SB
203

STATE OF ALASKA

WALTER J. HICKEL, GOVERNOR

DEPARTMENT OF REVENUE

ALCOHOLIC BEVERAGE CONTROL BOARD

550 W. 7TH AVE
ANCHORAGE, ALASKA 99501-6698

March 28, 1991

The Honorable Arlis Sturgulewski, Chair
Health, Education and Social Services Committee
Alaska State Senate
P. O. Box V
Juneau, Alaska 99811

RE: SB 203

Dear Senator Sturgulewski:

Betty Hargrave, of your office, asked that I provide you with the Alcoholic Beverage Control Board's position concerning SB 203.

The board has no objection to the legislation and, upon enactment, will provide new signs to appropriate licensees.

Thank you for the opportunity to comment.

Sincerely,

Patrick L. Sharrock
Director, ABC Board
277-8638

PS/cl

91-49

Revenue - ABC Bd. Position

THE FOLLOWING DOCUMENT(S)
MAY NOT FILM LEGIBLY BECAUSE OF
THE POOR QUALITY OF THE ORIGINAL

STEVE COWPER, GOVERNOR

DEPT. OF HEALTH AND SOCIAL SERVICES

BUREAU OF VITAL STATISTICS
P.O. BOX H
JUNEAU, ALASKA 99811-0675
PHONE: (907) 465-3392

April 9, 1991

Honorable Arliss Sturgulewski
Senator
State of Alaska
Room 427, Capitol

Dear Senator Sturgulewski;

As you requested I have enclosed a summary of the information I presented in testimony to the H&SS committee this morning.

Sincerely,

Alfred G. Zangri
Chief

06-142LH

DHSS -(Vital Stats)- Stmt

MATERNAL CONSEQUENCES

1980 - Surgeon General identified the following adverse affects on the fetus from smoking:

- nicotine, hydrogen cyanide, carbon monoxide and other poisonous cross the placenta

- oxygen deprivation

- deficits in behavior and cognitive development may occur

1988 study by National Committee to Prevent Infant Mortality found that;

a. annually 2,500 U.S. infant deaths are attributable to mothers' smoking

b. the ones who don't die are at increased risk of:

   - retardation
   - birth defects
   - learning disorder
   - chronic lung disorder

Alaska Data -- 1989 births

Overall, in Alaska, 6% of our births result in low birth weight babies; yet they account for 57% of our infant deaths

38.5% of Alaska low birth weight babies are born to the 24% of moms that report smoking on the birth certificate

Alaska mothers have the following low birth weight rates:

-smoking mothers	81/1000
-non-smoking mothers	31/1000
-mothers using smokeless tobacco	55/1000

THE FOLLOWING PAGES WERE TREATED AS A UNIT IN THE ORIGINAL FILE

THE FOLLOWING PAGES MAY NOT FILM LEGIBLY BECAUSE OF THE POOR QUALITY OF THE ORIGINAL

555 West Northern Lights Blvd., Suite 103, Anchorage, Alaska 99503-2501
(907) 276-5864 Fax (907) 258-9314
Walter L. Hays, Executive Director
Shannon Jones, President

AMERICAN LUNG ASSOCIATION of ALASKA

April 25, 1991

VIA FAX

To: Members of the Senate Finance Committee: Senators Kerttula, Pourchot Duncan, Adams, Hoffman, Shultz & Uehling

From: Walter L. Hays, Executive Director
American Lung Association of Alaska

RE: SB 203

SB 203 was introduced by Senators Sturgulewski and Menard at our request.

It is a simple and effective measure that would help extend the important message about the dangers of smoking and pregnancy.

According to the 1990 report of the Surgeon General (The Health Benefits Of Smoking Cessation), "if all women quit smoking during pregnancy, about 5% of deaths among newborn infants could be prevented." Alaska data for the year 1989 indicates that a full third of the low birthweight outcomes of babies born during that year were directly related to maternal smoking.

I would call your attention to the materials in your packet that were presented to the Senate HESS committee when this bill was considered by Anne Morris MD and Kenneth Kesler MD. As a neonatologist, Dr. Kesler has done an excellent job in summarizing for you the considerable health risks that smoking places on the pregnant woman and her unborn child.

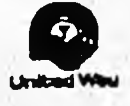
You will note that the Department of Health and Social Services has also testified in support of this legislation and that the Alcohol Beverage Control Board has indicated that the cost of providing new warning signs state-wide would be nominal indeed.

Similar warning signage has been in place in San Mateo County (CA) and in King County (WA) and the city of Seattle for the past two years. I checked recently with Tobacco-Free America, the legislative clearinghouse on tobacco and health issues sponsored by the American Heart Association, the American Cancer Society and the American Lung Association; they informed me that to the best of their knowledge no other state has yet enacted such comprehensive warning sign legislation. We in Alaska have the opportunity to pass model legislaiton in this important area of public health.

I urge your strong support for SB 203.

"Helping the Greatland Breathe Easier"

misc. back-up



Warning:

Drinking distilled spirits, beer, wine, coolers and other alcoholic beverages or smoking cigarettes during pregnancy may cause birth defects.

• King County Board of Health Rule & Regulation 42
• Seattle City Ordinance 114582

GBD:bjw
4/25/89

ORDINANCE 114582

AN ORDINANCE relating to the Seattle Food Code; amending SMC Chapter 10.11 by the addition of Section 10.11.696 requiring the posting of warning signs or notices in establishments serving alcoholic beverages.

WHEREAS, the Surgeon General of the United States has advised women who are pregnant, or considering pregnancy, not to drink alcoholic beverages or smoke cigarettes; and

WHEREAS, recent research indicates that alcohol consumption during pregnancy, especially in the early months, can harm the fetus, and result in birth defects including mental retardation, facial abnormalities and other defects involving heart and bone structure; and

WHEREAS, research indicates that maternal cigarette smoking during pregnancy slows fetal growth, lowers birth weight and increases the risk of stillbirths; and

WHEREAS, The City of Seattle finds that strategically located warnings to deter consumption of alcohol and cigarette smoking by pregnant women will reduce the incidence of these health effects and seeks to educate the public of this health problem; Now, Therefore,

BE IT ORDAINED BY THE CITY OF SEATTLE AS FOLLOWS:

Section 1. The Seattle Food Code (Seattle Municipal Code Chapter 10.11) is amended by adding thereto new section 10.11.696, as follows:

10.11.696. WARNING SIGNS OR NOTICES

A. Signs or notices, warning of the effects of alcohol consumption and cigarette smoking during pregnancy, shall be posted in all food service establishments serving any alcoholic beverage for consumption on premises. For the purpose of this section, the term "alcoholic beverage" means and includes wine, beer, malt beverage, liquor, and distilled spirits, each as defined in RCW Ch. 66.04.

Before the Board of Health of King County, Washington:

RULE AND REGULATION NO. 42

Amendment to King County Code of the Board of Health, Title 5 (Rule and Regulation No. 2), adding a new section relating to posting warning signs, Section 5.60.060.

BE IT ORDAINED BY THE BOARD OF HEALTH OF KING COUNTY:

SECTION 1. Purpose. The Surgeon General of the United States has advised women who are pregnant, or considering pregnancy, not to drink alcoholic beverages or smoke cigarettes. Recent research indicates that alcohol consumption during pregnancy, especially in the early months, can harm the fetus, and result in birth defects including mental retardation, facial abnormalities and other defects involving heart and bone structure. In addition, research indicates that maternal cigarette smoking during pregnancy slows fetal growth, lowers birth weight and increases the risk of stillbirths. The King County Board of Health finds that strategically located warnings to deter consumption of alcohol and cigarettes by pregnant women will reduce the incidence of these health effects. The King County Board of Health supports these findings and seeks to educate the public of this health problem.

SECTION 2. Section 5.60.060 (Part 69 of Rule and Regulation 2) of the King County Code of the Board of Health is hereby added as follows:

SECTION 5.60.060. WARNING SIGNS.

A. After February 1, 1989, signs, warning of the effects of alcoholic consumption and cigarette smoking during pregnancy, shall be posted in all establishments serving alcoholic beverages for consumption on premises. Alcoholic beverages shall include wine, beer, malt beverages and distilled spirits.

B. The sign or notice shall read as follows: "WARNING: DRINKING DISTILLED SPIRITS, BEER, WINE, COOLERS AND OTHER ALCOHOLIC BEVERAGES OR SMOKING CIGARETTES DURING PREGNANCY MAY CAUSE BIRTH DEFECTS."

C. Signs shall be either menu notations at least two inches high, table placards at least three by three inches or signs at least eight and one half inches by eleven inches and posted conspicuously at the bar or point of sale.

SECTION 3. Effective date. This chapter shall take effect on February 2, 1989.

Passed this 15th day of December, 1988.

KING COUNTY BOARD OF HEALTH
KING COUNTY, WASHINGTON

Cynthia Sullivan
Chair

[signature]
Member

Member

ATTEST:

[signature]
Secretary

Tom Fink, Mayor

Municipality of Anchorage

Department of Health and Human Services
825 "L" Street
P.O. Box 196650 Anchorage, Alaska 99519-6650

April 29, 1991

Senator Arliss Sturgulewski
Room 427, Capitol
P. O. Box V
Juneau, Alaska 99811

Dear Senator Sturgulewski:

SUBJECT: SB 203

I urge you to support SB 203. Section 1 (AS 4.21.065b) refers to a sign warning pregnant women that drinking alcoholic beverages and smoking cigarettes during pregnancy can cause birth defects. Information from numerous researchers and health professionals document this fact. C. Everett Koop, M.D., Surgeon General U.S.P.H.S., 1981-1989 stated "The benefits of smoking cessation are significant. Sensitive and supportive cessation and maintenance efforts can help pregnant smokers to quit. In addition to saving thousands of infants' lives, you will spare numerous children from having excessive respiratory and ear infections and from the burden, even pain, of having to compensate for a slower beginning in life, whether as a result of low birthweight or a birth defect. Researchers have also demonstrated that babies born to mothers and fathers who do not smoke are less likely to become smokers."

If there was any confusion on the Municipality of Anchorage, Department of Health and Human Services' stand on this issue I hope this clears it up.

Thank you for your support of this bill.

Sincerely,

Helen D. Beirne, Ph.D,
Director, Health and Human Services
Municipality of Anchorage

Submitted by: Assemblymember Flynn
Prepared by: Assembly Budget Analyst
For reading: February 19, 1991

ANCHORAGE, ALASKA
AO NO. 91- 23

AN ORDINANCE OF THE MUNICIPALITY OF ANCHORAGE AMENDING CHAPTER 16.60 OF THE ANCHORAGE CODE OF MUNICIPAL REGULATIONS PERTAINING TO POSTING WARNING SIGNS FOR PREGNANT WOMEN

THE ANCHORAGE MUNICIPAL ASSEMBLY ORDAINS:

Section 1: That Chapter 16.60 of the Anchorage Code of Municipal Regulations is amended by adding a new section to read as follows:

16.60.039 Warning Signs or Notices.

A. Signs or notices warning of the effects of alcohol consumption and cigarette smoking during pregnancy, shall be posted in all food service establishments serving any alcoholic beverage for consumption on premises. For the purpose of this section, the term "alcoholic beverage" means and includes wine, beer, malt beverage, liquor and distilled spirits.

B. Each such sign or notice shall read as follows:

"WARNING: DRINKING DISTILLED SPIRITS, BEER, WINE, COOLERS AND OTHER ALCOHOLIC BEVERAGES OR SMOKING CIGARETTES DURING PREGNANCY MAY CAUSE BIRTH DEFECTS."

C. Each such sign or notice shall be of the following size:

At least two inches (2") high if printed or included in a menu; at least three inches by three (3" x 3") per side if set forth on a single, double of multi-sided placard or display "tent" on any table provided for the establishment's customer; and not less than eight and one-half inches (8 1/2" x 11") if included on a sign that is posted conspicuously at a bar or other point of sale that is clearly visible to the public.

Section 2: That this ordinance is effective upon passage and approval.

SMOKING AND PREGNANCY

My name is Dr. Kenneth Kesler. Address 3340 Providence Dr. Ste 366, Anchorage, AK. I am a Neonatologist which is a Pediatrician trained to deal with sick or prematurely born infants. I have reviewed medical literature regarding the effects of cigarette smoking on both the mother and fetus during pregnancy and have lectured for the Alaska Lung Association on this topic.

The number of women in the reproductive ages who smoke has increased from 5% in 1920 to nearly 40% today. There is great interest in the effects of smoking on pregnancy and since 1966 over 2000 articles have been written on this subject, most of which have demonstrated adverse effects of smoking on the mother and fetus. I will try to briefly describe 12 of those effects to you.

1. Two major components of cigarette smoke are carbon monoxide and nicotine, both of which cross the placenta and invade the fetus when the mother smokes. Increased carbon monoxide levels in the fetus and mother decreases the amount of oxygen delivered to the fetus. If a women is a moderate smoker the effect on the fetus is similar to decreasing 40% of the fetal blood flow.

   Nicotine accumulates to high levels in the fetus and results in decreased blood flow to the fetus. This effect of nicotine on the placenta is very similar to effect of cocaine.

2. Increased number of cleft lips, heart defects and severe brain abnormalities have been reported among infants born to women who smoke.

3. Spontaneous abortions are more frequent among women who smoke.

4. There is an increase in the number of pregnancies complicated by placenta problems such as separation of the placenta from the uterine wall which may result in fetal distress or death.

5. The incidence of premature rupture of membranes is doubled in women who smoke.

6. There is a higher rate of stillbirths and neonatal deaths among women who smoke. Some have estimated that maternal smoking is strongly associated with 4600 infant deaths in the United States per year.

7. There are over 50 studies confirming the trend that women who smoke have babies of lower birth weight. Dr. Michael Kramer in association with the World Health Organization demonstrated that "In the developed country, the most important single factor, by far, is cigarette smoking" accounting for nearly one third of all low birth weight infants (meaning infants who weigh less than 5 1/2 pounds).

Limited information is available on smoking during pregnancy in Alaska. I reviewed the information for a recent 3 years period in the Newborn Intensive Care Unit at Providence Hospital. Of the nearly 900 admission 28 % of the mothers admitted to smoking during pregnancy. (These numbers are probably artificially low because they are based on self reporting.)

8. The risk of delivering a baby prematurely (more than 1 month) may be nearly 2 times higher among smoking mothers. The costs of caring for premature infants is extremely high. In 1983 it was estimated that over 3 billion dollars was spend on infants admitted to Intensive Care Nurseries in the United States per year. **Prematurely born infants may require intensive care for several weeks with a hospital bill in Alaska of $500.00 to $1,500.00 per day.**

9. Breast milk contains nicotine and may produce mild to severe symptoms in the newborn and some cases of nicotine poisoning have occurred in babies breast-fed by mothers who smoked heavily.

10. Some preliminary evidence suggest that children born to women who smoke are at higher risk for various cancers when they are adults. This effect of smoking during pregnancy will probably not be scientifically proven for many years because of problems related to designing an adequate study.

11. Some studies have demonstrated various deficiencies in school performance among children born to mothers who smoke which is independent of confounding variables.

12. Nicotine is transferred to growing children in households where smoking occurs. This results in a two fold increase in the rate of Sudden Infant Death Syndrome. Also the incidence of pneumonia and bronchitis are increased in children where the parents smoke.

I have not had time to site the references for the above information. I have made a list of some of these references from journals such as the New England Journal of Medicine, the American Journal of Obstetrics and Gynecology, Pediatrics, and The British Medical Journal which are attached.

No one should leave here with a misunderstanding of the impact of smoking on the fetus and newborn infant. The effects are not trivial. They are significant and may be severe even lethal to the fetus.

This Bill with the signage amendment should be considered carefully. If we are to have an impact on the well being of the unborn, society must address the human behaviors which can adversely affect the fetus and seek methods to alter those behaviors. Smoking and its effect on the fetus is perhaps one of the best documented and easily targeted of these behaviors. I urge you to give serious consideration to Senate Bill 203.

REFERENCE LIST - SMOKING AND PREGNANCY

1. McIntosh ID; Smoking and pregnancy: I Maternal and placental risks (and) Smoking and pregnancy:II. offspring risks, Public Health Review 12:1-63, 1984

(These two articles are excellent reviews of the most important effects of smoking on the mother, fetus and newborn and sites the literature to support them.)

2. Quigley ME, Sheehan KL, Wilkes MM, Yen SSC; Effects of maternal smoking on circulating catecholamine levels and fetal heart rates. Am J Obstet Gynecol 133:685, 1979

3. Peterson DR; The sudden infant death syndrome-reassessment of growth retardation in relation to maternal smoking and the hypoxia hypothesis, Am J of Epidemiology 113:583, 1981

4. Khoury MJ, Gomez-Farias M, Mulinare J; Does maternal cigarette smoking during pregnancy cause cleft lip and palate in offspring?, American Journal of Diseases of Children 143:333, 1989

5. Lichtensteiger W, Ribary U, Schlumpf M, Odermatt B, Widmer HR; Prenatal adverse effects of nicotine on the developing brain, Progress in Brain Research 73:137, 1988

6. Remmer H; Passively inhaled tobacco smoke: a challenge to toxicology and preventive medicine, Archives of Toxocology 61:89, 1987

7. Werner EJ. Stockman JA; Red cell disturbances in the feto-maternal unit, Seminars in Perinatology 7:139, 1983

8. Kramer MS: Intrauterine growth and gestational duration determinants, Pediatrics 80:502, 1987

9. Suzuki K, Minei LJ, Johnson EE; Effect of nicotine upon uterine blood flow in the pregnant rhesus monkey, American Journal of Obstetric and Gynecology 136:1009, 1980

10. Naeye RL; Influence of maternal cigarette smoking during pregnancy on fetal and childhood growth, Obstetrics and Gynecology 57:18, 1981

11. Rush D, Callahan KR; Exposure to passive cigarette smoking and child development. A critical review, Annals of the New York Academy of Science 562:74, 1989

12. Bergman AB, Wiesner LA; Relationship of passive cigarette smoking to sudden infant death syndrome, Pediatrics 58:665, 1976

13. Butler NR, Goldstein H; Smoking in pregnancy and subsequent child development, British Medical Journal 4:573, 1973

14. Naeye RL; Relationship of cigarette smoking to congenital abnormalities and perinatal deaths, American Journal of Pathology 90,:289, 1978

15. Naeye RL, Ladis B, Drage JS; Sudden infant death syndrome: a prospective study, American Journal of Diseases of Children 130:1207, 1976

16. Meyer MB; Maternal smoking, pregnancy complications and perinatal mortality, American Journal of Obstetric and Gynecology 128:494, 1977

17. Kline J, Stein ZA, Susser M, Warburton D; Smoking: a risk factor for spontaneous abortion, New England Journal of Medicine 297:793, 1977

18. Naeye RL; Abruptio placentae and placenta praevia: frequency, perinatal mortality, and cigarette smoking, Obstetrics and Gynecology 55:701, 1980

Members of the Senate HESS Committee:

My name is Anne Morris. I am a pulmonary physician in private practice in Anchorage. I am Past President of the Alaska Thoracic Society, the medical arm of the American Lung Association of Alaska. In this capacity I have served on the board of the American Lung Association of Alaska for the past twelve years. I have also served on the board of the national organization.

I am here to speak in support of SB 203 as one who sees each day patients whose life, health and happiness have been ruined by smoking and the deadly toll of nicotine addiction.

I want to urge your support for this change of language in the required warning sign about the dangers of alcohol and pregnancy. Let me share with you the summary findings of the 1990 Report of the Surgeon General (The Health Benefits of Smoking Cessation). These are findings from the chapter on Smoking Cessation and Reproduction - the section on Benefits For the Fetus. I quote from the summary of the report.

"Smoking is probably the most important modifiable cause of poor pregnancy outcome among women in the United States... the elimination of smoking during pregnancy could prevent about 5% of perinatal deaths, about 20% of low birthweight births, and about 8% of preterm deliveries in the United States. In groups with high prevalance of smoking (e.g. women who have not completed high school), the elimination of smoking during pregnancy could prevent about 10% of perinatal deaths, about 35% of low birthweight births and about 14% of preterm deliveries." (I have appended a copy of this five paragraph summary from the report to these written remarks.)

Some of the most gratifying work we do at the American Lung Association is with our "Smoke Free Family" program when we are able to help pregnant women overcome nicotine addiction for their own health and the welfare of their unborn child.

Dr. Kenneth Kessler, an Anchorage Neonatologist, has prepared a superb statement on the impact of cigarette smoking on both the mother and the fetus. Dr. Kessler could not be here today but has asked that I share this information with you. A copy of his testimony is in your packets. I call your attention to item 1 -- the effect of nicotine on the placenta is very similar to the effect of cocaine; item 3 - spontaneous abortions are more frequent among women who smoke and item 8 - premature infants may require intensive care for several weeks with hospital bills in Alaska from $500 to $1500 per day. (Need I remind you as persons concerned with fiscal management - that someone is paying that bill. If 35% of our population is uninsured, then it is the state and public and private charity that is picking up the bill for these babies at risk.) You will note that Dr. Kessler has given you a reference to eighteen (18) current scientific studies on this subject.

This concern has led our Association to ask our legislative leaders to set forth new warning signage. It is modeled on action that was taken by King County (Washington) by rule in December of 1988 and the city of Seattle by ordinance in July of 1989. Their actions were based on similar action taken in San Mateo County (CA) some months before. Recent contact with leadership of the King County Health Department by our Association reports overwhelming acceptance of these pro-health decisions.

This proposed ordinance is quite simple but its effects can be quite profound. If it will help one pregnant woman break the disease of nicotine addiction that is poisoning both her and her unborn child, then we will have made positive progress. But it will not be one woman, it will be many. The end result will be healthier pregnancies and a reduction in premature deaths and critical care for nicotine addicted, low birthweight babies. It will strengthen our communities and save tax and charity dollars.

Yesterday, our Association contacted the executive director of Tobacco-Free America, the legislative clearing house on tobacco and health issues sponsored by the American Heart Association, the American Cancer Society and the American Lung Association; they informed us that to the best of their knowledge no other state has yet enacted such comprehensive warning sign legislation. We in Alaska have the opportunity to pass model legislation in this important area of public health.

As our elected officials, you are custodians of the public good; this includes the public health. I urge your passage of this bill that is a positive step forward -- simple, effective pro-health, pro-family legislation that will help conserve our most precious resource -- Alaska's children.

Anne Morris MD
10630 East Tree Drive
Anchorage, AK 99516
907/346-2897

smoking. Smoking cessation reduces the risk of respiratory infections such as pneumonia, which are often the immediate causes of death in patients with an underlying chronic disease.

The important role of health care providers in counseling patients to quit smoking is well recognized. Health care providers should give smoking cessation advice and assistance to all patients who smoke, including those with existing illness.

Benefits for the Fetus

Maternal smoking is associated with several complications of pregnancy including abruptio placentae, placenta previa, bleeding during pregnancy, premature and prolonged rupture of the membranes, and preterm delivery. Maternal smoking retards fetal growth, causes an average reduction in birthweight of 200 g, and doubles the risk of having a low birthweight baby. Studies have shown a 25- to 50-percent higher rate of fetal and infant deaths among women who smoke during pregnancy compared with those who do not.

Women who stop smoking before becoming pregnant have infants of the same birthweight as those born to women who have never smoked. The same benefit accrues to women who quit smoking in the first 3 to 4 months of pregnancy and who remain abstinent throughout the remainder of pregnancy. Women who quit smoking at later stages of pregnancy, up to the 30th week of gestation, have infants with higher birthweight than do women who smoke throughout pregnancy.

Smoking is probably the most important modifiable cause of poor pregnancy outcome among women in the United States. Recent estimates suggest that the elimination of smoking during pregnancy could prevent about 5 percent of perinatal deaths, about 20 percent of low birthweight births, and about 8 percent of preterm deliveries in the United States. In groups with a high prevalence of smoking (e.g., women who have not completed high school), the elimination of smoking during pregnancy could prevent about 10 percent of perinatal deaths, about 35 percent of low birthweight births, and about 15 percent of preterm deliveries.

The prevalence of smoking during pregnancy has declined over time but remains unacceptably high. Approximately 30 percent of U.S. women who are cigarette smokers quit after recognition of pregnancy, and others quit later in pregnancy. However, about 25 percent of pregnant women in the United States smoke throughout pregnancy. A shocking statistic is that half of pregnant women who have not completed high school smoke throughout pregnancy. Many women who do not quit smoking during pregnancy reduce their daily cigarette consumption; however, reduced consumption without quitting may have little or no benefit for birthweight. Of the women who quit smoking during pregnancy, 70 percent resume smoking within 1 year of delivery.

Initiatives have been launched in the public and private sectors to reduce smoking during pregnancy. These programs should be expanded, and less educated pregnant women should be a special target of these efforts. Strategies need to be developed to address the problem of relapse after delivery.

The Health Benefits of SMOKING CESSATION

a report of the Surgeon General

1990

Executive Summary

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service
Centers for Disease Control
Center for Chronic Disease Prevention and Health Promotion
Office on Smoking and Health
Rockville, Maryland 20857

THE PRECEDING PAGES
WERE TREATED AS A UNIT
IN THE ORIGINAL FILE

STATE OF ALASKA
1991 LEGISLATIVE SESSION

BILL NO. SB 203

Revision Date: ______ Department Affected: ______

Title: That alcohol warning signs also warn of danger from smoking during pregnancy.

BRU: Alcoholic Beverage Control Board

Component: ______

Sponsor: Sen. Sturgulewski & Sen. Menard

Requestor: Sen. HES Committee

COMPONENT SERIAL NO. 0 1 0 0

Expenditures/Revenues: (Thousands of Dollars)

OPERATING	FY 92	FY 93	FY 94	FY 95	FY 96	FY 97
PERSONAL SERVICES	-0-	-0-	-0-	-0-	-0-	-0-
TRAVEL	-0-	-0-	-0-	-0-	-0-	-0-
CONTRACTUAL	2.0	.8	.8	.8	.8	.8
SUPPLIES	.2	.1	.1	.1	.1	.1
EQUIPMENT	-0-	-0-	-0-	-0-	-0-	-0-
LAND & STRUCTURES	-0-	-0-	-0-	-0-	-0-	-0-
GRANTS, CLAIMS	-0-	-0-	-0-	-0-	-0-	-0-
MISCELLANEOUS	-0-	-0-	-0-	-0-	-0-	-0-
TOTAL OPERATING	2.2	.9	.9	.9	.9	.9
CAPITAL	-0-	-0-	-0-	-0-	-0-	-0-
REVENUE	-0-	-0-	-0-	-0-	-0-	-0-

FUNDING: (Thousands of Dollars)

	FY 92	FY 93	FY 94	FY 95	FY 96	FY 97
GENERAL FUND	2.2	.9	.9	.9	.9	.9
FEDERAL FUNDS	-0-	-0-	-0-	-0-	-0-	-0-
OTHER	-0-	-0-	-0-	-0-	-0-	-0-
TOTAL	2.2	.9	.9	.9	.9	.9

POSITIONS:

	FY 92	FY 93	FY 94	FY 95	FY 96	FY 97
FULL-TIME	-0-	-0-	-0-	-0-	-0-	-0-
PART-TIME	-0-	-0-	-0-	-0-	-0-	-0-
TEMPORARY	-0-	-0-	-0-	-0-	-0-	-0-

Estimate of current year impact: This note intends that funds be appropriated for FY 92.

ANALYSIS: (Attach a separate page if necessary.)

See attached cost analysis for initial and annual issuance of signs to liquor licensees and permittees.

Prepared By: Patrick L. Sharrock/ [signature] Phone: 277-8638

Division: Alcoholic Beverage Control Baord Date: March 19, 1991

Approved by Commissioner: [signature]

Agency: Department of Revenue Date: 3-22-91

Distribution (by preparer): Legislative Finance, Legislative Sponsor, Requestor, OMB, & Impacted Agency(ies).

Rev 10/90

Revenue 2.2 FN

Senate Bill 203
Attachment to fiscal note
Alcoholic Beverage Control Board
March 19, 1991

Initial Issue

Beverage dispensary	679
Restaurant or eating place	314
Club license	81
Brewery	3
Package store	454
Common carrier	175
Recreational site	19
Pub license	1
Winery	0
Community license	3
Club caterer's permit	1
Theatre site license	2
Restaurant caterer's permit	5
Assume 2 signs per premises	1,737
	x 2
	3,474

Annual Issue

Caterer's permits	629
Special events permits	89
Club caterer's permit	6
Restaurant caterer's permit	5
wear and tear	50
Approximately 50%	779
	x 2
	1,558

	Initial	Annual
Approx. $175. per thousand		
Initial: $175. x 3,474.	608	
Annual : $175. x 1,558		272
Postage		
Initial: .75 x 1,737	1,303	
Annual : .75 x 779		584
Envelopes		
Initial: 1,737 x .12	208	
Annual : 799 x .12		93
Letters	26	
	2,145	949

Alaska State Legislature

SENATOR
ARLISS STURGULEWSKI

311 C STREET, SUITE 550
ANCHORAGE, ALASKA 99503
(907) 561-7615

While in Juneau
P.O. BOX V
JUNEAU, ALASKA 99811
(907) 465-3818

Senate

Sponsor Statement on:

SB 203 "An Act requiring that signs warning of possible danger from drinking alcohol during pregnancy also warn of possible danger from smoking cigarettes during pregnancy."

Senate Bill 203 was introduced at the suggestion of the American Lung Association of Alaska. This bill would amend state law to add "or smoking cigarettes" to the signs warning pregnant women that drinking alcoholic beverages during pregnancy can cause birth defects. A 1990 report from the Surgeon General states, "If all women quit smoking during pregnancy, about 5 percent of deaths among newborn infants could be prevented."

I have enclosed supportive testimony presented to the Senate HESS Committee from Dr. Anne Morris and Dr. Kenneth Kesler as well as statistical information provided by Alfred Zangri, Chief of the Bureau of Vital Statistics, Department of Health and Social Services.

Enclosed is a copy of Sec. 04.21.065(a) noting which license or permit holders are required to post the warning signs.

Patrick L. Sharrock, Director of the Alcoholic Beverage Control Board, has provided a letter stating the board has no objection to the legislation. Also enclosed is a Fiscal Note for SB 203 prepared by Mr. Sharrock.

Earlier this year, the Anchorage Municipal Assembly passed the enclosed Ordinance 91-23 pertaining to posting warning signs for pregnant women. These signs include a smoking warning. I have also enclosed a letter of support from Dr. Helen Beirne, Director of the Health & Human Services Department, Municipality of Anchorage.

Enclosures

- sponsor statement -

HOUSE COMMITTEE REPORT

(7)

Date Referred: May 6, 1991 FURTHER REFERRALS: Finance

Date of Committee Action: 5-15-91

The HEALTH, EDUCATION AND SOCIAL SERVICES Committee considered: SB 203

SENATE BILL NO. 203 ADD SMOKING WARNING TO ALCOHOL SIGNS

"An Act requiring that signs warning of possible danger from drinking alcohol during pregnancy also warn of possible danger from smoking cigarettes during pregnancy."

RECOMMENDATIONS:
be replaced with ______ [ ] the same title [ ] a new title

[ ] have attached amendments(s)
[✓] do pass
[ ] do not pass
[ ] no recommendations
[ ] individual recommendations
[ ] additional referral to the ______ Committee

ADOPTS: ______ letter of Intent

ATTACHES NEW FISCAL NOTE(s): (Dept)
[ ] fiscal impact ______
[ ] zero fiscal note ______

APPROVES PREVIOUS: (Dept/Date)
[✓] fiscal note(s) DOR 4/10/91
[ ] zero fiscal note(s) ______

SIGNING DO PASS	DP	OTHER RECOMMENDATIONS	DNP	NR	AM
Cheri Davis	✓				
[signature]	✓				
[signature]	✓				
John C. Davidson	✓				
Betty Davis	✓				

[signature]
CO-CHAIRMAN'S SIGNATURE (LINCOLN)

SB

211

Alaska State Legislature

During Session
P.O. Box V
Juneau, Alaska 99811
(907) 465-2828

During Interim
3111 C Street, Suite 510
Anchorage, Alaska 99503
(907) 561-2040

Senator Virginia Collins

February 10, 1992

Honorable Georgianna Lincoln, Co-Chair
House Health, Education, & Social Services
Committee
Alaska State Legislature
P.O. Box V
Juneau, Alaska 99811

Re: CSSB 211 (FIN) -- Medicaid coverage of advanced nurse practitioner services

Dear ~~Representative Lincoln~~ Georgianna,

Thank you for scheduling a hearing of CSSB 211 (Finance) in your committee. Enclosed please find material you may wish to include in your committee packets.

Last year the House Health, Education, and Social Services Committee passed out of committee Rep. Bettye Davis' HB 318, the companion legislation of CSSB 211 (Finance). I seem to recall that it did so in order to ease the passage of CSSB 211 (Finance) which many of us had expected the Senate to pass last year.

Because the committee has already heard and passed out the companion bill of CSSB 211 (Finance), I hope the enclosed information is sufficient enough to educate the committee about the issue.

Again, thank you for promptly scheduling my bill and for your consideration of my request that it be waived from your committee.

Sincerely,

Senator Virginia Collins
District F-B

Sponsor stmt

PRINTED ON RECYCLED PAPER

Alaska State Legislature

During Session
P.O. Box V
Juneau, Alaska 99811
(907) 465-2828

During Interim
3111 C Street, Suite 510
Anchorage, Alaska 99503
(907) 561-2040

Senator Virginia Collins

CSSB 211 (Finance)

Coverage of All Advanced Nurse Practitioners
Under Medicaid

CSSB 211 (Finance) would allow all advanced nurse practitioners to be reimbursed under Medicaid.

Under current state law, Alaska only allows nurse midwives, family, and pediatric advanced nurse practitioners (ANP's) in independent practice to enroll as Medicaid providers.

ANP's having different designations, such as "geriatric" nurse practitioners or "women's health care" nurse practitioners, are not allowed to enroll as Medicaid providers even though they may provide some of the same services as those who are allowed to enroll.

In Alaska, where nursing shortages abound, CSSB 211 (Finance) would encourage the involvement of more ANP's in health care. It corrects the current practice of discrimination against certain specialty groups within the general category of ANP's.

In many rural health clinics in Alaska, physicians must be flown in at a cost of several thousand dollars so that Medicaid patients can be treated. If all ANP's were allowed to enroll as Medicaid providers, that cost would likely be reduced.

CSSB 211 (Finance) also places ANP services on the priority list of optional services offered under the Medicaid program.

The Organization of Alaskan Nurse Practitioners and the Alaska Nurses Association support CSSB 211 (Finance).

additonal sponsor statement

PRINTED ON RECYCLED PAPER

DIVISION OF LEGAL SERVICES

LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

P.O. Box Y, Juneau, Alaska 99811
(907) 465-3867 or 465-2450
FAX (907) 465-2029

Deliveries to: 240 Main Street
Court Plaza, Room 500
Mail Stop 3101

M E M O R A N D U M

February 19, 1991

SUBJECT: Constitutional Issues - Advanced Nurse Practitioners (7LS-0778)

TO: Senator Virginia Collins

FROM: Terri Lauterbach
Legislative Counsel

You have asked whether it would be constitutional for the Alaska Medicaid program to cover directly only the services of pediatric and family nurse practitioners without covering directly the services of other advanced nurse practitioners.[1] You are concerned that there may be a violation of the equal protection clause of the state constitution.

In our opinion, offering direct reimbursement under Medicaid to only certain types of ANP's probably results in the kind of arbitrary classification prohibited under the state's equal protection clause. Since direct reimbursement of some types of ANP's is optional under federal law, however, the state Medicaid statutes would need to be amended to correct this constitutional deficiency.

The state's equal protection clause is found in art. I, sec. 1, Constitution of the State of Alaska, which provides that "...all persons are equal and entitled to equal rights, opportunities, and protection under the law...."

The Alaska Supreme Court has interpreted this clause to offer broader protection than the corresponding federal clause.[2] In so doing, our court has said that in order for a classification to be valid, it must be reasonable, not arbitrary, and must bear a fair and substantial relation to a legitimate governmental objective, and, depending on the importance of the individual's interest involved, a greater or lesser

---

[1] You have told me that some of the other types of advanced nurse practitioners are women's health, adult, neo-natal, school nurse, geriatric, and psychiatric.

[2] This is why the classifications may be valid under the federal constitution but not valid under the state constitution. However, I am not aware of any case upholding different treatment of these ANP classifications on the federal level either; they may turn out to also violate the federal constitution.

Legal Services Division

burden will be placed on the state to show this fair and substantial relationship.[3] Our courts have also said that the guarantee of equality of treatment prohibits a classification that denies to one group of persons the enjoyment of certain rights that are afforded to another group when, considering the purpose of the state program, there is no reasonable basis for not treating both groups the same.[4]

In the situation you have described to me, the services of two types of ANP's will be covered directly under the Medicaid program, as required under federal law, but the services of all other ANP's will not be covered directly, even though federal law would allow them to be and even though they may provide exactly the same type of service.[5]

Since services of all ANP's are covered when the ANP is associated with a physician or a hospital and federal law would only allow coverage of services performed within the scope of an ANP's certification, there does not appear to me to be any basis for saying that the services of other ANP's would be of an unacceptable quality.

You have also told me that, regardless of a particular ANP's certification, many of the services performed by one ANP are the same as those performed by ANP's with other types of certifications.

I also note that the Medicaid program covers all physician services, regardless of the fact that some physicians have specialties and some do not. In other words, the Medicaid program covers a given service performed within the scope of a physician's licensure and does not distinguish among family physicians, general physicians, pediatricians, gynecologists, etc., when they perform services that all are authorized to perform.

Furthermore, it appears that most of the other ANP specialties you told me about would be especially useful to the Medicaid population, which is primarily pregnant women, women with children, and elderly persons. It would seem that special training in women's health, adult, neo-natal, school nurse, and geriatric areas would be as useful to Medicaid recipients as special training in family and pediatric care.

Finally, I note that the state does not allow this type of discrimination among licensed providers to be practiced by insurance companies. See AS 21.36.090, which specifically lists advanced nurse practitioners among those whose services must be

---

[3] See, for instance, Wilson v. Municipality of Anchorage, 669 P.2d 569 (Alaska 1983).

[4] See, for instance, Leege v. Martin, 379 P.2d 447 (1963).

[5] "Direct" coverage means that the ANP does not have to be associated with a physician or other health care provider, like a hospital.

covered by insurance policies if the services are within the scope of their lawful authority. It would be rather inconsistent for the state to practice a type of discrimination that it prohibits private parties from practicing.

Given these facts, I am unable to conceive a constitutionally sound basis for the state to refuse to cover directly the services of all ANP's after it has started to cover directly the services of some ANP's. This seems to be exactly the kind of arbitrary classification prohibited under our state equal protection clause. It would deny to some ANP's the opportunity to be directly reimbursed for services that other ANP's are directly reimbursed for. It gives to some ANP's the opportunity to participate directly in the Medicaid program while denying that opportunity to other ANP's.

The insidiousness of this classification must be balanced against whatever legitimate governmental objective is served by the classification.

It is stated in AS 47.07.010 that the purpose of the Medicaid program is to provide "uniform and high quality medical care" to needy persons of the state. According to you, there is some evidence that ANP's provide the only medical care available in some rural communities and that many persons in these communities are eligible for Medicaid. The goal of providing Medicaid services to these people would not be served by a policy of covering only some types of ANP's when it may be another type of ANP that is in the community, providing the same basic services. Even when other health care providers are available, increased access to ANP's means increased access to health care delivery.

A second objective of the classification may be to save money by not covering services of some practitioners. While saving money is a legitimate goal, use of an arbitrary classification of providers is not well-tailored to that goal. There is already a statutory mechanism for dealing with shortfalls if the legislature fails to appropriate enough money for the Medicaid program. That mechanism is the priority listing of optional coverages in AS 47.07.035. The legislature has determined which **services** should be cut first when there is not enough money to cover everything. Therefore, there is no need to discriminate against **providers** of those services in order to save money.

In conclusion, there seems to me to be no legitimate basis for directly reimbursing some types of ANP's and not others, as long as they are delivering services that are within the scope of their practice.

However, because of the way the federal law is written, a change in Alaska's Medicaid law is required to achieve an equitable result. Under the federal law, direct reimbursement of some ANP's is **mandatory** and direct reimbursement of other

ANP's is **optional.** Under the Alaska statutory scheme, federally mandated provisions of Medicaid automatically become part of our program under AS 47.07.030(a). In order to add something that is optional under federal law, the state must amend AS 47.07.030(b).

Please let me know if you have questions about this memo or if I can be of other assistance.

TML:lmb/mai
91-054.lmb

Enclosure

STATE OF ALASKA ★ DEPARTMENT OF HEALTH & SOCIAL SERVICES

SENATE BILL 211

"An Act providing for coverage of advanced nurse practitioner services under the Medicaid program; and reordering the priorities granted to optional services offered under the Medicaid program."

This bill would amend AS 47.07.030 to allow Advanced Nurse Practitioners (ANPs) to enroll as Medicaid providers, provide Medicaid-eligible recipients with those services which Medicaid covers and which are within the scope of their licensure, and directly receive Medicaid reimbursement. This bill also amends AS 47.07.035 to place this new provider group 17th on the list of optional services to be deleted in the event of a finding shortfall.

Currently, many ANPs do receive Medicaid reimbursement, but only indirectly. For any ANP who is employed by a hospital, nursing home, physician's clinic, mental health or rural health clinic, or a physician, the enrolled provider for whom they work receives Medicaid reimbursement for their services.

However, ANPs, except nurse midwives who practice independently, cannot currently enroll as Medicaid providers.

This situation will change in early 1992, when Alaska will implement a provision of the Omnibus Reconciliation Act of 1989 which requires all states to grant Medicaid provider status to independently-practicing ANPs who specialize in family or pediatric medicine.

Industry sources indicate that, of 141 ANPs licensed to practice in Alaska, just 37 are either in full or part-time independent practice and are likely to choose to enroll. Of these 37, 24 are family specialists and one is a pediatric specialist. Whether or not SB 211 were to pass, these 25 will shortly be allowed to enroll in Medicaid if they choose to do so. (The Department of Health and Social Services expects virtually all will enroll.)

We therefore believe that SB 211 would initially affect only the following ANPs:

(a) 4 Mental Health specialists (all part-time practitioners;
(b) 5 Women's Health Care specialists (all full-time);
(c) 1 School Nurse Practitioner specialist (part-time); and
(d) 2 Geriatric specialists (one full-time, one part-time).

DHSS Position

Often, the opportunity to directly receive reimbursement from a major third-party payor can affect patterns of practice. The potential to directly receive Medicaid reimbursement might, over time, induce more ANPs to enter independent practice. This is a pattern that has occurred with other provider groups elsewhere. From conversations with many ANPs over the last two years, we have concluded that this is unlikely to occur in Alaska. The financial disadvantages, the loss of personal freedom, and the very strong traditional practice patterns of ANPs, argue against any significant growth in independent practice as a direct effect of Medicaid reimbursement.

However, those ANPs who currently practice independently do seem to serve a higher percentage of low-income patients than is true of many other provider types. We suspect that ANPs who do enroll in Medicaid will serve a higher percentage of Medicaid recipients than do most physicians, for example.

For many years, the Department of Health and Social Services has had ANPs as employees (both in administrative roles and in direct public health services positions), and has had extensive dealings with ANPs as part of the Medicaid program and as eligibles in health care. In our judgment, ANPs have extremely rigorous licensure requirements, a strong tradition of service, and unquestionably high professional standards.

Kimberly B. Busch

Kimberly B. Busch, Director
Division of Medical Assistance

DATE: ____________________

Theodore A. Mala

Theodore A. Mala, MD, MPH
Commissioner

DATE: 15 January 1992

FEB 25 1991

POSITION STATEMENT ON THIRD PARTY REIMBURSEMENT FOR NURSE PRACTITIONERS

Prepared by P.E.E.R., the Organization of Alaskan Nurse Practitioners

August, 1987

P.E.E.R.'s Position

P.E.E.R. strongly supports the policy of issuing direct third party payment as reimbursement for professional services rendered by all licensed Nurse Practitioners (NPs) in Alaska. The services offered by NPs are legally recognized by the State of Alaska in specific Nurse Practice Acts, and are equivalent, and in some cases, more holistic in approach, than services provided by physicians in primary care. Reimbursement for NP services would benefit the public by:

1. enabling NPs to establish independent practices and clinics by providing a mechanism to finance their businesses. Currently, most NPs are employed by physicians or other entitities, in part because they CANNOT receive direct third party payment.

2. offering more freedom of choice to the public in their selection of competent health care providers.

3. potential reduction in health care costs through competition for provision of services.

4. potential expansion of health care services of NPs in the private sector in under-served areas.

The Significant Contribution of Nurse Practitioners in Alaska

Licensed NPs in Alaska are in sufficient numbers to deserve recognition as an important group of health care providers: as of July, 1987, 129 NPs were licensed and claimed residence in the state. Another 40 NPs are estimated to work in federal governmental agencies (such as Elmendorf Hospital or the Indian Health Service); they are not required to apply for state licences in order to practice. This section describes only the licensed NPs.

Family nurse practitioners outnumber the other eight types of nurse practitioners in Alaska (Table 1). Nurse practitioners impact health care services in Alaska in a variety of work settings (Table 2). Only eleven are in independent practice; of those, six practice in rural settings. Independent practice became an option in December, 1984, with the passing of the new regulations that included placement of NPs under the sole jurisdiction of the Alaska Board of Nursing. Five of the independent practitioners are nurse midwives, who may collect fees from third party payers as stipulated in Alaska Statutes, Sec. 47.07.030--others may not, or do so with difficulty.

The majority of Alaskan NPs hold a Bachelor's or Master's

Nurse Practitioners Position

degree in nursing (86) in addition to their specialized nurse practitioner training, and certification through national certifying bodies (Table 3). In contrast to R.N. degree status for entry into NP training programs in the 1960s, the current national trend is for that training to take place in conjunction with Master's degree preparation, illustrated by the Family Nurse Practitioner program at the University of Alaska's College of Nursing and Health Sciences.

No studies have been conducted in Alaska to assess the quality of care provided by nurse practitioners, nor how their care might differ from that of a physician. Numerous studies in the lower 48, however, have shown that . . ."within their areas of competence, nurse practitioners provide care whose quality is equivalent to that of care provided by physicians", and that patients are generally satisfied with their care (US Congress, Office of Technology Assessment, 1986, pages 5-6). The American Academy of Nurse Practitioners provides a summary of the recent studies documenting the quality of services provided by NPs (addendum 1; also cites the OTA study mentioned above).

Alaskan NPs have demonstrated their willingness to work in under-served rural areas in Alaska: 51 of the currently employed 126 state-licensed NPs work in settings other than in Anchorage, Fairbanks, or Juneau. Their jobs entail multiple responsibilities and require high levels of expertise (see addendum 2 for an example of a rural practice).

The National Trends

Congress continues to consider a variety of proposals to mandate third party reimbursement for NPs. So far, federally mandated payments are limited to a few State Medicaid programs, Champus, and some programs in the Federal Employees Health Benefit Program (refer to Appendix B, US Congress, Office of Technology Assessment, 1986). At least 13 states currently permit direct payment for NP services, including Oregon, a state that also supports the independent practice of NPs.

Conclusion and Our Recommendations

We contend that without direct reimbursement to NPs in the State of Alaska, the practice settings of NPs are limited, which in turn, effectively limits competition among providers, patient choices of providers, and ultimately, adversely impacts upon health care costs. We therefore recommend that:

1. third party insurers voluntarily offer to provide direct reimbursement for NP services, and/or that

2. the state legislature amend the statutes to mandate such reimbursement to <u>all</u> licensed NPs, not just to nurse midwives as is now the case.

Thanks is extended to Gail McGuill, Executive Director, Alaska Board of Nursing, for her assistance in obtaining the NP data.

Table 1

Type of Nurse Practitioner Licensed and Residing in Alaska, July, 1987*

Type of Practitioner	Number
Family Nurse Practitioner (includes 3 with other NP designations)	48
Certified Nurse Midwife (includes 7 with other NP designations)	25
Women's Health Care Practitioner (includes 3 with other NP designations)	22
Pediatric Nurse Practitioner	13
Adult Nurse Practitioner	9
Neonatal Nurse Practitioner	5
School Nurse Practitioner	5
Geriatric Nurse Practitioner	1
Psychiatric Nurse Practitioner	1
	129

*Each NP was given a single designation, although some were certified in several areas. If an NP was a CNM, this was considered her primary designation. If an FNP was also an ANP, the practitioner was included in the FNP group (since the FNP designation covers a broader age-range in clients).

Alaska State Legislature

Please enter into the record my testimony to the House HESS
committee name,

committee on SB 211, dated 2/12/92.
bill/subject

including this. 2 pgs

SB 211 MEDICAID

February 9, 1992

Dixie L. Light PhD, ANP/FNP, MScN.
P. O. Box 382 Mile 61.5 Parks Highway
Houston, Alaska 99694
(907) 892-8804

I have a small private rural family nurse practitioner practice serving the middle to upper Susitna Valley residents of Houston, Willow, and Kashwitna. I also serve the Sunshine Community Health Center at Mile 97.0 Parks Highway one day a week. I am not currently eligible for Medicaid reimbursement under the present rules.

The present Medicaid reimbursement system discriminates against rural Alaskan families because it limits access to local health care when the village or rural area can't afford a physician, but could afford a nurse practitioner. Most of my rural Medicaid families have older cars and have trouble finding money for gas. When they are sick the system makes them travel from 60 to 200 miles or more round trip to find a health care provider who is both eligible and willing to see Medicaid patients. Winter weather also limits travel especially in their old trucks with bald tires. Medicaid rules do not permit recipients to own a new car or truck.
My Medicaid "Moms" have to get all the kids dressed and into the truck to drive all the way into town. They know they are going to have to sit in a physician's waiting room one to two hours waiting to be "fitted in." Mom has to keep the kids quiet all that time. My moms tell me its a lot easier just to go a little further and have their kid seen in an emergency room.

Medicaid recipients are barred from using local available services by a rural nurse practitioner although these services are approved by both state and federal laws. This costs everybody more money. The patient has to pay for travel costs. The state has to pay for inappropriate use of an emergency room at higher cost. In addition, these patients do not return for follow up care because of the added expense to the family.

I receive from 5 to 10 phone calls a week from people served by Medicaid requesting my services. If they are very ill or don't have money for gas I serve them and eat the costs. My practice just isn't big enough to do that for very many. I do follow up phone calls on most of the people I serve including the Medicaid recipients—I can't serve—to find out how they solved their problem.
Of 47 Medicaid calls from September to December 31, 1991 whom I referred to other health care providers eligible for Medicaid reimbursement: 10 did nothing and were waiting for the problem to go away citing gas money or car problems for a long trip as a major barrier. 15 visited a walk in medical clinic and 22 went

to the hospital emergency room. The fee to walk into an emergency room is from 200 to 400% of the total charge in my practice for the visit, some simple tests, and some generic medication. All of the patients who used the emergency room could have been treated through local primary care. In other words 37 people (79%) received services at much higher cost to Medicaid and higher cost to the patient: the patient had to find travel money, and follow up care cost Medicaid and the patient even more money than necessary. None of these patients were given sufficient self care instruction to prevent re-occurrence or complications. It falls to me to do that over the telephone.

Specific example: Last week a mother nursed her old truck 50 miles from Trapper Creek to my office with an 11 month old baby with a fever of 102. The child was suffering from bronchitis. There is a physician's office in Talkeetna but the physician was working the ER in Palmer and unavailable.

If I had refused treatment she would have had to drive another 28 miles to the ER or 156 miles round trip in a gas guzzling old truck. She probably will be unable to pay for these services but my husband and I just can't turn people like her away.

I am told that the fear that enactment of SB211 will increase Medicaid costs has been the major reason it is taking the legislature so long to act on this bill. That just doesn't make sense for my rural families. Care within the rural community costs much less than an emergency room visit and usually less than visits to private physicians.

I urge your passage of SB211.

Sincerely,

Dixie L. Light

Dixie L. Light PhD, ANP/FNP, MScN.

FISCAL NOTE

STATE OF ALASKA
1992 LEGISLATIVE SESSION

BILL NO. SB 211

Revision Date:
Title: An Act Providing for Coverage of Advanced Nurse Practitioners
Sponsor: Senator Collins
Requestor:

Department Affected: Health & Social Services
BRU: Medicaid
Component: Non-Facility

COMPONENT SERIAL NO. 0 2 3 0

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 93	FY 94	FY 95	FY 96	FY 97	FY 98
PERSONAL SERVICES	0	0	0	0	0	0
TRAVEL	0	0	0	0	0	0
CONTRACTUAL	17.4	14.1	16.7	19.9	23.5	28.0
SUPPLIES	0	0	0	0	0	0
EQUIPMENT	0	0	0	0	0	0
LAND & STRUCTURES	0	0	0	0	0	0
GRANTS, CLAIMS	40.4	99.7	123.0	151.8	187.3	231.1
MISCELLANEOUS	0	0	0	0	0	0
TOTAL OPERATING	57.8	113.8	139.7	171.7	210.8	259.1
CAPITAL	0	0	0	0	0	0
REVENUE FUND SOURCE:	0	0	0	0	0	0

FUNDING (Thousands of Dollars)

	FY 93	FY 94	FY 95	FY 96	FY 97	FY 98
GENERAL FUNDS	27.7	54.0	66.5	81.9	100.6	123.9
FEDERAL FUNDS	30.1	59.8	73.2	89.8	110.2	135.2
OTHER FUND SOURCE:	0	0	0	0	0	0
TOTAL	57.8	113.8	139.7	171.7	210.8	259.1

POSITIONS:

	FY 93	FY 94	FY 95	FY 96	FY 97	FY 98
FULL-TIME	0	0	0	0	0	0
PART-TIME	0	0	0	0	0	0
TEMPORARY:	0	0	0	0	0	0

Estimate of current year impact:

ANALYSIS: (Attach a separate page if necessary.)

See attached analysis

Prepared By: Kim Busch
Phone: 465-3355
Division: Division of Medical Assistance
Date: 1-15-92

Approved by Commissioner: [signature]
Agency: Health and Social Services
Date: 1/15/92

FN 57.8 DHSS

Distribution (by Preparer: Leg. Fin., Legislative Sponsor, Requestor, OMB/DBR, Gov. Legis. Ofc., & Impacted Agencies)

Revised 1/15/92

Fiscal Note Analysis

SB 211

(1) We assume: full-time ANP works 40 hrs/week, 48 weeks/year, charges $90/hour, and is likely to have a patient mix that is approximately 30% Medicaid-eligible. Medicaid pays ANPs 80% of the charges normally billed to the general public. Therefore, a full-time ANP is likely to bill Medicaid for $41,472 per year (1920 hours x $90/hr = $172,800 x 30% x .80 = $41,472)

(2) Part-time ANPs work, on average, 30% of full-time ANPs. $41,472 x 30% = $12,442 per year

(3) 6 full-time and 6 part-time ANPs will enroll in Medicaid.

6 x $41,472 =	$248,832
6 x 12,442 =	74,652
	$323,484

(4) Of this theoretical maximum billing, we assume 75% will be for services which Medicaid recipients would have received from an array of other types of enrolled providers. Many of those providers would have billed Medicaid more for their services, so it is reasonable to posit some program savings will occur. However, we have no way to estimate how many recipients will leave each existing provider type (and payment level), so we cannot estimate the savings involved.

(5) The remaining 25% will be new services, of two types: services which eligible persons now receive from ANPs (and for which ANPs probably receive little or no compensation) and services which eligibles now either defer or do without. From the latter category, the increased access to services patients would experience by adding ANPs as providers may result in services which are more timely or even preventive, thus producing a savings of later, more expensive Medicaid costs. However, again, those savings cannot be quantified.

FY 93

(a) A start date of January 1, 1993 is assumed, since time would be required to modify the Medicaid payment system and recruit, enroll, and train new providers. Benefits costs for FY 93 would therefore be 40.4 (323.5 x .25 x .5)

Benefits are 50% federal (20.2), 50% state funds.

(b) A one-time FY 93 cost is involved in modifying the payment system to accept this provider type. (A major portion of the cost of these changes are already budgeted for adding some ANPs under the OBRA '89 federal mandate.) Only 6 system edits will be required, at a cost of $1080 per edit = $6.5. (3.3 fed, 3.2 state)

(c) The systems contractor will travel to on-site-train new providers and provide them with service-specific manuals and materials, at a one time FY 93 cost of 5.0 (2.5 fed, 2.5 state.)

(d) These providers are expected to generate 950 claims in FY 93, (half-year) at a contracted processing cost of $6.23 per claim. 950 x $6.23 = 5.9. This cost is 70% federal (4.1), 30% state (1.8).

FY 94 and following

(a) FY 93 service costs are doubled for a full year of service, and this adjusted FY 93 cost is increased by 23.4% (4.6% for price increases, 7.0% for increases in the number of eligible recipients, and 11.8% for utilization increases).

(b) Claims processing contractual costs are adjusted for a full FY 93 year (1900 claims), then increased by 18.8% (7.0% for eligibles, 11.8% for utilization increases). The contract price per claim remains at $6.23.