The Board of Control consists of the elected representative from each regional association.

SECTION 2. Terms of Board Members

A. The term of office for each member of the Board of Control is two years, except that one-half of the members elected to the first elected Board are elected for one-year terms based upon a drawing of lots.

B. Subject to the approval of the Commissioner of Education, the Board of Control shall appoint an executive secretary, prescribe duties and fix the compensation. This person shall serve at the pleasure of the Board. The Board may appoint other officers, agents and employees and prescribe their duties and compensation.

SECTION 3. Department of Education Consultant

The Commissioner of Education, or his designee, shall serve as a consultant to the Board of Control for the purpose of coordinating the activities of the Association within the Department of Education.

SECTION 4. Powers and Duties of the Board

A. The Board of Control is the executive and administrative body of the organization, subject to the restraint of the Constitution and By-laws of the Association.

B. The Board of Control may determine the time and place of its meetings. A majority shall constitute a quorum.

C. The Board of Control has supervision of all sanctioned interscholastic activities of participating schools of member school districts and member schools and interprets the rules of the Association.

D. With respect to funds, not subject to state fiscal procedures, the Board of Control has the charge of Association funds, shall audit and approve all expenditures, and shall conform to the financial policies and audit as set forth by the membership of the Association and the regulations of the State Department of Education.

E. The Board of Control may delegate to the Executive Secretary the authority to rule on all protests and rule violations and determine the penalties, not otherwise specified, for violations of the provisions of the Constitution and By-laws.

F. The Board of Control may make investigations relative to the violation of the Constitution and By-laws and policies of the Association.

G. The Board of Control may appoint special committees to assist in the arrangement and supervision of various activities and contests.

H. The Board of Control may sanction out-of-state meets, contests or activities.

I. The Board of Control may determine suitable awards for winners of contests sponsored by the Association.

J. The Board of Control may approve and register contest officials for use in those activities sanctioned by the Association.

K. The Board of Control may sanction and operate state championship plans, sites and finances.

L. Regional placement: The regional placement of schools is determined and reviewed annually by the Board of Control at its summer meeting. Changes in regional placement take effect on July 1st of the following summer. The change may take effect earlier if all schools involved and affected as well as the state Board of Control concur. New member school placement becomes effective immediately.

M. The Board of Control shall report annually to the Commissioner of Education, the State Board of Education, and the Alaska Association of School Administrators for the purpose of receiving advice and comments. The report will show programs carried out and a financial statement.

N. The Board of Control shall submit an annual financial audit and budget to the Commissioner of Education.

O. The Board of Control may grant eligibility to a student in certain hardship and emergency cases when granting eligibility does not violate the intent and the purpose of any of the standards of eligibility. The purpose of this provision is to provide for certain cases that are beyond the control of the students or their parents. (Refer to Article XIII in By-laws for procedures.)

ARTICLE VI REGIONAL ASSOCIATIONS

SECTION 1. Powers

The Alaska School Activities Association encourages and supports the creation of regional associations. Each regional association administers its own activities in accordance with the provisions of this Constitution and the Association's By-laws and policies. Regions may adopt their own By-laws not in conflict with those of the Association.

SECTION 2. By-Laws

A current copy of the By-laws of each regional association must be on file with the Executive Secretary of the Association.

ARTICLE VII LOCAL CONTROL

The chief administrative officer of a member, or his designee, shall be the member school's official representative and shall be responsible for each member school's actions.

ARTICLE VIII AMENDMENTS

SECTION 1. Amendments

A. Proposed amendments to this Constitution must be introduced at a regular meeting of the Board of Control. Amendments which are proposed by the Board of Control must be endorsed by the authorized representative of ten different member schools.

B. Adoption of a proposed amendment requires a majority vote of all member schools by mail ballot and approval by the State Board of Education. The Board of Control may make recommendations on proposed amendments.

SECTION 2. Effective Date

Amendments take effect July 1 following their adoption unless otherwise provided by the amendment.

ARTICLE IX EFFECTIVE DATE OF CONSTITUTIONAL AMENDMENTS

This revised Constitution takes effect immediately upon the majority vote of the membership and approval of the State Board of Education.

ALASKA SCHOOL ACTIVITIES ASSOCIATION

BY-LAWS

ARTICLE I BOARD OF CONTROL ORGANIZATION AND OPERATION

SECTION 1. Organization and Terms of Members

A. The administration of the Association is vested in the Board of Control composed of a representative elected by the member schools of each regional association and selected in such a manner as to assure that a representative is elected from each judicial district. Each elected member of the Board of Control has one vote.

B. The term of office expires on December 31st.

SECTION 2. Dates of Election and Replacements

Board of Control members shall be elected by December 1 of the year in which the term for the regional representative expires. A person may not serve more than three consecutive terms. The Board of Control will certify new board members in order to assure representation of all judicial districts.

If an encumbent ceases to be a voting member of the Board of Control because of death, resignation, incapacity, change of assignments from administration in a school district, or because of moving out of the region in which elected, the member schools of the regional association shall elect a replacement to serve on the Board of Control for the remainder of the term.

SECTION 3. Alternate Regional Representative

A regional association may elect an alternate member to sit on the Board of Control in place of the regular member for only the following instances: weather and transportation problems, medical illness, or other excusable and acceptable reasons as approved by the majority of the other members of the Board of Control.

SECTION 4. Meetings

The Board of Control shall meet not less than four times annually. They may otherwise convene upon the call of the president or upon the request of a majority of the Board of Control, the call to be issued by the executive secretary. The membership will be informed of the meetings in a timely manner.

SECTION 5. Officers of the Association

The officers of the Association are a president, vice president, and a secretary-treasurer. The president and vice president shall be elected from among the members of the Board of Control, each to be elected annually for a term of one year. No one individual may serve as president for a period longer than a total of five years. If the offices of either the president or the vice president become vacant because of death, resignation, or other emergency, it shall be filled for the remainder of the term by election by the Board of Control at its next meeting.

SECTION 6. Secretary-Treasurer

The secretary-treasurer is the executive secretary and serves at the pleasure of the Board of Control. The duties and functions of the secretary-treasurer are the responsibilities of the executive secretary.

SECTION 7. Association Funds

To the extent applicable, the secretary-treasurer shall comply with state fiscal procedures. With respect to funds not subject to state fiscal procedures, the secretary-treasurer shall, under the supervision of the Board of Control, have charge of funds of the Association. He shall make complete financial statements to the Association members at the time of the fall meeting. The accounts shall be audited at least annually and the cost of the audit will be paid by the Association. The financial year for the Association shall be July 1 to June 30. An annual report and an audit will be furnished the State Department of Education by October first of each year.

ARTICLE II MEMBERSHIP DUES

SECTION 1. Member Schools

Each participating school for which a member school district has paid dues is a "member school" as that term is used in these By-laws.

SECTION 2. Scale of Dues

Annual Association membership dues for school districts and non-school district schools shall be determined as the sum of the dues for each participating member school, based on the actual enrollment as shown on the third quarter attendance report for the prior school year for each school, as shown in the following table:

Enrollment	High School Dues for Next School Year		Jr. High School Dues for Next School Year
1-100	$100.00	$150.00	$ 50.00
101-500	$200.00	$300.00	$100.00
501-1000	$400.00	$550.00	$200.00
1001-	$600.00	$800.00	$300.00

(as approved June 1978)

SECTION 3. Date of Payment

Dues must be submitted to the ASAA executive secretary, payable to the Department of Education, by September 1 for that school year and are delinquent October 1. Delinquent members will be charged a 10% per month penalty on the balance owing but unpaid.

SECTION 4. New Member Schools

New members will not be assessed the penalty for the first year of membership.

ARTICLE III VIOLATIONS OF BY-LAWS AND CONTEST RULES

SECTION 1. Conduct of Activities

All school sponsored interscholastic sports, events, and activities of member schools must be conducted in accordance with the Association's By-laws, rules and policies.

SECTION 2. Conforming to Rules

A. By-laws, including eligibility rules, contest rules, and Board of Control policies may not be waived by consent between or among member schools.

B. As used in these By-laws, "rule" includes these By-laws.

SECTION 3. Violations and Disputes

A. All rule violations must be reported to the Executive Secretary in writing. Assessment and a decision will be rendered in a timely manner.

B. All questions in dispute must be submitted to the Executive Secretary. The Executive Secretary's decision is final unless it is appealed to the Board of Control. All questions in dispute and their disposition will be reported to all member schools.

SECTION 4. Protests Against Member Schools

A. A member school entering a protest against another school shall submit to the Executive Secretary, in writing, a full statement of the facts relating to the alleged violations committed by the offending school (use the form as exhibited in Appendix A). The Executive Secretary will submit copies of the complaint to the superintendent or principal of the accused school. The accused school may present its case in writing to the Executive Secretary within 14 days after receipt of the complaint. After reviewing the submitted materials, the Executive Secretary will render a decision.

B. All protests must be accompanied by a filing fee of $100. If the final decision is in favor of the presenting school, the fee will be refunded. If the protest is denied, the fee shall be forfeited. No decision on a protest will be made unless the filing fee has been paid.

ARTICLE IV APPEAL PROCEDURE

SECTION 1. Appeal by Member Schools and Individuals

A. A member school may appeal decisions of the Executive Secretary by requesting of the Board President, within 14 days of receipt of the decision, and in writing, that the case be presented to the Board of Control for review.

B. An individual who is adversely affected by a decision of the Executive Secretary may appeal that decision by requesting, within 14 days of receipt of the decision, that his or her member school's officially designated administrator request of the Board President, in writing, that the case be presented to the Board of Control for review.

C. All appeals, including all relevant factual matter and legal arguments, must be presented to the Board of Control in writing. Oral hearings are not a matter of right, but will be granted for good cause shown.

D. All appeals will be considered and a decision rendered in a timely manner.

E. In appeals involving rule violations, the Board of Control may assess the costs of the appeal against the member who is found at fault.

SECTION 2. Appeals Review Commission

A. An Appeals Review Commission will review decisions or interpretations of the Board of Control when requested by an affected individual, a member school, or a member school district by formal written appeal within 14 days of receipt of the decision.

B. The Appeals Review Commission is the State Board of Education or a committee of the State Board of Education.

C. All appeals, including all relevant factual matter and legal arguments, must be presented to the Appeals Review Commission in writing. Oral hearings are not a matter of right, but will be granted for good cause shown.

D. All appeals will be considered and a decision rendered in a timely manner.

ARTICLE V PENALTIES

Penalties assessed by the Executive Secretary or by the Board of Control upon member schools for violation of the By-laws will vary depending upon the nature and character of the violation. Penalties assessed may include one or more of the following:

1. Warning
2. Forfeiture
3. Probation
4. Fine - not to exceed five hundred dollars
5. Suspension from the Association - not to exceed 365 calendar days

ARTICLE VI CONTEST RULES

SECTION 1. Contracts for Contests and Events

Final agreements relating to contests or events between or among member schools must be incorporated into contracts on forms provided by the Association. These contracts must be executed by mutual consent of the representatives of the respective schools and exchanged not less than 10 days prior to the contests. The contract may not be cancelled or altered except by mutual consent of the schools involved.

Breach of contract will be considered a rule violation.

SECTION 2. Non-Member School and Out-of-State Rule

A. As a condition of membership, members expressly agree that they and their member schools will not take part in any interscholastic activities or contests with schools eligible for membership but who are not member schools of the Association. A waiver may be requested to participate with a non-member school.

**See margin for addition.

B. A member school may not participate in any contest or event with an out-of-state school unless a sanction has been granted by the Board of Control.

C. Participation without a waiver under A or a sanction under B of this section will result in disciplinary action for the member school and may include suspension from Association membership and participation for a period of up to 365 days.

SECTION 3. Ineligible Students

A member school may not permit students who are ineligible under these By-laws to participate in or otherwise appear on the field or floor in uniform during any contest between itself and other member schools.

SECTION 4. Contest and Event Supervision

Each contesting school must have present at the contest or event a certificated faculty representative who is responsible for the conduct of its participants and students throughout the contest. The home school must have an administrator or his designee in attendance.

SECTION 5. Personal Conduct

A. High standards of courtesy, fair-dealing and sportsmanship must feature all Association contests or events.

B. In matters pertaining to personal conduct, such as gross violations of sportsmanship, attacks on officials and other acts of gross misconduct by any student, school staff member or school community members where the school has failed to act reasonably in controlling the community member, the Association will determine, after providing an opportunity to submit written statements or an oral hearing, or both, appropriate penalcies and whether or not the student or school will be suspended or barred from future contests or events.

SECTION 6. Records

Each school shall keep accurate records of contests and events for a period of four years. These records, or copies, must be forwarded to the Executive Secretary upon request.

SECTION 7. Sunday Contest or Event Rule

Interscholastic events or contests may not be held on Sunday. If inclement weather forces the cancellation of one contest of a scheduled series, and the series cannot be rescheduled at a later date, the host school may request of the State Executive Secretary and its Region's Executive Officer that they sanction a Sunday contest.

**Approved June 1978 - Add to Section 2-A.

A member school may participate in interscholastic activities with a non-member school of less than 25 students on an intermural basis as long as the schools are in the same school district and as long as they are in compliance with all other Association athletic eligibility regulations.

ARTICLE VII SANCTIONED ACTIVITIES

SECTION 1. Compliance with Title IX

The Association will comply with the provisions of Title IX of the Education Amendments of 1972. No person shall, on the basis of sex, be excluded from participation in, be denied the benefits of, be treated differently from another person or otherwise be discriminated against in any activities regulated by the A.S.A.A.

Separate teams for members of each sex may be allowed where selection for such teams is based upon competitive skill or the activity involved is a contact sport. Contact sports include boxing, wrestling, rugby, ice hockey, football, basketball and other sports the purpose or major activity of which involves bodily contact.

The Association will insure that, when separate teams are allowed, equal opportunities in athletics are provided members of each sex, in keeping with Title IX regulations.

SECTION 2. Sports Recognized by the Association

Badminton	Diving and Swimming
Football	Basketball
Soccer	Wrestling
Cross Country Running	Ice Hockey
Bowling	Cross Country Skiing
Volleyball	Track and Field
Gymnastics	Tennis

SECTION 3. Activities with No Season Restriction

Activities with no season restriction include but not limited to:

Bowling	Honor Band, Choir, Orchestra
Cheerleaders	Music Festivals
Drill Teams	Forensics - Speech - Debate - Drama
Rifle Teams	Office Education Association - OEA
Chess	Future Homemakers of America - FHA
Eskimo Games	Future Farmers of America - FFA
Student Governments Conferences	Vocational & Industrial Clubs of Am. - VICA
Journalism Workshops	Distributive Education Clubs of Am. - DECA

SECTION 4. Activities Confined to a Season: Sports and Sport Season Dates, Pre-season Practice, Number of Contests, Number of Game Periods per Day*

*Next page

Number of Game Periods per Day

A. All sports competition will be governed by National Federation of Interscholastic Athletics rules and guidelines where available, or by rules adopted by the Board of Control.

B. The following table sets out the seasons, the permissible pre-season practice periods, the permissible number of game periods per day exclusive of regional and state tournaments, and the permissible maximum games prior to regional tournaments for various interscholastic sport contests:

ADD NOTE: See page 11-a for Four-Season Plan for sport seasons (Regions I and II).

Sport	*Practice Prior to Participation	Date of First Game	No. of Game Periods/Day	Maximum Games Prior Reg. Tourn.	Season End Date
Football	Begin August 15 10 Separate Days	Last Weekend in August	Four	One Per Week	Third Weekend in October
Cross Country Running	Begin August 15 10 Separate Days				W/completion of Reg. or State meet
ADD Volleyball	Begin August 15 10 Separate Days (Except Reg. I & II)				W/completion of Reg. or State meet
Gymnastics	Begin August 15 10 Separate Days				W/completion of Reg. or State meet
Diving and Swimming	Begin August 15 10 Separate Days				W/completion of Reg. or State meet
ADD Girls' Basketball	Begin October 15[1] 10 Separate Days (Except Reg. I & II)	November 15[1]	6**	25[1] (30-77/78)	W/completion of Reg. or State meet
ADD Boys' Basketball	Begin October 21 10 Separate Days (Except Reg. I & II)	November 15	6**	25[1] (30-77/78)	W/completion of Reg. or State meet
ADD Wrestling	Begin January 2 10 Separate Days (Except Reg. I & II)			25[2] Matches (excl. forfeits) 20 day limit	W/completion of Reg. or State meet
Ice Hockey	Begin November 1 10 Separate Days	Last Weekend in November	3**	20	W/completion of Reg. or State meet
ADD Cross Country Skiing	Begin November 1 10 Separate Days (Except Reg. I & II)				W/completion of Reg. or State meet
ADD Track and Field	Begin March 15 10 Separate Days (Except Reg. I & II)				W/completion of Reg. or State meet
Tennis	Begin March 15 10 Separate Days				W/completion of Reg. or State meet

*excluding Sundays

**Overtimes not counted

[1]Effective 78-79 School Year

[2]Effective 77-78 School Year

INSERT - CONSTITUTITION & BYLAWS (See both sides of 11 and 11a)

Proposed March 1978
Effective August 1978

ALASKA SCHOOL ACTIVITIES ASSOCIATION

CONSTITUTION & BYLAWS

Article VII. Sanctioned Activities. Section 4 - add C & D (pp 11-a).

C. Four-Season Plan - Regions I and II

1. Any student transferring from one school to another who has completed a given sport season*in the current school year shall not be eligible for the same sport in the same school year at the receiving school within the state association.
(* Regional Tournament)
2. Region I and II teams and/or individual participants may compete and/or participate in state level meets, events or tournaments when Regions I and II do not jointly sponsor a similar activity, except in basketball, as a small-schools tournament plan has been previously approved by the Board of Control on June 4, 1977.

D. Four-Season Plan for Regions I and II

Fall Season:
X-Country-boys and girls:
Begins-Two weeks prior to opening of school(no earlier than Aug. 15).
Ends-2nd weekend in October or no later than the end of state x-country meet.

Early Winter:
Basketball-boys and girls:
Begins-October 1; first game, 3rd week-end (Friday of October)
Ends-First weekend of February or with the end of the state small-schools basketball tournaments.

Late Winter:
Girls Volleyball; Wrestling-boys; X-Country Skiing-boys & girls:
Begins-January 15 or third Monday in January, whichever is earlier. First meet-after ten separate days of practice.
Ends-First weekend in April or with the end of the state wrestling tournament and/or volleyball tournament, whichever is latest.

Spring:
Track:
Begins-4th Monday in March. First meet-after ten separate week days of practice.
Ends-With close of school or with completion of small-schools state tournament or meet.

Minor adjustments of dates for activity may be made as needed by the Board of Control.

ARTICLE VIII AMATEURISM

SECTION 1. Only Amateurs Are Eligible to Participate

A. Pupils representing member schools of the Association must be amateurs.

B. A pupil is a professional, not an amateur, and is ineligible if he or she receives or is promised money or other valuable consideration for competing in a sport recognized by the Association. This rule applies throughout the twelve months of the year. A professional in one of these sports is considered a professional in all. A pupil may play with or against those who are professional without losing amateur standing.

C. Acceptance of money or other valuable consideration as wages or expenses or of merchandise prizes for athletic competition renders a pupil ineligible for further athletic competition. No money is to be given to a contestant. However, it is permissible for a contestant to accept necessary meals, lodging and transportation while competing. Medals or trophies may be accepted. College scholarships may be accepted but the amount of the scholarship must be paid directly to the college of choice by the donors.

D. A pupil is ineligible if he or she competes under an assumed name for the purpose of concealing his or her status as a professional.

E. A high school student who has violated his or her amateur standing as set forth by these By-laws may apply to the Board of Control for reinstatement as an amateur, if 365 days have elapsed since the date he or she was declared ineligible, and if he or she has been in regular school attendance and not competed as a professional during the intervening period.

An application under this paragraph must be in writing and must be signed by the student and by the superintendent or principal, certifying that one calendar year has elapsed since the student was declared ineligible, that he or she has been in regular school attendance, and that he or she has not violated amateur rules during the intervening period.

SECTION 2. Signing of Contracts

The signing of any contract by a pupil whereby he or she agrees to compete in any athletic competition for profit immediately makes that pupil ineligible for further interscholastic athletic competition.

SECTION 3. Professional and College Try-Outs

Professional and college try-outs which interfere with a high school student's work or which involve a game in violation of Association rules may result immediately in that student's ineligibility for further interscholastic athletic competition.

ARTICLE IX AWARDS

The Board of Control designates, gives, and controls ribbons, medals, and trophies to be awarded to schools and individuals.

SECTION 1. Principal Approval

Awards must have symbolic value only. Awards may be accepted by a student only if granted through the school with prior approval of the school principal or school district superintendent.

SECTION 2. Value Limit

Awards, such as unattached letters, trophies, metal charms or pins, or similar articles, having symbolic value only, may be given to students by the school if the cost of the award does not exceed $10. In the case of state championships, the cost may be increased to an amount which does not exceed $15. This section does not apply to trophies awarded to teams by the state or regional associations.

SECTION 3. Invitational Tournaments

Leagues or schools conducting invitational tournaments or meets under Association rules may make awards to the winning schools or contestants if the awards are within the limits set forth in Sections 1 and 2 of this Article and in Article XV.

SECTION 4. Other Awards

Suitable awards, of symbolic value only, may be accepted by team members from service clubs, patriotic organizations, civic groups, Dads' and Mothers' Clubs, and similar organizations, provided they are given in compliance with the provisions of Sections 1 and 2 of this Article. However, jackets or sweaters may be accepted by state championship team members even if the cost exceeds $15. Gifts may not in any way advertise any firm or individual insofar as commercial or business interests are concerned.

SECTION 5. College Recruiting

Awards of transportation and entertainment by colleges and universities for recruiting purposes may be accepted by students, when carried on within the limitations of N.C.A.A., N.A.I.A., and college conference rules, if there is prior approval of the high school principal.

ARTICLE X QUALIFICATION OF COACHES

Coaches must be certificated teachers and must be regularly employed as teachers in the school district in which they coach. The Executive Secretary may waive temporarily these certification requirements upon satisfactory proof that a properly certificated coach could not be secured. A certificated staff member of the school district must accompany and be in charge of a traveling team.

ARTICLE XI PHYSICAL EXAMINATION, PARENTS' CONSENT

SECTION 1. General

A pupil may not be permitted to participate in a practice session or to represent his or her school in athletics, cheerleading, or other strenuous activities until there is on file with the superintendent or school principal a statement, signed by a practicing physician, nurse practitioner, physician's assistant, or a military medical examiner, and the pupil's parents or legal guardian, certifying that he or she has submitted to a physical examination within the prior

examiner, the student is physically fit to participate in strenuous physical activities. A waiver of this requirement may be temporarily made by the Executive Secretary in villages where no examiner is available.

Physical exam forms are available from the Association Executive Secretary.

SECTION 2. Wrestling Physicals

With respect to pupils participating in wrestling, the National Federation Rule Book for high schools governs all situations.

Prior to the pupil's first match, the examiner, as defined in Section 1 of this Article, must determine the lowest weight class the individual may wrestle during the season. This determination must be in writing, signed by the examiner and by the student's parents, before the student may be allowed to wrestle in a match. ~~Changes in weight class determination will be allowed during the season if the above procedure is followed.~~ Each school is responsible for the administration of the weight permit slips and the weight permit slips must be made an integral part of the eligibility roster.

DELETE Rule change approved June 1977. Effective Date July 1,1977

Individuals must have their weight permission slip on file with their school before their name may be placed on the eligibility list. There must be a place for the examiner's signature and the parent's signature on the weight permission slip.

ARTICLE XII RULES OF ELIGIBILITY

Unless expressly limited, the following rules are intended to be minimum requirements for student eligibility to participate in all interscholastic activities and do not preclude a school, a school district, or a regional association from imposing additional rules that are reasonable and prudent.

SECTION 1. Enrollment Rules

To be eligible during a school semester for participation in interscholastic activities, a student must:

A. be properly registered;

B. be carrying a minimum of four classes that lead to granting of credit toward graduation; and

C. be in regular attendance at school and classes in which enrolled.

SECTION 2. Eight Semester Rule

A student may only participate in interscholastic activities during the first eight semesters of school after enrollment in the ninth grade.

SECTION 3. School Grade Rule

Students in grade eight and below are ineligible for participation as members of high school athletic teams in interscholastic competition including cheerleading.

SECTION 4. Similar Sports Participation Rule

A student may not participate as a member of other than a high school athletic team in similar contests during the same school season.

SECTION 5. Undue Influence Rule

A student is not eligible to participate in interscholastic activities if he or she has been unduly influenced or offered any remuneration, directly or indirectly for the purpose of causing the student or the student's family to reside in a given school district or school attendance area in order to establish his or her eligibility for activities participation.

SECTION 6. Age Rule

A student is not eligible to participate in interscholastic activities when he or she is no longer of school age as defined in AS 14.03.070. However if the student started a sport season while still of school age, the student will be allowed to complete that sport season.

SECTION 7. Semester Credit Rule

In order to be eligible to participate in interscholastic athletics and cheerleading during any semester after completion of the first semester of ninth grade, a student must have passed, for the immediately preceding semester, at least four courses which grant a semester of credit toward graduation. A student who has been ineligible for a complete semester under this section may become eligible after having attended the first day of the succeeding semester.

A. For purposes of this section, academic deficiencies may be made up through correspondence courses or summer school.

B. A grade of incomplete is considered as not passing until the incomplete is changed on the official school records.

SECTION 8. School Transfer Rule

A. A student who transfers school enrollment corresponding with an actual change in the place or residence (home, abode) of his or her parents or legal guardian is immediately eligible to participate in the interscholastic activities of the school to which he or she has transferred, providing he or she satisfies all other applicable rules of eligibility.

B. A student who transfers school enrollment without a corresponding change in the place of residence (home, abode) of parents or legal guardian is not eligible for participation in the interscholastic athletic activities of the school to which he or she has transferred for a period of 18 weeks following the transfer of enrollment.

C. The 18 week ineligibility rule stated in B of this section does not apply when:

1. the transfer in school enrollment is ordered by the governing body or the chief school administrator of the school district which is responsible for the student's education, whether the transfer is to another school of the same district or not, so long as the transfer was not made for interscholastic activities reasons;

2. the transfer was made to permit the student to take courses or study at a grade level not offered at the school from which he or she transferred; or

3. the transfer was made as the result of an order of a court or of a state or local agency empowered to take custody of children.

D. A school district may establish its own policy regarding intra-district transfer, so long as it is at least as stringent as this transfer rule. The district's policy must be submitted to the Executive Secretary for his approval. Upon approval, the district policy will prevail.

SECTION 9. Eligibility Lists for Sports and Cheerleading

A. A master eligibility list listing all participants in each sport and cheerleading must be prepared on the form provided by the Association for that purpose.

B. A copy of the master eligibility list must be received by the state Executive Secretary and the appropriate regional executive officer before the sixteenth school day of the new semester. The list for sport seasons starting during a semester must be mailed ten days before the first contest of that season.

C. Any additions or deletions to the master eligibility list must be filed as an addendum to the master eligibility list before an individual is allowed to participate.

ARTICLE XIII WAIVERS OF ELIGIBILITY RULES

SECTION 1. Student Request

A student who has been determined to be ineligible to participate in interscholastic activities under one or more of the eligibility rules of Article XII may request a waiver of that rule or rules by the Executive Secretary.

SECTION 2. Request Procedures

A request for a waiver must be directed by the student to the involved member school's officially designated administrator who shall then file a written request stating the full particulars of the case and the reasons felt by the student or the administrator, or both, to warrant the granting of the requested waiver.

SECTION 3. Review by Executive Secretary

Upon receipt of the waiver request, the Executive Secretary shall review it to determine whether any additional information is necessary. If additional information is necessary, the Executive Secretary shall request the administrator to supply it. The Executive Secretary shall render his decision as expeditiously as possible after receiving the waiver request and any additional requested information.

SECTION 4. Guidelines for Consideration

To assist students and member schools to decide whether to request a waiver in specific circumstances, the following apply:

1. If the student is a transfer student, a transfer of eligibility form must be supplied the A.S.A.A. office.

2. Except in unusual circumstances and for good cause shown, the Executive Secretary will not hear a request involving waiving of the standards of eligibility regarding semesters of participation, age standards, semesters of enrollment, or a school administrator's ruling regarding the school citizenship (conduct) of a student.

3. The Executive Secretary will not grant eligibility in any case in which the asserted hardship is the sole result of knowing conduct by the student or his or her parents or guardian which had the effect of causing the hardship.

4. Ignorance of any standard is not sufficient reason for waiving a standard.

ARTICLE XIV A.S.A.A. REGIONS

SECTION 1. Member Schools by Regional Placement

The following shows the placement of schools in the regional associations, effective July 1, 1977:

I	II	III
Aniak	Anchorage Christian School	Barrow
Bethel	Anderson Village	Bob Reeve (Adak)
Bristol Bay	Christian School of Alaska	Cordova
Covenant	Fort Yukon	Delta Junction
Dillingham	Galena	Homer
Kiana	Glennallen	Kodiak
King Cove	Kenny Lake	Palmer
Kivalina	McGrath	Seward
Kongiganak	Nenana	Valdez
Kotzebue	Ninilchik	Wasilla
Nelson Island	Nulato	
Noatak	Susan B. English (Seldovia)	
Nome	Susitna Valley	
Noorvik	Tanana	
Nunapitchuk	Tok	
Selawik	Tri-Valley	
Shishmaref	Tyonek (Bartlett)	
Togiak		
Unalaska		

IV	V	VI
Bartlett	Angoon	Eielson
Chugiak	Haines	Lathrop
Dimond	Hoonah	Monroe
East Anchorage	Hydaburg	North Pole
Kenai	Juneau-Douglas	West Valley
Service	Kake	
West Anchorage	Ketchikan	
	Metlakatla	
	Mt. Edgecumbe	
	Petersburg	
	Prince of Wales (Craig)	
	Sitka	
	Skagway	
	Thorne Bay	
	Wrangell	
	Yakutat (Mt. St. Elias)	

SECTION 2. Changes in Regional Placement

A. Changes in regional placement take effect on July 1 of the following summer, unless all affected schools and the Board of Control agree to an earlier effective date.

B. Changes in regional placement may be initiated by the Board of Control or by request of any member school.

C. Initial regional placement for new member schools will be made by the Board of Control. The Board will give full consideration to a recommendation or request from the new member school. Placement of new member schools becomes effective immediately.

ARTICLE XV TOURNAMENTS

SECTION 1. Handbooks

The Board of Control will cause athletic and activity handbooks of policies and procedures to be developed for their approval. These handbooks will be implemented for the operation of state interscholastic activities.

SECTION 2. Trophy Size

The following sizes are adopted by the Board of Control to give order and meaning for trophies:

State	20-25 inches
Regional	15-20 inches
Invitational	12-18 inches
Individual	10-15 inches

NOTE: Size number 3 figures must be used for individual trophies.

ARTICLE XVI BY-LAW AMENDMENT

SECTION 1. Method

These By-laws may be amended by a simple majority vote of the Board of Control sitting in regular session provided that at least 30 days advance notice has been mailed to the general membership. Additionally, amendments must be approved and adopted by the State Board of Educatio.. under AS 14.07.053 (c) and the Administrative Procedures Act (AS 44.62).

SECTION 2. Effective Date

Unless otherwise specified, amendments to these By-laws take effect 30 days after their filing with the lieutenant governor.

ALASKA SCHOOL ACTIVITIES ASSOCIATION

650 INTERNATIONAL AIRPORT ROAD ANCHORAGE, ALASKA 99502

LESLIE D. WELLS, ED.D. 907-272-9045
EXECUTIVE SECRETARY

February 27, 1979

Dear Thelma:

While in Juneau last Friday, I heard that you had been called to the Philippians. May we express our sympathy to you and your family.

I understand that you will be out of the office until next week (March 5th). I will plan to contact you at your office by telephone to see when I might meet with you concerning the attached bill, Senate Bill 163.

Again, we are sorry to hear of the loss of your Mother and send our sincerest regards.

Sincerely,

Les Wells

ALASKA SCHOOL ACTIVITIES ASSOCIATION

650 INTERNATIONAL AIRPORT ROAD ANCHORAGE, ALASKA 99502

LESLIE D. WELLS, ED.D.
EXECUTIVE SECRETARY

907-272-9045

February 27, 1979

Hon. Thelma Buchholdt, Chairman
HESS Committee
House of Representatives
Pouch V
Juneau, Alaska 99811

Dear Mrs. Buchholdt:

The Board of Control and members of the Alaska School Activities Association request your support for the attached legislation, Senate Bill 163. Basically, it is a clean up bill and contains no request for funds. It will serve to improve the Association's operation and remove some limiting aspects. The full rationale is attached with the proposed bill, the current statute and other background information.

The proposal was drafted by Mr. Ron Lorensen of the Attorney General's office and has the support of the Commissioner of Education. Resolutions of support have been passed by the membership of the State School Boards Association, the Superintendent's Association and the Secondary School Principals Association and are enclosed.

The Association earnestly requests your leadership and assistance in this effort and assures you that it is in the best interest of girl's and boy's school activities and the total educational community. This office stands ready to give full attention to this effort and supply you with any information that may be requested.

I will contact you next week (March 5th) concerning this legislation. I am available to meet with you and/or your committee with 24 hours advance notice.

Sincerely,

Les Wells

Leslie D. Wells
Executive Secretary

LDW:jle
Attachments:
cc: HESS Committee:
Joyce Munson, Vice Chairman
Ramona L. Barnes
M. F. "Mike" Beirne
C. V. "Chat" Chatterton
Vernon L. Hurlbert
Bill Miles

Board of Control:

Region I	Dale Lunsford, Naknek
Region II	Wayne Taylor, Nenana
Region III	Ed Frandsen, Wasilla
Region IV	Ed Nash, Eagle River
Region V	Ed James, Juneau-Douglas
Region VI	Bill Brannian, Fairbanks
State Dept.	Vern Williams, Juneau
Student Mem.	Sheryl Hall, AASG

ALASKA SCHOOL ACTIVITIES ASSOCIATION
650 INTERNATIONAL AIRPORT ROAD ANCHORAGE, ALASKA 99502
LESLIE D. WELLS, ED.D.
EXECUTIVE SECRETARY
907-272-9045

February 1979

RATIONALE FOR ALASKA SCHOOL ACTIVITIES ASSOCIATION

LEGISLATIVE AMENDMENT

The membership and the Board of Control of the Alaska School Activities Association believe that school interscholastic activities programs, including athletics, music, and speech and drama, can best be accomplished by member schools through self organization and control, with a minimum of state supervision and involvement. It is recognized that the Association requires a legal basis and assistance in funding its efforts because of the relatively small number of schools and high costs associated with the coordination and operation of activities in such a large state.

The Association has done an outstanding job of sponsoring activities for Alaskan youth over the past twenty-two years and now believes that the current legislation passed in 1976 should be amended in order that the Association may better function to serve the needs of its membership. Current problems are:

1. There is duplication of effort and unnecessary administrative structure. It is agreed by the Commissioner of Education and the Association that it is unnecessary to operate the Association within the Department of Education. The authority for school participation and the operation of the Association also comes from member schools, their school boards, superintendents and principals.

2. The current statute is restrictive and does not allow each regional association to freely elect their Board of Control member.

3. The operation of the budget and the accounting system should be accomplished at the Association level to facilitate the needs of the organization, i.e., collection of officials' fees, purchase and sale of rule books, funding of officials' workshops, and the operation of state meets, tournaments and events.

The control of the Association lies with school districts and Boards of Education in the approval of organizational structure. The Association is operated by the superintendents of schools, either directly or through their appointed representatives. The revised legislation would foster this local control and would give the Association greater ability to react to the needs of its members.

Adequate funding from the state is essential in order to support the basic operation of the Association office. While other states have adequate income from state tournament receipts to support their total operation and to pay for participants' travel expenses, the small number of Alaskan schools and

(Over)

long distances between communities severely limits tournament gate receipts for such needs.

The Association has applied for funding of $65,000 for Fiscal Year 1980 through the Department of Education. At this time the amount included in their budget as submitted to the legislature is $57,700 for the Alaska School Activities Association. Current year funding is $57,200. This provides funding only for the Association office operation and salaries and represents about 50% of the total financial plan. The other 50% is raised by membership dues and income from officials' fees, rule books and tournaments' income.

Further information concerning the Association is given in the attached "11 Questions About Your Alaska School Activities Association."

LDW:jle

"11 Questions About Your Alaska School Activities Association"

Other Information That May Be Requested:

ASAA Constitution and Bylaws
ASAA Member School Director
ASAA 1978/79 Annual Report & Audit

LAWS OF ALASKA

1976

Source

SCS SSHB 399(Finance)

Chapter No.

128

AN ACT

Creating the School Activities Association within the Department of Education; and providing for an effective date.

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

* Section 1. AS 14.07 is amended by adding new sections to read:

Sec. 14.07.053. ALASKA SCHOOL ACTIVITIES ASSOCIATION. (a) There is created within the Department of Education the Alaska School Activities Association.

(b) The purposes of the association are to provide for the efficient governing of interscholastic activities through the promotion of those activities and other inter-school contests or programs sanctioned by the association and to assist in the promotion of those other activities and interests as it may from time to time elect.

(c) A public or private school or school district in the state may become a member of the association if it applies for membership. The Department of Education shall make applications available to all public or private schools or school districts in the state.

(d) The governing body of the association shall be the board of control with at least one member from each judicial district on the board of control. A member of the board shall be elected from each regional activities association by the members of that region. The term of office for each member is two years, except that one-half of the members elected to the first elected board shall be elected for one-year terms under regulations prescribed by the commissioner of education.

(e) The board in consultation with the Department of Education shall appoint an executive secretary, prescribe his duties and fix his compensation. He shall serve at the pleasure of the board.

(f) The board of control of the existing Alaska High School Activities Association in office on the effective date of this Act shall serve as the initial board of control for no longer than six months.

(g) The Department of Education shall approve the association's constitution and bylaws to ensure that all regions of the state are treated on an equitable basis and in the best interests of the state.

Sec. 14.07.054. ALASKA SCHOOL ACTIVITIES FUND. (a) The Alaska school activities fund is established within the Department of Education.

(b) The commissioner of education shall review the budget request of the Alaska School Activities Association and request a sum he approves that is equitable to all regions of the state.

(c) School districts and member schools of the Alaska School Activities Association may appropriate money to the fund.

* Sec. 2. This Act takes effect July 1, 1976.

AS 14.07.053
AS 14.07.054

Permitted to become law without signature
July 1, 1976

RESOLUTIONS FAVORING SENATE BILL 163

Alaska School Boards Association
Resolution Passed November 12, 1978 #24

ALASKA SCHOOL ACTIVITIES ASSOCIATION

LEGISLATION

WHEREAS, schools in Alaska have ever-increasing activities for students; and

WHEREAS, there is a statewide Alaska School Activities Association; and

WHEREAS, the Alaska School Activities Association is controlled by appointed representatives of the member schools, their administration and their school boards; and

WHEREAS, the Alaska School Activities Association is now tied to the Alaska Department of Education by law; and

WHEREAS, this position leaves the functions of Alaska School Activities Association hindered by further administrative and appeals channels; and

THEREFORE BE IT RESOLVED, that the Association of Alaska School Boards support separation of the Alaska School Activities Association from the Department of Education.

Alaska Association School Administrators
October 1978 - Passed - Resolution #14

Title: Legislation - Alaska School Activities Association

WHEREAS, schools in Alaska have ever increasing activities for students, and

WHEREAS, there is a Statewide Alaska School Activities Association, and

WHEREAS, the Alaska School Activities Association is controlled by appointed representatives of the member schools, their administration and their School Boards

WHEREAS, this position leaves the functions of Alaska School Activities Association hindered by further administrative and appeals channels, and

WHEREAS, the Alaska Commissioner of Education is in favor of a separate State of Alaska funded agency

NOW THEREFORE BE IT RESOLVED, that the Alaska Association of School Administrators support separation of the Alaska School Activities Association from the Department of Education and be established as a separate agency under the draft law attached.

(Over)

Alaska Association Secondary School Principals
Resolution 10-78 #10 Passed

ALASKA SCHOOL ACTIVITIES ASSOCIATION

LEGISLATION

WHEREAS, schools in Alaska have ever increasing activities for students, and

WHEREAS, there is a statewide Alaska School Activities Association, and

WHEREAS, the Alaska School Activities Association is controlled by appointed representatives of the member schools, their administration and their school boards,

WHEREAS, the Alaska School Activities Association is now tied to the Alaska Department of Education by law, and

WHEREAS, this position leaves the functions of Alaska School Activities Association hindered by further administrative and appeals channels, and

WHEREAS, the Alaska Commissioner of Education is in favor of a separate State of Alaska funded agency,

NOW THEREFORE BE IT RESOLVED, that the AASSP supports separation of the Alaska School Activities Association from the Department of Education and established as a separate agency.

ALASKA SCHOOL ACTIVITIES ASSOCIATION
650 INTERNATIONAL AIRPORT ROAD ANCHORAGE, ALASKA 99502
LESLIE D. WELLS
EXECUTIVE SECRETARY
907-272-9045

January 23, 1980

Ms. Shannon Garrett
Administrative Assistant
Health, Education & Social Services
Capitol - Room 112
Pouch V
Juneau, Alaska 99811

Dear Shannon:

Here is a complete set of the materials that we have sent to Mrs. Buchholdt and Committee members concerning Senate Bill 163am. Please note that we are asking them to amend the bill with the proposal by Bob Greene and the Association of Alaska School Boards which is also being recommended by the State Board of Education and our own Association Board of Control.

Please feel free to call me at my home if you have any word on having this bill calendared. My home number is 243-1621 - office number is 272-9045 or 272-9052.

Sure hope we can beat the rush of big bills!

Thanks for any help you can give us.

Sincerely yours,

Leslie D. Wells
Executive Secretary

LDW:jle

Enclosures

ALASKA SCHOOL ACTIVITIES ASSOCIATION
650 INTERNATIONAL AIRPORT ROAD ANCHORAGE, ALASKA 99502
LESLIE D. WELLS
EXECUTIVE SECRETARY
907-272-9045

December 20, 1979

The Honorable Thelma Buchholdt
Chairman, House HESS Committee
House of Representatives
2607 Kona Lane
Anchorage, Alaska 99503

Dear Mrs. Buchholdt:

The Board of Control of the Alaska School Activities Association seeks your support in passage of SB 163am. The bill, as it now sits in your committee, needs to be amended to strengthen the role of local boards of education.

The Association has worked to satisfactorily amend this bill. It has now been approved by the State Board of Education and the Alaska Association of School Boards Committee. The attached amendment is a product of this work. We seek your support of this amendment and place it as part of the bill.

This amendment further clarifies the role of local school district boards of education and the State Board of Education as proposed by them. The Board of Control has directed this office to work with your guidance and counsel to pass this legislation. Senator Hackney has reviewed this amendment and has agreed with its intent.

The amendment continues to accomplish the basic goal of clarifying the Association's role and increase local school district board of education role. It removes the limitations from Region I in Western Alaska of having to have an elected representative on the Board of Control from the second judicial district. Thus, it allows the full membership from this Region to be eligible. It will also allow grant funds to flow through the Commissioner of Education's Office to the Association with proper accounting and reporting.

We ask for your support. Your assistance is vital in moving the bill in this second half of the legislative session. We will be in contact with you by phone after the holiday season to seek your direction.

With warm regards,

Les Wells

ASAA Board of Control
BY: Leslie D. Wells
Executive Secretary

Attachment

cc: Board of Control - ASAA
Mrs. Thelma Langdon - President, S.B.E.
Dr. Marshall Lind - Commissioner
Mr. Robert Greene - AASB

ALASKA SCHOOL ACTIVITIES ASSOCIATION
650 INTERNATIONAL AIRPORT ROAD ANCHORAGE, ALASKA 99502
LESLIE D. WELLS
EXECUTIVE SECRETARY
907-272-9045

January 22, 1980

The Honorable Thelma Buchholdt
Chairman, House HESS Committee
House of Representatives
Pouch V
Juneau, Alaska 99811

Dear Thelma:

As we were working to get out the information to all Committee members, we accidently enclosed the copy of my letter to you of last February 27, 1979, instead of the December 20, 1979, copy. As you see by the enclosed we have corrected this so that they will have full information contained in the letter to you.

May we ask that you calendar this bill just as soon as possible so that we might get out of the way of all the traffic rush that will surely come.

Sincerely yours,

Leslie D. Wells
Executive Secretary

LDW:jle

Enclosures

ALASKA SCHOOL ACTIVITIES ASSOCIATION
650 INTERNATIONAL AIRPORT ROAD ANCHORAGE, ALASKA 99502
LESLIE D. WELLS
EXECUTIVE SECRETARY
907-272-9045

January 23, 1980

The Honorable Bill Miles
House HESS Committee
House of Representatives
Pouch V
Juneau, Alaska 99811

Dear Mr. Miles:

We goofed! Concerning Senate Bill 163am, it was our intention to send you a copy of the December 20, 1979, letter to Mrs. Buchholdt, not the February 27, 1979, introductory letter that we did enclose. Would you please note the attached letter as it states our desires to have Senate Bill 163am amended by your Committee to improve the local school board role.

Again, we ask your support for favorable action as soon as possible. Yes, we would like to beat the rush with this non-money housekeeping bill.

Sincerely yours,

Leslie D. Wells
Executive Secretary

LDW:jle

Enclosure

ALASKA SCHOOL ACTIVITIES ASSOCIATION
650 INTERNATIONAL AIRPORT ROAD ANCHORAGE, ALASKA 99502
LESLIE D. WELLS
EXECUTIVE SECRETARY
907-272-9045

January 18, 1980

The Honorable Vernon L. Hurlburt
House HESS Committee
House of Representatives
Pouch V
Juneau, Alaska 99811

Dear Mr. Hurlburt:

This letter concerns Senate Bill 163am which has been setting in the House HESS Committee since last spring. As you may know, we had asked that this bill be held without action as it was necessary for the Activities Association to work with the State Board of Education and the Alaska Association of School Boards to strengthen the concept of local school board control in this bill. This has been accomplished and both of these bodies have given their approval to the changes as outlined in the attached amendment. They support the bill as revised and we now seek favorable action by your committee.

I have been in contact with your Chairman, Mrs. Buchholdt, and have discussed the next steps with her. She agreed that it would be timely for this communication to bring you up to date on the status of this bill. Please note my letter to Mrs. Buchholdt and the complete backup materials.

We ask for your support and assistance in moving this bill favorably through the committee. If you have any questions, please call me at 272-9045.

Sincerely yours,

ASAA Board of Control
By: Leslie D. Wells
Executive Secretary

LDW:jle

Enclosures

cc: Board of Control
Mrs. Thelma Langdon
Mr. Robert Greene
Mr. Cliff Hartman

SB

227

6/9/1986

SB 227: See also ~~H~~HESS files on "STATE HEALTH INSURANCE".

Jeanie Henry

STATE OF ALASKA
THE LEGISLATURE

LEGISLATIVE AFFAIRS AGENCY

POUCH Y - STATE CAPITOL
JUNEAU, ALASKA 99811
907-465-3800

M E M O R A N D U M March 29, 1979

SUBJECT: CSSB 227, relating to alcoholism and drug dependence insurance

TO: Senator Mike Colletta

FROM: John B. Chenoweth, Legislative Counsel

I do not want to belabor the explanation you requested of this bill. The one-page summary provided by the insurance division seems more than adequate. I did question Don Koch concerning the distinctions among the several types of policies mentioned or referenced in lines 11-13 of page 1 of the bill, and thought I would share that informaton with you.

The subsection mentioned speaks to

(1) "group insurance policies providing coverage on an expense-incurred basis"; and

(2) "group service or indemnity type contracts issued by a non-profit corporation."

(1) identifies the contracts normally issued by private insurance contracts. Private corporation contracts are typically indemnification contracts, by the terms of which the insurance company agrees to reimburse the insured for covered expenses. These contracts are usually one of three types: the "specified sickness" policy, the "flat rate" policy (paying so much per day for hospitalization for whatever the reason), and the "expense-incurred" policy (reimbursing for certain expenses designated in the policy). This bill addresses only the "expense-incurred" policy, the insurance division spokesman says, for this is the type of policy usually written by companies for the benefit of employees, and is more nearly related to the kind of coverage for hospitalization and outpatient services than other kinds of company-written policies. By the term of the bill, only group policies must provide for the coverage.

(2) above -- the service or indemnity-type policy -- is typically the kind of coverage written by carriers providing direct subscription coverage. In a service contract, payment is made by the carrier to the hospital or health facility (and in some states to physicians) for medical services provided to persons covered. In Alaska, Blue Cross of Washington/Alaska is the principal carrier of service contracts for health care coverage. My understanding of the explanation is that only nonprofit corporations are able to enter into service contract relationships directly with hospitals and health facilities. The reference to "indemnity-type" contracts in this line extends the mandatory coverage for alcoholism and drug dependence to nonprofits who indemnify insureds as well as to those whose business follows the service approach.

I trust this helps to explain the differences in the types of coverage. From the explanation, it appears certain that the intended alcoholism and drug dependence coverage does reach all providing coverage on an expense-incurred basis, including, of course, "profit-seeking" insurance corporations writing this type of coverage.

JBC:nem

PROBLEM

THE PROBLEM IS THAT CURRENTLY IT IS NOT REQUIRED BY LAW THAT ALL GROUP INSURANCE PLANS INCLUDE COVERAGE FOR PERSONS WITH ALCOHOL OR DRUG DEPENDENCY PROBLEMS, YET STATISTICS INDICATE THAT;

1. 5% OF THE POPULATION ARE PROBLEM DRINKING EMPLOYEES
2. 15% OF HEALTH MONEY IS SPENT ON THE PROBLEM DRINKING EMPLOYEE
3. ALCOHOL IS RELATED TO 1/3 OF ALL SUICIDES, 1/2 OF ALL MURDERS 1/2 OF ALL TRAFFIC ACCIDENTS, 1/4 OF ALL ACCIDENTAL DEATHS
4. 70% OF THE PROBLEM DRINKING EMPLOYEES CAN BE REHABILITATED.

COST/BENEFITS

'AN EMPLOYER CAN EXPECT SIGNIFICANT HEALTH INSURANCE COST SAVINGS BY PROVIDING EMPLOYER HEALTH INSURANCE FOR ALCOHOLISM' ::

1. PROBLEM DRINKING EMPLOYEES USE $3 IN HEALTH BENEFITS TO $1 FOR THE AVERAGE EMPLOYEE
2. IF AN EMPLOYER PROVIDED ADEQUATE COVERAGE FOR ALCOHOLISM AND ONLY 20% OF PROBLEM DRINKING EMPLOYEES WERE REHABILITATED, THIS MINIMAL NUMBER ALONE COULD SAVE THE EMPLOYER AROUND 2% OF TOTAL CLAIMS PAID.

:: FROM THE REPORT 'INSURANCE COST SAVINGS DUE TO ADEQUATE ALCOHOLISM HEALTH BENEFIT' FROM THE BLUE CROSS MAGAZINE PERSPECTIVE, WINTER 1978

BRIEF SUMMARY OF CSSSSB 227

" AN ACT RELATING TO INSURANCE FOR ALCOHOLISM AND DRUG DEPENDENCE"

THIS BILL MAKES IT REQUIRED FOR GROUP INSURANCE POLICIES TO PROVIDE COVERAGE FOR ALCOHOLISM AND DRUG DEPENDENCE. THE MINIMUM REQUIREMENTS FOR THIS COVERAGE ARE DESCRIBED IN THE BILL AND INCLUDE:

1. 14 DAYS OF INPATIENT DETOXIFICATION CARE PER YEAR
2. 30 DAYS OF INPATIENT TREATMENT PER YEAR
3. 30 VISITS OF OUTPATIENT TREATMENT PER YEAR

ALL OF THE ABOVE MINIMUM REQUIREMENTS AS OUTLINED IN THE BILL ARE TO BE ADMINISTERED IN A/OR BY A

1. STATE APPROVED TREATMENT FACILITY
2. LICENSED HOSPITAL
3. LICENSED PHYSICIAN
4. STATE CERTIFIED PROFESSIONAL SUBSTANCE ABUSE COUNSELOR

THE INSURANCE AS REQUIRED BY THIS BILL WOULD INCLUDE BENEFITS FOR DEPENDENTS REGARDLESS OF AGE,SEX OR STATE OF ILLNESS.
HOSPITAL MEDICAL SERVICE CORPORATIONS IE. BLUE CROSS (THE LARGEST INSURANCE COMPANY WITH ALASKA) ARE REQUIRED BY THIS BILL TO INCLUDE ALCOHOLISM AND DRUG DEPENDENCE INSURANCE.

THIS BILL INSURES THAT ALL PERSONS COVERED BY A GROUP INSURANCE POLICY ARE COVERED FOR ALCOHOLISM AND DRUG DEPENDENCE WHETHER OR NOT SPECIFIED IN THE POLICY. (THE REASONING FOR THIS IS THAT SOME POLICIES ORIGINATE OUT OF STATE THERFORE THE POLICY MIGHT NOT SPECIFY ALCOHOLISM AND DRUG DEPENDENCE COVERAGE, SO THIS WOULD CHANGE THE LAW MAKING IT AUTOMATIC FOR ALASKAN EMPLOYEES COVERED BY INSURANCE.)

CSSSSB 227 PROVIDES FOR AN EFFECTIVE DATE OF NOVEMBER 1,1979 IN ORDER FOR INSURANCE COMPANIES TO COMPLY WITH THE NEW LEGISLATION.

SECTION ANALYSIS SS for SB 227 FROM THE DIVISION OF I''SURANCE

Sec 1 AS 21.42

Requires that all group health insurance policies issued by insurance companies and all service or indemnity type contracts issued by non-profit corporations such as Blue Cross, provide as a minimum, specified coverages related to alcoholism and drug dependence.

COVERAGES are:

A. not less than 14 days detoxification benefit at a rate equal to other benefits provided in the policy.
B. not less than 30 days inpatient treatment benefit
C. not less than 30 visits to specified outpatient treatment facilities.

Alcoholism and drug dependence coverage is to be provided for all persons covered under the group policy without regard to age, sex, state of illness, or pre-existing condition.

Section 1 also provides key definitions of alcoholism and drug dependence.

Section 2 Amends AS 21.87 347 to provide that Hospital Medical Service Corporations ie. Blue Cross, are also subject to the provisions of AS 21.42 as created by this bill.

Section 3 Specifies that coverage for alcoholism and drug dependence shall automatically apply to all persons covered by a group policy issued for delivery, delivered or renewed in this state after the effective date of the act; whether the policy wording specifically provides coverage or not.

Section 4 Provides for an effective date of November 1, 1979 in order for insurance companies to amend policies and adjust rates prior to the effective date.

Blue Cross®
of Washington and Alaska

Armand B Hoppel
President

15700 Dayton Avenue North/P.O. Box 327
Seattle, Washington 98111
206/361 3389

April 11, 1979

Representative Thelma Bucholdt
Alaska House of Representatives
Pouch V
Juneau, Alaska 99811

Dear Representative Bucholdt:

You are aware that Committee Substitute for Sponsor Substitute for Senate Bill 227 (CSSSSB 227) is before you for consideration.

This bill is designed to combine the resources from providers, business/industry, and third party payors from the private sector in an attempt to combat, through recognized treatment programs, the problem of alcoholism and drug abuse.

The proposed legislation does have a price tag and we estimate this to be between three percent and five percent of existing health insurance premium. However, there is strong evidence that this cost will ultimately be offset by a decrease among the alcoholic population in the incidence of other conditions and a reduction in loss-of-time benefits paid by employers.

Although the concept of mandating benefits is offensive to many, we believe that it is appropriate in this case in order to guarantee the availability of services. In this respect, we would also encourage your support on Committee Substitute for Senate Bill 228 amended (CSSB 228 am).

Overall I believe CSSSSB 227 is a sound piece of legislation and I would urge your support.

Sincerely,

Armand B Hoppel

Armand B Hoppel

ABH:eb
4A/10

file under SB 227

STATEMENT OF THE HEALTH INSURANCE ASSOCIATION OF AMERICA

SB 227-HEALTH INSURANCE FOR TREATMENT OF
ALCOHOLISM AND DRUG DEPENDENCE

The Health Insurance Association of America (HIAA) is a trade association of 311 insurance companies which write 85% of the health insurance written by insurance companies in the United States.

Our member companies are very much concerned about the problems of alcoholism and drug dependence. We have been leaders in developing insurance coverage for these conditions, and in encouraging the establishment of effective programs for early detection, diagnosis, and treatment. We have learned that an effective program requires much more than just some group insurance coverage. Where an employer does nothing more than furnish the coverage, little use is made of it.

One essential of an effective program is an employer who is willing to encourage the use of the treatment program, and who has specially trained supervisors and a medical department which participate in the program. Forcing unwilling employers to furnish insurance coverage is the worst possible approach.

SB 227, as it passed the Senate, takes this latter approach. It would require all group hospital and medical expense policies to include certain specified benefits for treatment of alcoholism, drunkenness (detoxification), and drug abuse. The required coverage differs in several important respects from coverage now being furnished by insurers, either in Alaska or in other states. We think it would be unwise to take an untested plan of insurance and mandate it for all policies.

The additional costs of this plan are estimated at 3 1/2% to 5% for those policies that already cover alcoholism and drug abuse, and would be considerably higher for one that does not. This will be in addition to the increases in premiums that will be needed to cover the rapidly rising costs of health care covered under other policy benefits.

While additional costs concern everyone, they hurt most employees who have to contribute to the cost of their group insurance, retired persons who pay for coverage under a group plan, and small employers.

Your House HESS committee, at our suggestion, recommended a substitute bill which would not mandate benefits for all policies, but would test the Senate plan of benefits by including it in the State employees insurance program. Blue Cross-Blue Shield is willing to provide the coverage. We think this is the place to test it, where costs and results can be most closely monitored.

This approach will not disrupt our existing plans of alcoholism and drug addiction coverage, which many groups already have and which can be purchased on a voluntary basis.

We urge you to support your HESS committee's substitute bill.

April 27, 1979

Charles D. Kuhnen, Counsel

TELEGRAM

RCA ALASKA COMMUNICATIONS, INC.
PHONE 586-6442
JUNEAU, ALASKA 99802

File under SB 227

APR 25 PM 5 14

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32261 ANCHORAGE ALASKA 105 04-25 244P AST

PMS THELMA BUCHHOLDT, CHAIRMAN

HOUSE HESS COMMITTEE POUCH V

JUNEAU AK 99811

ON BEHALF OF THE PARTICIPATING EMPLOYERS OF THE KETCHIKAN RETAILERS HEALTH AND WELFARE TRUST AS WELL AS MANY OTHER EMPLOYERS WE STRONGLY URGE THAT SENATE BILL 227 IF PASSED DOES NOT CONTAIN A MANDATORY PROVISION REQUIRING ALCOHOL AND DRUG COVERAGE. SUCH SHOULD BE A MATTER OF FREE CHOICE AND BARGAINING AND SHOULD BE A MATTER OF FREE CHOICE AND BARGAINING AND SHOULD NOT BE FORCED ON AN EMPLOYER OR AN EMPLOYEE. BOTH SHOULD BE FREE TO NEGOTIATE TYPES OF COVERAGE. A MANDATORY PROVISION WOULD BE INFLATIONARY AS WELL. FOR FURTHER INFORMATION PLEASE CONTACT THE WRITER. P.S. WITH THE EXCEPTION OF BLUE CROSS ALL OTHER INSURANCE COMPANIES OF WHICH THE WRITER HAS KNOWLEDGE. SUPPORT THE FOREGOING POSITION.

A FRED MILLER, ATTORNEY FOR KETCHIKAN
RETAILERS HEALTH AND WELFARE TRUST

Name	Address	Organization	Bill No.
Matt Felix	210 Admiral Way	Alcoholism - Drug Abuse Control Agency	SB. 227

6529
Chenoweth

Original sponsors: Colletta, Stimson and Hohman

IN THE SENATE

BY THE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

HOUSE CS FOR CS FOR SPONSOR SUBSTITUTE FOR SENATE BILL NO. 227

IN THE LEGISLATURE OF THE STATE OF ALASKA

ELEVENTH LEGISLATURE - FIRST SESSION

A BILL

For an Act entitled: "An Act relating to insurance for alcoholism and drug dependence; and providing for an effective date."

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

* Section 1. AS 21.42 is amended by adding a new section to read:

Sec. 21.42.347. REQUIRED PROVISION OF COVERAGE FOR ALCOHOLISM AND DRUG DEPENDENCE. (a) Group health insurance policies providing coverage on an expense-incurred basis and group service or indemnity type contracts issued by a nonprofit corporation

(1) shall provide coverage for alcoholism and drug dependence to include

(A) inpatient detoxification benefits for not less than 14 days of benefit each calendar year in a state-approved treatment facility or licensed hospital; payment of institutional and professional benefits shall be equal to and payable as any other covered condition, except a covered condition which, by the terms of the policy, has an internal restriction;

(B) inpatient treatment coverage benefits for not less than 30 days of benefit each calendar year in a state-approved treatment program; payment of institutional and professional benefits shall be at the same level as any other covered condition, except a covered condition which, by the terms of the policy, has an internal restriction; and

(C) outpatient treatment coverage benefits of not less than 30 visits each calendar year if treatment is provided by a

licensed physician, state-approved treatment program, or state-certified professional substance abuse counselor; coverage shall include individual, family or group therapy; benefits shall be paid at not less than 75 per cent of the usual, customary and reasonable charge for a medical procedure, treatment or service in the geographic area;

(2) may not exclude dependents otherwise covered and may not limit coverage for alcoholism or drug dependence because of age, sex or state of illness;

(3) may not apply preexisting or named condition exclusions to deny coverage for alcoholism or drug dependence; and

(4) may require a physician's certification of necessity as a condition of payment for alcoholism or drug dependence treatment.

(b) The provisions of this section apply to group health insurance contracts and group service or indemnity type contracts issued to an employer, as the policyholder, for the purpose of insuring his employees only if the employer employs 15 or more employees.

(c) In this section,

(1) "alcoholism" means an illness or condition characterized by the habitual lack of self control in the use of alcoholic beverages, or use of alcoholic beverages to the extent that health is substantially impaired or endangered, or social or economic function is substantially disrupted;

(2) "drug dependence" means the condition of being physically or psychologically addicted to an opiate, opiate derivative, tranquilizer, amphetamine, barbiturate, or similar substance, but excluding nicotine, caffeine and alcohol;

(3) "state" means any state in the United States and includes the District of Columbia.

* Sec. 2. AS 21.87.340 is amended by adding a new paragraph to read:

(17) AS 21.42.347.

* Sec. 3. The provisions of this Act apply to group policies or contracts delivered, issued for delivery, or renewed in this state after the effective date of this Act. A policy or contract providing coverage for persons in this state delivered, issued for delivery, or renewed after the effective date of this Act shall be considered to provide the minimum coverage required by this Act even if the language of the policy or contract does not so specifically provide.

* Sec. 4. This Act takes effect November 1, 1979.

approval of the Advisory Board on Alcoholism. The department is not required to award all money available under this program, or the full percentages specified in this subsection, when another source of money is available or could reasonably be made available to the applicant.

(d) Money used by the applicant to qualify for state money may be from any source other than the state. The cost of developing an application is not reimbursable from the grant. The value of real property to be used directly in conjunction with the grant may be used in calculating the required amount of community money, as allowed by regulations of the department. (§ 2 ch 101 SLA 1970; am § 1 ch 126 SLA 1975)

Effect of amendment. — The 1975 amendment, in subsection (c), substituted the language beginning "except that in communities" and ending "10 per cent community money" for "for the purpose of providing staff, and in the ratio of 75 per cent state money and 25 per cent community money" in the first sentence, inserted "staff and" in the second sentence, and substituted "percentages" for "percentage" in the third sentence.

Sec. 47.30.477. Grant-in-aid program regulations. The department shall adopt regulations implementing § 475 of this chapter. The regulations shall provide for the method of application, the time for consideration of applications, the processing of applications, the type of record keeping, the requirements for reporting the progress and statistics regarding the program, the notification of the applicant as to the action taken on the application, and the issuance of licenses for facilities receiving grants-in-aid under § 475 of this chapter. The department shall also establish the necessary forms of application and may adopt other regulations considered necessary to meet the requirements of health and safety and the orderly administration of the grant-in-aid program. (§ 2 ch 101 SLA 1970)

Sec. 47.30.480. Judicial notice. The superior courts of this state may take judicial notice of the fact that an alcoholic is suffering from an illness and is in need of proper medical, advisory or rehabilitative treatment. (§ 2 ch 163 SLA 1966)

Sec. 47.30.490. Acceptance of funds. The department may accept on behalf of the state and deposit, apart from other public funds, grants from the federal government or gifts or contributions from other sources to assist in carrying out the purposes of § 470 of this chapter. (§ 2 ch 163 SLA 1966)

Sec. 47.30.500. Definitions. In §§ 470—490 of this chapter

(1) "department" means the Department of Health and Social Services;

(2) "alcoholism" means a condition related to alcohol and concerns a physical compulsion which exists, coupled with a mental obsession;

(3) Repealed by § 2 ch 207 SLA 1972.

Sec. 47.37.270. Definitions. In this chapter

(1) "alcoholic" means a person who habitually lacks self-control in using alcoholic beverages, or uses alcoholic beverages to the extent that his health is substantially impaired or endangered, or his social or economic function is substantially disrupted;

(2) "approved private treatment facility" means a private agency meeting the standards prescribed in § 140(a) of this chapter and approved under § 140(c) of this chapter;

(3) "approved public treatment facility" means a treatment agency operating under the direction and control of the office or providing treatment under this chapter through a contract with the office under § 130(g) of this chapter and meeting the standards prescribed in § 140(a) of this chapter and approved under § 140(c) of this chapter;

(4) "commissioner" means the commissioner of health and social services;

(5) "coordinator" means the coordinator of the office of alcoholism;

(6) "department" means the Department of Health and Social Services;

(7) "emergency service patrol" means a patrol established under § 230 of this chapter;

(8) "incapacitated by alcohol" means a person who is unconscious or has his judgment otherwise so impaired that he is incapable of realizing and making a rational decision with respect to his need for treatment, as evidenced objectively by extreme physical debilitation, physical harm or threats of harm to others or chronic inability to hold regular employment;

(9) "incompetent person" means a person who has been adjudged incompetent by the appropriate court;

(10) "intoxicated person" means a person whose mental or physical functioning is substantially impaired as a result of the use of alcohol;

(11) "office" means the office of alcoholism within the Department of Health and Social Services;

(12) "treatment" means the broad range of emergency, outpatient, intermediate, and inpatient services and care which may be extended to alcoholics and intoxicated persons, including diagnostic evaluation, medical, psychiatric, psychological, and social service care, vocational rehabilitation and career counseling. (§ 1 ch 207 SLA 1972)

Quoted in Peter v. State, Sup. Ct. Op. No. 1112 (File No. 2185), 531 P.2d 1263 (1975).

Chapter 40. Purchase of Services.

Section	Section
10. Purchase of services	50. Services
20. Licensing and supervision	60, 70. [Repealed]
30. Required accounting procedures	80. Definitions
40. Determination of full cost of services	

Name	Address	Organization	Bill No.
Mike Thomas	Box 1211 Juneau 99802	Am Council of Life Ins.	SB 227
Charles Kuhnen	332 S. Michigan Ave, Chicago Ill. 60604	Health Insurance Association of America	SB 227
ROBERT L. COLE	819 G. ROBERT JUNEAU 99811	Office of ATG/DA	SB 227
DON KOCH	POUCH D 99811	DIV. OF INSURANCE	SB 227

Proofed 4-30

Original sponsors: Colletta, Stimson and Hohman

IN THE SENATE

BY THE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

HOUSE CS FOR CS FOR SPONSOR SUBSTITUTE FOR SENATE BILL NO. 227 (HESS)

IN THE LEGISLATURE OF THE STATE OF ALASKA

ELEVENTH LEGISLATURE - SECOND SESSION

A BILL

For an Act entitled: "An Act relating to health insurance for employees in the state; and providing for an effective date."

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

* Section 1. AS 21 is amended by adding a new chapter to read:

CHAPTER 50. ~~AS 21~~ COMPREHENSIVE HEALTH CARE PLANS

Sec. 21.50.010. INDIVIDUAL AND GROUP COMPREHENSIVE HEALTH CARE PLANS. (a) A carrier offering individual health insurance in the state shall, as a condition of transacting health insurance, make an individual comprehensive health care plan described in AS 21.50.040 available to each resident of the state who is not eligible for Medicare. An individual shall have a choice of the low option, the middle option, or the high option deductible described in AS 21.50.020(b). Individual comprehensive health care plans may be made available through participation in the Health Reinsurance Association in accordance with AS 21.50.050 or a residual market association, in accordance with AS 21.50.060. The premium charged for a plan which is not insured by or through the Health Reinsurance Association or ~~another~~ residual market association may not exceed the premium which is applicable through participation in a residual market association. The premium charged for a plan insured by or through the Health Reinsurance Association is the premium established for the particular classification under the Health Reinsurance Association.

(b) A self-insurer whose plan covers three or more employees shall make an individual comprehensive health care plan described in AS 21.50.040 available under a conversion privilege to each insured person

covered by the plan who is a resident of the state, who is not eligible for Medicare, and whose coverage under the self-insured plan ceases as a result of layoff, death, or termination of employment. An individual shall have the choice of the low option, the middle option, or the high option deductible described in AS 21.50.020(b). The individual comprehensive health care plans may be provided through a carrier or through participation in the Health Reinsurance Association under AS 21.50.050. The premium charged for a plan which is not insured by or through the Health Reinsurance Association may not exceed the premium established for that particular classification under the Health Reinsurance Association. The premium charged for a plan which is insured by or through the Health Reinsurance Association is the premium established for that particular classification under the Health Reinsurance Association.

(c) Each carrier offering group health insurance in the state shall, as a condition of transacting health insurance, make a group comprehensive health care plan described in AS 21.50.030 available to every resident employer of three or more eligible employees. An employer shall have the choice of the low option, the middle option, or the high option deductible described in AS 21.50.020(b). Group comprehensive health care plans may be made available to resident employers of between three and 25 eligible employees through participation in the Health Reinsurance Association under AS 21.50.050 or the residual market association under AS 21.50.060. The premium charged for a plan on groups of between three and 25 eligible employees which is not insured by or through the Health Reinsurance Association or a residual market association may not exceed the premium which is applicable through participation in a residual market association. The premium charged for a plan which is insured by or through the Health Reinsurance Association is the premium established for that particular classification under the Health

Reinsurance Association.

(d) ~~Except as provided in AS 21.50.070(c)~~ This chapter does not preclude the right of a carrier to transact another kind of insurance or another kind of health insurance which it is authorized to transact.

(e) This chapter does not require a carrier to make coverage available under a group or individual comprehensive health care plan to a person or group already covered under a plan.

Sec. 21.50.020. MINIMUM STANDARD BENEFITS. (a) Individual and group comprehensive health care plans shall include minimum standard benefits described in this section. Except as provided in (b) and (c) of this section, minimum standard benefits are benefits, including coverage for catastrophic illness, with a lifetime maximum of $1,000,000 per insured person for reasonable charges or, when applicable, the allowance agreed upon between a provider and a carrier for charges actually incurred for the following health care services rendered to an ~~individual~~ insured person covered by a plan for the diagnosis or treatment of nonoccupational disease or injury;

(1) hospital services;

(2) professional services which are rendered by a physician or at his direction, by a registered nurse, other than services for mental or dental conditions;

(3) the diagnosis or treatment of mental conditions as defined in regulations of the director during the year by one or more physicians on other than an inpatient basis or, at their direction, by their staffs of registered nurses up to a yearly maximum benefit of $1,000;

(4) legend drugs requiring a physician's prescription;

(5) services of a skilled nursing facility for not more than 120 days in a calendar year if the services begin within 14 days follow-

ing a confinement of at least three consecutive days in a hospital for the same condition;

(6) home health agency services, as defined in regulations of the director

(A) up to a maximum of 180 visits in a calendar year if the services begin within seven days following confinement in a hospital or skilled nursing facility for at least three consecutive days for the same condition;

(B) in the case of an insured person diagnosed by a physician as terminally ill with a prognosis of six months or less to live, home health agency services may begin even if the thresholds of (A) have not been met;

(7) medical social services not to exceed $200 in a calendar year;

(8) use of radium or other radioactive materials;

(9) oxygen;

(10) anesthetics;

(11) non-dental prosthesis;

(12) rental of durable medical equipment which has no personal use in the absence of the condition for which it is prescribed;

(13) diagnostic x-rays and laboratory tests as defined in regulations of the director;

(14) oral surgery for

(A) excision of partially or completely unerupted impacted teeth; or

(B) excision of a tooth root without the extraction of the entire tooth;

(15) services of a licensed physical therapist, rendered under the direction of a physician;

(16) transportation by a local professional ambulance to the nearest health care institution qualified to treat the illness or injury;

(17) other medically necessary services in the treatment or diagnosis of an illness or injury as defined in regulations of the director;

(18) confinement in a facility established primarily for the treatment of alcoholism and licensed for care of alcoholics by the state, or in a part of a hospital used primarily for such treatment, shall be a covered expense for a period of at least 45 days in a calendar year.

(b) Minimum standard benefits may include one or more of the following provisions:

(1) subject to (3) of this subsection, a plan may require deductibles. The low option deductible is $100 per person, the middle option deductible is $500 per person, and the high option deductible is $1,000 per person. The amount of the deductible may not be greater when a service is rendered on an outpatient basis than when the service is offered on an inpatient basis. Expenses incurred during the last three months of a calendar year and actually applied to an insured person's deductible for the year shall be applied to the insured person's deductible in the following calendar year. The $100 maximum, the $500 maximum and the $1,000 maximum shall be adjusted yearly by the director in regulations adopted by him to correspond with the change in the medical care component of the consumer price index. The base year for the computation is the first full year of operation of the plan.

(2) subject to the provisions of (3) of this subsection a plan shall require a maximum copayment of 20 percent for charges for all types of health care in excess of the deductible and 50 percent for

services listed in (a)(3) of this section in excess of the deductible.

(3) the sum of the deductible and copayments required in a calendar year under an option may not exceed a maximum limit of $1,000 per covered individual or $2,000 per covered family except ~~that~~ O.K. ~~(A)~~ covered expenses incurred after the applicable maximum limit has been reached are paid at the rate of 100 percent; and (B) expenses incurred for treatment of mental and nervous conditions may be paid at the rate of 50 percent under (a)(3) of this section. The $1,000 and $2,000 maximums shall be adjusted yearly to correspond with the change in the medical care component of the consumer price index as adjusted by the commissioner.

(4) the plan may limit lifetime benefits to a maximum of not less than $1,000,000 per insured person.

(5) a plan may not exclude coverage of a preexisting condition unless (A) the condition first manifested itself within the period of six months immediately before the effective date of coverage in a manner that would cause a reasonably prudent person to seek diagnosis, care or treatment; (B) medical advice or treatment was recommended or received within the period of six months immediately before the effective date of coverage; or (C) the condition is pregnancy existing on the effective date of coverage. A policy may not exclude coverage for a loss due to preexisting conditions for a period greater than 12 months following the effective date of coverage. An individual comprehensive health care plan issued as a result of conversion from group health insurance or from a self insured group shall credit the time covered under the group health insurance toward an exclusion.

(c) Plans providing minimum standard benefits need not provide benefits for a charge for

(1) care for an injury or disease either

(A) arising out of and in the course of an employment subject to a workers' compensation or similar law; or

(B) to the extent benefits are payable without regard to fault under a coverage statutorily required to be contained in a motor vehicle or other liability insurance policy or equivalent self-insurance;

(2) treatment for cosmetic purposes other than surgery for the prompt repair of an accidental injury sustained while covered;

(3) travel other than medically necessary transportation as defined in regulations of the director;

(4) private room accommodations to the extent it is in excess of the institution's most common charge for a semiprivate room;

(5) services or articles to the extent that it exceeds the reasonable charge in the locality for the service;

(6) services or articles which are determined not to be medically necessary;

(7) services or articles the provision of which is not within the scope of the license or certificate of the institution or individual rendering the services or articles;

(8) services or articles furnished, paid for or reimbursed directly by or under a law of a government, except as otherwise provided in this chapter;

(9) services or articles for custodial care ~~of~~ or designed primarily to assist an insured person ~~or person's~~ in meeting his activities of daily living;

(10) services which would not have been made if no insurance existed or for which the insured person ~~or person's~~ is not legally obligated to pay;

(11) eyeglasses, contact lenses or hearing aids, or the

fitting of them;

(12) dental care not specifically covered by this chapter; and

(13) services of a registered nurse who ordinarily resides in the insured ~~person or~~ person's home, or who is a member of the insured ~~person or~~ person's family or the family of the spouse.

(d) If an insured person who receives benefits for an injury possesses a right of recovery, a carrier that has paid benefits to or for the insured person is subrogated to a right of recovery to the extent of its payments.

(e) The minimum standard benefits of an individual or group comprehensive health care plan may be satisfied by catastrophic coverage offered in conjunction with basic hospital or medical-surgical plans on an expense-incurred or service basis as approved by the commissioner as providing at least equivalent benefits.

Sec. 21.50.030. ADDITIONAL REQUIREMENTS AND ELIGIBILITY UNDER GROUP COMPREHENSIVE HEALTH CARE PLANS. (a) A group comprehensive health care plan shall cover each regular employee and the dependents of the employee.

(b) A group comprehensive health care plan shall

(1) provide the option to continue coverage under each of the following circumstances until the insured person is eligible for other group insurance:

(A) layoff, leave of absence, or termination of employment, other than as a result of death of the employee, continuation of coverage for the employee and his covered dependents to the end of the 39th week following the day on which the employee lost eligibility to participate in the group;

(B) on the death of the employee, continuation of coverage for the covered dependents of the employee to the end of

the 39th week following the day on which the employee lost eligibility to participate in the group;

(C) during an employee's absence due to illness or injury, continuation of coverage for the employee and his covered dependents during continuance of an illness or injury or for up to 12 months from the beginning of the absence;

(D) on termination of the group plan, coverage for covered individuals who were totally disabled on the date of termination continues without premium payment during the continuance of the disability for a period to 12 calendar months following the calendar month in which the plan was terminated;

(E) any continuation of coverage required by this section except (D) of this paragraph may be subject to the requirement, on the part of the individual whose coverage is to be continued, that the individual contribute that portion of the premium he would have been required to contribute had the employee remained an active covered employee, except that the individual may be required to pay the entire premium at the group rate if coverage is continued under (A) of this paragraph but the employer is not legally obligated by this section to pay the premium if it was not paid timely by the employee.

(2) terminate the coverage of an insured person

(A) as to a child, at the end of the month following the month in which a child marries, ceases to be dependent on the employee or attains the age of 19, whichever occurs first, except that

(i) if the child is a full-time student at an accredited institution, the coverage continues while the child remains unmarried and a full-time student, but not beyond the month following the month in which the child attains the age of 23;

LA-L 20A

the 39th week following the day on which the employee lost eligibility to participate in the group;

(C) during an employee's absence due to illness or injury, continuation of coverage for the employee and his covered dependents during continuance of an illness or injury or for up to 12 months from the beginning of the absence;

(D) on termination of the group plan, coverage for covered individuals who were totally disabled on the date of termination continues without premium payment during the continuance of the disability for a period to 12 calendar months following the calendar month in which the plan was terminated;

(E) any continuation of coverage required by this section except (D) of this paragraph may be subject to the requirement, on the part of the individual whose coverage is to be continued, that the individual contribute that portion of the premium he would have been required to contribute had the employee remained an active covered employee, except that the individual may be required to pay the entire premium at the group rate if coverage is continued under (A) of this paragraph but the employer is not legally obligated by this section to pay the premium if it was not paid timely by the employee.

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(A) as to a child, at the end of the month following the month in which a child marries, ceases to be dependent on the employee or attains the age of 19, whichever occurs first, except that

(i) if the child is a full-time student at an accredited institution, the coverage continues while the child remains unmarried and a full-time student, but not beyond the month following the month in which the child attains the age of 23;

LA-L 20A

shall contain provisions

(1) which obligate the carrier to continue the contract until the earlier of (A) the date on which the individual in whose name the contract was issued first becomes eligible for coverage under Title XVIII of the Social Security Act or under a group comprehensive health care plan or, (B) the plan anniversary date which occurs at least 60 days after the carrier has mailed to the individual at his last address shown on the carrier's records written notice of its decision not to continue coverage on a class basis only; the carrier may reserve the right to adjust premiums by classes in accordance with its experience for policies or contracts not written by or through the Health Reinsurance Association but a premium may not exceed the premium established for the particular class by the Health Reinsurance Association;

(2) which, upon the death of the individual in whose name the contract was issued, permits every other individual covered under the contract to elect, within a period established in the contract, to continue coverage until a time when he would have ceased to be entitled to coverage had the individual in whose name the contract was issued lived; and

(3) under which the benefits payable shall be excess to all other sources of health insurance benefits, including benefits provided under a state or federal law other than Medicaid.

Sec. 21.50.050. HEALTH REINSURANCE ASSOCIATION. (a) There is created as a nonprofit legal entity the Health Reinsurance Association. Each insurer and self insurer doing business in the state, as a condition to its authority to transact the applicable kinds of health insurance defined in AS 21.50.100 is a member of the association. The association shall perform its functions under a plan of operation established and approved under (b) of this section and shall exercise its

powers through a board of directors established under this section.

(b) The board of directors of the association shall consist of seven individuals selected by participating members and subject to approval by the ~~commissioner~~ director. The director shall give notice to all members of the time and place of the organizational meeting to select the first board of directors and to organize the association. In determining voting rights at the meeting a member is entitled to vote in person or proxy. The vote shall be weighted based on the net health insurance premium derived from business in the state in the previous calendar year. If the board of directors is not selected within 60 days after notice of the meeting, the director may appoint the board. In approving or selecting members of the board, the ~~commissioner~~ director may consider whether all members are fairly represented. Members of the board may be reimbursed from the money of the association for expenses incurred by them as members but are not otherwise entitled to compensation by the association for their services.

(c) The board shall submit to the director a plan ~~of~~ of operation for the association to assure the fair, reasonable and equitable administration of the association. The plan of operation becomes effective on approval in writing by the director consistent with the date on which the coverage under this chapter must be made available. The director shall, after notice and hearing, approve the plan of operation if the plan is determined to assure the fair, reasonable and equitable administration of the association and provide for the sharing of association gains or losses on an equitable proportionate basis. If the board fails to submit a suitable plan of operation within 180 days after its appointment or if at any time the board fails to submit suitable amendments to the plan, the director may, after notice and hearing, adopt a plan or amendments to a plan as are necessary to carry out the provisions of

this section. A plan and amendments to a plan continue in force until modified by the director or superseded by a plan submitted by the board and approved by the director. A plan of operation shall, in addition to requirements enumerated in this chapter;

(1) establish procedures for the handling and accounting of assets and money of the association;

(2) establish regular times and places for meetings of the board of directors;

(3) establish procedures for records to be kept of all financial transactions and for the annual fiscal reporting to the director;

(4) establish procedures under which selections for the board of directors shall be made and submitted to the director;

(5) establish procedures to amend, subject to the approval of the director, the plan of operations;

(6) establish procedures for the selection of an administering carrier and set out the powers and duties of the administering carrier;

(7) contain additional provisions for the execution of the powers and duties of the association; and

(8) establish procedures for the advertisement on behalf of all participating carriers of the general availability of the comprehensive coverage under this chapter.

(d) The association has the general power and authority granted under the law of the state to a carrier to transact the kinds of health insurance defined under AS 21.50.100 and in addition, may

(1) enter into contracts necessary to carry out the provisions of this chapter;

(2) sue or be sued and may take legal action necessary to

recover an assessment for, on behalf of, or against a participating member;

(3) take legal action necessary to avoid the payment of improper claims against the association or the coverage provided by or through the association;

(4) establish with respect to health insurance provided by or on behalf of the association, appropriate rates, scales of rates, rate classifications and rating adjustments which may not be unreasonable in relation to the coverage provided and the operational expenses of the association not to exceed the limits set under (e)(3) of this section;

(5) administer a reinsurance program for participating members;

(6) pool risks among participating members;

(7) issue policies of insurance in its own name or on behalf of participating members on an indemnity ~~of~~ or provision of service basis providing the coverage required by this chapter;

(8) administer separate pools, separate accounts or other plans considered appropriate for separate members or groups of members;

(9) operate a combination of plans, pools, reinsurance arrangements or other mechanisms considered appropriate to accomplish the fair and equitable operation of the association;

(10) set limits on the amounts of reinsurance which may be ceded to the association by its members; and

(11) appoint from among participating members appropriate committees necessary to provide assistance in the operation of the association.

(e) Each member of the association shall participate in the association under the following provisions of this subsection:

(1) A participating member shall determine the particular

risks it elects to have written by or through the association.

(2) A member shall designate which of the following classes of risks it shall underwrite in the state, from which it may elect to reinsure selected risks:

(A) individual, excluding group conversion;

(B) individual, including group conversion; and

(C) groups of between three and 25 employees or members.

(3) A member or employer may not select out individual lives from an employer group to be insured by or through the association. Members electing to administer risks which are insured by or through the association shall comply with the benefit determination guidelines and the accounting procedures established by the association. A risk insured by or through the association cannot be withdrawn by the participating member except under rules established by the association.

(4) Rates for coverage issued by or through the association may not be excessive, inadequate or unfairly discriminatory. Separate scales of premium rates based on age apply for individual risks and group risks. Group rates may be adjusted for area variations in provider costs but individual rates may not be adjusted for area variations in provider costs. Premium rates shall consider the substantial extra morbidity and administrative expenses for association risks, reimbursement or reasonable expenses incurred for the writing of association risks and the level of rates charged by insurers for groups of 10 lives. The rate for a given classification or group may not be more than 125 percent of the average group rate charged for the classification or group at standard risk with similar characteristics under a policy covering 10 lives. All rates shall be promulgated by the association through an actuarial committee consisting of five persons who are members of the American Academy of Actuaries, shall be filed

with the director and may be disapproved within 60 days from the filing if the director determines that the rates are excessive, inadequate, or unfairly discriminatory.

(f) Following the close of a fiscal year, an administering carrier shall determine the net premiums, reinsurance premiums less administrative expense allowance, the expense of administration pertaining to the reinsurance operations of the association and the incurred losses for the year. A net loss shall be assessed to participating members of the association in proportion to their respective shares of the total health insurance premiums earned in the state during the calendar year, or with paid losses in the year, coinciding with or ending during the fiscal year of the association or on another equitable basis provided in the plan of operations. For self-insured members of the association, health insurance premiums earned shall be established by dividing the amount of paid health losses for the applicable period by 85 percent. Net gains, if any, shall be held at interest to offset future losses or allocated to reduce future premiums.

(g) A net loss to the association represented by the excess of it actual expenses of administering policies issued by the association ove the applicable expense allowance shall be separately assessed to participating members who do not elect to administer their plans. Assessments shall be on an equitable formula established by the board.

(h) The association shall conduct periodic audits to assure the general accuracy of the financial data submitted to the association and the association shall have an annual audit of its operations by an independent certified public accountant. The annual audit shall be filed with the director for his review and the association is subject examination by the director under AS 21.06.

(i) Policy forms issued by the association shall conform to prot

type forms developed by the association and to the requirements of this chapter and shall be approved by the director. The director may disapprove a form if it contains a provision which is unfair or deceptive or which encourages misrepresentation of the policy.

(j) The association may not issue comprehensive health care plan coverage for a person who is covered under an individual or group comprehensive health care plan, who is eligible for Medicare, or who is not a resident of this state.

(k) Benefits payable under a comprehensive health care plan insured by or reinsured through the association are paid net of all other health insurance benefits paid or payable through another source and net of all health insurance coverages provided by or under another state or federal law including Title XVIII of the Social Security Act, Medicare but not including Medicaid.

(l) No liability and no claim arises against a carrier or its agents or its employees, the association or its agents or its employees or the residual market mechanism established under AS 21.50.060 or its agents or its employees, or the director for any action taken by the director in the performance of his duties under this chapter. This subsection does not apply to the obligations of a carrier, a self-insurer, the association or the residual market mechanism for payment of benefits provided under a comprehensive health care plan.

(m) A carrier may credit an assessment paid to the association under (f) of this section against its income tax payable under AS 43.20 or its premium tax payable under this title for the year in which the assessment was paid. If a carrier's total assessment exceeds its tax liability for the year, the commissioner of revenue shall directly reimburse the carrier in the amount of the excess.

Sec. 21.50.060. HOSPITAL AND MEDICAL SERVICE CORPORATIONS;

RESIDUAL MARKET MECHANISM; DIRECTOR'S POWERS CONCERNING MECHANISMS. (a) A hospital ~~and~~ or medical service corporation may elect to meet the obligations of AS 21.50.010 by participating in the association either as a full member or by making comprehensive health care plans available directly through a subscriber contract or combination of contracts or by forming a separate residual market mechanism similar to the association.

(b) If a hospital ~~and~~ or medical service corporation forms a separate residual market mechanism, the director has the same regulatory powers over the residual market mechanism as he has over the association and the residual market mechanism has the same powers and duties as the association. Rating classifications under a residual market mechanism established under this section need not be the same as classifications established under the association but rates established by the residual market mechanism shall be approved by the director. The director may adopt regulations to implement this section.

(c) If a hospital ~~and~~ or medical service corporation does not participate in the association, it is required to make an individual comprehensive health care plan available to every resident of the state who is not eligible for Medicare and whose coverage under a group or individual contract issued by the hospital or medical service corporation has terminated. The coverage may be made available through a separate residual market mechanism established under this section.

Sec. 21.50.070. POWERS OF DIRECTOR. The director may

(1) formulate general policies to advance the purposes of AS 21.50.010 - 21.50.060 and may adopt regulations under the Administrative Procedure Act (AS 44.62) to carry out the provisions of AS 21.50.010 -21.50.060;

(2) adopt regulations upgrading minimum benefit standards under AS 21.50.020 - 21.50.040 as may be appropriate due to inflation or

changes in the prevailing standards of the industry;

(3) supervise the establishment of the association under AS 21.-50.050 or a residual market mechanism under AS 21.50.060;

(4) approve the selection of the administering carrier by the association and approve the association's contract with the administering carrier including the comprehensive health care plan coverage and the premiums to be charged;

(5) adopt by regulation reasonable limits on administrative expenses of the administering carrier which may be paid from comprehensive health care plan premiums, and minimum standards for the proportion of comprehensive health care plan premiums to be paid out in claims;

(6) appoint advisory committees;

(7) conduct audits to assure the general accuracy of the financial data submitted by the administering carrier and the association;

(8) contract with the federal government or with another unit of government to ensure coordination of the comprehensive health care plan with other governmental assistance programs;

(9) undertake directly or through studies or demonstrations programs to develop awareness of the benefits of AS 21.50.010 - 21.50.060 so that residents of the state may avail themselves of the health care benefits provided by these sections.

Sec. 21.50.080. APPLICATION TO NEW OR RENEWED GROUP HEALTH POLICIES AND CONTRACTS (a) Group health policies or contracts delivered or issued for delivery or renewal in the state on or after January 1, 1981, shall, subject to the provisions of (c) of this section, contain the provisions established under AS 21.50.030(b).

(b) The commissioner shall within 180 days after January 1, 1981,

adopt regulations under the Administrative Procedure Act (AS 44.62) covering group coverage discontinuance and replacement.

(c) Nothing in this section alters or impairs existing group policies or contracts which have been established under an agreement which resulted from collective bargaining and the provisions required by this section are effective on the next regular renewal and completion of the collective bargaining agreement.

Sec. 21.50.090. PREMIUM SUPPLEMENTATION. (a) A resident employer who employs 10 or less regular employees who are provided with health insurance coverage as an employee benefit is entitled to premium supplementation if

(1) the employer's share of the cost of providing the coverage exceeds 1.5 percent of the total wages payable to regular employees; and

(2) the amount of the excess under (1) of this subsection is greater than four percent of the employer's income before taxes directly attributable to the business in which the regular employees are employed.

(b) The amount of the supplementation shall be 80 percent of that portion of the employer's share of the premium cost which exceeds the limits specified in (a)(2) of this section.

(c) An employer entitled to premium supplementation may file a claim in the manner provided by regulation of the commissioner. The employer has the burden of establishing his entitlement.

Sec. 21.50.200. DEFINITIONS. In this chapter,

(1) "association" means the Health Reinsurance Association established under AS 21.50.050;

(2) "carrier" means an insurer, hospital service corporation or medical service corporation, or fraternal benefit society;

(3) "commissioner" means the commissioner of commerce and economic development;

(4) "dependent" means

(A) a spouse;

(B) an unmarried child under the age of 19 years;

(C) a child under the age of 23 years who is a full-time student and is financially dependent on the parent;

(D) a child of any age who by reason of mental retardation or physical handicap is incapable of self-sustaining employment and is chiefly dependent on the parent for support and maintenance; and

(E) a household member who is financially dependent on the primary insured;

(5) "director" means the director of the division of insurance in the Department of Commerce and Economic Development;

(6) "family" means the primary insured and his covered dependents;

(7) "health insurance"

(A) means hospital and medical expenses incurred policies written on a direct basis, nonprofit service plan contracts, and self-insured or self-funded employee health benefit plans;

(B) does not include accident only policies, disability income policies or casualty insurance coverages subject to regulation under AS 21.39;

(8) "home health agency" has the same meaning as "home health agency" as defined in 42 U.S.C., sec. 1395x;

(9) "hospital" has the same meaning as "hospital" as defined in 42 U.S.C., sec. 1395x;

(10) "income directly attributable to the business"

(A) means gross profits from the business less deductions for

(i) compensation of officers;

(ii) salaries and wages, except wages paid by an individual proprietor to himself;

(iii) repairs;

(iv) taxes on business and business property;

(v) business advertising;

(vi) amounts contributed to employee benefit plans;

(vii) interest on business indebtedness;

(viii) rent on business property; and

(ix) other expenses necessary for the current conduct of business;

(B) does not mean

(i) bad debts;

(ii) contributions or gifts, other than those listed under (A)(vi) of this paragraph;

(iii) amortization and depreciation; or

(iv) losses by fire, storm, casualty, or theft;

(C) means zero for organizations with a nonprofit tax status under ~~section~~ O.K. 501(c) of the Internal Revenue Code;

(11) "insurer" means an insurance company licensed to transact accident and health insurance business in the state;

(12) "medical social services" means services rendered, under the direction of a physician by a qualified social worker holding a master's degree from an accredited school of social work, including but not limited to

(A) assessment of the social, psychological and family

4-L 20A

(B) appropriate action and utilization of community resources to assist in resolving such problems;

(C) participation in the developments of the treatments for ~~the~~ the insured person;

problems related to or arising out of an insured person's illness and treatment; (B) see above

(13) "physician" means a licensed practitioner of medicine, osteophathy, acupuncture, chiropractic, podiatry, psychology, and, for purposes of oral surgery only, a doctor of dental surgery or a doctor of medical dentistry;

(14) "psychologist" means a person who is licensed or certified as a clinical psychologist and has a doctoral degree and at least two years of supervised experience in clinical psychology in a licensed hospital or mental health center;

(15) "regular employee" means, with respect to an employer, an employee who either is a full-time employee, or who is expected to work at least 20 hours a week for at least 26 weeks during the next 12 months or who has actually worked at least 20 hours a week for at least 26 weeks in a continuous 12-month period;

(16) 'resident employer"

(A) means a person, partnership, association, trust, estate, corporation, whether foreign or domestic or the legal representative, trustee in bankruptcy or receiver or trustee of one of these, or the legal representative of a deceased person, including the state and a municipality of the state which has in its employ one or more individuals during a calendar year;

(B) refers only to an employer with a majority of employees employed in the state;

(17) "self-insurer"

(A) means an employer or an employee welfare benefit fund or plan which provides payment for or reimbursement of the whole or a part of the cost of covered hospital or medical expenses for covered individuals;

(B) does not include an employee welfare benefit fund or plan established before January 1, 1981, by an organization which is exempt from federal income taxes under the provisions of sec. 501 of the Internal Revenue Code and amendments to it except an organization described in section 501(c)(15) of the Internal Revenue Code;

(18) "skilled nursing facility" has the same meaning as "skilled nursing facility" under 42 U.S.C., sec. 1395x;

(19) "totally disabled" means the inability of an employee because of an injury or disease to perform the duties of an occupation for which he is suited by reason of education, training or experience, and, with respect to a dependent, the inability of the dependent because of an injury or disease to engage in substantially all of the normal activities of persons of the same age and sex in good health.

* Sec. 2. AS 39.30.090(1) is amended to read:

(1) A group insurance policy shall provide one or more of the following benefits: life insurance, accidental death and dismemberment insurance, weekly indemnity insurance, hospital expense insurance, surgical expense insurance, dental expense insurance, audio-visual insurance. alcoholism and drug dependency insurance, or other medical care insurance.

* Sec. 3. AS 39.30 is amended by adding a new section to read:

Sec. 39.30.092. COVERAGE FOR ALCOHOLISM AND DRUG DEPENDENCE. (a) The group insurance policy required by AS 39.30.090(1)

(1) shall provide coverage for alcoholism and drug dependence to include

(A) inpatient detoxification benefits for not less than 14 days of benefit each calendar year in a state-approved treatment facility or licensed hospital; payment of institutional and profes-

sional benefits shall be equal to and payable as any other covered condition, except a covered condition which, by the terms of the policy, has an internal restriction;

(B) inpatient treatment coverage benefits for not less than 30 days of benefit each calendar year in a state-approved treatment program; payment of institutional and professional benefits shall be at the same level as any other covered condition, except a covered condition which, by the terms of the policy, has an internal restriction; and

(C) outpatient treatment coverage benefits of not less than 30 visits each calendar year if treatment is provided by a licensed physician, state-approved treatment program, or state-certified professional substance abuse counselor; coverage shall include individual, family or group therapy; benefits shall be paid at not less than 75 per cent of the usual, customary and reasonable charge for a medical procedure, treatment or service in the geographic area;

(2) may not exclude dependents otherwise covered and may not limit coverage for alcoholism or drug dependence because of age, sex or state of illness;

(3) may not apply preexisting or named condition exclusions to deny coverage for alcoholism or drug dependence; and

(4) may require a physician's certification of necessity as a condition of payment for alcoholism or drug dependence treatment.

(b) The provisions of this section apply to group health insurance contracts and group service or indemnity type contracts issued to provide coverage for employees of the state and may apply to contracts for the benefit of employees of other participating governmental units only if the governing body of the governmental unit elects to have the provi-

sions apply.

(c) In this section,

(1) "alcoholism" means an illness or condition characterized by the habitual lack of self control in the use of alcoholic beverages, or use of alcoholic beverages to the extent that health is substantially

(B) appropriate action and utilization of community resources to assist in resolving such problems;

(C) participation in the development of treatment for the insured person;

impaired or endangered, or social or economic function is substantially disrupted;

(2) "drug dependence" means the condition of being physically or psychologically addicted to an opiate, opiate derivative, tranquilizer, amphetamine, barbiturate, or similar substance, but excluding nicotine, caffeine and alcohol;

(3) "state" means any state in the United States and includes the District of Columbia.

* Sec. 4. AS 39.30.100 is amended to read:

Sec. 39.30.100. DEFINITIONS. In AS 39.30.090 - 39.30.100 [AS 39.-30.090]

(1) "eligible employee" means

(A) an employee who has served in permanent full-time or part-time employment with the same governmental unit for 30 days or more, except an emergency or temporary employee, and

(B) an elected or appointed official of a governmental unit, effective upon taking the oath of office;

(2) "governmental unit" means the state, a borough, municipal corporation, or other political subdivision of the state, and the North Pacific Fishery Management Council;

(3) "insurance", "insurance carrier" and "insurance policy" include health care services, health care service contractors and contracts.

* Sec. 5. The provisions of secs. 2 - 4 of this Act apply to group policies or contracts delivered, issued for delivery, or renewed in this state after the effective date of this Act. A policy or contract providing coverage for eligible employees in this state delivered, issued for delivery, or renewed after the effective date of this Act shall be considered to provide the minimum coverage required by this Act even if the language of the policy or contract does not so specifically provide.

* Sec. 6. AS 47.05 is amended by adding new sections to read:

Sec. 47.05.070. MEDICAL ASSISTANCE BY INSURANCE OR SERVICE CONTRACTS. (a) The commissioner shall use available medical assistance funds to purchase and pay premiums on policies of insurance or pay the expenses on health maintenance organization service contracts or medical or hospital service contracts that provide one or more ~~the~~ of the medical services available under state medical assistance programs.

(b) The policy of insurance or the contract must by its terms guarantee

(1) to provide the medical services allowed under Alaska law;

(2) to provide medical services under policies of insurance or contracts in compliance with applicable laws and regulations;

(3) to provide the statistical data, records, and reports relating to the provision, administration, and costs of providing medical services as required by the commissioner.

Sec. 47.05.080. CONTRACTS WITH DIRECT PROVIDERS OF CARE AND SERVICE. (a) The commissioner may enter into nonexclusive contracts under which funds available for medical assistance may be administered and disbursed by the contractor to direct providers of medical and

remedial care and services available under medical assistance for services rendered and supplies furnished by them.

(b) A contract under this section shall

(1) oblige the contractor to make payments under the contract promptly and not later than 30 days after receipt of the proper evidence of the claim; and

(2) provide data, records, and reports required by the commissioner.

Sec. 47.05.090. IMPLEMENTATION. The commissioner shall implement the provisions of AS 47.05.070 - 47.05.100 when the commissioner determines that comparable benefits are available at equal or less cost than direct payments by the department to the providers of medical assistance.

Sec. 47.05.100. INTERIM PAYMENT. The department may make an interim payment before receipt of billing for service to providers who serve a large volume of state medical assistance clients under regulations of the department.

Sec. 47.05.110. INTEREST ON LATE PAYMENTS. When presented by a provider of medical services with a clean claim, the state shall pay

(1) interest at the rate of one percent per month when payment is delayed more than 30 days after presentation of the clean claim;

(2) interest at the rate of two percent per month when payment is delayed more than 90 days after presentation of the clean claim; and

(3) a full months interest entitlement if the claim is not paid by the 15th day of a calendar month.

Sec. 47.05.120. DEFINITIONS. In AS 47.05.070 - 47.05.120

(1) "clean claim" means a claim for payment which can be processed without obtaining additional information from the provider of

the service or from a third party; it includes a claim with errors originating in the department's claims processing system, but does not include claims from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity;

(2) "commissioner" means the commissioner of health and social services;

(3) "department" means the Department of Health and Social Services;

(4) "medical assistance" means Medicaid (AS 47.07), general relief medical (AS 47.25.120), catastrophic illness (AS 47.08), and crippled children's and maternal and child health programs (AS 18.05.-010).

* Sec. 7. AS 47.07.020(b) is repealed and re-enacted to read:

(b) Residents of the state for whom the Social Security Act allows optional medical coverage qualifying for federal financial participation are eligible for medical assistance.

* Sec. 8. AS 47.07.030 is repealed and re-enacted to read:

Sec. 47.07.030. MEDICAL SERVICES TO BE PROVIDED. Medical services to be offered to eligible persons include services eligible for federal financial participation under Title XIX of the federal Social Services Act.

* Sec. 9. AS 47.25.120 is amended to read:

Sec. 47.25.120. ELIGIBILITY FOR ASSISTANCE. Financial assistance may be given under AS 47.25.120 - 47.25.300 [, SO FAR AS PRACTICABLE UNDER THE CONDITIONS IN THIS STATE,] to

(1) a needy person who is eligible under the regulations of the department; and

(2) a medically needy person whose income is less than the medically needy income standard or who has incurred medical expenses

which equal or exceed the difference between the person's monthly income and the medically needy income standard; the medically needy income standard is 150 percent of the current Federal Community Services Administration poverty income guidelines for Alaska (45 C.F.R., sec. 1060.2).

* Sec. 10. AS 47.07.020(d) is repealed.

* Sec. 11. Sections 1, 7 and 9 of this Act take effect January 1, 1981.

* Sec. 12. Sections 2 - 6, of this Act take effect July 1, 1980.

Here's a quiz on "drinking and working" . . . and the answers:

Questions	Answers
• What percentage of an employee population are problem drinkers?	5%
• How many more company dollars in health benefits does a problem-drinking employee use than the average employee uses?	3 to 1
• What share of employee health claims are by problem drinkers?	15%
• What can be done about problem-drinking employees?	Rehabilitation
• What percentage of problem-drinkers can an employer expect to rehabilitate successfully?	70%
• At what cost to the employer?	None?

Large employers such as Scovill, Economics Laboratory, Illinois Bell, the Philadelphia Fire Department and Kennecott Copper have an edge on most readers. They knew the answers even before PERSPECTIVE provided them. That's because these five employers helped contribute the data.

But Kenneth Sarvis, insurance consultant to the Florida Department of Health & Rehabilitative Services, brought the facts into focus.

His report, INSURANCE COST SAVINGS DUE TO AN ADEQUATE ALCOHOLISM HEALTH BENEFIT, makes four major contentions borne out by employer data:

1. "Problem drinkers utilize a disproportionately high portion of health benefits."
2. "There is a high rehabilitation rate for problem-drinking employees."
3. "There is a significant reduction in the utilization of health and sickness benefits by rehabilitated problem drinkers."
4. "An employer can expect significant health insurance cost savings by providing employees health insurance for alcoholism."

Sarvis' data to support each of these contentions are considerable.

THE TOLL . . .

The U.S. Department of Health, Education & Welfare has issued a report on alcohol abuse. It says:

- An estimated 10 million Americans are either problem drinkers or alcoholics.
- Drinking may be to blame for as many as 205,000 deaths a year.
- The economic toll from alcohol problems was about $43 billion in 1975 (lost production, medical bills, other expenses).
- Alcohol may be involved in: up to one-third of all suicides, half of all murders, half of all traffic deaths, one-fourth of all other accidental deaths.
- Alcohol is "indisputably involved" in causing cancer.

But . . .

- Programs to treat problem drinkers and alcoholics increased from 500 in 1973 to nearly 2,400 in 1977.

CONTENTION NO. 1:

"Problem drinkers utilize a disproportionately high portion of health benefits."

Sarvis says:

"Employee health is considerably affected by problem drinking."

He cites work done by Dr. Wilton Maxw , studying a sample of employees with sickness or injury absence of eight days or more for which sickness payment was made. Each eight-day absence is called a "case" in the following tabulation:

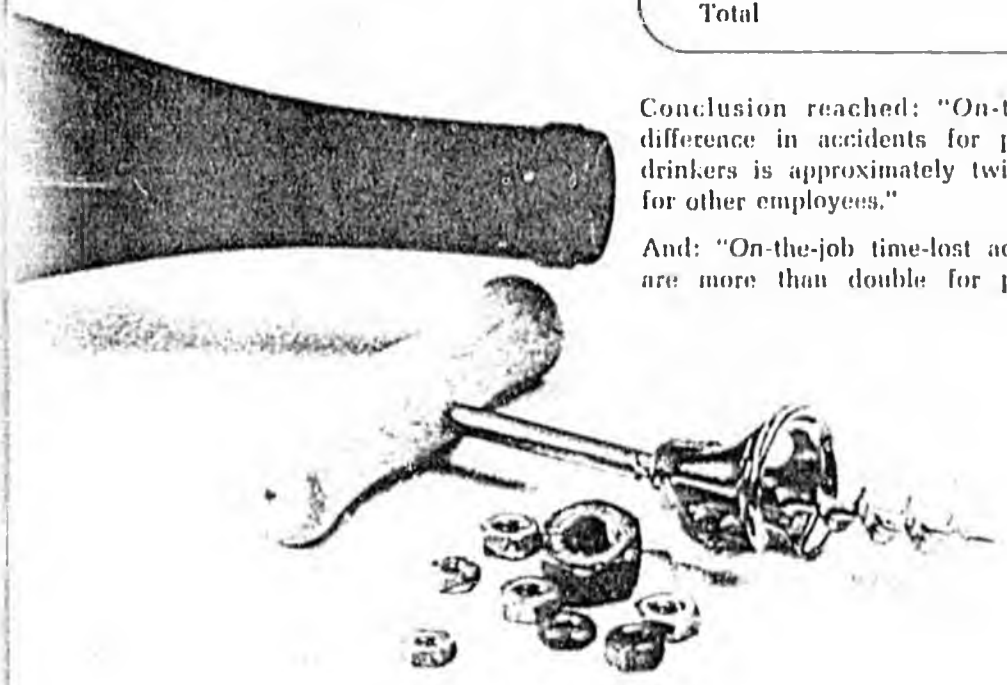
Description	Problem Group	Control Group
Number of cases	364	149
Average number of cases per employee	7.6	3.1
Total days absent	11,672	4,648
Average number of days absent per employee	243.2	96.8
Total sickness payments	$108,495	$36,862
Average sickness payment per employee	$ 2,260	$ 768

Conclusion reached: *"The average and total sickness payments indicate alcoholics cost employers three times the sickness payments of other employees."*

Moreover: "The problem group's total days absent is 2½ times that of the control group, indicating a tremendous loss in production time to the employer."

Maxwell, a PhD in sociology, also studied how frequently accidents happened to members of the two study groups:

Accident Class	Problem Group	Control Group
On job (no time lost)	29	16.0
On job (time lost)	26	11.5
Off job (eight days or more lost time)	44	0.0
Total	99	27.5



Conclusion reached: "*On*-the-job difference in accidents for problem drinkers is approximately twice that for other employees."

And: "*On*-the-job time-lost accidents are more than double for problem drinkers, indicating that the type of accident attributable to problem drinkers is more costly to the employee than other non-alcohol related accidents."

Worst of all: "*Off*-the-job accidents numbered 44 for the problem-drinking group, zero for the control group."

Overall: "The problem-drinker accident rate was 3.6 times that of other employees, a distinctive cost differential to the employer."

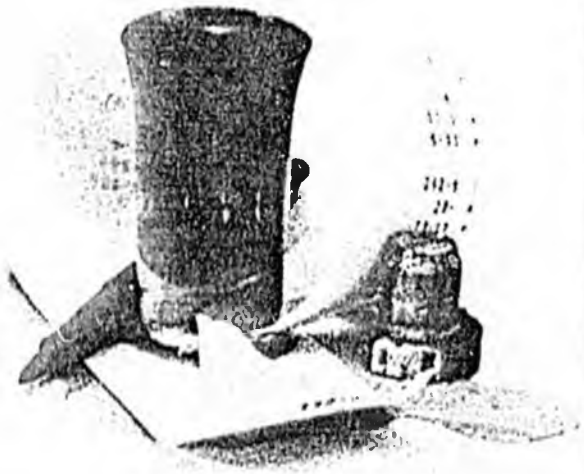
Maxwell explored the question of "how many hospital stays are attributable to problem drinking?" He cites the work of S. Pell and C.A. D'Alonzo in establishing frequency rates by type of illness or injury:

Selected Digestive Disorders		No. of Absences	Frequency Rate %
Gastrointestinal upsets	A	167	21.9
	C	66	7.6
Cirrhosis of liver	A	6	0.8
	C	0	0.0
Peptic ulcer	A	18	2.4
	C	13	1.5
Hernia	A	11	1.4
	C	4	0.5
Gall bladder disease	A	6	0.8
	C	7	0.8
Other digestive disorders	A	7	0.9
	C	13	1.5
Total	A	215	28.1
	C	103	11.9

A = Alcoholics C = Controls

Selected Respiratory Infections		No. of Absences	Frequency Rate %
Upper respiratory infection	A	173	22.6
	C	116	13.4
Influenza	A	71	9.3
	C	51	5.9
Bronchitis	A	35	4.6
	C	24	2.8
Pneumonia	A	15	2.0
	C	4	0.5
Total	A	294	38.5
	C	194	22.5

Selected Musculoskeletal Disorders		No. of Absences	Frequency Rate %
Arthritis	A	18	2.4
	C	5	0.6
Rheumatism	A	15	2.0
	C	7	0.8
Low back disorders, cause unspecified	A	22	2.9
	C	7	0.8
Bursitis	A	17	2.2
	C	5	0.6
Disc disorders	A	14	1.8
	C	2	0.2
Muscular strain	A	16	2.1
	C	6	0.7
Other	A	9	1.2
	C	14	1.6
Total	A	111	14.5
	C	46	5.3



Conclusion reached: "*The frequency rate of alcoholics is about three times that of other employees* for digestive and musculoskeletal disorders, and about two times that of other employees for respiratory infections," replicating other findings.

Sarvis comments: "These and similar studies indicate that problem-drinking employees are sick people who use a disproportionately high portion of employee group health insurance, contributing to high group insurance costs."

CONTENTIONS NO. 2 & 3:

"There is a high rehabilitation rate for problem-drinking employees."

"There is a significant reduction in the utilization of health & sickness benefits by rehabilitated problem drinkers."

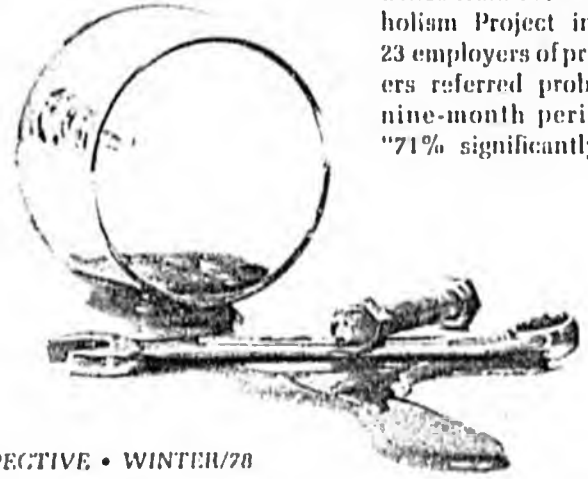
Sarvis finds "the success rate for rehabilitation of problem-drinking employees" to be "very high," indicating that "the possibility of job loss is an incentive for employees to seek rehabilitation."

He also finds that, "after problem drinkers are rehabilitated, there is a great reduction in their utilization of health and sickness benefits," thereby "significantly decreasing the cost of group health insurance."

He cites five employers who have proven track records at rehabilitating problem-drinking employees through a formal mechanism for early identification and referral:

Employer	# of Employees	"Processed"	% Rehabilitated	Savings
Scovill Mfg. Co. Waterbury, Conn.	6,500	180 in 3 years	78%	$186,550
Economics Laboratory, Inc. St. Paul, Minn.	3,500	N/I	80% for employees; 50% for dependents	Not indicated; but treatment costs were cut as much as 65% by using non-hospital facilities, such as alcoholism treatment centers.
Illinois Bell Telephone Co. Chicago, Ill.	N/I	402 in 5 years	72%	46% reduction in sickness disability and "a tremendous decrease in utilization of insurance plans."
Philadelphia Fire Department	3,410	N/I	N/I	55% decrease in sick leave for referred cases; 67% reduction in injuries; "a significant decrease in health insurance utilization."
Kennecott Copper Corp. New York City	N/I	N/I	N/I	After a year, costs for hospital, medical and surgical care were reduced 55%; alcoholics vs. other employees cost 5-to-1 for all sickness & accident activity, 3-to-1 for hospital, medical & surgical care.

N/I = not indicated



Sarvis also cites equally pointed evidence from the DePaul Industrial Alcoholism Project in Milwaukee, where 23 employers of primarily factory workers referred problem-drinking over a nine-month period. Their findings: "71% significantly improved, 46% of them reporting total abstinence and 26% 'essential' abstinence."

The consultant concludes that "*an employer can expect a high rehabilitation success rate for problem-drinking employees* — 70% is average — and a tremendous decrease in the utilization of health benefits." Savings are "maximized when an employer couples a formal mechanism for early identification and referral with appropriate health insurance coverage for alcoholism."

CONTENTION NO. 4:

"An employer can expect significant health insurance cost savings by providing employees health insurance for alcoholism."

Sarvis quotes some key numbers:

- *"5% of an employee population are problem drinkers."* (Source: National Institute on Alcohol Abuse & Alcoholism)
- *"A problem-drinking employee uses $3 in health benefits to $1 for the average employee."* (Source: Dr. Maxwell)
- "An employer can therefore estimate that problem-drinking employees are responsible for 15% of claims paid *annually*" . . . by multiplying the 5% times the 3 in the 3-to-1 ratio.
- If all problem drinkers could be rehabilitated and it could then be "assumed that alcoholism did not exist in an employee group, the employer would pay 10% less in claims" . . . reducing the 15% above by the difference between the numbers in the 3-to-1 ratio to arrive at the use by non-problem-drinkers.
- "It is impractical to believe that 100% of such savings could be achieved. Some can. If an employer provided adequate coverage for alcoholism and only 20% of problem-drinking employees were rehabilitated, this minimal number alone could save the employer around 2% of total claims paid" . . . multiplying the maximum 10% savings by the 20% rehabilitated.

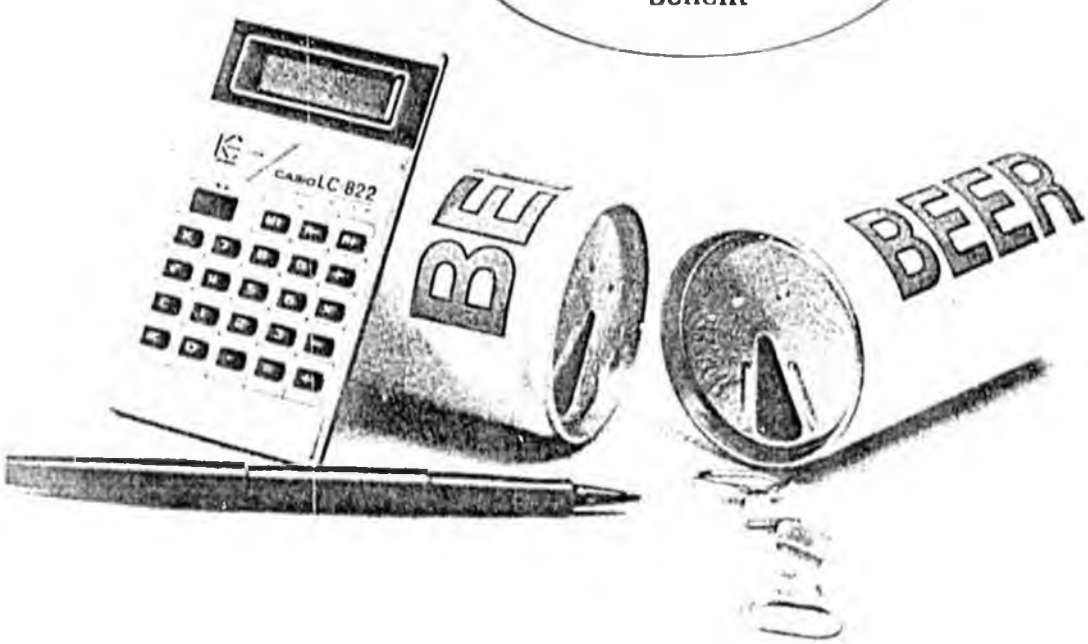
Sarvis then addresses four types of employer situations and presents evidence of savings from each.

A.
With an employee assistance program, *and* an alcoholism health benefit

B.
With an employee assistance program *but not* an alcoholism health benefit

C.
With an alcoholism health benefit, *but not* an employee assistance program

D.
With *neither* an employee assistance program nor an alcoholism health benefit



PROBLEM DRINKERS

Savings depend on the use of the following data:

Expected REDUCTION IN CLAIMS PAYMENTS As A Percent Of Total Claims Payments*

Problem Drinkers Referred As Percent Of Total Employee Population	Percent Increase In Total Premiums Due To Cost Of Alcoholism Benefit				
	0.5%	1.0%	1.5%	2.0%	2.5%
1.0%	1.0%	0.5%	0.1%	—	—
2.0%	2.4%	1.9%	1.4%	1.0%	0.6%
3.0%	3.7%	3.2%	2.8%	2.3%	1.9%
4.0%	5.1%	4.6%	4.2%	3.7%	3.3%
5.0%	6.5%	6.0%	5.6%	5.1%	4.7%

* Problem-drinking employees should have been rehabilitated for at least one year to achieve the expected reduction in claims payments.

Expected REDUCTION IN PREMIUMS As A Percent Of Total Premiums*

Problem Drinkers Referred As Percent Of Total Employee Population	Percent Increase In Total Premiums Due To Cost Of Alcoholism Benefit				
	0.5%	1.0%	1.5%	2.0%	2.5%
1.0%	0.8%	0.3%	—	—	—
2.0%	2.2%	1.7%	1.1%	0.6%	0.0%
3.0%	3.5%	3.0%	2.4%	1.9%	1.3%
4.0%	4.9%	4.4%	3.8%	3.3%	2.7%
5.0%	6.3%	5.8%	5.2%	4.7%	4.1%

* An actual reduction in total premiums from one year to the next could be expected only if overall insurance program costs did not increase.

Here's what the tables tell an employer with 1,000 employees whose total premium is $1,200,000 a year ($100 a month x 12 months x 1,000 employees) and whose total claims payment is $1,080,000 — a 90% claims ratio (claims as a percentage of total premium):

If PROBLEM-DRINKING EMPLOYEES were referred at the rate of:	If the ALCOHOLISM BENEFIT increased total annual insurance premiums by:	These decreases would occur in		For net savings of				
		CLAIMS PAYMENTS	PREMIUMS PAID	CLAIMS PAYMENTS		PREMIUMS PAID		TOTAL
				%	Dollars	%	Dollars	Dollars
2% a year	1%	1.9%	1.7%	.9%	$ 9,720	.7%	$ 8,400	$18,120
5% a year	2.5%	4.7%	4.1%	2.2%	$23,760	1.6%	$19,200	$42,960

The two tables also alert employees to these facts:

Employer "A" — with both referral program and benefit — can determine the percent of problem drinkers who need to be referred vs. the cost of the alcoholism benefit to reach the cost savings he desires.

Employer "B" can determine what it will cost to add an alcoholism health benefit in order to achieve desired insurance cost savings.

Employer "C" can determine how the cost of establishing an employee assistance program in order to increase problem-drinking referrals would net out insurance cost savings.

Employer "D" can determine the cost of both referral program and benefit to produce desired insurance cost savings. ◻

THE LEGISLATURE OF THE STATE OF ALASKA
ELEVENTH LEGISLATURE

FISCAL NOTE

I. REQUEST

Bill/Resolution No. CS for SS Senate Bill 227

Title Insurance for Alcoholism and Drug Dependence

Requested by _____ Date _____

II. FISCAL DETAIL

Agency Affected Administration - Division of Retirement and Benefits

Program Category Affected Retirement and Benefits (OTHER BENEFITS)

BRU, Program, or Subprogram(s) Affected 02-96-8-01-02-00

(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

		FY 79	FY 80	FY 81	FY 82	FY 83	FY 84
100	PERSONAL SERVICES						
200	TRAVEL						
300	CONTRACTUAL						
400	COMMODITIES						
500	EQUIPMENT						
600	LAND & STRUCTURES						
700	TRS STATE MATCH						
100	BENEFITS		282.0	338.4	406.1	487.3	584.8
	TOTAL		282.0	338.4	406.1	487.3	584.8

FUNDING (Thousands of Dollars)

GENERAL FUND	230.8	277.1	332.6	399.2	478.9
FEDERAL FUNDS	13.0	15.6	18.7	22.4	26.9
VETERAN'S FUND	0.6	0.7	0.8	1.0	1.2
FISH & GAME FUND	1.7	2.0	2.4	2.9	3.5
HIGHWAY FUND	3.7	4.4	5.3	6.3	7.6
AIRPORT FUND	8.2	9.8	11.8	14.1	17.0
CAPITAL FUND	24.0	28.8	34.5	41.4	49.7
PERS					
TRS					

POSITIONS NONE

FULL TIME						
PART TIME						
TEMPORARY						

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

1. Approximately 8,900 State employees are currently covered under the State Group Health Care Plan.

2. The cost to implement the provisions of this bill will be $2.64 per employee per month.

3. Estimate that the cost to provide continued coverage will increase 20% each year for the immediate future. However, an effective alcoholism/drug dependency program should help to reduce overall health care claim experience in the future.

4. Cost for coverage of political subdivisions (approximately 50 subdivisions) participating in group insurance not included; recommend that the Alaska Municipal League, 204 Franklin St., Juneau, AK 586-1325, be contacted for input.

Paul B. Arnoldt

IV. DATE 3/30/79 PREPARED BY Paul B. Arnoldt, Director

AGENCY Division of Retirement & Benefits

PHONE 465-4460

Original: Legislative Finance

cc: Budget and Management

Prime Sponsor (First Legislator Named) Senator Colletta & Senate HESS

THE FOLLOWING DOCUMENT(S) MAY NOT FILM LEGIBLY BECAUSE OF POOR QUALITY OF THE ORIGINAL.

Health

(Albany, N.Y.) Times-Union, May 2, 1978

Blue Cross insuring alcoholism treatment

By [illegible] FAIRFIELD

Pioneering insurance coverage for alcoholism treatment will be provided later this year by Blue Cross of Northeastern New York, which is hosting a two-day Albany conference on the plan with other Blue Cross systems in the state.

The Slingerlands-based Blue Cross group will be the first to provide the coverage in New York state, and among the first in the nation.

But other Blue Cross groups may not be far behind, and they sent representatives to the Quality Inn Monday to discuss the design and introduction of alcoholism coverage for every region in the state.

Coverage now exists for hospital treatment of alcoholics in the acute final stages of the disease. The sort of coverage planned by the local Blue Cross group will dramatically expand the availability of treatment programs.

The coverage will include 30 days of "intermediate care" in a residential facility; 30 outpatient visits per individual, and 15 outpatient visits for the individual's family.

These options would be available to a patient during a 365-day period; he can renew them once. He is then entitled to 30 visits during the rest of his life.

The present hospital acute care only coverage "really does not get at the drinking behavior itself," explained James M. Stewart, community consultant to Blue Cross of Northeastern New York.

[illegible] ded by the [illegible], however, [illegible] Blue Cross [illegible] the coverage in the [illegible] areas of the country have found that [illegible] alcoholics who need help still don't seek it, partly because many don't recognize the problem, according to Howard Dallowitz of the Blue Cross and Blue Shield Associations in Chicago.

To counter that expected problem Stewart says the local Blue Cross will actively market the expanded coverage, which may become available as early as October.

It will initially be available to [illegible] employer groups which comprise 50 percent of Blue Cross' membership. Blue Cross covers 13 counties, "50 percent of the citizens here," said Dr. Clifton C. Thorne, Blue Cross president.

Stewart couldn't provide specific figures on the added cost of the coverage to subscribers, but said "relatively speaking, as new benefits go," it is "modest."

Among the speakers Monday at the conference, which concludes today, was State Sen. Dale M. Volker, chairman of the Senate Subcommittee on Alcoholism.

He described the high cost of alcoholism to society and its prevalence, even stating it was a problem at the Capitol. He said if the problem were examined there, or in "any pressure place" or "any state capital . . . you might come up with some frightening results."

50:E7

THE PRECEDING DOCUMENT(S) MAY NOT FILM LEGIBLY BECAUSE OF POOR QUALITY OF THE ORIGINAL.

Health

(Albany, N.Y.) Times-Union, May 14, 1978

Blue Cross to sell alcoholism coverage

By JOHN FAIRHALL

Blue Cross' "hardest marketing job" ever will begin locally this fall when its salesmen start knocking on subscribers' doors with comprehensive alcoholism insurance plans.

The first Blue Cross group in the state to announce the added coverage, Blue Cross of Northeastern New York has its work cut out.

Unlike insurance benefits such as general hospital coverage, which obviously are necessary, alcoholism has long been an underestimated problem.

"Only in the last decade" has the problem been viewed as a disease, points out James M. Stewart, community consultant to the 13-county Blue Cross group.

He thinks "of the Dick Van Dykes who only in the last few years have come forward and said 'I am an alcoholic' or the Betty Fords who make public acknowledgement."

So although alcoholism is "the third largest health problem confronting American society after heart disease and cancer," according to one area expert, Blue Cross believes it will have to add community education to its marketing efforts.

"It is perhaps the hardest marketing job we've ever taken on," Stewart says.

What Blue Cross will be selling, as early as October, is alcoholism insurance beyond the hospitalization coverage already provided. An alcoholic suffering from organic problems caused by the disease or in need of detoxification can under present policies get inpatient hospital treatment, according to Stewart.

What he can't get, but will soon be offered, is a package providing 30 days of "intermediate care" at a residential facility; 30 outpatient visits per individual, and 15 outpatient visits for the individual's family.

These are available during a 365-day period and be may be repeated once. A patient is then entitled to 60 other visits during the rest of his life.

This treatment will get at "the drinking behavior itself," which is not addressed in present hospital care.

The insurance, which initially will be provided to Blue Cross groups totaling 70 percent of its subscribers, will eliminate the financial barrier now separating many alcoholics from treatment.

But at the outset Stewart doesn't expect a rush to buy the added protection, which he says will come at a relatively "modest" cost. Part of the reason is that the disease is so little acknowledged, even by its victims.

If there were a sudden and large demand, it would probably overwhelm treatment programs available in the area. There is no "intermediate care" residential center now available in the area, Stewart says.

But Blue Cross believes the insurance coverage will stimulate growth of treatment programs.

59:E8

Wilmington (Del.) Evening Journal, January 24, 1978

Blue Cross Stops Funds, Dooming New Center for Alcoholics

By IDA KOSCIESZA

Blue Cross says it won't pay for treatment at Delaware's only private alcoholism rehabilitation center, and the people who run the center say that means Delaware won't have a private alcoholism treatment center.

The board of Blue Cross and Blue Shield of Delaware yesterday voted not to extend a contract to Harbour House, a 33-bed facility in Milford.

And James F. Edwards, director of HarbourHouse, said the decision probably means the end of the 6-month-old center.

"I would assume we will close tomorrow," Edwards said bitterly.

Occupancy at Harbour House, described as "excellent' three months ago, has fallen sharply since word got out that Blue Cross might not pay for care there, Edwards said. There are six patients at the center now, he said.

Blue Cross officials said the decision against paying for the Harbour House program was a "cost containment" measure, but both Edwards and M.T. "Ted" Lassiter, director of the Delaware Alcoholism Council, charged that the health plan picked alcoholism for its economy move because of the "stigma" attached to the disease.

"That's typical. Nobody cares about alcoholics," Edwards said.

Blue Cross had been studying the Harbour House issue since mid-August. Charles R. Richards, vice president for provider and professional relations, said Blue Cross staff recommended against paying for the program because: Blue Cross's resources are limited, alcoholism has not been designated a priority by federal or state authorities, and the region has adequate alcohol treatment facilities.

"When it comes to providing money, [alcoholism] may not be a priority," said Lassiter. "But as far as problem areas, it is one of the largest in the country."

Two doctors on the Blue Cross board agreed.

"Alcoholism is a national problem. Why it's not a priority I don't know," said Dr. John M. Levinson.

Dr. Alfred Lazarus suggested that Blue Cross, which has recently been pushing the idea of preventive health care, is going back on its commitment by refusing to pay for alcoholism treatment. Lazarus added, however, that he has had no trouble finding a bed in a treatment facility for his own alcoholic patients.

"If the bed situation is adequate, let's say so . . . not that alcoholism is not a priority," he said.

Delaware residents currently can be treated for alcoholism at private facilities in Maryland, Pennsylvania and New Jersey. There is a one-to-two-week waiting period for these centers, Richards said. The Delaware Blue Cross plan will pay for treatment at these out-of-state rehabilitation facilities.

Harbour House officials claim Blue Cross would save money by paying for the Delaware facility because Harbour House's $1,712 charge for its 30-day program is lower than rates at the out-of-state rehabilitation centers.

But Blue Cross president William E. Flaherty said that is not the case. Harbour House will not substitute for the out-of-state facilities, but will add to them, Flaherty said.

"When you add facilities they get filled," he said.

With alcoholism facilities both in and out of state, Blue Cross would wind up paying for both, Flaherty predicted.

In any case, Blue Cross does not pay the full charges of the Maryland and Pennsylvania facilities, Flaherty said. It pays on a cost basis that works out at about $55 a day, he said.

Two recent Blue Cross cost containment initiatives, a fee cap negotiated with the state's doctors and an improved budget review process with the hospitals, have achieved savings of $[illegible] to $[illegible] a year, Flaherty said. A contract with Harbour House would cost Blue Cross more than $100,000 a year and would completely wipe out the other savings, he said.

The state's health planning agencies approved Harbour House last year. In the past Blue Cross has gone along with the decisions of these planning groups, but Richards said plan[illegible] criteria for alcoholism rehab[illegible] centers are "weaker than [illegible] facilities."

[illegible] House is [illegible] by [illegible] Health [illegible] welcomes a component [illegible] It [illegible] [illegible] from [illegible] Harbour [illegible] House, which is owned [illegible] Joint Ventures, Inc., [illegible] [illegible] of private [illegible] [illegible]

(Newark, N.J.) Star-Ledger, September 20, 1978

Dispute slows health plan for alcoholics

By VINCENT R. ZARATE

The program that was supposed to aid thousands of alcoholics through added benefits from Blue Cross and Blue Shield has barely gotten off the ground, even though the law ordering it is more than a year old.

The Star-Ledger has learned the Department of Insurance and Blue Cross have been wrangling for months on language in new policies to provide those extra benefits.

Richard J. Diehl, executive director of the New Jersey Alcoholism Association Inc., charged yesterday that because of "unbelievable bureaucracy" thousands of alcoholics and near-alcoholics aren't getting the benefits unless they pay for them out of their own pockets.

The law was signed June 2, 1977, and became "effective immediately" requiring all health insurance companies, including Blue Cross and Blue Shield, to pay the cost of rehabilitation, detoxification and out-patient treatment of those suffering alcoholism.

"There's been a continuous policy of delay which is resulting in alcoholics in New Jersey slowly losing rights gained on the floor of the Legislature," Diehl said.

"All I know is we were promised in June of 1977 by the Governor and the Legislature that Blue Cross and Blue Shield would be required to give alcoholics the added benefits for treatment, and nothing has happened . . . nothing."

Diehl and Steven Blader, assistant deputy public advocate in the Division of Public Interest, have quietly been fighting for months — not only to get the program off the ground but to get government employes covered, too.

Because of an apparent "technical oversight" government employes cannot be included, Blader explained.

Blader said, "They forgot to amend the Public Health Benefits Act to include government employes, and we are now attempting to get the Public Health Benefit Commission to include them by a special order."

The sponsor of the legislation, Assemblyman James W. Bornheimer (D-Middlesex), said, "It's unbelievable" that the new benefits have not been implemented. Bornheimer said he would "push to get this whole thing rolling."

Insurance Commissioner James J. Sheeran said Blue Cross forms to amend contracts to include the added benefits have been rejected "because they do not conform to the intent of the law."

Donald Daniels, executive vice president for Blue Cross, said the nonprofit hospital insurance company has been trying to implement the program but can't until the Insurance Department approves its new contract forms.

"We have here," said Diehl. "The inability of the bureaucracy to implement the law . . . it's everybody's fault."

Gov. Brendan Byrne signed into law four bills requiring private insurance companies as well as Blue Cross and Blue Shield to, for the first time, pay for the rehabilitation of alcoholics.

• • •

While the law became effective last year, it was acknowledged then by both Blue Cross and Insurance Department officials that at least two months would be needed to spell out the regulations on how to deal with new aspects of the extended insurance coverage.

But according to Sheeran, the first regulations were not published until May, after a series of meetings with the companies involved.

Blue Cross officials blame the department for the delay, while Sheeran said, "Meetings had to be held and public hearings had to be held to cover all the points."

Blue Cross contends the program's benefits should be paid when "medically necessary," while Sheeran says they should be "therapeutically necessary."

Sheeran said if Blue Cross has its way it would

Continued

undermine the legislative intent, which was to "throw all weapons we have to combat alcoholism and treat it as a disease."

Blue Cross' attempt to restrict the added coverages to "medical necessity," Sheeran said, would limit the benefits.

Daniels said Blue Cross wants to provide the added coverage and "cooperate" with the department, denying there is a "fight between Blue Cross and the Insurance Department."

The recent newsletter of Blue Cross/Blue Shield to its subscribers heralds that both "will soon expand their coverage to include state-mandated benefits for the treatment of alcoholism."

That article states, "The new rider includes a provision to assure that all treatment is medically necessary, is provided at the appropriate level of care, and is administered by licensed professionals under a state-certified alcoholism treatment program."

An alcoholic at present gets paid full Blue Cross payments for the days spent in a hospital, but does not get paid for rehabilitation or out-patient treatment even though the law of June 2, 1977 requires it.

The alcoholism association, a public interest group based in Trenton, reports that at least one residential center has suffered $43,850 in losses because Blue Cross has refused to pay for added benefits to government employes.

Diehl said Seabrook House in Bridgeton treated 35 state employes, incurred the unpaid claims, and then had to stop admitting state employes because they are not covered under the law.

He said two other clinics, Alina Lodge in Blairstown and the Carrier Clinic in Princeton, have also had to reject government employes unless those employes paid for rehabilitation out of their own pockets.

The issue of including the thousands of government employes into the added Blue Cross benefits program for treatment of alcoholics is to be brought up today at a special meeting of the State Health Benefits Commission.

(Newark, N.J.) Star-Ledger, September 21, 1978

Alcoholic aid is ordered for state workers

By VINCENT R. ZARATE

The State Health Benefits Commission yesterday directed that an estimated 175,000 government employes be included in the health insurance program treating alcoholism.

The commission took the action in Trenton to correct an "oversight" in the law enacted 15 months ago requiring Blue Cross and Blue Shield and all other health insurance companies to pay for benefits of rehabilitation, detoxification and other out-patient treatment of alcoholics.

The government employes were inadvertently omitted from the law because the Legislature forgot to amend the State Health Benefits Act when it approved the added health benefits for alcoholics.

• • •

Attorney General John S. Degnan had in January ruled that public employes enrolled in the state health benefits program could not be included in the extended program for alcoholics because the act was not amended by the Legislature.

However, he said the three-man State Health Benefits Commission could use its discretionary power to extend the alcoholic treatment program to state employes.

William Joseph, director of pensions, said yesterday's action will bring into the program 65,000 state employes, and 110,000 employes of 17 county governments, 318 municipalities, 453 school districts and 180 public agencies enrolled in the state health program.

Riley Regan, director of the Division of Alcoholism in the State Health Department, estimated there are "at least" 10,500 state employes with alcoholic problems and they would benefit from the program.

Even though the law became effective 15 months ago, no payments for out-patient treatment, rehabilitation or detoxification have been made and the program has not been implemented for anyone.

The major reason for the delay is the fight between Blue Cross and the Insurance Department over language in riders to the Blue Cross policy on what benefits would be offered.

The Health Benefits Commission is composed of the insurance commissioner, state treasurer, and president of Civil Service.

• • •

They were represented at yesterday's meeting by George LaPalce of the Insurance Department, Robert DeNicholas of Civil Service, and John Flynn of Treasury.

The drive to get state employes included in the program was initiated by Richard J. Diehl, executive director of the New Jersey Alcoholism Association Inc., and Steven Blader, assistant public advocate in the Division of Public Interest.

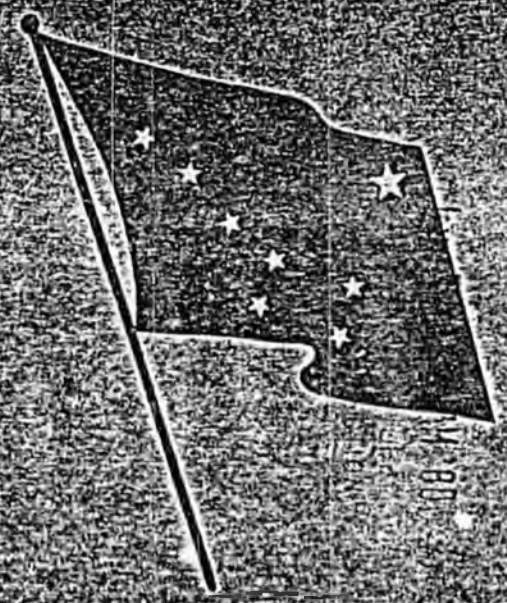
The sponsor of the legislation extending alcoholism treatment benefits to health insurance policies and pending in the Assembly is Assemblyman James Bornheimer (D-Middlesex). He was represented at the meeting by his aide, Leona Kaufman.

For information regarding claim payments for allowable charges, please call this toll-free number:

(Access Code) + 800-426-6933

The State of Alaska's Group Health Care & Life Insurance Benefits are administered by:

The Division of Retirement and Benefits
Pouch CR
Juneau, Alaska 99811
Paul B. Arnoldt, Director



State of Alaska

Group Health Care & Life Insurance Benefits

For Employees of the State of Alaska

General Government, Confidential, Peace Officers, and Employees Not Covered by Collective Bargaining

July 1, 1979

Travel/Ambulance

The following travel and ambulance costs will be paid by the Plan:

- Transportation to a hospital by professional ambulance.
- Round trip transportation by commercial airline from the place where the illness or injury occurred to the nearest place professional treatment can be obtained.

Your air transportation will be covered only if:

(a) a life-endangering situation exists that requires immediate transfer to a hospital that has special facilities for treating the condition;

(b) surgery is needed that cannot be performed locally; or

(c) a condition exists which cannot be treated locally. In that case, transportation benefits in any one benefit year will be limited to:

(1) one visit and one follow-up visit which is preauthorized as a condition requiring therapeutic treatment which cannot be provided locally;

(2) one visit for pre- or postnatal maternity care and one visit for the actual maternity delivery which cannot be treated locally;

(3) one pre- or postsurgical visit and one visit for the actual surgical procedure which cannot be provided locally; or

(4) one visit for each allergic condition which cannot be treated locally.

If you require air transportation for (b) or (c), your doctor must provide written certification and detailed medical documentation of the existing condition in advance of your trip. The Blue Cross Plan will then determine how much of the transportation charges, if any, are eligible for coverage under the plan.

If the patient is a child under 12 years of age, the transportation charges of a parent or legal guardian accompanying the child will be allowed if the attending physician certifies the need for such attendance.

Transportation charges for a physician and/or registered nurse may be covered only when determined necessary by the Blue Cross Plan.

IMPORTANT: Travel benefits apply only to the conditions covered in the medical section of your Group Health Care & Life Insurance Benefits booklet. They do not apply to the audio, dental or vision section.

Travel preauthorization will not be given for diagnostic purposes or second opinion diagnosis. Postauthorization may be given after review of medical documentation for these procedures.

Travel claims submitted under items (b) and (c) will be subject to denial unless they are preauthorized.

An "Air Travel Preauthorization Application," Form 400-4868, is required in all instances that do not involve a genuine life endangering emergency. You may obtain a supply of these forms from your employer.

For travel which is not of a life endangering nature, but must be made before preauthorization can be obtained by using this form, you should call the Blue Cross travel representative, (access code) and 800-426-6933 for information and instructions.

Alcoholism Treatment Services

Your Plan will pay for treatment as an inpatient in a hospital or alcoholism treatment facility. If services are received in an alcoholism treatment facility that does not have an agreement with the Blue Cross Plan, payment will be limited to $1,000 in any benefit year.

Mental and Nervous Disorders

Physician's services for mental and nervous disorders will be covered as follows:

- 50 percent of eligible expenses.
- Care received in the hospital or physician's office.

The maximum amount of benefits available is $2,500 for each covered member in any one benefit year. Services must be provided by a M.D., D.O. or licensed psychologist.

MEDICAL EXPENSES NOT COVERED

Limitations and Exclusions

The State's Comprehensive Medical Plan does not cover any condition, ailment or injury for which you may receive:

(a) benefits from your employer's liability or Workmen's Compensation Law;

(b) benefits available under any state or federal act, even though you or your dependents waive rights to such benefits; or

(c) services provided by a hospital owned or operated by a state or federal agency.

Services provided in the following facilities are not covered:

(a) an institution which is primarily a rest home, home for the aged, nursing home, skilled nursing facility, convalescent home or any facility of like character; or

(b) convalescent or custodial services regardless where such services are provided, or any portion of a hospital stay which is primarily convalescent or custodial.

Charges for or in connection with cosmetic treatment or surgery will not be paid unless:

(a) treatment or surgery is for injuries sustained in an accident which occurs while you or your dependents are covered, and such treatment or surgery is started within 90 days of the accident; or

ARTICLE 7. MEDICAL TRANSPORTATION SERVICES.

Section
500. Prior authorization
505. Emergency transportation coverage
510. Type of transportation
515. Mortuary expenditure
520. Public rates
525. Medicare coverage
530. Definitions

7 AAC 43.500. PRIOR AUTHORIZATION. (a) All non-emergency, in-state medical transportation under $250 per person one way must have prior authorization by the division's regional office manager or his or her designee. All non-emergency, in-state medical transportation exceeding $250 per person one way and all non-emergency, out-of-state medical transportation must be authorized in advance by the medical practice review section of the division.

(b) Evidence of prior authorization must be present on the billing form before payment will be made.

(c) The division will not authorize payment to a provider of medical transportation for non-emergency medical transportation without first verifying medical need for those services.

(d) The medical assistance coupon or identification card is not to be used as an authorization for medical transportation. Rather, the coupon or identification card is evidence of current eligibility. (Eff. 8/18/79, Reg. 71)

Authority: AS 47.05.010
AS 47.07.050

7 AAC 43.505. EMERGENCY TRANSPORTATION COVERAGE. In emergency situations, the division will assume only the necessary expenses of transporting the beneficiary to the nearest facility where the emergency medical need can be met. (Eff. 8/18/79, Reg. 71)

Authority: AS 47.05.010
AS 47.07.050

7 AAC 43.510. TYPE OF TRANSPORTATION. (a) The choice of provider of medical transportation will be determined by the beneficiary's medical condition, distance to the place of treatment, and availability of a suitable provider of medical transportation, using the least expensive conveyance consistent with these conditions.

(b) If a friend or relative will provide the required medical transportation, payment may be made as a medical expense at a reasonable rate determined by the division.

(c) When the services of more than one provider of medical transportation are available, the division will use the services of the provider with the lowest rate which can provide services appropriate to the beneficiary's medical needs.

(d) The division will not pay for ambulance service which appears to be excessive for the distance traveled and the medical needs of the beneficiary.

(e) While ambulance service may be required to transport a beneficiary to a medical provider, a less expensive mode of travel may be adequate for the return of the beneficiary.

(f) The division will work cooperatively with providers of medical transportation to schedule travel on the least busy days and during the most convenient hours during those days, and will make every effort to arrange for transport of more than one beneficiary on a single trip where appropriate. Such arrangements will reduce charges as may be agreed upon by the provider of medical transportation and the division. (Eff. 8/18/79, Reg 71)

Authority: AS 47.05.010
AS 47.07.050

7 AAC 43.515. MORTUARY EXPENDITURE. Medical transportation services are those services provided by the carrier up to the time death is known or until the deceased beneficiary, alive at the time of pickup, reaches the source of medical care. Thereafter, transportation expense of the deceased beneficiary is a mortuary expenditure which is not covered by medicaid. (Eff. 8/18/79, Reg. 71)

Authority: AS 47.05.010
AS 47.07.050

7 AAC 43.520. PUBLIC RATES. (a) In order to qualify for payment by the division, an ambulance service must comply with the provisions of secs. 5-85 of this chapter. In addition, ambulance providers shall:

(1) file with the division a current schedule of public rates;

rates may be changed only by filing an amended public rate schedule; for medicaid purposes, original rates become effective upon filing; rate changes are effective on the first day of the first month which is at least 30 days after the date of filing the change; in no event may the effective date of the change in rates precede the date the rates are effective for the general public; all rates are subject to final acceptance, rejection, or modification by the division;

(2) customarily charge the general public at those rates specified in the public rate schedule and routinely pursue unpaid charges in anticipation of collection; i.e., a volunteer or community ambulance that operates without charge for services to the community must not charge the division for services provided to beneficiaries;

(3) be in compliance with the regulations and policies of the Division of Public Health or other local licensing body; out-of-state ambulance companies providing services to Alaska residents must be suitably licensed in the state where they operate.

(b) Charges to the division include only those services and specific charges detailed on the certification form, and may not exceed the charges to the general public for like services; any carrier may charge the division at rates less than those charged to the general public for like services. (Eff. 8/18/79, Reg.71)

Authority: AS 47.05.010
AS 47.07.050

7 AAC 43.525. MEDICARE COVERAGE. For those beneficiaries 65 years of age or older, or those under 65 who receive medicare coverage due to disability, every effort must be made by the ambulance company to use fully the benefits of 42 CFR 405.201--405.488 before billing the division. (Eff. 8/18/79, Reg.71)

Authority: AS 47.05.010
AS 47.07.050

7 AAC 43.530. DEFINITIONS. In secs.500-525 of this chapter

(1) "ambulance" means any privately or publicly owned vehicle that is regularly provided or offered to be provided for the emergency transportation of persons suffering from illness, injury or disability and licensed by the Division of Public Health or local licensing body; police, fire, funeral home, and other vehicles which serve a dual purpose, one of which meets this definition also may be considered ambulances;

(2) "emergency transportation" means that transportation necessary immediately when a sudden, unexpected occurrence creates a medical emergency;

(3) "escort" means a person who accompanies a beneficiary to or from a source of medical care; the purpose of their accompanying a beneficiary may be the result of medical necessity or may be due to the age or physical or mental capacity of the beneficiary; the accompanying person may be medically-trained but is not required; no compensation will be paid by the division to the accompanying person;

(4) "food and lodging" means meals and sleeping facilities for the beneficiary, escort, or both, while the beneficiary is receiving medical care at a facility away from the place where the beneficiary regularly resides; meals and lodging provided by friends or relatives of either the beneficiary or the escort are not included; nor are accomodations provided by hospitals or nursing homes included in this definition;

(5) "medical transportation" means transportation for medical purposes to and from any source of medical care or between medical facilities, and food and lodging incidental to such transportation for both beneficiaries and escorts when needed;

(6) "provider of medical transportation" means the owner or operator of a private automobile, municipal bus, inter-community bus, taxi, scheduled airline, ferry, wheelchair coach, train, chartered aircraft, chartered boat, or other mode of transportation commonly used to transport a person. (Eff. 8/18/79, Reg. 71)

Authority: AS 47.05.010
AS 47.07.050

CURRENT STATUTE

Chapter 07. Medical Assistance for Needy Persons.

Section
10. Purpose
20. Eligible persons
30. Medical services to be provided
40. State plan for provision of medical assistance
50. Implementation of the medical assistance program
60. Receipt of federal money
70. Reimbursement for cost settled providers
80. Definitions

Sec. 47.07.010. Purpose. It is declared as a matter of public concern that the needy persons of this state receive uniform and high quality medical care, regardless of race, age, national origin, or economic standing. Accordingly, this chapter authorizes the Department of Health and Social Services to apply for participation in the national medical assistance program as provided for under title XIX of the federal Social Security Act. (§ 1 ch 182 SLA 1972)

Sec. 47.07.020. Eligible persons. (a) All residents of the state for whom the Social Security Act requires medicaid coverage are eligible to receive medical assistance under title XIX of that Act (42 U.S.C. 1396 et seq.).

(b) In addition to the persons specified in (a) of this section, the following optional groups of persons for whom the state may claim federal financial participation are eligible for medical assistance:

(1) persons eligible for but not receiving assistance under any plan of the state approved under part A of title IV (aid to families with dependent children), or title XVI (supplemental security income), of the Social Security Act;

(2) persons in a general hospital, skilled nursing facility or intermediate care facility, who, if they left the facility, would be eligible for assistance under one of the federal programs specified in (1) of this subsection;

(3) persons under 21 years of age under supervision of the department for whom maintenance is being paid in whole or in part from public funds and who are in foster homes or private child-care institutions; and

(4) aged, blind, or disabled persons, who, because they do not meet income and resources requirements, do not receive supplemental security income under title XVI of the Social Security Act, and who do not receive a mandatory state supplement, but who are eligible, or would be eligible if they were not in a general hospital or skilled nursing facility or intermediate care facility to receive an optional state supplementary payment;

(5) persons under 21 years of age in an institution designated as an intermediate care facility for the mentally retarded who are financially eligible as determined by the standards of the Federal Aid to Families with Dependent Children program;

House CS for CSSSSB227 (HESS) Revisions

* Sec. 7. AS 47.07.020(b) is repealed and re-enacted to read:

(b) Residents of the state for whom the Social Security Act allows optional medical coverage qualifying for federal financial participation are eligible for medical assistance.

(6) persons in a medical or intermediate care facility whose income while in the facility does not exceed 300 per cent of the supplemental security income benefit rate under title XVI of the Social Security Act but who would not be eligible for an optional state supplementary payment if they left the hospital or other facility.

(7) persons under 21 years of age receiving active treatment in a psychiatric hospital who are financially eligible as determined by the standards of part A of title IV (aid to families with dependent children) of the Social Security Act.

(c) Receipt of medical assistance under this chapter is considered to be an additional benefit to these individuals and does not affect other assistance payments, federal or state, for which the recipient is eligible.

(d) No additional groups may be added unless approved by the legislature. (§ 1 ch 182 SLA 1972; am § 1 ch 105 SLA 1974; am § 1 ch 117 SLA 1975; am § 1 ch 221 SLA 1976; am § 1 ch 11 SLA 1978)

Effect of amendments. — The 1975 amendment added paragraph (5) of subsection (b).

The 1976 amendment added paragraph (6) of subsection (b).

The 1978 amendment added paragraph (7) of subsection (b).

Legislative history reports. — For report on ch. 182, SLA 1972 (FCCS HCS CSSB 56), see 1972 House Journal, p. 1684. For report on ch. 105, SLA 1974 (CSSB 465), see 1974 Senate Journal, p. 525 and 1974 House Journal, p. 763.

* Sec. 10. AS 47.07.020(d) is repealed.

Sec. 47.07.030. Medical services to be provided. Medical services to be offered to eligible persons include inpatient hospital, outpatient hospital, rural health clinic, outpatient surgical care centers, laboratory and X-ray, refractions and eye examinations by ophthalmologists or optometrists, eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist, inpatient psychiatric hospital for persons age 65 or older and persons under age 21, skilled and intermediate nursing home, physician, home health care services, early periodic screening diagnosis and treatment of persons under 21 years of age, clinic services, treatment of speech, hearing and language disorders, and reasonable transportation to and from the point of medical care. No additional services may be provided unless approved by the legislature. (§ 1 ch 182 SLA 1972; am § 1 ch 35 SLA 1973; am § 2 ch 105 SLA 1974; am § 1 ch 12 SLA 1976; am § 2 ch 221 SLA 1976; am § 1 ch 82 SLA 1978)

* Sec. 8. AS 47.07.030 is repealed and re-enacted to read:

Sec. 47.07.030. MEDICAL SERVICES TO BE PROVIDED. Medical services to be offered to eligible persons include services eligible for federal financial participation under Title XIX of the federal Social Services Act.

Summary Sheet

House CS for CS for Sponsor Substitute for Senate Bill No. 227
(In thousands of dollars)

	Total	Federal	State	New Positions
1. Addition of Medicaid Services and New Eligibles	$24,194.5	$15,717.0	$ 8,477.5	17
2. Decrease of GR-Med. as Result of Adding Medicaid Svcs. and Eligible Groups	4,471.8	-0-	4,471.8	-0-
3. State Only Medically Needy	11,169.4	-0-	11,169.4	16
4. Interest Payment	282.2	-0-	282.2	-0-
TOTAL	$31,174.3	$15,717.0	$15,457.3	33

THE LEGISLATURE OF THE STATE OF ALASKA
ELEVENTH LEGISLATURE

FISCAL NOTE

I. REQUEST

Bill/Resolution No. House CS for CS for Sponsor Substitute for Senate Bill No. 277
Title An Act relating to the health of residents of the State.
Requested by The Hess Committee Date May 2, 1980

II. FISCAL DETAIL

Agency Affected Department of Health and Social Sevices
Program Category Affected Health/Social and Economic Assistance
BRU, Program, or Subprogram(s) Affected Medicaid/Eligibility Determination/PAA
(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 80	FY 81	FY 82	FY 83	FY 84	FY 85
100 PERSONAL SERVICES		448.3				
200 TRAVEL		17.0				
300 CONTRACTUAL		175.5				
400 COMMODITIES		8.5				
500 EQUIPMENT		17.5				
600 LAND & STRUCTURES		-0-				
700 GRANTS, CLAIMS, ETC.		23,527.7				
TOTAL		24,194.5				

FUNDING (Thousands of Dollars)

GENERAL FUND		8,477.5				
FEDERAL FUNDS		15,717.0				
OTHER (Specify Fund Source)		-0-				

POSITIONS

FULL TIME		17				
PART TIME		-0-				
TEMPORARY		-0-				

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

Medical benefits would be provided to approximately 3,065 new cases under the Medicaid program. Administration of program benefits would require 15 field staff positions and 2 central office positions, office space, and additional computer time to be divided between the Eligibility Determination and Public Assistance Administration BRUs. Funding is 50% federal except for the Indian Health Care program which is funded at 100% federal funds. Since the bill proposes to add new coverage groups and new categories of coverage to Medicaid, there will be a reduction in General Relief Medical program expenditures as indicated on page 2. Thus, the actual increase in state General fund revenues needed for this increased Medicaid coverage is 8,477.5 - 4,471.8 = 4,005.7.

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)

Prepared by: David M. Davidson Date: May 2, 1980
Division/Office: Public Assistance PH: 465-3347
Department of Health & Social Services

33-001 (Rev. 12/79)
Modify by DHSS (11-28-79)

Approval DHSS Mgt. & Bdgt.: _____ Date: _____

THE LEGISLATURE OF THE STATE OF ALASKA
ELEVENTH LEGISLATURE

FISCAL NOTE

I. REQUEST

Bill/Resolution No. House CS for CS for Sponsor Substitute for Senate Bill No. 277

Title An Act relating to the health of residents of the State.

Requested by The Hess Committee Date May 2, 1980

II. FISCAL DETAIL

Agency Affected Department of Health and Social Sevices

Program Category Affected Health

BRU, Program, or Subprogram(s) Affected General Relief Medical

(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 80	FY 81	FY 82	FY 83	FY 84	FY 85
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL						
400 COMMODITIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC.		(4,471.8)				
TOTAL		(4,471.8)				

FUNDING (Thousands of Dollars)

GENERAL FUND		(4,471.8)				
FEDERAL FUNDS						
OTHER (Specify Fund Source)						

POSITIONS

FULL TIME		-0-				
PART TIME		-0-				
TEMPORARY		-0-				

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

Decrease in General Relief Medical program expenditures due to the transfer of coverage for certain service categories from state funding to coverage under the Medicaid program, and the addition of certain groups under Medicaid that are currently covered by General Relief Medical.

riginal: Legislative Finance
Budget and Management
Prime Sponsor (First Legislator Named)

Prepared by: David M. Davidson Date: May 2, 1980
Division/Office: Public Assistance PH: 465-3347
Department of Health & Social Services

(Rev. 12/79)
HSS (11-28-79)

Approval DHSS Mgt. & Pdgt: _____ Date: _____

THE LEGISLATURE OF THE STATE OF ALASKA
ELEVENTH LEGISLATURE

FISCAL NOTE

I. REQUEST

Bill/Resolution No. House CS for CS for Sponsor Substitute for Senate Bill No. 277
Title An Act relating to the health of residents of the State.
Requested by The Hess Committee Date May 2, 1980

II. FISCAL DETAIL

Agency Affected Department of Health and Social Sevices
Program Category Affected Health/Social and Economic Assistance
BRU, Program, or Subprogram(s) Affected General Relief Medical/Eligibility Determination/PAA
(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 80	FY 81	FY 82	FY 83	FY 84	FY 85
100 PERSONAL SERVICES		423.3				
200 TRAVEL		16.0				
300 CONTRACTUAL		154.0				
400 COMMODITIES		8.0				
500 EQUIPMENT		16.5				
600 LAND & STRUCTURES		-0-				
700 GRANTS, CLAIMS, ETC.		10,551.6				
TOTAL		11,169.4				

FUNDING (Thousands of Dollars)

GENERAL FUND		11,169.4				
FEDERAL FUNDS		-0-				
OTHER (Specify Fund Source)		-0-				

POSITIONS

FULL TIME		16				
PART TIME		-0-				
TEMPORARY		-0-				

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

Medical benefits would be provided to approximately 2,821 new cases under a state-only medically needy program as part of the General Relief Medical program. Administration of program benefits would require 14 field staff positions and 2 central office positions, office space, and additional computer time to be divided between the Eligibility Determination and Public Assistance Administration BRUs. Funding is indicated as 100% state funds, but it may be possible to receive federal funding for certain individuals with income less than 133% of the state need standard for the particular eligibility categorical group to which they are related.

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)

Prepared by: David M. Davidson Date: May 2, 1980
Division/Office: Public Assistance PH: 465-3347
Department of Health & Social Services

33-001 (Rev. 12/79)
Modify by DHSS (11-28-79)

Approval DHSS Mgt. & Bdgt.: _____ Date: _____

THE LEGISLATURE OF THE STATE OF ALASKA
ELEVENTH LEGISLATURE

FISCAL NOTE

I. REQUEST

Bill/Resolution No. House CS for CS for Sponsor Substitute for Senate Bill No. 277

Title An Act relating to the health of the residents of the State.

Requested by The Hess Committee Date May 2, 1980

II. FISCAL DETAIL

Agency Affected Department of Health and Social Sevices

Program Category Affected Health

BRU, Program, or Subprogram(s) Affected General Relief Medical

(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 80	FY 81	FY 82	FY 83	FY 84	FY 85
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL		282.2				
400 COMMODITIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC.						
TOTAL		282.2				

FUNDING (Thousands of Dollars)

GENERAL FUND		282.2				
FEDERAL FUNDS		-0-				
OTHER (Specify Fund Source)						

POSITIONS

FULL TIME		-0-				
PART TIME		-0-				
TEMPORARY		-0-				

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

Funding necessary to make interest payments to providers for Medicaid and General Relief Medical clean claims not processed within 30 days of receipt by the Department. Federal law requires states to process 90% of Medicaid clean claims within 30 days of receipt, however no provision is made under federal law for funds to be used to make interest payments. Thus, all interest payments must be made using state funds only.

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)

Prepared by: David M. Davidson Date: May 2, 1980
Division/Office: Public Assistance PH: 465-3347
Department of Health & Social Services

Approval DHSS Mgt. & Bdgt: _____ Date: _____

33-001 (Rev. 12/79)
Modify by DHSS (11-28-79)

DIVISION OF PUBLIC ASSISTANCE

BRU	FY79 ACTUAL TOTAL AS OF 11/27/79	FY80 FCC AUTHORIZATION		FY80 SUPPLE-MENTAL CURRENT REQUEST	FY80 PROJECTED TOTAL NEED		FY81 REQUEST	
			(GF)			(GF)		(GF)
GEN. POP:								
DISCRETIONARY								
Elig. Det.	$3718.3	4377.1	(2638.2)		4377.1		4695.9	(2831.0)
Staff Dev.	253.8	130.4	(40.8)		130.4		140.0	(69.1)
Quality Control	407.0	496.0	(248.5)		496.0		549.0	(274.5)
General Relief	707.1	650.0	(650.0)		650.0		650.0	(650.0)
TOTAL	5086.2	5653.5	(3577.5)		5653.5	(3677.5)	6034.9	(3824.6)
NON-DISCRETIONARY								
AFDC	21276.6	22734.5	(11367.2)	3447.9	26182.4	(13091.2)	31133.1	(15566.5)
AD	3130.2	3782.8	(3782.8)	202.7	3985.5	(3985.5)	4974.1	(4974.1)
AB	108.7	118.8	(118.8)		118.8	(118.8)	140.9	(140.9)
*OAA	2950.2	3141.4	(3141.4)	421.8	3563.2	(3563.2)	4344.9	(4344.9)
TOTAL	27465.7	29777.5	(18410.2)	4072.4	33849.9	(20758.7)	40593.0	(25026.4)
* AGED COVER PROGRAM								
HEALTH:								
NON-DISCRETIONARY								
MEDICAID								
Hospitals	6047.9	5617.7	(1160.7)	1066.7	6684.4	(1694.0)	8923.7	(2461.9)
Physicians	2872.4	2819.2	(621.9)	1217.6	4036.8	(1230.7)	5331.1	(2690.6)
Other Services	889.9	735.1	(276.[illegible])	435.8	1170.9	(494.5)	1563.1	(671.1)
EPSDT	1600.8	1711.5	(855.[illegible])	480.0	2191.5	(1095.7)	2925.7	(1462.8)
Nursing Home	12947.8	15825.6	(967.4)	1716.0	17541.6	(858.0)	21927.0	(3563.5)
Indian Health	1458.7	6557.6	-0-		6557.6	-0-	7239.6	-0-
TOTAL	25817.5	33266.7	(3882.3)	4916.1	38182.8	(5372.9)	47960.2	(10849.9)
GENERAL RELIEF MEDICAL								
Hospitals	4137.9	4147.9		1356.8	5504.7		7348.8	(7348.8)
Physicians	1443.4	1150.3		900.0	2050.3		2737.1	(2737.1)
Other	1338.0	1224.1		473.4	1697.5		2266.1	(2266.1)
Nursing Homes	328.8	683.9		231.7	915.6		1144.5	(1144.5)
Catastrophic Illness	801.8	754.2		-0-	754.2		977.3	(977.3)
Residential Nurse	-0-	166.4		-0-	166.4		166.4	(166.4)
TOTAL	8049.9	8126.8	(8126.8)	2961.9	11088.7	(11088.7)	14640.2	(14640.2)
DISCRETIONARY								
PA Admin & Support	970.4	910.9	(529.2)		910.9	(529.2)	979.8	(594.8)
Collections	42.8	44.8	(44.8)		44.8	(44.8)	47.4	(28.4)
SUBTOTAL	67432.5	77780.2	34570.8		89730.6	(41471.8)	110225.5	(54964.3)
+FEDERAL FOOD STAMPS	10400.0	14976.0			14976.0		18637.0	
+ENERGY ASSISTANCE PROGRAM	N/A	N/A			3636.7		unknown	
DIVISION TOTAL	77832.5	92756.0	34570.8		108343.3	(41471.8)	128892.5	(54964.3)

SB

522

THE LEGISLATURE OF THE STATE OF ALASKA
ELEVENTH LEGISLATURE

FISCAL NOTE

I. REQUEST

Bill/Resolution No. SB-522

Title An Act relating to the Compact for Education

Requested by Senate HESS Date 3/18/80

II. FISCAL DETAIL

Agency Affected Education

Program Category Affected Elementary and Secondary Education

BRU, Program, or Subprogram(s) Affected Office of the Commissioner

(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 80	FY 81	FY 82	FY 83	FY 84	FY 85
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL		18.5	18.5	18.5	18.5	18.5
400 COMMODITIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC.						
TOTAL						

FUNDING (Thousands of Dollars)

GENERAL FUND		18.5	18.5	18.5	18.5	18.5
FEDERAL FUNDS						
OTHER (Specify Fund Source)						

POSITIONS

FULL TIME		-0-	-0-	-0-	-0-	-0-
PART TIME						
TEMPORARY						

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

Cost related to membership dues, not adjusted for inflation.

IV. DATE 3/18/80 PREPARED BY William D. Thomas

AGENCY Education

PHONE 465-2800

Original: Legislative Finance

cc: Budget and Management

Prime Sponsor (First Legislator Named)

33-001 (Rev. 12/79)

SB

539

Funding Information
General Fund $59,000,000
Other Funds -0-
$59.000,000

IN THE HOUSE BY THE FINANCE COMMITTEE

~~HOUSE BILL NO.~~ SB 539

IN THE LEGISLATURE OF THE STATE OF ALASKA

ELEVENTH LEGISLATURE - SECOND SESSION

A BILL

For an Act entitled: "An Act making an appropriation to the Alaska medical facilities bond guarantee account; and providing for an effective date."

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

* Section 1. The sum of $59,000,000 in obligations of the United States government or other instruments which are held in the general fund and which will not mature during fiscal year 1981 is appropriated to the Alaska medical facilities bond guarantee account for bond guarantees made under a version of an Act entitled "An Act relating to bond guarantees for the purchase of mortgage loans made to medical facilities in Alaska and creating the Alaska medical facilities bond guarantee account; and providing for an effective date."

* Sec. 2. The unexpended and unobligated portion of the appropriation made by of this Act lapses into the general fund June 30, 1982.

* Sec. 3. This Act take effect on the effective date of a version of an Act entitled "An Act authorizing the Alaska Medical Facility Authority to purchase mortgage loans made to medical facilities in Alaska, relating to bond guarantees for the purchase of the mortgage loans and creating the Alaska medical facilities bond guarantee account; and providing for an effective date."

NORTH POLE	ambulance	30,000
	fire fighting accessories	6,000
	extrication equipment	8,000
	simulators for defibrillators	2,000
	portable suction	390
CHENA GOLDSTREAM COLLEGE	2 attack trucks	64,000
	2 500 gallons per minute tanker/pumper	100,000
	EMS equipment	14,000
TRAPPER CREEK	extrication equipment	1,200
	mast suit	475
	IV supplies	1,000
	pager system	2,000
BETHEL	aerial pump	150,000
	class A pumper	125,000
ALASKA STATE TROOPERS	40 emergency trauma kits	30,000
18 VILLAGES	basic fire suppression kits	71,500
NORTHERN REGION EMS	various equipment & training aids	10,000
SOUTHERN REGION EMS	various equipment	55,000
SOUTHEAST REGION EMS	various equipment	59,000
INTERIOR VILLAGES	air transport equipment for 30 villages including aircraft compatible stretchers, back-boards, blankets	10,000
EMT	training 60 EMT's per year at $80,000 (request 2 years with continual funds)	160,000
STATEWIDE	2 year funding, maintenance & fuel costs, replacement EMS supplies - expendable	50,000
FIRST RESPONDERS	Basic emergency equipment for 5 first responders designated along Alaska-Richardson & Parks Highways in areas where existing ambulance services are over 75 miles apart @ $540 each	2,700
KING COVE	SSB Radio with battery, CB's	
NELSON LAGOON	SSB Radio with battery, CB's CB Base Station	
NIKOLSKI	Batteries for SSB radio, CB's	
SAND POINT	SSB Radio with battery, CB's	73,[illegible]
ST. GEORGE	Battery for SSB radio, CB's	
ST. PAUL	Battery for SSB radio, CB's	
UNALASKA	Battery for SSB radio, CB's	
ST MARY'S	Fire Truck	85,000
		4,868,419

	EPA	.50
KODIAK BOROUGH	pumper/tanker	90,000
UNALASKA	pumper/tanker	125,000
	EMS equipment	5,000
DILLINGHAM	portable monitor-defibrillator	3,000
NAKNEK/KING SALMON	EMS equipment	10,000
AUKE BAY	air compressor for oxygen	7,000
	salvage vehicle	20,000
	tank truck 1000 gallon	60,000
	air packs MSA - pressure demand800	6,400
DOUGLAS	quick attack 4x4 truck with 500tank	50,000
	portable pumps - 250 gallons per minute with 10 foot suction hose	1,000
	single jacket hose - 500 ft -1½in.	750
GLACIER	tanker with pump - 5000	125,000
	2 recording annies	2,000
HOMER	attack pumper	35,000
EMS	highway signs	600
	communications equipment	300,000
HAINES	2 portable pumps	3,000
	50 gallons lightwater	550
	EMS equipment	2,000
SKAGWAY	portable suction unit	390
KETCHIKAN	recompression equipment	22,000
	walkie-talkies	1,800
WRANGELL	pumper tanker 1000to2000	125.000
	modular ambulance	30,000
	resuscitator with bag mask	500
PETERSBURG	EMS training	10,000
	Disaster	3,000
	EMS Equipment	20,800
SITKA	fire protection	10,800
	EMS equipment	7,400
	training	7,500
	extrication equipment	5,000
YAKUTAT	EMS equipment	6,000
	2 portable pumps	2,000
	5 KW generator	7,00
	modular ambulance	30,0
SEWARD	ladder & aerial truck	160,0
	scott air packs	5,0
	fire protection equipment	10,0
FAIRBANKS	EMS equipment	30,0
	Esther Volunteer F.D. ambulance	30,00
U of A	EMS Equipment	5,00
	Hurst Tool	6,000

NINILCHIK	Valve Oxygen	500
	Portable Suction	390
	Ambulance	30,000
	Pumper tanker	75,000
	fire fighting equipment	5,000
NIKISKI	MICU Equipment	3,000
KENAI/NIKISKI	Ambulance	30,000
KENAI	Fire fighting accessories	5,000
	EMS Equipment	5,000
	Training Aid	5,000
	2 scanners	800
BARROW	Portable suction	390
	Fire fighting equipment	75,000
	pumper/tanker	60,000
	EMS Equipment	6,200
KIANA	fire fighting maintenance	7,000
NOORVIK	fire fighting maintenance	7,000
KOTZEBUE	Attack fire rig	35,000
	Trauma Kits	1,500
	Portable Suction	390
	Equipment	6,000
	Ambulance	30,000
	1 recording ANNI	1,000
	11 CPR Mannikins	3,300
	Trauma kits	1,500
	2 portable suction	780
	Backboards for each village	1,650
	Portable oxygen for each village	3,300
	N.W.Search & Rescue, equipment	14,000
	N.W.Search & Rescue, communications	20,000
NOME	Portable Pump	2,000
	Pumper/tanker	65,000
	Air Equipment	8,000
	Compressor/Oxygen	4,000
	Fire protection equipment	7,800
	EMS Equipment	3,600
	Salt Water fire protection	75,000
CANTWELL	Portable suction	390
	Extrication Equipment	5,000
	Therapy mask	50
	Pry Banks	200
	Thiz winch	500
	maintenance & fuel	2,50.
	modular ambulance	30,0
DELTA JUNCTION	8 pumper tankers	460,0
	communication equipment	55,0
	4 chemical suits	2,5(
	30 sets bumper gear	9,0(
	rescue truck	31,0(
	modular ambulance	30,00
HEALY	repay cost on current ambulance	10,900
	Upgrade EMS	10,000
MT. VILLAGE	Ambulance	15,000

	[illegible] calibrator	3,000
	encoder with 7 pagers	2,000
	portable suction	390
	hose	2,800
	Ambulance	30,000
	compressor oxygen	2,000
	portable pump	500
Central Fire Truck	Fire Truck	85,000
Ambulance 100,000	communications	6,500
DELTA	monitor	3,000
	portable suction	390
TOK	cardiac care unit	3,000
	extrication equipment	5,000
	portable suction	390
	ambulance	30,000
	portable pond	2,000
	bunker gear	5,000
	fire fighting equipment	5,000
	4 scott air packs	6,000
	portable compressor oxygen	500
TANANA	Ambulance equipment recommended by DOT	5,000
PALMER	Extrication Equipment	25,000
	Communication equipment	6,000
	hose	10,000
	fire truck - sutton	70,000
	fire truck - houston	70,000
	disability vehicle - pioneer's home	20,000
	5 KW generator	2,500
WASILLA	Ladder trucker	185,000
	ambulance	30,000
	extrication equipment	5,000
	pagers	1,000
WHITTIER	fire protection equipment	5,000
	ambulance	38,000
	fire truck	75,000
	communication equipment	17,000
	air pack	8,000
	2 trauma kits	2,000
CORDOVA	Tanker/pumper	50,000
	4 wheel squad vehicle	15,000
	4 portable pumps	2,400
	Ambulance	30,000
COOPER LANDING	Mast pants	475
	Extrication Equipment	1,200
	Maintenance & fuel	2,500
WILLOW	Extrication equipment	5,000
GLENNALLEN	Flight bag emergency kit	1,000
	Ambulance	30,000
PORTAGE	Modular ambulance	34,000
COPPER RIVER	Training Equipment	8,2[illegible]
	EMS Equipment	2,67[illegible]
SOLDOTNA	video equip. for EMT training	5,000
GALENA	tanker/pumper	75,000
	bunker gear	5,000
STEESE HIGHWAY VFD	modular ambulance	30,000

POSITION PAPER/Department of Health & Social Services

POSITION PAPER

on

SENATE BILL NO. 539

"An Act making a special appropriation to the Department of Public Safety for emergency medical services; and providing for an effective date."

This bill would make $4,868,419 available to the Department of Public Safety, primarily for equipment for fire suppression and emergency medical services in communities throughout Alaska. Of the total amount, approximately $3.3 million is for fire suppression equipment and the remaining amount is for EMS equipment and training through the Public Safety Academy. None of the proposed funding is for operating expenses of the EMS Program within the Department of Health and Social Services.

The Emergency Medical Services Section of the Division of Public Health, Department of Health and Social Services, feels this equipment and training is needed. The Section has been involved, with assistance from the regional EMS councils, in assessing EMS equipment and training needs throughout the state. The Department recommends that the Department of Public Safety obtain endorsement from Regional EMS Medical Advisors before purchasing advanced medical equipment such as defibrillator monitors for communities since this equipment requires advanced training before it can be used safely.

Recommended by: D F T...

Dean F. Tirador, M.D.
Director, Division
of Public Health

Date: 4/22/80

Approved by: Helen O Beirne

Helen D. Beirne
Commissioner

Date: 5/7/80

FISCAL NOTE

I. REQUEST
Bill/Resolution No. Senate Bill No. 539
Title "...making a special appropriation to Dept. Public Safety for emergency medical svcs."
Requested by Commissioner's Office Date 4/8/80

II. FISCAL DETAIL
Agency Affected Department of Health and Social Services
Program Category Affected Health/Division of Public Health
BRU, Program, or Subprogram(s) Affected Emergency Medical Services Section
(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 80	FY 81	FY 82	FY 83	FY 84	FY 85
100 PERSONAL SERVICES	0	0	0	0	0	0
200 TRAVEL	0	0	0	0	0	0
300 CONTRACTUAL	0	0	0	0	0	0
400 COMMODITIES	0	0	0	0	0	0
500 EQUIPMENT	0	0	0	0	0	0
600 LAND & STRUCTURES	0	0	0	0	0	0
700 GRANTS, CLAIMS, ETC.	0	0	0	0	0	0
TOTAL	0	0	0	0	0	0

FUNDING (Thousands of Dollars)

GENERAL FUND	0	0	0	0	0	0
FEDERAL FUNDS	0	0	0	0	0	0
OTHER (Specify Fund Source)	0	0	0	0	0	0

POSITIONS

FULL TIME	0	0	0	0	0	0
PART TIME	0	0	0	0	0	0
TEMPORARY	0	0	0	0	0	0

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)

Prepared by: M. Deaver Date: 4/8/80
Division/Office: P.H. Admin. PH: 5020
Department of Health & Social Services

Approval DHSS Dpt. & Dpt: Date:

33-001 (Rev. 12/79)
Modify by DHSS (11-28-79)

SB
549

Sec. 1 -- Brings Board under "Centralized Licensing" Chapter of Title 8.

Sec. 2 -- Allows OL to provide investigative services to Board.

Sec. 3 -- Provides "exception" to current statute which renews licenses biennally and allows our "health boards" to renew licenses every four years.

Sec. 4 -- Provides that R.N. have no direct financial interest in an nursing home.

Sec. 5 -- Allows for board members to serve terms of four years instead of three. Limits membership on board to two consecutive four year terms.

Sec. 6 -- Gives board "approval" power in the issuance of licenses and license renewal.

Sec. 7 -- Provides for the imposition of disciplinary sanctions.

Sec. 8 -- "Continued competency requirement" before license can be renewed.

Sec. 9 -- Provides for removal of board members by governor for cause.

Sec. 10 - Deletes provision "unless excepted by this chapter." The reason for this is that the board feels that if they were to make exceptions this would put them in a vulnerable position -- i.e., if they made an exception in one case they might be setting a precedent to make an exception in other /matters and they would just as soon avoid this.

Sec. 11 - Allows for license renewal to occur every four years

- Provides for continued competency to be established before license can be renewed

Sec. 12 - Provides for individual to apply for examination if his license has expired for a period of 24 months (it currently is 12 months).

Sec. 13 - Fee revision.

Sec. 14 - Grounds for imposition of disciplinary sanctions

Sec. 15 - Disciplinary sanctions enumerated.

Sec. 16 - Penalty clause.

Sec. 17 - Brings board under "administrative adjudication" section of Title 44.

Sec. 18 - Repealers.

Sec. 19 - Effective date.

STATE OF ALASKA

JAY S. HAMMOND, GOVERNOR

DEPARTMENT OF ADMINISTRATION

OFFICE OF THE COMMISSIONER

POUCH C
JUNEAU, ALASKA 99811

465-2200

May 21, 1980

Honorable Thelma Buchholdt
Chairman
Health, Education & Social Services
Committee
Alaska State Legislature
Pouch V
Juneau, Alaska 99811

Dear Representative Buchholdt:

To clarify our Department's recommendations on this bill, SB 549 am, we are in support of the bill but recommend an amendment that would read as follows:

> "Add to Sec. 08.70.080 the following: This section does not apply to Pioneers' Home Managers who are incumbents on the effective date of this Act."

We believe that those incumbents with proven experience should be retained.

Sincerely,

Sue S. Greene
Deputy Commissioner for Personnel Management

SSG/mjc

NURSING HOME ADMINISTRATORS SB549 AM

Sec. 1 — Brings Board under "Centralized Licensing" Chapter of Title 8.

Sec. 2 — Allows OL to provide investigative services to Board.

Sec. 3 — Provides "exception" to current statute which renews licenses biennally and allows our "health boards" to renew licenses every four years.

Sec. 4 — Provides that R.N. have no direct financial interest in an nursing home.

Sec. 5 — Allows for board members to serve terms of four years instead of three. Limits membership on board to two consecutive four year terms.

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Sec. 7 — Provides for the imposition of disciplinary sanctions.

Sec. 8 — "Continued competency requirement" before license can be renewed.

Sec. 9 — Provides for removal of board members by governor for cause.

Sec. 10 - Deletes provision "unless excepted by this chapter." The reason for this is that the board feels that if they were to make exceptions this would put them in a vulnerable position — i.e., if they made an exception in one case they might be setting a precedent to make an exception in other matters and they would just as soon avoid this.

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Sec. 13 - Fee revision.

Sec. 14 - Grounds for imposition of disciplinary sanctions

Sec. 15 - Disciplinary sanctions enumerated.

Sec. 16 - Penalty clause.

Sec. 17 - Brings board under "administrative adjudication" section of Title 44.

Sec. 18 - Repealers.

Sec. 19 - Effective date.

POSITION PAPER/Department of Health & Social Services

POSITION PAPER

SENATE BILL NO. 549am

"An act relating to professional licensing and to the regulation of Nursing home administrators, and providing for an effective date."

Senate Bill 549am revises current statutes and adds new sections to clarify and strengthen the administration of nursing home administrators licensing procedures. The bill gives the Board of Nursing Home Administrators the authority to develop regulations for the purpose of requiring disciplinary sanctions and making renewal of licenses dependent upon proof of continued competency.

The bill provides specific administrative procedures for applying disciplinary sanctions, and spells out specific grounds for discipline.

The terms of members of the Board of Nursing and limited to approximately eight years and the nursing home administrators license is to be renewed every four years rather than annually.

The Department of Health and Social Services supports Senate Bill 549am as it is written.

As evidenced by the attached letter from Rod Betit, Director, Division of Public Assistance, the existance of and the smooth operation of a Board of Nursing Home Administrators is important to the operation and funding of the State of Alaska's Medicaid program.

The bill does not fiscally affect the cost of operation of the Department of Health and Social Services other than the federal fund participation for the Medicaid program.

Recommended By: Rod Betit Date May 5, 1980

Rod Betit, Director
Division of Public Assistance

Approved By: Helen O Beirne Date 5/9/80

Helen D. Beirne, Commissioner
Department of Health and Social Services

March 31, 1980

Document Number 59-80

The Honorable Glenn Hackney
Chairman, Senate HESS Committee
Alaska State Legislature
Pouch V
Juneau, Alaska 99811

Dear Senator Hackney:

House Bill 447 proposes terminating the existence of the Board of Nursing Home Administrators on January 1, 1981 and reassigns its responsibilities to the Department of Commerce and Economic Development.

At the time various Boards and Commissions were being considered for "sunsetting" by the Legislature in 1979, it was found that the existence of the Board of Nursing Home Administrators or some similar type of "peer review" system was, by federal law, (U.S. Code 42 Sub-Chapter XIX S. 1396 a(29)) necessary if the State of Alaska was to continue to receive federal fund participation for Medicaid nursing home services.

Federal fund participation is an essential part of the Medicaid nursing home services funding. Nursing home services comprise 70% of the total Alaska Medicaid budget (twenty-nine million dollars) and therefore, approximately fourteen million dollars (50% matching) could be lost in federal fund participation if some type of "peer review" licensing function is not provided for in Alaska Statute.

When viewed superficially, it is difficult to justify the need for, and cost of a statewide, regionally represented, five member Board of Nursing Home Administrators when only approximately 35 licenses have been issued since 1976. However, with approximately fourteen million dollars in federal fund participation dependent upon the state having "either a Board of Nursing Home Administrators or an agency of the state responsible for licensing under the Healing Arts Act of the state" the cost and need is easier rationalized.

What seems needed is a method of administrating the issuance of Nursing Home Administrators licensured through the Department of Commerce and Economic Development while at the same time providing a method of inexpensive "peer review." Some alternatives that we have considered are as follows:

I. Establish the Long Term Care Division of the Alaska State Hospital Association as the board the Department of Commerce and Economic Department must consult with regarding:

a. Promulgating of regulations.

b. Revocation of licenses.

c. Establishment of procedures to insure that licenses uphold standards.

d. Adoption of criteria for educational requirements.

The Long Term Care Division of the Alaska State Hospital Association meets at least bi-annually and at no expense to the State could provide the professional support needed to fulfill federal statute requirements. The Long Term Care Division of the Alaska State Hospital Association is composed of all the nursing home administrators in the State of Alaska.

II. Establish a Board, for federal purposes, composed of state employees who's offices are in Juneau. This type of board should meet during regular working hours and therefore, should be no added expense to the State.

a. Director of Occupational Licensing.

b. Director of Public Assistance.

c. Director of Public Health.

d. Director of Nursing Board.

III. The development of a comprehensive healing arts act, which would encompass all healing professions.

IV. Reinstatement of the existing Board of Nursing Home Administrators with appropriate funding and staffing in the Division of Occupational Licensing to accomplish the tasks required.

The Division of Public Assistance opposes House Bill 447 and support the reinstatement of the Board of Nursing Home Administrators. We feel the cost of supporting the operation of such a board are justified when compared to the amount of federal fund participation involved.

Sincerely,

Rod Betit
Director

RB:BO:lar
bcc: DHSS Commissioner's Office

STATE OF ALASKA MEMORANDUM

TO: Debra Behr, Special Assistant to the Commissioner
Health & Social Services

DATE: April 13, 1980

FILE NO:

TELEPHONE NO:

FROM: Portia Kaufmann, Administrator
State Health Planning & Development
Certification & Licensing

SUBJECT: Position Paper - Senate Bill 549

For an act entitled: "An Act relating to professional licensing and to the regulation of nursing home administrators; and providing for an effective date."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA.

* Section 1. AS 08.01.010 is amended by adding a new paragraph to read:

(22) Board of Nursing Home Administrators.

Discussion:

1. A current license is required by Federal regulations for nursing home administrators.

2. Federal regulations do not require the administrator of a hospital with long term care beds to be a licensed nursing home administrator unless state regulations have this requirement.

   As of this date, the State of Alaska has required a hospital administrator to be licensed as a nursing home administrator if the hospital has a long term care unit.

3. Intermediate Care Facilities for the mentally retarded federal regulations require the administrator to be a qualified Mental Retardation Specialist (A educational background in preference to medical background), unless the State requires him/her to be a licensed nursing home administrator.

   Intermediate Care Facilities for the mentally retarded (ICF/MR) that care for persons with developmental disabilities have an orientation to normalization and a wellness model as opposed to the medical model. Therefore, the administrator of an ICF/MR must have a different background. Alaska has adopted for licensure the Federal Regulations for ICF/MR. Therefore, ICF/MRs are not licensed as nursing homes, but as ICF/MRs.

Senate Bill No. 549 refers to the re-establishment of the Board of Nursing to administer the required licensure program for nursing home administrators.

Comment: The Department of Health & Social Services concurs with the content of this Bill.

cc Phoebe Lindsley, Director
State Health Planning & Development
PK:arn

THE LEGISLATURE OF THE STATE OF ALASKA
ELEVENTH LEGISLATURE

FISCAL NOTE

I. REQUEST
Bill/Resolution No. Senate Bill No 549am
Title "An act relating to professional licensing & regulation of Nursing Home Administrators"
Requested by Commissioner's Office Date 5/6/80

II. FISCAL DETAIL
Agency Affected Department of Health and Social Sevices
Program Category Affected Health /Division of Public Assistance
BRU, Program, or Subprogram(s) Affected Medicaid
(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 80	FY 81	FY 82	FY 83	FY 84	FY 85
100 PERSONAL SERVICES	0	0	0	0	0	0
200 TRAVEL	0	0	0	0	0	0
300 CONTRACTUAL	0	0	0	0	0	0
400 COMMODITIES	0	0	0	0	0	0
500 EQUIPMENT	0	0	0	0	0	0
600 LAND & STRUCTURES	0	0	0	0	0	0
700 GRANTS, CLAIMS, ETC.	0	0	0	0	0	0
TOTAL	0	0	0	0	0	0

FUNDING (Thousands of Dollars)

GENERAL FUND	0	0	0	0	0	0
FEDERAL FUNDS	0	0	0	0	0	0
OTHER (Specify Fund Source)	0	0	0	0	0	0

POSITIONS

FULL TIME	0	0	0	0	0	0
PART TIME	0	0	0	0	0	0
TEMPORARY	0	0	0	0	0	0

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)

Prepared by: Rod Betit Date: 5/6/80
Division/Office: Public Assistance PH:465-3355
Department of Health & Social Services

Approval DHSS Dpt. & Bdgt: Date:

SENATE SB 549 am	HOUSE	HOUSE COMMERCE REPORT	ANALYSIS & RECOMMENDATIONS
s existing statutes.		Concludes that the Board has not operated in the public interest because of problems inherent in the regulatory scheme. Recommends that the Board be sunset and the licensing function be transferred to the Division of Occupational Licensing.	
s Board under centralized sing.			
es terms of membership to years and limits members o successive terms.			
Board power to approve sing, to impose discip- y sanctions, and to require of continued competency.			
des for the removal of members.			
res licensed administrators ll nursing homes.			
s fees.			
olishes grounds for the sition of disciplinary ions and specifies what ions may be imposed.			

SENATE SB 549 am	HOUSE	HOUSE COMMERCE REPORT	ANALYSIS & RECOMMENDATIONS
the Board to those ed by the administrative ication procedures. ls the sanctions ing exp nses and the cability of the istrative Procedures			ACCEPT SB 549 am

Introduced: 4/7/80
Referred: Health, Education and Social Services

IN THE SENATE

BY THE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

SENATE BILL NO. 549 am

IN THE LEGISLATURE OF THE STATE OF ALASKA

ELEVENTH LEGISLATURE - SECOND SESSION

A BILL

For an Act entitled: "An Act relating to professional licensing and to the regulation of nursing home administrators; and providing for an effective date."

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

* Section 1. AS 08.01.010 is amended by adding a new paragraph to read:

(22) Board of Nursing Home Administrators.

* Sec. 2. AS 08.01.050(19) is amended to read:

(19) provide investigative services to the boards established under AS 08.20, [AS 08.32,] AS 08.36, AS 08.64, AS 08.68, AS 08.70, AS 08.71, AS 08.72, AS 08.80, AS 08.84, and AS 08.86, for the purpose of assisting those boards in matters of professional discipline.

* Sec. 3. AS 08.01.100(a) is amended to read:

(a) Except as provided in this title, [ALL] licenses shall be renewed biennially on the dates set by the department with the approval of the respective board.

* Sec. 4. AS 08.70.020(a) is amended to read:

(a) The board consists of five members: two nursing home administrators licensed under this chapter and practicing in the state, a registered nurse licensed in the state and having no direct financial interest in any nursing home, and two persons from the general public.

? Does this mean an employee? owner? what? definition

* Sec. 5. AS 08.70.020(c) is amended to read:

(c) Board members serve staggered terms of four [THREE] years or until their successor is appointed, except that a member appointed to a vacated term serves the duration of that term. A person who has served

two successive complete terms may not be reappointed until four years from the expiration of the second term [ON THE FIRST BOARD TWO MEMBERS SERVE ONE-YEAR TERMS, TWO MEMBERS SERVE TWO-YEAR TERMS AND ONE MEMBER SERVES A THREE-YEAR TERM].

* Sec. 6. AS 08.70.050(a)(2) is amended to read:

(2) examine, approve issuance of licenses and renewal of [LICENSE, AND RENEW THE] licenses of qualified persons;

* Sec. 7. AS 08.70.050(a)(3) is amended to read:

(3) establish procedures to insure that licensees continue to uphold the board's standards; impose disciplinary sanctions upon [REVOKE, SUSPEND, OR REFUSE TO RENEW LICENSES OF] persons who fail to uphold the standards;

* Sec. 8. AS 08.70.050(a) is amended by adding a new paragraph to read:

(6) adopt regulations insuring that renewal of a license is contingent upon proof of continued competency by the licensee.

* Sec. 9. AS 08.70 is amended by adding a new section to read:

Sec. 08.70.055. REMOVAL OF BOARD MEMBERS. A member of the board may be removed from office by the governor for cause. The board may by regulation provide that unexcused absences from meetings constitute cause for removal.

* Sec. 10. AS 08.70.080 is amended to read:

Sec. 08.70.080. LICENSE REQUIRED. Only a licensed nursing home administrator may manage, supervise, or be generally in charge of a nursing home [UNLESS EXCEPTED BY THIS CHAPTER]. Only a nursing home or which is supervised by a licensed nursing home administrator may operate in Alaska [UNLESS SPECIALLY EXCEPTED BY THE BOARD. THIS SECTION DOES NOT APPLY TO THE ALASKA PIONEERS' HOMES].

* Sec. 11. AS 08.70.140(b) is amended to read:

(b) An administrator may apply to the board for renewal of his

license [every four years] by submitting an application for renewal and proof of continued competency as required by regulation [TO THE BOARD]; application forms for renewal are provided by the department.

* Sec. 12. AS 08.70.140(c) is amended to read:

(c) A person whose license has expired for a period of 24 [12] months or more must apply for a license in the same manner as an applicant who has not been licensed before.

* Sec. 13. AS 08.70.150 is amended to read:

Sec. 08.70.150. FEES. The following fees shall be imposed under this chapter when applicable:

(1) examination fee . . . . . $50 [$25]

(2) investigation fee for persons applying for a license under AS 08.70.110(b) . . . . $50 [$25]

(3) [ANNUAL] license renewal fee [(required every four years)] . . . . . $200 [$50]

* Sec. 14. AS 08.70 is amended by adding a new section to read:

Sec. 08.70.155. GROUNDS FOR IMPOSITION OF DISCIPLINARY SANCTIONS. After a hearing the board may impose disciplinary sanctions when it finds that a licensee

(1) secured a license through deceit, fraud, or intentional misrepresentation;

(2) engaged in deceit, fraud, or intentional misrepresentation in the course of providing professional services or engaging in professional activities;

(3) advertised professional services in a false or misleading manner;

(4) has been convicted of a felony or other crime which affects his ability to continue to practice competently and safely;

(5) intentionally or negligently engaged in or permitted the

performance of patient care by persons under his supervision which does not conform to minimum professional standards regardless of whether actual injury to the patient occurred;

(6) failed to comply with this chapter, with a regulation adopted under this chapter, or with an order of the board;

(7) continued to practice after becoming unfit due to

(A) professional incompetence;

(B) failure to keep informed of or use current professional theories or practices;

(C) addiction or severe dependency on alcohol or other drugs which impairs his ability to practice safely;

(D) physical or mental disability;

(8) engaged in lewd or immoral conduct in connection with the delivery of professional service to patients;

(9) sold or furnished a license to another;

(10) practiced as a nursing home administrator or used a designation tending to imply that he is a nursing home administrator without a license issued under this chaper.

* Sec. 15. AS 08.70.160 is repealed and re-enacted to read:

Sec. 08.70.160. DISCIPLINARY SANCTIONS. (a) When it finds that a licensee is guilty of an offense under AS 08.70.155, the board may impose the following sanctions singly or in combination:

(1) permanently revoke a license to practice;

(2) suspend a license for a determinate period of time;

(3) censure a licensee;

(4) issue a letter of reprimand;

(5) place a licensee on probationary status and require him to

(A) report regularly to the board upon matters involving

the basis of probation;

(B) limit practice to those areas prescribed;

(C) continue professional education until a satisfactory degree of skill has been attained in those areas determined by the board to need improvement;

(6) impose limitations or conditions on the practice of a licensee.

(b) The board may withdraw probation status if it finds that the deficiencies which required the sanction have been remedied.

(c) The board may summarily suspend a license before final hearing or during the appeals process if the board finds that the licensee poses a clear and immediate danger to the public health and safety if he continues to practice. A person whose license is suspended under this section shall be entitled to a hearing by the board no later than seven days after the effective date of the order. The person may appeal the suspension after a hearing to a court of competent jurisdiction.

(d) The board may reinstate a license which has been suspended or revoked if the board finds after a hearing that the applicant is able to practice with skill and safety.

(e) The board shall seek consistency in the application of disciplinary sanctions, and significant departure from prior decisions involving similar situations shall be explained in findings of fact or orders.

* Sec. 16. AS 08.70.170 is amended to read:

Sec. 08.70.170. PENALTIES. A person convicted of violating a provision of this chapter is <u>guilty of a class B misdemeanor</u> [PUNISHABLE BY A FINE OF NOT MORE THAN $500, OR BY IMPRISONMENT FOR NOT MORE THAN ONE YEAR, OR BY BOTH].

* Sec. 17. AS 44.62.330(a) is amended by adding a new paragraph to read:

(47) Board of Nursing Home Administrators (AS 08.70.010).

* Sec. 18. AS 08.70.060, 08.70.070, and 08.70.140(a) are repealed.

* Sec. 19. This Act takes effect immediately in accordance with AS 01.10.070(c).

By dej amend ~~to~~ nursing home to read (?) full nursing home or Hosp. w/ nursing wing?

SCR
40

POSITION PAPER/Department of Health & Social Services

POSITION PAPER
ON
SENATE CONCURRENT RESOLUTION NO. 40 am

"Relating to expansion of the period during which Older Alaskans may travel free on the state marine highway system."

Senate Concurrent Resolution 40 am provides for increasing the time that Older Alaskans can ride on the Alaska Marine Highway System on space-available basis within Alaska without charge. Senate Concurrent Resolution 40 am would increase the days that seniors would travel free on the ferries to include the full month of October and the first 15 days of May. Mr. James Eide, Director of Marine Highways testified at Senate Finance Committee hearings on this resolution that the added service would not "hamper the operations of the system."

The Department of Health and Social Services recognizes that transportation is one of the key services that seniors need. Lack of transportation is often cited as a major obstacle in the provision and receipt of other necessary services such as medical care for the elderly. We believe this is especially true for seniors on low or fixed incomes. Travel expenses have recently been rising dramatically in response to high fuel costs. These added costs place an increased burden on these elderly citizen's already tight budgets.

Our Office on Aging reports that seniors have utilized free ferry service in the past for many purposes including to visit friends and relatives, meet with other senior groups, and attend recreational activities such as regional fairs. Also, the expansion of free ferry service might allow seniors living in small villages, such as Hoonah, to come to larger towns, such as Juneau to receive medical care or purchase supplies that are unavailable at home.

The Department of Health and Social Services recognizes the need for increased availability of transportation services for our older citizens and, therefore, supports the passage of this resolution.

Approved by: Helen D. Beirne 2-24-80

Helen D. Beirne, Commissioner (DATE)
Department of Health and Social Services

FISCAL NOTE

I. REQUEST

Bill/Resolution No. Senate Concurrent Resolution #40 am

Title "Expansion period-older Alaskans travel on state marine highway system."

Requested by _____ Date _____

II. FISCAL DETAIL

Agency Affected Department of Health and Social Sevices

Program Category Affected Social and Economic Assistance to the Aged

BRU, Program, or Subprogram(s) Affected Office on Aging

(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 80	FY 81	FY 82	FY 83	FY 84	FY 85
100 PERSONAL SERVICES	-0-	-0-	-0-	-0-	-0-	-0-
200 TRAVEL	-0-	-0-	-0-	-0-	-0-	-0-
300 CONTRACTUAL	-0-	-0-	-0-	-0-	-0-	-0-
400 COMMODITIES	-0-	-0-	-0-	-0-	-0-	-0-
500 EQUIPMENT	-0-	-0-	-0-	-0-	-0-	-0-
600 LAND & STRUCTURES	-0-	-0-	-0-	-0-	-0-	-0-
700 GRANTS, CLAIMS, ETC.	-0-	-0-	-0-	-0-	-0-	-0-
TOTAL	-0-	-0-	-0-	-0-	-0-	-0-

FUNDING (Thousands of Dollars)

GENERAL FUND	-0-	-0-	-0-	-0-	-0-	-0-
FEDERAL FUNDS	-0-	-0-	-0-	-0-	-0-	-0-
OTHER (Specify Fund Source)	-0-	-0-	-0-	-0-	-0-	-0-

POSITIONS

FULL TIME	-0-	-0-	-0-	-0-	-0-	-0-
PART TIME	-0-	-0-	-0-	-0-	-0-	-0-
TEMPORARY	-0-	-0-	-0-	-0-	-0-	-0-

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)

Prepared by: M.D. Plotnick Date: 2/25/80
Division/Office: on Aging PH: 465-4902
Department of Health & Social Services

Approval DHSS Mgt. & Bdgt [signature] Date 2/26/80

33-001 (Rev. 12/79)
Modify by DHSS (11-28-79)