STATE OF ALASKA
1988 LEGISLATIVE SESSION

BILL VERSION: CS SB 2
PUBLISH DATE: 4/29

FISCAL NOTE

5/

REQUEST:

Revision Date: _____
Title: Relating to pharmaceutical medical assistance for needy persons
Sponsor: _____
Requestor: _____

Agency Affected: Health/Social Serv
BRU: MA Administration/Medical Assistance
Components: Claims Processing/Gener Relief Medical, Medicaid Non-Facil

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 88	FY 89	FY 90	FY 91	FY 92	FY 93
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL		17.0				
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	0	17.0	0	0	0	0
CAPITAL						
REVENUE						

FUNDING: (Thousands of Dollars)

GENERAL FUND		(1,362.1)				
FEDERAL FUNDS		1,379.6				
OTHER						
TOTAL		17.0				

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY						

ANALYSIS: (Attach a separate page if necessary)

To correct CS SB 255 (Finance) Fiscal Note Dated 4/29/88
See Attached.

Prepared by: _____ Phone: _____
Division: _____ Date: 5/4/88

Approved by Commissioner: Myra M Munson Date: 5/4/88
Agency: Department of Health & Social Services

Distribution (by preparer):
Legislative Finance
Legislative Sponsor
Requestor
Office of Management and Budget
Impacted Agency(ies)

SPEECH BEFORE THE HOUSE FLOOR

Mr. Speaker thank you for this opportunity to speak about ~~HB 342~~ SB 348 or what has become to be known as "The Alaska Healthy Baby Project."

During the interim work of the House HESS Committee, I was shocked and embarrassed to learn that Alaska has the highest post neonatal mortality rate in a nation that has the highest infant mortality rate of all the industrialized countries.

"The Alaska Healthy Baby Project" is an important and necessary first step in reducing this rate. More than 40% of all infant deaths can be attributed to low birthweight, a symptom which can be detected and prevented through basic prenatal care. An infant born to a mother without prenatal care has twice the risk of dying as an infant born to a mother who received adequate prenatal care.

The results of low birthweight are expensive, and if family financial resources are insufficient, require state support In a twelve month period (1983-84), over 4.5 million state dollars were spent for the care of babies in Providence Hospital's Newborn Intensive Care Unit. The average cost per baby was $47,200, and the care of 14 babies cost more than $100,000 each.

Passage of ~~HB 342~~ SB 348 would allow nearly 1,000 more low-income pregnant women to receive prenatal care under Medicaid. In 1986, Congress passed legislation that allows states to offer

health care for pregnant women and their young children with incomes up to 100% (up from 78%) of the federal poverty level for Alaska. Under ~~HB 342~~ SB 348, Alaska will join the 26 other states that have seized this opportunity to better provide health care for their residents.

Nutritional services would be made available to those pregnant women identified as having complex nutritional and medical risk factors requiring intensive nutrition education and counseling beyond what is available through WIC. Also case management services would be provided.

Through the services provided in the Alaska Healthy Baby Project, low-income pregnant women and young children in both urban and rural areas of the state will receive more affordable and accessible health care. The continuum of care will be extended to needy children up through the age of five with critical follow-up services, such as nutrition and well-baby care.

Included in your packet is a fiscal note with extensive analysis. Fifty percent of the program costs and 75% of the position costs would be covered by new federal dollars.

Mr. Speaker, national statistics show that for every dollar spent on prenatal care, $9-$11 are saved in health costs later on. With the passage of ~~HB 342~~ SB 348, the bottom line is that the state will save money and will have increased the quality of life for needy children and pregnant women.

I would like to note, Mr. Speaker, that the State Health Plan for Alaska written in June 1984 had as one of its goals the reduction of infant mortality by ensuring that "all women have access to early and continuous prenatal care by 1985". Obviously we have not reached that goal. Now the availability and affordability of prenatal care for all pregnant women is a GICCY recommendation. I believe that it is time to take this step, and I urge your support in giving our families the opportunity to lead healthier, happier and fuller lives.

STATE OF ALASKA
1988 LEGISLATIVE SESSION

BILL VERSION: SB 348
PUBLISH DATE: 1-27-88

FISCAL NOTE

REQUEST:

Revision Date:
Title: An Act relating to Medical Assistance for needy persons
Sponsor: Uehling
Requestor: House HESS Committee

Agency Affected: Health & Social Services
BRU: MA Admin/Medical Assistance
PA Admin/State Health Services
Components: Claims Processing/Med. Fac./ Med. Non-Fac. Eligibility Determination/ PA Data Proc./Family Health

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 88	FY 89	FY 90	FY 91	FY 92	FY 93
PERSONAL SERVICES		245.9	461.0	461.0	461.0	461.0
TRAVEL		46.0	48.0	48.0	48.0	48.0
CONTRACTUAL		31.9	37.5	37.5	37.5	37.5
SUPPLIES		2.1	2.9	2.9	2.9	2.9
EQUIPMENT		14.0	9.0	-0-	-0-	-0-
LAND & STRUCTURES						
GRANTS, CLAIMS		2,610.8	6,430.6	7,597.5	8,764.4	9,931.3
MISCELLANEOUS						
TOTAL OPERATING		2,950.8	6,989.0	8,146.9	9,313.8	10,480.7
CAPITAL						
REVENUE		1,527.8	3,567.7	4,146.8	4,730.3	5,313.8

FUNDING: (Thousands of Dollars)

GENERAL FUND		1,423.0	3,421.3	4,000.1	4,583.5	5,166.9
FEDERAL FUNDS		1,527.8	3,567.7	4,146.8	4,730.3	5,313.8
OTHER						
TOTAL		2,950.8	6,989.0	8,146.9	9,313.8	10,480.7

POSITIONS:

FULL-TIME		7	10	10	10	10
PART-TIME						
TEMPORARY						

ANALYSIS: (Attach a separate page if necessary)

SEE ATTACHED

Prepared by: Kim Busch, Director — Phone: 465-3355
Division: Medical Assistance — Date: 1-28-88

Approved by Commissioner: Myra M. Munson — Date: 1-29-88
Agency: Health and Social Services

Distribution (by preparer):
- Legislative Finance
- Legislative Sponsor
- Requestor
- Office of Management and Budget
- Impacted Agency(ies)

ANALYSIS

ALASKA HEALTHY BABY PROJECT

PLAN FOR IMPLEMENTATION

1. Add all pregnant women and children up to one year of age with monthly incomes up to 100% of the federal poverty level for Alaska to the Medicaid Program. The program design includes:

    * one time eligibility determination for pregnant women. Once found eligible, the woman would retain Medicaid through the 60 day postpartum period. An income eligible pregnant woman may receive Medicaid as soon as pregnancy is medically verified. Children are automatically eligible for the 60 day postpartum period once the mother verifies the birth date.

    * no resource (asset) limit for pregnant women and children.

    * pregnant women and children will be eligible for all Medicaid services offered under the State Plan.

    (Estimate 974 eligibles: $4,163 per pregnant woman x 974 = $4,054,762 + $1,198 per child x 974 = $1,166,852 = Total $5,221,614). These cost estimates are based on actual average 1986 expenditure data for pregnant women and children age 5 and under. NOTE: the January 1, 1989 implementation date will result in ½ the program expenditures under Medicaid services for pregnant women and children during the first year.

2. Add case management services, as an enhanced service to pregnant women, to coordinate health care service delivery. This service will be particularly targeted at women with high risk pregnancies, and must be offered to all Medicaid-eligible pregnant women. The program will be implemented by hiring four nurse consultant public health nurses in the Division of Public Health to be case managers. These positions will operate from Anchorage, Fairbanks, Bethel and Juneau. The nurses will receive Medicaid referral of all pregnant women in order that each may be evaluated as to their pregnancy risk factor. The case managers will coordinate the health care services delivered, assure that pregnant women receive necessary services, and assist with arranging appointments and transportation. Uniform perinatal guidelines will be adopted to assure that pregnant women are receiving adequate care. Also hired, will be a Nurse IV Pre-Natal Coordinator for the Division of Medical Assistance to coordinate case management services, perform a utilization review function on expenditures for pregnant women and children, design and manage computer reports to monitor program objectives, establish criteria to evaluate improved pregnancy outcome, and evaluate program compliance. All positions will be at 75/25 federal/state match since each will be filled with medical personnel.

3. Add nutrition services under enhanced services to pregnant women beginning in the second year. This service must be provided to all pregnant women. (Estimate that 15% of pregnant women would need nutrition counseling because of high risk pregnancy. Average two visits per person X 600 persons x $35/visit)

4. New eligibility technicians in the Division of Public Assistance to review applications, conduct interviews, verify eligibility and authorize medical coupons for the new population of pregnant women and children eligible under this Medicaid option. There will be two new positions in year one and three new positions in year two, with a one time outlay of $3,000 per position for desk, chair, file cabinet and computer terminal.

5. This change in the Medicaid Program will require a system support increase to the Eligibility Information System (EIS) of the Division of Public Assistance, and will require lead time to accomplish (the January 1, 1989 implementation date).

Year One

		Fed match	GF match
Cost	Medicaid services for pregnant women assuming ½ year costs	$1,013,690	$1,013,690
	Medicaid services for children one year of age assuming ½ year costs	$ 291,713	$ 291,713
	Case management services 5 nurses at 75/25 federal state match plus travel, supplies, equipment and risk insurance assuming 3/4 year cost and 10.0 for outreach	$ 193,743	$ 88,956
	Two new eligibility technicians for the Division of Public Assistance - $36,300 assuming ½ year cost of $18,150 each at 50/50 state/federal match plus equipment	$ 21,150	$ 21,150
	Public Assistance computer system data processing	$ 7,450	$ 7,450
	TOTAL	$1,527,746	$1,422,959

Year Two

NOTE: This will be the first full year of the program, so the costs for medical services for pregnant women and children, and new positions have been restated indicating full year costs.

Add children up to age two with incomes up to 100% of the federal poverty level to the Medicaid Program.

		Fed match	GF match
Cost	Medicaid services for pregnant women	$2,027,381	$2,027,381
	Medicaid services for children one and two years of age.	$1,166,852	$1,166,852
	Nutrition services	$ 21,000	$ 21,000
	Case management services, full year cost	$ 249,700	$ 103,200
	Three new eligibility technicians for the Division of Public Assistance - $36,300 each at 50/50 state federal match plus equipment	$ 59,000	$ 59,000
	Full year cost of two eligibility technicians added year one	$ 36,300	$ 36,300
	Public Assistance data processing	$ 7,450	$ 7,450
	TOTAL	$3,567,683	$3,421,183

Year Three

Add children up to age three with incomes up to 100% of the federal poverty level to the Medicaid Program.

		Fed match	GF match
Cost	Medicaid services for children three years of age.	$ 583,426	$ 583,426
	Public Assistance data processing	$ 7,450	$ 7,450
	TOTAL	$ 590,876	$ 590,876

NOTE: Assumes base includes year 1 and year 2 costs.

Year Four

Add children up to age four with incomes up to 100% of the federal poverty level to the Medicaid Program.

		Fed match	GF match
Cost	Medicaid services for children four years of age.	$ 583,426	$ 583,426
	Public Assistance data processing	$ 7,450	$ 7,450
	TOTAL	$ 590,876	$ 590,876

NOTE: Assumes base includes years 1, 2 and 3 costs.

Year Five

Add children up to age five with incomes up to 100% of the federal poverty level to the Medicaid Program.

		Fed match	GF match
Cost	Medicaid services for children five years of age.	$ 583,426	$ 583,426
	Public Assistance data processing	$ 7,450	$ 7,450

TOTAL	$ 590,876	$ 590,876

NOTE: Assumes base includes years 1, 2, 3 and 4 costs.

ASSUMPTIONS: An inflation factor has not been added to medical care costs for years two, three, four and five. An inflation factor will have to be applied each fiscal year to the Medicaid budget to adequately fund this option.

ALASKA HEALTHY BABY PROJECT
Summary

	YEAR				
	1989	1990	1991	1992	1993
Pregnant Women Coverage for medical services	2,027.4	4,054.8	4,054.8	4,054.8	4,054.8
Medical services for children:					
Age one year	583.5	1,166.9	1,166.9	1,166.9	1,166.9
Age two years		1,166.9	1,166.9	1,166.9	1,166.9
Age three years			1,166.9	1,166.9	1,166.9
Age four years				1,166.9	1,166.9
Age five years					1,166.9
Division of Public Assistance Eligibility Technicians plus equipment					
two - first year	42.3	72.6	72.6	72.6	72.6
three - second year		118.0	109.0	109.0	109.0
DPA computer upgrade	14.9	14.9	14.9	14.9	14.9
Case Management	282.7	352.9	352.9	352.9	352.9
Nutrition Services		42.0	42.0	42.0	42.0
Total Yearly Cost	2,950.8	6,989.0	8,146.9	9,313.8	10,480.7
Yearly General Fund Cost	1,423.0	3,421.3	4,000.1	4,583.5	5,166.9
Yearly federal cost	1,527.8	3,567.7	4,146.8	4,730.3	5,313.8

AFDC INCOME STANDARDS

Adult included		ANNUAL	Adult not included		ANNUAL
			1	$275	$3300
2	$692	$8304	2	$550	$6600
3	$779	$9348	3	$637	$7644
4	$866	$10392	4	$724	$8688
5	$953	$11436	5	$811	$9732
6	$1040	$12480	6	$898	$10776
7	$1127	$13524	7	$985	$11820
each add	$87		each add	$87	

single adult pregnant woman	$437
increment for incapacitated spouse	$162

ALASKA'S FEDERAL POVERTY LEVEL

Family size	annual income
1	$6,860
2	$9,240
3	$11,620
4	$14,000
5	$16,380
6	$18,760
7	$21,140
8	$23,520
each additional	$2,380

NOTE: THESE INCOME LEVELS WILL BE CHANGED IN FEBRUARY 1988.

RESOURCE LIMITS

AFDC

- a home of any value
- a car worth $1,500
- other real or personal property worth up to $1,000

APA/SSI

- a home of any value
- a car worth $4,500
- personal effects worth up to $2,000
- liquid resources worth $1,800 for individuals and $2,700 for couples
- a burial plot
- up to $1,500 for burial expenses
- life insurance with face value up to $1,500

Alaska's Medicaid Program pays for the following services:

- inpatient hospital care
- outpatient hospital care
- laboratory and x-ray services
- skilled nursing facility and home health services for individuals 21 and older
- physicians services
- rural health clinic services
- early and periodic screening, diagnosis and treatment for individuals under 21 (EPSDT)
- family planning
- medical transportation
- nurse midwife services
- community mental health clinic and state operated mental health clinic services
- intermediate care facility services
- intermediate care facility for the mentally retarded services
- skilled nursing facility services for individuals under 21
- optometrists services and eyeglasses
- mental institution services for persons under 21
- institution for mental diseases services for persons aged 65 and older
- treatment of speech, hearing and language disorders
- outpatient surgical care center services
- physical therapy
- occupational therapy
- prosthetic devices
- medical supplies
- adult dental services (limited to relief of pain and acute infection)
- chiropractic services
- personal care attendant services

Prescription drugs are provided to Medicaid recipients through the 100% state-funded General Relief Medical Assistance Program.

FY89

BRU	Medical Assistance Administration	Medical Assistance	Medical Assistance	Public Assistance Administration	Public Assistance Administration	State Health Services
Component	Claims Processing	Medicaid Facility	Medicaid Non-Facility	Eligibility Determinations	PA Data & Word Processing	Family Health
Personal Serv.	33.9	-0-	-0-	36.3	-0-	175.7
Travel	16.0	-0-	-0-	-0-	-0-	30.0
Contractual	3.8	-0-	-0-	-0-	14.9	13.2
Supplies	.3	-0-	-0-	-0-	-0-	1.8
Equipment	-0-	-0-	-0-	6.0	-0-	8.0
Land & Street	-0-	-0-	-0-	-0-	-0-	-0-
Grants/Claims	-0-	1,740.6	870.2	-0-	-0-	-0-
Misc.	-0-	-0-	-0-	-0-	-0-	-0-
Total Op	54.0	1,740.6	870.2	42.3	14.9	228.7
General Fund	18.5	870.3	435.1	21.15	7.5	70.4
Fed Fund	35.5	870.3	435.1	21.15	7.4	158.3
FTE	1	0	0	2	0	4

FY90

INCLUDES NUTRITION SERVICES

BRU	Medical Assistance Administration	Medical Assistance	Medical Assistance	Public Assistance Administration	Public Assistance Administration	State Health Services
Component	Claims Processing	Medicaid Facility	Medicaid Non-Facility	Eligibility Determinations	PA Data & Word Processing	Family Health
Personal Serv.	45.2	-0-	-0-	181.6	-0-	234.2
Travel	8.0	-0-	-0-	-0-	-0-	40.0
Contractual	5.0	-0-	-0-	-0-	14.9	17.6
Supplies	.5	-0-	-0-	-0-	-0-	2.4
Equipment	-0-	-0-	-0-	9.0	-0-	-0-
Land & Street	-0-	-0-	-0-	-0-	-0-	-0-
Grants/Claims	-0-	4,259.1	2,171.5	-0-	-0-	-0-
Misc.	-0-	-0-	-0-	-0-	-0-	-0-
Total Op	58.7	4,259.1	2,171.5	190.6	14.9	294.2
General Fund	14.7	2,129.5	1,085.7	95.3	7.5	88.5
Fed Fund	44.0	2,129.5	1,085.8	95.3	7.4	205.7
FTE	1	0	0	5	0	4

SPEECH ON PRENATAL CARE DELIVERED BY ELIZABETH WARD TO CHILDREN'S CAUCUS

SB 348 AND HB 342

JANUARY 20, 1988

GIVING BIRTH TO A CHILD IS A UNIVERSAL HUMAN EXPERIENCE, A PROCESS ASSOCIATED IN THE MINDS OF MOST OF US WITH JOY AND FULFILLMENT, BUT WE ALSO KNOW THAT PREGNANCY AND CHILDBIRTH ARE NOT WITHOUT RISKS THAT ARE SOMETIMES SERIOUS AND OCCASIONALLY EVEN FATAL. MEDICAL CARE AND THE PROVISION OF NUTRITIONAL, EDUCATIONAL, AND OTHER SUPPORT SERVICES BEFORE, DURING, AND AFTER BIRTH AND DURING THE FIRST FIVE YEARS OF A BABY'S LIFE ARE ESSENTIAL TO ENSURE THE BEST POSSIBLE OUTCOME FOR MOTHERS AND CHILDREN. THIS PROPOSED LEGISLATION IS IMPORTANT BECAUSE NOT ALL ALASKANS CAN TAKE HIGH-QUALITY MATERNITY CARE FOR GRANTED.

WHEN PEOPLE WHO HAVE NO HEALTH INSURANCE NEED MEDICAL CARE, THEY MUST DEPEND ON THEIR OWN RESOURCES OR DELAY OR AVOID PRENATAL CARE BECAUSE MOST PHYSICIANS REQUIRE SOME FORM OF PAYMENT THE FIRST TIME THE WOMAN SEES THE PHYSICIAN. SOME WOMEN ASSUME LARGE DEBTS, WHICH MAY OR MAY NOT BE PAID. IF THESE DEBTS ARE NOT FULLY PAID, THE BURDEN OF THE UNPAID PORTION--CALLED UNCOMPENSATED CARE--FALLS FIRST ON THE HEALTH CARE PROVIDERS BUT ULTIMATELY ON THE TAXPAYER OR ON EMPLOYERS AND EMPLOYEES THROUGH INCREASED HEALTH INSURANCE PREMIUMS. WOMEN OF REPRODUCTIVE AGE ARE LESS LIKELY THAN MOST OTHER PEOPLE TO HAVE HEALTH INSURANCE, AND MEDICAL TECHNOLOGY HAS MADE IT POSSIBLE TO SAVE VERY IMMATURE OR SEVERELY ILL INFANTS. THUS, A SUBSTANTIAL PROPORTION OF TODAY'S UNCOMPENSATED CARE IS THE RESULT OF HOSPITAL SERVICES PROVIDED TO MATERNITY PATIENTS AND THEIR BABIES.

THE NATIONAL STATISTICS ARE A TRAGEDY. IN THE 1950's, THE U.S. RANKED SIXTH IN INFANT MORTALITY AMONG TWENTY INDUSTRIALIZED NATIONS. IN THE 1980's, WE

ARE TIED FOR LAST PLACE.

A PERSISTENTLY HIGH RATE OF LOW-BIRTHWEIGHT BABIES AND HIGH MORTALITY RATES AMONG OLDER INFANTS HAVE CONTRIBUTED TO THIS DECLINE.

IN ALASKA, THE MORTALITY RATE FOR INFANTS BETWEEN ONE MONTH AND ONE YEAR IS THE HIGHEST IN THE NATION.

FOR THE MOST RECENT YEAR THAT WE HAVE RELIABLE STATISTICS, OVER 600 BABIES BORN IN ALASKA WEIGHED LESS THAN 5 1/2 POUNDS AT BIRTH; 142 BABIES DIED BEFORE REACHING THEIR FIRST BIRTHDAY.

IN 1986, AN ESTIMATED 2,000 WOMEN WERE NOT ABLE TO AFFORD PRENATAL CARE IN THEIR FIRST THREE MONTHS OF PREGNANCY.

WE KNOW THAT FOUR TO FIVE DELIVERIES OCCUR MONTHLY IN ANCHORAGE EMERGENCY ROOMS BECAUSE THESE WOMEN HAVE HAD NO PRENATAL CARE.

<u>WE ALSO KNOW THAT INADEQUATE PRENATAL CARE AND LOW-BIRTHWEIGHT BABIES HAVE EXPENSIVE CONSEQUENCES.</u>

- THE HOSPITAL COST FOR CARING FOR A LOW-BIRTHWEIGHT INFANT FOR ONE DAY IN ALASKA IS $1500.00.

- THE AVERAGE TOTAL COST FOR PRENATAL, LABOR, AND DELIVERY CARE IN ALASKA IS $3500.00; THIS IS LESS THAN THE COST OF 1 1/2 DAYS IN A NEONATAL INTENSIVE CARE UNIT.

- IN THIS STATE, A LOW-INCOME WOMAN WHO DOES NOT HAVE MEDICAL INSURANCE AND IS NOT ELIGIBLE FOR MEDICAID WILL HAVE TO SPEND UP TO 25% OF HER INCOME TO PAY FOR AN UNCOMPLICATED PREGNANCY.

PREVENTION CAN BE COST EFFECTIVE

- EVERY $1.00 SPENT ON ADEQUATE PRENATAL CARE SAVES $2.00 IN MEDICAL CARE DURING THE FIRST YEAR OF AN INFANT'S LIFE.

- WE CAN SAVE UP TO $11.00 FOR EVERY $1.00 SPENT ON PRENATAL CARE IF ALL COSTS ASSOCIATED WITH CARING FOR PERMANENTLY DISABLED CHILDREN WHOSE MOTHERS RECEIVED INADEQUATE PRENATAL CARE ARE INCLUDED.

PRENATAL CARE IN ALASKA AS IT NOW STANDS LEAVES MANY GAPS, INCLUDING UNDER-EMPLOYED POOR WOMEN WHO ARE NOT ELIGIBLE FOR MEDICAID, TEENAGERS UNDER 18 WHO LIVE AT HOME, WOMEN WHO HAVE MEDICAL INSURANCE BUT WHO CANNOT AFFORD THE COST OF TRANSPORTATION TO CARE, AND INDIAN HEALTH SERVICE ELIGIBLE WOMEN WHOSE TRANSPORTATION TO RECEIVE SPECIAL CARE OR TESTS IS NOT PROVIDED AND WHO CANNOT AFFORD TO PAY FOR THE TRANSPORTATION THEMSELVES.

ADEQUATE PRENATAL CARE MEANS THAT CARE BEGINS DURING THE FIRST THREE MONTHS OF PREGNANCY; THE PROVIDER IS A PHYSICIAN, NURSE MIDWIFE, OR NURSE PRACTITIONER; THE CARE FOLLOWS A SET SCHEDULE OF VISITS; AND THE CARE IS COMPREHENSIVE.

EQUALLY IMPORTANT IS ADEQUATE CONTINUING FOLLOWUP OF THE CHILDREN, PARTICULARLY THOSE AT RISK FOR NUTRITIONAL DEFICIENCY, CHRONIC ILLNESSES, INADEQUATE PARENTING, AND ABUSE AND NEGLECT.

POOR CHILDREN GET POOR HEALTH CARE. THAT MEANS WE PAY AND THEY PAY FOR THE CONSEQUENCES OF THAT POOR HEALTH CARE FOR THE REST OF THEIR LIVES. THE ACADEMY OF PEDIATRICS HAS DOCUMENTED THAT CHILDREN WITH THE LEAST CARE COST THE MOST.

PUBLIC HEALTH NURSES ARE SEEING A CONTINUOUS STREAM OF SICK CHILDREN SHOWING UP AT THEIR WELL-BABY CLINICS WITH CHRONIC RESPIRATORY AND EAR INFECTIONS THAT ADVERSELY AFFECT THE CHILD'S HEARING, SPEECH, DEVELOPMENT, AND NUTRITIONAL STATUS. THESE NURSES ARE FRUSTRATED IN THEIR EFFORTS TO GET HELP FOR THESE CHILDREN BECAUSE THEIR FAMILIES DO NOT HAVE HEALTH INSURANCE AND MAKE JUST ENOUGH MONEY TO MAKE THEM INELIGIBLE FOR MEDICAID. THESE ARE THE CHILDREN WHO WILL END UP WITH BEHAVIORAL AND LEARNING PROBLEMS BY THE TIME THEY ENTER SCHOOL, WHO WILL BE UNNECESSARILY LESS PRODUCTIVE THAN THEIR PEERS, AND WHO WILL OVER THEIR LIFETIMES CREATE INCALCULABLE COSTS TO SOCIETY AND THE PUBLIC TREASURY.

THIS PROPOSED LEGISLATION IS NOT THE WHOLE SOLUTION OR A PANACEA. IT WILL NOT ELIMINATE ALL BAD PREGNANCY OUTCOMES OR ALL DISABLED CHILDREN. IT IS, HOWEVER, A FIRST STEP IN PROVIDING BASIC HEALTH SERVICES TO THE MEDICALLY NEEDY.

IT IS CLEAR THAT PROVIDING COMPREHENSIVE HEALTH COVERAGE FOR PREGNANT WOMEN, FOR INFANTS, AND FOR PRESCHOOLERS IS NOT ONLY THE RIGHT THING DO, IT IS THE MOST COST EFFECTIVE THING TO DO AS WELL.

ALASKA HEALTHY BABY PROJECT

TESTIMONY OF NANCY BENNETT, DIVISION OF MEDICAL ASSISTANCE, DEPARTMENT OF HEALTH AND SOCIAL SERVICES TO THE CHILDRENS' CAUCUS, JANUARY 20, 1988.

WHEN THE MEDICAID PROGRAM WAS CREATED BY CONGRESS IN 1965, IT WAS DESIGNED TO PROVIDE HEALTH CARE COVERAGE FOR POOR WOMEN AND CHILDREN WHO QUALIFIED UNDER THE AID TO FAMILIES WITH DEPENDENT CHILDREN (AFDC) PROGRAM.

SINCE 1965, THE HIGH COST OF LONG TERM CARE FOR THE ELDERLY AS WELL AS THE MORE LIBERAL ELIGIBILITY CRITERIA FOR THE AGED AND DISABLED HAVE CHANNELLED MEDICAID FUNDING AWAY FROM POOR WOMEN AND CHILDREN. MEANWHILE, WOMEN AND CHILDREN HAVE SUNK DEEPER INTO POVERTY THAN ANY OTHER GROUP IN AMERICA. TWENTY YEARS AGO 25% OF THE ELDERLY LIVED IN POVERTY. THROUGH WELL ORGANIZED GROUPS, MANY INITIATIVES BROUGHT ABOUT CHANGES THAT HAVE RESULTED IN ONLY 12% OF THE ELDERLY LIVING IN POVERTY TODAY.

CONVERSELY, ONE IN FOUR CHILDREN IN THIS COUNTRY LIVE BELOW THE POVERTY LEVEL, BUT THIS MEASURE IS AN OPPORTUNITY TO MAKE SOME IMPROVEMENT IN THEIR LIVES. IN ALASKA, THE FINANCIAL NEED STANDARDS FOR THE AFDC PROGRAM (WHICH DETERMINE WHO RECEIVES CASH ASSISTANCE AND MEDICAID) ARE AT 77.8% OF THE POVERTY LEVEL: THE NEED STANDARDS FOR THE ELDERLY ARE AT 115%, AND AT 186% FOR THOSE REQUIRING NURSING HOME CARE.

CONGRESS NOTED THE SLIPPAGE OF THE AFDC NEED STANDARDS WITH CONCERN. THEY WERE ALSO ALARMED BY THE INFANT MORTALITY RATES IN THIS COUNTRY, AND THE NUMBER OF WOMEN UNABLE TO RECEIVE ADEQUATE PRENATAL CARE. NUMEROUS STUDIES

HAVE SHOWN THAT THE TWO AREAS IN WHICH PREVENTIVE HEALTH CARE CAN HAVE A MAJOR EFFECT ON OUTCOME IS WITH PRENATAL CARE AND WELL CHILD CARE.

IN 1986, CONGRESS CREATED A NEW MEDICAID OPTION WHICH ALLOWS STATES TO GRANT MEDICAID COVERAGE TO PREGNANT WOMEN AND CHILDREN UP TO AGE 5 WHOSE FAMILY INCOMES DO NOT EXCEED 100% OF THE FEDERAL POVERTY LEVEL. 26 STATES SELECTED THIS OPTION BY JANUARY 1, 1988, AN UNPRECEDENTED LEVEL OF ACTION AMONG STATES IN ADOPTING A NEW MEDICAID PROGRAM. THE OPTION WAS DESIGNED TO GRANT STATES GREAT FLEXIBILITY IN AN EFFORT TO ASSURE BROAD ACCESS TO PRENATAL AND DELIVERY SERVICES BY REDUCING THE PAPERWORK AND OTHER BARRIERS TO MEDICAID ELIGIBILITY.

THIS MEDICAID OPTION WAS CONSIDERED SO SUCCESSFUL THAT CONGRESS JUST PASSED IN DECEMBER, 1987, ENABLING LEGISLATION TO ALLOW MEDICAID COVERAGE OF PREGNANT WOMEN AND CHILDREN UP TO THE AGE OF EIGHT WHOSE HOUSEHOLD INCOMES DO NOT EXCEED 185% OF THE FEDERAL POVERTY LEVEL.

THE MEASURES BEFORE YOU TODAY, SPONSORED BY REPRESENTATIVE ELLIS AND SENATOR UEHLING, ARE DESIGNED TO ALLOW ALASKA TO TAKE FULL ADVANTAGE OF THE 1986 OPTION TO PROVIDE MEDICAID TO PREGNANT WOMEN AND CHILDREN WITH HOUSEHOLD INCOMES UP TO 100% OF THE POVERTY LEVEL. WE CALL IT THE ALASKA HEALTHY BABY PROJECT.

SPECIFICALLY, THE LEGISLATION PROPOSES TO PROVIDE MEDICAID COVERAGE TO AN ESTIMATED 974 PREGNANT WOMEN, AND A LIKE NUMBER OF CHILDREN UNDER AGE ONE, BEGINNING JANUARY 1, 1989. EACH YEAR, THE AGE OF COVERED CHILDREN WILL

INCREASE BY ONE YEAR UNTIL CHILDREN UP TO AGE FIVE ARE COVERED, JUST UNDER 5,000 ALASKAN PRE-SCHOOL AGE CHILDREN.

THE WOMEN AND CHILDREN WOULD RESIDE IN FAMILIES WHOSE INCOMES DO NOT EXCEED 100% OF THE FEDERAL POVERTY LEVEL FOR ALASKA. THERE WILL BE NO RESOURCE OR ASSET LIMIT FOR THESE TWO GROUPS. PREGNANT WOMEN AND CHILDREN WILL RECEIVE ALL MEDICAID COVERED SERVICES; IN ADDITION, PREGNANT WOMEN WILL RECEIVE CASE MANAGEMENT AND NUTRITION SERVICES.

UNDER CURRENT RULES A PREGNANT WOMAN MUST HAVE LESS THAN $692 PER MONTH TO QUALIFY FOR MEDICAID. THAT'S $8,304 PER YEAR. WITH THIS CHANGE, A PREGNANT WOMAN CAN HAVE APPROXIMATELY $9,700 PER YEAR AND STILL QUALIFY FOR MEDICAID.

IT IS NOT INEXPENSIVE TO ADD PRENATAL CARE, DELIVERY, POSTPARTUM CARE AND WELL CHILD CARE FOR A NEW GROUP OF WOMEN AND CHILDREN. WE ESTIMATE THAT THE COST FOR A FULL YEAR WILL BE $3.4 MILLION IN GENERAL FUNDS FOR A TOTAL COST OF $6.9 MILLION WHEN COMBINED WITH FEDERAL MEDICAID DOLLARS. THE COST PER CASE IS ESTIMATED TO BE $4,163 PER PREGNANT WOMAN AND $1,298 PER CHILD INCLUDING STATE AND FEDERAL FUNDS.

ACCESS TO PRENATAL AND WELL CHILD CARE IS AN ISSUE WHICH MOST OF US BELIEVE IS TOO IMPORTANT TO BE DECIDED ON THE BASIS OF COST ALONE. HOWEVER, STATE AND FEDERAL DOLLARS ARE LIMITED, AND THE CURRENT WATCH WORDS IN BOTH THE STATE AND FEDERAL ECONOMIES ARE "BUDGET NEUTRAL".

THE REASON THAT THE HEALTHY BABY PROJECT WAS SUCCESSFUL IN CONGRESS AND IN 26 STATES IS THAT THEY ALL KNOW, JUST AS YOU DO, THAT THE AVERAGE COST OF NEO-NATAL INTENSIVE CARE IS IN EXCESS OF $50,000, NOT INCLUDING THE LIFE-LONG COST OF SPECIAL EDUCATION AND INSTITUTIONALIZATION. WHEN COMPARED TO $5,461 PER YEAR FOR PREVENTIVE HEALTH CARE FOR PREGNANT WOMEN AND CHILDREN, IT SEEMS LIKE A BARGAIN FOR EVERYONE'S BUDGET.

From "State Health Plan for Alaska", June 1984

INFANT MORTALITY

HEALTH STATUS GOAL:
REDUCE THE INFANT MORTALITY RATE TO 15 PER 1,000 LIVE BIRTHS AND THE NEONATAL DEATH RATE TO 9 PER 1,000 LIVE BIRTHS.

HEALTH SYSTEMS RESPONSE:
Provide an adequate range of preventive, primary and acute care services.

HEALTH SYSTEMS OBJECTIVE:	RELATIONSHIP TO PART II: SERVICES OBJECTIVES & ACTIONS
H. Ensure that all women have access to early and continuous prenatal care, including prenatal education and access to obstetrical services, by 1985.	
I. Maintain the High Risk Infant Critical Care System of the Alaska Newborn Project.	
J. Ensure that 100% of families have access to autopsy confirmation in cases of unexplained infant death, and that 100% of families that have experienced sudden infant death received information and counseling.	

BACKGROUND **RECOMMENDATION**

Teenage Prenatal Care: 73

A comprehensive prenatal and infant care program is essential to ensure nutritional and medical care needs for healthy pregnancies and healthy children. In 1986, the U.S. Congress broadened states' ability to provide this care for poor women and their children and appropriated federal dollars to match state dollars. Families with incomes up to the poverty level can be included. Alaska has the ninth highest infant mortality rate in the nation, and the highest rate of postneonatal mortality. Low birth weight, which is significantly reduced by good prenatal care programs, is responsible for 40% of Alaska's infant deaths. Alaska's teenagers, just 50% of whom receive adequate prenatal care now, are more likely to have low birth weight babies. The new federal option allowed under the Sixth Omnibus Budget Reconciliation Act (SOBRA) has already been adopted by more than half the states. If adopted in Alaska, an estimated 974 additional women would receive pregnancy and postpartum coverage, and 5,000 children would have medical insurance coverage under Medicaid for their first five years of life. For every $1 spent on women at high risk of having low birth weight babies, $3.40 is saved in the surviving infant's first year of life alone.

Comprehensive prenatal care programs for teenagers and low income women should be created and funded through expanded Medicaid coverage options allowed under SOBRA. The programs would ensure medical care, access to community social services, adequate nutrition, and emphasize home visits to teenage parents by public health nurses or lay companions during the last three months of pregnancy through an infant's first birthday. The visitors should teach parenting skills and monitor the health of mother and infant.

A comprehensive prenatal and infant care program is essential to ensure nutritional and medical care needs for healthy pregnancies and healthy children.

BACKGROUND

RECOMMENDATION

Teenage Prenatal Care: 73

A comprehensive prenatal and infant care program is essential to ensure nutritional and medical care needs for healthy pregnancies and healthy children. In 1986, the U.S. Congress broadened states' ability to provide this care for poor women and their children and appropriated federal dollars to match state dollars. Families with incomes up to the poverty level can be included. Alaska has the ninth highest infant mortality rate in the nation, and the highest rate of postneonatal mortality. Low birth weight, which is significantly reduced by good prenatal care programs, is responsible for 40% of Alaska's infant deaths. Alaska's teenagers, just 50% of whom receive adequate prenatal care now, are more likely to have low birth weight babies. The new federal option allowed under the Sixth Omnibus Budget Reconciliation Act (SOBRA) has already been adopted by more than half the states. If adopted in Alaska, an estimated 974 additional women would receive pregnancy and postpartum coverage, and 5,000 children would have medical insurance coverage under Medicaid for their first five years of life. For every $1 spent on women at high risk of having low birth weight babies, $3.40 is saved in the surviving infant's first year of life alone.

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A comprehensive prenatal and infant care program is essential to ensure nutritional and medical care needs for healthy pregnancies and healthy children.

EXAMPLES OF GAPS IN PRENATAL CARE

Women earning over 78% of poverty are **not** eligible for medicaid; these women must pay cash out of pocket for prenatal care unless insured.

-- *uncomplicated pregnancy = 25% of her income must go toward prenatal care*

The 1984 Vital Statistics Report states that 25% (605) of Native women had inadequate prenatal care and 13% of White Alaskan women received inadequate prenatal care.

Four to five deliveries occur monthly in Anchorage emergency rooms because these women have had no prenatal care.

Alaska Women's Health Clinic in Anchorage reports 27% of their patients are not eligible for any third party reimbursement.

Providence Hospital reported that in 1986, 667 of the 2,480 births there occurred to women who had **no** third party reimbursement for their birth; 555 of these women have established some sort of payment plan for their birth, but 112 of these have not been able to establish a payment plan.

The state demographer estimates that 11% of the Alaska population has incomes above the Alaska poverty line, but **below** $18,000.

POSTNEONATAL MORTALITY IN ALASKA

Definitions:

Infant Mortality (IM) - death of an infant during its first year of life

Neonatal Mortality (NM) - death of an infant during its first 28 days of life

Postneonatal Mortality (PNM) - death of an infant between 28 days and one year of age

Facts: *(based on Alaska data for 1979-85)*

1. Alaska's PNM rate is the **highest** of any state in the union.
   - AK's 1984 PNM rate: 5.5
   - U.S. 1984 PNM rate: 3.8

2. In Alaska, the PNM rate for Natives is **twice** as high as that for Whites.

   1984
   - Natives - 9.2
   - Whites - 4.5

   1979-85
   - Natives - 9.6
   - Whites - 4.3

3. The Native's PNM rate is higher than the rate for Whites in **each** of the 6 geographical regions in the state.

4. The PNM rate (for all races) is **highest** in these 2 regions:

	1985 Rate
• Southwest AK	10.0
• Northern AK	9.1

5. Low Birth Weight (LBW) is more common among Neonatal deaths than among Postneonatal deaths.

2/3 of neonatal deaths are LBW

1/4 of postneonatal deaths are LBW

This is true for both Whites and Natives.

6. 3/4 of all Postneonatal deaths are Normal Birth Weight (NBW).

7. Teens account for:

(1984 - 85 data)

9% of births

17% of Neonatal deaths

17% of PN deaths (between 6 mos. and 1 year)

8. Single mothers account for:

16% of births

24% of Neonatal deaths

33% of all PN deaths

9. Natives account for:

20% of births

26% of Neonatal deaths

42% of all PN deaths

10. The bush accounts for.

14% of births

18% of Neonatal deaths

26% of all PN deaths

11. Inadequate Prenatal Care was characteristic of 3-4% of infant deaths compared to <2 % of all births.

Higher percentage of Inadequate Prenatal Care was found among teens and among Natives.

(Adequacy of Care could not be determined for 1/3 of all infant deaths)

12. Causes of Death

- Neonatal: (of Whites and Natives respectively)

  Congenital Anomalies (29% and 22%)

  Respiratory Distress Syndrome (16% and 16%)

  Other Conditions of Perinatal Origin (30% and 31%)

- Postneonatal: (of Whites and Natives respectively)

  Sudden Infant Death Syndrome (SIDS) - (54% and 44%)

  (90% of PN SIDS occurred before the age of 6 months).

  For Whites, Congenital Anomalies (13%)

  For Natives, Pneumonia and Influenza (11%)

All other causes (18% and 27%). More detailed information is needed here.

Further Detail:

(1) **Low Birth Weight (LBW)** - less than 2500 grams (5.5 lbs)

Normal Birth Weight (NBW) - 2500 grams (5.5 lbs.) or more

(2) **PNM rate** = # postneonatal deaths in a year/# live births in a year X 1,000

(3) The 6 geographical regions of the state (with census areas included in each):

- Anchorage/Matanuska - Susitna Region

  Anchorage Borough

  Matanuska-Susitna Borough

- Gulf Coast Region

  Kenai Peninsula Borough

  Kodiak Island Borough

  Valdez-Cordova Census Area

- Interior Region

  Fairbanks North Star Borough

  Southeast Fairbanks Census Area

  Yukon-Koyukuk Census Area

- Northern Region
  - Nome Census Area
  - North Slope Borough
  - Northwest Arctic Borough (Kobuk C.A.)

- Southeast Region
  - Haines Borough
  - Juneau Borough
  - Ketchikan Gateway Borough
  - Prince of Wales-Outer Ketchikan C.A.
  - Sitka Borough
  - Skagway-Yakutat-Angoon Census Area
  - Wrangell-Petersburg Census Area
- Southwest Region
  - Aleutian Islands Census Area
  - Bethel Census Area
  - Bristol Bay Borough
  - Dillingham Census Area
  - Wade Hampton Census Area

(4) The bush: Census Areas

Nome, North Slope, Northwest Arctic (Kobuk), Aleutian Islands, Bethel, Bristol Bay, Dillingham, Wade Hampton, Yukon-Koyukuk

(5) Inadequate Prenatal Care: Initial visit was in the third trimester of pregnancy or fewer than five prenatal visits.

PRENATAL CARE COSTS

Adequate Prenatal Care - for uncomplicated pregnancies must begin in the first trimester

-- visits should be every 4 weeks for first 28 weeks

-- one visit every 2 weeks for next 8 weeks

-- one visit every week thereafter until delivery

-- total number of prenatal visits = 14 to 15 visits

-- prenatal care provider - obstetrician/gynecologist, certified nurse midwife, or advanced nurse practitioner

Alaska Women's Health Service - Prenatal Care

1st Prenatal Visit	$ 200
Each Subsequent Visit @ $45 x 13 visits	$ 585

Since the recommended prenatal visit schedule for prenatal care totals 14 visits for a low risk full term gestation, I multiplied the $45 per visit rate by 13 visits.

Delivery Fees

Vaginal delivery	$ 700
Cesarean Section	$ 1,400

Cost of Vaginal Delivery		Cost of a C-Section Delivery	
Prenatal Care	$ 785	Prenatal Care	$ 785
Delivery-Physician Chg.	700	C-Section Del.	$ 1,400
Total Fees	$1,485	Total Fees	$ 2,185
Providence Hospital Fees	1,950	Providence Fees	$ 5,000
Grand Total	**$3,435**	**Grand Total**	**$ 7,185**

Neighborhood Health Center

Fee includes **all** prenatal visits plus delivery charges

0 Fee	25% Fee	50% Fee	75% Fee	Full Fee
Medicaid	125% Poverty	150% Poverty	175% Poverty	200% Poverty
$0.00	$300	$600	$900	$1,200

OPTIONS FOR INCREASING PRENATAL SERVICES

I. Increase the number of women and children who qualify for medicaid

II. Provide a prenatal care program that would pay a portion of the cost of the medical prenatal care of the eligible women. Each woman would have a participation amount that would be dependent on her income and family size.

Eligibility

-- **low income,** but not eligible for medicaid

-- **high risk pregnancy** due to a medical condition or lack of access to prenatal care because of geographic location.

III. Enhancement of Services

-- case management

-- nutritional services

-- presumptive eligibility

-- no resource limit

-- one time eligibility

Solutions can be limited to one of these three choices or be combination of the three - see schematic.

NUMBER OF WOMEN OF CHILD BEARING AGE IN ALASKA

BY AGE AND RACE

1984 Alaska Vital Statistics Annual Report

Age	White	Native	Other	Total
15-19	13,605	4,051	1,684	19,340
20-24	14,455	3,980	2,139	20,574
25-29	23,497	3,338	3,902	30,737
30-34	24,205	2,939	1,785	21,248
35-39	17,192	2,271	1,083	14,459
	104,604	18,305	13,873	136,782

1984 LIVE BIRTHS BY AGE AND RACE OF MOTHER

Age	White	Native	Black	Other	Unknown	Total
< 15	4	4	0	0	0	8
15-17	158	136	17	3	0	314
18-19	531	294	41	11	6	883
20-24	2,929	848	160	82	30	4,049
25-29	3,163	628	126	119	25	4,061
30-34	1,911	328	51	77	23	2,390
35-39	567	117	5	39	0	733
40-44	55	22	0	4	0	81
45 +	1	1	0	1	0	3
Unknown	1	2	0	0	0	3
	9,320	2,380	400	336	89	12,525

PROBLEMS TO BE DISCUSSED

Access to Care

Teen Pregnancies

Nutrition for Pregnant Women

Sudden Infant Death Syndrome

Data Related to Infant Births and Deaths

STEVE COWPER, GOVERNOR

DEPT. OF HEALTH AND SOCIAL SERVICES

DIVISION OF PUBLIC HEALTH

POUCH H-06
JUNEAU, ALASKA 99811-9976

PHONE:

PREVENTION SAVES ALASKA'S BABIES AND THE STATE'S MONEY

- National data shows lack of prenatal care as the most significant factor in problem births, including prematurity, infants of low birthweight and infant deaths and disabilities.

- A woman without adequate prenatal care has twice the risk of her infant being born with low birthweight and twice the risk of infant death as the infant born to a mother with adequate care.

- Low birthweight babies can suffer tragic outcomes and must endure extensive and costly medical care: about 20% of all neonatal intensive care unit graduates have major medcial problems by age two. Up to 60% have some physical or intellectual difficulties by age five.

- Every $1.00 spent on comprehensive prenatal care saves $2.00 in the first year of an infant's life alone, because of the reduced need for hospital care.

- Every $1.00 spent on prenatal care saves up to $11.00 when all costs of caring for permanently disabled children are included.

- Every $1.00 spent on women at high risk for delivering low birthweight babies saves $3.40 during the surviving infants' first year of life.

- Prenatal care that begins early in pregnancy and provides a woman with the medical, nutritional and supportive services she and her baby need has been shown to reduce the incidence of low birthweight by 30%.

- Prenatal care is most effective in improving the health of high risk mothers and babies, whether the risk is from medical factors, or social factors or both.

- 3/4 of the factors that lead to low birthweigth can be evaluated in the first prenatal visit and appropriate intervention, such as counseling on substance abuse, can begin early to reduce risks.

- Prenatal visits routinely include blood pressure checks and blood urine tests to screen for conditions which if left unprotected and untreated can cause major problems to the mother or her baby.

- Routine prenatal tests can detect treatable conditions which lead to poor pregnancy outcomes.

STEVE COWPER, GOVERNOR

DEPT. OF HEALTH AND SOCIAL SERVICES

DIVISION OF PUBLIC HEALTH

POUCH H-06
JUNEAU, ALASKA 99811-9976

PHONE:

THE HEALTH OF ALASKA'S MOTHERS AND BABIES

- Each year, about 2,000 or 16% of all births in Alaska occur to women who recieve inadequate or no prenatal care.
- The average total cost for prenatal, labor and delivery care in Alaska is $3,500..... less than the cost of 1 1/2 days in a neonatal intensive care unit.
- In 1984, 608 babies were born low in Alaska weighing less than 5 1/2 pounds, most of whom required expensive ($2,500/day) neonatal intensive care; 142 babies died before reaching their first birthday.
- In 1986, an estimated 2,140 women in Alaska were not able to afford prenatal care in their crucial first trimester.
- Low birthweight babies constituted less than 5% of all births in Alaska in 1984, but accounted for more than 40% of all infant deaths.
- Alaska's low birthweight rate has remained fairly constant.... we have made very little progress in preventing low birthweight.
- Alaska's women most in need of prenatal care are least likely to receive it: single, nonwhite, teens and those with little education or income.
- The hight cost of prenatal and hospital delivery care is cited repeatedly as the predominant barrier in preventing low income women from obtaining needed prenatal care.
- Medicaid provides coverage for < 78% of the poor in Alaska.

A PROPOSAL FOR COMPREHENSIVE PRENATAL CARE AND HEALTH SERVICES FOR CHILDREN

ALASKA HEALTHY BABY PROJECT

WHAT IS IT?

The Alaska Healthy Baby Project would provide prenatal care, delivery and other health services to pregnant women who have incomes up to 100% of the federal poverty level.

The Alaska Healthy Baby Project would insure that prenatal care can begin as soon as pregnancy is confirmed, to include regular physical examinations, monitoring of the pregnancy, treatment of correctable conditions, assistance in making behavioral changes to reduce the risk of harm to mother and child, and assistance in securing basic needs such as good nutrition.

Children whose families have incomes up to 100% of the federal poverty level would receive a broad spectrum of preventive, screening and treatment services to assure optimum health status in the first five years of life. It is estimated that 5,000 children would receive additional medical coverage over the five year period.

Case management would be available through Public Health Nurses to Medicaid-eligible pregnant women to assess their health problems, coordinate their access to necessary medical care, and refer them to providers of social, education and other services. Promoting individual needs and appropriate prenatal care and health services, case management would aid in reducing complications of pregnancy, and diminish the frequency and severity of handicaps associated with premature delivery and low birth weight infants.

Nutrition services would also be made available to Medicaid-eligible pregnant women to assist those women identified as having complex nutritional, medical and social risk factors requiring intensive nutrition education. Through case managers, all pregnant women would be referred to the Women Infants and Children (WIC) Nutrition Program, however certain high risk women require services beyond the scope of WIC and would be served through enhanced nutritional services.

WHO

Under this Medicaid option, an estimated 974 low income women would be eligible for Medicaid coverage through their pregnancy and postpartum periods. This would increase, by a minimum of 22.2%, the number of pregnant women eligible for Medicaid services.

All children with incomes under the federal poverty level would also be eligible for Medicaid, up to age one the first year and phasing in children each year until all children under the age of five are covered.

WHY

The Alaska Healthy Baby Project is important because of the increasing number of women in Alaska who do not have access to prenatal and delivery care because they are low income but ineligible for Medicaid, or cannot afford health insurance or the cash outlay to cover the cost of those services.

Lack of prenatal care is associated with poor delivery outcomes, including prematurity, infants of low birthweight, and infant deaths and disabilities.

Research shows that improvement in the quality and availability of prenatal and delivery care reduces the need for expensive newborn intensive care.

In FY 84 the Medicaid program spent over $4.6 million dollars for 96 infants in newborn intensive care; 11 of those babies had medical costs exceeding $100,000 each.

In 1984, 141 Alaskan babies died before reaching the age of one; 72 of those infants died in the first 28 days of life.

HOW

All of these changes would require an amendment by the legislature to AS 47.07.020, 47.07.030 and 47.07.035 to allow the department to provide Medicaid to pregnant women and children whose incomes do not exceed 100% of the federal poverty level; to allow these pregnant women to receive case management and nutrition services; and to prioritize this group and these services under AS 47.07.035.

The state would also have to provide funding for these services: The FY 89 cost of adopting the option is $3,063.1 million ($1,477.5 state funds); for FY 90 the cost is $6,880.8 million ($3,397.1 state funds). The increase from FY 89 to FY 90 is because the program cannot be implemented until January 1, 1988 resulting in only ½ year funding the first year.

WHAT WILL HAPPEN?

These provisions will reduce the incidence of infant deaths, birth defects, and developmental disabilities related to insufficient prenatal care, premature birth and low birthweight; and will provide a system of preventive health care and early intervention, promote health and reduce long-term health care costs.

CONTACTS:

Elizabeth Ward, Director, Division of Public Health - 465-3090
Nancy Bennett, Medical Assistance Administrator, Division of Medical Assistance - 465-3355

* The federal law allows many different ways to provide coverage to all or part of this target group, The Alaska Healthy Baby Project is one way. These options are explained in more detail in additional materials.

Senator Rick Halford

Senate District I
Chugiak, Eagle River, East Anchorage, Fort Richardson

Senate Finance Committee
Co-Chairman

TO: All Legislators

FROM: Senator Rick Halford

DATE: March 26, 1988

SUBJECT: "Prenatal Care in Alaska: More Costs Less"

Alaskan newborn infants whose mothers do not seek enough prenatal care are in danger of being born too soon, too small and too sick. These babies have a much greater chance of dying than normal weight babies. But those who live -- and the majority do -- are at high risk to suffer from lifelong disabilities such as mental retardation, blindness, cerebral palsy and deafness.

Just ten years ago most low birthweight babies died. Today they are rushed to newborn intensive care units and many are saved. But this has created a public policy problem nationwide. The medical technology that keeps a fragile baby alive is staggeringly expensive. And infants who survive with serious physical and mental damage have enormous expenses lasting a lifetime.

These costs are likely to become the public's responsibility. Parents who cannot afford $1,100 for nine months of prenatal care in Alaska probably cannot afford $1,800 a day for intensive care in the Providence Hospital newborn intensive care unit, or $35,000 for the average 20-day stay in the unit or $1 million in costs for the sick babies who live at the unit two and even three years. They are unlikely to be able to pay $87,000 a year to institutionalize the baby with severe mental retardation or the $24,000 a year for special education for the child blinded by the very efforts to save its life.

Fortunately, much of the expense of low birthweight is preventable. Extensive studies document that pregnant women who obtain adequate prenatal care have a better chance of delivering healthy babies. This report, "Prenatal Care in Alaska: More Costs Less", prepared at my request, shows that if all Alaskan pregnant women were to obtain sufficient prenatal care, up to $6 in long-term medical and institutional costs alone might be saved for every $1 spent on prenatal care. The report shows that lives can be saved as well as money. As many as 27 low birthweight Alaskan babies will die this year who might have been born healthy if their mothers had obtained enough care during pregnancy. Babies with preventable low birthweight suffer from a perverse reversal of effort. We are very good at making the heroic and expensive efforts to save their lives but we are less adept at assuring the prenatal care which could prevent the baby's sickness in the first place. This report shows that adequate prenatal care makes good economic sense.

Post Office Box V, Juneau, Alaska 99811 (907) 465-4958 • Post Office Box 190, Chugiak, Alaska 99567 (907) 694-4958

STATE OF ALASKA
THE LEGISLATURE

POUCH Y · STATE CAPITOL
JUNEAU, ALASKA 99811
907-465-3800

LEGISLATIVE AFFAIRS AGENCY

LEGISLATIVE REFERENCE LIBRARY

May, 1988

Copies of minutes listed below were originally included in this file. The minutes are available on the STAIRS database CMPR. In order to save space copies of minutes have not been left in the files.

Mary Van Nimwegen

HHESS	2-2-88	8:30 a.m.
H HESS	4-7-88	8:30 a.m.

A M E N D M E N T

Offered in the Finance Committee by Boyer

HCSSSB 348 (HESS)

pg. 3 line 12 delete [prescribed drugs]

Page 4, line 3:delete

(12) prescribed drugs;

(renumber accordingly)

Page 5:

delete lines 5-11

STATE OF ALASKA
1988 LEGISLATIVE SESSION

BILL VERSION: HCSSB 348 (HESS)
PUBLISH DATE: _____

FISCAL NOTE

REQUEST:

Revision Date: _____
Title: An Act relating to Medical Assistance for needy persons
Sponsor: Dehling
Requestor: House HESS Committee

Agency Affected: Health & Social Services
BRU: MA Admin/Medical Assistance/PA Admin
State Health Services
Components: Claims Processing/Med. Fac./ Med. Non-fac./Eligibility Determination/ PA Data Processing/General Relief Medical/ Family Health

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 88	FY 89	FY 90	FY 91	FY 92	FY 93
PERSONAL SERVICES		245.9	461.0	461.0	461.0	461.0
TRAVEL		56.0	58.8	59.7	60.6	61.6
CONTRACTUAL		137.9	136.9	144.8	153.4	162.7
SUPPLIES		3.6	4.5	4.6	4.8	4.9
EQUIPMENT		14.0	9.0	-0-	-0-	-0-
LAND & STRUCTURES						
GRANTS, CLAIMS		2,610.8	6,430.6	7,597.5	8,764.4	9,931.3
MISCELLANEOUS						
TOTAL OPERATING		3,068.2	7,100.8	8,267.6	9,444.2	10,621.5
CAPITAL						
REVENUE		2,957.1	5,597.2	6,338.6	7,097.5	7,870.3

FUNDING: (Thousands of Dollars)

GENERAL FUND		111.2	1,503.6	1,929.0	2,346.7	2,751.2
FEDERAL FUNDS		2,957.1	5,597.2	6,338.6	7,097.5	7,870.3
OTHER						
TOTAL		3,068.3	7,100.8	8,267.6	9,444.2	10,621.5

POSITIONS:

FULL-TIME		8	11	11	11	11
PART-TIME						
TEMPORARY						

ANALYSIS: (Attach a separate page if necessary)

This Committee Substitute incorporates the provisions of SB 255, Pharmaceutical Medical Assistance for needy persons, and SB 348 which are described in detail in the attached documents.

Prepared by: Kim Busch, Director Kim Busch — Phone: 465-3355
Division: Medical Assistance — Date: 4-6-88

Approved by Commissioner: Myra M. Munson Myra M Munson — Date: 4-7-88
Agency: Health and Social Services

Distribution (by preparer):
Legislative Finance
Legislative Sponsor
Requestor
Office of Management and Budget
Impacted Agency(ies)

ANALYSIS

ALASKA HEALTHY BABY PROJECT

PLAN FOR IMPLEMENTATION

1. Add all pregnant women and children up to one year of age with monthly incomes up to 100% of the federal poverty level for Alaska to the Medicaid Program. The program design includes:

   * one time eligibility determination for pregnant women. Once found eligible, the woman would retain Medicaid through the 60 day postpartum period. An income eligible pregnant woman may receive Medicaid as soon as pregnancy is medically verified. Children are automatically eligible for the 60 day postpartum period once the mother verifies the birth date.

   * no resource (asset) limit for pregnant women and children.

   * pregnant women and children will be eligible for all Medicaid services offered under the State Plan.

   (Estimate 974 eligibles: $4,163 per pregnant woman x 974 = $4,054,762 + $1,198 per child x 974 = $1,166,852 = Total $5,221,614). These cost estimates are based on actual average 1986 expenditure data for pregnant women and children age 5 and under. NOTE: the January 1, 1989 implementation date will result in ½ the program expenditures under Medicaid services for pregnant women and children during the first year.

2. Add case management services, as an enhanced service to pregnant women, to coordinate health care service delivery. This service will be particularly targeted at women with high risk pregnancies, and must be offered to all Medicaid-eligible pregnant women. The program will be implemented by hiring four nurse consultant public health nurses in the Division of Public Health to be case managers. These positions will operate from Anchorage, Fairbanks, Bethel and Juneau. The nurses will receive Medicaid referral of all pregnant women in order that each may be evaluated as to their pregnancy risk factor. The case managers will coordinate the health care services delivered, assure that pregnant women receive necessary services, and assist with arranging appointments and transportation. Uniform perinatal guidelines will be adopted to assure that pregnant women are receiving adequate care. Also hired, will be a Nurse IV Pre-Natal Coordinator for the Division of Medical Assistance to coordinate case management services, perform a utilization review function on expenditures for pregnant women and children, design and manage computer reports to monitor program objectives, establish criteria to evaluate improved pregnancy outcome, and evaluate program compliance. All positions will be at 75/25 federal/state match since each will be filled with medical personnel.

3. Add nutrition services under enhanced services to pregnant women beginning in the second year. This service must be provided to all pregnant women. (Estimate that 15% of pregnant women would need nutrition counseling because of high risk pregnancy. Average two visits per person X 600 persons x $35/visit)

4. New eligibility technicians in the Division of Public Assistance to review applications, conduct interviews, verify eligibility and authorize medical coupons for the new population of pregnant women and children eligible under this Medicaid option. There will be two new positions in year one and three new positions in year two, with a one time outlay of $3,000 per position for desk, chair, file cabinet and computer terminal.

5. This change in the Medicaid Program will require a system support increase to the Eligibility Information System (EIS) of the Division of Public Assistance, and will require lead time to accomplish (the January 1, 1989 implementation date).

Year One

		Fed match	GF match
Cost	Medicaid services for pregnant women assuming ½ year costs	$1,013,690	$1,013,690
	Medicaid services for children one year of age assuming ½ year costs	$ 291,713	$ 291,713
	Case management services 5 nurses at 75/25 federal state match plus travel, supplies, equipment and risk insurance assuming 3/4 year cost and 10.0 for outreach	$ 193,743	$ 88,956
	Two new eligibility technicians for the Division of Public Assistance - $36,300 assuming ½ year cost of $18,150 each at 50/50 state/federal match plus equipment	$ 21,150	$ 21,150
	Public Assistance computer system data processing	$ 7,450	$ 7,450
	TOTAL	$1,527,746	$1,422,959

Year Three

Add children up to age three with incomes up to 100% of the federal poverty level to the Medicaid Program.

		Fed match	GF match
Cost	Medicaid services for children three years of age.	$ 583,426	$ 583,426
	Public Assistance data processing	$ 7,450	$ 7,450
	TOTAL	$ 590,876	$ 590,876

NOTE: Assumes base includes year 1 and year 2 costs.

Year Four

Add children up to age four with incomes up to 100% of the federal poverty level to the Medicaid Program.

		Fed match	GF match
Cost	Medicaid services for children four years of age.	$ 583,426	$ 583,426
	Public Assistance data processing	$ 7,450	$ 7,450
	TOTAL	$ 590,876	$ 590,876

NOTE: Assumes base includes years 1, 2 and 3 costs.

Year Five

Add children up to age five with incomes up to 100% of the federal poverty level to the Medicaid Program.

		Fed match	GF match
Cost	Medicaid services for children five years of age.	$ 583,426	$ 583,426
	Public Assistance data processing	$ 7,450	$ 7,450

TOTAL	$ 590,876	$ 590,876

NOTE: Assumes base includes years 1, 2, 3 and 4 costs.

ASSUMPTIONS: An inflation factor has not been added to medical care costs for years two, three, four and five. An inflation factor will have to be applied each fiscal year to the Medicaid budget to adequately fund this option.

ALASKA HEALTHY BABY PROJECT
Summary

	YEAR				
	1989	1990	1991	1992	1993
Pregnant Women Coverage for medical services	2,027.4	4,054.8	4,054.8	4,054.8	4,054.8
Medical services for children:					
Age one year	583.5	1,166.9	1,166.9	1,166.9	1,166.9
Age two years		1,166.9	1,166.9	1,166.9	1,166.9
Age three years			1,166.9	1,166.9	1,166.9
Age four years				1,166.9	1,166.9
Age five years					1,166.9
Division of Public Assistance Eligibility Technicians plus equipment					
two - first year	42.3	72.6	72.6	72.6	72.6
three - second year		118.0	109.0	109.0	109.0
DPA computer upgrade	14.9	14.9	14.9	14.9	14.9
Case Management	282.7	352.9	352.9	352.9	352.9
Nutrition Services		42.0	42.0	42.0	42.0
Total Yearly Cost	2,950.8	6,989.0	8,146.9	9,313.8	10,480.7
Yearly General Fund Cost	1,423.0	3,421.3	4,000.1	4,583.5	5,166.9
Yearly federal cost	1,527.8	3,567.7	4,146.8	4,730.3	5,313.8

AFDC INCOME STANDARDS

Adult included		ANNUAL	Adult not included		ANNUAL
			1	$275	$3300
2	$692	$8304	2	$550	$6600
3	$779	$9348	3	$637	$7644
4	$866	$10392	4	$724	$8688
5	$953	$11436	5	$811	$9732
6	$1040	$12480	6	$898	$10776
7	$1127	$13524	7	$985	$11820
each add	$87		each add	$87	

single adult pregnant woman	$437
increment for incapacitated spouse	$162

ALASKA'S FEDERAL POVERTY LEVEL

Family size	annual income
1	$6,860
2	$9,240
3	$11,620
4	$14,000
5	$16,380
6	$18,760
7	$21,140
8	$23,520
each additional	$2,380

NOTE: THESE INCOME LEVELS WILL BE CHANGED IN FEBRUARY 1988.

RESOURCE LIMITS

AFDC

- a home of any value
- a car worth $1,500
- other real or personal property worth up to $1,000

APA/SSI

- a home of any value
- a car worth $4,500
- personal effects worth up to $2,000
- liquid resources worth $1,800 for individuals and $2,700 for couples
- a burial plot
- up to $1,500 for burial expenses
- life insurance with face value up to $1,500

Alaska's Medicaid Program pays for the following services:

- inpatient hospital care
- outpatient hospital care
- laboratory and x-ray services
- skilled nursing facility and home health services for individuals 21 and older
- physicians services
- rural health clinic services
- early and periodic screening, diagnosis and treatment for individuals under 21 (EPSDT)
- family planning
- medical transportation
- nurse midwife services
- community mental health clinic and state operated mental health clinic services
- intermediate care facility services
- intermediate care facility for the mentally retarded services
- skilled nursing facility services for individuals under 21
- optometrists services and eyeglasses
- mental institution services for persons under 21
- institution for mental diseases services for persons aged 65 and older
- treatment of speech, hearing and language disorders
- outpatient surgical care center services
- physical therapy
- occupational therapy
- prosthetic devices
- medical supplies
- adult dental services (limited to relief of pain and acute infection)
- chiropractic services
- personal care attendant services

Prescription drugs are provided to Medicaid recipients through the 100% state-funded General Relief Medical Assistance Program.

HRD	Medical Assistance Administration	Medical Assistance	Medical Assistance	Public Assistance Administration	Public Assistance Administration	State Health Services
Component	Claims Processing	Medicaid Facility	Medicaid Non-Facility	Eligibility Determinations	PA Data & Word Processing	Family Health
Personal Serv.	33.9	-0-	-0-	36.3	-0-	175.7
Travel	16.0	-0-	-0-	-0-	-0-	30.0
Contractual	3.8	-0-	-0-	-0-	14.9	13.2
Supplies	.3	-0-	-0-	-0-	-0-	1.8
Equipment	-0-	-0-	-0-	6.0	-0-	8.0
Land & Street	-0-	-0-	-0-	-0-	-0-	-0-
Grants/Claims	-0-	1,740.6	870.2	-0-	-0-	-0-
Misc.	-0-	-0-	-0-	-0-	-0-	-0-
Total Op	54.0	1,740.6	870.2	42.3	14.9	228.7
General Fund	18.5	870.3	435.1	21.15	7.5	70.4
Fed Fund	35.5	870.3	435.1	21.15	7.4	158.3
FTE	1	0	0	2	0	4

FY90

INCLUDES NUTRITION SERVICES

Unit	Medical Assistance Administration	Medical Assistance	Medical Assistance	Public Assistance Administration	Public Assistance Administration	State Health Services
Component	Claims Processing	Medicaid Facility	Medicaid Non-Facility	Eligibility Determinations	PA Data & Word Processing	Family Health
Personal Serv.	45.2	-0-	-0-	181.6	-0-	234.2
Travel	8.0	-0-	-0-	-0-	-0-	40.0
Contractual	5.0	-0-	-0-	-0-	14.9	17.6
Supplies	.5	-0-	-0-	-0-	-0-	2.4
Equipment	-0-	-0-	-0-	9.0	-0-	-0-
Land & Street	-0-	-0-	-0-	-0-	-0-	-0-
Grants/Claims	-0-	4,259.1	2,171.5	-0-	-0-	-0-
Misc.	-0-	-0-	-0-	-0-	-0-	-0-
Total Op	58.7	4,259.1	2,171.5	190.6	14.9	294.2
General Fund	14.7	2,129.5	1,085.7	95.3	7.5	88.5
Fed Fund	44.0	2,129.5	1,085.8	95.3	7.4	205.7
FTE	1	0	0	5	0	4

FISCAL NOTE ANALYSIS

SB 255

"An Act relating to pharmaceutical medical assistance for needy persons, and providing for an effective date"

FY89 Governor's Medical Assistance Request

	GF	Total
GENERAL RELIEF MEDICAL Request	9,380.4	9,380.4
C-4 Transfer to Medicaid	[1,370.6]	[1,370.6]
Decrement to Remove Pharmacy	[1,370.6]	[1,370.6]
REVISED	6,639.2	6,639.2

	FED	GFM	Program	Total
MEDICAID NON-FACILITY Request	17,145.4	17,213.2	169.0	34,527.6
C-4 Transfer from GRM	-0-	1,370.6	-0-	1,370.6
Increment for Federal	1,370.6	-0-	-0-	1,370.6
REVISED	18,516.0	18,583.8	169.0	37,268.8

With a move of prescription drugs for Medicaid recipients from the General Relief Medical (GRM) Component to the Medicaid Non-Facility Component, Medicaid funds would become available at a 50/50 federal financial participation ratio. The Governors FY 89 General Relief Medical budget request for Title XIX pharmacy is $3,654.8. This fiscal note assumes an October 1, 1988 implementation date.

The national rate of increase for prescription drug costs in 1987 according to the U.S. Department of Labor was 8%. For purposes of this fiscal note the Department has assumed 8% as the annual rate of inflation for prescription drugs.

Medical Assistance Administration - Claims Processing

The administrative costs except for the $14,000 for computer programming changes will not be necessary if the increment in the Governor's budget is approved as introduced.

Travel:

On-site pharmacy reviews for dispensing fees, validating acquisition costs for drugs, meetings with the pharmacy association, and gathering data for pricing compounded drugs.	$10,000

Contractual:

Professional services contract for pharmacist/ pharmacy services*	$84,000
One time funding for fiscal intermediary to change computer system documentation including provider manuals, change the collocation code table to shift expenditures from GRM to Medicaid, change pricing logic, and add new edits	$14,000
On-going funding for fiscal intermediary for Blue Book update of average wholesale prices into MMIS claims processing system	$ 3,000
Space Rent $1.25/sq. ft. X 200 sq. ft.	$ 3,000
Communications - Long Distance and Printing	$ 1,000
Advertising and Printing	$ 1,000
Supplies:	$ 1,500
Total	$117,500
Federal	$58,750
SGFM	$58,750

Increases from fiscal year to fiscal year are projected at 8%.

* The Department proposes using the services of a contractor to do the initial work of design, development, and implementation of a Medicaid pharmacy program. However, the Department may elect in subsequent years to seek legislative approval of a permanent position for these services.

5-1496Ab
Hein

A M E N D M E N T

Offered in the HOUSE

TO: SB 348

Page 3, line 12, after "21;":

Insert "prescribed drugs;"

Page 4, line 3, after "(12)":

Insert "prescribed drugs;

(13)"

Renumber the following paragraphs accordingly.

Page 5, after line 3:

Insert the following new bill sections to read:

"* Sec. 4. AS 47.07 is amended by adding a new section to read:

Sec. 47.07.200. PAYMENT FOR PRESCRIBED DRUGS. Payment for prescribed drugs must be made in accordance with 42 CFR Part 447, Subpart D.

* Sec. 5. AS 47.07.900 is amended by adding a new paragraph to read:

(11) "prescribed drugs" has the meaning given in 42 CFR 440.120."

WE OF THE PHARMACY COMMUNITY IN SITKA APPLAUD YOUR EFFORTS TO ADD HOME HEALTH CARE LANGUAGE AS SPECIFIED IN HB 315. ALREADY IN ALASKA THIS NEW TREND CAUSED BY PISING HOSPITAL COSTS HAS FORCED PEOPLE TO BE CARED FOR OUTSIDE THE HOSPITAL ENVIRONMENT SOONER. MANY CASES DOCUMENT THAT COSTS TO THE FIRST, SECOND OR THIRD PARTY ARE 1/3 OR 1/2 AND IN SOME CASES AS LITTLE AS 1/10TH THE COST OF HOSPITALIZATION, SIMPLY BY PROVIDING HOME CARE THROUGH AN AGENCY AND A DURABLE MEDICAL EQUIPMENT PROVIDER WHILE A PATIENT RECOVERS FROM AN ILLNESS OR AS AN ALTERNATIVE TO LONG TERM CARE IN AN INSTITUTION. WE SEE JUSTIFICATION FOR KEEPING MORE PATIENTS HOME IN ALASKA WHERE THEY RECOVER FASTER AND MORE COMPLETELY THAN EXCURSIONS TO OUT OF STATE HOSPITALS.

AS PROVIDERS FOR BOTH PHARMACY AND DURABLE MEDICAL SERVICES, WE HAVE SOME VERY REAL CONCERNS ABOUT THE FUTURE. ARE WE TO EXPECT TO PROVIDE USUAL AND CUSTOMARY QUALITY FOR OUR PRODUCTS AND SERVICES AND IN TURN BE PAID A USUAL AND CUSTOMARY RETURN? OUR COSTS OF DOING BUSINESS IN OUR AREA CONTINUE TO RISE YET WE ARE BEING TOLD WHAT WE ARE TO BE PAID BASED NOT ON THE QUALITY OF GOODS AND SERVICES BUT ON THE CHEAPEST PRICE IN THE INDUSTRY. WE FEEL AN OBLIGATION TO SERVE OUR PATIENTS WITH THE BEST CARE FOR THE BEST PRICE; HOWEVER, WE STILL MUST MAINTAIN AN INVENTORY OF GOODS AND BE ABLE TO PAY OUR PROVIDERS IN A TIMELY MANNER AND COVER THE OVERHEAD COSTS TO ALLOW US TO DO BUSINESS THE NEXT MONTH WHEN SOMEONE ELSE REQUIRES OUR SERVICES. A GOOD EXAMPLE ARE WHEELCHAIRS AND BEDS. THESE ARE EXPENSIVE ITEMS RUNNING ANYWHERE BETWEEN $250 AND WELL OVER $1000. THERE ARE MANY TO CHOOSE FROM AND MOST PATIENTS REQUIRE SPECIAL NEEDS IN THEIR CHAIRS AND BEDS OR WHY WOULD THEY NEED THE SERVICE IN THE FIRST PLACE. WILL YOU PAY THE $750 FOR THE RECIPIENTS PROPER CHAIR OR ONLY $250 FOR THE "CHEAPEST" CHAIR BECAUSE IT'S AVAILABLE? THE RECIPIENT'S ABILITY TO PAY A FEW DOLLARS ABOVE YOUR MAXIMUM ALLOWABLE COST OF A DRUG IS ONE MATTER WHILE $500 WILL ALMOST CERTAINLY BE A BARRIER TO GOOD MEDICINE.

NOTIFICATION WAS SENT RECENTLY ABOUT A COMPANY IN TENNESSEE BEING AWARDED THE ALASKA MEDICAL PAYMENTS ASSISTANCE (AMPS) CONTRACT. WE ARE TO UNDERSTAND THE TRANSITION WILL OCCUR OVER THE NEXT FEW MONTHS TO BE COMPLETED IN MAY BUT, WE DO NOT UNDERSTAND THE FULL IMPACT OF THE CHANGES THEY INTEND TO MAKE. IT APPEARS THEY INTEND TO PURSUE THE METHOD WHEREBY PHARMACIES GET

REIMBURSED ONLY A PORTION OF THEIR COSTS THROUGH A MAXIMUM ALLOWABLE COST BASIS PLUS A PRE-DETERMINED FEE. WE DO NOT KNOW WHAT THIS FEE IS. SEVERAL YEARS AGO THIS MATTER WAS ADDRESSED AND MANY PHARMACIES STATED THEY MIGHT NOT BE ABLE TO DO BUSINESS WITH AMPS IF USUAL AND CUSTOMARY WAS NOT REIMBURSED. THE STATE, AT THAT TIME INSTITUTED THE ONE DOLLAR CO-PAY TO HEDGE AGAINST RISING COSTS. WE SEEM TO HAVE MISSED NOTIFICATION OF THIS NEW ACTION.

PHARMACY IS NOT ASKING FOR A HAND-OUT. WE ONLY ASK TO BE ALLOWED TO DO BUSINESS AND PROVIDE THE BEST CARE AT THE MARKET VALUED PRICE. LET FREE ENTERPRISE DETERMINE OUR PRICES. HELP US BY GETTING OUR PAYMENTS TO US WITHIN 30 DAYS AND TRY TO MAKE THE SYSTEM SIMPLER BY NOT REQUIRING A REFUSAL FROM MEDICARE WHEN EVERYONE KNOWS THEY REFUSE 100% OF SUCH CLAIMS. GIVE US SOME LEVERAGE TO FALL BACK ON WHEN YOUR CONTRACTED INSURANCE CARRIER DECIDES NOT TO PAY 50% OF YOUR CLAIMS BECAUSE THEY ARE "PENDING". (WE HAVE NEVER BEEN GIVEN A CLEAR DEFINITION OF "PENDING" AS IT IS REFERRED TO BY INSURANCE COMPANIES.) FINALLY, GIVE US A LITTLE RECOGNITION FOR THE JOB WE DO IN OUR COMMUNITIES. ALLOW OUR CONTINUATION OF PROVIDING HIGH QUALITY HEALTH SERVICES.

THANK YOU FOR REQUESTING INPUT ON THIS AND OTHER CONCERNS AFFECTING LEGISLATION THIS SESSION. WE APOLOGIZE FOR NOT SPEAKING WITH YOU PERSONALLY.

SINCERELY,

DAVID E. MOORE R.PH. &
JOHN W. COOPER R.PH.
OF SITKA PHARMACY, INC.

TRISH WHITE R.PH. &
DIRK T. WHITE R.PH
OF WHITE'S, INC.

STATE OF ALASKA
1988 LEGISLATIVE SESSION

BILL VERSION: HB 315
PUBLISH DATE: _____

FISCAL NOTE

REQUEST:

Revision Date: _____
Title: An Act relating to pharmaceutical medical assistance for needy persons.
Sponsor: _____
Requestor: _____

Agency Affected: Health and Social Services
BRU: MA Administration/Medical Assistance
Components: Claims Processing/General Relief Medical, Medicaid Non-Facility

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 88	FY 89	FY 90	FY 91	FY 92	FY 93
PERSONAL SERVICES						
TRAVEL		10.0	10.8	11.7	12.6	13.6
CONTRACTUAL		106.0	99.4	107.3	115.9	125.2
SUPPLIES		1.5	1.6	1.7	1.9	2.0
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING		117.5	111.8	120.7	130.4	140.8
CAPITAL						
REVENUE		1,429.3	2,029.5	2,191.8	2,367.2	2,556.5

FUNDING: (Thousands of Dollars)

GENERAL FUND		(1,311.8)	(1,917.7)	(2,071.1)	(2,236.8)	(2,415.7)
FEDERAL FUNDS		1,429.3	2,029.5	2,191.8	2,367.2	2,556.5
OTHER						
TOTAL		117.5	111.8	120.7	130.4	140.8

POSITIONS:

FULL-TIME		1.0	1.0	1.0	1.0	1.0
PART-TIME						
TEMPORARY						

ANALYSIS: (Attach a separate page if necessary)

SEE ATTACHED

Prepared by: Kim Busch, Director Kim Busch Phone: 465-3355
Division: Medical Assistance Date: 2-1-88

Approved by Commissioner: Myra Munson Myra M. Munson Date: 2-2-88
Agency: Health and Social Services

Distribution (by preparer):
Legislative Finance
Legislative Sponsor
Requestor
Office of Management and Budget
Impacted Agency(ies)

FISCAL NOTE ANALYSIS

HB 315

"An Act relating to pharmaceutical medical assistance for needy persons, and providing for an effective date"

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POSITION PAPER/Department of Health & Social Services

HB 315

"An Act relating to pharmaceutical medical assistance for needy persons; and providing for an effective date."

I. Purpose of HB 315:

The purpose of HB 315 is to allow the Department of Health and Social Services to increase federal revenue by funding prescribed drugs for Medicaid recipients under the Medicaid Program rather than under the 100% state general funded General Relief Medical Program (GRM).

II. Sectional Analysis:

Section 1 establishes prescribed drugs as a Medicaid service which allows the Department to claim 50 percent federal Medicaid funding. This alone will result in an estimated $1,311.8 million savings of state general funds in FY89.

Section 2 adds prescribed drugs to AS 47.07.035 and provides the Department with legislative direction on the priority of prescribed drugs in the event of a funding shortfall.

Section 3 requires adoption of federal Medicaid procedures for purchasing prescribed drugs.

Section 4 gives "prescribed drugs" the same meaning as in federal Medicaid regulations.

Section 5 provides an effective date of July 1, 1988.

All states, except Alaska, that offer full prescription drug coverage for their Medicaid-eligible citizens, have chosen to fund this coverage through the federal Medicaid program. There is no indication that this has in any way harmed medical assistance recipients or resulted in withdrawal of pharmacies from participation as medical assistance providers.

III. Background

The governor first introduced legislation for the addition of coverage for prescription drugs under the Medicaid program in 1985. If this legislation had been adopted the state would have saved an estimated $4.5 million that could have been claimed in federal funds for those years. Today, pharmacy

remains the single service provided to Medicaid recipients for which the State of Alaska cannot claim federal matching dollars.

Basically, four arguments have been made against adding pharmacy services to the Medicaid program:

Argument: "The Medicaid rules concerning payment for drugs would cause Alaska pharmacies to lose money".

Response: The Medicaid rules concerning payment for drugs were amended last October. The new rules offer the state substantial flexibility including increased freedom from federal rules in setting payment rates for drugs. Under these rules there are two categories of drugs defined as follows:

1. Multiple Source Drugs

   These drugs are commonly referred to as "generic" drugs. They are therapeutically equivalent drugs that can be purchased from three or more suppliers. The Health Care Financing Administration (HCFA) publishes a list of these drugs. There are approximately 134 drugs listed. For these drugs only the State cannot pay more in the aggregate than a dispensing fee plus an amount established by HCFA that is equal to 150 percent of the published price for the least costly therapeutic equivalent. According to Region X HCFA, the payment for these drugs in Alaska could be increased in recognition of the cost of shipping and handling. Further, if Alaska can show that the listed drugs are not available at these prices we can pay a higher price using the methodology established for the second category of drugs, "other drugs".

B. Other Drugs

   These are all drugs that are not contained on HCFA's list. The State payment for these drugs cannot exceed, in the aggregate, more than the lower of the estimated acquisition cost plus a dispensing fee or the pharmacist's usual and customary charges to the general public. The estimated acquisition cost can be determined through a variety of methods. One method is to obtain a monthly microfiche of wholesale costs from the pharmaceutical distributors in the state.

   The dispensing fee can also be established by several methods. One method would be to survey Alaska pharmacies to gather cost data for dispensing drugs. The dispensing fee may allow for geographical differentials and differentials in the volume of business conducted by the pharmacies.

The Department is proposing to either contract with or hire a pharmacist. The pharmacist's role would be to first work with the pharmacies throughout the state to design a program that would be

least disruptive to their businesses and that would ensure continued access for Medicaid and GRM recipients. The pharmacist would also:

- Ensure that Alaska's payments do not in the aggregate exceed the federal limits;
- Set prices above the federal limits for multiple source drugs that are documented as not available in Alaska at the federally listed prices;
- Establish codes and payments for FDA approved compounded drugs (drugs which are not contained in a national drug compendia);
- Work as liason with HCFA to ensure that any future federal changes in Medicaid payments for drugs allow sufficient flexibility for Alaska implementation;
- Work with pharmacies to ensure efficient and rapid processing of claims for payment.

Argument: "Many pharmacies would not participate in a drug program under Medicaid".

Response: In Washington State 1,156 pharmacies which comprise 95+% of the pharmacies in the state participate in the Medicaid drug program. Most states have little problem attracting pharmacies to participate in this program.

Argument: "Medicaid recipients will be forced to use generic drugs which will result in lower quality care".

Response: This legislation will have no impact on current practice regarding whether a generic drug is dispensed. Both Alaska and federal laws state that a generic drug should be dispensed when possible (i.e. available and therapeutically equivalent) but are clear that the ultimate choice always remains with the medical provider.

Argument: "A large number of Alaskan natives would cross over from using Indian Health Service (IHS) pharmacies to using non-IHS pharmacies, costing the state 50 percent where the previous financial participation had been zero".

Response: The shift of dental coverage from the 100% state funded General Relief Medical Program to the 50 percent federally funded Medicaid Program caused no noticeable increase in utilization by natives. In the Department's estimation the majority of natives who wish to purchase drugs at non-Indian health facilities are already doing so through the General Relief Medical Assistance

Program. The shift in funding sources from GRM to Medicaid is unlikely to have any effect on the utilization patterns of most Medicaid-eligible natives. In rural areas, the IHS facility or contractor will remain the pharmacy of choice because it is either the most convenient or the only available provider. In urban areas the cross over has already occurred largely because IHS does not stock many of the drugs commonly prescribed to a large group of these recipients, IHS rules and hours of operation have already made this an unavailable option, and any recipient who wishes to can avoid restriction by not declaring his or her ethnic heritage.

Conclusion:

The Department believes that a Medicaid drug program will continue to result in reasonable payments to pharmacies, will not discourage the participation of this provider group, will not effect the quality of service, and will not result in the state assuming costs formerly borne by the IHS. Most importantly, the Department can assure that the addition of this option will result in a significant annual cost savings to the state without compromising services to Alaskans.

IV. Recommendations

The Department recommends amending Section 5 to change the effective date from July 1 to October 1, 1988. The delay in implementation is necessary to allow the Department time to amend the Medicaid state plan, promulgate and adopt regulations, contract with or hire the pharmacist, and effect changes in the claims processing system.

The Department strongly recommends passage of HB 315 so that the state may begin to receive 50 percent federal financial participation for prescribed drugs through the Medicaid Program. The savings will begin to accrue to the State in October, 1988.

Recommended by: Kim Busch
Kim Busch, Director
Division of Medical Assistance

Date: 2-1-88

Approved by: Myra M. Munson
Myra M. Munson, Commissioner
Department of Health and
Social Services

Date: 2-2-88

FISCAL NOTE ANALYSIS

HB 315

"An Act relating to pharmaceutical medical assistance for needy persons, and providing for an effective date"

FY89 Governor's Medical Assistance Request

	GF	Total
GENERAL RELIEF MEDICAL Request	9,380.4	9,380.4
C-4 Transfer to Medicaid	(1,370.6)	(1,370.6)
Decrement to Remove Pharmacy	(1,370.6)	(1,370.6)
REVISED	6,639.2	6,639.2

	FED	GFM	Program	Total
MEDICAID NON-FACILITY Request	17,145.4	17,213.2	169.0	34,527.6
C-4 Transfer from GFM	-0-	1,370.6	-0-	1,370.6
Increment for Federal	1,370.6	-0-	-0-	1,370.6
REVISED	18,516.0	18,583.8	169.0	37,268.8

With a move of prescription drugs for Medicaid recipients from the General Relief Medical (GRM) Component to the Medicaid Non-Facility Component, Medicaid funds would become available at a 50/50 federal financial participation ratio. The Governors FY 89 General Relief Medical budget request for Title XIX pharmacy is $3,654.8. This fiscal note assumes an October 1, 1988 implementation date.

The national rate of increase for prescription drug costs in 1987 according to the U.S. Department of Labor was 8%. For purposes of this fiscal note the Department has assumed 8% as the annual rate of inflation for prescription drugs.

Medical Assistance Administration - Claims Processing

The administrative costs except for the $14,000 for computer programming changes will not be necessary if the increment in the Governor's budget is approved as introduced.

Travel:

On-site pharmacy reviews for dispensing fees, validating acquisition costs for drugs, meetings with the pharmacy association, and gathering data for pricing compounded drugs.	$10,000

Contractual:

Professional services contract for pharmacist/ pharmacy services*	$84,000
One time funding for fiscal intermediary to change computer system documentation including provider manuals, change the collocation code table to shift expenditures from GRM to Medicaid, change pricing logic, and add new edits	$14,000
On-going funding for fiscal intermediary for Blue Book update of average wholesale prices into MMIS claims processing system	$ 3,000
Space Rent $1.25/sq. ft. X 200 sq. ft.	$ 3,000
Communications - Long Distance and Printing	$ 1,000
Advertising and Printing	$ 1,000
Supplies:	$ 1,500
Total	$117,500
Federal	$58,750
SGFM	$58,750

Increases from fiscal year to fiscal year are projected at 8%.

* The Department proposes using the services of a contractor to do the initial work of design, development, and implementation of a Medicaid pharmacy program. However, the Department may elect in subsequent years to seek legislative approval of a permanent position for these services.

(7)

HOUSE COMMITTEE REPORT

Date referred: 2/10/88 FURTHER REFERRALS: Finance

DATE: April 7, 1988

The Health, Education and Social Services Committee has considered SB 348

"An Act relating to medical assistance for needy persons."

RECOMMENDS:

[X] replace with HCS SB 348 (HESS) [X] the same title

[ ] attached amendment(s) [ ] a new title

[X] do pass

[ ] do not pass

[ ] no recommendation

[ ] individual recommendations

[ ] additional referral to the _____ Committee

ADOPTS: [ ] _____ letter of intent

ATTACHES NEW FISCAL NOTE(s):

[X] fiscal impact

[ ] zero fiscal note

[ ] zero with analysis

[ ] same as previous fiscal note published _____

[ ] same as previous zero fiscal note published _____

SIGNING DO PASS:

Nick F. Kosmo

Al Ellis

Bill Hutson

Mary Gunderson

SIGNING OTHER RECOMMENDATIONS:

Rolf E. Phillips No Rec.

Co-Chairman's signature

Nick Kosmo

Al Ellis

Alaska State Legislature

Senate Advisory Council

MEMORANDUM

TO: Senator Faiks
Alaska State Senate

ATTN: Jens Zehbe

FROM: Maureen Weeks
Senate Advisory Council

DATE : March 25, 1988

SUBJECT SB 255; IR# 88-003261

In a recent memo you asked for statistical data on the type and number of businesses that sell prescription drugs in Alaska; whether Alaska pharmacies are predominantly small "mom and pop" operations or large companies; what percentage of pharmaceutical sales are Medicaid reimbursed; and other pertinent data. I am responding to these questions in the order in which they were asked.

I. THE TYPE AND NUMBER OF PHARMACIES IN ALASKA.

1. Number.

The Board of Pharmacy lists 125 in-state licenses expiring June 30, 1988.

2. Type.

After consulting with the president of the Alaska Pharmacy Association, Chris Coursey, I have divided the types of pharmacies into chains, non-chains, facilities contracting with non-chain pharmacies, facilities contracting with chain pharmacies and state and federal pharmacies. They are listed on Table I below.

Table 1 shows that 24 percent of pharmacies are chain stores and 50 percent are non-chain stores. When facility contracts with non-chain pharmacies are included, 58 percent of Alaska's pharmacies are non-chain pharmacies.

TABLE 1

Types and Number of Alaska Pharmacy Licenses

Type of license	Number	Percent of total (%)
Chain pharmacies:*	30	24
Non-chain pharmacies:	63	50
Facility contracts with non-chain pharmacy:	10	8
Facility contracts with chain pharmacy:	2	2
Facility owns pharmacy:	14	11
State purchases pharmaceuticals:	3	2
Federal government purchases pharmaceuticals:	3	2
Total:	125	

Source: Alaska Board of Pharmacy

* The 30 chain pharmacies are in the Railbelt area and in Juneau. They include 4 in Fairbanks, 20 in Anchorage, 2 in Kenai-Soldotna, 3 in Palmer-Wasilla and 1 in Juneau.

II. PERCENT OF PHARMACY SALES REIMBURSED BY MEDICAID

1. Dittman Poll. Dittman Research is currently conducting a poll for the Alaska Pharmacy Association to determine what percent of pharmaceuticals are Medicaid reimbursed. The poll will be complete next week, according to the association president.

I have asked for a copy for your office. When I receive it, I will send it to you.

2. Informal survey. An informal telephone survey of a small number of pharmacists was conducted from this office. The survey shows the following estimates of Medicaid-reimbursed pharmaceuticals:

Carrs at Gambell in Anchorage:	18-25%
Hewitt's Drug in Spenard:	45%
Ron's Apothecary in Juneau:	10%
White's Pharmacy in Sitka:	15-20%

3. Medicaid reimbursement in pharmacy contracts. Some private pharmacies contract to provide pharmaceuticals to hospitals, long-term care (including all Pioneer Homes) and mental health facilities. Following are reports from two of these pharmacies, selected at random.

A. Hewitt's Drugs in Spenard. Owner Dennis Jurgens says Hewitt's contracts with the Anchorage Pioneer Home and with all the mental health intermediate care facilities in Anchorage. Jurgens estimates that 45 percent of his business is Medicaid reimbursed. (If the Pioneer Home is not counted, 30% of Hewitt's business is Medicaid.) Jurgens says chain stores probably aren't interested in competing for high-volume Medicaid business because it is too time-consuming. He said a chain looked at buying him out and declined for that reason.

B. White's Pharmacy in Sitka. Co-owner Trish White says the pharmacy contracts to the Sitka Pioneer Home where 17 of the 112 residents are Medicaid patients. White estimates that 20 percent of the pharmacy's business is Medicaid-reimbursed. (If the Pioneer Home is not counted, 15-20 percent of the pharmacy's business is Medicaid reimbursed.) This is a "mom and pop" pharmacy (White co-owns the pharmacy with her husband). White says in the past two years, the number of non-Pioneer Home Medicaid clients using their pharmacy has doubled. There are two other pharmacies in Sitka.

4. The proportion of Medicaid recipients who use Medicaid each month. Nancy Bennett of the Department of Health and Social Services reports there are 25,000 Medicaid-eligible Alaskans and that out of these, 36 percent (about 9,000) use Medicaid-reimbursed pharmaceuticals. This is about two percent of the Alaska population of 537,800.

III. OTHER PERTINENT DATA.

1. Income of pharmacists

A. Wages paid to registered pharmacist employees. The Alaska Career Information System, published in 1987 by the Alaska Department of Labor, surveyed pharmacists for a report on wages paid to Alaska pharmacists. The results are on Table 2 below.

TABLE 2

Wages Paid to Alaska Pharmacist-Employees -- 1987*

Level	Average per month ($)	Range per month ($)
Entry wage:	2,900	2,400-3,100
After 2 years:	3,200	2,900-3,400
Maximum:		3,300-3,700

Source: Alaska Department of Labor

* There are about 220 licensed pharmacists in Alaska. About 25% are self employed.

B. Income of self-employed pharmacists. Following are three examples of income reported earned in non-chain pharmacies:

1) Ron's Apothecary, Juneau. Co-owner Ron Sedgwick is a volunteer lobbyist for pharmacists and formerly was on contract with the Department of Health and Social Services. He reports his pharmacy netted $52,000 in 1987, after expenses and before wages. Sedgwick and his wife, both pharmacists, are the only employees. Sedgwick says between them, they work 100 hours a week and make $10 an hour each.

2) A Southeast Alaska pharmacy (not in Juneau). This pharmacy reports a net profit of $43,659 in 1987. It is a "mom and pop" pharmacy, owned by a husband and wife pharmacist. They estimate they earn $5.25 an hour. (The pharmacist asked to remain anonymous.)

3) An Anchorage pharmacy. The owner says over the past ten years he has broken even. Last year he earned $42,000 and the business made a profit of $15,000 after paying other employee wages. He said he works 10-12 hours a day and could make the same wages at a chain store in an eight hour day with less headache. He recently sold his business.

C. The price of pharmaceuticals.

Background. Pharmacists say there has been an influx of expensive drugs on the market in the last two years. They say this impacts their business because competition forces them to use a "sliding scale" profit margin, making less margin on expensive drugs. State officials say the cost of Medicaid pharmaceuticals to the State increased by $1 million in the past two years.

1) The average cost of prescriptions. In 1973, the average cost to the consumer of pharmaceuticals statewide was $7. In 1985, the average cost of pharmaceuticals was $16 at McCorkle's Pharmacy and $18.67 at Ron's Apothecary (both stores are in

Juneau). Today the average cost of prescription drugs at Ron's Apothecary is $25.61. McCorkle's went out of business in 1985. (Source: Sedgwick).

2) Expensive prescription drugs. Table 3 shows the wholesale prices of certain costly prescription drugs. The prices were provided by pharmacists during telephone conversations.

TABLE 3

Wholesale Price of Certain Costly Prescription Drugs -- 1988

Name of drug	Cost per month ($)	Quantity
Navane (a psychotrophic drug):	143	200
Loxitane (for mental health patients):	102	100
Tagomet (for ulcers):	64	100
Mevacor (anti-cholesterol)	90	bottle ($2/pill)
AZT (AIDS)	1,000	?

Note: The AZT cost was estimated by R. Sedgwick.

3) Increases in cost of pharmaceuticals. The nationwide cost increase in pharmaceuticals between 1986 and 1988 is as follows:

Cost to druggist: 8% increase
Cost to consumer: 18% increase
Two explanations have been advanced to explain this discrepancy:

(a) Chris Coursey, president of the Alaska Pharmacy Assn., speculates that the discrepancy reflects what paying customers are charged to make up for the federal government's fixed dispensing fee policy.

(b) Ron Sedgwick, pharmacist lobbyist, says the discrepancy reflects the recent influx of new, expensive drugs. He points to his own profit margin, which fell from 51.9% in 1985 to 37% in 1987, while the average price of the pharmaceuticals he sold rose from $18.67 in 1985 to $25.61 in 1987. Sedgwick says his margin fell because the market place will not allow a 50% markup on expensive drugs.

(Note on markup: Hewitt's Drug in Anchorage marks its prescription drugs up an average 28 to 29 percent. Dennis Jurgens says that some Anchorage pharmacies have higher markups.)

2. Pharmacists' objections to SB 255.

A. "A fixed fee concept will not work on a profit margin system." Pharmacists say pharmacies will get a lower return, forcing them to do one of three things: 1. Charge more to paying customers. 2. Go out of business. 3 Stop serving Medicaid patients. Pharmacists object that they are the only retail merchants asked to support the federal government.

The Department of Health and Social Services says a fixed dispensing fee is adequate. Why should a pharmacist who takes two bottles -- one expensive and one inexpensive-- out of a box and gives them to customers be paid more for handing over the expensive bottle? Remember that the pharmacist is already paid for the cost of the drug. The Department's 2/2/88 position paper says there is "no indication" federal Medicaid coverage in other states has "resulted in withdrawal of pharmacies from participation".

B. "Small pharmacies were forced out of business when the federal government took over Medicaid payments for pharmaceuticals in the late 60's and early 70's." Virtually every Alaska pharmacist interviewed said the professional journals were full of "horror stories"

recounting the "devastation to Mom and Pop pharmacies" after the federal switch over in the Lower 48.

My efforts to check these assertions with the National Association of Retail Druggists as well as the executive directors of pharmacy association in other states have been unsuccessful because those with historical perspective are all in an annual meeting in Phoenix this week. I will have more information on this later.

C. Pharmacists are being asked to buy a "pig in a poke". Pharmacists say they do not want to put their imprimatur on a plan they haven't seen. They say the State has not set a fixed dispensing fee or determined how the base cost would be calculated.

The Department has included funds to hire a pharmacist consultant to design a program that would be least disruptive to pharmacists. A Department official two years ago told pharmacists the fixed dispensing fee would be about $5.

D. "The reimbursement price on expensive items could be less than the wholesale cost of the product." Pharmacists say one popular method used in the Western States to determine base cost is "Average Wholesale Price" minus an 11 percent discount (for bulk buying) OR the pharmacist's usual and customary price -- whichever is lower. They say this is unworkable because small Alaska pharmacies do not get a discount for bulk buying. They cite as an example a bottle of Mevcor, an anti-cholesterol drug, which costs the pharmacist $90 a bottle wholesale. At a 11 percent discount, the reimbursement would be $80.10 plus a dispensing fee. If the dispensing fee were $5, the pharmacist would be paid $85.10 -- which is less than the product cost him.

E. "Alaska is unique."

1) Distance from the market forces Alaska pharmacists to stock inventory for two weeks in order to have a supply. Trish White, co-owner of White's Pharmacy in Sitka, said Alaska pharmacies must stock an inventory two to three times that of pharmacies in the Lower 48. She made that estimate after attending a Pharmacy Management Clinic at the University of North Carolina

in Chapel Hill this year. She said that compared to Lower 48 pharmacies, her pharmacy's turn-over rate is "amazingly low". If pharmacies in Lower 48 cities don't have a bottle on the shelf, "they can run over to a chain store and get it," she said. " We can't."

2) Alaska pharmacists have to pay high freight costs, while those in the Lower 48 have low trucking costs. A small box of prescription drugs costs $10 through the mail (pharmaceuticals are mailed to keep the product fresh). White says that the policy in her store is to absorb the air mail or Gold Streak cost if the pharmacy must special order a drug which is normally stocked.

3) Rural paying customers may be charged more for drugs. Eleven rural towns in Alaska have only one pharmacy (list attached). Pharmacists contend that under the new plan, paying customers will surely be charged more in one-pharmacy towns to make up for losses from Medicaid, there being no local competition to keep the prices down.

4) Rural areas may be left without Medicaid service -- or without a pharmacy. Pharmacists contend that in the 12 one-pharmacy towns, pharmacists may be forced by economics to stop serving Medicaid-reimbursed clients. Those pharmacists who feel an ethical obligation to continue serving Medicaid clients may be forced out of business, leaving the entire town without a pharmacy.

5) Region X is unwilling to consider alternative suggestions. Pharmacists contend that Region X does not appear willing to accept alternatives put forth by pharmacists, both in Alaska and other states. Pharmacists say Hawaii, which has problems of distance similar to Alaska's, has tried twice to modify its Medicaid-reimbursement plan (the latest try was this year), with no luck. A long-time Oregon pharmacist and consultant agrees. Stan Hartman of Beaverton says Region X is concerned about "sovietizing" the Medicaid pharmacy plan, but that if the State is "firm" and has back up in the law, it can prove the legality of a proposed alternative and go back to national headquarters to force Region X to accept the plan.

3. An alternative suggestion. In a recent telephone conversation, Stan Hartman, an Oregon pharmacist and author of articles in trade journals, recommended that Alaska use a plan in place in his state. This plan is the Pharmacists Service Group.* It has been in place for four years and sells its services to insurance companies to fulfill health plans. The group competes with national companies providing similar services in Oregon. These companies use a payment plan similar to that used for Medicaid reimbursement: an average wholesale price less 11 percent, plus a $2.70 dispensing fee. But the Pharmacists Service Group uses a usual-and-customary charge plan with a cap at the 90th percentile (the payment is not more than that charged by 90 percent of participating pharmacies).

   In 1987, the plan had 10,000 recipients; it has added the Oregon State Employees as well as other organizations and will number over 150,000 recipients next year.

   Why the plan is "better", according to Hartman:

   A. The plan saves more money than a dispensing fee system.

   B. Pharmacists on this plan show a higher use of generic drugs than pharmacists on competing fixed-fee plans.

   C. The plan cuts down on drug costs by allowing up to a 90-day supply (Alaska has a 30-day supply system, in order to reduce consumer abuse.) Audits show that a 90-day supply of one drug sold for $47 while three 30-day supplies of the same drug cost $19 more. The decreased cost was the result of the economy of scale plus lower administrative costs. Under a fixed fee system, pharmacists are encouraged to dispense smaller amounts of the drug in order to reap more dispensing fees.

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* Information about this plan was supplied by Hartman and by lobbyist Ron Sedgwick. The plan's state director was out of the office this week and I was unable to contact him. I will contact him next week for written information on his plan and when it arrives, I will send it to your office. Should you wish to contact him yourself, his name is Robin Richardson, 503-585-4887. The plan's designer is Dr. Lee Strandberg of the School of Pharmacy at Oregon State University. His telephone number is 503-754-3424.

D. The Oregon plan uses a "co-pays" system (the recipient pays a fee when the prescription is picked up). The aim is to reduce utilization. (In Alaska, the Bristol Bay Hospital, which buys its drugs through the Public Health Service, requires a fixed pick-up fee of $10.) See Table 3.

TABLE 3

Amount charged customer compared to the average per capita prescription cost under the Oregon Pharmacists Service Group plan

Amount co-paid for prescription	Percent of utilization (%)	Average per capita amount spent monthly on prescription ($)
$2.00	57.5	$4.80
$2.50	48.6	$4.72
$3.00	38.9	$3.18
$4.00	32.4	$2.18
$5.00	35.6	$1.75

Source: Ron Sedgwick

Enclosed for your information is a position paper by Ron Sedgwick explaining these and other pharmacist objections in detail. Also enclosed are the bill's fiscal note and a 2/2/88 position paper by the Department of Health and Social Services entitled "SB 255". Other enclosures include a list of possible reimbursement schemes proposed by pharmacists Ron Sedgwick of Juneau and Bill Larson of Anchorage; the Department of Labor list of pharmacist-employee salaries; a list of Alaska towns with a single pharmacy; the Federal Register with an explanation of new Medicaid regulations concerning pharmaceuticals; and the Board of Pharmacy list of pharmacy licenses which expire in June of 1988.

If you require additional information, please let me know.

Attachments